Greater Manchester
Mental Health
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL

Mr Nicholas Rheinberg
Assistant Coroner for Lancashire and
Blackburn with Darwen
HM Coroner's Court and Office
Coroner's Court
2 Faraday Court
Faraday Drive
Preston
Lancashire
PR2 9NB

Trust Management Offices
First Floor, The Curve
Bury New Road
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Manchester
M25 3BL

[redacted]

WE ARE SOCIAL

3rd November 2022

Dear Mr Rheinberg

Re: Daniel Nelson (deceased) Regulation 28 Preventing Future Deaths Response

On behalf of Greater Manchester Mental Health NHS Trust (GMMH) I would like to offer Mr Nelson's family our sincere condolences at this difficult time.

Mr Rheinberg, thank you for highlighting your concerns during Ms Nelson's Inquest which concluded on 12th September 2022.

On behalf of the Trust can I apologise that you have had to bring these matters of concern to the Trust's attention.

Please see the Trust's response in relation to the concerns you have raised, and the actions taken by the Trust:

Within the Trust there was no protocol, policy or adequate standard operating procedures governing section 117 discharges.

The Trust has a Section 117 Project Group that has developed a Section 117 Aftercare Policy that addresses responsibilities of services to someone who is subject to Section 117 of the Mental Health Act 1983 (MHA).
The policy has been widely consulted upon and is due to be ratified at the Trust Mental Health Act and Mental Capacity Act Compliance Committee on 24th November 2022.
Following ratification the policy will be shared with staff through the Social Care Leads in each division of the Trust.
The policy will be uploaded to the Trust intranet and will be shared with staff through the Trust's weekly communication briefing and the Trust Patient Safety Newsletter.

In addition to the policy the Trust Section 117 Project Group has reviewed and updated the existing training in respect of Section 117 and staff responsibilities that will be delivered to staff on a quarterly basis. This group has developed training aimed at members of multi-disciplinary teams working in the Trust inpatient wards that is being delivered across all sites.

The Trust's clinical record, Paris, has been updated and now automatically displays a 'flag' to identify aftercare eligibility for those patients who have a history of detentions within GMMH. The flag will remain live on the person's clinical record until Section 117 duties are ended via a formal review and Section 117 discharge process.

Across GMMH learning from incidents to reduce the risk of reoccurrence is key. Learning events are either held locally within the team or division that the incident occurred and /or the Trust hold larger Trust wide learning events where the details and learning from either one incident or a group of similar themes identified are shared with staff across the Trust. These events are held monthly. On 16th December 2022 the learning event being delivered is *Safe Discharge and 117 Responsibilities – a Salford case study* where the learning from events surrounding Mr Nelson's discharge and subsequent death will be shared along with resulting Trust developments. Following the event the learning is summarising in a briefing that is shared with staff and uploaded to the Trust's Patient Safety intranet page.

Mr Rheinberg, on behalf of the Trust can I thank you for bringing these matters of concern to the Trust's attention. I hope this response demonstrates to you and Mr Nelson's family that GMMH have taken the concerns you have raised seriously. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,

[redacted]

[redacted]
Medical Director
GMC 3548585