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New born enters world by rare EXIT

A 50 strong team of specialist medics crammed into an operation theatre recently to carry out a globally rare procedure on a newborn baby and save his life.

Little Freddie Verschueren was delivered at St George's hospital in South West London using the Ex-utero Intrapartum Treatment (EXIT) procedure which delivers babies who could potentially have serious challenges at birth.

This procedure is used when an unborn child has an obstruction in their airway which means they would be unable to breathe independently once they are removed from the placenta.

Professor Asma Khalil, consultant obstetrician at St George's, led the entire operation, which involved about 50 medics and other staff in the operating theatre.

She said: "An EXIT procedure involves a large number of healthcare professionals from various backgrounds including an obstetrician, fetal medicine specialist, an anaesthetist, a paediatric anaesthetist, a paediatric ENT surgeon, midwives and the neonatal team, as well as other theatre staff."

In little Freddie's case there was a cyst on his tongue that could potentially block his airways it was detected in a scan during his mum's second trimester. The team made an incision in mum Anna's tummy and delivered Freddie's head and shoulders first, leaving him attached to the placenta and able to breathe.

They established an airway so he could breathe independently before delivering the rest of him. Freddie weighed 6lbs 8oz (3.1kg) at birth and was able to go home with his parents Anna and Peter Verschueren a healthy baby.

Anna said: "We've been incredibly impressed with the service we have had at St George's, at every step it has been outstanding care. When we found out we needed to have the procedure we felt in such safe hands with the experts at St George's. We never doubted their skill and advice."

Professor Khalil added: "I am very grateful to the efforts by every member of our large team who ensured that we delivered the best care to Anna and Freddie. Saving babies' lives and caring for the parents during challenging times is the most rewarding aspect of my job."

An EXIT procedure is extremely rare. However, despite its global rarity this is the second time it has been carried out in St George's this year.

Dr Richard Jennings, Group Chief Medical Officer for St George's, Epsom and St Helier University Hospitals and Health Group, said: "St George's is one of the few hospitals in the country that carries out this rare procedure and saves the lives of many babies. I am pleased to hear that Freddie is doing well thanks to our dedicated and skilled teams and everyone at St George's wishes him and his family all the best for the future."

Virtual care to rise under ambulance plan

Over a third of South East Coast Ambulance (SECAmb) service responses will be done remotely in a new five-year strategy. (Here "remotely" means by video call or telephone rather than sending out an ambulance.)

The NHS Trust said its care model is no longer "fit for purpose" as it prepares for a 15 per cent increase in patient demand over the next five years, at a board meeting last week (April 4). Increasing demands on the service included health care becoming more complex, the ageing population and changing areas of deprivation.

By 2029, the Trust aims that over a third of all its patients will be signposted to another service- leaving 65 per cent of patients with an ambulance response. The change will affect Surrey, Thames Valley, Kent and Medway as well as Sussex Integrated Care Systems (ICS).

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Simon Weldon, CEO, reassured that SECAmb would still be there to protect and look after the sick who needed an ambulance. He added: “If patients don’t need an ambulance, we can help you get you to a place which can meet your healthcare needs.”

Urgent medical needs such as cardiac arrest, a stroke, heart attack, pneumonia, childbirth and newborn care would still be attended to by ambulances, the Trust said.

Delivering this strategy, over the next three years, SECAmb expects it to meet emergency care needs within the national standards of 7 minutes for calls for immediate life-threatening and time-critical injuries and illnesses; and 18 minutes for emergency calls.

For non-emergency patients, virtual care will be provided via an assessment by a remote senior clinician. Meeting documents said this would enable patients to be “cared for directly or referred to the most appropriate care provider”.

Investing in a data and digital strategy was highlighted as a key part of the new direction. The board heard how new technology like AI would help the SECAmb make better decisions and lead virtual consultations. These could be used to respond to patient needs in a remote and professional setting rather than sending an ambulance.

Meeting documents revealed that 88 per cent of patients received an ambulance response; but an SECAmb officer said the outcomes from the cases indicated only 30.5 per cent of patients needed clinical care.

Only 12 per cent of patients are currently referred or signposted to another service rather than receiving ambulance care; but under the new strategy for 2029, this will increase to 35 per cent.

Team Member for SEAmb, Matt Dechaine, said: “Sending a fully kitted ambulance is a very expensive way for the public purse to respond to patient needs, when other services may be able to address it in a cost-effective way.”

Covering five years, the new strategy will be carried out in three phases: designing new models of care, collaborating with partners and developing a digital strategy; implementing the change and finalising and improving the operational model. Digitalisation of the service will begin in phase 2, with electronic health records deployed by March 2025.

SEAamb identified its model as “unsustainable when challenged” from an operational, workforce and financial perspective. The Trust found it would need to employ 600 more people over the next five years to respond to demand.

Not all non-emergency patient consultations will be resolved solely over the telephone. Simon told the board that the strategy aims to “align patient needs with ambulance services”.

Over 2,000 staff, 400 volunteers and 350 members of the public have been consulted on the strategy, with the Trust saying it has been “clinically led”. System partners have also been invited to 20 sessions to share their views.

The full new SECAmb strategy is set to be published in May 2024.

Call staff at South East Coast Ambulance NHS Foundation Trust. Credit SECAmb

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Psychiatric bed shortages in Surrey

A man tragically took his own life in Surrey after a mental health relapse, prompting a coroner to warn of a shortage of psychiatric beds in Surrey hospitals.

Jonathan Harris, 52, who suffered from paranoid schizophrenia, died by suicide on June 27, 2022.

If an inpatient psychiatric hospital bed had been available just days earlier, Jonathan would not have died, the coroner ruled. Coroner Anna Crawford judged that action should be taken to prevent future deaths.

Bed shortages for mental health patients in Surrey, as well as nationwide, has been an ongoing issue for NHS Trusts. Many patients are forced to move up to 60 miles away from home to receive treatment because there are few beds in their area. The court heard that this is in the context of a national shortage of suitably qualified psychiatrists.

Following a lengthy psychiatric inpatient stay in Camberley in November 2021, Jonathan was under the care of Surrey Heath Community Mental Health Recovery Service, which is part of Surrey and Borders Partnership NHS Foundation Trust.

Jonathan was prescribed anti-psychotic medication. In February and May 2022, Jonathan requested for his medication to be reduced to fortnightly and then once every three weeks.

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The reduction in medication in May 2022 was judged as "premature" by the coroner. Jonathan had reportedly shown signs of appearing "suspicious" when he was seen by the Surrey Heath Mental Health Team (MHT) on May 4. However, these signs were not explored.

The mental health team were also aware Mr Harris was moving house, meaning and move to a new community mental health team, which may affect his wellbeing.

Jonathan's mental health continued to deteriorate and on June 24 it the MHT decided that he required an assessment under the Mental Health Act.

No inpatient bed was available and therefore the assessment did not take place. If Jonathan had been assessed, he would have been detained under the Mental Health Act and admitted to hospital.

The coroner said: "Mr Harris would not have taken his own life had he remained well and the relapse of his paranoid schizophrenia materially contributed to his death.

"Mr Harris would not have died had an inpatient psychiatric hospital bed been available on either 24, 25 or 26 June 2022.

"The court also heard that there is an ongoing shortage of available inpatient psychiatric beds in Surrey and that this is in the context of a national shortage of inpatient psychiatric beds. The court is concerned that both of these matters present a risk of future deaths."

The Prevention of Future Deaths report was issued to NHS England rather than to Surrey and Borders Partnership. NHS England was invited to comment; it said it is working to the coroner's deadline of 56 days to respond with the action it will take or proposed to take, and such information is not yet available.

Related reports:

Coroner catalogues care failures in diabetic death

Better private – public health communications could prevent deaths

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Cancer patient getting the right royal treatment

The first cancer patient set to undergo a revolutionary new procedure that could cut treatment time to almost a quarter said it was a " privilege" to be given the opportunity.

The **Royal Surrey NHS Foundation Trust** is taking part in a new clinical trial led by the **Royal Marsden** into prostate cancer. Currently, patients are treated with radiotherapy over a minimum of 20 treatments which lasts four weeks or more. Under this new process, that time could be reduced to one and a half weeks.

Michael Robson, 78, is the first patient to be part of the trial in Royal Surrey. He was diagnosed in December 2023. He said: "One of my friends was diagnosed with prostate cancer and he said I should get a test so I had a blood test and I was called by my GP and sent for an appointment at urology. I was fortunate enough to meet Dr Philip Turner who gave me the options and went through everything. Everything has been explained to me in a way that is easy to understand and made the journey so much easier to deal with. All of the staff I couldn't complement them highly enough. They have been fantastic."

Michael was given options for treatment and was asked if he was interested in taking part in the clinical trial and he agreed straight away. He added: "It's been fantastic here. I feel very privileged to be the first patient. The service has been first class from everybody concerned."

Patients with low and intermediate risk disease who took part in a trial called PACE-B demonstrated that the process would work in the tighter time frames. This new study is to determine whether those considered high-risk would get the same benefits. The trial, called PACE-NODES, was opened at The Royal Marsden and was designed jointly by investigators from Queen's University Belfast and The Institute of Cancer Research, London.

Dr Philip Turner, consultant clinical oncologist and principal investigator for the trial, said: "We are delighted to be opening the PACE NODES trial in Royal Surrey. This is part of our drive to give Surrey patients access to the very best oncology clinical trials from across the UK and indeed from across the world.

"The benefits with regard to timing are enormous – the standard of care for these men is a minimum of four weeks of daily visits which is very disruptive to life. The rates of side effects are low. Crucially, the five fraction treatment appears just as safe as

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conventional 20 fraction treatments which we have been using for years very safely."

Chief executive Louise Stead said: "Royal Surrey has a long and proud tradition of being a premier centre of UK oncology research and we are determined, with the support of our patients and other partners, to ensure as many patients as possible have access to ground-breaking research close to home. If successful, this could make a huge difference to patients receiving treatment for prostate cancer."

L-R: Radiographer Kate Maltby, Michael Robson, Dr Philip Turner

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Better private – public health communications could prevent deaths

A young woman tragically took her own life in Surrey prompting a warning from a coroner over communication barriers between hospitals. Meghan Chrismas, who suffered from anxiety disorder, depression, complex PTSD and ADHD, died by suicide on October 20, 2021 at a Premier Inn in Guildford.

Less than three weeks prior, Meghan had impulsively attempted suicide by overdose and was admitted to Royal Surrey Hospital on the following day. She was offered further psychiatric treatment through the NHS at this time, which she declined in favour of continuing with her private treatments at The Priory Hospital. Information about Meghan Chrismas' attempted overdose was only sent to her GP and not her private psychiatrist.

Meghan took her own life the same day as her private psychiatrist said she was "progressing well". Following Meghan's inquest Coroner Darren Stewart OBE wrote in a Prevention of Future Deaths report to NHS England over the 'concerning' communication barriers between private and public healthcare services.

He wrote: "At a time where pressures on the NHS exist, particularly for mental health services, it is of concern that measures which could alleviate this pressure (where someone sources private care) do not exist. There is little or no policy, guidance or other effective arrangements to share important clinical information about patients between private and public healthcare sectors."

"The passage of information between NHS and private healthcare providers is hindered due to the absence of an adequate structure to share important clinical information about patients in a timely and effective manner. Action should be taken to prevent future deaths ."

Meghan was prescribed antidepressants after a face-to-face appointment with her GP in February 2021. She started seeing a private psychiatrist around July, and received prescriptions both privately and from her GP.

The coroner also raised this as a key concern. They wrote: "This means Mrs. Chrismas had access to double prescriptions. Healthcare professionals treating Mrs. Chrismas placed significant reliance on the perception that she would be open and honest in her communication with them."

The coroner also raised concerns around police forces communication between each other. It was at, 4.54pm that Meghan contacted Surrey Police to explain that she was fine. At 5.18pm, the call handler in the Hampshire Police control room communicated with Surrey Police only via email.

After receiving no response from Surrey Police, the handler in the Hampshire Police control room communicated with them via telephone Surrey Police then attended the location in Guildford and found Meghan's room barricaded. Upon gaining access to the room, officers found that Meghan had sadly died.

Officers attempted to resuscitate Meghan and her heartbeat restarted. After resuscitation, Meghan was transported to Royal Surrey County Hospital where she died two days later on October 20, 2021 from a Hypoxic Brain Injury.

The coroner wrote: "The handling of the incident involving Mrs. Chrismas in Hampshire Constabulary's Force Control Room which resulted in a hour delay in determining that an important communication (being a request for assistance) had not been received by a neighbouring force." It was not concluded however that this shortcoming contributed to her death.

Hampshire Constabulary have since said they have made significant improvements to their process. These measures included: Revision of training provided and the introduction of additional training for supervisors and control room staff. Implementation of National Policy concerning Missing Persons, including documentation to assist in control room responses to similar

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circumstances. Revision of the recording of risk assessment measurements on the computer aided dispatch record (CAD) system.

It was further explained to the court that the measures should be seen in the context of wider cultural change management in the supervision and leadership being undertaken by Hampshire Constabulary in the operation of the Control Room.

A spokesperson for Surrey and Borders Partnership NHS Foundation Trust said: “Following Meghan’s death an amendment was made to our Psychiatric Liaison Service policy stating discharge letters will be sent not just to the GP, but also to any other relevant external professional – provided we have the explicit consent of the individual to do this. The measure was welcomed by the Coroner.”

SABP added it has developed new guidelines for both community and in-patient clinicians to ensure it routinely and actively seeks a person’s consent to contact and share information with or from their private practitioner.

The Priory Hospital did not make an additional comment. NHS England has been approached for comment.

Varying opinions on local maternity services

Epsom and St Helier Hospital NHS Trust claims it has a ‘strong’ maternity service despite failings in a recent CQC report. Safety in the maternity service was rated ‘inadequate’ in a report published by the Care Quality Commission (CQC) in February. The service overall was downgraded from ‘good’ to ‘requires improvement’.

Managing Director of the Trust **James Blythe** said, at an Epsom and Ewell Health Liaison Panel on March 3, he was “disappointed” with the CQC report. He added: “The hospital has a really strong service and what the CQC identified are processes we need to get stronger at.”

However, the CQC’s report highlights practical issues including qualifications and competence of staff, and an environment ‘not fit for purpose’.

An update report by the Trust given to the Epsom and Ewell Health Liaison Panel said: “All of our maternity services meet 10 out of the 10 safety actions required nationally.” The 10 safety actions are specific to maternity services and range from submitting maternity data, workforce planning, training and action plans, to delivering best practice.

However, the CQC report found the leadership team ‘did not take timely action’ to make change where non-compliance with four safety actions was identified in the 2022/23 inspection.

A report in July 2022 identified a shortfall of midwives, yet this had still not been addressed in January 2023. The service was therefore unable to declare compliance with safety action 5 on midwifery workforce planning.

The CQC report said: “On inspection, there was a lack of clarity from managers and leaders about whether the service was on track to make improvements and declare compliance for 2023/24.”

Epsom and St Helier hospital Trust were asked about the discrepancy between the agenda stating they met all 10 safety actions and the CQC inspection report outlying non-compliance of safety actions. The Trust did not comment on the difference.

The Trust is planning to invest more than £2m over two years to increase midwifery staffing in the unit by 8% so the Trust can declare full compliance with safety action 5.

Visiting the hospital in August 2023, the CQC found the service “did not have enough midwifery and nursing staff in the right areas with the right qualifications, skills and training to care for women, birthing [partners] and babies”.

Staff working in transitional care for babies who require extra support “did not have the qualifications and competence for the role they were undertaking.”

A spokesperson from Epsom and St Helier said: “Our priority is to ensure women and birthing people receive the best possible care, and we have already taken steps to improve and strengthen our maternity services – rated by mums in the CQC’s own survey as the best in London.”

Days before the inspection report was published, the Trust secured a strong result in a CQC patient experience survey of women and birthing partner’s experiences of maternity care in England.

Maternity services at Epsom and St Helier received the best scores in London, with maternity care at St George’s joint second place.

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The environment in some areas was ‘not fit for purpose’, and on the maternity ward this posed an ‘infection prevention and control risk’. Bereavement and recovery facilities did not meet national standards for privacy.

The Trust is said it is ‘fast-tracking’ estates work with new doors and blinds fitted to improve privacy and dignity.

The hospital’s environment was “not fit for purpose in all areas” and the facilities and equipment were found to “not always keep people safe”.

An Epsom and St Helier spokesperson implied that patients deserve better than the current crumbling estate – but the hospital can still deliver and receive safe care.

Founded in 1938, approximately 90% of St Helier Hospital pre-dates the NHS itself. A further 98% of the St Helier estate is said to be either in very poor or bad condition and requires capital investment or replacement.

Millions are said to be invested every year to address the most urgent estate challenges, while also improving the buildings, facilities, equipment and environment for patients and staff.

A spokesperson for Epsom and St Helier University Hospitals NHS Trust said: “This new rating is partly a reflection of our ageing estate, and – while the care they receive is safe – mums, babies and other patients deserve better, which is why we’re pleased the Government has promised us a new hospital and upgrades to our existing facilities by 2030.”

Bags of Confidence in Epsom for cancer survivors

Epsom-based cancer support charity **Look Good Feel Bette**r is partnering with Epsom **Café Moka** in the Ashley Centre for a pop-up sale of preloved bags on Thursday 29th February 2024 from 11am until 2pm. Funds raised will go towards supporting people facing cancer to build back their self-confidence and improve their overall well-being.

Leigh Beth Stroud, Look Good Feel Better’s Community Fundraising Manager, explains: “Our first ever ‘Bags of Confidence’ pop-up sale is open to everyone and will raise much-needed funds for people undergoing treatment for cancer. Pre-loved, quality handbags will be available to buy, so do come along and have a browse on the day.”

This year, Look Good Feel Better celebrates its 30th anniversary. The charity embarked on its journey in 1994 to support people living with cancer and has helped over 200,000 people to date regain their confidence and self-esteem. Look Good Feel Better knows how challenging it can be to process a cancer diagnosis and manage the physical and emotional side effects of cancer treatment.

The charity runs workshops face-to-face and classes virtually to support women, men, and young adults through this time. Services are free and open to anyone facing cancer, and the workshops are led by trained volunteers in the beauty industry to provide practical advice about changes to skin, eyebrows, eyelashes, hair, and nails during treatment, and body confidence.

Ann M, who was recently diagnosed with cancer, attended a workshop and said: “I signed up to a number of the charity’s workshops, including the hand and nail care; the headwear, wigs, brows and lashes, and the styling for confidence sessions. And I haven’t looked back. The biggest thing was that I felt less alone. Cancer can make you feel very isolated, but here I was surrounded by other people, soaking up the good advice and information. It was just what I needed and I would recommend anyone undergoing treatment for cancer should sign up for a workshop.”

If you are interested in hosting your own ‘Bags of Confidence’ event, the charity will provide you with all the support you need, with a colourful fundraising pack with helpful hints and tips available at www.lookgoodfeelbetter.co.uk

Leigh adds: “You might find your favourite designer bag or pick up another hidden gem. ‘Bags of Confidence’ is a simple and sustainable event where these handbags will go to a new home, while raising funds for the charity. And no bags go to landfill, so it’s a win-win situation.”

Established 30 years ago, Look Good Feel Better delivers cancer support services in local communities across the UK through a series of face-to-face and online group workshops, along with video tutorials. Its services help people face cancer with confidence, regain their sense of normality, make friends, and most of all look good and feel better. Its vision is to be recognised as one of the UK’s leading cancer support charities and the only one dedicated to improving the physical appearance and overall well-being of people living with cancer.

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Surrey's hotline for mental health

Ahead of Helpline Awareness Day (Friday, 23 February), Surrey and Borders Partnership NHS Foundation Trust and Surrey County Council are highlighting a local 24-hour NHS mental health crisis helpline that supports almost 50,000 people each year.

The Mental Health Crisis Helpline, run by Surrey and Borders Partnership, is open 24 hours a day, 365 days a year. Since it started in 2010 it has helped around 600,000 people.

It is staffed by trained professionals who are ready to listen and offer advice, support and signpost to a range of community services.

A mental health crisis is when you feel at breaking point, and you need urgent help. You might be:

- Feeling extremely anxious and having panic attacks or flashbacks
- Feeling suicidal, or self-harming
- Having an episode of hypomania or mania, (feeling very high) or psychosis (maybe hearing voices, or feeling very paranoid)
- Other behaviour that feels out of control and is likely to endanger yourself or others

As well as the Mental Health Crisis Helpline, Surrey and Borders Partnership also provides five Safe Havens across Surrey which provide out-of-hours help and support to adults who are experiencing a mental health crisis or emotional distress.

These Safe Havens are in Aldershot, Epsom, Guildford, Redhill and Woking and are open evenings, weekends and bank holidays. Each one is staffed by a mental health practitioner from Surrey and Borders Partnership and two trained Safe Haven workers.

Mark Nuti, Surrey County Council's Cabinet Member for Health said: "*We are committed to breaking the silence surrounding mental health and providing a safe, confidential and non-judgmental way for people in Surrey to seek hel*p.

"*We believe that mental health support should be available to everyone. No one should have to suffer in silence – the Mental Health Crisis Helpline is here for anyone who needs it.*

"*There is help out there, whether it's through the Mental Health Crisis Helpline or one of the Safe Havens. Let's break the silence and start the journey towards better mental health together.*"

Emily Hackett, Mental Health Crisis Line Service Manager said: "*If you are experiencing a mental health crisis or emotional distress or if you have concerns regarding someone that you care for, please call us. Our dedicated crisis call handlers are on hand to support you 24 hours a day 7 days a week.*"

If you or someone you know is struggling with their mental health, don't hesitate to call the Mental Health Crisis Helpline on 0800 915 4644.

Image – illustration only – Carl von Essen CC BY-SA 4.0

Coroner catalogues care failures in diabetic death

Surrey County Council (SCC) has been accused of not taking its responsibilities seriously after an eighteen-year-old tragically died from diabetes.

Jake Baker, an 18-year-old with a learning disability and type 1 diabetes, died at home following Diabetic Ketoacidosis. He required residential care since the age of eight, under the guardianship of the council. An inquest concluded a catalogue of failures by Surrey County Council and other bodies contributed to Jake's death.

The coroner found Surrey Care Leavers team and Children Services had failed to obtain information about Jake's cognitive ability and his capability of managing his diabetes independently, a Prevention of Future Deaths report published this month reads.

Coroner **Caroline Topping** said: "I am not satisfied that Surrey County Council have undertaken a rigorous review of the

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circumstances of the death, nor that the risk of future deaths has been averted. The issues surrounding the inadequacy of Jake's pathway plan have not been addressed comprehensively in the last 4 years. Training for personal advisers is not mandatory and is only now being rolled out."

The court was not provided with copies of the training or any protocol to be assured of the adequacy of the training and its implementation.

The coroner said that Jake's death was "avoidable" and was "contributed to by neglect". In September 2018 Jake (then 17) was placed in a full-time residential placement at **Ruskin Mill College**.

At the time of his death, Jake was staying with family for a few days when he became seriously ill from uncontrolled diabetes. Jake's mother and stepfather found him unresponsive. His family previously said "there is nothing that can take away the pain" of losing their son.

The days before his death were the first time he had stayed away from his care facilities for more than two nights in a row, since being placed in the care of Surrey County Council when eight years old, his family's lawyers said.

He was entitled to a personal adviser who had a statutory duty to write a pathway plan for Jake, including consideration of how his health needs were to be met. However, when away from home, no advice was sought from specialist diabetes services to inform the pathway plan and no risk assessment was made for Jake having unsupported contact with his family and managing his diabetes, the coroner's report concludes.

Meetings discussing Jake staying over at his family's house without support were unminuted. The emails which refer to meeting decisions made no reference to any of the dangers inherent in Jake's diabetic condition nor his ability to manage it unsupported. The family were also not given any advice or training on how to keep Jake safe if he became unwell nor any emergency contact numbers.

The coroner added: "The local authority employees held the mistaken belief that if Jake wanted to go home unsupervised once he turned 18 there was nothing they could do to stop him. No capacity assessment was undertaken in relation to Jake's ability to make a decision to go home unsupported. In my opinion there is a risk that future deaths could occur unless action is taken"

Four years on from Jake's death, the coroner found the process of obtaining learning disabilities diagnoses remains opaque and difficult as there is no protocol in relation to this. Vulnerable care leavers are at risk of being denied necessary support due to the confusion and delay teams accessing adult social care assessments.

Jake was assessed not to meet the threshold for SCC Transitions Team because a report containing his original disability diagnosis was lost. Children's Services were unable to obtain an up to date diagnosis. He did not have the support of an adult social work team and this outcome was being challenged when he died.

Overnight from the 28 to the 29 December 2019, Jake developed diabetic ketoacidosis as a result of being hyperglycaemic in the preceding days. He began to vomit and required immediate hospitalisation. On 30 December 2019 the college was notified by his family that he was too ill to travel. The staff who were travelling to collect him were told to return to the college. His family was not told to take him to hospital.

He was last seen alive at 11pm and found dead at 3am on 31 December 2019. If Jake had been admitted to hospital at any time prior to 5pm on the 30 December 2019 he would have been successfully treated."

The family claim that Jake's death was avoidable if he had been admitted to hospital any time before 5pm on December 29. In a statement, the family said: "Losing Jake has been incredibly difficult for our family, especially as he died in our home at what should have been a happy time. We trusted Ruskin Mill Trust with Jake's care, and we have been let down by them in the worst possible way.

"Jake was an enthusiastic and determined young man who always put his mind to things. As a family we did all we could to make sure that Jake was looking after himself and was well taken care of, but those that were put in charge of his care didn't give us the information necessary to ensure Jake's safety"

Clare Curran, SCC Cabinet Member for Children, Families and Lifelong Learning, said: "Our deepest sympathies remain with Jake's family and friends. The services provided to Jake fell short of what he and his family needed to keep him safe, and we are very sorry for our part in that. We have taken a number of actions over the past four years to improve our support for young adults leaving care and we will be responding to the Coroner outlining our action plan to prevent future deaths. While we have already made changes, we know there is still further to go and we will carefully consider the Coroner's concerns as we take our next steps."

Published on 14 February 2024, SCC have up to 56 days to formally respond to the coroner's report and outline the service's

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action plan.

Dementia nurses coming closer to Epsom

Dementia UK, the specialist dementia nursing charity, in partnership with Leeds Building Society, is launching free face-to-face 'Closer to Home' clinics to provide life-changing support to families living with dementia in **Epsom**.

The clinics will be held in the **Epsom branch** of Leeds Building Society, bringing emotional and practical support closer to families with dementia through the charity's specialist dementia nurses, known as Admiral Nurses. Dementia UK's Closer to Home clinics will run on 28th and 29th of February and the 5th, 6th and 7th of March 2024.

The face-to-face clinic will offer a safe, comfortable, and private space for families to discuss any aspect of dementia and receive the specialist support of Admiral Nurses. Between June 2021 and December 2023, over 4,000 families have been helped through Dementia UK's 'Closer to Home' clinics, and the charity has partnered with Leeds Building Society to offer in-person support across the United Kingdom since 2022.

Nationwide research conducted by Dementia UK into the impact of dementia revealed that nearly half (47%) of people in the South East of England have been affected by dementia, and 51% of people in the region are worried about how a diagnosis would affect their relationships with family and friends. Only 16% of people in the South East have heard of Dementia UK's specialist Admiral Nurses.

In April 2020, Dementia UK and Leeds Building Society announced a four-year partnership to raise £700,000 to help over 2,500 families with dementia across the UK. As part of this partnership, the innovative 'Closer to Home' project was also launched in June 2021, to improve access to dementia care and support.

The partnership's initial target of £500,000 has now been exceeded. Thanks to this, Dementia UK has been able to develop and deliver virtual appointments with specialist dementia nurses for an even larger number of families and individuals.

Hannah Gardner, Admiral Nurse at Dementia UK, said:

"We're proud to bring our Closer to Home project to Epsom to offer specialist face-to-face clinics in the area. We know the difficulties that families in Epsom and the surrounding area often experience. We know that dementia doesn't just affect the person with the diagnosis: families, friends, and carers are also impacted.

"Dementia is a huge and growing health crisis – someone in the UK develops dementia every three minutes. This means it's more important than ever for us to reach families and offer one on one support from our dementia specialist Admiral Nurses. From worries about memory problems to understanding a dementia diagnosis and how the condition progresses, we will be providing practical and emotional advice on caring for someone who lives with this progressive condition, along with giving advice on financial and legal issues."

Richard Fearon, CEO of Leeds Building Society, said:

"Dementia UK was voted as our charity partner by our members and colleagues, and we are thrilled to have raised over £700,000 for them, exceeding the £500,000 fundraising target we set ourselves at the start of this partnership."

Dementia UK's Closer to Home clinics will take place in Epsom on the 28th and 29th of February and the 5th, 6th and 7th of March 2024.

To book a confidential and in-person appointment with an Admiral Nurse, visit dementiauk.org/closer-to-home

dementiauk.org