NHS
Pennine Care
NHS Foundation Trust

13th March 2026

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

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 Linda Fury

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 Linda Fury.

May I take this opportunity to extend my own condolences to Linda's family and apologise that you had to raise concerns relating to the services she accessed prior to her sad death.

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

1. **In view of the importance of robust NHS investigation in preventing future deaths undertaken from the perspective of seeking to derive as much learning as possible, I am concerned the Trust's investigation in this case was insufficiently rigorous or probing given:**

    a) **It has not focussed in any detail on the consequences arising for Linda (in terms of continuity of care and more broadly) as a result of the fact that no bed was available for her locally;**
    b) **The investigation does not undertake any meaningful critical analysis of the decision-making process which resulted in her section being rescinded and her therefore being discharged notwithstanding family concerns in circumstances where no s17 leave had first been trialled; and leave had first been trialled; and**
    c) **In respect of findings made in relation to the care provided on the day before Linda's death, it remains unclear even after hearing all of the evidence how the investigators concluded (at page 24 of 44) '[t]here was no reason to doubt Linda's capacity at this stage' in**

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circumstances where the Trust was on notice she not attending to self-care, barely eating or drinking and refusing to speak with or see her Care Co-ordinator.

The Trust acknowledges the coroner's concerns arising from Linda's placement into the Tameside locality as the first available acute bed and that this meant a break in her continuity of care from the Stockport medical consultant who knew Linda. There was no change to her community provision.

The Trust has an established practice of always seeking to ensure that an individual that requires an inpatient admission is admitted as soon as possible. The patient flow team (a team that manages all the requests for access to beds) will start from the position that admission to the patient's locality bed should be sought first. If no immediate bed is available, then the team will seek to use another bed within the Trust's available bed-base. This will mean an admission to another area, different to that of the patient's locality. The Trust acknowledges the risk associated with out of area (outside of the Trust's footprint and bed base) admissions and since 2024 has reduced our Out of Area admissions significantly. We note the most recent Care Quality Commission's report into the use of the Mental Health Act and the risks associated with out of area placements and waiting too long for admissions where clinical indicated - Monitoring the Mental Health Act in 2024/25 - Care Quality Commission.

Our patient flow team support the process for admission and will work hard to ensure a continuity of care where possible. The clinical decision to admit a patient is always based on the nature and degree of the presenting risk and that to delay an admission until a locality bed is available, may present the patient and their family an intolerable risk and further potential harms of waiting at home. Once the gatekeeper makes the referral, they will be told by patient flow team where the available bed is. Its then up to the gatekeeper to have that conversation / assessment with the patient/patients family if a local bed isn't available for them and to assess and judge on balance the admission to the local bed or another within the Trust. Every borough now has a discharge coordinator and a patient flow senior practitioner who would be responsible for liaising with local teams to ensure safe admissions and discharges.

The Trust's Executive's agreement is that we use beds across the trust footprint rather than at a locality level and this actually supports reduced out of area bed usage. This is a common position used by Mental Health NHS Trusts. As a Trust our principle is such that whilst we repatriate patients where clinically indicated, our data demonstrates that movement between inpatient wards increases length of stay by an average of 50% and essentially starts the patient's clinical journey again, unsettles patients with change.

As a Trust however, we acknowledge the importance of patient choice, of carer access to their loved ones and the importance for some patients of the continuity of care. To clearly articulate the process and to deliver consistency for patients we are therefore reviewing our Standard Operating Procedures for the process of

repatriation to reflect this. The development of the SOP will be overseen by the senior patient flow lead (clinical) which will be approved by the relevant group.

Having provided the rationale for the way in which beds are allocated, and processes in place for management and oversight of this, we acknowledge that analysis within our investigation could have been different. PCFT have identified a Trust wide risk in relation to *'…a lack of MDT and SME involvement in patient safety investigations'.* The risk specified *that 'If the correct MDT representation in investigation teams and subject matter expert involvement does not provide structured involvement in investigation, then the investigations may not capture correct learning, may have poor actions set and the investigation may not lead to improved patient outcomes and appropriate response for patients, carers and staff'* (risk ID 2513. Score likelihood-3x consequence 4=12).

Part of the mitigation of this risk involves the undertaking of a subject matter expert mapping exercise to identify appropriate subject matter experts within the Trust (including appropriate medical representatives), reviewing their visibility of appropriate incidents and their roles and responsibilities in regard incident investigation. A subject matter expert draft framework and contact sheet has been created and the contact sheet has been trialled within the Trust Quality teams when identifying appropriate investigation teams for patient safety incident investigations (PSIIs).

The subject matter expert framework is under further review from all stakeholders and due to be ratified in Clinical Effectiveness Group on 21st April 2026. The quality improvement project also has focussed on the correct visibility within the incident reporting system for all subject matter experts which is also due to be launched at the end of April 2026.

The Quality teams for all investigations (Patient Safety Incident Investigation; PSII) have identified subject matter experts to support in the PSII process moving forward and this is being monitored through the Network Quality and Safety Panels and through Central Safety Summit.

Following the risk identified, the Central Safety Summit has refreshed it's terms of reference in line with Patient Safety Incident Response Framework principles to oversee the terms of reference and learning response lead undertaking the PSII, to ensure appropriate parties are able to support the learning response lead to assess all appropriate avenues in a patient's care that has sadly come to harm. The terms of reference were ratified on 5th March 2026.

The Trust is committed to ensuring that our investigation reports are subject to appropriate levels of critical scrutiny and this occurs at the Network Quality & Safety panels. During this process a range of professional and non-professional individuals have the opportunity to comment on the draft report. At the Mental Health Network's Quality & Safety panel, lived experience expertise is provided by our carers representative. The panel also has a medical representative who is a consultant psychiatrist; all members of the panel provide a critical challenge to the quality of

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investigation reports. These actions should strengthen our processes and reduce the likelihood of instances where you have cause to raise concerns such as these again.

2. **I am concerned that the current processes for ward rounds do not routinely facilitate an opportunity for family members to disclose any concerns relevant to risk privately to the multi-disciplinary team.**

Risk Assessment

The Trust has identified a trust wide risk in relation to a *'lack of assurance regarding consistent high quality, collaborative clinical risk assessment, formulation and planning'* (Risk ID 2496- score likelihood 4 x consequence 4= 16). This is following further learning from incidents such as this, the overarching incident profile, audit and learning from suicide thematic analysis.

As part of the mitigation of this risk, the Trust commenced a task and finish group in July 2025 to review our current risk assessment processes, policies and PARIS forms in line with NHS England staying safe from suicide best practice guidance NHS England » Staying safe from suicide which focuses on a full biopsychosocial risk assessment and safety plan collaboratively created with patients and carers.

The Trust's PARIS form has been revised, policy, Standard Operating Procedure (SOP) and suite of guides to support staff to review the full context of patient's needs and goals involving all appropriate loved ones within the planning process. Within this form is a more explicit area for carers views. The launch of the new PARIS form is due on 1st April 2026 and the policy and SOP is due for ratification at Clinical Effectiveness Group on 21st April 2026.

We fully acknowledge the issue raised in the Prevention of Future Deaths report and are committed to strengthening organisational systems to ensure that families, carers and loves ones are able to disclose sensitive concerns safely, privately and promptly. We recognise that clear communication pathways for carers are essential to maintaining patient safety.

Ward Rounds:

It is known and understood that our current ward-round structures do not consistently provide families with an accessible, confidential mechanism to raise concerns separate from the main discussion. While some teams have developed local solutions, approaches vary and a more reliable, standardised trust wide process is required.

As part of both our trust wide improvement programme and the national Culture of Care Programme (2024–2026), commissioned by NHS England, we are implementing a comprehensive set of actions directly aligned to the concerns raised.

We have initiated trust wide improvement work to ensure Multi-Disciplinary Team (MDT) documentation reliably captures patient and carer views. The identified aims of this are to:

- ensure mandatory use of the MDT ward-round document for every ward round and completion of all relevant sections, including the family/carer section.
- Undertake a trust wide review of MDT forms to identify improvements that better support the inclusion of patient and carer perspectives.
- Piloting a new questionnaire for carers about the MDT process, to help shape further improvement.
- Consideration of how we will Audit this

A standardised Pre-Ward-Round Form for Patients and Carers has been developed with the support of the Culture of Care programme, who provide quality improvement (QI) coaches and lived experience support. These have been implemented in pilot sites and is planned to be rolled out to all inpatient wards. The form enables both patients and carers to feel heard when they are not able to attend ward round or feel unable to speak in a ward round due to feeling uncomfortable or worrying about damaging relationships with their loved ones.
The form is able to explore:

- Changes noticed in behaviour
- Concerns about risk or relapse
- Medication observations,
- Home environment considerations
- Questions around discharge planning

Forms can be submitted discreetly ahead of ward rounds, ensuring information is reviewed confidentially by the MDT, even when carers are unable to attend in person. This supports collaborative partnership working and meets the Triangle of Care principles.

In addition to this, we are strengthening the expected standards through which carers can share risk-related information outside the main ward-round or visiting environment, this includes an ability to contact the nurse-in-charge or delegated clinician privately, dedicated email/telephone routes for sharing concerns, the option to request a short one-to-one discussion with the MDT outside of the formal ward round. All information is documented in the PARIS carer space, ensuring visibility across the MDT.

This will be achieved through information leaflets that have been reviewed and updated. These have been printed and shared with wards from 4th March 2026 onwards.

As part of the trust wide Triangle of Care work, Standard 3: Confidentiality is being actively worked on. The Triangle of Care is a nationally recognised framework developed by the Carers Trust to strengthen collaboration between service users, carers, and mental health professionals. It is built on six key standards that ensure carers are identified, included, informed, and supported throughout the care

pathway. A working group has been established consisting of our Carer Experience Lead, Involvement Team Manager, Information Governance Lead and Carers with lived experience. The group is updating the information-sharing section of the Trust confidentiality policy, guidance for staff and carers on confidentiality and revising Carer awareness training content to ensure it includes the policy update and staff guidance.

In 2025 we developed a new Carer Lead Role, working across the Trust, to support the development of Triangle of Care. For 2026 an annual calendar has been devised to deliver a full self-assessment against the 6 standards, which will determine good practice and areas for development and will inform trust wide improvement work streams.

Alongside this, we are strengthening how information from carers is captured, recorded, and used. Learning is being shared through the care planning improvement work stream to shape improvements to the PARIS Carer Space. A trust wide review of the PARIS Carer Space is under way to improve visibility, usability and guidance, and monthly audits will begin once the revised system is in place. In addition to this, guidance is being developed to support staff on what elements of carer engagement should be captured. A new care-planning PARIS form will go live toward the end of April 2026, embedding clearer documentation of carer involvement.

Another way in which we will monitor this is via our ward accreditation programme, which has been developed by the Deputy Director of Nursing, Quality and AHP's with Board level oversight, commencing in April 2026. As part of this, inpatient wards will be assessed against agreed standards, including documentation, patient and carer involvement, and communication processes. While this is too late to change the care provided to Ms Fury and the experience of her family, I hope that this provides assurance that the Trust is committed to developing its assurance mechanisms and improving the quality of care.

Following review during 2025, Carer Awareness Training is now mandatory for all frontline staff. In our training carer involvement and support is asserted with exploration of how understanding helps the service user toward a better outcome. It acknowledges that carers often have more knowledge and experience of the needs of the person they care for than anyone else, but also that even without consent, we can and should listen to carers.

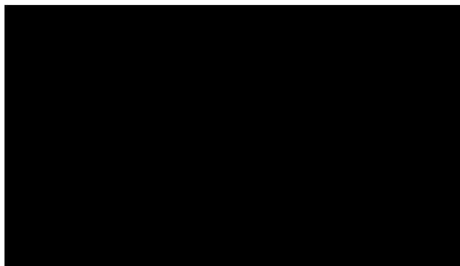
Conclusion

We recognise and share the coroner's concerns regarding the need for clear, reliable and confidential mechanisms for families and carers to raise risk-related information. The actions outlined in this response including strengthened MDT documentation processes, the introduction of patient and carer submission forms, enhanced ward-round communication pathways, improvements to PARIS functionality, the ward peer-review programme, and mandatory carer-awareness training represent a comprehensive and sustainable trust wide approach.

Together, these measures are designed to improve the consistency, transparency and quality of carer engagement and to reduce the likelihood of similar risks arising in the future. We remain fully committed to embedding these improvements and maintaining robust oversight to ensure the safest possible care for our patients and their loved ones.

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



Chief Executive

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