NHS
Pennine Care
NHS Foundation Trust

19 February 2019

Service/Department Name
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Strictly Private and Confidential
Joanne Kearsley
HM Senior Coroner
Coroner's Court
The Phoenix Centre
L Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

Dear Ms Kearsley

Re: Gregory Rewkowski

I write following the Inquest of Gregory Rewkowski heard on the 17th to 20th December 2018. Your concerns after hearing all the evidence had been brought to my attention and I have subsequently reviewed the Regulation 28 letter.

I am responding to the concerns raised into the circumstances surrounding the tragic death of Mr Rewkowski. The matters of concern raised and the actions we will take to address these concerns are as follows:

'The Court heard from the nurses who were tasked to raise a concern for welfare of the practical time difficulties in doing this, given they were working on an acute in-patient psychiatric ward. It was unclear why the clinical lead did not deal with this matter as she was the person to whom the information had been initially provided.'

Information received from the Clinical Lead, who works across both wards on the unit indicates that she passed the request to the nurse in charge of the ward where Mr Rewkowski had recently been cared for as an inpatient. It is recognised that the response of inpatient staff on this occasion was delayed due to the competing demands of dealing with the patients they were directly responsible for on the unit, and this information relating to a patient discharged from their ward but open to another part of the pathway. Staffing levels on the wards have since increased as a response to the 'Safer Staffing' initiative with the aim of releasing more time to care.

In addition to this we anticipate that with the increasing use of social media all teams, inpatient and community will become aware of such notifications and we are seeking to update our polices and practice in how we respond to information in the public domain in the most effective manner. Our initial plan is for those working with adult services to review this

with colleagues internally with our children and young people's services to determine if they have any learning that can be applied.

'No-one considered at any stage the escalation of this incident to the on-call Senior Manager when they were having difficulties contacting the emergency services or when GMP had provided the advice to contact NWAS.'

PCFT have issued the memo (attached) to all staff to ensure that there is greater awareness of the requirement to seek support from the On-Call managers.

'None of the ward staff were aware of the restrictions on the ward telephones which prohibit 111 calls from being made, this meant time was spent trying to make such calls.'

As per the response to second concern please see attached.

I hope that the information provided offers assurances that the findings of your investigations and the areas highlighted for the prevention of future deaths have prompted action and are a focus of our continuing commitment to improving mental health services.

Please do not hesitate to contact me should you require any further information.

Yours sincerely

[redacted]
Executive Director of Nursing, Healthcare Professionals & Quality Governance