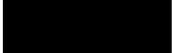




21st December 2020

Corporate Services
Trust Headquarters
225 Old Street
Ashton Under Lyne
Lancashire
OL6 7SF

Private & Confidential

Telephone: 

Ms C McKenna
HM Area Coroner
HM Coroner's Court
Floors 2 & 3, Newgate House,
Newgate
Rochdale
OL16 1AT

Dear Ms McKenna

I write in response to your Regulation 28 report dated 23rd October 2020 and in respect of the concern you have highlighted after hearing evidence of the inquest of Mr Sean Owen.

Your concern has been reviewed and Pennine Care's response is outlined below.

Coroners Concern

I heard evidence that there is currently no system in place at Pennine Care NHS Foundation Trust for quality assurance of the Discharge Summary Letters which are sent to General Practitioners when a patient is discharged from Inpatient care. The evidence heard at the inquest and recorded in the clinical records was that Mr Owen's admission to Hollingworth ward on 6th December 2018 had been precipitated by an overdose; that there were two further incidents of overdose during the admission; that he was changeable in relation to risk, sometimes stating that he wanted to end his own life and at other times denying it and that he presented a significant risk to himself and others if he became non-compliant with medication.

The discharge letter that was sent to Mr Owen's GP on 6th February 2019 was prepared by a doctor who had little involvement in his care and was not counter checked by a senior clinician. It omitted references to the overdoses and was erroneous in stating that there had been 'no issues or incidents' during the admission; that the Deceased 'never showed any DSH behaviour as an inpatient' and that 'we did not see and SH behaviour or expressed thought from Sean during his admission.' The letter made no reference to the significant risk associated with non-compliance.

