

REPORT TO THE TRUST BOARD IN PUBLIC
24 MARCH 2022

Title	Coroner Regulation 28 Report - Prevention of Future Deaths
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Purpose of the report

On 21 May 2020, Mr Luke Wilden was found deceased in his flat. Mr Wilden had been a service user of Luton and Bedfordshire Children and Adolescent Mental Health Services. On reaching his 18th birthday he had recently transitioned to adult mental health services in the area.

The Trust's Serious Incident Investigation identified several areas of care that were below acceptable standards. An action plan was put in place to address the problems which were identified.

At the conclusion of the inquest into Mr Wilden's death on 20 July 2021, HM Coroner was critical of the care Mr Wilden received under the care of East London NHS Foundation Trust.

Subsequently on 16 January 2022, HM Coroner delivered the report outlining areas of action for purpose of preventing future deaths. In particular, there were concerns that transition arrangements (for children turning 18) within ELFT for individuals with high functioning autism were inadequate.

This report is an update on progress to address the shortcomings in these areas of practice.

The Board is reminded that the Board Quality Report in January 2022 reviewed the transition of service users between children's and adult mental health services across the whole of the organisation. It found the processes in place were robust, with 6-month transition periods, joint working and transition support workers (in Bedfordshire and Luton).

Summary of key issues

- New systems have been put in place to reinforce transitions protocols for children turning 18 year moving on from Child and Adolescent Mental Health Services (CAMHS).
- Staffing capacity has been increased specifically for transition planning.
- Joint working with the relevant Local Authorities to ensure smooth transition arrangements in both health and social care is underway.

Strategic priorities this paper supports (please check box including brief statement)

Improved population health outcomes	<input type="checkbox"/>	
Improved experience of care	<input checked="" type="checkbox"/>	Safer, more effective care
Improved staff experience	<input checked="" type="checkbox"/>	Clearer expectations and process for staff to follow
Improved value	<input type="checkbox"/>	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	None

Implications

Equality Analysis	This case relates to a service user with high functioning autism and poor services provided in transitioning to adult mental health services. The outcome of this paper aims to address this inequality in the high functioning autism group of service user.
Risk and Assurance	This report summarised actions taken to respond to risk-related interventions and an assurance of the processes for safe practice and oversight
Service User/Carer/Staff	The outcomes of this report is to improve provision of services for service users transitioning from CAMHS to adult service to ensure that high quality and safe care in maintained throughout. From staff perspective there is clarity of what is required from them and extra resources have been provided to ensure that this can take place.
Financial	There is cost associated with introduction of transition workers which have been agreed.
Quality	The issues highlighted are related to patient safety. Patient safety is the cornerstone of high-quality health care.

Supporting documents and research material

a.
b.

Glossary

Abbreviation	In full
HM	Her Majesty's
CAMHS	Child and Adolescent Mental Health Services

1.0 Background

- 1.1 On 21 May 2020, Mr Luke Wilden was found deceased in his flat. Mr Wilden had been a service user of Luton and Bedfordshire Children and Adolescent Mental Health Services. On reaching his 18th birthday he had recently transitioned to adult mental health services in the area.
- 1.2 The Trust's Serious Incident Investigation identified several areas of care that were below acceptable standards. An action plan was put in place to address the areas which were identified.
- 1.3 At the conclusion of the inquest into Mr Wilden's death on 20 July 2021, HM Coroner was critical of the care Mr Wilden received under the care of East London NHS Foundation Trust.
- 1.4 Subsequently on 16 January 2022, HM Coroner delivered the report outlining areas of action for purpose of preventing future deaths.

Transition arrangements within ELFT for individuals with high functioning autism were inadequate when Luke turned 18 and, as a result, he was not transferred to the appropriate adult mental health team for continued treatment and to enable provision of an appropriate adult social care package, including suitable accommodation for him. Whilst I understand that changes have been made within ELFT in order to address this gap in services, I am concerned that these may still not be sufficient. Furthermore, I am concerned that this gap in services may also exist on a national level.

- 1.5 The Board is reminded that the Board Quality Report in January 2022 reviewed the transition of service users between children's and adult mental health services across the whole of the organisation. It found the processes in place were robust, with 6-month transition periods, joint working and transition support workers (in Bedfordshire and Luton).

2.0 Reinforcing transition protocols

- 2.1 Following the death of Mr Wilden the Trust took measures to reinforce its transition policy and protocols on the transition of children to adult mental health services.
- 2.2 The serious incident report into Mr Wilden's death and the Trust's transition policy and protocols were reviewed with relevant staff members at the CAMHS away day on 16 September 2020.
- 2.3 Since 31 December 2020, the administrator within each CAMHS team, pulls a list of all existing service users on a monthly basis. Those age 17.5 (6 months from their 18th birthday) are identified and discussed at the relevant CAMHS teams' multidisciplinary meeting so that appropriate planning and transitioning to the correct adult services may be commenced.

- 2.4 CAMHS supervisors were reminded of the importance of the transition policy and protocols and their monthly clinical supervision with staff members now includes performance monitoring of the transition policy and protocols.
- 2.5 An audit was undertaken. A sample of 5 patients were reviewed over a period of 3 months to assess services' compliance with the protocols. All cases reviewed met the required targets.
- 2.6 Since the inquest into Mr Wilden's death, further work to reinforce transition protocols has been undertaken. Audits take place on a quarterly basis to review service user's transition from children to adult services. The audits aim to identify and share good practice, ensure the young person and their family carers voice is central to support provided, identify areas for improvement and share the learning from this. More recently, both CAMHS and adult services have committed to undertaking joint audits to promote cross team learning and ensure improvements to the young person's experience remains central to practice.
- 2.7 Bedford and Luton's Transition Policy has been reviewed. A decision has been made that the policy be revamped to include the latest transition protocols with both CAMHS and Adult Mental Health services feeding into the final document. It is anticipated that this will be complete on 14 April 2022. The new policy will be reviewed at the first CAMHS away day following completion and reinforced through supervisors via monthly supervision.

3.0 Additional capacity for supporting transitions

- 3.1 To assist staff in reinforcing the transition policies and protocols outlined above, the Trust has also increased its capacity for supporting transitions from CAMHS to adult mental health and social care services.
- 3.2 Since 1 March 2020, a full-time transition worker has been based in the Neuro Developmental Team dedicated to supporting the transitions of young people with autistic spectrum disorders including high-functioning autism. The transition worker works with patients from identification (6 months before their 18th birthday), through the transition and after their birthday to support and embed the transition. This includes supporting the young person, their family, partner agencies and the relevant adult service to smooth the transition as far as possible. They work with both referring and receiving local authority where relevant to ensure progress in transition planning. Particularly where the patient is referred into a non-specialist neurodevelopmental team, the transition worker will also provide advice on engagement and support of that young person. Since the inquest, a second transition worker has joined the Neurodevelopmental Team.
- 3.3 As of February 2022, two additional transition support workers have been hired to work across CAMHS to support service users on transition pathways from 6

months prior to their 18th birthday until they are embedded within adult mental health and social services.

- 3.4 The Trust has also appointed a Strategic Transitions Lead. This role will provide system leadership across all agencies, including ensuring that robust transitions systems between children's (CAMHS) and Adult Mental Health Care are maintained. They will work with the relevant local authorities to ensure that robust transition pathways are in place across mental health services. They will ensure that the experience of the young person is at the heart of how of the systems and processes develop and operate.

4.0 Working with Local Authorities

- 4.1 Since the inquest, it has become clear that the Trust's transition protocols and policies across both mental health services and adult social care would benefit from more cohesive working with the relevant local authority's children's services.
- 4.2 There is currently a safeguarding adults review (SAR) taking place in relation to Mr Wilden's case. Bedford Borough Council safeguarding has requested a specific joint multi-agency, task and finish group (Task Group) to identify gaps in transitions across local authority and health. The findings will be fed back to the safeguarding board. The Trust is taking an active role in the SAR and the Task Group. Any significant findings will be fed into Trust Policy.
- 4.3 As part of the Strategic Transitions Lead's role, ELFT is developing a strategic multi-agency forum with all key partners, particularly its local authority partners, to ensure that transitions retains a system wide focus and that leadership can be provided on a collaborative basis, to the many teams and services that have the potential to interface with a young person and their family carers during their journey to adulthood.

5.0 Action being requested

- 5.1 The Board is asked to NOTE this report and CONSIDER any further assurance required.