NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
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Hellesdon Hospital
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Ms Jacqueline Lake
Norfolk Coroner's Service
County Hall
Martineau Lane
Norwich
NR1 2DH

30th March 2022

Dear Ms Lake

I write in respect of Theo Brennan – Hulme who tragically died on 12th March 2019, his inquest concluded on 9th February 2022. At this point I would like to express my sincere condolences for the loss of Theo. I can only re-iterate that the Trust is genuinely committed to improving the experience of services for all people who need to access support for their mental health.

In response to evidence heard at the inquest you raised some concerns in relation to the care and treatment provided by the Trust specifically around discharge processes as well as concerns in respect of the culture within the crisis and home treatment team who saw Theo in February 2019

The matters of concern are as follows:

1. Evidence was heard of a historic culture of bullying and harassment within the Crisis Resolution Home Treatment Team which has led to a loss of compassion in some instances with the view that some suicides are "inevitable" and some reluctance to recognise when cases should be referred to the Team. Work has been undertaken by the Trust to improve such cultural attitudes. However, it was recognised in evidence that there is "still a distance to go" and areas where the culture needs to change. It is of concern that this culture remains three years following Theo's death

2. Following an Assessment, a person is still discharged from the Community Team without any immediate "check" or discussion as to the correctness of this decision. It was heard that following Theo's death immediate discharge from the Community Team following assessment is relatively rare. In these circumstances, such a discussion would not place an onerous burden on the Team and would enable a review of the discharging decision to be undertaken to ensure it is the correct decision.

With particular reference to the presumption that some suicides are "inevitable" I would like to emphasize than when we discussed this with the team they were saddened and dismayed that this had been portrayed as a belief they held and continue to hold as a collective. However, to offer further reassurance I would like to share the additional activities undertaken to challenge and dispel any preconceptions or mistruths in respect of suicide the team may have;

- All members of the Team will be allocated time to watch the "Live Q&A - Suicide Prevention Magical Thinking" (overtime paid if necessary)
- Supporting paper written by Dr [redacted] *Magical thinking and moral injury: exclusion culture in psychiatry* BJPsych Bulletin Vol 46 issue 1. 2021.
- The Live Q&A and "Magical Thinking" paper will be a live agenda item for at least four team meetings to ensure all staff are captured, where staff will be able to reflect on the learning and challenge each other on whether or not this perception has changed.
- Should any of the management team still feel that more training is required this will be provided by [redacted] our Suicide Prevention Lead and [redacted] our Advisor in Suicide Prevention, with lived experience. Content of this to be discussed as it will need to fill unidentified gaps
- More widely the language and view that "Suicide is inevitable" will be addressed in the Trusts 2023-2028 *Self Harm and Suicide Prevention Strategy*, this is in the early stage of review following wide consultation with service users and other stakeholders. This will be a co-produced document.

The team have worked hard to challenge, address and improve in respect of a "bullying" culture, in part this has been progressed through the change in management of the team, away days and renewed focus on staff wellbeing. This includes ensuring that the team are aware of how to raise concerns whether in confidence or directly to senior leaders within the organisation, or through the Freedom to Speak Up Guardian and/or Cultural Champions in post across all service lines.

The Trust has a Staff Support Service which can be accessed by self-referral or managers are able to refer staff directly this service offers therapeutic support, as well as the usual occupational health support available. Staff also have access to Human Resources and/or Union representatives who are able to support with employment issues. The Executive team, including myself, also offer direct access for any staff member to speak to us or raise concerns through our open *Hear to Listen* sessions which are held weekly and invariably chaired by an Executive, contact through these forums can be anonymous if required. We also are undertaking targeted listening events with all teams across the Trust as part of our cultural improvement strategy.

In response to your second concern, I would like to draw your attention to the extensive safety action plan put in place by the Norfolk Youth Teams post the deaths of young people in those teams in 2021, this has been discussed at the subsequent inquests into the deaths of those young people therefore I will not repeat the safety actions here. The salient aspects in respect of Theo's case being that the Clinical Director for the Norfolk Youth Teams has implemented a triage tool which includes the directive that no young person is discharged without being seen face to face or contacted via phone or virtual contact if face to face not possible, plus the referrer and any significant other where appropriate. This also links to the recently reviewed Clinical Harm Policy which speaks to the review and potential regrading of referrals and outlines the support required whilst a person is on a waiting list. This tool links to the Trust overarching "Did not attend, non – access or not brought" Policy Q12a which directs staff not to discharge a person who does not attend appointments without robust follow up, which is further strengthened in Discharge from Trust Services Policy C70b see extracts below:

"The decision to discharge a service user from specialist mental health services must be made on a case-by-case basis. Effective communication between all parties (including the service user, family/carers) is key to safe and effective discharge. In all cases the Care Coordinator/Lead Professional must make sure the multi-

disciplinary team (MDT) is adequately informed. This is to make sure that decision making is shared when needed and that there is opportunity to raise concerns as well as to support the Care Coordinator/Lead Professional" and "It is recognised that sometimes a service user may not be willing to engage in the discussion and planning around discharge, or there may be disagreement over the plan. In such cases it is important that decision making is shared with the MDT and well documented in the health record. Consider if an MDT/CPA meeting is required. Consider what advice or support family/carers may need".

This is an area of primary focus for the Trust as we are aware that communication in respect of discharge is a theme within complaints and service user feedback surveys. The customer service team are working with our Peoples Participation Leads to bring lived experience to the care groups around these themes, this work is supported by learning from Trust wide audits into discharge planning and communication with service users and significant others during that process. The young persons Peoples Participation Lead in Norfolk is working with service users on how the teams communicate with young people, their preferences and also what information would help young people to feel more confident about engaging with our teams. The purpose of this work is to make our services more accessible to young people, this is based on young people's feedback and progressing in partnership with our Clinical Commissioning colleagues to ensure a wider system-based approach to improving engagement with young people.

The Trust continues to work with Norfolk Public health led suicide prevention initiatives and attends various meetings alongside our Higher Education, local authority and emergency services colleagues to agree and progress safety actions to prevent suicide in our county.

I hope that this information offers you reassurance that our response to the tragic loss of Theo was and continues to be taken seriously.

Yours sincerely

[redacted] (he/him/his)
Chief Executive