Greater Manchester West
Mental Health NHS Foundation Trust

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RECEIVED
09 FEB 2016
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8th February 2016

Miss J Kearsley
HM Coroner Manchester South
Area Coroner
Coroners Court
1 Mount Tabor Street
Stockport SK1 3AG

Dear Mrs Kearsley

Re Regulation 28: Jake Robinson (deceased)

I am responding to the Regulation 28 you issued to the Trust on 17/12/15.

Following the outcome of the Trust's Serious Incident Review into the death of Jake and the subsequent inquest, a number of actions have been taken.

You note a concern that there was no indication in the review by Greater Manchester West (GMW) as to whether a letter had been received by Drug Services and if not, why not?

I can confirm that the Serious Incident Review Team and Trafford Aim were unaware that a letter had been sent to Trafford Aim until the issue was highlighted in a meeting with the reviewer lead and [redacted] after the conclusion of the review. Trafford Aim have carried out a robust search of both its office base and the electronic database and have found no evidence to indicate the faxed letter from the GP had been received.

A fax is usually sent when information is required quickly it is good practice in accordance with Information Governance processes in an attempt to maintain confidentiality for the sender to alert the recipient of the fax to it being sent and subsequently for the sender to confirm with the service that it has been received. As the GP practice did not do this the service were unaware that a faxed letter had been sent.

Trafford Aim however have taken the opportunity to review their administration process regarding receipt of letters and faxes sent to the service. A more streamlined process has been put in place which has reduced the points at which a letter or fax may get lost.

The Trust encourages reviewer leads to give all parties, who maybe involved in the serious incident, the opportunity to be involved in Serious Incident Review process, including GPs. If the reviewers had invited the GP to contribute to the process and the GP took this opportunity, it is likely the issue of the missing letter would have come to light and have been included in the review. The Trust will continue to highlight to review leads through training events and local guidance the importance of ensuring all key agencies and professionals such as GPs are invited to contribute to the GMW review process where appropriate.

At the start of the review process the reviewers met with Jake's mother, [redacted] who initially did not raise the issue of the letter with the reviewers. However an interrogation of the reviewers' email has shown that [redacted] sent several emails to the reviewers and the missing letter was mentioned in one of them amongst other subjects. The reviewers missed the particular email and sincerely apologise for this error. The missing letter was subsequently raised by [redacted] in a meeting with the reviewers following the completion of the report, and the reviewers took steps to establish its whereabouts, and were able to conclude that Trafford Aim did not have possession of it.

A further concern is raised in that Phoenix Futures have no ability to prescribe medication to their service users and have to access Trafford Aim for this, leading to a disconnected approach to dealing with Jake's difficulties.

Trafford Aim is an advice, recovery and treatment service for adults over 25 with dependent drug or alcohol use.

Phoenix Futures is a service that is commissioned by Trafford Local Authority to provide psycho social interventions to individuals with alcohol problems and those under 25 with substance misuse problems.

Both Phoenix Futures and Trafford are commissioned to meet the needs of different groups of service users however they work closely together.

The number of service users under the age of 25 who require medical intervention and treatment for a drug problem is very small. However, the Trust recognises that on occasion this can occur and has an established protocol between both services that allows those service users under the age of 25, who require a medicines review, to quickly assess the service. All efforts to reduce duplication and streamline the pathway for the service user are made.

As part of the review Trafford Aim identified that Jake should have been booked straight in for a medical review. Instead however, he was booked in for an assessment with a non medical member of staff. This was inappropriate as the assessment provided by Phoenix Futures had been carried out and a clear need for a medical review established. All staff have been reminded of the established protocol.

The Trust acknowledge that whilst this process and close working relationship between Trafford Aim and Phoenix Futures exist, the disjointed nature of the commissioned services is not ideal. The Trust had developed a Dual Diagnoses Steering Group to review how these services and mental health services work together. There has already been two planning meetings. The aim is to ensure effective partnership working by collocating services, effective joint assessment and joint working of cases with dual diagnosis.

Trafford alcohol and drug services will be retendered in April 2017. The Trust are hopeful that this will provide an opportunity to develop a lead provider model which will mitigate against the difficulties you describe. The Trafford Commissioner is aware of these concerns and is also organising a multiagency review.

Finally you note that an explanation is needed in the review as to why the appointment clash between Trafford Aim and the CMHT led to the appointment with CMHT being rearranged.

The appointment at the CMHT was for an assessment by a qualified mental health practitioner and not an appointment with a psychiatrist. Due to the specialised area and knowledge required to treat drug problems, a general adult psychiatrist would not have the knowledge and expertise to prescribe for Jake's drug problem. Given this context and the fact that Jake had previously informed the CMHT he wished to prioritise appointments with Phoenix Futures and Trafford Aim, the CMHT cancelled their appointment.

The CMHT however did not consider the fact that they could have also attended the appointment at Trafford Aim in order to facilitate an assessment and engage Jake in the service. They also did not discuss the clash of appointments with Jake or Trafford Aim.

The CMHT now have dedicated duty workers whose role it is to solely provide an assessment and duty worker role function. The duty workers have been reminded of the need to consider alternative ways to carry out an assessment and it is hoped that the consistency of duty workers means that when a dual diagnosis referral is received there will be a more consistent response to engaging service users in the assessment process.

I hope this response provides assurance to Jake's family and yourself that GMW have taken the learning from Jake's death very seriously and have put in place measures to ensure safe and effective services.

Yours sincerely

[redacted]

Bev Humphrey
Chief Executive

cc: [redacted]