Greater Manchester
Mental Health
NHS Foundation Trust

**PRIVATE & CONFIDENTIAL**

**Trust Management Offices**
First Floor, The Curve
Bury New Road
Prestwich
Manchester
M25 3BL

[redacted]
Web: www.gmmh.nhs.uk
WE ARE SOCIAL

Mr Nigel Meadows
Senior Coroner for Manchester City Area
HM Coroner's Court and Office
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester
M2 7EF

29th November 2021

Dear Mr Meadows

**Re: Anthony Declan Schofield (deceased) Regulation 28 Preventing Future Deaths Response**

Thank you for highlighting your concerns during Mr Schofield's Inquest which concluded on 23rd September 2021. Please see the Trust's response in relation to the concerns you have raised and the actions taken by the Trust:

(a) **No thorough comprehensive risk review was undertaken by a member of staff who had detailed knowledge of the Deceased prior to his discharge from the Inpatient Unit. This was not identified before he left the ward, and it was not discovered by the HBTT when they took over his care.**

Mr Schofield was admitted to Safire Ward on 8 August 2019. He was discharged from Safire Ward on 20 August 2019. The GMMH risk assessment tool, Star V2 Risk Assessment was completed by Safire staff during Mr Schofield's inpatient admission on 9, 11 and 19 August 2019. As the Trust's Investigation Report identified that staff explored risk with Mr Schofield over the night of the 18th and the morning of 19 August 2019 although did not update the Star V2 Risk Assessment. During the review of his risk Mr Schofield confirmed that he had no thoughts of wanting to [redacted] despite these matters being explored.
When Mr Schofield was discharged to the HBTT his risk was explored by staff with him although the Star V2 Risk Assessment was not updated.
GMMH Trust Clinical Risk Policy clearly sets out when a risk assessment should be undertaken.

During the period under review the Manchester services had recently changed to a new patient clinical record system, Paris, and were in the process of implementing the associated documents such as the Star V2 Risk Assessment which meant that there were some gaps in the services adhering to the Trust Policy.
The Standard Operating Procedures (SOP) for both the Inpatient wards and the HBTT have been updated to reflect the Trust Clinical Risk Policy and when staff should be completing a risk assessment. This includes on entry and discharge from a service as well as identified periods in between and in response to any changes to a person's risks. The Safire SOP clearly outlines that a patient's risk assessment should be reviewed and updated prior to discharge from the ward and that a crisis plan should be in place. There is a discharge checklist that prompts the activities to be completed before and upon discharge that is scanned into the patient clinical record on completion. This checklist identifies that the Star V2 Risk Assessment should be reviewed and updated prior to discharge. The manager of the ward will undertake a quarterly audit on the checklists and discharge process to provide assurance that they are being completed and uploaded to the patient clinical record.

The HBTT SOP states that there should be an up-to-date Star V2 Risk Assessment in place for people who are referred to HBTT, this was in place when Safire referred to HBTT. The HBTT SOP has been updated to clearly articulate the requirements of the HBTT staff on initial assessment which includes a review of and update of the Star V2 Risk Assessment and initial assessment are completed on the day of the assessment. This will lead to a 72 hour care plan being put into place by HBTT which will be shared with the service user.

(b) **The transfer and communication process from the Inpatient Unit to HBTT appeared inadequate.**

During the Trust investigation interviews with staff from the inpatient ward and HBTT highlighted that HBTT staff did attend the ward to review Mr Schofield prior to his discharge and were satisfied that they would be able to support Mr Schofield following discharge. Whilst this discussion to plan Mr Schofield's transfer was not documented in the clinical record, as would be expected, the staff were confident that information required to support his transfer had been shared verbally. To support the communication process from the Inpatient Unit to HBTT there is now in place on Safire a daily Multi-Disciplinary Team (MDT) meeting held to discuss all patients on the ward and the plans for their care and treatment going forward. HBTT staff attend this meeting daily and can discuss with the inpatient MDT any discharge plans and what is required to support the discharge.

(c) **There was no clear plan to deal with the risk of his condition deteriorating and him**

**experiencing significantly more [redacted] thoughts as well as obtaining the means by which to [redacted]. It is well known that a history of [redacted] thoughts and actions increases the risk when they are repeated.**

During the visit by HBTT staff on the late afternoon of 20 August 2019, crisis pathways were discussed with Mr Schofield and he was aware of pathways and support that he could access in the event of any deterioration and an increasing experience in [redacted] thoughts. During this visit, the HBTT staff further discussed ongoing support that Mr Schofield could access, and which would be provided. This included an agreement that there would be a further HBTT visit in two days, 22 August 2019 and a psychology appointment the following week, which took place on 26 August 2019. Crisis pathways were discussed with Mr Schofield and details provided to Mr Schofield should he need support in the intervening period.

Mr Schofield was seen on 22 August 2019 when he underwent a comprehensive review undertaken by an ST5 doctor and an HBTT Practitioner during which his risks were assessed, and a management plan was discussed and agreed that included increasing visits from HBTT to twice daily and monitoring of his medication to reduce the risk of overdose. Following this plan there were further visits from HBTT to Mr Schofield on 22 August and again on 23, 24, 25 and 26 August. On each of these occasions risk was explored and no concerns of risk of [redacted] were identified and / or disclosed by Mr Schofield.

(d) **When he disclosed that he bought [redacted] there was no risk review planning involving a senior HBTT clinician which was then monitored even when he indicated that he had received it.**

During the review with the ST5 doctor and HBTT Practitioner on 22 August 2019 and as part of the assessment of risk to self, Mr Schofield disclosed he had ordered the [redacted] but had now realised that this wouldn't be an option and indicated plans to hand it over to the team when it arrived. This concern was then reflected in the management plan with the increase in visits and the sharing of information indicating that Mr Schofield intended to hand over the [redacted] when he received it.

The notes record this being followed up by HBTT staff in a visit later that day and again on 26 August 2019 during a visit when Mr Schofield disclosed that he had received the medication and disposed of it in a bin in the community which he believed had now been emptied. Mr Schofield participated in a detailed review of his psychological health with a senior clinician from HBTT, clinical psychologist, during which he said that he did not wish to [redacted] rather he wanted to 'escape the emotional turmoil'. There was no indication at this point that Mr Schofield posed an imminent risk to himself and the HBTT staff considered that he could continue to work with HBTT and be supported in the community rather than being readmitted to hospital.

To support the communication within HBTT there are daily MDT meetings where all patients are discussed, any new information, risks, and the plan for the next 24 hours and

who will carry out that plan. All information, including known risks is kept live on a digital screen, any member of the team can update the information and the process has oversight from the Senior Practitioner within the team.

(e) **On several occasions before he died the Deceased saw members of the HBTT but they failed to demonstrate professional curiosity and enquire about his [redacted] thoughts and plans. They were either inadequate or no records about this.**

The clinical records show that HBTT staff did review Mr Schofield prior to his discharge from Safire ward including risks to self and on 20 August 2019 when the records identify risk was explored and a plan of care that included Mr Schofield being given numbers for the Crisis Line, Sanctuary and Crisis Point. During the assessment by the Clinical Psychologist on 26 August 2019 issues in respect of [redacted] thoughts were explored including risk during which Mr Schofield indicated he was able to keep himself safe and denied any thoughts to [redacted] himself in any way and a plan arising from that assessment was made accordingly.

Following the Trust's review into Mr Schofield's death it was acknowledged that the documentation was not always in keeping with Trust Record Keeping Policy in respect of the notes being recorded in the clinical record and that they did not always reflect the discussions that were occurring with the patient and so had the potential to impact on communication and decision making within the team. The HBTT SOP has been updated and states that *clinical risk and management are reviewed at each contact with the service user and changes responded to where necessary and escalated to the MDT if necessary*.
Since the review, in addition to the daily MDT meetings, HBTT have introduced a structured note format to prompt staff to review and record the purpose of the HBTT visit, how the patient was presenting and specific prompts in respect of assessing risk to self and others.
All staff have undergone training in respect of what they should be addressing in an HBTT contact and how this should be recorded and have received support from senior colleagues to embed the process.
Since the introduction of the structured note the Team Manager has put into place a process whereby senior staff undertaking supervision select notes to review prior to the staff members supervision, as per Trust Supervision Policy. There is also a quarterly audit planned to be undertaken across the team in respect of record keeping providing assurance that this structured note is being adhered to and record keeping is in line with Trust policy.
The Trust Clinical risk policy and training has been updated to reflect the use of professional curiosity, this training is mandatory and all staff should attend the training every three years as a minimum.

(f) **There were a number of missed opportunities for the HBTT to assess changes in his presentation and risk profile.**

The Trust would refer to the responses provided in respect of the previous concerns that highlight members of the HBTT did monitor Mr Schofield and assess/explore any

changes in his presentation and risk profile and what has been put into place since his death to improve the recording and communicating of these risks.

(g) **There was no robust audit system for checking compliance with the Trust's own policies and protocols, in particular with regard to medical record keeping, risk assessments and reviews.**

As outlined in point (e) supervisors review a selection of clinical records as part of the preparation for monthly supervision with staff and there is an expectation that any issues relating to the quality of medical record keeping, risk assessments and reviews would be picked up and addressed with staff during management supervision sessions.
In addition to individual reviews of documentation Ward and Team Managers should carry out quarterly audits on a selection of records to ensure that SOPs and Trust Policy is being adhered to as outlined earlier in this response.

(h) **The GMMH SUI investigation report contained several factual errors and misinterpretations. It was only discovered at the inquest hearing that one of the last members of HBTT staff to see the Deceased had given an account that was not the same as given to their Line Manager. This meant that all the lessons for future care and planning were not learnt. There was inadequate overview of the report before it was signed off.**

We apologise if there were factual errors within the Trust Serious Incident (SI) investigation report. The Trust process for obtaining information from staff involved in an SI has been updated to ensure we gather statements from staff at an early stage following the SI and use these statements in the SI review.
When a team of clinical staff are allocated to complete a review following a serious incident, they are allocated a Patient Safety Practitioner to support and advise the review team throughout the review process. The Patient Safety Practitioner is an experienced professionally qualified member of staff who has additional knowledge and skills in incident management.
Following completion of the review the final draft is shared with Senior Managers and Clinical Leads in the area of the Trust where the SI occurred to check for factual accuracy and approve content and recommendations.
The report is then taken to a Post-Incident Executive Review Panel who can raise questions of the Review Authors and the Service Managers. Following any amendments, the Executive Panel approve the report and it's content for release to the family and other concerned stakeholders, i.e. commissioners, coroners.
It is expected that any factual inaccuracies are addressed during the review, the Trust have addressed this concern with the Author of the Trust's RCA investigation in this case.

Mr Meadows, on behalf of the Trust can I thank you for bringing these matters of concern to the Trust's attention. I hope this response demonstrates to you and Mr Schofield's family that GMMH have taken the concerns you have raised seriously. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,

[redacted]

**Medical Director**

[redacted]