Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Mr Andrew Foster
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[redacted]

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2 June 2016

Mr A P Walsh
HM Area Coroner
HM Coroner's Office
Paderborn House
Civic Centre
Bolton BL1 1QY

Dear Mr Walsh

Regulation 28 Response: Joyce Carney (Deceased)

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 7 April 2016.

I understand that on 23 March 2016 an inquest was held relating to the death of Mrs Joyce Carney. I have been fully advised of the circumstances relating to Mrs Carney's death and having read your report, I am grateful to you for bringing these concerns to my attention.

Since the conclusion of the inquest Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") has been working with Greater Manchester Police (GMP) to ensure lessons have been learnt from the events surrounding Mrs Carney's death.

I would now like to take the opportunity to advise you of the actions already taken by the Trust to address the concerns outlined below and the proposed action to be taken in the near future.

The review has addressed the following:

1. **The security of patients under arrest, or in the presence of, or supervised by, Police Officers in any location within a Hospital.**
2. **The protection of other patients in the Hospital, visitors to the Hospital, members of the public and staff employed in the Hospital whenever a patient is detained under arrest, or in the presence of or supervised by Police Officers in any location within a Hospital.**

3. **The provision of protocols, policies and procedures as between Police Forces and Hospital Trusts in relation to the formulation of joint risk assessments and the inclusion of liaison and consultation between Police Forces and Hospital Authorities in the formulation of joint risk assessments in relation to patients detained at a Hospital under arrest or in the presence of or supervised by Police Officers.**

The following actions have been undertaken in relation to hospitals only under the management of the Trust. It is our understanding that GMP will also be working with other Hospital Authorities within the Greater Manchester area.

Upon receipt of the Regulation 28 Report the concerns raised were discussed at the Trust's Executive Scrutiny Committee (ESC). ESC is a weekly meeting, chaired by the Medical Director and Director of Nursing, and all issues arising from coronial proceedings are discussed within this forum. It was agreed by the Committee that the review would be led by [redacted] (Assistant Director of Nursing & Patient Services (Operational)), [redacted] (Head of Nursing for Unscheduled Care), and [redacted] (Head of Legal Services).

Following the conclusion of Mrs Carney's inquest [redacted] contacted [redacted] (Detective Inspector) of GMP and it was agreed that both organisations would work jointly to address the actions outlined at points 1 – 3 above. The Trust already has a very good relationship with GMP and this would be utilised to formulate the required protocols, policies and procedures for the protection of patients, staff and visitors to the hospital.

The first meeting between the Trust and GMP was held on **Friday 6 May 2016** by way of telephone conference. In attendance from the Trust was [redacted], and from GMP the following persons were present; [redacted] (Chief Inspector), [redacted] (Chief Inspector), [redacted] (Detective Inspector), [redacted] (Professional Standards Branch), [redacted] (Detective Constable), [redacted] (Inspector – Custody Branch) and [redacted] (Mental Health). The number of high ranking officers allocated to this review is testament to how serious both organisations are dealing with this matter.

At the meeting it was agreed that both the Trust and GMP would make enquiries with other organisations within Greater Manchester to establish if other policies and procedures existed elsewhere to address the concerns highlighted above. [redacted] had already started contacting other Hospital Authorities to see what 'good practice' was in place. However it had soon become apparent that no other NHS Trusts within Greater Manchester had procedures in place to deal with patients attending hospital in the presence of, or under police supervision. In light of this it was agreed that the Trust and GMP would have to work together to formulate a new document in the form of a joint risk assessment that could be used by all police escort staff and health professionals responsible for that patient.

The document would need to contain the patient information, the reasons for requiring police escort / supervision, any known risk factors and brief details of that patient's past criminal background (where relevant). The document would also need to contain a risk assessment which would be completed jointly by the police officer and hospital staff, and this would assess the level of risk that the patient presented to themselves, staff, or other members of the public. This would then trigger a Patient Management Plan that would take into account the location, environment and any other factors relevant to their treatment. Any change in condition or locality would trigger a joint review of that Plan.

A further meeting was held on **Monday 16 May 2016** between [redacted] from GMP. The purpose of this meeting was to formulate a draft document in readiness for sharing at the next conference between the Trust and GMP. A working draft was agreed that incorporated all of the factors identified above.

On **Friday 20 May 2016** a conference was held at the police headquarters in Manchester. I enclose a copy of the draft "Patient Under Escort Record" that has been ratified by both organisations. As you will note there are some minor amendments that are still required, but the overall content has been agreed. Both the Trust and GMP feel that good progress had been made and the attached document will ensure the security of patients under police escort, as well as other patients within the hospital, visitors and staff.

The "Patient Under Escort Record" will be completed by the police officer when they attend the hospital site with the patient. The document will then be completed jointly by GMP and hospital staff throughout the course of the patient's stay, and will remain with them until discharge. Upon discharge the document will become the property of GMP who will hold it on file to form part of their intelligence of that patient (should it be required in the future).

As I am sure you will appreciate there are a number of actions that remain outstanding to ensure the "Patient Under Escort Record" is embedded within both organisations, and to ensure that operationally it is fit for the purpose intended. The timeline below provides an estimate of the action that will be taken in the near future:

- Final draft of the "Patient Under Escort Record" to be agreed by the Trust and GMP – *estimated deadline end of June 2016*
- The "Patient Under Escort Record" will be taken to the Trust's Consultant body, Nursing forums, Safeguarding Leads for discussion – *estimated deadline end of July 2016*
- Final version of the "Patient Under Escort Record" to be agreed between the Trust and GMP following consultation – *estimated deadline end of August 2016*
- Training on the use of the "Patient Under Escort Record" to be rolled out initially to all staff in A&E and the assessment areas (MAU and Lowton) – *September 2016*

- An audit of the "Patient Under Escort Record" will be undertaken after 3 months – *results to be made available by December 2016*

The above actions will be monitored by the Trust's Quality and Safety Committee which is chaired a Non-Executive Director and attended by several members of the Executive team.

Whilst the above actions are on-going the Trust will continue to work closely with GMP to ensure the security of all patients brought to the hospital under escort and / or supervision. The welfare and safety of our patients, staff and visitors to our hospital sites is paramount and something we take extremely seriously.

I hope the above response is testament to how serious both the Trust and GMP have dealt with the events surrounding Mrs Carney's death. If you have any comments or suggestions in relation to the proposed actions above, I would be only too pleased to hear from you.

I understand you have also written to the Home Secretary and the Secretary of State for Health to consider the concerns raised. I would be grateful if you could share their response so that we may seek to take further action in addition to that outlined above.

Yours sincerely

Andrew Foster
Chief Executive