Department
of Health

From Norman Lamb MP
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27 FEB 2015

Dear Miss Haskey,

Thank you for your letter following the inquest into the death of Rebecca Overy. I was very sorry to hear of Miss Overy's death and wish to extend my sincere condolences to her family.

The inquest concluded that Miss Overy died of a hypoxic brain injury as a result of asphyxia whilst a patient in adult secure mental health detention. Her fatal injury was self- inflicted. Miss Overy had been transferred from a secure child and adolescent mental health unit to an adult secure mental health unit the day after her 18th birthday. No plans had been made for a gradual transition to the adult facility nor had she visited the adult institution before her transfer.

This case highlights issues about the transfer of adolescents into adult mental health units and the provision of secure mental health for young people aged 18 to 24. You raise the following concerns for our attention :

- *The immediate transfer of Rebecca the day after her 18th birthday was not in her best interests, it was detrimental to her mental health and occurred due to the operation of a s30 of the Health and Social Care Act, whereby the commissioners were obliged to arrange an immediate transfer, and the clinicians to concur with it, lest they be in breach of the Act.*

- *There is no provision for secure mental health care for young adults aged 18 – 24, with a clinical picture similar to Rebecca's.*

I have obtained information from NHS England about this case. I understand that Miss Overy's death was the subject of a serious case review, for which NHS England provided a detailed report.

Your first concern is about the age of transition from CAMHS. The Government is aware that there is wide variation in NHS practice when children and young people move from a Child and Adolescent Mental Health Service (CAMHS) ward or elsewhere. Different services choose to transition at different ages: 16, 18 or older. A person aged 18 is legally an adult. An adult patient on a CAMHS ward could lead to child protection and adult safeguarding issues. For this reason, some services currently choose to move a patient to an adult ward at age 18, with the move taking place on the 18th birthday or the day after.

However, it is the Government's clear aim that transition between services should not focus on age, but on the needs of the individual. Transition between services should always be based upon the needs of the individual, and subject to professional clinical judgement. Transition requires careful planning and we want to see a whole system approach in which the child or young person is supported along the care pathway according to needs.

The key to successful transition planning and actual transition arrangements is that the CAMHS provider is supportive of plans by local clinicians and teams, working as part of that team in the transition process. Likewise the provider of adult services must anticipate and meet the additional needs for a young adult in the service.

Improving transition and ending the 'cliff edge' of support many children and young people face as they reach 18 is a key commitment and priority for action in *Closing the Gap: Priorities for essential change in mental health,* launched by the Deputy Prime Minister and me on 20 January 2014. In support of this, in December 2014 and January 2015, NHS England published new service specifications for commissioners, giving guidance and best practice on transition from CAMHS. These fulfil a major objective for this priority. These specifications intentionally do not stipulate an age threshold for transition but state transition should be built around the needs of the individual, not focussed on age[1]. This is part of the Government's commitment to parity of esteem between mental and physical health services.

In addition, I commissioned the Children and Young People's Mental Health and Wellbeing Taskforce in August 2014 to improve the way children and young people's mental health services are organised, commissioned and provided to make it easier for young people to access help and support. Transition is one of the key issues I have asked the Taskforce to address.

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[1] Available at http://www.england.nhs.uk/resources/resources-for-ccgs/#camhs-tools

Department
of Health

The Taskforce has sought the views of young people, their families and carers as well as those working with children and young people. A report will be published in the Spring.

You refer to the "*operation of a section 30 of the Health and Social Care Act, whereby the commissioners were obliged to arrange an immediate transfer*". I am not aware of a provision from either the Health and Social Care Act or the Mental Health Act which stipulates this, so am unable to comment on this specific matter. However, if you are able to provide clarification for this reference I am happy to respond further on this point.

NHS England have assured me that Miss Overy's future care had been considered for many months prior to her transfer including the appropriate type of environment and level of security required. They have confirmed that an independent clinical access assessment had been undertaken that identified that Miss Overy should be in an adult low secure placement when she turned 18. The CAMHS placement where she was, was not of a low secure environmental or therapeutic standard that would meet her identified needs. In addition, Miss Overy's significant levels of risk and patterns of behaviour meant that she would not have been able either to remain within a CAMHS or be discharged to the community when she became an adult.

I would expect providers of adult secure mental health services to act in accordance with the Mental Health Act 1983 Code of Practice to ensure that the needs of the patient are identified on admission to an adult secure hospital and an individual care plan for meeting these needs is put in place.

I would also expect patients, families and carers to be involved in decisions to admit to a secure hospital. The Code of Practice identifies a number of factors for consideration in making this decision, including the wishes and views of patients, their ages and physical health, cultural backgrounds and their social and family circumstances. However, the safety of the person and others is an important consideration in making this decision and should be guided by an assessment of risk including suicide, self-harm, self-neglect and jeopardising health and safety accidentally or intentionally.

Assessments of patients should also be made to understand their needs and identify potential risks. Individual care plans should be put in place to meet patients' needs and manage risks in a therapeutic way within the least restrictive environment.

Where there is a risk of disturbed behaviour such as self-harm or risk of suicide, the Code of Practice identifies a number of factors to be considered such as the impact of the physical and therapeutic environment, emotional distress and the mix of patients within the secure ward or unit.

The Department of Health is currently revising the Code of Practice, which will come into effect from 1 April. The Department has worked with partners, expert bodies and an extensive range of stakeholders including mental health professionals, carers, advocates and service users to strengthen the Code of Practice in key areas.

The revised Code of Practice will include a strengthened section on meeting the needs of patients upon admission to hospital and brings to the fore the need to involve patients, their carers/advocates and families in decisions about care. The revised Code of Practice will make clear that providers should have policies and guidance in place for conducting individualised assessments which are based around the needs of the patient. However, it will go further by highlighting that strategies should be developed to enhance quality of life and prevent disturbed behaviour through individualised behaviour support plans, which patients, carers/advocates and families should be fully involved in developing.

You were concerned that there is no provision for secure mental health care for young adults aged 18 – 24 with a similar clinical picture. Whilst there are no dedicated wards for 18 to 24 year olds, there are wards that meet the clinical needs of patients with the same and similar presentation to Miss Overy. There is transition guidance in place which advises that arrangements are made within adult wards to ensure that appropriate patient needs, as highlighted in clinical assessments, are met. Receiving providers should make appropriate plans and extend the services available to aid the transition arrangements for young adults.

One such example of this is a 'Buddy System'. I understand that in this case, Partnerships in Care, who were the provider of the adult mental health services that Miss Overy received, had established a Buddy System for Miss Overy with another young person, who was already on that ward and aged 18.

Relevant transition guidance can be found in the *Access Assessment Commissioning Guidance May 2012 for secure services* (copy enclosed with this reply). This guidance provides commissioners of secure mental health services with direction on how best to ensure high quality outcomes for the assessment of need. The assessment determines if a referred patient requires care under conditions of security and, if so, at what level.

Department
of Health

An Access Assessment is the clinical assessment of the mental health and risk-management needs of an individual. This assessment determines the most appropriate placement for the individual in terms of need and level of security, with consideration of the whole care pathway. The guidance contains an expected outcome for the transition from Adolescent Services to Adult Secure Services. There should be a managed pathway between adolescent mental health services and adult secure services.

Best practice guidance is also highlighted within the *Children's and Families' Services Guide 44 – Mental health service transitions for young people* from the Social Care Institute for Excellence (SCIE) which can be found at

www.scie.org.uk/publications/**guides/guide44**/files/**guide44**.pdf

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Miss Overy's death to my attention.

NORMAN LAMB