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NHS Foundation Trust

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Private & Confidential

FAO Mrs Samantha Marsh
Senior Coroner for Basingstoke
Coroner's Office,
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Goldings,
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17th April 2020

RE: Inquest touching the death of Sophie Boothe

Dear Madam

I write in relation to the above inquest which concluded on 18 February 2020.

On 2 March 2020 you made a report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. In that report, you identified a matter of concern, as follows:

> ***"It became very clear in evidence that the overseas involvement was not properly flagged up when the CPE came to triage Sophie's referral; this includes both the discharge summary and Sophie's own self-referral via email whilst she was in Australia. The full discharge summary from Australia was sent by the GP along with his referral on 8 May 2019 to ensure that all relevant information was shared at the earliest stage. These notes were either not fully reviewed and/or understood by the CPE and this appears to have contributed to the downgrading of Sophie's referral.***
>
> ***It became clear in evidence that the UK services did not understand that "Scheduled" is the Australian equivalent of being "Sectioned" and there was a lack of probity and curiosity to as what this meant and what treatment Sophie had in Australia; albeit that the evidence was not convincing (or even persuasive) that the Australian discharge summary had been thoroughly read at all on being received by the CPE.***
>
> ***Overall, there appears, on the evidence, to be very poor communication between the departmental services and, as a result, opportunities appear to have been missed to fully appreciate Sophie's full clinical presentation when making an assessment about the timeliness of appropriate interventions and assessments. I believe that whilst the***

service remains disjointed, with insufficient exploration of information sent from foreign jurisdictions, there remains a risk that future death will continue to occur"

Your report was sent to Berkshire Healthcare NHS Foundation Trust (the "**Trust**"). I am writing to provide you with the Trust's response.

The Trust has given careful consideration to the concerns highlighted in your report. This has prompted a further review into the circumstances that led to your concerns to understand how to best respond and learn from this case.

Issues highlighted by the concern you have raised

Having considered the concerns you have raised the Trust has reflected that it touches upon a number of different important issues. These all relate to the way in which referrals into mental health services are made and triaged, particularly where the potential client has recently experienced an episode of mental health crisis abroad. In order to best respond to your concerns we have broken down these issues into the points below:

- Ensuring salient information is best captured by referrers when completing and sending referrals forms to the Trust's Common Point of Entry ("**CPE**");
- The importance of effective due diligence when triaging referrals where the potential client has experienced an episode of mental health crisis abroad;
- Assurance that downgrading referrals from red to amber is consistently conducted in a rational and proportionate manner, including seeking further information from the referrer or potential client as required; and
- Ensuring that mental health services communicate effectively – particularly in relation to information sharing where someone is referred into more than one service.

I have set out the Trust's response below, divided into headings reflecting the above.

Effective capture of salient information in referral forms

The CPE receives on average between 900-1200 referrals per month. The CPE must review and triage referrals quickly with the limited information on the referral form plus any information it has on the psychiatric electronic record recording previous involvement with services. The Trust has observed that the majority of referrals received from GP surgeries are rated red requiring a response from CPE within 24 hours and these must be triaged and, where appropriate, regraded to amber and contacted within 14 days in order to be able to prioritise those referrals which require the most urgent response.

The CPE relies on referrers to capture salient information and communicate this in their referral as far as is possible. Whilst the salient information will be different in each individual case, the referral form contains prompts to assist clinicians referring in to the service. This includes a question as to whether the potential client has been recently discharged from secondary mental health services so that this information is not missed. The importance of this point is that it

indicates to the person triaging that there is further recent information related to psychiatric care and treatment that may inform their triage assessment.

In Sophie's case, the GP helpfully attached a 17 page discharge summary completed by the Australian general hospital following Sophie's overdose. This contained detailed information about the extensive physical health interventions Sophie received there. The notes from the general hospital did not include any summary from a mental health professional. This would be expected if there had been a substantive period of psychiatric care and treatment.

Within the discharge summary, the Upper Gastro-Intestinal Intern documents briefly under a paragraph labelled "5. suicidal ideations" that Sophie was "*scheduled and monitored with 1:1 nursing*", and that she was "*transferred to PMBC Mental Health Centre"*. This was a very small part of an otherwise lengthy and detailed summary of Sophie's care, and the absence of any psychiatric care notes potentially confounded the potential to overlook this information.

It is, however, acknowledged that there was a missed opportunity to appreciate Sophie had been a psychiatric inpatient, and consider contacting the Australian psychiatric services for discharge notes. However, it is the Trust's view, having reflected on Sophie's case, that this information would have been difficult to interpret from the general hospital discharge summary alone and it would have been best obtained by way of a conversation with the referring GP.

The CPE has not historically been able to contact the referrer for more information due to difficulty making contact with GPs who have a tight schedule of appointments each day. In addition, whilst it is strongly recommended that a GP calls through its most urgent referrals, so that discussions can be had on the telephone at that time, the GP surgeries in the Trust's catchment area have fed back that due to their own time constraints, this is rarely possible.

The Trust keeps under review the best way to obtain salient information from referrers. This includes regularly meeting with GP forums to provide feedback in relation to current trends and also learning/recommendations from investigations can be shared through this mechanism. The CPE referral form was originally developed utilising this approach. Interface meetings are held with West Berkshire GP surgeries and the relevant service manager to resolve issues, provide feedback from individual incidents as requested, discuss complex clients and also work with specific surgeries who have high referral rates. Work is underway to extend the interface meetings to East Berkshire surgeries which is where Sophie's GP surgery is located.

Following learning from this case, the CPE service is piloting a policy that requires triage workers to contact all referrers before downgrading referrals. This is explored further below. This pilot has the additional benefit that there is dialogue between CPE and referrers in relation to specific cases. The information within the referral forms can be discussed and evaluated as there is the opportunity for professional discussion and challenge over the rationale for downgrading. This provides specific feedback and education to referrers about how the information they provide on referral forms is used and interpreted, and how they can improve the content.

The Transformation Team is working to improve the referral system through e-referrals, which will include timescales for 'drop-downs', and immediate feedback to GPs. The E referrals went live

from 1 April 2020 and add greater clarity to the nature of the presentation and greater information about the specific service remit within the Trust (included on the drop down)

Due diligence on referrals with an international element

It is not uncommon for the Common Point of Entry Team ("**CPE**") to receive referrals in relation to potential clients who are still abroad or else have recently returned from abroad. In these cases the CPE will regularly coordinate with psychiatric health providers in the international country to share information (as appropriate) with a view to facilitating the smooth handover of care. In cases where the client remains compulsorily detainable under mental health legislation, the Trust can facilitate repatriation of clients from inpatient units abroad to inpatient units in the Berkshire area, accompanied by psychiatric staff.

In Sophie's case it is now understood that following 18 days of treatment for the physical effects of her overdose (which occurred on 1 April 2019) she was transferred to an inpatient unit in Australia for a short time. As set out above, unfortunately there was limited information available about psychiatric intervention in Australia at the time of Sophie's referral to CPE, other than the brief note in the 17 page general hospital discharge summary mentioned above. Sophie's mother gave evidence at the inquest to explain that Sophie received 1:1 support in a mental health inpatient setting before being discharged into the community with a recommendation that psychological therapy be commenced on return to the UK. This information was not within the referral documentation, as the discharge summary covered only the treatment given to Sophie by the general hospital.

It is understood that Sophie was discharged into the community without any planned support from Australian community psychiatric services. She remained in Australia for approximately 10 days before returning home with her mother on 3 May 2019. When Sophie returned to the UK she attended her GP on 8 May 2019 and was referred to mental health services via the CPE.

The body of the referral form from the GP indicated Sophie had taken a life threatening overdose in Australia with intent to complete suicide. The only reference to psychiatric care in the general hospital discharge notes was the note of a plan to '*transfer to the PMBC Mental Health Centre*.' However, within the section within the referral form that asks whether the client had been discharged from mental health services within the past six months the GP recorded 'no'.

The Trust has recognised that the CPE triage team may not always have sufficient time to complete the due diligence required to interpret and translate referrals with substantial additional information from abroad. As a result, all referrals with a substantive international element are now referred up for triage by a manager. This has been taking place successfully since Sept 2019.

It is recognised that protecting time to complete due diligence on all referrals has become an increasing issue as the number of referrals, particularly urgent referrals, has exponentially increased. The Trust is committed to horizon scanning and being proactive in relation to

responding to demand changes, however it is not always possible to predict the best solution to such resource issues.

In light of these resource pressures, the Trust has recognised that the current model of triaging referrals needs re-evaluating. It is in a process of transformation of all of its wellbeing services which will aim to address these issues. The final permutation of this transformation remains a work in progress, however the current plan is that Talking Therapies will be the 'front door' for all referrals. Talking Therapies will undertake the initial triage and ensure sufficient information is obtained from the referrer. As part of this new model all referrals will receive timely feedback on their referrals.

Talking Therapies will refer on to CPE the referrals that cannot be managed in primary care due to risk and complexity. This will relieve the pressure that CPE currently experiences in sifting through all of the referrals to find those that require its urgent support and/or evaluation. It is hoped this will also allow time for ample due diligence when triaging red and amber referrals, and also reduce waiting times for assessment appointments for those graded amber.

Downgrading of referrals is consistent, rational and proportionate

In Sophie's case, the CPE tried to call Sophie before downgrading the referral. Sophie did not answer and an exploration of the events in Australia did not take place when Sophie called back. The Trust acknowledges that this was a missed opportunity to capture information.

Having reflected on this case the Trust has sought to explore new methods to be assured that, where referrals are downgraded, this is appropriate and is consistently applied according to clinical need. The following measures have been introduced to assist the Trust with achieving this aim.

As mentioned above, following an initial pilot the CPE now has a policy that requires triage workers to document and write back to referrers when downgrading their referral providing a rationale for why this has been done and to allow the referrer to make contact with CPE if they disagree with this decision. Whilst we would favour a verbal feedback process this proved extremely resource intensive on clinician time and whilst this is the gold standard it was not possible to achieve within existing resources. However, the CPE senior leadership team are seeking further administrative support to assist with this and will continue to explore how it can implement this policy in a sustainable way, working closely with primary care providers.

At the time of Sophie's referral to CPE, individual triage workers would make decisions about downgrading referrals as part of clinical judgement. As set out in the Trust's action plan, the triaging tool has now been updated to prompt triaging workers to record a rationale for downgrading, decisions are also discussed with a team leader or manager if particular concerns relating to risk or need are identified.

The learning from this case has been explored and discussed in a learning event and also in team meetings to ensure the team are consistent in terms of decision making relating to triaging.

Further training on risk assessment with an emphasis on documentation of the rationale for decision making has been provided.

Information sharing within mental health services

At the time of Sophie's self-referral to Talking Therapies and subsequent GP referral to CPE, Talking Therapies and CPE were holding daily meetings to discuss referrals and share information. One purpose of such meetings was for Talking Therapies to handover referrals to CPE where the needs of the referred client appeared to be beyond that which would usually be managed in primary care. In addition, whilst Talking Therapies has a separate record-keeping system for their confidential therapy discussions with clients, they are able and should record salient information like referrals and risk on the Trust's main record keeping system, RiO.

Unfortunately the systems in place to ensure communication between the services were not successfully utilised in this case. Learning events have subsequently taken place reflecting on Sophie's case attended by both Talking Therapies and CPE teams. This has included utilising Sophie's referral as a case study for further training on the way in which Talking Therapies and CPE should work as one, as per the Trust's vision and model.

Notwithstanding these immediate changes and the significant learning embedded following Sophie's death, the transformation of the Trust's wellbeing services is a much larger piece of work with changes that are designed to ensure that missed opportunities to share such referral information are minimised as far as is possible. Ongoing work within Talking Therapies will focus on clear shared mechanisms for recording referrals, risk information and escalating to the CPE.

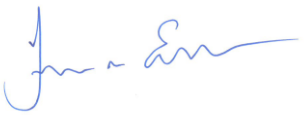
The service transformation will include a whole new redefinition of roles for those in Talking Therapy with a suite of training to support this. During the implementation of this wide ranging transformation there will be careful supervision and auditing. Auditing shall continue thereafter to ensure that the triaging works efficiently and meets its aims as demand changes and evolves.

Conclusion

I hope this response provides assurance in relation to the concerns raised.

Should you have any queries or wish to discuss the response further, please do not hesitate to contact me.

Yours faithfully,



Julian Emms
Chief Executive Officer