Pennine Care
NHS Foundation Trust

3 December 2025

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

[redacted]

Private & Confidential
Christopher Morris
HM Area Coroner
HM Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Morris,

RE: Inquest touching on the death of Derek Crowther

I set out below the Trust's response to your letter to Pennine Care NHS Foundation Trust (PCFT) and the issuing of a Prevention of Future Deaths Notice (Regulation 28), arising from the inquest into the death of Derek Crowther.

May I take this opportunity to extend my own condolences to the family of Mr Crowther and apologise that you had to raise concerns relating to the services he accessed prior to his sad death.

The Trust sets out its response to the points below raised by HMC's as areas of concern:

1. **The Court heard evidence that a registered nurse working on the Unit at the time of Mr Crowther's death was not up to date with Immediate Life Support ('ILS') training, despite this being termed 'mandatory'. Having heard evidence from the Trust's Clinical Excellence Lead for Older Peoples' Services, I am concerned that instances continue to arise across the Trust whereby clinical staff are undertaking shifts despite not being up to date with the required level of Life Support training.**

At Mr Crowther's inquest you heard evidence from the Trust's Clinical Excellence Lead for Older People that staff member trained in Immediate Life Support (ILS) is present on all shifts. As you have noted, this forms part of the mandatory training requirements for staff working within all Healthcare settings. Ideally, staff would receive refresher training before the expiry of their existing competency, meaning that their compliance was continuous. It is recognised that this may not always be possible and so NHS organisations are able to agree a tolerance or target threshold.

The Trust recognises the critical importance of ensuring staff are appropriately trained to respond to medical emergencies and has taken further action to mitigate risk and improve compliance rates. It also acknowledges the risk associated with non

compliance and availability of training, which is overseen within our Resuscitation Committee but also reported as part of our management structures and governance meetings.

The Trust has increased its Trust wide compliance target to 85%. This figure has been benchmarked against other NHS Trusts and is understood to be at the higher end of expectation for Mental Health organisations. To support reaching this increased compliance rate, training uptake is monitored via the mandatory training dashboard and reported through divisional governance to the Care Quality Oversight Group. The ILS training compliance for inpatient ward staff is currently between 73 and 74%. While we acknowledge this is below our revised target, we continue to work hard to improve this, with the oversight of our Trust Board.

Increased training capacity has been created by ensuring additional ILS training sessions have been made available. This has increased capacity and reduced waiting times for staff who need to book onto available training. Timetabling of training has been adjusted to improve access for ward-based staff. The Trust is also addressing non-attendance on ILS training, which is recognised to impact on compliance rates. Non-attendance on a booked courses is escalated to Ward Managers and Network Quality Leads to support awareness but also understanding of the underlying causes or reasons why staff could not attend as planned.

ILS compliance is being incorporated into ward rota planning to ensure wards are appropriately staffed whilst simultaneously releasing those staff who require refresher training, which will in turn lead to an increase in compliance. The Trust is extending ILS training to additional clinical staff groups such as Bank staff and trainee doctors to increase resilience and the number of ILS trained staff present on the ward on a shift.

Each ward is required to have at least one ILS trained member of nursing staff on every shift, including nights and weekends. Compliance with this requirement is monitored daily through Safer Staffing meetings, with escalation where gaps arise to ensure an ILS trained staff member is available for all shits on every inpatient ward across the Trust.

The Trust acknowledges your concerns and is committed to ensuring safe staffing and prompt emergency response capability across all inpatient settings. The actions set out above provide immediate mitigation whilst longer-term improvements continue to strengthen the ILS cover on the wards.

2. **Whilst the Court heard evidence as to relevant changes made to the Trust's Observations Policy since Mr Crowther's death, I am concerned that despite having an Electronic Patient Records system, there is currently no mechanism in use on the wards for contemporaneous digital recording of observations. I am concerned that an ongoing risk of future deaths arises from this position, in the view of the potential for such systems to accurately record timings of observations, facilitate**

trend analysis (particularly in the context of a deteriorating patient), and reduce the potential for errors, either arising from incorrect / unclear manual recording of observations

The Trust has undertaken some focused improvement work on therapeutic observations of care, from December 2024 into the spring of 2025. This was led by our Deputy Director of Nursing, Quality and AHP's and informed by nationally indicated best practice and published guidance. This included the creation of a policy, and the development of a targeted training course which was supported by an implementation plan for staff to deliver this at scale and pace, within the individual care areas.

This method of delivery was intended to maximise staff attendance and was coordinated as part of a 'focus week', in which there was increased communications about the policy, requirements and methodology. This approach also allowed for our temporary workforce to be included in this.

The Trust also established an Enhanced Therapeutic Observations of Care (ETOC) Task and Finish Group in March 2025. One of the workstreams within that group is the development of an electronic observations (eObs) app. This response will provide additional information pertaining to that workstream in addition to the information provided previously regarding the broader work of the group around, policy, training, culture and improvement. The development of an eobs app is just one element of that workplan. The build and configuration work has began on the app. This will be ready for testing by March 2026 and pilot of the app commenced in April 2026. At this stage we are unable to give a full implementation go live date Trust wide but can update you in our progress as the pilot progresses and concludes.

I was sorry to learn that the Clinical Excellence Lead attending Mr Crowther's inquest was not aware of these developments whilst he gave evidence, as this may have provided you with the assurance of action that you were seeking. I understand that steps have been taken to ensure this is communicated effectively to them directly, but also reviewing the ways in which this progress can be shared with staff more broadly as we approach the testing phase of this process. We are working with our digital team we have set April '26 as a realistic date that we can deliver a pilot on eObs.

We understand a question was asked in relation to the eObs app in place at Greater Manchester Mental Health NHS Foundation Trust (GMMH) and the ability for the Trust to adopt this. Whilst GMMH has been able to implement therapeutic observations on some of their wards, which had Wi-Fi upgrades, there are challenges still with their coverage. GMMH are currently not utilising 'offline' capability, which has been identified as key requirement for our e-Obs solution, given feedback to date and the lessons that have been learnt at GMMH. Without 'offline' capability we cannot guarantee that should there be a drop in Wi-Fi connection; data

integrity would be maintained. We are working closely with colleagues at GMMH, sharing learning and progress to inform our project and ensure we are able to implement an effective system at PCFT.

I hope that the information within this response has provided you with the assurance that you were seeking in relation to learning from these events. Should you require any further information or clarification on the details within this letter, please do not hesitate to get in touch with me again.

Yours sincerely,

[redacted]

Chief Executive