NHS England

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Lydia C Brown
Exeter and Greater Devon Coroner's Office
Room 226
Devon County Hall
Topsham Road
Exeter
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Dear Ms Brown,

Regulation 28 Report to Prevent Future Deaths following the inquest of George Werb who died.

We are writing to you to respond to the concerns raised by your investigation into the circumstances surrounding the tragic death of George Werb.

NHS England and Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) takes very seriously its responsibility to act upon what it learns from deaths of young people in receipt of services commissioned by us.

Responsibilities and commissioning arrangement across Child and Adolescent Mental Services (CAMHS) is complex and much has changed since George was in receipt of these services. Throughout our response we will provide the required clarification and details of improvements relating to the areas of concern you have raised.

CAMHS is delivered within a 4 tier framework and since April 2013 the Commissioning Framework for CAMHS is as follows:-

Tier 1 (Universal services)
These are services whose primary remit is not that of providing a mental health service, but as part of their duties, they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

Tier 2 (Targeted services)
These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings. Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies. Arrangements vary

across the country and according to the nature of the service.

Tier 3 (Specialist services)
These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities. The latter varies across the country.

Tier 4 (Specialised CAMHS)
These include day and inpatient services and some highly specialist outpatient services including services for children/young people with gender dysphoria, CAMHS for children and young people who are deaf, highly specialised autism spectrum disorder (ASD) services, and highly specialised obsessive compulsive disorder services. These services have, since April 2013, been commissioned directly by NHS England.

Concern 1

The community team had to spend much time making numerous telephone calls to locate a child psychiatric bed. There was not at that time, and still appears to no, or no effective bed bureau system to identify spaces. This is wasteful of clinician time, creates inevitable delays and is indicative that there are routinely too few available beds to serve the needs of our young psychiatric patients

Since August 2013, NHS England has implemented a situation report (SITREP) process each Friday which requires all Child and Adolescent Mental Health Services (CAMHS) inpatient providers to submit numbers of available beds to a national database. This data is used to produce a report that is available from lunch time on a Friday indicating available capacity at each of the inpatient services commissioned. The report is circulated via the Area Teams to all Tier 3/Community CAMHS so they can identify capacity as required and particularly on a Friday when there is often a peak in demand and over the weekend. In parallel, there is a national Friday teleconference which is attended by all the CAMHS case managers from the ten Area Teams, where capacity is discussed in detail and also provides an opportunity for individual case managers to gain support from colleagues in other areas to identify suitable placements. From this teleconference, a detailed report is circulated to all Area Teams, providing details of capacity available as well as other key information for example Staffing issues that may prevent a unit from admitting. Again, this report is used to support timely identification of available capacity by case managers and community teams.

NHS England has conducted two separate processes during 2014 to identify and commission additional inpatient general CAMHS and psychiatric intensive care capacity from existing providers that should result in an additional 50 beds nationally by the end of the financial year. This includes additional capacity in the South West area.

All ten NHS England Area Teams have recruited CAMHS case managers who have been instrumental in supporting timely and appropriate access to commissioned beds. The case managers work closely with providers and the community CAMHS teams to ensure timely discharge and to address barriers that may cause delays to those plans.

Concern 2

On a previous admission in May 2013 the bed located was in Huntercombe, and George was removed by his father as the bedroom had inadequate furniture, had no bed linen and there was a concern the environment was adding to George's

distress. The distance between home and this placement was in excess of 3 hours travel time.

The NHS England Area Team Bristol, North Somerset, Somerset, South Gloucester (BNSSSG) has no record of the prior approval for admission into the Priory Hospital. The young person's admission was just after NHS England was established. The current processes for approval to admit were not being followed by all community teams and admission may well have taken place without the Area Team's knowledge. This process has since been rectified and is now part of robust process of assessment and admission. In respect of bed availability, there was at that time a shortage within the South West region due to the temporary closure of Wessex House, Bridgewater, Somerset. Following concerns regarding poor staffing levels and a number of significant incidents, it was decided that the unit was no longer viable to operate safely. This temporary closure remained in place for nearly two years. Finding a bed is the responsibility of the referring community CAMHS team and they would have contacted available units and taken the bed that was made available to them. Whilst every effort is made to keep patients/children and young people as close to home as possible, sometimes lack of available beds mean that this cannot always happen.

Concern 3 &6

On the index admission George was placed in the Priory Hospital, Southampton, a distance of over 2 hours travelling time from home. This is not an NHS facility and is specifically for 'overflow' patients from across all England, many of whom are therefore huge distances from their home, their family, their friend and community support.

Having local accessibility where inpatient care is required was recognised in the Mental Health Crisis Care Concordat published 18 February 2014 to be important to keep the young person close to home, school and friends and this was also recognised by all the clinicians at the inquest to be important and necessary. With current position of beds this is not being met, and is impacting on patient care

With regards to Priory Hospital Southampton, this is not an overflow facility but is commissioned by NHS England to provide twelve general CAMHS beds and is one of a number of Priory Hospital sites throughout England providing CAMHS beds.

The South West region can now also report that Wessex House, Bridgewater, Somerset is now in the process of a phased reopening. There are currently four generic beds open, with a further four opening during January 2015 and the full twelve bed compliment will be open by March 2015. In addition there has been a further six generic beds and four Psychiatric Intensive Care Unit (PiCU) beds commissioned from the Huntercombe Group with a unit now based in Torquay, Devon. Again this unit has a phased opening plan, with four generic beds currently open, a further two will open during January 2015 and the PiCU beds will be available by the end of January 2015. In total this will give the South West a total of fifty two generic beds and four PiCU beds.

Concern 4 and 5

Due to the distance, the hospital made the decision that family therapy could not take place (although the parents would have engaged had the importance of this was explained) and the periods of home leave were extended due to travelling times rather than in response to clinical need.

There was poor attendance at the CPA meeting, and both parents and the community team only 'attended by telephone, which was far from ideal and impacted on the effectiveness of communication between all parties.

The opening of Tier four CAMHS beds in Wessex House, Bridgewater, Somerset and in

Torbay will reduce the need for children to be placed at a distance from their home unless there are specific clinical indications for this. This allow for improved communication and joint planning between the tier four providers, local practitioners and families face to face.
It is also likely that the issue of communication between placement providers and local CAMHS will be addressed in the Devon Safeguarding Children Board (DSCB) Serious Case Review (SCR) that looks into the circumstances leading up to the death of George and which is yet to be published. Health agencies involved in the SCR have been as follows:

- NHS England
- Tier 4 providers
- Local CAMHS
- Integrated Children Services
- NEW Devon CCG
- Primary Care

Once the SCR is published there will be a programme developed to disseminate the lessons learnt and embed such learning in practice.

Concern 7

In this case I consider the distance of the unit directly contributed to the circumstances that led to George's death.

In response to this unfortunate incident, the Priory Group conducted a detailed internal review. This was led by a team of experts from other parts of the Priory Group and overseen by NHS England as commissioners of the service. Southampton Priory put in place an action plan which went beyond the report in terms of actions identified. This was developed in response to the NHS England feedback, and the actions were monitored through contract monitoring meetings until completed.

The review report highlighted issues that could have contributed to the death of George Werb although it could not say conclusively that his suicide would not have happened in the absence of these issues. Many of these contributory factors are highlighted in the regulation 28 report, namely gaps in information used in risk assessments and clinical records and internal communications. It is our view that, regardless of the issues related to distance from home and families as reflected above, these are themes that contribute to similar incidents across mental health providers. Key developments from the action plan to ensure the safety of other patients included:

- A full review of the process from the point of enquiry to discharge, updating all relevant protocols. This included developing processes to ensure all relevant background information is requested and provided, including information on previous admissions. Training in these updated process was provided for staff with role play and scenarios
- A process was put in place to review CPA dates weekly to ensure first CPA meetings are being held within 14 days of admission. This enforces the principal whereby all patients commence discharge planning at the point of admission.
- Weekly audits introduced to ensure that risk assessments are clearly documented prior to and upon return from leave. In addition to the risk assessment, all patients now have an individual session with a member of the team upon return from leave to allow the opportunity to discuss their leave.

- Quality Walk Rounds have been further developed to ensure that risk assessments are clear and include explanation of conflicting information, and that when observation levels are reduced there is a clear clinical rationale included.
- Handover templates have been amended to ensure that any expression of suicidal ideation is reported to the nurse in charge and communication of this evidenced in the clinical records. A section on key risks in the past week has been added.
- The observation policy was updated and a process established to follow up any gaps in recording of observations and the patients mental state.
- Refresher training was provided for staff on care planning, with a focus on ensuring care plans are developed with the young persons and their carer/family; and that these are reviewed and updated. When they are developed without them, the reason is for this is now clearly documented. The Chair of the CPA has a clear and understood key role in ensuring that patient and family voice is heard and recorded in the minutes.
- A full review of the therapy programme was completed to demonstrate that it is aligned to the evidence base, QNIC standards and the Tier 4 NHS contract requirements and ensures there is sufficient provision of appropriate therapy for young people. The procedure for referral to therapy was reviewed, communicated and audited.
- The Hospital Director had a forum with staff regarding communication and lessons learned from this incident overall especially with regards communication. These forums were also used to promote the reporting culture and ensure all clinical incidents are reported as well as being recorded in notes.
- The Quality Walk Round for documentation was temporarily increased to weekly to ensure that all staff including medical and therapy staff was keeping contemporaneous high quality records.
- A review of staffing levels was carried out against the QNIC Standards.

We also used the contract meeting process to ensure learning points from this incident were shared through the Priory Group and were assured that there were processes in place to do this.

We have used the forums we have with providers in Wessex House and across the South of England to share this learning wider than the Priory Group.

Yours sincerely,

[redacted]

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National Medical Director
NHS England