Greater Manchester
Mental Health
NHS Foundation Trust

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Mr Nigel Meadows
Senior Coroner for Manchester City Area
HM Coroner's Court and Office
Exchange Floor
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Cross Street
Manchester
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Date 10th January 2022

Dear Mr Meadows

Re: Darren Lawrence (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for highlighting your concerns during Mr Lawrence's Inquest which concluded on 4 October 2021.

On behalf of the Trust can I apologise that you have had to bring these matters of concern to the Trust's attention. I hope the response below demonstrates to you and Mr Lawrence's family that GMMH have taken the concerns you have raised seriously and will learn from this.

Please see the Trust's response in relation to the concerns you have raised, and the actions taken by the Trust:

a) The transfer and communication process from the HBTT to the CMHT in 2019 and 2020 was unsatisfactory with inadequate follow up as required. The court has received evidence about similar problems in other inquests in which GMMH was the treating NHS Trust and is a repeated issue of concern.

The Trust investigation into the care and treatment received by Mr Lawrence from GMMH was completed in March 2021. This investigation report reflected those changes that had been made to the CMHT processes in respect of receiving and allocating referrals. Each CMHT has identified staff that manage all individuals who are referred into the team and ensure they have an assessment undertaken within the timeframes set out in the Standard Operating Procedure. Once assessed as requiring CMHT a Care Coordinator is identified by the Team Manager who has oversight of all cases under the care of the CMHT.

The Trust has implemented daily multi-disciplinary zoning meetings in CMHT to review individuals who may be in crisis and require additional support. These daily meetings are now attended by staff from HBTT twice per week allowing for better communication between the teams and the ability for both teams to communicate with each other in respect of

transfers of care and which individuals can be stepped down from HBTT back to CMHT and who may require stepping up to HBTT.

HBTT has introduced a discharge coordinator who is a Senior Practitioner in the team who as part of their role quality checks all discharge plans before an individual is discharged from HBTT.

HBTT have also introduced a discharge checklist that includes joint visits with CMHT staff when discharging to CMHT which has had an audit undertaken to ensure this is embedded. Going forward the HBTT Team Manager will carry out a quarterly audit of discharges from HBTT to ensure that individuals are being stepped down from HBTT to CMHT in line with both services operational policies and receiving the support they require. The first one of these will be completed by 31st March 2022.

The Trust acknowledges that there was inadequate follow up from the CMHT following the Care Coordinator leaving the team.

The Trust now using Management and Supervision Tool (MaST) across all CMHT's. MaST is a software platform which analyses data from the Trust's existing clinical records system, Paris, to supplement decision making in CMHT's regarding likely resources required to provide effective mental health care. MaST is being used in individual supervision and in team zoning meetings where it can be easily identified when someone was last seen by the service and any gaps can be picked up by the Team Manager and the clinical team.

There is also a clear process in place in respect of any Care Coordinators that are leaving the service and the review required by the Team Manager to ensure that an individual has continued access to CMHT support in the absence of an identified Care Coordinator.

Caseload reports are provided to the CMHT's on a weekly basis and are reviewed by the management team and any issues in respect of team capacity are raised with Senior Managers to enable a plan to be put into place so that individuals are not left without the support required from the CMHT.

Following a Trust internal investigation, a multi-disciplinary learning event is held to share findings and learning from the investigation. This learning event is usually held within two months of the investigation being completed. Due to the need to prioritise clinical care during the COVID pandemic a learning event has not been held to share learning from this investigation. The Senior Management Team will share learning from this event with staff across the Division by the by 14th January 2022. To enable the learning to reach more staff the learning event will be held, led by the Operational Manager for CMHT's by 28th February 2022.

b) There was lack of appropriate escalation following the deceased's disengagement with community services in 2019 but also in 2020 when there was a repeated lack of direct contact with him as well as the recognition of its importance. From June 2020 no other methods were tried to have direct contact with the deceased apart from attempts from phone calls which were repeatedly unsuccessful.

As outlined in the point above the Trust acknowledges that there was lack of escalation and follow up for Mr Lawrence form the CMHT following his discharge from HBTT in February

2020. This has been addressed in above and in addition the Trust has reviewed it's policy for disengagement.

In autumn 2020 the Trust implemented a policy for Managing Did Not Attend (DNA) and Cancellations. The policy provides information regarding the appropriate response to service user non-attendance at planned appointments as well as detailing different categories of non-attendance and non-engagement to support decision making across GMMH services and teams.
This policy clearly outlines what staff should do and when/how to escalate that someone has not attended a planned appointment or staff have been unable to access them for a visit in the community. The escalation is based upon the person risk assessment and any concerns that the care team may have. As well as any risks being considered there are identified timeframes for escalation following no access visits across different services including HBTT and CMHT.

The policy also states that those service users engaged with services who are known to DNA should have contingencies in place to manage DNAs as part of their care plan. This plan should be informed by the individuals risk assessment.

The policy has been disseminated to all clinical staff across the Trust and is referenced in service operational policies. The team managers of CMHT's and HBTT will ensure this policy is discussed in a Team meeting by the end of January 2022 and evidenced in the team meeting minutes. The Team Managers are responsible for monitoring compliance with this policy and do so through individual staff supervision and weekly monitoring of the team caseload via a caseload report.

c) There was no consideration of referral back to the HBTT by the CMHT when the deceased may have benefited from it when circumstances changed. There was disengagement from services after the end of February 2020 as well as evidence of noncompliance with medication.

Following the Care Coordinator carrying out a 'cold call' visit to Mr Lawrence on 7th February 2020 he was referred to HBTT on the same day and remained under their care until 26th February 2020.

Following Mr Lawrences discharge back to the CMHT he did not have consistent support from a Care Coordinator and so the CMHT were unaware that he was not compliant with his medication. When Mr Lawrence was allocated a new care coordinator in May 2020, he would not answer his telephone or engage with them and so contact was made through his ex-partner. This let to missed opportunities to assess Mr Lawrence, his mental health, compliance with medication and any changes to risks to self which could have led to a referral back to HBTT. The lack of a Care Coordinator is addressed in point a of this response.

d) There was no GMMH procedure or process to check regularly if the deceased was being prescribed the correct medication and it being collected. In addition his response to it.

The procedure for checking on the prescribed medication and an individual's compliance with this should be part of the care plan and the staff seeing the individual should be carrying out mental state assessments that include compliance with any medication and the effectiveness

of this. In Mr Lawrence's case the fact he was prescribed medication for his mental health that the GP was asked to provide was not reflected in the care plan and so conversations were not held regularly regarding compliance which led to missed opportunities to liaise with the GP about Mr Lawrence's medication and the fact he was not always collecting it.

During supervision with staff the 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 adherence to the Trust CPA Policy would be picked up and addressed with staff during management supervision sessions.

Compliance with the Trust CPA Policy is monitored individually through staff supervision and through the Trust annual CPA Audit.

e) **The GP practice failed to ensure that medication (for a patient with a serious mental health problem with a history of suicidal ideas, plans and previous attempts) was prescribed. This is despite them receiving letters from GMMH clinicians requesting this. Consequently, the deceased did not receive the therapeutic benefit the medication would have provided.**

GP to provide response

f) **The GP system for recording receipt of correspondence and ensuring that they were seen and reviewed by a GP was inadequate. As was communication with and from the Pharmacy team. Nor was there consideration of a system or process for contacting the secondary care provider GMMH in such circumstances when medication was not prescribed as requested and no contact could be made with the deceased. There was no escalation process/procedure.**

GP to provide response

g) **There was no CMHT/HBTT planned involvement with the GP in the overall management and treatment of the deceased apart from simply requesting that they issue repeat prescriptions. This meant that opportunities to develop other lines of communication and information sharing as well as support were lost.**

When under the care of the Community Mental Health Team the service user's medication including what is prescribed and who is monitoring this should be included as part the holistic assessment and resulting care plan, the GP should be involved in this process. The Trust Care Programme Approach policy outlines the process for contacting all people involved in a patient's care, at least annually, as part of the CPA review and update of the care plan. The patients GP should be invited to attend the CPA review or asked to provide written feedback for the review. If the GP is too busy to make contact GMMH staff have access to the Greater Manchester care record and can check this to ascertain if service users are attending the GP and collecting prescribed medication. The Trust acknowledges that the CPA review carried out by the CMHT in January 2020 did not follow this process, therefore missing an opportunity to liaise with the GP in relation to the prescribing and management of Mr Lawrence's medication to support his mental health.

Compliance with the Trust CPA policy is monitored individually through staff supervision and through the Trust annual CPA audit.

In addition, the Team Manager for this CMHT will carry out an audit of a selection of the teams care plans and CPA reviews to provide assurance that the Trust CPA process is being followed and that the GP's are being contacted and requested to contribute as part of the review. This audit will take place by 31st January 2022 and the audit, and any resulting action plan will be shared at the Divisional Senior Leadership Group.

h) The CMHT Responsible Clinician was an important witness but the GMMH SUI investigation did not obtain a statement from him and the those carrying out the investigation failed to recognise the significance of this. Nor was this identified in the overview of the report before it was signed off. This meant the all the lessons for future care and planning were not learnt. The court has received evidence about the same issue in other inquests involving deaths of GMMH patients and is a repeated matter of concern

The CMHT Responsible Clinician did not see Mr Lawrence during the timeframe being examined during the GMMH internal review of the care and treatment delivered to Mr Lawrence prior to his death. Mr Lawrence was seen by medical staff, on one occasion at his home address. The medical staff discussed the case with the CMHT RC and the RC gave advice which was acted upon.

The Trust acknowledge that the CMHT RC could have been interviewed as part of the internal review, although do not consider that this would have changed the findings of the review.

Following a review of the Trust management structure an Assistant Director for Quality has been appointed for the Manchester services to work alongside the Assistant Medical Director and the Assistant Director for Operations. The Assistant Director for Quality will be taking forward the actions outlined within this response and will be working with the Senior Leadership team to address the concerns you have raised in recent inquests.

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 Lawrence'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]

Dr [redacted]
Medical Director
[redacted]