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10 March 2023

Dear Ms Kearsley

Re: Regulation 28 Report to Prevent Future Deaths – Rowan Louis Thompson who died on 03 October 2020

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18 November 2022 concerning the death of Rowan Louis Thompson on 03 October 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Rowan's family and loved ones. NHS England are keen to assure Rowan's family and the coroner that the concerns raised about Rowan's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise to the family for the delay, as I appreciate this will have been an incredibly difficult time for them.

Your Report concludes that Rowan's death at the Gardner Unit at Prestwich Hospital was contributed to by neglect; in that there was a failure to communicate the finding of blood tests analysed at Salford Hospital on 2nd October which showed a life-threatening severe hypokalaemia. In your Report you listed three main concerns:

1. **the system by which observations and documentation were audited within the Gardner Unit;**

2. **missed opportunities during their initial investigation into failures to complete observations as well as allegations staff were falsifying records; and**

3. **the lack of a deputy or ward manager working at the weekend.**

We understand you have also addressed this Report to Greater Manchester Mental Health NHS Foundation Trust. They will address specifics as to the changes being implemented on the ground.

We would also like to share with you the wider strategic interventions that NHS England has commenced. Greater Manchester Mental Health NHS Foundation Trust is already receiving support to make improvements to the quality of their care as part of the NHS England Recovery Support Programme.

We acknowledge the importance of, and rigour required when undertaking, recording, documenting, and auditing observations and this forms a significant area of work as part of an Improvement Plan that has been put in place by Greater Manchester Mental Health NHS Foundation Trust and which will be monitored by the System Improvement Board. As part of this improvement work, the Trust has appointed an Improvement Director to support this work as well as an Interim Chair of the Trust.

The Improvement Plan includes a workforce establishment review for nursing, based on the national Mental Health Optimal Staffing Tool (MHOST). The tool embraces all the principles that should be considered when evaluating/implementing decision support tools described in 'Safe, sustainable and productive staffing: An improvement resource for mental health (Safer_staffing_mental_health.pdf (england.nhs.uk) (NHSI, 2018). This work is supported by a safer staffing lead, baseline assessments of staffing levels have been commenced and it is anticipated the 1st assessment will be completed within six months and the results will form part of the enhanced recruitment plan. The aim of the assessment is to ensure the right staff with the right skills are available at the right place and time, specifically in relation mental health this relates to reviewing the models of care, the resources and clinical risk mitigation to allow the safe and effective patient assessment and treatment. In addition, daily reviewing and reporting of the current staffing levels are occurring.

On a national level, NHSE are prioritising making improvements to mental health services, which are being implemented under the NHS Mental Health Implementation Plan 2019/20 – 2023/24. The plan looks to increase spending and, crucially, staffing levels, to include for secure mental health services, and will help ensure that patients receive high quality, safe and therapeutic care.

In addition, NHS England's (NHSE) have nationally commissioned an Independent Review which is being managed and led by the Northwest Region. An external Independent Chair has been appointed who is currently in the process of developing the Terms of Reference for the review. As part of the review process the Independent Chair will be making contact with Rowan's family, to understand their experiences of the care Rowan received.

The review will cover patient services at the Edenfield centre along with wider service provision across GMMH. The review will particularly consider the patient failings and clinical escalation concerns raised/identified by the Panorama programme and other intelligence such as Care Quality Commission reports, and indeed Regulation 28 reports. It will identify whether these are systemic issues throughout the service or isolated clinical incidents and to make recommendations as to what the Trust must take to improve patient safety in the service. It is important to note, the review will also look at the Trust's other medium and low secure services and will include reviews of ward to board escalation and oversight of patient safety and staff culture. We expect the review to have concluded by the end of September 2023.

It should be noted that the Independent Review will not be an investigation of individualised care received by Rowan, but a broader review of services and culture across the organisation.

NHS England has committed itself to transparency and will publish the findings of the external Independent Review in the public domain on the website of NHS England, in order that any learning identified can be shared as it is generally accepted that there is a public benefit in the learning identified in such reviews.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action. The Working Group will review the findings of the Independent Review in due course.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information. We will of course publish the Independent Review once it has been completed and welcome your and Rowan's family's involvement in its development, to ensure that the Review is as effective in improving mental health care services not only in Manchester, but nationally too.

Yours sincerely,

National Medical Director
NHS England