Tees, Esk and Wear Valleys
NHS Foundation Trust

[redacted]
Community Modern Matron
Stockton & Hartlepool AMH Planned Care
Marton Road, Middlesborough
Cleaveland
TS4 3AF

[redacted]

10th April 2026

HM Senior Coroner
Teesside Coroner's Service
Middlesbrough Town Hall
Albert Road
Middlesbrough
TS1 2QJ

Dear Madam

I write following conclusion of the Inquest touching the death of Grant Lowry. Following the Inquest, you asked the Trust to confirm "that staff are reminded to undertake a risk assessment when undertaking medication reviews".

To provide further assurance regarding risk assessment processes following clinical reviews, it is important to note that risk assessment is a continuous process in which clinicians are required to assess an individual's risks and any changes thereto on an ongoing basis. Should any changes in risk be identified during a review, these must be clearly documented within the electronic care records and within the patient's risk assessment.

During patient consultations, it is expected that risks are reviewed in accordance with the individual's presentation, mood, and sleep patterns, and that direct questions are posed in relation to self-harm and suicidal ideation. In addition to risks to self, whether intentional or unintentional, clinicians are required to review risks from others, risks to others, forensic risks, risks arising from the service itself (including iatrogenic harm), safeguarding concerns, and risks relating to physical health, among any other relevant risk factors.

In Grant's case a call was made to Grant's mother by a trainee nursing associate, has previously agreed, to discuss Grant's medication. Where contact is made with carers, their views are sought in accordance with the domains set out within the safety summary (risk assessment). In circumstances where information is being obtained from carers, it is expected that a general discussion is undertaken regarding any changes in presentation that may have an impact upon the individual's risks.

Following the Inquest this matter has been escalated through the Quality Standards Group, which is chaired by the Associate Directors of Nursing and attended by Team Managers, Matrons, and Clinical Specialists. A formal discussion was held at the Quality Standards meeting on 8th April 2026 to address this information, with a request that the findings be cascaded to clinical teams accordingly.

I can confirm that, following GL's death, changes have been made to the electronic care recording system currently in place. The system now incorporates an automatic prompt requiring clinicians to confirm whether a risk assessment has been reviewed when completing a clinical entry; where it has not, a documented rationale must be provided.

The electronic system is configured such that a clinician is unable to save a clinical entry without either confirming that an individual's risks have been reviewed or providing an explanation as to why this was not possible. Where risks have not been reviewed directly with the patient, for example in circumstances where contact was made solely with a carer, this would be recorded as the rationale upon saving the clinical entry.

I hope you are assured that learning arising from the Inquest has been acted upon and discuss with clinical teams. We reiterate our sincere condolences to Grant's family.

Yours sincerely,

[redacted]

Community Modern Matron