[redacted] QPM
**Chief Constable**

GREATER MANCHESTER POLICE

HM Assistant Coroner Mr Matthew Cox
HM Coroner's Court
The Phoenix Centre
Church Street
Heywood
OL10 1LR

22 May 2020

Dear Mr Cox

**Re: Regulation 28 report to prevent future deaths following the Inquest touching upon the death of Mr Jason Pendlebury**

Thank you for your report sent by email dated 12 March 2020 in respect of Jason Pendlebury (deceased) and pursuant to Regulations 28 and 29 of the Coroners (investigations) Regulations 2013 and paragraph 7, Schedule 5 of the Coroners and Justice Act 2009
Having carefully considered your report and the matters therein, I reply to the concerns raised chronology as follows, with additional information in the concluding summary:-
**Extract from Regulation 28 (Point 1):**

> *"Between 13 August and 22 August 2018, telephone calls were made to Greater Manchester Police (GMP) on 8 separate dates by the Deceased, his wife and his business partner. On all but one of these dates those concerns related to the Deceased's mental health. Of the calls that were made by the Deceased, the call handler reached the conclusion that he had mental health issues. On 3 of the occasions, GMP referred the matter to North West Ambulance Service (NWAS) which resulted in telephone assessments by mental health nurses. The purposes of those telephone assessments was to determine whether an ambulance should attend the Deceased. On two occasions a decision was taken that no ambulance was required. On one occasion an ambulance was dispatched although the deceased refused medical assistance and was not taken to hospital.*
>
> *It was not clear from the evidence that the (nwas)mental health nurses carrying out the telephone assessments were aware of the number of calls that had been made to GMP or of the preivous telephone assessments".*

In 2018, if GMP needed to refer an incident to NWAS, GMP would call NWAS and verbally pass on the information contained within the FWIN. A note would be made on the FWIN stating that the incident had been switched to NWAS. There is normally no record of exactly what information was passed.

Our IT systems in 2018 were OPUS and GMPICS. Our GMPICS system would only auto search incidents in the last 12 months at the address where the FWIN was created and populate this on the FWIN.

In July 2019 Greater Manchester Police invested in a major new IT system, iOPS, which is split into ControlWorks and PoliceWorks. All calls that come into GMP are created on ControlWorks. There are now capabilities within ControlWorks to auto search on a phone

number, address and informant details, providing more information to the call handler compared to the GMPICS system.

One aspect of our ongoing IT Change Programme is the feasibility ofan electronic Force to Force data exchange, which could potentially be used to share data electronically with agencies such as NWAS. It is anticipated that these advances in technology would improve the quality and efficiency of information sharing and is subject to ongoing review.

At the time of Mr Pendlebury's death a new "in-house" mental health tactical advice service, called the Control Room Triage (CRT), had just been established within our Operational Communications Branch (OCB). On the 22nd August 2018 the CRT went live and operated between the hours of 8am until midnight. The CRT did not start covering 24/ 7 until 1st October 2018. The CRT still operates in the same way today, however is now called the Mental Health Tactical Advice Service (MHTAS).

MHTAS includes a small team of mental health practitioners, collacted within OCB, with on average practitioners on duty at any one time. When a call is received into OCB and the initial call takers assess it as a mental health incident, the staff member will switch the incident through to the Vulnerability Support Unit (VSU).

The VSU will review the person in crisis on Police systems and switch the incident through to a MHTAS practitioner. The mental health practitioners access a patients electronic mental health records and provide professional information and telephone advice to either officers at a scene or directly to the person in crisis.

This consultation enables the most appropriate support plan to be put in place, which will consider all pathways to treatment and support. MHTAS will then send a letter to the person's GP and any care teams involved, informing them of the incident and any clinically relevant information. This is all recorded electronically on a system called 'Rio'.

Currently, MHTAS are a small team and on occasion work to full capacity , unable to advise on all mental health related calls. However, If MHTAS are unable to support due to capacity, the officer has the option of contacting a local service for consultation where necessary (additional information contatined with the Summary section below).

There are two FWINS for Mr Pendlebury that occurred following the formation of the CRT – FWINS 302 22/08/18 and 425 19/09/18.

FWIN 302 22/08/18 was called in at 0420 hours and was attended by officers at 0435 hours and would therefore not have been referred to the CRT as on that date they finished operating at midnight.

FWIN 425 19/09/18 came in as a domestic and was finalised as a domestic. There was nothing on the FWIN to indicate any mental health issues and therefore no requirement to switch the incident through to the CRT.

Our records show no additional relevant information in relation to the calls outlined in Point 1.

**Extract from Regulation 28 (Point 2):**

> *"None of the calls made to GMP or the fact that telephone mental health assessments had taken place was communicated to the Deceased's GP. This meant that when the*

*Deceased's wife contacted the GP on 6th September 2018 with concerns about this threats of suicide, the GP did not have all the information that he might have had to determine what action to take ".*

GMP does not routinely or automatically send referrals directly to an individual's GP. Information is shared via standard local multi-agency arrangements, where a referral is sent through to the appropriate Adult, Child or Mental Health Services triage point for that Area.

GMP are part of a pilot NHS England patient data sharing scheme. Patient information is shared by GP's with 'appropriate people' in NHS and social care systems, and only when it is needed. The referrals supplied by GMP therefore are fed into these agencies initially for onward sharing, if judged necessary by the social care and mental health practitioners. One action that they may complete upon receipt of the GMP referral will be to contact the individual's GP and share information as they consider appropriate and necessary. It is preferred that the individual has given consent for the sharing of their information.

GMP's revised 'Mental ill health, mental incapacity and learning disabilities policy and procedure V3.3', published in July 2019 states: "As a matter of good practice, services needing to share information should routinely consider getting explicit written consent or documented verbal consent to the information sharing from the person about whom the information is concerned. Consent must be given freely and cannot be inferred or provided under duress. When gaining consent the individual should be told clearly what the purpose of sharing information is, how it will happen, what information will be shared and with whom. The individual should be informed of their right to refuse consent but assured they will be kept informed".

It is my understanding that the AMHP, [redacted] did contact the GP's surgery, after the MAAST meeting on 28th August and prior to 6th September 2018 to enquire about Mr Pendlebury. [redacted] reported back that she had been told that Mr Pendlebury did not attend GP appointments and he hadn't been there since 2015. [redacted] stated that in the circumstances, there was little further that she could do. Multiple cases are discussed in each MASST meeting, which means it is not practicable for GP's to attend in person. As on this occasion, it is normal for professioanls such as AMHP's to liaise separately with the relevant GP.

GMP's Public Service Reform leads, Chief Supt. [redacted] and DCI [redacted] are to consider the effectiveness of the current arrangements regarding this type of information sharing with partners and the Greater Manchester Health and Justice Board will be briefed on the concerns raised here (additional information on this body is included in the Summary below).

**Extract from Regulation 28 (Point 3):**

*"I also heard that a Multi-Agency Adult Care Safeguarding Team meeting was held at Rochdale Police Station on 28th August 2018. The Approved Mental Health Professional (AMHP) who attended that meeting was not provided with the full details of the telephone calls that had been made to GMP regarding the Deceased's mental health and consequently assessed the risk of harm to himself and others as low. Had the AMHP been provided with the full information, it would have automatically generated a referral to the Single Point of Access and led to the involvement of mental health services".*

Multi Agency Adult Safeguarding Teams (MAAST) were still relatively new to Greater Manchester in August 2018, having been introduced initially in April 2018. My understanding is that the AMHP was provided with information about those incidents that had been coded as Public Protection Incidents (PPIs) and were deemed to be relevant.

Whilst FWIN's 633 16/8/18, 1856 19/8/18, 376 20/8/18 and 329 21/8/18 related to Mr Pendlebury, the closing codes used did not highlight any mental health or adult safeguarding concerns for him and were not recorded as PPIs. Three of the four FWINs above relate to the involvement by NWAS and *these have been addressed within the above response.*

As per DC [redacted] statement, Mr Pendlebury's was heard at the MAAST meeting due to this being the fourth reported Police incident in 2018 that identified that Mr Pendlebury was at risk due to potential mental health concerns. DC [redacted] wanted to bring Mr Pendlebury's case to the meeting to ascertain whether there was any further support that could be offered from partnership agencies, namely mental health.

The Operational Communications Branch (OCB) radio operator on the remaining FWIN (376 20/8/18) did not identify Mr Pendlebury as a repeat caller nor any vulnerability. Besides the introduction of the 24/7 CRT and Vulnerability Support Unit in 2018, the OCB have been transitioning through a key change project. The Command & Control Project aims are to develop the capability and professional expertise of our staff so they are fully supported in triaging demand effectively, confidently identifying and assessing vulnerability, threat, harm and risk. Knowledge Support Officers (KSO's) are now in role within OCB and currently have a scheduled upskill programme for all Radio Supervisors. The matters addressed relate to structural changes within the OCB, and cultural and behavioural factors that had previously contributed to tragic incidents. These measures put a focus on developing staff capability within their role and supporting them throughout the day.

**Extract from Regulation 28 (Point 4):**

"*A further contact with GMP was made on 19th September 2018 and I heard that this triggered a referral to the mental health services. However, GMP were unable to confirm what had happened to the referral and the mental Health Trust confirmed that they had no knowledge of any referral being made. In addition, GMP did not notify the Deceased's GP that a referral to mental health services had been made".*

The mental health services referral form from the incident on 19th September 2018 is recorded on GMP's safeguarding system as having been created on 25th September 2018. Ordinarily it would then be emailed to the relevant mental health trust. Due to the passage of time, it has not been possible to confirm the existence or not of that email referral.

However, it is confirmed that a number of other referrals were made after that incident to support the family, including an Early Help and Safeguarding Hub referral. It is recorded on the system that Vulnerable Adult Referral forms for earlier incidents had been created on 16th and 23rd August 2018 and these did appear to have been received and actioned.

As outlined above, current multi agency arrangements are that GMP make any referral directly to the local social care and mental health triage services, who are responsible for onward referral to the relevant GP.

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**Extract from Regulation 28 (Summary):**
For North West Ambulance Service and Greater Manchester Police

> *"The matters of concern relate to the quality and systems of communication regarding concerns relating to potential mental health needs between GMP and NWAS and onward communication to General Practitioners and Approved Mental Health Practitioners tasked with assessing risk levels".*

**Response**: Greater Manchester Police acknowledges your concern. The Force recognises the importance of ensuring that partners including GMP have a common understanding of the respective roles and responsibilities of each agency in their collective response to people in mental health crisis. Furthermore this includes a shared understanding of risk and effective communication between agencies when incidents are reported and as circumstances change.

In 2019 The Greater Manchester Health and Justice Board oversaw work to develop and implement a common approach to people in mental health crisis. The involed a working group, Health and Justice Task and Finish Group, which included senior representatives form GMP and the North-West Ambulance Service, in addition to the mental health trusts serving Greater Manchester, local authority approved mental health practitioners and Greater Manchester Combined Authority.

This group examined multi-agency protocols and worked towards a common, documented, and consistently applied GM-wide procedure for responding to 'risk to life' where it presented as a result of mental health to blue light services.

A key issue identified was the lack of 24-hour mental health services and provision of the best qualified people to respond to people in mental health crisis.

Prior to the implementation phase and in response to the COVID-19 pandemic, two significant mental health crisis lines have been established, which assists in addressing this gap in services:

Firstly, Greater Manchester Mental Health and Pennine Care Foundation Trust now offer a 24-hour, 7 days a week mental health crisis line to known service users. Secondly, North West Borough Healthcare offer a 24-hour, 7 days a week mental health crisis line to known and unknown service users.

In addition to these lines, in April 2020, a Clinical Assessment Service (CAS) line went live for known and unknown service users. Any 999 calls and 111 calls that are an NWAS category 3 or 4 are sent for review by NWAS mental health practitioners. Incidents for the CAS are then inputted into the 'Adastra' system and reviewed by the CAS. The CAS is currently staffed by GP's who call the patient back, complete an assessment and refer to the appropriate service.

Phase 1 of the CAS has now been implemented, with further phases planned to expand this service. One of areas of expansion is to look at a referral pathway for GMP into the CAS. GMP lead, DCI Whittaker-Murray, attends the Greater Manchester Mental Health CAS planning meeting with key stakeholders, which are reviewing and developing future phases.

The introduction of mental health Trust lines and CAS lines is a significant step forward in addressing the collective response to people in mental health crisis and ensuring effective communication between agencies.

Furthermore, GMP have an embedded 24/7 Mental Health Tactical Advice Service (as per point one) who share information with GP's and any local care teams involved. GMP also has an established referral pathway to partnership agencies for onward referrals to GP's (as per point 2).

It is important to note that GMP does not commonly have access to or hold details of an individual's GP. Sharing infroamtion with GP's is carried out via local partnership referral mechanisms.

GMP has undergone a major IT system upgrade, an aspect of which has now given the Force the opportunity to look at the feasibility of an electronic information sharing system from GMP call handlers to NWAS call handlers (as per point one). This would improve the quality and system of communication between GMP and NWAS.

Work within the Health and Justice Task and Finish Group and previous Regulation 28 investigations have identified a training need within OCB and plans are in place to look at developing an appropriate training package for OCB staff.

Following on from this Regulation 28, it is recommended that OCB training should also include clear instructions regarding what information is shared with NWAS and guidelines to improve the quality of information shared.

We anticipate, this response illustrates some of the ongoing work within GMP to diligently work to address concerns raised and take on board the lessons learned. Greater Manchester Police and partners are committed to improving our individual agency and collective response to the needs of people with mental ill-health. We are using the knowledge we have gained from this case in our continuing work with partners.

I hope that this response is helpful in outlining the actions that we are taking to address the issues you raised and in demonstrating our total commitment to learning from the tragic death of Mr Pendlebury, so that we can prevent death or serious injury arising in similar circumstances in the future.

Yours sincerely

[redacted]

**Chief Constable**

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