South West Yorkshire Partnership Teaching NHS Foundation Trust

3rd July 2026

South West Yorkshire Partnership NHS
Teaching Foundation Trust
Fieldhead Hospital
Block 7
Ouchthorpe Lane
Wakefield
WF1 3SP

Ms Hannah Berry
HM Assistant Coroner, Yorkshire South West
Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

Dear Ma'am,

Regulation 28 Response – Ollie Lee

We write in response to the Regulation 28 report following the inquest touching the death of Ollie Lee. We would like to start this response by offering Ollie's family our sincere condolences for their loss.

We hope the information in this response provides assurance that the Trust has carefully considered the concerns of relevance to the Trust. You heard oral evidence in respect of the Trust's learning following Ollie's death, and this information is also repeated in our response below.

The Trust has a Patient Safety Incident Response Framework (PSIRF) policy with overarching systems and processes to learn and to improve care and services following notifiable patient safety incidents. This includes a Trust Patient Safety Oversight Group (PSOG) and a Children and Young Peoples Mental Health Service (CYMPHS) Patient Safety Oversight Group (PSOG), which provide organisational and operational oversight of the Trust's response to incidents and any associated learning.

Following the death of Olllie, a review of Ollie's electronic patient records, also known as a case note review, was undertaken by the General Manager of the Barnsley Child and Adolescent Mental Health Service (CAMHS). The case note review was presented to, and subsequently approved by, the CYPMHS PSOG on 12 November 2024.

The case note review identified areas of learning local to Barnsley CAMHS, including Information Sharing and Multi Agency Discharge Planning; the clinical quality of the Risk Assessment for Non-Engagement form (RANE); and the associated discharge processes. The local actions were completed by June 2025

A Patient Safety Improvement Plan to address the system-based learning was developed and overseen by the CYPMHS PSOG. The Patient Safety Improvement Plan focused on embedding the use of the clinical frameworks that are in place within the Trust to support practice, including: Capturing the Childs Voice; the Consent to Care, Treatment & Discharge tool and Engagement & Communication of Care; and Crisis, Discharge Planning and Risk Assessment. The completion of the Patient Safety Improvement Plan actions was approved by the CYPMHS PSOG in October 2025.

On receipt and review of the Regulation 28 report, it is noted that the concerns raised, as set out below, were consistent with learning identified in the Trust's case note review approved by the CYPMHS PSOG in October 2025 and the learning presented at Ollie's inquest. The learning from the case note review, and other relevant systems or processes across CAMHS, has been detailed below against the concerns raised in the Regulation 28 report. Additionally, multi-agency communications have taken place since the conclusion of Ollie's inquest, and these too are detailed below.

1. **Poor communication and engagement between the agencies involved with Ollie including her school, CAMHS and targeted early help.**

   Branching Minds is the single point of contact for emotional help and wellbeing support and is co-delivered by CAMHS and 'Compass Be' who are the Mental Health Support Team in Schools (MHST) commissioned provider for Barnsley. CAMHS developed crisis guidance for schools in June 2024 which described clinically appropriate approaches when supporting children and young people in times of distress. School staff were encouraged to utilise their 'Compass Be' senior practitioners for discussion and learning in the once per term link sessions held at their schools. The crisis guidance specified how to access support at the point of crisis and how children and young people and parents/carers can self-refer to Branching Minds.

   Having identified local learning from the case note review related to multi-agency communication and engagement, on 4 April 2025, training was provided to Barnsley CAMHS by the Trust Safeguarding Children Team on Information Sharing and Multi-Agency Working. The purpose of the training was to reinforce the importance of multi-agency working and information sharing to promote best practice. The Trust also has a Safeguarding toolkit which supports clinical staff on a range of practice areas including information sharing, and quality and accuracy of documentation.

The Trust's 'Did not attend/was not brought/no access visits policy' reiterates that 'Was Not Brought' is a term used instead of 'Did Not Attend' because it encourages professionals to think about the situation from the child or patient perspective and potentially take action, including the consideration of any safeguarding concerns. The policy advises that communication with all relevant and involved agencies with the child or young person must take place to ensure that information and decisions are shared in a timely way, subject to considerations of patient confidentiality. Additionally, the policy advises that clinicians should exercise professional curiosity, make reasonable attempts to establish face to face contact, and consider reasonable adjustments to support engagement.

As noted above, there are a range of clinical tools and frameworks in place within the Trust to support communication and engagement including, for example the Consent to Care, Treatment & Discharge tool that documents discussions related to confidentiality and consent to share information during the child or young person's care with CAMHS; and the Risk Assessment for Non-Engagement form (RANE), which can be used when children, young people and families have declined to engage with Trust CAMHS and which documents a rationale regarding sharing of risks with and any follow up required from other agencies.

2. **A lack of communication and engagement between targeted early help and CAMHS despite both agencies being aware that the other was involved. This led to a confusing picture and a missed opportunity for Ollie to remain open to CAMHS and receive psychosocial intervention and continued support from CAMHS.**

Having identified learning related to multi agency communication and engagement in the case note review, on 28 January 2025 the Branching Minds Clinical Lead delivered training to Targeted Early Help Practitioners, who are children's social care employees, in relation to the CAMHS referral process and access to mental health support for children and young people. The purpose of the training was to reinforce the multi-agency arrangements and set a clear expectation that communication between practitioners is active, timely, and accountable. This training is scheduled to be repeated in August 2026. In recognition of potential staff turnover within children's social care, the Trust will be providing these training sessions annually, supported by additional sessions to be arranged at the request of social care services.

Additionally, and whilst not an action taken by the Trust, we are aware that on 12 February 2025 the Team Leaders for 'Compass Be' Mental Health Support Teams in Schools – MHST) delivered training to Integrated Front Door staff (children's social care employees and first point of contact for children's social care) in relation to referral process and access to mental health support for children and young people. The purpose of the training was to reinforce the multi-agency arrangements and set a clear expectation that communication between practitioners is active, timely, and accountable. The Trust are not responsible for the MHST training provision as this responsibility sits with the commissioned provider of that service.

Future and on-going multi-agency communication and learning

Following Ollie's inquest, on 4 June 2026, a multi-agency meeting was held between senior leaders from the Trust**,** Barnsley Metropolitan Borough Council (BMBC) Children's Social Care, and Barnsley Academy. The purpose of the meeting was to hold an open discussion regarding the concerns raised in the Regulation 28 report and to consider how the partners could continue to work together towards developing shared improvement actions. Subsequent to this meeting, a proposal was made and accepted by the Partnership Board for the respective learning identified by the Trust, BMBC and Barnsley Academy to be shared amongst the partner agencies in order to coordinate and formulate any multi-agency pathway developments.

On 8 June 2026, the General Manager for Barnsley CAMHS met with the Service Manager for the Targeted Early Help Service (TEHS) to explore opportunities for improving joint working and strengthening timely and effective information sharing between services. To further improve communication between CAMHS and TEHS, three key actions were agreed for initial implementation:

- **Daily briefing attendance**
  A representative from the Targeted Early Help Service will join the existing daily briefing at Branching Minds. This will enable TEHS to share relevant information about children and young people (CYP) known to their service and facilitate timely consultation with the crisis team where required.

- **Fortnightly case review meeting**
  An initial fortnightly meeting will be established between CAMHS and TEHS, attended by a CAMHS Team Manager and a TEHS Team Manager, to review cases awaiting allocation or intervention. This will support information sharing and identify opportunities for coordinated or joint working.

- **Bi-monthly strategic review**
  The TEHS Service Manager and the CAMHS General Manager will meet on a bi-monthly basis to review progress, evaluate the effectiveness of joint working arrangements, and consider the development of a Memorandum of Understanding (MoU). This will be informed by learning from these initial actions.

All children's services, including CAMHS, are involved in the broader Children's Reform Agenda, which is a comprehensive plan aimed at transforming children's social care and child protection policy, with a focus on improving multi-agency collaboration and enabling earlier, more effective support for children and families. BMBC are the lead agency of the wider Barnsley children's services response to the Children's Reform Agenda, and the Trust are committed to supporting the multi-agency response to the Children's Reform Agenda. We understand BMBC have included a number of the initiatives, or proposed plans, in their response to the Regulation 28 report.

Finally, in April 2026, the Children's Wellbeing and Schools Act 2026 received royal assent, and this includes the statutory duty for partner agencies to share information relevant to safeguarding and promoting the wellbeing of children and young persons. This statutory duty is intended to apply from September 2026 and national guidance to support its implementation is in a consultation process. We are currently considering this within the Trust and with partner agencies to ensure a collaborative and robust response to the information sharing provisions of the Children's Wellbeing and Schools Act 2026.

We hope that this response emphasise our continued commitments to learning and working with partner agencies to ensure robust care and treatment for all children and young persons that come into contact with our services.

We do hope the above information is of assistance and answers the concerns raised within your Regulation 28 report following the sad death of Ollie Lee.

Yours sincerely,

Chief Medical Officer

Chief Nurse / Director of Quality & Professions