Pennine Care
NHS Foundation Trust

23 January 2024

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

[redacted]

Private & Confidential
Ms Joanne Kearsley
HM Senior Coroner
HM Coroner's Court
Floors 2 & 3, Newgate House,
Newgate
Rochdale
OL16 1AT

Dear Ms Kearsley

Ref: Inquest touching on the death of Ms Donna Marie Donnellan

I write in response to your Regulation 28 report dated 30 November 2023, and in respect of the concerns you have highlighted after hearing evidence at the Inquest of Ms Donna Marie Donnellan on 25 September 2023.

I was sorry to learn that following witness evidence, you had concerns which had not been addressed. These have been reviewed and I understand that you have also received a response from Northern Care Alliance NHS Foundation Trust as the second party who provided witness evidence at inquest and received your concerns. This response

Matters of concern:

1) **There was a lack of understanding between the Acute Trust clinicians and the Mental Health Trust as to the role of the Mental Health Liaison Team. Clarity is required as to whether the MHLT when asked to review a patient by the acute clinicians are reviewing so as to (i) make a diagnosis of an eating disorder or (ii) assess and assist in the consideration as to whether the Mental Health Act can be used to treat someone if they are refusing treatment.**

Teams at Pennine Care NHS Foundation Trust have worked closely with colleagues at the Northern Care Alliance NHS Foundation Trust to review policies and procedures following the Inquest, to add clarity regarding referral. We have agreed to jointly review the policy owned by Northern Care Alliance NHS Foundation Trust, Management of Medical Emergencies in Adult Patients with Eating Disorders, which provides clear guidance for staff working within the Accident and Emergency

Department where to refer for the assessment and consideration of the Mental Health Act, with instruction to make a referral specifically related to an eating disorder.

As teams work in partnership to meet the needs of patients within the Accident and Emergency Department, the policy will be available to staff from both organisations. The learning from this inquest and the policy detail has been shared with the appropriate teams by managers to support understanding.

2) **There was a lack of understanding as to the pathways available to the acute clinicians for making a referral / seeking advice from the Specialist Eating Disorder Service i.e., the Willows.**

A meeting was held following the conclusion of the inquest, with representation from both organisations to review the Policy mentioned in response to point 1. This is available to all staff which should reduce any lack of understanding of referral processes or pathways, to ensure staff working in the Accident and Emergency Department can refer to this as guidance.

I am sorry that you had cause to raise concerns with us directly at the conclusion of Ms Donnellan's inquest and I trust this response, along with that provided by colleagues at Northern Care Alliance NHS Foundation Trust assures you that we have taken your concerns seriously and have thoroughly reviewed the issues raised.

Yours sincerely

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Executive Director of Quality, Nursing & Healthcare Professionals/Deputy CEO