INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

Professor Ted Baker
Chief Inspector of Hospital
Care Quality Commission
151 Buckingham Palace Rd
London
SW1W 9SZ

16 September 2021

Dear Professor Ted Baker,

Multiple Deaths At Greater Manchester Mental Health NHS Foundation Trust

I am writing to you to make you aware of three deaths involving children and young people at Prestwich Hospital, Greater Manchester Mental Health NHS Foundation Trust. In light of these deaths and the serious concerns we have about the safety of Greater Manchester Mental Health NHS Foundation Trust I am asking you, on behalf of bereaved families, to use CQC's statutory powers to urgently visit this Trust and independently assess its treatment of young patients.

As of September 2021, INQUEST have been made aware of three deaths, including two self-inflicted deaths, of young people at Greater Manchester Mental NHS Foundation Trust.[1] These deaths have all taken place in the last ten months. We are working with the families of [redacted] and [redacted], two of the individuals who have died. It is our understanding all three of these deaths took place on the Junction 17 ward or Gardener Unit which are part of the Trust's CAMHS units.

The fact of these deaths in such a short period of time - less than one year - is cause for great concern and we believe warrants immediate action from CQC.

I understand the CQC have resumed in-person visits from Mental Health Act reviewers. In evidence to the UK Parliament's Joint Committee on Human Rights[2], the then lead inspector for Mental Health Services, Kevin Cleary, stated CQC Mental Health Act reviewers were undertaking some in-person visits to units where intelligence from complaints and whistle-blowers had led to specific concerns. Dr Cleary also stated that two in-person, unannounced CQC inspections had been carried out to CAMHS units alongside a programme of "virtual visits".

We therefore urge CQC to use the multiple mechanisms at its disposal to visit Junction 17 and the Gardener Unit at Prestwich Hospital to assess the treatment and conditions for

[1] Manchester Evening News, July 2021, [redacted].

[2] JCHR, June 2020, Human Rights and the Government's response to COVID-19: The detention of young people who are autistics and/or have learning disabilities, https://publications.parliament.uk/pa/jt5801/jtselect/jtrights/395/39507.htm

patients and report publicly on the circumstances surrounding these extremely concerning deaths.

As you will be aware, the CQC has not visited the Trust since July 2019 and this inspection did not assess the conditions in Junction 17 or the Gardener Unit.[3] To my knowledge, the last inspection of Junction 17 and the Gardener Unit was almost four years ago, in December 2017.[4] In the 2017 report, CQC inspectors stated CAMHS services in the Trust required improvement to be good and noted not all safety checks were completed when due and that physical observations were not recorded properly.

It is deeply worrying that very similar criticisms of Junction 17 were made at a previous inspection, in February 2016.[5] For instance, the 2016 report found staff were not always completing records of when patients were observed and that in Junction 17 specifically there were 15 missing entries on patient observation records. Further, we are troubled by the fact the Trust has been rated as 'Requires Improvement' for safety in every inspection report since 2016. This indicates a worrying lack of improvement.

In light of the lack of recent scrutiny of the Trust and the concerning number of deaths occurring in such a short period of time, we hope you will proceed with the following steps:

- Conduct an urgent visit by Mental Health Act reviewers to the Junction 17 ward and Gardener Unit; and
- Prioritise an unannounced inspection of the Trust, focussing on its mental health in-patient services for young people.

INQUEST continues to be deeply concerned by deaths of children and young people in mental health settings, many of which raise serious questions about the quality of treatment and care and patient safety.

Publicly available data and scrutiny of these deaths is in both in the family and public interest. It is our view that data on the issue needs to be more publicly available. Further to this, we ask that you provide us with statistics on the number of deaths of children and young people **for the past five years broken down by age, gender, race/ethnicity and geographic location**.

If you require further information on the cases I have made reference to, please do not hesitate to contact me.

Yours Sincerely,

[I/S]

Deborah Coles

Executive Director

[3] CQC, January 2020, Greater Manchester Mental Health NHS Foundation Trust Inspection Report, https://api.cqc.org.uk/public/v1/reports/20c7f62c-7288-4dd8-a0d8-0eed3caf0a7c?20210114205309
[4] CQC, February 2018, Greater Manchester Mental Health NHS Foundation Trust Inspection Report, https://api.cqc.org.uk/public/v1/reports/42abfe7f-23e4-466c-bc95-00eebc16e694?20210112202915
[5] CQC, June 2016, Greater Manchester West Mental Health NHS Foundation Trust, https://www.cqc.org.uk/sites/default/files/new_reports/AAAF1696.pdf