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NHS Foundation Trust

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J.P. Ellery
Senior Coroner
HM Coroner's Services
Shirehall
Abbey Foregate
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- 5 JAN 2018

8th December 2017

Dear Mr Ellery

RE: Jeff David ANTWIS
Report to Prevent Future Deaths

Thank you for your letter dated 13th November 2017, reporting a matter to us, in accordance with Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

As identified in your letter South Staffordshire and Shropshire Healthcare NHS Foundation Trust were not providing CAMHS services within Shropshire at the time of Jeff's death therefore South Staffordshire and Shropshire Healthcare NHS Foundation Trust were not in a position to have carried out an investigation into the care of Jeff prior to his death. The Serious Incident Investigation presented at the inquest was carried out by Shropshire Community Health NHS Trust who were providing CAMHS services in Shropshire in January 2017.

May I take this opportunity to reassure you that South Staffordshire and Shropshire Healthcare NHS Foundation Trust Emotional Wellbeing Service have received a copy of the Serious Incident Investigation Report from Shropshire Community Health NHS Trust and in addition are taking action in response to the concerns you raised at the inquest as follows:

1. Following an urgent referral by Jeff's GP to (the then) Shropshire CAMHS on the 10th January 2017 a timely response was made with an initial appointment with a mental health practitioner taking place on the 12th. A further appointment was arranged for the 25th January (an earlier date clashed with an existing medical appointment) and in the meantime Jeff was given a miracle question to complete.

2. Jeff answered the miracle question indicating that he wished to die. He passed it to his mother who immediately contacted the mental health practitioner who in turn referred it and the initial assessment to a consultant physiatrist for review. The consultant physiatrist did not consider the matter urgent and arranged for a routine medical review for the 17th March 2017.

3. At the second meeting on the 25th January 2017 Jeff and his mother were informed of the appointment for the 17th March 2017. Jeff's mother immediately raised concerns and asked for it to be brought forward. She was told she would have to write in and make a complaint. This was a time sensitive situation adding to the problem without resolving it.

4. On the 30th January 2017 Jeff killed himself on the railway line.

5. Independent expert evidence from a child and adolescent consultant physiatrist indicated that Jeff should have been offered an urgent medical review appointment for the 27th January 2017 (i.e. within 7 days of the internal referral to the consultant physiatrist) and not, as a routine appointment, the 17th March 2017. It cannot be said that such earlier appointment would have addressed Jeff's problems and altered his wish to die but it is it possible that earlier intervention may have lifted his spirits and not, according to his mother, 'wilted'. It undoubtedly would have helped and at least been an earlier step in seeking to help Jeff.

6. Other matters of concern arose from the evidence. The mental health practitioner:
    a) Was aware of the deliberate self-harm protocol but not its content.
    b) Carried out a risk assessment on a subjective basis without reference to any known definition e.g. serious or significant.
    c) Had no mechanism for referring back to the consultant physiatrist appointment, whether she agreed with the request or not.

7. As stated Jeff had a diagnosis of Asperger's Syndrome with autistic spectrum disorder. Concerns were raised to what extent these conditions have may have masked Jeff's suicidal ideation on presentation and to what extent, if it is the case, they were recognised.

8. From evidence given at the inquest it is clear that the provision of child and adolescent mental health service is in transition, having moved from Shropshire CAMHS to part of South Staffordshire and Shropshire NHS Trust. Certain actions are already being taken and these concerns are raised so that a holistic approach can be taken and fed in to what is already an ongoing wider review. Following discussions and feedback from the clinical leads and operational management team in the Specialist & Family Directorate,

Since the service transferred to our organisation in May 2017 we have been working with the staff to improve the access and effectiveness of services provided. In response to the concerns that you identified the following actions have already occurred:

ACTION ALREADY TAKEN

- A single point of access to the service was implemented on 4th Dec 2017 to ensure that young people's needs can be appropriately identified at the point of referral and an appropriate, timely response provided (point 1 and 7). Introduction of standardised validated clinical risk assessment tool with associated pathway to enable timely robust response to changes in risk level (Also points 2, 3, 5, 6 & 7)
- One assessment appointment each week is ring fenced for urgent assessments in each Consultant Child & Adolescent Psychiatrist job plan to ensure that young people presenting in crisis are provided with urgent psychiatric review (points 2, 4, 5 & 7)
- We have commenced reviewing the caseloads of all practitioners within the service to ensure that all young people within the service have appropriate care plans and risk assessments in place (points 2, 3, 5, 6 & 7) this will be completed by 31st March 2018.
- When a young person is accepted within the service, a clear pathway for their care is identified, this enables the case holding clinician to access additional support for example, psychology, family therapy consultant psychiatry (Also points 2, 3, 6 & 7) Healios are delivering online therapeutic interventions as part of core MH service (point 8).
- Escalation processes have been agreed within clinical pathways so that urgent psychiatric reviews can be obtained when concerns are raised (points 2, 4, 5 & 7)
- Reflective learning/OD sessions for the clinical teams are taking place to improve communication between members and improved team based working (points 2, 5, 6 & 7) The Home Treatment / crisis team now respond to young people who present in crisis and offer additional support within the home during episodes of crisis (Also points 3, 4 & 7)
- Implementation of electronic patient records, to ensure that young people's current and historical risk history is available to all practitioners working with the young person, including "out of hours". (points 3, 4 & 7)
- Bespoke training on all assessment documentation used within the electronic patient record system is being provided to all clinical staff to ensure consistent use (points 3, 5, 6 & 7)
- New services are available from Kooth (open access online service for young people 11-25) and The Childrens Society (open access drop-in service for CYP,

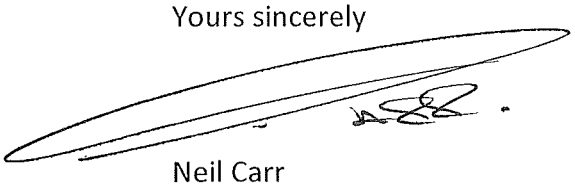
families and professionals) in order to provide a wider range of service for young people. (point 8)

FURTHER ACTIONS TO BE COMPLETED

- By end of March 2018 – Completion of the review of all cases currently open to Mental Health services to ensure recording appropriately reflects levels of need to improve capacity planning based on need/priority (points1, 2, 3, 5 & 7)
- By end of June 2018 – Completion of appointment to vacant posts within the Mental Health service to ensure skill mix and capacity in place to better meet needs of children and young people. (Posts are currently out to advert) (points1, 2, 3, 5 & 7)
- By end of June 2018 - Development of a joint crisis pathway between adult and children's mental health services to improve the response further for children and young people in crisis (also points 2, 3, 5 & 7).

I hope this response helps to address your concerns. However if you require any further information please do not hesitate to contact me

Yours sincerely



Neil Carr
Chief Executive