NHS
Humber Teaching
NHS Foundation Trust

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Ref: [redacted]

25 February 2025

Professor Marks
Hull Coroner's Court
The Guildhall,
Alfred Gelder Street,
Hull
HU1 2AA

Dear Professor Marks

This is the Trust's Response to the Regulation 28 report issued by yourself at the conclusion of the Inquest touching upon the sad death of Eden Street.

Humber Teaching NHS Foundation Trust would like to express our deepest condolences to the family of Eden Street. We take all patient deaths very seriously and investigate them thoroughly to establish if lessons can be learned or services can be improved.

The concern outlined in that report was described as follows:

> "*Whereas the Humber Teaching NHS Foundation Trust has implemented a number of measures following the publication of a Serious Incident Investigation Report in light of admitted failings, evidence was heard that information provided by parents of autistic children via a telephone helpline operated by the Trust, is not fed back to the weekly audit meeting convened by the Trust. As a result, information about children with neurodiversity issues that might have altered for the worse, may not be available to those who can alter their clinical priorities.*"

The Trust made further enquiries via those representing Eden's family and sought detail of the case that had been referred to during the Inquest, which we understand was the basis for the PFD report. Helpful information was forthcoming including the name of the child, which enabled the Trust to review that matter. It transpires that child was not and is not on the Trust's Core CAMHS waiting list and the circumstances pertaining to that child do not in any way relate to the substantive issue raised within the PFD report.

I do however take this opportunity to re-iterate the reassurance as to the substance of the issue raised within the report which was discussed at the Inquest. The nub of the concern is that you can have a child, who may have neurodiversity issues (diagnosed or undiagnosed) on a core CAMHS waiting list for support with therapy for their mental health. They may have been triaged, assessed and thereafter based on these assessments allocated a routine slot on the waiting list for therapy deemed most suitable to their needs. Whilst waiting for the intervention/therapy to commence, information may become available which could suggest a change in presentation or risk and such information is often received via contact from parents, education or healthcare professionals.

If a call is received about a child on the waiting list, we have dedicated duty workers, who are senior band 7 nurses, whose sole responsibility is to operate the duty system, a large part of the role being to receive calls into the service. The senior clinician receiving the call will ascertain the nature of the information, and where the call is related to concerns or changes related to mental health presentation or safeguarding information, they will gather information and assess need via the telephone in this call. Immediate safety planning work will be included as clinically indicated. Further to the call, a decision will be made regarding next appropriate steps which may form part of the safety plan. These could include further telephone contact with the young person or their carer, a face-to-face contact with the young person, a referral to the crisis and/or intensive home treatment service for more prompt intervention if clinically indicated, or the young person's referral to the waiting list as "routine" could be upgraded to "urgent" and allocated accordingly. Having senior clinicians undertaking this role provides assurance that we have a consistent and expert response to calls received outside of planned contact by core CAMHS, both in relation to children who are neuro divergent and those who are not. In addition, it is now mandatory for all Trust staff to have received the Oliver McGowan Mandatory Training on Learning Disability and Autism. The duty team incorporate this into their assessments and decision making for those on the waiting list that may have a diagnosis or be awaiting assessment for autism. Matthew's Hub, a specific autism charity has been commissioned as waiting list support. They are a specialist voluntary agency who can be directly contracted through Humber Teaching NHS Foundation Trust to offer waiting list support to young people aged 13+ and parents of all-age children. This support currently involves one-to-one sessions with a peer mentor; topics are needs-led; training sessions for young people and parents; school training, a youth club and small group sessions on specific issues (as identified by young people), for example, emotional regulation, daily living skills.

An additional safeguard is that where contact about a young person has been received and dealt with as above by the duty worker, then where there is an increase in risk (e.g. expressions of suicidality of any degree, or a change in known risk profile, no matter what the outcome of that contact, the contact is referenced within a clinical discussion within three working days at the weekly waiting list or weekly MDT meeting (whichever is next due to take place). This gives an opportunity for any further input into the information and decision-making to be provided by the broader professional group. This would include cases where the outcome of the contact is that there will be no change to clinical prioritisation, and this gives an opportunity for this decision to be "double checked" by the wider group and safeguarding responses provided if required.

Additionally, the Trust is implementing a new electronic record keeping system and as part of that, is introducing a risk review form for use by the duty team which will capture calls made to the service. The form will outline the nature of the call and the information provided, and the agreed actions with the supporting clinical rationale. This form will be used as the basis for review of such contacts in the weekly waiting list or weekly MDT meetings. (The use of these forms is just being introduced now with the new electronic system and in the future record keeping audits will include checks to see they are being utilised.)

Additionally, the team are establishing 'safety huddles' in March 2025, which are a brief daily meeting allowing for staff to raise any areas of concern – this will provide a more frequent forum for duty clinicians to gain wider clinical perspectives on decision making.

I would like to thank you for drawing your concerns to my attention. However, with the benefit of the additional information which came to light post inquest confirming the name of the young person which

Eden's family had referred to, which we understand was the basis for the PFD report, we do not think there is in fact evidence that there is a systemic issue or that the system was not operating as described. As detailed above, the young person is not known to the Trust's Core CAMHS or autism services. I am reassured that there is a robust system for dealing with contacts received in relation to children and young people on the CAMHS waiting list.

I hope the above is helpful in addressing your concerns. Please let me know if you require any further information or clarification in relation to these matters.

Yours sincerely

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Chief Executive