Greater Manchester
Mental Health
NHS Foundation Trust

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PRIVATE AND CONFIDENTIAL
Ms Catherine McKenna
HM Area Coroner
Manchester North Coroner's Office
Floors 2 and 3 Newgate House
Rochdale
OL16 1AT

4th April 2023

Dear Ms McKenna

Re: Ania Sohail (deceased) Regulation 28 Preventing Future Deaths Response

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

Ms McKenna, thank you for highlighting your concerns during Ania's Inquest which concluded on 30 January 2023. 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:

(1) The Recovery and Discharge plans contained inaccurate information regarding Ania's consent to share information with her mother. The evidence was that this was an entry made in error in June 2020 and was not picked up by any of the Nurses who updated the Recovery and Discharge Plan over the subsequent eleven months.

The Recovery and Discharge Plan that was in place prior to the incident Ania's death is no longer used by GMMH and has been replaced by the care plan document that is used in all other inpatient areas of the Trust. This document is called the ATAC (Acute Triage and Assessment Care Plan). A local audit of care plans will be undertaken by the ward manager by the end of May to ensure learning is embedded and consent is evidenced in the care plans.

The Service has developed training that has been delivered through 'Lunch and Learn' events in respect of capacity, consent and the Trust's ATAC document.

There has been a Trust wide learning event how to assess and record decisions around testing a patient's capacity and formally record the decision made. This was recorded and is available to all Trust employees.

(2) The Recovery and Discharge Plans did not address the risks associated with Ania's procurement of Propranolol from online Pharmacies. The evidence was that an update of the Recovery and Action Plan involved members of Nursing staff simply adding a note that the overdoses had taken place. The plan did not show that any meaningful thought had been given to addressing the particular risk associated with the procurement of online medication.

During the Trust review, following Ania's death, it was unclear whether all staff were aware that Ania was buying medications from online Pharmacies or that this was an easily accessible way to obtain medication. In response, GMMH have created a Safety Briefing regarding the use of online pharmacies and Propranolol, aimed at communicating to staff the risks associated with the procurement of medication via online Pharmacies and the General Medical Councils 'ten principles' around online purchasing. This briefing, and the circumstances leading to its development featured in the Trust patient safety Newsletter in February 2023. This Newsletter is developed monthly and is shared with all staff across the Trust. A copy of the Safety Briefing is attached to this response.

(3) Mandatory refresher training on basic aspects of Nursing care, such as good record-keeping, searches, care-planning, undertaking pre and post-leave assessments and confidentiality is not provided to staff.

The Trust has developed an inpatient 'Care Bundle – Leave from inpatient units'. The care bundle provides guidance to staff when supporting service users who are inpatients to access leave into the community and return to the ward safely. The care bundle prompts staff to complete pre and post-leave assessments and where to document these. This care bundle has been shared with all inpatient staff through established communication systems and was featured in the Patient safety Newsletter in January 2023.

An audit of pre and post leave assessments and related documentation will be carried out by the ward manager by the end of May 2023.

The Care Bundle is attached to this response.

In respect of searches, a Trust Risk & Safety Advisor has facilitated training sessions regarding how to conduct both room and personal searches effectively. All ward staff have completed this training and the ward manager keeps a record of staff compliance.

Confidentiality and when to breach this is included in the Trust Clinical Risk Assessment policy and the training. This was also included in the learning event held in respect of Capacity and Consent, that is available to all staff via the Trust Intranet. All staff on Griffin ward will have access to this training event by the end of April 2023.

(4) There is no requirement for the outcome of negative personal searches to be documented in the records and consequently there is no ability to effectively audit whether searches are taking place and the treating team are unable to assess a patient's level of compliance with rules around bringing contraband items onto the ward.

As part of the Inpatient Leave Care Bundle, outlined in point 3, pre and post leave assessments should be recorded in the clinical record, including any reason to search a person following leave. The Trust Search Policy includes clear guidance on what should be recorded when a search is undertaken and whether anything was found or not.

(5) Searches undertaken of Ania's room following the overdoses on 10 March and 5 June 2021 were ineffective and did not uncover the Propranolol that Ania had been stockpiling.

GMMH Trust did carry out room searches on the above dates and did not find any medication. Staff did not conduct intimate searches of her person as there was no indication that this was required at the time. As outlined in point 3 the staff on the ward have received training on how to search a person's room and carry out a personal search.

The Trust policy HS13 Search of service users, visitors and belonging policy was reviewed and updated to include the learning from Ania's death. This included a review of contraband items and reinforcement of search procedures.

(6) Documentation on which 1 :5 observations are recorded does not evidence that a check has taken place every 5 minutes. Instead, the current documentation, simply requires one signature per hour. There is therefore no mechanism by which observations can be effectively audited.

The current Trust observation policy does have a 1:5 minute recording sheet that requires a signature every 5 minutes. This has now been adopted by the service and its completion is audited by the ward manager as a minimum weekly.

The Trust is currently undertaking a review of our Observation policy and practices through a task and finish working group which to date has reviewed best practice standards and guidance on the management and practice of therapeutic observations & engagement including the review of any digital innovations to support practice.

Senior members of this group have attended workshops facilitated by the CQC who acknowledge that carrying out and recording observations is a National issue. A training needs analysis of the requirements for staff training and education is being undertaken and a training package and competency assessment framework is being developed.

(7) There is no requirement to make a separate entry evidencing that a post-leave assessment has been undertaking. The post-leave assessments are currently subsumed within Day Notes and do not clearly state whether an assessment was undertaken, what was discussed and the outcome of the assessment.

As outlined in point 3 pre and post leave assessments should be undertaken and recorded in the patient's clinical record. The care bundle that has been developed sets out clear expectations of what assessments staff should be doing and what they should be recording.

In addition to the audit being caried out in this service, an audit tool will be developed by the Head of Nursing on the back of this to be rolled out across the Trust.

Ms McKenna, on behalf of the Trust can I thank you again for bringing these matters of concern to the Trust's attention. I hope this response demonstrates to you and Ania'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,

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[redacted]
Chief Clinical Information Officer
Associate Medical Director
Consultant Psychiatrist on behalf of

[redacted]
Medical Director