Pennine Care
NHS Foundation Trust

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

[redacted]

10th July 2023

**Private & Confidential**
Mr Christopher Morris
HM Area Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Morris

I write in response to your Regulation 28 report dated 15th May 2023 and in respect of the concerns you have highlighted after hearing evidence at the Inquest of Drew Howe

Your Matters of Concern below have been reviewed and Pennine Care's response is outlined below.

The MATTERS OF CONCERN are as follows. –

*The Trust's own investigation into events leading to Mr Howe's death did not consider the full extent of his contacts with mental health services, lacked any meaningful degree of critical analysis of events, and omitted to seek to explore fundamental issues such as access to services from the patient's perspective. As a consequence, it is a matter of concern that the Trust has not taken the opportunity to derive all available learning from Mr Howe's death.*

**Investigation Report**
The template used to complete the investigation was a '***Rapid Initial Review'*** template, these were introduced within the trust in March 2022 and signified a change in the way serious incidents were initially reviewed. These were introduced in order to support a factual account of the incident and identify any immediate patient safety concerns and actions taken and to identify any areas of learning where immediate actions need to be taken to manage a risk or strengthen an existing process or system.

Rapid initial reviews can indicate if further investigation is required. In this case the incident of Mr Howe's death was recorded on 03/11/22 and the Rapid Initial Review was allocated to be completed on 04/11/23. A Coroner memo was received by the service on 01/12/22 with the inquest date set for 03/02/23.

There are a number of factors contributing to the delay of the Rapid Initial Review being completed:

- Most significantly, the authors ability to engage with the NoK (sister) to complete the Duty of Candour (DoC) process, the author subsequently managed to engage the NoK following a few planned face to face meetings being cancelled by the NoK to discuss the report and consider any questions that she had, and DoC was eventually completed. The author recognised the family's distress and need to cope with their own feelings and was sensitively trying to support this whilst ensuring that the DoC process was completed
- Time pressure due to the Christmas period impacting on authors time to complete the report in additional to clinical role and responsibilities, NoK being able to be contacted and consideration of further emotional distress during this period of time as well a delay in governance processes due to bank holidays impacting on ability to review the report.
- Information required from multiple sources – Access team, Healthy Minds, consultant psychiatrist, TILS (Transition intervention and Liaison service) and there were also attempts to obtain further information from an external trust due to Mr Howe presenting at an Emergency department in Grimsby prior to coming in contact with PCFT services.
- The final version of the Rapid Initial review was submitted to the Quality and Safety panel on 30/01/23 prior to the inquest on 03/03/23.
- We also recognise that the author was new to role (acting up into the team manager post) with limited experience around patient safety processes, whilst also trying to support team who were deeply upset by the passing of Mr Howe. The author was completing more than one Rapid Initial Review at the time, and [redacted]hat the service manager was unwell and absent from [redacted]rovide additional support around these processes.

[redacted]f this case the following has been identified to provide a clear structure to support services whilst completing Rapid Initial Reviews:

[redacted]

**Process support:**

- Trust wide review of the learning in this case from a process perspective. The Rapid Initial Review template has been reviewed to include a brief explanation of the purpose of the review – detailed on the front page of the report.
- A brief support guide for completing a Rapid Initial Review to be completed to support authors – this is being led by the Head of Patient Safety for the trust.
- A Trust wide review of the 72-hour review (Rapid Initial Review) process to ensure that it is being followed as originally intended with early identification of further action and investigation required. Appendix1.
- The trust is also reviewing the training offer for authors completing investigations with a view to developing this to support staff.

**Support for Authors:**

- In addition to the above, the Quality team will give further consideration to the person identified to complete the Rapid Initial Review and any extenuating circumstances. This will allow for consideration of additional support required from the outset and plan for any change to level of support required. This may also take into consideration if the Rapid Initial review would be best placed to be completed by another identified professional.
- Supportive check-ins with authors of Investigations are offered by the Quality team, these will continue with an emphasis on time frame as detailed in the 72-hour process.

**Understanding patient journey – Deriving all available learning for Mr Howe's death**

A professionals meeting has been held to review the Rapid Initial Review and to consider our understanding of Mr Howe's patient journey within PCFT services. With the benefit of the appropriate personnel convened to provide critical appraisal we have been able to establish some further learning, however we feel Mr Howe's case would benefit from further formal investigation and therefore an objective Serious Incident Investigation has been commissioned. This will allow for full exploration including contributory systems and processes that were not considered as part of the Rapid Initial Review, in order for us to derive all available learning for Mr Howe's death.

**The investigation will further explore:**

- Information sharing between PCFT services (Access team, Healthy Minds, TILS service).
- Clinical decision making.
- [redacted] by suicide.
- [redacted] g reflecting hopelessness, his experience of services [redacted] consideration of a Trauma informed formulation.
- Current staff training compliance in relation to risk assessment.
- A wider understanding of system impact including service Standard Operating Procedures, Time scales for referrals, and what else is impacting on service provision and potential onwards referrals.
- What else could have happened to support Mr Howe.

**Actional actions following the professional's meeting:**

- Pursue Raising Awareness sessions as offered by the TILS service.
- Ensure trust wide learning including exploring themes around death by suicide of Military veterans in mental health services given concerns relating to the perspective of the client in navigating mental health services.
- Case reflection with teams involved with a focus on recognising risk and the impact of trauma on risk formulation.

- Understanding trauma – exploring training the training offer for staff. This includes the current training being developed within the Trust around understanding Trauma, as well as seeking support from the GM Resilience Hub or Military Veteran Service (MVS).
- Teams to ensure that information, including assessment information is shared between services when referrals are made – to be discussed at team meetings, supervision, operational meetings. Trust to also explore if a digital prompt can be added to our Electronic Patient records to further support the inclusion of information when a referral is made.

**Additional point:**

A point regarding the Military Veteran service (MVS). Mr Howe was referred to the TILS service (Transition intervention and Liaison service) Now call Ops Courage; it was thought at the time that this was part of the Military Veterans Service however these services are different. PCFT has two military services: Ops Courage (then TILS) and Military Veterans Service.

Mr Howe unfortunately passed away on 19/10/22, which was prior to a discussion with the TILS service (21/10//22) and receiving the formal referral (27/10/22) from the Access team, therefore Mr Howe was not open to the MVS at the time of his death.

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

Yours sincerely

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**Acting Executive Director of Quality, Nursing & Allied Healthcare Professionals**
**Director of Infection Prevention and Control**

Enc. Appendix1