Department of Health & Social Care

From Baroness Gillian Merron
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

39 Victoria Street
London
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Our Ref: [redacted]

Alison Mutch
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

5th August 2024

By email: [redacted]

Dear Alison,

Thank you for your Regulation 28 report to prevent future deaths dated 29 May 2024 about the death of Elizabeth Sarah Jayne McCann and I'd like to thank you for agreeing an extension. I am replying as the newly-appointed Minister with responsibility for mental health and patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Elizabeth's death and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

Most of the concerns you have raised are matters for the Ministry of Justice, Home Office and Greater Manchester Police and I understand that these organisations will be responding to your report.

You have also raised concerns about health and wellbeing colleges and, in preparing this response, Departmental officials have made enquiries with NHS England and Pennine Care NHS Foundation Trust. I understand that the Trust is also in the process of responding to you directly.

The Health and Wellbeing College in Tameside is based on the 'recovery college' model which takes an educational approach to developing people's strengths to enable them to understand their own challenges, become experts in their own self-care and develop the skills and confidence to manage their own recovery. Courses are co-produced, co-delivered and co-received by people with personal and professional experience of mental health problems.

In this instance, it is clear that information sharing protocols and safeguarding provisions within the College were not effective or well enough understood.

I have been informed that prior to your report being issued, the Trust had already commissioned an external review of the Health and Wellbeing College, which is currently ongoing. The Network Director of Quality, Nursing and Health Professionals for the South Network is working with the team there in relation to risk management systems and processes.

The Trust recognises that, at the time of the incident the College did not have a clear written protocol in place to manage risk. As an educational establishment the College did not have plans or processes in place to communicate effectively with other teams within the Trust such as the clinical teams or externally to organisations such as the Probation Service about the risk of harm occurring to others. The College is bound by Trust policies in relation to safeguarding and the College team did have access to and used Trust internal incident reporting systems.

Since the incident occurred, the College has developed a standard operating procedure outlining steps and processes required by College leads and administrators in relation to information required by the College for every student's successful enrolment to commence. These checks include self-disclosure by prospective students relating to activity and engagement with other agencies in addition to checks against internal clinical systems.

Any student with an open referral to another agency will be requested to give permission to contact and explore issues of risk with that agency as appropriate. For any student with open and ongoing engagement with a clinical team, College leads will have full access to the Trust's patient record systems to enable a review of any risks associated with the student. College leads are required to liaise with the clinical team for a position on whether enrolment is appropriate for the individual.

It is expected that the ongoing review will analyse these new risk management protocols and provide the Trust with assurance or recommendations.

The Trust's safeguarding leads have supported College leads in developing more robust safeguarding policy for enrolees at the College. The safeguarding team has provided additional learning sessions to college staff and volunteers and there is a rolling programme of support in place. College leads report compliance with safeguarding training through newly established governance systems and are also receiving support to access and utilise core governance processes such as reporting and management of risk in accordance with the expectations within the organisation.

Following your inquest, a review of the process followed in this case was requested by the Trust’s Executive Director of Quality, Nursing and Healthcare Professionals to identify learning. This review made recommendations in relation to strengthening triggers for an investigation, more robust systems for the recording of decisions made in relation to commissioning investigations, agreement of scope and terms of reference and ensuring training and skills of investigators beyond arrangements already in place. It was also recommended that the quality assurance process for the presentation and ratification of investigation findings could be reviewed and strengthened.

In response, the Executive Director of Quality, Nursing and Health Professionals has introduced new governance processes including a Central Safety Summit with an approved scope and purpose agreed at Board level with reporting into the Trust's Quality Committee for continuous oversight at a Non-Executive Director level. Progress in relation to the embedding of these new structures will form part of the Trust's regular discussions with integrated care board colleagues and reporting within the quarterly compliance schedule.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

All good wishes,

BARONESS GILLIAN MERRON