23.07.21

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Mr Nicholas Moss QC
Assistant Coroner for Peterborough and Cambridgeshire

BY EMAIL.

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Dear Mr Moss QC,

Inquests touching the deaths of Sam and Chris Gould – response to Report to Prevent Future Deaths.

I write in response to your Report to Prevent Future Deaths, dated 28.05.21. Within that report, you raised four issues of concern, namely:

(1) **Overnight assistance for adolescent mental health patients being cared for at home but with high levels of need (For CPFT and CCC).** I heard evidence of increased funding for CPFT being used to extend home treatment options, but that this would be unlikely to extend to a 24/7 service. I also heard evidence from CCC that available support would now be considered under s17 Children Act or s117 Mental Health Act or both but that this would need to be jointly funded between social care and health. I remain concerned that a clear pathway to securing overnight assistance (even if only on a respite basis) for similar cases of exceptional need has not yet been clearly agreed between CPFT and CCC. I am concerned that if alternative supported accommodation in the community were the best solution, there does not appear to be provision for it in-area, so that admission to a mental health unit becomes more likely.

(2) **Not for CPFT but included for completeness**

Involvement of CCC alongside CPFT in complex adolescent mental health cases where the risk is of suicide / self-harm (For CCC). In some respects CCC's involvement in Chris and Sam's care (social care and education) lacked direction, focus, knowledge and efficiency. I heard evidence of improvements in training in the relevant education and social work teams, and concerning the new Strong Families, Strong Communities Securing Best Outcomes for Children Strategy (March 2021). Further, that CCC is restructuring all of its early help and adolescent services and will be implementing a formal contextual safeguarding framework and that these developments will be in place by the end of 2021. I am concerned that in the midst of restructuring and new guidance, there remains a risk that education inclusion officers and social workers on the ground may still not have sufficient knowledge, guidance and supervision to ensure that CCC give practical and robust support to parents and adolescent patients, alongside treating healthcare agencies, where the main risk of serious harm to the child is from self-

harm or suicide arising from adolescent mental health disorders, rather than neglect of harm by a third party.

(3) **Diagnosis of Borderline Personality Disorder (For CPFT).** I am concerned that the evidence in Chris' case, in particular, suggested a degree of age-related reluctance consistently to use the terminology of Borderline Personality Disorder (or Emerging Personality Disorder or EUPD), even when a highly specialist second opinion had supported this and appeared to have been accepted. There are risks associated with a reluctance to use a personality disorder diagnosis (c.f. Position Statement from the Royal College of Psychiatrists dated January 2020). I received evidence that there have already been some changes/improvements in the preparedness to recognise Borderline Personality Disorder and that further consideration will be given in the context of the new ICD 11.

(4) **AWOL patients from Darwin Centre for Young People (For CPFT).** I heard evidence that since Chris' death, staff have been reminded of the applicable policies; and that an audit has shown good compliance with the provision for calling the local signallers. I heard evidence that there is to be a further review of CPFT's own AWOL policy. I remain concerned that: (i) CPFT's own policy is too lengthy and complex to serve as reference-guidance during a live AWOL incident. In particular the flow chart summary is unnecessarily complex and hard to follow (at least as a tool to consult during a stressful incident); (ii) there is a risk of confusion in having two policies both of which are meant to be followed; (iii) there did not appear be desktop-drills / other training exercises / information grab-packs (etc.) to ensure that all nurses in charge are properly equipped and trained to deal with AWOL incidents efficiently (iv) steps ought to be taken at managerial level to ensure that the confusion over the two policies and whether one had been superseded (evidence of which only emerged during the inquest) cannot recur in this, or other areas, when new policies are introduced.

CPFT has considered with care the issues that you raised, and I will now address points (1), (3) and (4) in turn. (Point (2) has been directed to CCC).

Point (1)

CPFT are committed to working with the CCG to continue to develop services for children with significant mental health difficulties. Since the death of Sam and Chris Gould the CCG have commissioned the expansion of the First Response Service (FRS) to include a dedicated CAMHS crisis team. This provides direct access for children and families to a CAMHS professional to provide advice and home, hospital or clinic based face to face assessments. This service is commissioned by the CCG to operate 8-8 five days a week and offer brief interventions (up to two weeks).

Outside of these times young people and families have direct access to the FRS, an all age 24/7 telephone advice crisis service. This service has embedded CAMHS practitioners and a CAMHS consultant to provide direct work and supervision for non-CAMHS staff.

Additionally, the CCG have commissioned a CAMHS home treatment team. Recruitment to this is ongoing. It will work intensively with young people and families as an alternative to hospitalisation. This is a multi-disciplinary team and will be able to operate 9-9 with up to 3 contacts per day in the family home to provide treatment to young people and families. This will include supporting rapid discharge of patients from hospital who may not be best helped by hospital admission. As part of this the home treatment team is developing a DBT treatment programme for children with severe self-harm.
This service is not commissioned to provide 24/7 in home support for young people. If this level of support were needed then this would be raised through either the joint funding panel or through the CCG Section 117 funding stream.

The discussion about the need for 24/7 in home care will continue with the CCG and the Local Authority and whether any needs are best met though bespoke arrangements, or the demand is such as to require a fully funded service.

I also refer the coroner to CCC's separate response, to this point.

Point (3)

CPFT have been reviewing diagnostic processes in the light of the coroner's recommendations and the new ICD 11 (International classification of Disease). National implementation of the ICD 11 will follow in January 2022. ICD 11 changes many of the current diagnostic classifications including removing the diagnosis of emotionally unstable personality disorder. Rather than identifying discrete personality disorders the new ICD 11 defines mild, moderate or severe personality disorder and then and optional clarifying behaviour description. There six subtype descriptions any number of which can be combined. One of these is "borderline pattern".

There are also changes to the diagnosis that will make it easier to use the diagnosis for CAMHS professionals. One is that personality disorders are no longer listed as "disorders of adult personality" but acknowledge that personality disorders can start in childhood. It is recognised that personality disorders are long lasting so ICD 11 specifies that the features must have been present for at least two years. Another difference is that, while ICD-10 states that Personality Disorders tend to be stable over time, the ICD-11 guideline explicitly states that "Personality Disorders are only "relatively" stable after young adulthood and may change such that a person who had a Personality Disorder during young adulthood no longer has one by middle age." These two things taken together will reduce the reluctance to use a personality disorder in older adolescents however, due to the duration criteria it is still unlikely that teenagers will meet the diagnostic threshold before the age of 16.

In CPFT we will be reminding all doctors of the changes to ICD 11 and we have contacted our electronic medical records provider to ask that they confirm that the changes will be embedded in the system.

The changes in diagnostic recommendations will be subject to ongoing research and review and further research into personality disorders will hopefully lead to clearer therapeutic recommendations for young people with these severe and life limiting conditions.

Point (4)

CPFT accepts the concerns with regard to the AWOL policy and has commenced the process of reviewing this. In order to ensure that the concerns about meaningfulness and useability are fully addressed this will involve engagement with staff groups, service users and carers. That work is expected to be completed by October 2021. In the meantime clarity has been given with regard to the superseded policy.

The Trust is currently undertaking a full review of all policies which will ensure that they are fully in line with the latest best practice guidance and that they are written in such a way that they are clearly understandable and usable by all members of staff. The review is led by myself as Medical Director and [redacted], the Director of Nursing, Allied Health Professions and Quality, and will run over the next six months.

I hope that this response provides assurance to Chris and Sam's family and yourself that the CPFT has taken the learning from the Inquest very seriously and has and continues to improve its policies and put in place measures to ensure safe and effective services.

Yours sincerely

Dr [redacted]
Medical Director, Cambridgeshire and Peterborough NHS Foundation Trust