Greater Manchester Health and Social Care Partnership
4th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN

T: [redacted]
E: [redacted]

26 November 2020

Ms A Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Alfie Ian Samuel Gildea 18.11.2020

Thank you for your Regulation 28 Report dated 18 November 2020 concerning the sad death of Alfie Gildea on 14 September 2018. Firstly, I would like to express my deep condolences to Alfie Gildea's family.

The inquest concluded that Alfie's death was a result of 1a) Head Injury.

Following the inquest you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership (GMHSCP) that there is a risk future deaths will occur unless action is taken.

I have noted that your Regulation 28 letter has also been sent to Greater Manchester Police, Trafford Metropolitan Borough Council, Greater Manchester Mental Health NHS Foundation Trust, Pennine Care NHS Foundation Trust, The Crown Prosecution Service, the Home Office and the Department of Health and Social Care and I will leave it to the named respondents to address the concerns which you have expressed. My letter therefore addresses the issues that fall within the remit of GMHSCP more widely around how we can share the learning from this case.

NHS England / Improvement Regional Safeguarding and Quality Team use a variety of approaches to share learning and good practice across the North West and North East & Yorkshire Regions. This includes a weekly safeguarding bulletin which is disseminated to CCG Designated Professionals and dissemination of "7 minute briefings" following published serious case reviews (SCR), domestic homicide

reviews and serious adult reviews across the regional footprint to promote learning and share good practice.

An SCR was completed and published in December 2019 which resulted in the identification of a number of actions that are being overseen by the Trafford Strategic Safeguarding partnership. In light of the findings of the inquest the SCR action plan is being reviewed and scrutinised with a view to ensuring that all local learning is ascertained, acted upon and shared. Further details on this will be within the individual responses to the regulation 28 from other partners.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

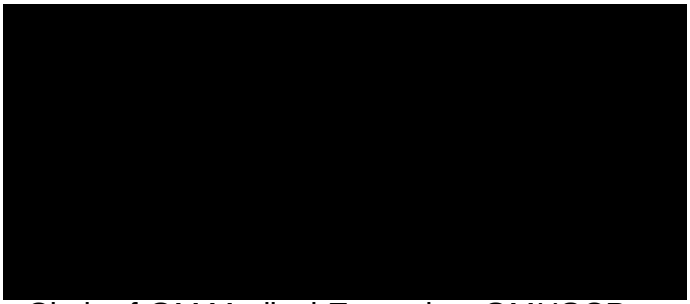
1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Learning to be shared with the Greater Manchester commissioners of services to consider the findings of the investigation within the context of the services they commission

The Greater Manchester Health and Social Care Partnership (GMHSCP) is committed to improving outcomes for the population of Greater Manchester. In conclusion key learning points and recommendations will be monitored to ensure they are embedded within practice.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely



Chair of GM Medical Executive, GMHSCP