NHS
West Suffolk
NHS Foundation Trust

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18 December 2024

Dear HM Coroner

Re: Response relating to Regulation 28 Report into the death of Erin Louise Tillsley

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 November 2024 concerning the death of Erin Tillsley on 14 July 2023. This is a joint response prepared on behalf of both West Suffolk Hospital NHS Foundation Trust (WSFT) and the Integrated Care Board (ICB).

For reference, the specific work relevant to WSFT follows first and from page 5, the ICB's specific reply is set out in full.

WSFT

In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Erin's family and loved ones. WSFT are keen to assure the family and HM Coroner that the concerns raised about Erin's care have been listened to and reflected upon. Whilst the inquest concluded on 31 May 2024, WSFT have been proactive in continuing improvement work in respect of the access to Mental Health Services since that time and specific details of that work, and the further work planned, is set out below.

Your Report specifically raises concerns over the failure to ensure that the Emergency Department (ED) followed NICE Guidance (NG225) dated 7 September 2022 regarding the management and assessment of patients presenting with signs of self-harm, and that you received evidence during the course of the Inquest that neither the NICE Guidance, nor the SNEE/SCC Policy (Suffolk and North East Essex Health & Social Care Protocol for the Support of Children and Young People in Crisis) were applied in relation to the care and treatment extended to Erin.

Please find below details of the action taken to date to address this concern, as well as some additional information regarding how the referral process works:

1. The WSFT Mental Health Liaison Team work closely with all clinical staff across the hospital. For those patients who attend ED with a mental health need, the aim is for the MHLT to review the patient within one hour. For those patients already admitted to the wards, they are seen within 24 hours.

   WSFT's policy: *Mental Health – supporting patients with their mental health (PP459)* specifically highlights that:

   "All patients who attend the hospital who have self-harmed should be offered to be seen by the MHLT as per Nice Guideline (NG225) Self Harm: assessment, management and preventing recurrence.

   The service provides mental health assessment and support for service users who have attended hospital to access mental health services or those with both physical and mental health difficulties. This is not a Mental Health Act Assessment ***(see section Care under the Mental Health Act (1983))****. The team will meet with patients to explore their mental state and will collaboratively create a care and risk management plan that helps to improve their mental health. This information will be recorded on E- Care.*

   The service is available 365 days per year, 24/7 and is age inclusive.

   Referrals can be made to the Mental Health Liaison Team via E-Care or by telephoning 01284 713386/713391."

   We hope this reassures HM Coroner that WSFT staff are aware of the NICE guidance and the SNEE/SCC policy and continue to apply it regularly. For added reassurance, a review of WSFT data regarding referrals of patients aged under 18 accessing mental health services at WSFT confirms the following:

Year	ED Referral	Ward Referral	Total
2023	313	64	377
2024*	287	85	372

*YTD

   Sadly, what this data shows is that every day a patient under 18 is referred by ED or the ward to the MHLT for specialist input and support. Whilst terribly sad, this does show that the referral system is working and WSFT staff do have a low threshold for making referrals so that specialist input from the MHLT can be provided.

2. The reason a MHLT referral was not made in Erin's case was because of an error of clinical judgment. Staff believed that Erin's case was one of an accidental not an intentional overdose. Therefore, they believed a MHLT referral was not needed. Hindsight confirms that was incorrect and our work has been focused on helping staff make the right clinical decisions first time in future. That work, led by the Mental Health team and ED Matrons has consisted of the following steps: -

a. additional reminders sent to the whole team about having a low threshold for referrals to MHLT.

b. Additional training – this is targeted at specific staff groups for maximum effect:

Adult ED Nurses have bespoke mandatory MHLT training package run by the MHLT.

Junior doctors have induction training every 4 months as new cohorts join us and the Head of Mental Health will lead on that training moving forwards. The focus on the training is for staff to feel encouraged and supported to have a low threshold for suspecting a mental health condition/illness and for making a referral.

Paediatric ED Nurses have been provided with additional training to make sure staff know when an automatic referral to the MHLT has been made and how to use the new triage form (discussed below). This is in addition to the mental health training that is part of the new induction training for all new ED nurses. The focus of the training is on the team working together and nurses are encouraged to ask doctors to consider making a referral if they have any suspicions. The above data confirms this is happening.

3. To further support staff to make the right decisions in future, *WSFT's policy: Mental Health – supporting patients with their mental health (PP459)* has been updated in August 2024. A new section 5.3 has specifically been added, focussing on how the policy applies to emergency admissions, an extract is below:

"5.3. Emergency Admissions
Patients admitted through ED will be triaged using the Manchester Triage Tool. If the patient presents following for example, overdosing and self-harm this will then trigger a bespoke/extended patient safety checklist which provides a closer assessment of the patient's mental health risk state. Part 1 of the Mental Health Risk Assessment should also be completed which is triggered on E care.

If the patients are assessed as vulnerable or at high risk to self or others the "Observation of patients: One to one "Clinical guideline must be followed, to ensure that their safety and safety others is met. Observations will be recorded on the observation form (Appendix 1).

Whilst being cared for in ED staff must ensure that the patient isn't placed in a high-risk ligature area (as per ligature assessment) and complete the environment safety checklist (Appendix 2).

Waiting can be difficult for anyone who is ill or in pain, the patient may find the waiting extremely difficult, and this can lead to additional problems, for example, 'behaviours which may challenge'. ED staff should consider offering a quieter waiting area with clear information to the patient and their family/carer if they are with them.

A safe room is available to be used by the MHLT for assessing the patient. This meets the PLAN standards:

- *Patients without a medical need will be referred directly to the MHLT.*
- *Patients with a medical need will be referred to the MHLT once assessed as being medically fit enough for their mental health to be assessed. The MHLT will assess the patient within one hour."*

4. Further work following a review of Erin's case by the ED team has resulted in the triage process discussed in point 3 being extended to patients under 18. The Manchester Triage system used for suspected mental health conditions was originally designed for adult patients and has been working successfully for some time. However, that has been adapted and extended for use in under 18's care. Briefly there are 5 categories within the triage process that trigger automatically at the point of triage for MHLT review/referral. These include patient's that present with an overdose. This leads to an additional assessment by the triage nurse at that time and, once completed, that sends an alert to the MHLT for them to complete part 2 of the referral. Examples of the new process and subsequent risk assessments are included in *Appendix 1*. The categories are highlighted red in the boxes on the form. This process has been developed over the summer and has now been included on the electronic patient record system – Ecare. It went live two weeks ago.

5. Whilst safety netting did work in Erin's case, as the safeguarding team reviewed her case the following day and made contact with the GP so that further assistance could be provided, during the reviews after her sad death, we have identified the opportunity to improve the safeguarding process further. There is now a triage for safeguarding which allows them to prioritise patients attending with a mental health condition which are graded as red so that they are reviewed as a priority.

6. All under 18's attending ED also have their discharge letter sent to the GP and school nurse, or if under 5 the Health Visitor, automatically in every case.

Patient Safety Review & Learning

WSFT also undertook a Patient Safety Review, which was completed on 24 October 2023. This proved the catalyst for further review and discussion and helped to bring together a number of projects and workstreams, discussed and highlighted above. Policies have been reviewed, training refined and extended, triage forms changed, and additional safety netting put into place The report was also shared with external partners and incorporated into their wider review.

Future Action and Proposed timetable for implementation

As part of the constant evolution of Mental Health Services in acute care, the Mental Health team, led by Natalie Bailey (Head of Mental Health at WSFT), confirms that the children and young people in crises protocol is currently under review by SNEE (Suffolk and North East Essex Integrated Care Board). Currently there is a consultation exercise underway with all key stakeholders, including WSFT, Norfolk and Suffolk Mental Health trust, parents, service users, ESNEFT and the ICB. This consultation and review will be completed next year and a working group will be established thereafter at WSFT to implement any changes.

In order to minimise harm and prevent occurrences like this happening in future, WSFT will continue to work with all system partners, both to monitor and review performance as we look for new ways to address the difficulties treating this cohort of patients.

ICB

The ICB would like to begin its part of the formal response by extending its deepest condolences to Erin's family. The concerns within the Regulation 28 report have been carefully reviewed.

For ease of reference, the concern relating to the ICB indicated that neither the NICE guidance nor the Suffolk and North East Essex Health and Social Care Protocol for the Support of Children and Young People in Crisis was applied in relation to the care and treatment provided to Erin during her attendance at West Suffolk Hospital.

Response:

The ICB, in partnership with its provider services and system partners, regularly reviews the Suffolk and North East Essex Health and Social Care Protocol for the Support of Children and Young People in Crisis. This is to ensure it contains the latest guidance, evidence-based practice, configuration of local services, children and young people's (CYP) mental health services, and support for our clinicians in delivering care for CYP in crisis. An update is currently underway, which the ICB will share widely on completion, seeking robust assurance of local implementation across its services.

The ICB has forums in place to review and monitor all Regulation 28 reports. This will include the actions taken for improvement as identified in this response.

Thank you for bringing this important patient safety issue to our attention. We hope this information assists to address your concerns and please do not hesitate to contact us should you need any further information.

Yours sincerely

[redacted]

Chief Executive, WSFT

Yours sincerely

[redacted]

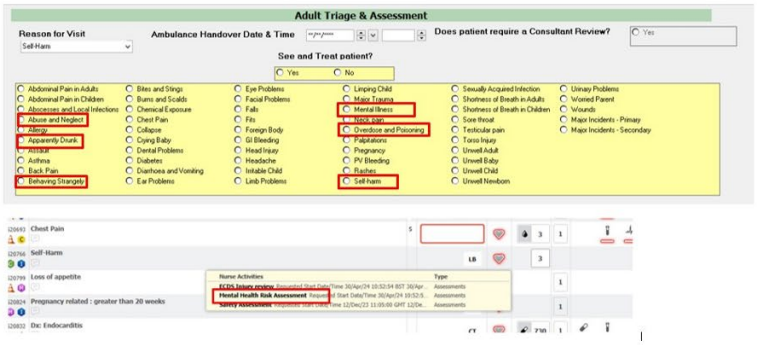
Chief Executive, SNEE ICB

Encs – Appendix 1 Triage and Assessment forms

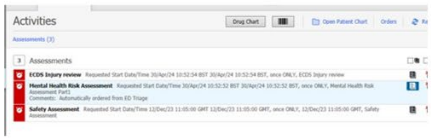
Appendix 1

NHS West Suffolk NHS Foundation Trust

Mental Health Assessment



- Additional mental health assessment will trigger with specific triage categories highlighted
- The MH assessment will trigger in the nursing activities column
- To be completed alongside the triage assessment



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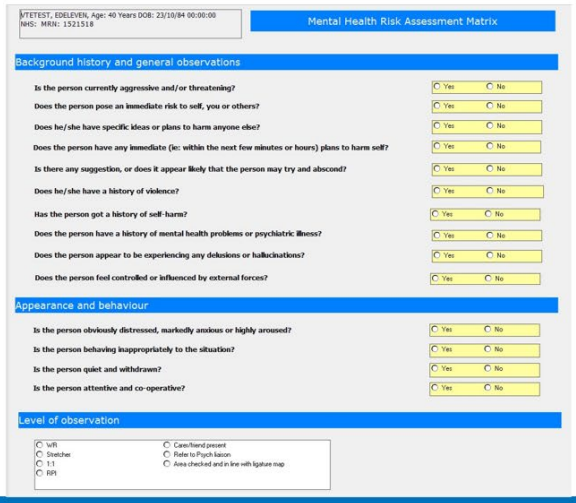
Mental Health Risk Assessment Matrix



Part 1

- To be completed by the nursing team
- Completion will trigger an alert to Psych liaison team to complete the Part 2 doc

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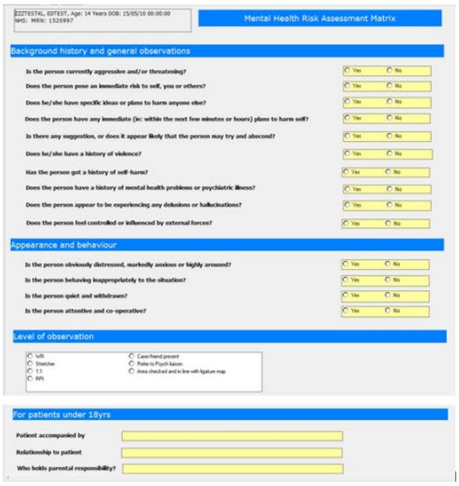
Mental Health Risk Assessment Matrix (under 18s)



Part 1

- To be completed by the nursing team
- Completion will trigger an alert to Psych liaison team to complete the Part 2 doc

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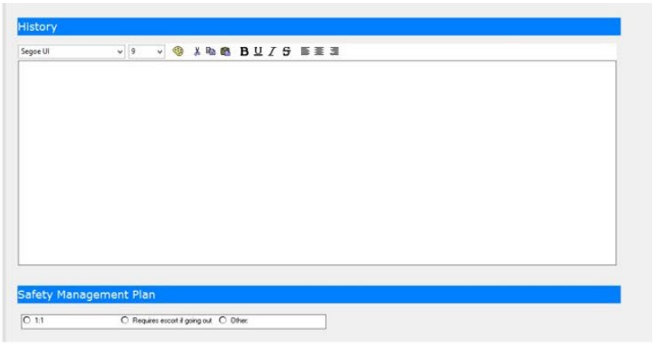
Mental Health Risk Assessment Matrix



Part 2

- To be completed by the psych liaison team

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