NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

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Private and Confidential
HM Senior Coroner Mrs Hunt
Birmingham Coroner's Court
50 Newton Street
Birmingham
B4 6NE

5 April 2019

Dear Mrs Hunt

REGULATION 28 REPORT – MR S KENNEDY

Thank you for your communication relating to the investigation into the death of Stephen Anthony Kennedy. I note that the investigation concluded at the end of an inquest on 7th February 2019 with a conclusion of Suicide.

It is evident that the deceased suffered from emotional unstable personality disorder and depression. At the time of his death Stephen had been under the care of our mental health team for several years. His condition resulted in frequent attempts to self harm which was managed through hospital admissions and at home with support from the home treatment team. His condition deteriorated during 2018. He was seen regularly by the mental health team with his last admission being from 22/08/18 until 11/09/18. He was then reviewed by the home treatment team. Stephen presented to Good Hope Hospital on 07/10/18 with chest pains and low mood. He was assessed by a mental health nurse and arrangements were made for ongoing support from the home treatment team and to see his consultant on 08/10/18. Tragically, Stephen was found hanging from a door frame at his home address on 08/10/18 and was declared deceased at 10.07. Our serious incident investigation RCA report highlighted a gap in care relating to non compliance with NICE guidelines for psychological therapy whereby Stephen had not been in receipt of Psychological Therapy throughout his time on our Community caseload.

During the course of the inquest the evidence revealed matters giving rise to concern. The matters of concern are noted as follows:-

1. The deceased suffered from emotional unstable personality disorder and was in crisis for most of 2018. The recommended treatment for his condition was psychological therapy. He had not had any psychological input since 2010. The inquest heard that whilst he was under the care of the home treatment team there was no access to psychology services. He had to be under the community mental health team to be able to access

psychological services. There were periods when he was under the care of the community mental health team but at this time he remained on a long waiting list for psychological services. Throughout 2018 he never received any psychological services. I am concerned that the main treatment option for the deceased was not available to him due to internal structures and long waiting lists.

2. In August 2018 the deceased required inpatient treatment. There were no beds available and as a result he had further episodes of self-harm and suicide attempts. The availability of acute beds is a serious concern.

With regard to the matter of Psychological Therapy, I am able to confirm that we now have a plan for investing in clinical psychology capacity within our Home Treatment Team services. From September 2019, subject to recruitment, we anticipate to be in a position whereby every individual Home Treatment Team has a 0.5WTE Clinical Psychologist within their team. Approval has been given to advertise these posts and this will help us to ensure compliance with NICE guidance and to deliver clinically effective care as per recommended guidelines. The Clinical Psychologist will also contribute to multi disciplinary team assessments, discussions and decisions relating to care planning and treatment options for patients, aswell as providing supervision to other members of the team. We are also increasing nursing capacity to ensure that community caseloads are more manageable.

In addition, we have developed a tiered training programme in the best practice management of patients with Personality Disorder. This will be a mandated training requirement for all staff working within our Home Treatment Teams during 2019/20.

Our Chief Psychologist is leading a Personality Disorders Strategy which includes clinical standards to be met for patients with a diagnosis of Personality Disorder. We are currently in discussion with our Clinical Director of Community Mental Health Teams about the opportunities to roll out these standards in a clinically effective way. There are some challenges relating to resources which we have raised with our Commissioners and at the time of writing this response these have not yet been resolved. We will continue to pursue this matter and also seek to understand any further opportunities for improvement if investment is not forthcoming.

On the matter of bed availability, it is recognised that at times patients are unable to access a bed at the point of clinical decision making and that this can lead to increased risk, despite best efforts to manage patients safely in an alternative environment. We are undertaking a number of initiatives to try to mitigate this risk including:-

- A review of patient flow
- Efforts to reduce delayed discharges
- Appointment of patient flow coordinators

In the longer term, our Estates Strategy aims to increase the inpatient bed stock of the Trust to try to meet the increased demands and acuity of patients across the City and in Solihull.

I would like to take this opportunity to express my sincere apologies for the failings in the care delivered to Stephen by our Trust and to extend these apologies to his family members. This is clearly a tragic event for all and one that the Trust is taking seriously in its efforts to prevent future incidents of this nature.

I do hope that this response gives you some assurance of the efforts being taken by the Trust in response to your matters of concern.

Yours sincerely

Roisin Fallon-Williams
Chief Executive