Somerset Partnership NHS
NHS Foundation Trust

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PRIVATE AND CONFIDENTIAL

Mr Tony Williams
Senior Coroner
Old Municipal Buildings
Corporation Street
TAUNTON
Somerset TA1 4AQ

Dear Mr Williams

CONCLUDED INQUEST INTO THE DEATH OF SOFIA LEGG

I am writing to respond to the Regulation 28 (Preventing Futures Deaths) Notice that you issued to Somerset Partnership NHS Foundation Trust on 5 October 2017.

My predecessor, Dr Nick Broughton, as Chief Executive, met with Mrs Legg in October of this year and offered our sincerest condolences and an unreserved apology for the areas of Sofia's care and the handling of the investigation that were not of the high standard expected. Whilst we cannot begin to imagine the pain Sofia's family have experienced, we would like to express the sadness that we, as an organisation, and our CAMHS staff in particular, have experienced as a result of Sofia's death.

Somerset Partnership provides a Tier 3 community CAMH Service. Tier 3 services are frequently referred to as Specialist CAMHS. These are multi-disciplinary teams which work in the community with children and young people who present with the most complex mental health presentations and severe levels of risk. This would include severe mood and anxiety disorders, eating disorders, the impact of complex trauma as well as serious self-harm and suicide risk. The treatments offered by a Tier 3 services include a range of specialist psychological interventions and medication which can only be delivered by staff who have a high degree of specialist training and experience. What is known as Tier 2 CAMHs is the level of service, based primarily in schools and the wider community, providing early detection of emotional and mental health difficulties and offering timely, preventative interventions.

You will be aware that there has been national publicity and Government recognition of the need to invest further in children's mental health services. The organisation welcomed this national investment which has been translated locally into the CAMHS Transformation Plan for Somerset and has led to considerable service improvements over the last year.

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However, Somerset continues to be in the lower quartile for investment and we believe that further service development will be needed if we are to address the increase in demand and the complexity of the mental health presentations we are seeing in young people.

The Trust's response is intended to convey the range of actions that have already been taken since the tragic death of Sofia in September 2016 and to provide reassurance that the proposals for further action are to prevent future incidences of suicide for children and young people in our care.

1. Access to CAMHS. Sofia was rejected for referral in April 2015. Might a lower threshold and earlier proactive interventionist policy have been of positive benefits to Sofia?

1.1 It is certainly true that a lower threshold might have allowed Sofia to access the service earlier. However, for the reasons described above, capacity within the Tier 3 CAMH Service is limited.

1.2 Over the past year the Trust has introduced a Single Point of Access (SPA) for CAMHS and the remit has been to more consistently screen referrals, allow more time for advice and discussion with referrers and to maintain and monitor service thresholds. We believe this is making a difference by improving access as well as improving the quality of the advice and guidance that is given.

1.3 Whilst, the introduction of the SPA has been a significant step forward, it has highlighted the unmet need in what we refer to as the CAMHS Tier 2 resources.

1.4 Our specialist CAMHS team has raised concerns that the Tier 2 options in Somerset are not equitable with much of the rest of the country. An increase in the Tier 2 resource would be an important and effective investment decision to improve the long term mental health of children and young people.

1.5 The Trust has raised this concern with Somerset Clinical Commissioning Group and the Local Authority and is working closely with these colleagues on a gap analysis, which is anticipated will assist in informing future funding priorities. The need for a Tier 2 early intervention service was also raised directly with the Secretary of State for Health when he visited the Trust on 24 November 2017 and he indicated that a new green paper will soon be published which sets out plans to transform services in schools, universities and for families. The Trust welcomes this focus on children's and young people's mental health and the plans to address the current gap in Tier 2 service provision.

1.6 As part of this review we are also currently undertaking work to benchmark our own internal threshold processes for CAMHS Tier 3, with the national definition of what a Tier 3 service is expected to provide, and with what is commissioned: to ensure that we have our threshold in the right place, and that if it is set too high that we can identify that, to ensure that we look to get the right level commissioned.

2. Availability of CBT. Sofia was placed on a six month waiting list for CBT. This delay appears considerable.

2.1 The Trust agrees that a six month waiting time for CBT is unacceptable and has been working hard to reduce this. Waiting times for all specialist therapies have been successfully reduced and CBT waiting times in the Trust are now measured in weeks, rather than months. However, CBT is not an emergency intervention and a review of Sofia's care has led us to conclude that she should have been offered a more generic, therapeutic intervention with more frequent appointments at an earlier stage. This would involve using psychoeducation and a range of therapeutic techniques to engage and build a trusting relationship with a focus on understanding and managing risk.

2.2 The way the CAMHS teams operate has been changing to ensure that there is a much greater focus on generic interventions, relationship building and increased frequency of contact when suicidal thoughts are one of the main presenting problems.

2.3 During 2017 the way initial assessments are performed has also changed. This includes the re-structuring of clinics to better support all staff in their decision making and to include psychiatrists and senior clinicians at an earlier stage. Weekly multi-disciplinary meetings with psychiatrists in attendance have been implemented to guide staff through complex case discussions and identify those cases which may need their input.

3. Sofia's care co-ordinator at CAMHS did not obtain the urgent input of a psychiatrist in accordance with NICE guidance.

3.1 The guidance for urgent and emergency response times also involves making complex clinical judgments and these are made by staff on an individual patient basis. Within CAMHS the decisions are made not only by psychiatrists but by other experienced senior clinicians who are able to assess and intervene to manage suicidal presentations safely as part of the urgent care pathway. If a referral to a psychiatrist is considered as urgent the family are seen within 24 hours of the referral and if the assessment results in an emergency referral these are made within 7 days. The numbers of psychiatrists within the Trust is limited and they would be unable to see all cases where suicidal ideation is a feature.

3.2 The care coordinator did view Sofia's presentation as sufficiently concerning to take advice from senior staff, including her clinical supervisor on the day of the appointment, while Sofia and her mother waited in the building. The outcome of those discussions was that the situation was deemed as urgent and the care coordinator should complete a safety plan and seek an urgent psychiatric appointment. The Trust has reviewed its escalation procedures and introduced new service provision since this tragic incident.

3.3 The last year has seen a transformation in the urgent care pathway for CAMHS. An Enhanced Outreach Team (EOT) is in place. This team can, where necessary, do daily home visits and seek to provide more frequent monitoring of young people's mental state. Sadly, this service did not exist in this form at the time of

Sofia's death but it is envisaged that young people will benefit from an increased crisis and home treatment provision in the future.

3.4 In addition the Trust now has a team of highly experienced psychiatric liaison nurses based at both acute hospitals in Somerset, these nurses assess young people who self-harm or experience suicidal thoughts on presentation to an emergency department. If the child/young person is discharged and they require further CAMHS input this information is communicated to the relevant local team for follow up. This team can also admit to the paediatric ward if they need to keep a young person safe and this would prevent a delay in care if the young person could only be seen by a psychiatrist to undertake these assessments.

4. The recollections of Sofia's Care Co-ordinator and Sofia's mother as to the meeting of the 19 September were at odds with each other. Sofia's Care Coordinator recollected in her evidence telling Sofia's mother that Sofia was not to be left alone. Sofia's mother deemed the impression from Sofia's Care Co-ordinator's evidence was of Sofia being an extremely vulnerable and dangerous position but this was not reflected in Sofia's care plan which made no mention of her not being left alone and it was not reflected in the Care Co-ordinator's actions in not urgently contacting Sofia's school, where she would be during the following days to a psychiatrist. Her care plan appears to be the critical written record of the outcomes of this meeting as it was not of sufficient detail to safeguard Sofia.

4.1 It has been recognised that the recollections of Mrs Legg and Sofia's care co-ordinator are not in agreement with regards to the level of detailed safety advice given. Mrs Legg herself has told us that we, as a service, may not fully understand how challenging this situation was for her as a parent. She was being asked to absorb new information about her daughter's mental state and her risk of ending her life, which was new and shocking for her. I extend again my own and the Trust's sincere apologies to Mrs Legg for this. The Trust appreciates and fully understands this feedback given by Sofia's mother and realises that services need to work much harder to help families understand the impulsive and fluctuating nature of suicide risk in young people. CAMHS practitioners have been made aware of the importance of ensuring care plans are explicit and information is written clearly. This work will continue to be monitored through staff clinical supervision.

4.2 The information about suicide risk needs to be given in a number of different ways and the Trust is creating a range of information leaflets that give general advice about suicide risk, as well as continuing to develop the knowledge and skills of our CAMHS teams in assessing, managing and communicating around risk. The Trust is working with Public Health in Somerset County Council on Suicide Prevention and it is expected that these leaflets will be launched in 2018.

4.3 It has been fully recognised that family members need to be involved at the earliest stage when young people are expressing suicidal ideation and given time to absorb information and to process advice. The CAMH service is continuing to work with staff through risk training and via local team business meetings to emphasise the importance of crisis plans which give advice to both the young

person and parent as to the level of supervision needed, in clear language. These directions are reinforced in training and supervision for staff.

4.4 A recently conducted review of Sofia's care has highlighted the issue of communication with the school as one of the most significant areas of learning for the service. It has been concluded that the school might have been able to take different actions in their care of Sofia had they been aware of the increased risk. It has not been standard for CAMHS staff to share risk assessments and crisis plans with schools and has been a matter for individual clinical judgement. We believe that in cases where young people are expressing suicidal ideation then this information should be shared with schools as standard practice. This will involve cultural and practical changes and will have implications for our education colleagues. We are starting a process of talking with the CCG, schools and our staff to work towards implementing this approach as standard.

5. Language used in the SIRI Report was felt to be inappropriate. The SIRI Report effectively said if the care plan had been followed the outcome might have been different and that no change in clinical practice would have resulted in any different outcome. I do not believe either of these statements was true.

5.1 The Trust wishes to apologise unreservedly for the poor and extremely distressing choice of words within the investigation report which it acknowledges has caused considerable anxiety for Sofia's family. A review of the investigation, which took place following the inquest, did not support the statements as described above made in the report. The Trust has identified several areas for improvement to ensure that this does not happen again.

5.2 The Trust has prioritised the need for all investigators to have the knowledge and ability to conduct a thorough, accurate and reliable investigation using national tools and techniques. Training of key staff in the use of these national tools and techniques has already commenced and by the end of 2017 a cohort of trained investigators will be in place.

5.3 The scope and terms of reference for the investigation will be clearly defined to include the needs of families and there will be oversight throughout the process to ensure key questions are asked and answered, this will ensure that the Trust achieves credible investigations. This new process has already been implemented.

5.4 The investigation process will seek to review all aspects of care and treatment that may have had an impact on an event such as this. The Trust has recognised that the involvement of families is essential right from the beginning of the investigation until the eventual sharing of findings. Work to embed this process is underway with revised documentation and education.

5.5 Bereaved families are being asked to meet and contribute to the learning by sharing their own experiences, in order to inform current and future working to ensure that openness and support is in place. Initial meetings with family representatives who wish to be part of this have taken place.

5.6 In addition the Trust will further review the investigation into the death of Sofia. This review will seek to challenge the statements made and provide a balanced and sensitive report. This is due to complete by the end of January 2018.

Yours sincerely

PETER LEWIS
Chief Executive