Nottinghamshire Healthcare
NHS Foundation Trust

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Mr Gordon Clow
HM Assistant Coroner for Nottingham and Nottinghamshire
Nottinghamshire Coroner's Office
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mr Clow

Please find the organisational response to the recently received Preventing Future Deaths Report following the death of Sean Fegan, the inquest of which was concluded on 25th March 2021. We once again take this opportunity to offer our sincere condolences to Mr Fegan's family.

For ease, we will respond to each of the concerns you raised in turn.

1. **Decision making surrounding the need for secondary mental health care**

A decision was taken in December 2019 that Mr Fegan did not require mental health treatment at all in the absence of adequate information or assessment and for reasons which appeared incorrect.

The Trust has reviewed this case in terms of the decisions made at the initial referral, from the perspective of whether too narrow a view was taken at the time.

At the time the decision was made, it was made in joint approach with the commissioned service for drug and alcohol support, Change, Grow, Live (CGL), who were present at the time, and with the benefit of his substance misuse notes. The prescriber and the consultant were also there and considered the referral carefully. Whilst the patient wanted clonazepam and melatonin to be considered it is felt unlikely that these particular drugs would have been prescribed given his risks, particularly given the addictive potential of clonazepam. Melatonin is not licensed for use in adults, it is a grey drug on the Area Prescribing Committee, as the evidence for benefit is too limited.

Nevertheless we acknowledge that at this point in time he had had a previous admission of some length and more information could have been obtained from his GP about his current mental health, and more consideration could have been given to the details pertaining to his previous admission into B2. The team have reflected over this, and consider that undertaking an assessment at this point would have enabled a clearer formulation to be developed with him, with a rounded consideration of the interplay between Mr Fegan's ASD, substance misuse and any underlying mental illness, to inform a plan for him. The Clinical Director will explore opportunities for shared learning with other clinicians and teams from Mr Fegan's story. This will also be explored in discussion with his family.

The NHS long term plan identifies some key objectives for change in relation to the management of mental health care across primary and secondary services. This includes the employment of mental health practitioners in primary care settings, who will be actively engaged in the management of referrals

with the Local Mental Health Teams. This will ensure much better oversight, closer working relationships and better communication. As part of the Trust's Transformation Project, we are now working more closely with primary care. There is a pilot scheme due to start in May 2021, involving band 6 mental health nurses, triaging referrals by contacting both the referrer and the patient. There will be access to a senior MDT panel for discussion in complex cases.

A Neurodevelopmental Specialist Service (NeSS) is now established, from 1st April 2021, to offer diagnosis and post-diagnostic support for autistic people. NeSS will provide training and development of competence in mental health services to support assessment, care planning, advice, and crisis support for autistic people with mental health conditions in the community. Advice can be sought in relation to complex referral decision making involving individuals with autism as a diagnosis.

The Trust is also strengthening the support provided to people with autism in crisis by recruiting a speech and language therapist dedicated to work with autistic people in crisis in the community, by making use of the additional funding that will be made available from NHS England. There is an ongoing mental health division wide steering group for autism that brings together clinical and non-clinical colleagues to clarify treatment pathways for autistic people and share good practice within the mental health division.

2. **Access to mental health treatment**

Mr Fegan had complex mental health conditions and experienced very high levels of distress and anxiety as a consequence. He was declined mental health treatment on two occasions by the Trust. Mr Fegan took an overdose due to his frustration at not being able to access mental health services which he needed. Whilst this was not the cause of Mr Fegan's death, it created a dangerous state of affairs.

The Trust is clear that substance misuse is often part of a wider MH presentation and we work routinely and without hesitancy with patients with co-morbid drug use. It must be understood that when drug use is very significant, it can act as a barrier to specific psychological therapies, and in some circumstances, this needs to be addressed as a first priority. We aim to address the immediate needs in the context of the whole patient, including treatment of substance misuse. Mr Fegan had engaged well with the commissioned service for substance misuse, CGL.

We accept that, the rationale behind decisions such as those made in this case could be shared with the patient and family at an earlier stage and in a clearer fashion, which would have been of clear benefit to patients such as Mr Fegan who might otherwise feel like they are being denied treatment. Additionally, this would provide patients with direction and reassurance that there is an overall plan for their care, and this was a missed opportunity to engage with Mr Fegan in a positive way. There is currently work in the Trust on involving the patient in the triage process which is being piloted and this is detailed later. .

As a trust we regret that Mr Fegan was discharged from CRHT without being made aware that he had been accepted for assessment by the LMHT and without an appointment date. Upon discharge from the CRHT Mr Fegan was made aware that he could contact the CRHT for support at any time. The Local Mental Health Team have reviewed their process to ensure that the referrer and patient is contacted as soon as a decision is made after considering the referral letter. As identified above the service transformation will ensure joint working and delivery of care across primary and secondary care, with improved continuity.

3. **Dual diagnosis**

it was acknowledged that there was a 'gap' within the services in relation to dual diagnosis patients. There was evidence of a resistance to agreeing to provide a service to patients with significant drugs misuse problems.

There is no resistance to, or policy within the Trust against treating dual diagnosis patients. The Trust is commissioned to work with CGL (Change, Grow, Live), who provide this service. We regret that the family and the inquest were left with the impression that the Trust is reluctant to engage with this patient group and reassert that this is not the case; people with co morbid substance misuse are supported by our services.

As part of the Trust's Transformation Project and as part of a pilot there will be three substance misuse workers embedded within the LMHTs, who will facilitate closer working with CGL, and recruitment is now underway to fill these posts . The substance misuse workers will also provide training and best practice procedures to staff, whilst also assisting with the more complex presentations.

The Trust's strategy for promoting integrated care for people with comorbid mental health and substance misuse comprises of a number of components. This includes training on dual diagnosis which is enhanced by the appointment of the substance misuse staff. There is a bi-monthly collaborative clinical reference group for dual diagnosis now established, which includes a range of clinical staff from different services across Nottinghamshire, enabling case discussion and identification of pathways for mental health and substance misuse. There is also good engagement with public health in relation to the wider strategy in developing this area. The trust is currently exploring employment of peer support workers including number of posts and their deployment, supervision and training requirements, any specific roles to be undertaken by peer support workers and how to evaluate their impact.

4. **Liaison with family members**

There was no evidence of proactive attempts to engage with family members, even when services withdrew. When a family member sought to share concerns, these were rebuffed.

Continuity in a person's care and liaison with family is really important to us. The Crisis Resolution Home Treatment (CRHT) Team operate to respond to, manage and contain risk, and therefore liaison with the family is very helpful and essential to support holistic assessment and treatment where they are engaged. The Trust has now implemented a carer peer support worker post in the Mid-Notts CRHT team which can specifically assist with this liaison.

We recognise and sincerely regret that the family's experience of contact with the crisis team led to a feeling of being rebuffed, and we have reviewed a recording of the telephone call. A sense of a time pressure is evident in the call. We note that the crisis worker did listen to the concerns raised and managed to relay that there was a plan in place for contact with Mr Fegan the following day. The CRHT Team has since been expanded to relieve some of these pressures on staff. This includes an additional 5/6 band 6 nurses and 3 health care support workers. There is also an additional prescribing clinic run at the weekend by the team's non-medical prescriber.

CRHT training on handling of telephone calls was rolled out at the start of the pandemic and is about to resumed. This includes triage of call (including family member calls), how to handle calls, and subsequent actions.

The Trust operates under the Triangle of Care. The Triangle of Care (ToC) membership scheme promotes shared working between carers, professionals and people using services. Each service within the Trust has to self-assess what this will look like. Within the CRHT, considering the terms of the ToC, the communication of the care plan will be more carefully considered. Upon discharge from the service, a checkpoint will be added to the checklist for the discharging team evaluate and discharge their obligation to liaise with the family at that point.

The Trust has written to Mr Fegan's family who have confirmed their willingness to be engage with us and share their experience. There is a meeting planned with the Clinical director and governance team to discuss their experience in more detail with the aim of improving our practice.

5. **Implementation of care plans**

A care plan was devised by the liaison nurse and psychiatrist, only to be overruled by persons who had not themselves assessed Mr Fegan, on an incorrect basis, and without a review of the risk assessment justifying that decision. Mr Fegan was called and invited to agree to the withdrawal of services. Such a practice runs the significant risk that patients who are less assertive or who have poor insight into their mental health needs will be said to have 'agreed' that a service is no longer required.

The CHRT Teams provide services for those with immediate needs and aim to prevent admissions to hospital. If there are no immediate risks, the patient can be discharged from the CRHT caseload, with the option to self-refer if risks were to increase.

The Trust will always aim to work with patients to decide the most appropriate level of care. This process is a dynamic one, and we will always seek to include the patient in the decision making. The decision making to discharge from CRHT at that point was based on immediate needs and in the knowledge that We acknowledge that Mr. Fegan did have psychiatric diagnoses and he had an open referral for assessment with the LMHT and could re refer to CRHT if his situation changed. It will be emphasised to staff that if a care plan is changed, there needs to be clear, accurate documentation relating to the discussion and rationale for this change, including review of risk. This will be captured in feedback to the team, including reflections on the decision making to discharge at that point and the evidence behind it. We are reviewing guidance to staff in the Standard Operating Procedure for the crisis teams to ensure accurate decision making when stepping down from crisis team care, and an audit will be developed to provide ongoing assurance. Findings will be shared through our internal lessons learned bulletin, and the Trust's regular Quality & Risk Meetings.

The Crisis team has since been enhanced and expanded to allow for the increasing number of patients on its caseload, and there will be more training available specifically relating to ASD presentations as outlined in paragraph one and six.

6. **Autism awareness**

I was concerned that Mr Fegan's presentation acted as a barrier to a proper understanding of his mental health needs. In line with his autism diagnosis, he did not present in a socially typical way of expressing his feelings and emotions in a demonstrative manner, but rather 'jumped' to his view about what treatment he required, namely prescriptions. This was misunderstood by professionals on more than one occasion.

The [redacted] mandatory training in learning disability and autism is being piloted from April 2021 for all health and social care staff. This training will be delivered in three tiers; Tier 1: autism awareness, Tier 2: for all clinicians and Tier 3, for advanced specialists. There is an ongoing national pilot on the delivery of this training. The Trust's Learning and Development teams are involved in planning delivery of this training within the Trust in line with national recommendations. As mentioned earlier the Trust has the Neurodevelopment Steering group established with a working group in place, including AMH and NeSS, with the aim of developing and enhancing the clinical care pathways. Also established is the Neurodevelopmental Case Discussion Forum, facilitated by an experienced clinician in the NeSS service, where clinicians can bring complex cases to present and discuss, and obtain advice.

The service has also undertaken work around learning from deaths of individuals with autism, part of which is the Learning from Autism Deaths Thematic Review. The learning from this will be included in training and future service developments.

These actions will be monitored within the Trust through a specific Quality Improvement Plan with the General Manager as the nominated lead.

I hope the information above provides the assurance that we have considered your recommendations seriously and are actively seeking to improve the services we provide by implementing the actions outlined.

Yours sincerely

[redacted]
Chief Executive