Greater Manchester
Mental Health
NHS Foundation Trust

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

[redacted]
WE ARE SOCIAL

21st December 2022

PRIVATE AND CONFIDENTIAL
Ms Joanne Kearsley
HM Senior Coroner
Manchester North Coroner's Office
Floors 2 and 3 Newgate House
Rochdale
OL16 1AT

Dear Ms Kearsley

Re: Rowan Thompson (deceased) Regulation 28 Preventing Future Deaths Response

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

Ms Kearsley, thank you for highlighting your concerns during Rowan's Inquest which concluded on 31st October 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:

1. **System by which observations and documentation are audited lacks rigour and is ineffective.**

And

2. **At the time of the CCTV review and investigation following Rowan's death there was a missed opportunity for management to understand the gravity and nature of the situation. There was no higher level, so example:**

    A) Whether the staff who failed to complete observations/falsify records did so when working a particular shift ie night shift
    B) Whether the staff who failed to complete observations/falsify records did so when working weekends rather than during the week
    C) Whether there was any correlation between missed observations / falsifying of records and shifts when there was no deputy or ward manager on duty.

During the inquest the Associate Director of Quality gave evidence in relation to the daily audits of observation records in our Child and Adolescent Mental Health Services (CAMHS). Concerns were raised that these audits lacked vigour and were ineffective due to the themes and times, days not being considered in the longer term, rather they are completed daily.

The managers of the service, supported by the Patient Safety Team will carry out a thematic review of audits to identify any specific themes and resulting actions, this will be completed by 31st January 2023.

The Trust acknowledge that the review carried out at this time did not provide a comprehensive overview of observations that considered the practice of staff undertaking these outside the timeframe reviewed. This was an HR investigation that appropriately met the terms of reference set out for this review. The thematic review will address this.

The Trust is reviewing the use of therapeutic observations and engagement across the whole Trust, being led by the Head of Nursing Practice. The purpose of the review is to identify best practice standards and guidance on the management and practice of therapeutic observations & engagement, legal framework and requirements for staff training and competency assessment.

The task and finish group has been established, membership agreed, and terms of reference developed.

A workshop was held with staff and patients on December 16th 2022 where priorities have been agreed for the review of observations including:

- Review of Trust policy and practice by January 2023
- Review of staff training needs and development programme to support by February 2023
- Identify a Division to carry out a test of change that will test out the priorities before being implemented across the Trust

3. **Given the specialist nature of the Gardner, the fact that this is a high risk environment and somewhere where the situation can change in an instant given the nature of the patients the experience of the staff in charge on the 3rd October 2020 was a concern. There was no rationale other than the commissioning why a deputy or ward manager was not working at a weekend (when there are less activities to occupy the patients). The evidence heard suggested to the court that a more experienced nurse was always required on this unit.**

Staffing requirements for the Gardener Unit are determined both by the number of ward based nursing staff required to undertake planned tasks and duties during each shift (clinical care, administration of medication, liaison with other professionals and security/environmental requirements for example) and by the individual clinical and risk needs of the young people resident on the ward at that time. Staffing numbers and skill mix are therefore dynamic and can fluctuate on a shift-by-shift basis requiring close oversight of staffing to ensure that the needs of the young people are met safely, and that staff are supported to provide effective care.

Staffing at the Gardener Unit – as is the case for all other wards within CAMHS – is continually monitored by local managers with review and approval processes in place at the time each staff rota is produced and proactively, and on a rolling basis, to ensure that each individual shift is fully staffed and takes into account any changes that may have occurred at ward level since the staff rotas were first prepared e.g. a change in observations. Briefing meetings occur in advance of every weekend to review staffing requirements for the full weekend and provide the opportunity for local managers to make any required changes. This meeting had taken place in advance of the weekend of the 3rd and 4th of October 2020 and no concerns about the experience and skill mix of the staff had been identified; had there been such concerns, corrective action would have been taken by local managers and the issue escalated to more senior CAMHS managers.

It is sometimes the case that the clinical needs of a ward can quickly change e.g. following an incident or an increase in a young persons risk and out of hours there are clear systems in place to enable ward based staff to request additional staffing to meet increased need; the Nurse in Charge of a shift is able to utilise the Duty Manager to request additional short term support e.g. immediately after an incident or to request an increase in staffing across a number of shifts for an identified reason. In turn, the Duty Manager has access to on-call systems to escalate and discuss any staffing concerns although it is important to note that the Duty Manager is supported to make local decisions about staffing and additional permissions to increase numbers are not required from the on-call structure.

The Gardener Unit has one Ward Manager and three Deputy Ward Managers in its establishment; while Ward Managers do not typically work weekends, Deputy Ward Managers do work shifts across the full week (including nights) but it is not possible to have a Deputy Ward Manager working every shift at the Gardener Unit (and other wards). Weekends are often viewed by the young people as an opportunity for more relaxed and individual time (different to attending planned College lessons or sessions with an MDT member during the week for example) but other activities and sessions do still take place supported by the nursing team and these also include leave, planned visits and social type activities on the ward.

Ms Kearsley, 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 Rowan'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

Medical Director