Pennine Care NHS
NHS Foundation Trust

Corporate Services
Trust Headquarters
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Telephone: 0161 716 3000

25th January 2018

PRIVATE & CONFIDENTIAL
Ms A Mutch
Assistant Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Lindsey Theresa Hassall

Thank you for your Regulation 28 report dated the 30th November 2017, and for bringing to my attention the concerns you had after hearing all the evidence. Your concerns relevant to Pennine Care have been reviewed, and the Trust's response is outlined below.

Concern 1:

There is no provision for a record to be kept of the information, which Police Officers provide verbally to the RAID practitioner in the s.136 suite. The inquest heard that there was a record of the initial circumstances, but no further record was kept.

Response:

A plan has been prepared to ensure that staff record information from a verbal handover from the police on a paper history sheet and ensure the assessing doctor and AMHP have access to this so they can review the information. This will be uploaded onto PARIS once the assessment is completed. The following actions are in place:

- *Advice to be included in staff briefing.*
- *Flowchart to be developed which reflects guidance in staff briefing – laminated copy to be displayed in 136 suite so it is available to staff coordinating and undertaking s136 assessments.*
- *Include in the local induction processes.*
- *Add flowchart to the s136 Standard Operating Procedure and policy.*

Concern 2:

Lifeline, now known as CGL, had dealt with the deceased in the period leading up to her death. The notes relating to that engagement were not input onto the electronic system at the time. The inquest was told that the electronic system was updated from the notes after her death. Contemporaneous notes were then destroyed by the worker on the advice of her manager.

Response:

Not a PCFT issue – no further action.

Concern 3:

The documentation held by Pennine Care was not easily accessible to all of the staff working for Pennine Care which meant that the full history of engagement was not known to workers dealing with Ms Hassall.

Response:

As part of the above plan the following actions are in place:

- *Remind staff that they need to be aware of the process to access notes in and out of hours. If they are new staff members of not familiar with PCFT systems they should seek the assistance of a colleague.*
- *Where a patient is brought to the s136 suite for assessment the staff coordinating the s136 will support this process if required.*
- *Advice to be included in staff briefing.*
- *Advice to be included in flowchart to be developed which reflects guidance in staff briefing – laminated copy to be displayed in 136 suite so it is available to staff coordinating and undertaking s136 assessments.*
- *Include in the local induction processes.*

Concern 4:

The form completed by the s136 suite team was sent to the GP with the box 'refer to GP' ticked. After receipt by the GP practice there was an assumption that any necessary referral had already been made and no referral was discussed or made.

Response:

- *Remind all junior doctors that if a person is to be referred back to the care of their GP they make this clear in the summary letter sent to the GP.*
- *Advise staff that where a service user requires a PCFT pathway following s136 assessment that the assessment team are to make the referral and document the action in the care record and in the summary letter sent to the GP.*
- *Advice to be included in staff briefing.*
- *Advice to be included in flowchart to be developed, which reflects guidance in staff briefing – laminated copy to be displayed in s136 suite so it is available to staff coordinating and undertaking s136 assessments.*
- *Include in the local induction processes.*

I hope this response assures you that the Trust takes seriously any concerns that you raised.

Yours sincerely

Claire Molloy
Chief Executive

Dr Marshall & Partners

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Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

14th December 2017

Dear HM Coroner,

Re: Regulation 28 Report following inquest of Lindsey Hassall

Thank you for bringing the above report to our attention. The full details of your report and this case have been reviewed and discussed at a practice meeting involving all relevant practice staff. We have looked in particular at the fourth bullet point in section 5 of your report headed "Coroner's concerns".

The relevant practice policies have been reviewed and, as a result of this case and the Regulation 28 Report, a new policy has been implemented to ensure that when notification of an assessment by the RAID team on a section 136 is received by the practice, patients will be contacted and invited for review with a GP to ensure appropriate follow up is in place.

The practice took the opportunity to review the clinical care provided to this patient. It was noted that on review of the clinical records, it was clear that a full clinical assessment was made when the deceased attended for review at the surgery. The assessment shows that the deceased was planning for the future, seeking a sick note for future benefits and engaging with the appropriate services. Appropriate follow up with the GP was discussed and arranged. No additional onward referral was necessary at that time.

I trust this is satisfactory.

Yours sincerely,

C. Marshall

Dr C Marshall
On behalf of The Partners.