MANCHESTER CITY COUNCIL

Directorate for Families, Health & Wellbeing

Hospital Discharge and Manchester Community Response
Adult Social Care
PO Box 532
Town Hall
M60 2LA

Email: [redacted]

Lauren Costello, Assistant Coroner, for the Coroner Area of Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

5th September 2024

Dear HM Assistant Coroner Costello,

RE: John Howe: Prevention of future deaths report

Firstly, I would like to apologise for the delay in my response to your issuing of the report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

I am extremely saddened by the events of the Mr John Howe's death and, following your report, we have amended the inaccuracies in the report and reshared the Serious Incident Review (SIR) with Derbyshire Safeguarding Adults Board. I have also reshared the amended SIR with Manchester Foundation Trust Safeguarding Team.

I recognise the delay in completing the initial SIR due to myself not being in work, and as such we have set up a system, as a service, to ensure all investigations are completed in a timely manner going forward. In reviewing the systems it is essential we are not dependent on a single person within the service and, as such, we have put in place processes to ensure that this does not happen again.

We are also reviewing our processes where a person is discharged from a Manchester hospital into an 'out of area' locality and if a safeguarding concern takes place on discharge. This will include ensuring engaging with partners in carrying out the SIR and sharing with them the outcomes and recommendations to those organisations. We will also ensure that, in future, we will share with agencies who have been consulted so the information provided can be reviewed and checked for accuracy, before finalising the report.

Where there is still a need for further engagement with other partners to review where the areas of learning which the serious harm experienced by an adult at risk of abuse or neglect could have been prevented, it will be sent to the appropriate Safeguarding Board for screening with a recommendation for a Safeguarding Adults Review.

I hope that this satisfies the matters of concerns that you have raised in your report and that the actions taken demonstrates how serious we take the investigation and completion of SIRs in a timely manner as well as involving partners in those investigations.

Yours sincerely

[redacted]

[redacted]

Strategic Lead for Hospitals, Reablement and Digital