Prevention of Future Deaths Reports concerning persons having contact with NHS mental health services in Greater Manchester in 2016-2023

Technical Report

January 2025

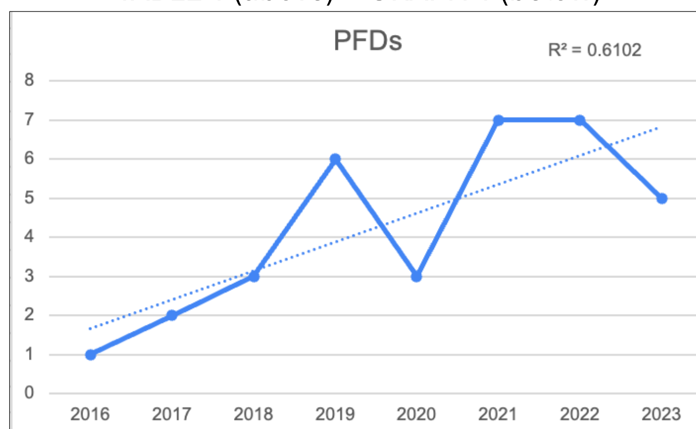
Executive Summary

This technical report has been produced by a data analysis project delivered by a group of CHARM volunteers. A volunteer project manager was chosen from within this group. This was a task-and-finish group, which ran from August to December 2024. (paragraph 1).

Overall, from the data we can say that there is a trend from 2016 to 2023 of roughly one extra PFD each year, from 1 a year to 7 a year; and we can say this with a level of confidence that is statistically accepted as 'moderately strong.' (paragraph 21).

Year	PFDs	T-	B-	G-	S-	C-	E-	H-	I-	L-	N-	P-	D-	O-	A-	F-	M-	J-	R-	U-	Q-
2016	1	1	1	1		1	1		1				1		1						
2017	2	2	2	2	2	2	2			2	2		2		1	2	1			1	
2018	3	3	3	2	3	1	2	3	2							2					1
2019	6	4	4	6	4	3	4	5	5	4	5	4	3	2	3	2	3	4	2	1	
2020	3	3	3	2	1	2	3	2	2	2	1	2	1	1	2	1					
2021	7	7	6	6	7	7	4	7	2	5	5	1	3	5	2	1	4		1		
2022	7	6	5	6	5	7	4	5	5	5	4	5	2	3	2	2					
2023	5	3	4	2	5	1	3	1	3	1	2	4	1	2	1	1	1	2	1		
TOTALS	34	29	28	27	27	24	23	23	20	19	19	16	13	13	12	11	9	6	4	2	1

TABLE 1 (above) GRAPH 1 (below)



Main Report

Methodology

1. This technical report has been produced by a data analysis project delivered by a group of CHARM volunteers. A volunteer project manager was chosen from within this group. This was a task-and-finish group, which ran from August to December 2024.

2. For clarity here, the volunteers are supporters of CHARM who are in the "CHARM Society" unincorporated group, however the report and campaign messages are being formally presented by the Directors of "CHARM Projects CIC."

3. "PFDs" refers to Prevention of Future Deaths reports, which are legal documents produced by coroners when they investigate a death and find that the underlying causes could have been avoided and risk being repeated. The PFD is sent by the coroner to the organisation best suited to reducing the future risk. Statutory organisations such as NHS Trusts are obliged to reply to the coroner with a report on what steps they have taken or plan to take. The dates used here are those of when the PFD was issued, not the date of death, for reasons of data availability.

4. This data analysis project was self-initiated by CHARM members who have a strong concern that the Greater Manchester Mental Health NHS Foundation Trust ("the Trust") was not responding to the rising number of PFDs being issued to it over the last 10 years. The majority (27/34) of the PFDs analysed here relate to the Trust.

5. A further 2 PFDs related to its predecessor, Greater Manchester West Mental Health Trust, GMW MHT; 2 related to the Greater Manchester Integrated Partnership Board (GM ICB), 2 related to the Department of Health and Social Care (DHSC), and 1 related to both GM ICB and DHSC. (n=34: 27 + 2 + 2 + 2 +1)

6. This data analysis was inspired by the work of fellow campaigners in Norfolk & Suffolk who had undertaken a similar campaign and data analysis in their area, leading to an independent health data audit being commissioned which confirmed the findings, with the matters being raised by MPs and others. At the time of writing their campaign continues to seek a police detectives investigation into alleged corporate homicide.

Data availability

7. In the months leading up to the project here, a number of FOI (Freedom of Information) requests had been sent to the Trust asking about PFDs. The worrying reply was that this information was in the public domain elsewhere, and therefore exempt from further details being given.

8. This reply was disingenuous. There is an independent website with a database of details of every PFD in Britain in recent years, over 5,000 in all. However, this data cannot be extracted by geographic area (eg Greater Manchester), plus there are difficulties with the number of probably relevant organisations (eg Pennine Care, the Integrated Care Board) plus PFDs sent to the Department of Health and Social Care HQ in London when coroners began to conclude that the local organisations were ignoring their concerns.

9. This reply also raised our suspicions that a deeper failure was coming to light. If the Trust managers had been processing PFDs professionally then there would be, for example, a tracker spreadsheet or similar to log the receipt of each PFD, the actions taken, the reply given, and the lessons embodied for example in future frontline staff inductions and in-service training.

10. Instead, the suspicion was that Trust managers were "fobbing off" coroners on a disorganised and ad-hoc basis, with no central system of accountability, leading to their inability to respond to a FOI request with a competent set of data.

11. The Edenfield scandal reinforced this suspicion of a senior management team which was focussed on reputation management and budget control to the exclusion of their other professional duties, and lethally so. Thus CHARM members decided to investigate this further, in the absence of efforts by other scrutiny bodies.

12. This project had to work with the best available evidence and identified 45 PFDs which could be in scope, and a detailed tracker was created to produce a controlled environment for data processing. PFDs do include personal details but these are exempt by law from the usual GDPR restrictions. As a matter to public health policy to avoid contagion descriptions of the means of a suicide are redacted at source.

13. Of the 45 PFDs in the period 2015-2024 some were removed because the two years 2015 and 2024 were only partly available, and thus the chosen timeframe is 2016-2023 where each year is a full 12 months and therefore the numbers are comparable year-on-year. This timeframe included 34 PFDs. There is a data feature concerning 2022 where four PFDs were unable to be sourced, so there may be some under-reporting in that year.

14. We also identified press stories of sudden deaths being possibly referred to coroners where there seemed to be a Greater Manchester and a mental health component, however at the time of investigating these has not resulted in a sourced PFD. Also, not every coroners hearing produces a PFD.

Ethics

15. From the outset the group of CHARM volunteers were very aware of the sensitive nature of PFDs and the possible distress that reading and processing them can cause to individuals, especially people with lived experiences which mirror the PFD narratives. Because of these concerns the following ground-rules were established at the start:
1. To limit the number of PFDs to 5 per person.
2. To allow volunteers to withdraw at any stage.
3. Not to set a deadline for PFD assessments, not to chase for assessments, and not to use blame or comparisons for any silences etc.

16. One volunteer chose to assess all the known PFDs in the time period, and a one-to-one training session with the project manager where the risks were discussed in depth was held before the data was made available. All other volunteers did no more than five, though some offered to do more later if necessary.

Benchmarking training

17. Before the PFD data files were shared out, an online training session was held in an early evening, repeated as necessary. This session used two real-life case studies from Norfolk & Suffolk, chosen as outliers because they had very few and very many harm-related issues within their narratives. The objective was to benchmark people’s assessments as far as was reasonable given our circumstances and limited resources.

18. Because some PFDs were assessed ("scored") by more than one volunteer it was possible to get an impression on the degree to which different peoples' judgments converged. The largest divergence between individuals was 6/21 in terms of the issues identified.

Comparability

19. The project team were concerned to keep the work in Greater Manchester comparable with the earlier work in Norfolk & Suffolk. Thus, as well as the benchmarking case studies described above, we liaised beforehand with the volunteer project manager at Norfolk & Suffolk at our design stage. We followed their 20 issues in the assessment process, and added a 21st issue ("U") based on reported local concerns by our membership. The assessment proforma is attached, as are the [anonymised] training case studies.

Findings

20. The findings here are derived from the data derived from the best available evidence to the project (see Table 1). Other CHARM reports will draw out the wider policy issues which relate to this data analysis.

21. Overall, from the data we can say that there is a trend from 2016 to 2023 of roughly one extra PFD each year, from 1 a year to 7 a year; and we can say this with a level of confidence that is statistically accepted as 'moderately strong.'

22. The trend line is shown in the graph here as the dotted line, known as the "line of best fit" (see Graph 1).

23. Statistically this line has a R^2 value ("R squared") of 0.6102. The R^2 value is known as the "coefficient of determination."

24. In plain language the R^2 for the data table here can explain 61% of the time trend in the data, which is statistically deemed to be a "moderately strong" time relationship. Note, it doesn't explain the other 39%, and it does not explain cause and effect, just the visible underlying trend.

25. There are two statistical caveats – the R^2 value might be an under-estimate of the true value if the data relationship is actually non-linear; equally it might be an over-estimate if the underlying model is highly complex, leading to "over-fitting."

A	Inpatient death	F	No care plan	K	GP ignored	P	Staffing issues
B	Unclear policies	G	Information not shared	L	Poor records	Q	Diagnostic errors
C	Delays	H	Fragmented services	M	Family ignored	R	Relapse signs ignored
D	Waiting	I	Ineffective care plan	N	Inadequate obs	S	Risk ignored
E	Unclear roles	J	Suicide signs ignored	O	Unsafe discharge	T	Poor communication
U	Medication related	-		-		-	

TABLE 2 – Issues being assessed (for further details see Appendix)

26. We can also see from the table (grid) that issues of

T Poor communication
B Unclear policies
G Information not shared, and
S Risk ignored

were raised most often, based on our assessments. (see Table 2).

27. Averaged over the time period, the issues of

C Delays
E Unclear roles
H Fragmented services
I Ineffective care plan
L Poor records, and
N Inadequate observation

are also assessed as being present in over half of the PFDs. One issue, K (GP ignored), did not arise in any assessment across these eight years. (see Table 2).

END

ASSESSOR TRAINING GUIDANCE NOTES

The following themes are used in the Norfolk & Suffolk (N&S) campaign to code both individual inquests resulting in a PFD and media-reported deaths not subject to a PFD. The intention here within the similar Greater Manchester CHARM campaign is to use the same themes to provide an ease of comparability between our regions.

The table on pages 2 to 4 is an expansion of the N&S guidance for use in GM. Along with our training for new assessors, this approach is intended to provide a reasonable level of consistency.

ASSESSMENT			
Person's name and unique number	**P -**		
Assessor's name			
Failure theme 1 -- "A" to "U"		Failure theme 7 -- "A" to "U"	
Failure theme 2 -- "A" to "U"		Failure theme 8 -- "A" to "U"	
Failure theme 3 -- "A" to "U"		Failure theme 9 -- "A" to "U"	
Failure theme 4 -- "A" to "U"		Failure theme 10 -- "A" to "U"	
Failure theme 5 -- "A" to "U"		Failure theme 11 -- "A" to "U"	
Failure theme 6 -- "A" to "U"		Failure theme 12 -- "A" to "U"	
Trust etc Response:			
Any other thoughts, comments, from the assessor:			

Note: Trust etc response can include: not available / root cause analysis / new procedure / serious incident review / audit undertaken / etc

A	Inpatient death	**F**	No care plan	**K**	GP ignored	**P**	Staffing issues
B	Unclear policies	**G**	Information not shared	**L**	Poor records	**Q**	Diagnostic errors
C	Delays	**H**	Fragmented services	**M**	Family ignored	**R**	Relapse signs ignored
D	Waiting	**I**	Ineffective care plan	**N**	Inadequate obs	**S**	Risk ignored
E	Unclear roles	**J**	Suicide signs ignored	**O**	Unsafe discharge	**T**	Poor communication
U	Medication related						

Code	Keywords	Description	Examples	Notes
A	**Inpatient death**	Any death that has taken place whilst the person was a patient within an NHS hospital or private hospital.	This includes the death happened outside of the ward, on the grounds, away from the grounds on leave, while still a patient.	
B	**Unclear policies**	Unclear policies and procedures - any death that occurred as a result or from a contributing factor of the trust having confusing policies and procedures that staff have struggled to follow.	It would also include staff being unclear of which team to refer to, referrals getting lost, mismatched risk escalation or downgrading risk unnecessarily, and lack of follow ups that do not match with policy.	If docs confused, choose B If people confused, choose E If inter-service confusion, choose H
C	**Delays**	Failure to act within timescales - any death that occurred as a result or with contributing factors of either trust or NHS guidance timescales not being met.	For example, a 4-hour crisis team referral not taking place, or a 72-hour GP referral taking 2 weeks.	If delay was for an appointment or assessment, choose D
D	**Waiting**	Waiting for an appointment or assessment - any death that occurred as a result or by contributing factors of waiting for an appointment or assessment.	This includes while being 'parked' awaiting a ward bed or external placement.	For other delays, choose C
E	**Unclear roles**	Unclear roles and responsibilities - any death that occurred as a result or with contributing factors of ineffective multi- agency working.	Specifically where individuals or organisations are unclear of who is responsible for which part of a patient's care.	If unclear docs, choose B If people issue, choose E If inter-service issue, choose H
F	**No care plan**	Any death that occurred as a result or from contributing factors of the complete absence of a care plan.		If an existing but ineffective care plan, choose I
G	**Information not shared**	No system for effective communication / information sharing - any death that occurred as a result or from a contributing factor of different agencies or organisations being unable to access the relevant information needed, the lack of sharing of important information because they are unsure how to or there is no effective way to do so.		If an information systems fault, choose G If a fault in records, choose L If a staff behaviour fault, choose T

H	**Fragmented services**	Fragmented or uncoordinated services - any death that occurred as a result or from a contributing factor of services not working together when they should be, not involving relevant agencies or poor joint management and consolidation of care.		If unclear docs, choose B If people issue, choose E If inter-service issue, choose H
I	**Ineffective care plan**	Any death that occurred as a result or from a contributing factor of a care plan not being updated or added to match the patient's presentation or needs.		If no care plan at all, choose F
J	**Suicide signs ignored**	Any death that occurred as a result or from a contributing factor of a person seeking help, expressing suicidal ideation or planning and there has been no action or escalation.		If concerns come from GP, choose K too … from family, choose M too If part of a relapse, choose R too
K	**GP ignored**	GP concerns ignored - any death that occurred as a result or from a contributing factor of GP's concerns being undermined or dismissed.	Includes where a GP has made an urgent referral and this has been downgraded by trust staff without explanation.	If part of a relapse, choose R too
L	**Poor records**	Recording issues - any death that occurred as a result or from a contributing factor of a patient's clinical record being absent, inaccurate, changed or altered and access to records not being possible.	Includes falsifying and destruction of records.	If an information systems fault, choose G If a fault in records, choose L If a staff behaviour fault, choose T
M	**Family ignored**	Family concerns ignored - any death that occurred as a result or from a contributing factor of family members being dismissed, excluded or ignored when they tried to seek help for their loved one or express concerns.		If part of a relapse, choose R too
N	**Inadequate observations**	Any death that occurred as a result or from a contributing factor of observations that may have not been done in line with the person's presentation, e.g. not being given additional observations when risk has increased.	Ward based only.	If risk related, choose S too

O	**Unsafe discharge**	Any death that occurred as a result or from a contributing factor of unsafe discharges, which were not in line with trust policy, or did not match up with the person's presentation or risk, discharges to formal or informal support, discharges with extensive medication or any unplanned discharge.		If risk related, choose S too
P	**Staffing issues**	Any death that occurred as a result or from a contributing factor of lack of staffing, staff sickness, or over reliance on agency staff.	This could also include staff not being adequately trained, Locum doctors, lack of psychiatrists etc.	If staffing issues impacted on comms, choose T too
Q	**Diagnostic errors**	Diagnostic overshadowing - any death that occurred as a result or from a contributing factor of the mis-attribution of a person's symptoms of one illness to an already diagnosed illness or co morbidity leading to compromised patient care.		
R	**Relapse signs ignored**	Any death that occurred as a result or from a contributing factor of the person showing signs of relapse.	The trust may have known that the person was getting worse, yet ignored or failed to identify that.	
S	**Risk ignored**	Any death that occurred as a result or from a contributing factor of the person having been overtly at risk of harm or suspected to be at risk, however, it was not escalated or acted upon.		If includes on-ward observations faults, choose N too
T	**Poor communication**	Any death that occurred as a result or from a contributing factor of poor communication within the teams, between agencies, between families and patients.		If an information systems fault, choose G If a fault in records, choose L If a staff behaviour fault, choose T
U	**Medication related**	Any death where the coroner specifically **names** one or more items of medication as being a contributing factor that needs to be recognised and learnt from to prevent future deaths.	This does not include 'drugs errors' where a mistake was made in the provision of a medication.	

PREVENTION OF FUTURE DEATHS (PFDs)

ASSESSMENT TRAINING BENCHMARKS

CASE 1 – "Jordon Smith"

3 INVESTIGATION and INQUEST

On 6 March I commenced an investigation into the death of JS, 54. The investigation concluded at the end of the inquest on 1 December. The conclusion of the inquest was that he died from multiple skull and rib fracture with pneumohaemothorax due to a road traffic collision and that he had taken his own life.

4 CIRCUMSTANCES OF THE DEATH

On 15 January JS who had a long history of mental health informal admissions ran into the path of a lorry on the A14 Westbound. Eye witnesses confirmed that his actions were deliberate. His injuries were incompatible with life. Recognition of Life Extinct (ROLE) at 20:50 hours. JS had been unescorted awaiting test results on Acute Assessment Unit (AAU). He had expressed to a security guard that he was feeling suicidal and that was why he was under Wedgewood unit. He appeared withdrawn but this information did not reach Wedgewood or the Staff Nurse.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. – (1) The Hospital Security Guard guided JS back to AAU looking lost and confused (following a cigarette break) when in a general way saying that he was feeling suicidal and that that had been the reason why he was under the care of Wedgewood. There were no immediate concerns for him, but the Security Guard had been concerned enough to ask for the Wedgewood staff member escort when he returned to AAU. Andrew's presentation had not been reported to any clinician at either AAU or Wedgwood.

PREVENTION OF FUTURE DEATHS (PFDs)
ASSESSMENT TRAINING BENCHMARKS

CASE 2 – "Alex Jones"

3 INVESTIGATION and INQUEST

On 15th November I commenced an investigation into the death of AJ aged 72. The investigation concluded at the end of the inquest on 4th February. The cause of death was 1a) Acute Pulmonary Embolus (PE) 1b) Deep Vein Thrombosis (DVT) The conclusion from the jury was Natural Causes. There were a number of collective failings and missed opportunities that may have contributed to AJ'S death. 1) There was no written Venous Thrombus Embolism (VTE) assessment for AJ after July 2019. 2) Insufficient consideration was given to AJ's reduced mobility because of diagnostic overshadowing. 3) The clinical notes failed to highlight AJ's past medical history of Deep Vein Thrombosis (DVT) and associated risks. 4) There was inadequate DVT training for ward staff. 5) Administering a prophylactic dose of heparin may have resulted in a different outcome.

4 CIRCUMSTANCES OF THE DEATH

AJ was admitted twice under section of the Mental Health Act in 2019. She had a diagnosis of Bi-polar Affective Disorder and suffered from depression and anxiety together with Hypothyroidism and 2 previous DVTs. She had Chronic Lymphoedema to both legs. In October 2019 AJ was transferred to a rehabilitation ward to ready her for discharge to supported housing prior to going to her home, as it was felt that her presentation and mental health had improved. She was usually independently mobile but on 25th and 26th October she requested a wheelchair and one was brought in from home. She used this to push and walk about the ward. By 31st October when AJ complained of feeling unwell her mobility had declined and she was not coming out of her room. There was no evidence that she was walking then except briefly when seen by a doctor. No specific illness was detected although physical observation and blood tests were done, these were all normal. The same doctor saw her on 1st November again nothing specific was found. On both occasions AJ was examined for a current DVT but no documented formal assessment of her future risk of DVT was made. She had several risk factors, she was over 60, obese and had a past history of DVT. Her reducing mobility was not considered a further risk factor even though it put her into the very high category because it was thought to be due to her mental

(more)

health and may therefore improve. After the 1st November the doctor went on leave and left instruction that any further concerns be raised and if needed a doctor would review. AJ was not reviewed on 2nd November and remained on her bed in her room and on 3rd November another doctor reviewed her, again looking for current DVT but finding none and no consideration was given to her future risk given that her mobility was greatly reduced. On 4th November a doctor was called for general not specific concerns and he chose not to examine AJ since on the notes her presentation had not changed from 3rd November. On the morning of 5th November AJ collapsed whilst being moved and suffered a cardiac arrest. Resuscitation was prompt and emergency services attended but she died in the ambulance. An expert opinion concluded that on the balance of probabilities the DVT was not formed before the 2nd November and that prophylaxis given then would have prevented the DVT and the PE.

5 CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The matters of concern are as follows: Irrespective of the reason for a person's mobility reducing, if it does so and this is a known risk factor then notice must be taken of it and appropriate steps taken. Medical staff should follow the Trust's protocols and perform and document a VTE risk assessment when the reduction in mobility is reduced (from their baseline) even if it is not known if / how long the reduction will continue. All staff should raise concerns and if they have specific ones, document what these are in the clinical notes. Clinical notes should contain more detail about the patient since they are what is relied upon (with a verbal handover) to inform staff on later shifts. If a patient is to be reviewed then a specific plan should be placed on to the care plan so that everyone knows what is needed to be done. All staff should be aware of a patient's relevant past medical history. Junior staff should consult more senior staff if they are unsure of the effect that anticoagulation will have on anti-psychotics or other medication and are thus concerned about administering this.