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Ms Hamilton-Deeley
The Coroner's Office
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Your Ref: VHD/TS/Kirby

26 February 2019

Dear Ms Hamilton-Deeley

Thank you for your letter dated 7 December 2018 enclosing your Report to Prevent Future Deaths under Regulation 28 Coroners (Investigations) Regulations 2013. I write to formally respond and to provide you with details of the actions taken by the Trust as a result of the matters identified during the Inquest.

I will address each of the eight Matters of Concern contained within your Report, in turn:

Delay in dealing with Mr Kirby between August 2017 and March 2018.

Mr Kirby was referred by his GP on 4 August 2017 and was offered an initial appointment for 15 August 2017. When he did not attend he should have been contacted to reschedule the appointment. Instead, almost a month passed and then Mr Kirby's wife made contact to seek support. Whilst an appointment was then made for 20 September 2017, in light of the information provided by Mrs Kirby, Mr Kirby should have been followed up more quickly and assertively. Additionally, Mr Kirby should not have then experienced unacceptably long gaps between his first Medical review on 31 October 2017 and his second and final review on 20 March 2018. The Trust's Serious Incident investigation identified these lack of assertive follow-ups and unacceptably long gaps as failings in Mr Kirby's care. The recommended measures to address those failings involved establishing that Mr Kirby's Lead Practitioner's caseload was such that he had sufficient capacity to ensure an appropriate level of care was delivered and that there be greater oversight and management of his caseload. I confirm that those measures were and continue to be taken. Specifically, there has been a significant reduction in his caseload coupled with robust and ongoing review of that caseload and supervision to secure that he is fully supported to deliver the level of care that is expected.

Decision to ask Mr Kirby to complete ADHD questionnaires and apparently suggest that he should be prescribed Concerta.

I understand that Mr Kirby was provided with the ADHD questionnaires by his Lead Practitioner following his initial assessment with Mr Kirby on 20 September 2017. At that assessment, Mr Kirby was questioning his diagnosis. His Lead Practitioner considered there to be a number of ADHD indicators in Mr Kirby's presentation so explored it as a possibility and as part of the picture of Mr Kirby's mental health difficulties. Subsequently, at the first medical review on 31 October 2017, [redacted] explained to Mr Kirby that he would discuss the findings of his assessment with his Neurobehavioral colleagues, with a prescription of Concerta being a possible outcome.

As your concern centres on clinical decision-making I asked the Trust's Chief Medical Officer [redacted] to set up a group of senior medical colleagues to review [redacted] medical practice in relation to ADHD. The terms of reference of that medical decision-making group (DMG) included consideration of the use of ADHD questionnaires for diagnosis as well as consideration of the assessment and diagnosis of ADHD and recommended prescribing.

An immediate action that was taken was to ensure that all [redacted] ADHD patients were co-managed with the Neurobehavioural Team. Additionally, a clinical review of all ADHD prescribing within the relevant team was completed which, I am pleased to say, did not identify any concerns.

An outcome of the DMG review was to seek assistance from Professor [redacted] (Chair in Psychiatry, University of Sussex) who has agreed to review Mr Kirby's case with [redacted] on 25 March 2019 and recommend any training needs, focussing on using NICE guidance and local shared care protocol for ADHD cases.

Although [redacted] made a diagnosis he did not follow the NICE Guidance, inform the GP, start prescribing, consider alternatives to prescribing, have a formal note made of the consultation with Mr Kirby when the impact of the diagnosis was discussed with him or discuss the diagnosis with his next of kin.

As indicated above, the Trust has taken the action of seeking the assistance of Professor Critchley, as an ADHD expert, to ensure that [redacted] practice in relation to ADHD accords with good practice. Additionally, further assurance is provided by the co-management of ADHD patients with the Neurobehavioural Team.

Prior to this case, Professor [redacted] worked with our Neurobehavioral Service to ensure their understanding of NICE guidance. A further action from the DMG review of this case is that Professor [redacted] has been asked to repeat that piece of work he did last year to re-inforce working with the NICE guidance.

Upon receipt of the GP's letter dated 16 April, [redacted] did not further review Mr Kirby before he was prescribed Concerta which is outwith the NICE Guidance.

As referred to above, the action taken by the Trust to evaluate [redacted] clinical decision-making and understanding of the NICE guidance is through the assistance of Professor Critchley.

Why was Mr Kirby prescribed Concerta without any (further) review?

The DMG review found that [redacted] practice style favoured consultation via telephone rather than face-to-face discussion; in part, this was considered to be a result of his large caseload but also due to the relationships he has established with GPs. Those relationships were considered to be good and his availability to GP's for their consultation was considered as positive. However, it was recognised that [redacted] did not work in line with the local shared care protocol. The DMG have discussed this with [redacted] to enable him to reflect on his practice and establish good practices in the future when sharing care with GPs.

Why was he not properly monitored as he should have been had the NICE Guidance been adhered too?

[redacted] wholly accepts that he should have arranged for Mr Kirby to be reviewed by him in clinic so that he could be monitored. It is highly regrettable that this did not happen and [redacted] assures me that he has reflected on his practice. The aforementioned actions taken by the Trust, particularly co-management by the Neurobehavioural Team, ensures that ongoing monitoring occurs for our ADHD patients.

The A&E admission on 4th-5th April should have alerted the Trust to the information Mr Kirby had given that he was suicidal and 'wanted to die'.

[redacted] informs me that he reviewed the details of Mr Kirby's A&E admission upon receipt of the letter from the GP seeking the prescribing advice. His clinical opinion at that time was that Mr Kirby's presentation at A&E was not new; that is to say that he had previously presented similarly when under the influence of alcohol. [redacted] also took into account that Mr Kirby was assessed by the Mental Health Liaison Team who didn't consider re-referring him. Therefore [redacted] concern for Mr Kirby was not heightened by this attendance at A&E.

Why did those interviewing Mr Kirby in A&E not take more details of the suicide attempt when the rope broke?

I am informed that the evidence at the Inquest showed that Mr Kirby provided the Pavillions A&E liaison nurse with this suicide attempt information but that our Mental Health Liaison nurse was not aware of it. As this has identified a gap in the working between the two services the manager responsible for our Mental Health Liaison Team has worked with her Pavillions counter-part to create an information sharing protocol

which sets out the steps that the teams now take to establish robust communication between them.

In addition to the above, the DMG took a number of further steps to establish wider learning. Firstly, the ADHD NICE guidance was shared with all doctors via Mediconnect which is our doctors' intranet forum for highlighting items of importance/interest/learning etc. Additionally, the issues arising from this case are to be presented for learning and discussion at the Trust's forthcoming Effective Care & Treatment Conference next month. Furthermore, we are to publish a story, based on this case and to specifically include the issues surrounding co-morbid substance misuse, in our Patient Safety Matters; this is an internal learning publication that we use to improve patient safety.

Finally, I would like to assure you that [redacted] shared your concerns and the actions we have taken with Practitioner Performance Advice (formerly NCAS) to ensure that there was no further action that they felt ought to be taken and I confirm that they were satisfied with our actions.

I trust that the content of this response addresses your concerns and provides you with complete reassurance. However, if any further clarification is required or I can assist further in any way then please do not hesitate to contact me.

With kind regards

Samantha Allen
Chief Executive