NHS
Midlands Partnership
NHS Foundation Trust
*A Keele University Teaching Trust*

Trust Headquarters
St George's Hospital
Corporation Street
Stafford
ST16 3SR

[redacted]

18th November 2022

Mr J Ellery
Her Majesty's Senior Coroner for Shropshire, Telford & Wrekin
[redacted]

Dear Mr Ellery,

**RE: Liam Joseph Lyes-Watson (deceased)**
**Report to Prevent Future Deaths**

Thank you for your letter dated 27th September 2022, reporting a matter to us, in accordance with Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

May I take this opportunity to reassure you that following Mr Lyes-Watson's death, we undertook a thorough investigation into the care delivered by the Midlands Partnership Foundation Trust.

***MATTER OF CONCERN**:*

The four areas of concern were:

a. The call handler on the second occasion was not trained and needed to take professional advice from a colleague which colleague did not then speak directly with the caller.

b. The apparent blanket response that they could not discuss the case with the caller yet they could take information from him.

c. With that information more should have been done.

d. Consideration should be given whether incoming calls to the Access Team should be recorded.

Following discussions within the mental health services in the Shropshire, Telford and Wrekin Care Group and with corporate services, I am now in a position to respond to the specific concerns raised during the course of the inquest.

**a. The call handler on the second occasion was not trained and needed to take professional advice from a colleague which colleague did not then speak directly with the caller.**

Response:

The Call Handler has discussed in supervision meetings with the Quality Lead of the Access Team on a monthly basis since the Serious Incident. All concerns regarding their working practice have been addressed. These meetings also ensure all Mandatory Training is up to date and learning needs have been addressed. These meetings have led to the following further training:

- The Call Handler has attended a Stress and Resilience course to help them understand how to manage their own emotional responses to difficult calls received during their work.
- The Call Handler has attended the course provided by Zero Suicide Alliance.
- The Call Handler is due to attend the Shropshire Council's Joint Training in Suicide Prevention Awareness along with a cohort of her peers on 28th Nov 2022.

We have reviewed the training needs for all call handlers. All new call handlers will only shadow trained colleagues until they have completed their training and then will be supervised whilst taking calls until assessed as competent by the Quality Lead.

We have reviewed the suicide prevention awareness training for call handlers and the decision has been made that all call handlers will have received the training below by the end of November 2022 https://www.zerosuicidealliance.com/training. A record of who has received this training will be held by the team manager and compliance monitored through supervision. In addition to this training, it has been agreed by the service manager that the training offered by Shropshire Council's Joint Training in Suicide Prevention Awareness Suicide prevention | Shropshire Council is undertaken by all call handlers in the Access Team on a yearly basis and that this is built into their mandatory training for recording purposes on their electronic staff record.

The aide memoire for call handlers is also included at Annex A.

We have addressed the fact that the shift coordinator did not then speak to Mr Heaton is our response at C.

**b. The apparent blanket response that they could not discuss the case with the caller, yet they could take information from him.**

Response:

We have shared MPFT's Guide to Carers Confidentiality with all the staff in the Access Team. This reinforces the message to our staff that a confidentiality breach only occurs when new, person identifiable, information is given to a third party and does not exclude gathering information from carers and providing them with support and advice. This message has been reinforced in team meetings in October 2022.

We are also developing new guidance for carers which contains a range of resources to provide support to carers in the form of a fact sheet which will include:

- Contact details of local organisations who can provide further support
- Information on how to support their family member to make a safety plan
- How to support the person they are concerned about to have "hope"
- Links to approved internet resources such as the Mental Health Foundation
- How to seek help in an emergency

**c. With that information more should have been done.**

Response:

We have further reviewed our actions in relation to the period immediately prior to Liam's tragic death, these include:

- The Call Handler is due to attend the Shropshire Council's Joint Training in Suicide Prevention Awareness along with a cohort of her peers on 28th November 2022.
- To allow for shift patterns the remaining Call Handlers on Access Team will undertake this training on 11th January 2023.
- The Call Handlers have been provided with MPFT's newly published Guide to Carers Confidentiality and are awaiting the Triangle of Care Training that all staff on the Access and Crisis Teams will be undertaking to enhance their skills when communicating with family members in contact with their teams.
- We have reinforced to all call handlers that concerns raised by family members are of high significance and must be referred to the shift co-ordinator. We have stressed the importance to all shift co-ordinators that, where family are expressing concerns, they must speak to them to clinically formulate the changes in behaviours.
- We have reviewed this case with shift co-ordinators and agreed that Liam should have been referred to the Crisis Team for them to make the decision about further action.
- We recognise that the shift co-ordinator should have spoken to Mr Heaton and listened to his and Liam's mother's concerns. We apologise for this omission and learning from this missed opportunity has been shared with the Team to ensure all attempts are made to re-engage service users who disengage.

**d. Consideration should be given whether incoming calls to the Access Team should be recorded.**

The Trust and the investigator apologise for mistakenly stating that the calls to the Access Team are not recorded. All calls are recorded and are kept for audit and quality assurance and kept by the company who provides the service for 30 days. The Trust has requested that the company examine whether they can access the recording in question and will be reviewing whether calls can be kept for a longer period of time.

It is not stated on the call that the calls are recorded for training and audit purposes which is a matter that we have rectified. In future it has been agreed that when an unexpected death is reported that the relevant call will be retrieved immediately and reviewed as a part of the investigation process.

Our Health Informatics Service has confirmed that we are unable to retrieve the specific calls in relation to this case due the exceeding the period of storage for such recordings. Calls recorded are erased automatically after 30 days and are not able to be retrieved. We have changed our process and following the notification of a serious incident within 30 days of contact with MPFT, the Access Team Manager will retrieve the calls related to the case and secure them in preparation for any subsequent investigation.

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

**Chief Executive Officer**

Annex A

# Call Handlers Aide Memoire – Self referral

To be used to gather relevant information when patients call to self-refer.

- Find patient on RiO. **IF THEY ARE ALREADY OPEN TO A PATHWAY, AND ARE CALLING DURING THEIR WORKING HOURS, PROVIDE THE NUMBER FOR THEIR PATHWAY AND ADVISE THEM TO CALL THE PATHWAY DIRECTLY (END CALL).**
- Check demographics of caller and update contact details as required. Take tel. number caller is calling from. Check caller's current location. Are they with anyone?

**MENTAL HEALTH CONCERNS**

- Ask the caller to explain in their own words why they are calling Access and what are their current Mental Health issues? How do they feel this is affecting them?
- Are they currently receiving / or have previously received support from any other Mental Health services? (i.e. counselling /IAPT/ Social Services etc.).
- Establish risks:

**RISKS**

- Have they ever Deliberately Self Harmed? If yes, when was the last time? How do they harm themselves?
  *If actively self-harming at the time of call then to go to Shift Co, or if OOH to relevant Crisis Team and consider calling Emergency Services (follow the UK Triage Tool)*
- Are they having any thoughts to harm others?
- Are they having any suicidal thoughts? YES/N0 if Yes is there a plan? If Yes, is the plan imminent?
  *(If Yes, call to go to Shift Co, if OOH's this must be discussed with the relevant Crisis Team).*

**Place caller on hold and ensure unvalidated progress note is inputted on RiO. Speak with Access shift co. who will advise how to proceed.**

Plan:

Document next steps clearly in progress notes i.e. Referral opened to Access. Tracker sheet to Shift Co (document full name of Shift Co). Or Tracker sheet updated and passed to Shift Co etc.

If OOH, discuss with / advice sought from CRHT Shift Co and include any advice given and steps to be taken either by Access or Client.