Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Our Ref: [redacted]

Date: 16 December 2024

Simon Milburn
Area Coroner
Coroner's Office
Cambridgeshire & Peterborough Coroner's Service
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

Response to be sent via email
[redacted]

Dear Mr Milburn

Re: Regulation 28 Report to Prevent Future Deaths – Declan Gordon Gerard Morrison

Thank you for your Regulation 28 Report dated 23rd October 2024 concerning the death of Declan Gordon Gerard Morrison who died on 2nd April 2022.

Firstly, we would like to express our sincere condolences to Mr Morrison's family and friends. We have taken this matter extremely seriously.

We have fully participated in the two Safeguarding Review processes that took place prior to the inquest and continue to embed the learning from these. We want to ensure that we do all we can to learn from Declan's life and death and to improve care for future patients.

The Regulation 28 Report concludes that Declan's death resulted from traumatic acute on chronic sub dural haemorrhage (operated). Following the inquest, you raised four concerns which we consider in two groups below.

Processes to identify and best manage a breakdown in placement for someone with Learning Disability and Autism who is at risk of hospital admission

Concern (2) Once it was clear that Declan's community placement had broken down in late 2021 no suitable alternative could be found. This resulted in a decline in Declan's mental health and behaviour which ultimately necessitated his detention under the Mental Health Act. There was then nowhere suitable to detain him under Section 2 of the Mental Health Act.

Since 2022 we have reviewed the functioning of the Dynamic Support Register (DSR) across Cambridgeshire and Peterborough and associated Care and Treatment Reviews. The Dynamic Support Register works across the whole Integrated Care System to prevent unnecessary hospital admissions for people with learning disabilities and autism of all ages. The process of the Dynamic Support Register uses a risk stratification approach to identity people at risk of admission to a mental health hospital, allow multidisciplinary teams to work together to review the needs if each person on the register, and mobilise the right multi-agency support to help prevent hospital admission.

We have:

- Identified clear and robust criteria for rating individual risk and ensured this is consistent across Cambridgeshire and Peterborough.
- Ensured that Standard Operating Procedures (SOPs) are in place for both children and adults. The outcome of which is to clarify actions and responsible commissioners for the care that care that the review decides is indicated.

Care Treatment Reviews are a critical component to keep someone with a Learning Disability and Autism well cared for and out of hospital. They are triggered through the process of the Dynamic Support Register. We have:

- Trained more people to undertake these reviews.
- Established a register of people who can chair an emergency Care Treatment Review as required.

The availability of other placement options so admission to hospital can be avoided

Concern (1) The evidence revealed that there is currently a widespread shortage of available placements for someone with Declan's complex needs both in the community and within the NHS. Concern (3) The Section 136 suite was completely inappropriate. Declan's mental health and behaviour declined further and ultimately resulted in his death
Concern (4) Declan was in crisis for several months – the facilities were simply not available in the community and once detained, in order to prevent his death

We agree that there is currently a widespread shortage of available placements for someone with Declan's complex needs both in the community and within the NHS.
Generally, we do not commission these beds on our own as an ICB as they tend to be for welfare and not for medical treatment. We do tend to commission these beds jointly with our Local Authority colleagues. As availability of these types of beds is a nation-wide issue, we have raised our concerns on the difficulty in finding them with NHS England.

The Cambridgeshire and Peterborough Learning Disability and Autism Board reports into the ICB Quality Performance and Finance Committee and has a Quality Improvement Programme work underway. One of the five priority programmes of work across the system to find a solution and build contingency plans and processes for when there is no accommodation and or no staffing available to meet the needs of someone who has a learning disability and is in mental health crisis. Locally, a short pilot community crisis bedded model was implemented from November 2023 to April 2024 with service development funds from NHS England and the understanding from this pilot is informing the improvement work which will report to the ICB Quality Performance and Finance Committee in early 2025.

Historically care for people with Learning Disabilities has been delivered by the Learning Disability Partnership which is a joint agreement between the CCG/ICB and Cambridgeshire County Council. In this agreement Cambridgeshire County Council had the lead responsibility for the management of care for the people with learning disabilities. Declan's care was delivered via this arrangement. In November 2022, a joint review of the Learning Disability Partnership commenced. The results of this review and the outcomes of the system learning event being held on 12th December 2024, will support the formation of a new service model for patients like Declan.

We recognise the importance of learning all that we can from tragic events like this one and of taking action to change services to improve the outcomes and experiences for local people.

Please do not hesitate to contact us should you need any further information.

Yours sincerely

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MA FRCP MRCGP FFPH DTM&H
Chief Medical Officer

[redacted]
Chief Executive