Pennine Care
NHS Foundation Trust

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

[redacted]

30th December 2021

Private & Confidential

Mrs 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 19th November 2021 and in respect of the concerns you have highlighted after hearing evidence of the Inquest of Ms Sarah McGarrigle.

Your concerns have been reviewed and Pennine Care's response is outlined below.

Matter of concern - point 1:

That the Clinicians on Aspen Ward did not consider relevant information provided to the ward by the allocated Social Worker and the AHMP in the assessment of the deceased mental disorder. There was an over-reliance on Sarah's presentation on the ward and insufficient consideration given to the concerns that had been raised by community agencies, her psychiatric history, and behaviours in the community setting.

Response - Point 1

During Sarah's admission to Aspen Ward, there was not enough consideration of Sarah's historical mental health diagnoses, contextual clinical information from previous inpatient admissions and community care and her overall complexity. There is evidence of the MDT completing an assessment of Sarah's mental health and associated risks over the course of her admission to Aspen Ward. The assessment did not identify any signs or symptoms of acute mental illness. The MDT assessed her main risks to be alcohol dependence and the physical health problems associated with this. The findings of the MDT's assessment were consistent with many of the previous assessments of Sarah's physical and mental health.
It is clear from Sarah's records that she had gone through detoxification while in the Royal Oldham Hospital medical wards and was not experiencing any significant

physical symptoms of withdrawal. On admission to Aspen Ward, she was not experiencing any alcohol-related behavioural issues. It is widely accepted that alcohol use can cause or increase symptoms of behavioural and/or mental illness. For some patients, when they stop alcohol, their symptoms can significantly improve or stop all together. Sarah's overall presentation from the time she was assessed and detained under the MHA in the Royal Oldham Acute Hospital, compared to while an inpatient on Aspen was significantly better. Sarah appeared to improve in the time between being detained under Section 2 and being transferred to Aspen Ward (which was a period of several days). Sarah had been safely using leave off the medical wards for a cigarette break. While on Aspen Ward, she also used leave off the ward for cigarettes. At no time were there any significant concerns regarding her mental state or immediate risk. There was no evidence Sarah had drunk any alcohol during this period either.

Sarah's mental capacity to make decisions regarding alcohol and the associated risks and medical treatment had been assessed previously by the medical staff involved in treating Sarah's physical health. The Aspen Ward MDT's assessment of Sarah concluded that in the absence of an acute mental disorder, an inpatient mental health ward was not the most appropriate environment for her to receive ongoing support for her alcohol dependence. However, Sarah's discharge could have been carried out in a slower and more measured way. This process should have included all relevant professionals from partner agencies and Sarah's family. [redacted] provided a forum for a more coordinated multi-agency approach to [redacted]'s future care and support needs.

[redacted] of similar incidents occurring in the future, the PCFT Oldham Triumvirate Leadership Team have held several meetings to renew the discharge process on its inpatient adult acute mental health wards. A number of [redacted] of discharges have been taken, which include:

A new inpatient and community interface meeting which is designed to improve information sharing and communication during the discharge planning process.
A new process for arranging and facilitating discharge planning and ward round meetings.

- Communication from the Oldham Triumvirate Leadership Team to inpatient MDTs to reiterate the requirements of safe discharges.
- A task and finish group is planned for January 2022 to review the actions so far and plan for ongoing improvements. This will include senior Consultant Psychiatrists and managers.
- The concerns identified during the inquest have been reviewed by Professor Nihal Fernando, PCFT's Executive Medical Director. Professor Fernando will share a copy of PCFT's Regulation 28 response with the Aspen ward consultant Psychiatrists Responsible Officer, in his new Trust.
- PCFT have also been engaged in the Oldham Safeguarding Adult Review process led by the Safeguarding Adults Partnership Board. PCFT have submitted chronologies, reports and the learning identified after the initial review of this incident. PCFT will continue to engage with the SAR process as required.

Matter of concern - Point 2:

That the Consultant Psychiatrists who reviewed the deceased on Aspen Ward made the assumption that concern about the deceased's capacity were raised in the context of her withdrawal from alcohol. Consideration of the information that had been communicated to Aspen ward (which included the specific limb of the capacity test that was in doubt) and a more longitudinal approach to the assessment would have shown that the concern related to the far more complex picture that the deceased presented in the community and management of the risks associated with self-neglect. This was not addressed by those responsible for assessing the deceased on Aspen ward.

Response - Point 2

There is evidence that the Aspen Ward MDT considered Sarah's mental capacity to make decisions about drinking alcohol, the risks associated with, however the Aspen Ward MDT did not complete and document a formal mental capacity assessment. This area of practice that required improvement had been identified in a PCFT investigation completed after Sarah's death (but before Sarah's inquest). Several actions have been taken since the time of Sarah's admission to Aspen Ward which improve how inpatient wards consider and apply the mental capacity act in practice:

- [redacted] commissioned Mental Capacity Act training for all clinicians. [redacted] rding team have delivered lunch and learn sessions on mental capacity in Oldham.
- Oldham's mental health services now have a route to refer patients to the Oldham multi-agency *Adults with Multiple Complex Needs Meeting*. This [redacted] to support professionals to work with complex patients who present with high levels of risk but are assessed as having the mental capacity to make unwise decisions or do not engage with their care and treatment.
- The PCFT safeguarding team are designing a Mental Capacity Act audit.
- PCFT's Named Professional for Safeguarding Adults is now a high-profile source of support and guidance that clinicians can contact. The Named Professional is also an active member in the Oldham multi-agency safeguarding forums.
- PCFT has successfully implemented PARIS in all its inpatient mental health wards. This electronic patient record system includes a mental capacity assessment template that clinicians can use to document their assessments.
- The learning from Sarah s Inquest regarding a potential missed opportunity for clinicians to consider a more longitudinal approach to assessing mental capacity assessments has been shared with senior Consultant Psychiatrists in Oldham. There was some agreement that additional education in this area could be beneficial. This will be escalated to the PCFT Safeguarding Team and the Mental Health Law and Scrutiny Group.

- The Oldham Adults Safeguarding Board Self-Neglect toolkit has been distributed, and some learning sessions have been facilitated in Oldham.
- PCFT's Head of Safeguarding and the Named Professional for Safeguarding Adults will make a recommendation to the Oldham Safeguarding Adult Partnership Board that a multi-agency protocol be developed. The recommended protocol would outline the roles and responsibilities of each agency when assessing mental capacity for complex patients with a mixture of health and social care needs. The guidance would also outline how multi-agency partners can request specialist mental health input for a mental capacity assessment.

PCFT's Internal Investigation Report
The target date for completion of PCFT's internal investigation is 21/01/22 and will be submitted to you in due course.

I trust this response assures you that the Trust has taken your concerns seriously and has thoroughly reviewed the issues raised.

Yours sincerely

[redacted]
[redacted]
Executive Medical Director

[redacted]