Report On The Look Back Review Into Child & Adolescent Mental Health Services Mental Health Services Area A

This Easy Read version of the Executive Summary respects the Inclusion Europe easy-to-read guidelines and carries the European Easy to Read Logo. It is intended to make the report summary accessible to all audiences.

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Easy Read Executive Summary

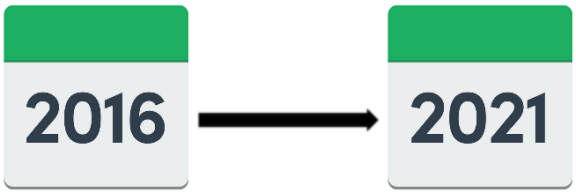
This executive summary is about concerns relating to a Doctor in Child and Adolescent Mental Health services known as CAMHS.

These concerns were reported in September 2020 about how the Doctor worked and prescribed medications.

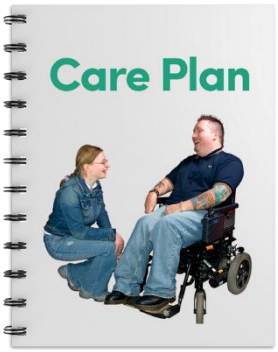
An audit was carried out on 50 files of patients.

This is where all the files are looked at to make sure that procedures were carried out properly by the Doctor.

In April 2021, the Chief Officer of the Community Healthcare Organisation Area also called CHO Area asked for a Look Back Review known as LBR.

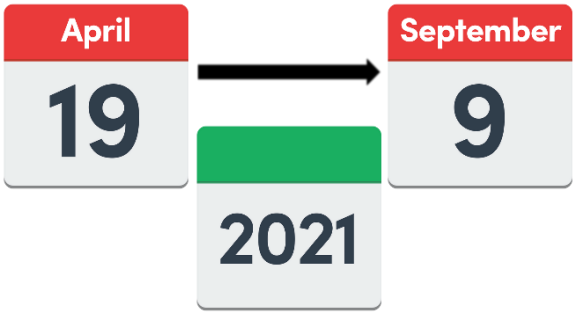


The dates covered by the review between 01 July 2016 to the 19 April 2021.



The LBR looked at the issues like:

- prescribed medications
- care planning
- diagnosis
- how the Doctor under review was supervised



We started the LBR on
19th April 2021 and the file review was complete on
09th September 2021.

Statement of findings

We reviewed 1,332 files.

We found that no extreme or catastrophic harm was caused to the patients in these files.

Not all of the children who the Doctor worked with were put at risk of harm.

The treatment by the Doctor to 227 children was risky.

The risks included one or more of these:

- sleepiness
- dulled feelings
- slowed thinking
- serious weight gain
- distress

The care and treatment of 13 other children by other Doctors was also risky.

We found proof in the review of significant harm to 46 children.

The harm included:

- production of breast milk
- putting on a lot of weight gain
- sleepy during the day
- raised blood pressure.

The HSE have met with many of the children young adults and parents affected.

Key Causal Factors

The diagnosis of ADHD for secondary school children was often made without the right amount of information from their teachers on how the children were at school.

We found checks also called observations of unwanted effects of medications did not happen including:

- pulse
- blood pressure
- height and weight

These observations were not regularly checked or not recorded properly.

Necessary blood tests were not always done.

The Doctor was not available for interview.

We believe that the Doctor thought they were helping the patients and did not intend to harm the patients they treated.

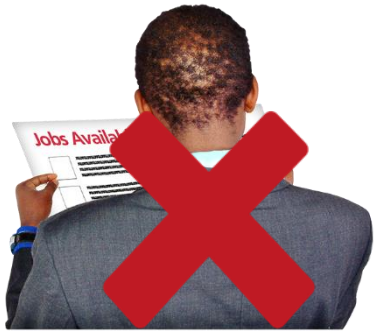
The exposure of the children to risk and harm by the Doctor was because of lack of knowledge about the best way to do things.

Key Contributory Factors

There was no clinical lead for the CAMHS Area A Team.

This was one of the reasons for failing to provide and keep a high quality service.

There was no Consultant Child and Adolescent Psychiatrist from 2016 for the CAMHS Area A Team.



Another Consultant Child and Adolescent Psychiatrist agreed to cover this vacant job until the HSE hired someone.

It was expected that it would only be for a short while.

It took much longer than expected to find someone to fill the vacant position.

Not enough attention was paid to the possible risks while this job was vacant.

The Consultant Child and Adolescent Psychiatrist supervising the Doctor did not see problems that developed throughout 2017 and 2018.

Concerns about the Doctor were first reported in 2018.

No proof was found that these concerns were addressed after being reported.

In 2019 concerns about prescribing medication were clear.

The supervisor at the time advised changes but did not insist these happened.

The Doctor worked extra hours.

They were observed to be very tired at work.

This issue was not addressed.

There was no system used to check

the prescribing of medications
or the quality of service
by the Doctor's supervisors.

In 2020 the Doctor was recommended for other jobs even though there was concerns about them.

A new senior medical manager started in the service.

The concerns about the Doctor were not handed over to the new medical manager.

The service has not put in place
many of the recommendations of the
National CAMHS Operating Procedure
2015 or the CAMHS Operational Guideline
2019.

This includes:

- Not having updated treatment plans that are shared with the patient their family and the person who referred them to CAMHS.
- Not naming a Key Worker to all cases.
- Not naming a Team Coordinator.
- Not naming a Practice Manager.

CAMHS Area A Team had a lot more referrals of new patients than other areas across the country.

This had not reduced at the same rate as other services.

Some of the referrals which were not accepted were not dealt with quickly. They were left awaiting on a decision of acceptance to the service.

Line managers for the CAMHS Area A Team have tried over the last few years to get Team A to keep a shared diary but this has not happened.

Reception staff do not know who is coming in for appointments.

Staff cannot quickly know who is working on a case.

All of this means cases get lost.

Rules on looking after case files were not being followed properly.

Staff and Doctors were able to take files from the file room without signing them out.

This is not safe or in line with HSE Policy on Health Record Management.

Clinical information was not always recorded in the patient file.

There is proof of two missing referrals and 10 full case records.

This has been reported in line with the HSE Data Protection Policy.

A link for this policy is here: https://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-data-protection-policy.pdf

Even though Doctors were one quarter of clinical staff they were present in over half of the initial assessments of patients.

The Doctors hold over 100 cases.

Other team members have about 23 cases.

CAMHS Area A Team have a Governance Group.

They are responsible for supervision of the quality of the service provided by Area A Team.

The Governance Group did not check that CAMHS Area A Team was working safely and effectively.

The Governance group did not talk about the risks of a long term vacancy.

Thinking about the risks for CAMHS Area A Team involved:

- Making the problem go away
- Fixing something that was broken
- Hiring for a vacant job

Instead of thinking more widely about the problems for the team.

If a Review had been done in 2019 problems might have been noticed sooner.

The service managers have limited numbers to help them know about the work the team does.

There are nationally approved Key Performance Indicators (KPI's) which include:

- numbers who came to the clinic
- how long patients wait for an appointment

These KPI's do not show quality and risk.

Recommendations

35 recommendations have been made

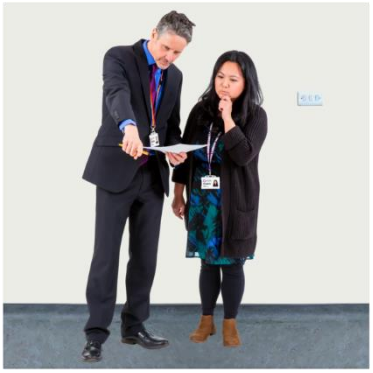
1. Children and their families should be invited to be part of the governance structure of the CAMHS service.

2. The recruitment of a permanent full-time clinical lead Consultant Psychiatrist must remain a priority for the service.

3. The CHO managers should think about setting up a working group to look at the current and future needs of CAMHS.

4.Training for all staff in risk and incident management.

5. When a team does not have a consultant, there should be one clinical lead identified for clinical and leadership tasks.



6. Hire a Team Coordinator.

7. Hire a Practice Manager.

8. The CAMHS Area A Team with the Governance group should use the CAMHS Operational Guidelines 2019.

9. The CAMHS Area A Team with the Governance group should make sure there are the right number of cases for the staff.

10. The CAMHS Area A Team should do “Enhancing Teamwork" training provided by the HSE.

11. The CAMHS team should implement the Key Worker role for all cases.

12. The members of the CAMHS Governance group should agree and use a diary to keep track of cases in the CAMHS clinic.

13. The CAMHS Governance Group should check clinical records are looked after properly.

14. How the Governance group operates must be reviewed.

The group should list the things they have to do and who is to do it.

15. Training in how to check that important tasks have been done should be given to the CAMHS Area A Team and all of CAMHS teams in the CHO.

Children and families should be involved in deciding what is important.

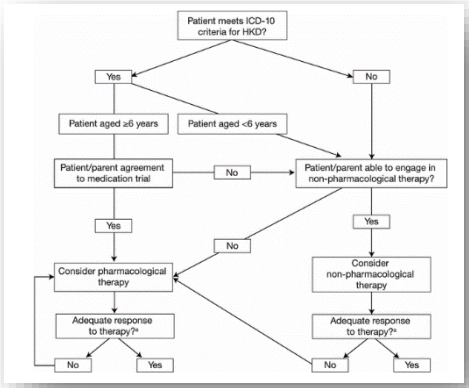
16. Try out permanent instead of temporary jobs for two of the County Mental Health Service Area A Junior Doctor jobs.

17. A group should be set up to develop a plan to provide an integrated mental health service for 0 to 25-year-olds.

18. The CHO service should find out what the laws are for consultants outside Ireland in Europe or elsewhere to be able to see patients by video link.

19. Think about developing a CAMHS management structure on its own which will work alongside the adult mental health service structure.

20. Think about developing specialist services within the CHO.



21. Well respected clinical guidelines and tests should be used for ADHD assessment and treatment.

22. Agreements should be developed with GP's to share the treatment of children with ADHD.

Pharmacists might help if that causes problems for GP's because of difficulties with the medication.

23. Medication for mental illnesses for children should only be started by or with the written agreement of their Consultant.

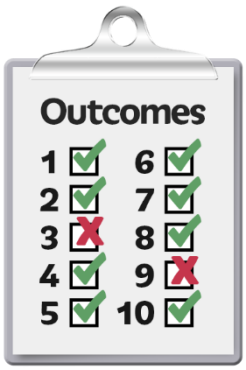
24.The CHO should consider setting up a group of specialists to advise on the use of medication for mental illness in children alone or with adults.

25. Clear written guides for the use of a particular medication called antipsychotic medication should be developed.

26. The way medication for mental illness in CAMHS is used should be checked every year.

27. The Doctor who wants a blood test for a patient should ask for it and check it themselves.

28. Clinical reports from the Team should be shared with the GP and with others who may refer children.



29. There should be clear written guides about how to find out what patients think about their treatment.

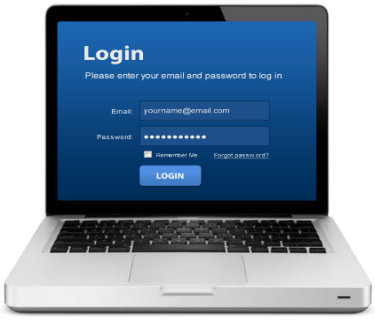
30. Treatment and care plans for all children should be updated regularly in consultation with the patient their parents or guardians.

A copy should be sent to the person who referred the child to CAMHS.

31. The CHO should set out specific educational and training expectations for its junior Doctors in Child Psychiatry and possibly other services.

32. The Clinical Director for CAMHS should make sure that all junior Doctors are meeting the legal requirements to show they are competent doctors.

33. CHO should think about joining together its plans for service developments with the training plans for its doctors.



34. The CAMHS Governance Group should explore the Information and Computer Technology options to improve CAMHS services in the CHO.

35. Across Ireland, the head of the CHO's and the senior Doctors should be told about the risks for their teams which have not had consultants for a long time.

Independence

The review team was independent of the issues mentioned in this document.

No team members were directly involved in the incident.

This document was proof read by an independent advocate.