West Sussex Safeguarding Adults Board

Safeguarding Adult Review

In respect of

Adult F

Publication: 13 April 2018

Independent Author:

Leighe Rogers

WEST SUSSEX SAFEGUARDING ADULTS BOARD

Everyone's business
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Contents

Reason for Safeguarding Adult Review

1.1. F was a 23-year-old male brought up by his parents in a small market town in rural West Sussex. Known to Mental Health Services since 2010, and diagnosed with Schizoaffective Disorder and Asperger's syndrome (AS) (see Appendix3).

1.2. On 16th January 2016 F attended the Accident and Emergency (A&E) department at St. Richard's Hospital, Chichester, part of Western Sussex Hospitals Foundation Trust (WSHFT) following a mixed overdose. He was admitted overnight and discharged at 17:10 the following day (17th January 2016) under the care of the Mental Health Community Crisis Home Resolution Team (CRHT).

1.3. Later that night at 23:31, South-East Coast Ambulance Service (SECAmb) staff took F to WSHFT Worthing Hospital A&E department, where he was admitted. They observed he was very anxious, saying he would 'jump off a building' if not given help. F's family expressed concern for his safety if not admitted. They told staff their son was vulnerable, in poor mental health and at that time they felt unable to care for him.

1.4. F was assessed by hospital staff and told them that he wanted to be admitted to a mental hospital. F was referred to the psychiatric on call team at 01:55 (18th January 2016). That assessment was carried out at 03:30 when it was noted that F was 'fixed on voluntary admission'. F and his father were told there were no mental health beds currently available. A decision not to admit F was made, as 'the presentation did not fulfil the criteria for admission'. The plan was for F to be admitted to the Clinical Decision Unit (CDU) overnight and for a review by the psychiatric team the following morning due to 'patient uncertainty and immediate family safety'. F's father agreed to stay with him.

1.5. At 07:00 F was complaining of increasing agitation and appeared psychotic. He was transferred back to A&E Majors unit and was reviewed by the psychiatric liaison team. Following a psychiatric review at 10:00 the plan was for a voluntary admission to an Adult Mental Health Unit (AMHU) and the search for a suitable bed began. F was given an anti-psychotic medication and when calmer transferred back to the CDU.

1.6. F absconded from the Unit at 16:15 whilst in the hospital CDU, still waiting for a psychiatric bed. At 16:36, following a search, F was found in the hospital grounds in cardiac arrest. His injuries were

consistent with a fall and attempts at resuscitation failed. He was pronounced dead at the scene.

1.7. This case was referred for a Safeguarding Adults Review (SAR) because F is identified as a patient who had mental health care and support needs. At the time of his death F had contact with and was under the care of several agencies. There was a delay in a suitable mental health bed being found. It is believed that there may be learning from this case for many agencies.

2. Overview

2.1 Review Process

2.1.1 In April 2017 The West Sussex Safeguarding Board commissioned the author of this report to undertake a review in line with the guidance set out in the Care Act 2014.

2.1.2 Good practice in relation to case reviews suggests that they should be conducted in line with certain principles:

2.1.2.1 there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

2.1.2.2 the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

2.1.2.3 reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;

2.1.2.4 professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and

2.1.2.5 families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed 'appropriately and sensitively' (Department of Health Care Act Statutory Guidance 14:138).

2.1.3 **The** primary purpose of a Safeguarding Adult Review (SAR) is to promote effective learning and improvement action, so that lessons can be learned and applied to future cases. This is designed to prevent future deaths or serious harm occurring again. The review will recognise good practice and strengths that can be built on, as well as identifying where things need to be done differently.

2.2 Methodology

2.2.1 Terms of Reference were produced and agreed (Appendix 1). The following agencies were involved with F during the review period. Each submitted an Individual Management Review (IMR).

- Sussex Partnership Foundation Trust (SPFT)
- Western Sussex Hospitals Foundation Trust (WSHFT)
- General Practitioner (GP)
- South East Coast Ambulance Foundation Trust (SECAmb)
- Sussex Police (SP)
- The Dene Hospital, Burgess Hill (Private Hospital)

2.2.2 A SAR panel made up of senior managers from all but one of the named agencies who submitted an Independent Management Review (IMR) was appointed to work with the author. The Dene was not invited to form part of the panel, as initially it was, mistakenly, thought that his stay at The Dene was outside the timescale of this review. The author met with The Director of The Dene to discuss their contribution to the review

2.3 Review Period

2.3.1 The panel agreed that the review period be from January 2015 to January 2016. This allowed them to review how agencies worked together in the year before F's death. Agencies were asked to provide a summary of either significant events or relevant knowledge outside of the specific timescale to add context for a better understanding of F and his care.

2.4 Parallel Processes

2.4.1 In addition to the Safeguarding Adult Review the following were undertaken:

2.5 Coroner's Inquest:

2.5.1 An inquest was held in February 2017 the **Jury's Conclusion was a Narrative Conclusion as follows**: the evidence does not fully explain whether he intended that the outcome would be fatal. F made a deliberate decision to gain access to the roof by means unknown / undetermined. On the balance of probabilities, the act was deliberate, but the evidence does not determine the intended outcome.

2.52 SPFT conducted a Serious Incident Investigation/Review (SII/R) using the Root Cause Analysis (RCA) methodology.

2.53 WSHFT conducted a Root Causes Analysis Report with an appendix containing an agreed joint chronology of events between SPFT and WSHFT.

2.6 Family Involvement

2.6.1 An important part of the SAR process is engaging with family members, so they can contribute to and to share their experiences and concerns. F's parents were invited to meet with the Independent Author. This was shortly after the Coroner's Inquest and whilst they asked to be advised of the review's progress and findings they decided they did not wish to meet with the author. WSHFT (Deputy Director of Nursing) contacted F's family to offer condolences. A home visit to F's home was carried out by Dr Rob Haig (WSHFT Deputy Medical Director) & Maggie Davies (WSHFT Deputy Director of Nursing) to offer condolences to the family, giving an opportunity for the family to ask any questions and explain the RCA process and next steps. Contact with the family was maintained through Maggie Davies before the inquest and subsequently as the SAR was commissioned.

2.6.2 The family also spoke with the SPFT Director of Nursing Standards and Safety and senior managers from SPFT immediately following F's death. They similarly offered their condolences. F's father asked that the following be explored:

2.6.3 Whether his son should have been admitted earlier when issues with compliance were again noted in December 2015 or when he was reviewed by his Consultant 3 days prior to the incident. (Para 4.81)

2.6.4 The above appointment reportedly took some time (approximately 1 month) to arrange / agree following many telephone calls by his wife. (Para 4.81)

2.6.5 Why was their son not on observation? (Para 4.107-109 and 5.6)

2.6.6 Why was he not transferred immediately to an inpatient bed? (Ref Para 4.110- 115 and 5.7)

2.6.7 These areas were a part of the joint health Serious Incident Investigation and will be further explored and addressed in this report.

2.7 Report Structure

2.7.1 It is the responsibility of the Safeguarding Adults Board (SAB) Chair in consultation with others to consider publication of all SARs on a case-by-case basis. This report has been written with publication in mind. Accordingly, names have been changed to ensure confidentiality.

2.8 How learning will be disseminated

2.8.1 The SAR subgroup is responsible for ensuring that all named agencies agree ownership of actions following the recommendations from this review. Each agency that identifies actions based on the review will be asked to provide regular reports to the SAR subgroup to monitor the progress made and report to the full Board as required.

2.8.2 Once all actions have been completed, monitoring the impact of those actions may be identified for testing by the Quality and Performance Subgroup. This to measure the impact of recommendations and to ensure that learning and actions are embedded effectively.

2.8.3 The learning from this SAR will be shared through single and multi-agency learning and development opportunities and Safeguarding Adults Board bulletins.

Independent Author

Leighe Rogers is an accredited SCIE reviewer, with considerable experience of investigations and report writing from a career in criminal justice where she held several posts at Director level in the Probation Service. Leighe was her organisational lead for Child Protection and has held membership of several Child and

Adult Local Safeguarding Boards. A former Chair of the Brighton & Hove LSCB Case Review Subcommittee, Leighe also has experience as Chair of SCRs and as the author of Individual Management Reviews (IMRs).

3. Background Information and chronology

3.1.1 F was of dual heritage with a white British father and a Filipino mother. The family retained links to Filipino family members and the family were planning a trip to the Philippines shortly before his death. F had one sister who lived locally and was in regular contact.

3.1.2 F attended a local secondary school. From summer 2007 onwards, there was an escalating pattern of F and other family members, contacting the Police to assist in resolving family issues. Most of the calls related to F's behaviour in the family home, including incidents where F had been violent. At other times F called the police alleging various individuals had threatened him.

3.1.3 In January 2010, aged 17, F's GP referred him to Mental Health Services provided by Sussex Partnership Foundation Trust (SPFT). The referral was connected to a first episode of psychosis. His case was allocated to the Early Interventions Service (EIS) who made several unsuccessful attempts to engage F with their services.

3.1.4 23rd October 2010, police were again called to the family home. Their records note concern that F was acting very strangely. He was arrested for 'Breach of the Peace' and then seen and assessed by a Mental Health Practitioner. This led to his admission to the Acute Mental Health Unit (AMHU) under Section 2 of the Mental Health Act (MHA) (See Appendix 2).

3.1.5 The pattern of police attendance and interventions continued through 2010-14 with 20-recorded contacts of a non-crime nature. Both Police and family members came to recognise that F's mental health problems were at the root of these incidents.

3.1.6 There were further admissions to AMHU's in 2011. From 23rd April 2011- 7th June 2011 he was a patient of Worthing and later Crawley hospitals.

3.1.7 On discharge Acute Adult Mental Health Services provided F with support.

3.1.8 Between July 2012 until July 2013 F attended 8 psychology sessions as a part of his overall treatment plan. The exact nature of this intervention has not been established.

3.1.9 In December 2013, Early Intervention Service (EIS) staff contacted the police because F told them he had assaulted a boy who had made a racist remark towards him. F alleged the boy called him a 'golliwog'. However, police were unable to trace the alleged perpetrator - the matter was logged as a racist incident.

3.1.10 F, now aged 21 years, was, in late 2013 transferred to the Recovery and Wellbeing Team (R&W). His treatment plan included an anti-psychotic medication in the form of a long-acting monthly intra-muscular (IM) depot injection. By now F had been diagnosed with Asperger's syndrome (AS).

3.1.11 4th August 2014, police attended the family home and found F in possession of a knife which he was using to stab his fingers. He was arrested for 'Breach of the Peace' for his own safety and seen and assessed by a mental health professional, who determined that F needed treatment and he was detained under Section 2 of the Mental Health Act 1983 (MHA). F was taken to hospital in Chichester before being transferred to Langley Green Hospital in Crawley.

3.1.12 23rd October 2014, F was sectioned Under Section 3 of the Mental Health Act 1983 (See Appendix 2) and remained at Langley Green Hospital Crawley for treatment. F remained in their care for most of this period until 22nd December 2014.

3.1.13 Between 23rd December until 1st January 2015 F had support from the Crisis Resolution Home Treatment Team (CRHT).

January 2015 - March 2015

3.1.14 1st January 2015, F was admitted to The Dene Hospital under Section 2 of the MHA 1983. This was just 10 days since F's discharge from the Langley Green Hospital, Crawley. The admission was connected to his recurrent psychosis and reports from the Approved Mental Health Practitioner (AMHP) that his behaviour at home was increasingly challenging with verbal aggression towards his parents.

3.1.15 Initially, the AMHP requested an ambulance. SECAmb responded, but other calls were assessed as a higher priority. F absconded before an ambulance could be despatched. Police were called and while they were searching, F came home, barricading himself in his room. F was later detained by Police and transported to The Dene Hospital.

3.1.16 F remained resident at The Dene until 3rd March. His stay there is reported to have 'passed without incident'. His discharge notes his mental health as 'stable'. Throughout his stay at The Dene, F had frequent contact with his parents. Within days of his admission, his father made a request that F be sent on home leave. The CRHT visited on 7th January to make their own assessment of F. They record that he was '*unstable, guarded and paranoid with a propensity to aggression*'. F told them that he was happy to be at The Dene before quickly walking out of the meeting.

3.1.17 17th January 2015, was the first of a series of home leaves. The initial agreement was given for an overnight stay. This appears to have been automatically extended to two nights when F did not return.

3.1.18 24th January 2015 saw a further period of planned home leave - again extended when F did not return. Staff, satisfying themselves as to F's mental state by speaking by telephone with F's father.

3.1.19 Between admission on the 1st January 2015 and formal discharge on the 3rd March 2015 *F spent 28 nights with his parents on home leave*. On numerous occasions the periods of home leave appear to have been extended on an *ad hoc* basis in accordance with an apparent agreement between the Dene, F and his family. On 4th February 2015 F's Section was rescinded and F became an informal patient.

3.1.20 17th February 2015, a Discharge Care Programme (CPA) meeting was held. Attendees were the new Care Coordinator (CC) (see Appendix 5) from the Community Mental Health Team (CMHT), the Registered Mental Health Nurse (RMN) from the ward, the responsible doctor, F and his father. There were no identified psychotic symptoms for the previous three weeks. F had lost his bank account because of having spent large amounts of money buying items on eBay. This included a £1500 second hand laptop. F had returned from one period of home leave elated after using cannabis. The family were seeking

suitable alternative accommodation, having been given two months' notice on their rental property. F's father said that he was happy to continue caring for F at the family home.

3.1.21 The new CC CMHT lead confirmed that he would do a 7-day follow up in the community. The family were given advice on accessing Autistic Spectrum Disorder (ASD) services. F was reported to be speaking positively about getting back into employment. His father asked that F should have random drug tests (USD) in the community and The Dene supported this. Discharge was agreed upon to follow administration of F's depot injection. The Dene's notes suggest that he was late in receiving his depot and that 100mg of paliperidone were prescribed that day to cover this.

3.1.22 18th February 2015, the CMHT lead called to know when F would be discharged. The Dene staff told him that a 'clinical decision' had been made to keep F at The Dene. This was based on F's presentation after the Care Coordinator's meeting, when he is reported to have threatened suicide if discharged.

3.1.23 20th February 2015 until 3rd March 2015, F was on home leave from The Dene. A further discharge meeting was planned for 24th February. This did not happen as F failed to return from home leave at the appointed time. He was formally discharged back into the care of CMHT on the 3rd March.

3.1.24 4th March 2015 until 13th March 2015 F was described as 'relatively well' and followed up by the CRHT and seen by a new CC who is an Occupational Therapist (OT). As an OT the CC will not be able to administer any injections. On the 9th March 2015, there was a record that 'no psychosis is detected'.

3.1.25 13th March 2015, F's mother returned from work and found F unresponsive. She noted that three doses of his medication were missing and that he may have taken one days' worth of medication in one go. The CRHT are contacted and they arrange for an ambulance to attend. SECAmb arranged transportation to the WSHFT, Worthing A&E department, where he was treated for a mixed overdose and referred to the psychiatric team.

3.1.26 F's mother provided background information to the hospital about his recent series of hospital admissions and that her son had a diagnosis of Schizoaffective Disorder and Asperger's. Hospital staff also noted that there was a background of Ketamine use, but F was unsure whether he had taken any. A

mental health assessment was requested. The Senior House Officer (SHO) saw F at 18.30.

3.1.27 The SHO's impression was that there was a relapse of F's psychotic illness with possible secondary non-compliance with prescribed medication/illicit drug use. He was assessed as needing further assessment and not felt suitable for CRHT community support at home. A discussion followed with the on-call Consultant for Crawley CRHT and a Mental Health Act Assessment (MHAA) was arranged.

3.1.28 14th March 2015, at 22.50 F was seen by the on-call psychiatrist and Approved Mental Health Practitioner (AMHP) for a MHAA. F was described as 'floridly psychotic, thought disorder, hallucinating and distracted'. F tried to leave the hospital and required additional clinical and security staff to maintain his safety, as his judgement was severely impaired. He had plunged his hands into sharps containers. The assessment concluded that F '*lacked any insight into his condition', and was 'unable to engage in any therapeutic work to avoid admission'*, and F was sectioned under Section 3 of the MHA.

3.1.29 15th March 2015, at 9.15 a bed was found at Worthing Adult Mental Health Unit (AMHU). Later that evening at 20.00 hours F was admitted to the Worthing AMHU. F remained at the hospital for treatment for several days before the Section was removed and F discharged on the 23rd March 2015. F's GP was notified of the discharge and a seven-day follow up was booked with the CC from the CRHT.

3.1.30 The original seven day follow up was planned for 25th March, however as F was not at home this took place on 30th March. F is reported to be presenting well and supporting parents in their planned house move. F also talks about his girlfriend in the Philippines and his desire to visit her in 2016. F's father reported that his son was doing well.

April – September 2015

3.1.31 7th April 2015, F is seen at home by the CC from the CRHT. F is reported as being 'in very good spirits' and continuing to support his parents in preparation for their move. F said that he was taking his medication, but shares some concerns about Clonazepam, which he said was making him very tired. An outpatient follow up for medical review was agreed where this could be discussed. The CC notes that F continued to have a

'*degree of delusional content to his speech*'; he talked about the *"Avatar planet"* and "*The people there were good"* and "*We will all end up there some d*ay."

3.1.32 The CC noted that F's next depot (intramuscular treatment for psychosis) injection was due on the 17th April and that an R &W CN, was to administer and monitor this.

3.1.33 20th April 2015, CC and the Community Nurse (CN) conducted a joint home visit. The CN administered the depot injection. F was said to be '*a little suspicious 'initially*, however he accepted it. He asked the CN to administer to his arm but eventually agreed to the injection in his buttock (in accordance with the protocol). The CC records that F remains '*quite delusional, with paranoid content'*. Further noting that F is '*functioning with day to day tasks'*. An appointment with the CC was agreed for the following week, and a CN appointment agreed for the next depot that the CC would also attend.

3.1.34 18th May 2015, a home visit was conducted by the CC and CN. The CN administered the depot injection. F was sleepy (seemingly because he had been chatting on line to his girlfriend in the Philippines). The CC noted that F presented well and accepted the depot. A medical review appointment was set to take place the following day with the SPFT Consultant Psychiatrist at New Park House (NPH) mental health centre. F was to be supported by his father. The CC was unable to attend.

3.1.35 19th May 2015, the medical review took place as planned. F said that he was doing well and had no concerns. His father agreed. F denied hearing voices or paranoia. F described spending most of his time listening to music, talking to his girlfriend who lives in the Philippines and playing computer games. On mental state examination F was described as '*alert, calm, cooperative, with eye contact and sporadic smile appropriately'*. He did not present with active depressive/psychotic symptoms. A history of recurrent psychosis was recorded and GP correspondence advised of the plan going forward. The Care Plan was that medication would continue and on-going follow up with the CC. The Consultant Psychiatrist was to review again as required.

3.1.36 17th June 2015, the CN conducted a home visit and administered F's depot injection.

3.1.37 10th July 2015, the CC called F's father to confirm the date for administration of F's next depot injection. This was agreed for the 16th July. The father informed the CC that the family would shortly

be rehoused and that he would update the CC once details were known.

3.1.38 12th July 2015, police were called by Domino's Pizza. F had just found employment with them and on arrival at work for a second shift, told staff that he wanted to take an overdose. Police attended and spoke with F who was upset at work, but fine on police attendance. Attending officers observed that F did not present as being at risk from self-harm or suicide. A Single Combined Assessment Risk Form (SCARF) was completed and e-mailed to Sussex Adult Services. The Police spoke with F's parents who said they would refer this to the CRHT.

3.1.39 16th July 2015, the CN made a home visit and the depot was administered.

3.1.40 4th August 2015, F saw his GP and requested a 'fit to work certificate'. He told the GP that he had started work at Domino's Pizza and had been sent home after telling them he was suicidal. He couldn't say why he felt suicidal in July, reporting that he 'felt quite happy' and now wanted to return to work. He also, talked about a fiancée in the Philippines whom he had met the previous year and who wanted to move to the UK.

3.1.41 6th August 2015, the GP sent a letter to the CMHT. In the letter, he requested an update on F's care package or if there was none requested that F be seen.

3.1.42 10th August 2015, the GP contacted the CMHT by telephone. He was told that the CC was on annual leave and would be returning the following week. The GP responded that the letter was not urgent; as F did not need a 'fit to work' certificate to be able to go back to work. The CMHT received the GP's letter on the 10th August; it was identified as an open referral letter for the attention of the CC who was on annual leave.

3.1.43 13th August 2015, the CN undertook a further home visit and a depot was administered. F was described as subdued. He did not engage in conversation and was watching the television in his bedroom. He had told his parents that he had had his depot the day before. His parents were packing as they were moving to a new address. The new address was given to the CN.

3.1.44 17th September 2015, the CN undertook a further home visit and the depot injection was administered. There are no notes made on F's presentation or the family situation.

October - December 2015

3.1.45 7th October 2015, the CN visited to administer the depot injection - accompanied by a Support Worker (SW). F's mother let them in as F refused to get out of bed or let them enter his room to administer his depot injection. F's mother reported that he was not taking his oral medication. She had found it in a bin, pockets of his trousers and thrown in garden bushes. The CN recorded: '*it was unclear if he was concordant with medication as father oversaw his taking medication'*. F was noted to be very easily irritated especially in interactions with his mother to whom he said, "It was because of me you got this house, without me and my benefits you would not be here". F told the CN and SW that he was, 'Not ill' and had been, "Pretending all the time to get benefits".

3.1.46 The CN expressed a concern for everyone's safety including F's. F's mother said that if things got like they did last time she would call the police. CN spoke to F about the planned house move, which he replied was "Okay, but smaller than previously'. The CN records concerns about F's thoughts:

3.1.46.1 *He spoke about Zion, said he was not allowed there but he knew people who had been there and that although he knew it sounded crazy it was real. Spoke about wings on his back, that he had 8 of them and that his new bedroom was too small for his wings and therefore he was getting backache. Stated that he was different to most people and that he was aware that not everyone could see them. Discussed different religions and cultures and their being respected.*

3.1.47 F said that he was not sleeping much but was okay and was still in contact with girlfriend. He refused to take the depot saying that he would only take oral medication. CN noted that he was aware that the injection could not be administered against his will. Efforts were made to persuade F to take the depot, however he continued to refuse. The CN ensured that the parents were made aware that if the situation became too strained and aggression occurred police could be called, also that mental health services could be accessed in an emergency via an A&E department or mental health line which offered support and advice. The professionals left without being able to administer

the depot injection. The duty nurse completed a Level 2 risk assessment.

3.1.48 9th October 2015, the CN telephoned F's father, following up on the visit asking him if he was aware of their recent visit. The father confirmed that he was. They discussed F's current presentation of irritability, hostility and verbal rudeness towards his mother. Both agreed that the signs were that F was becoming unwell and at risk of relapse. The CN advised that a medical review could take place the following day and requested that F's father transport him to New Park House (NPH). His father declined as he had other commitments and stated that F had spent the previous day with his sister and in his opinion F was, "Fine, ok". The conversation ended. However, F's father called back a short time later and spoke with CN, He said that his son had agreed to take his medication and his depot. The CN explained that this would need .to happen as soon as possible. After some discussion, it was agreed that F's father would transport his son to NPH for his depot (Paliperidone 100mg) on the 12th October.

3.1.49 12th October 2015, F was seen at NPH and the depot duly administered. F was described as 'quite angry, not physically/verbally aggressive'. The plan was for a further depot to be administered four weeks later at the family home.

3.1.50 Five weeks later, 17th November 2015, the CN attended at F's house accompanied by a SW. F was described as not pleased to see the CN he was 'very annoyed' and stated did not want depot injection. He repeated, "Don't speak talk, I told you not to talk". F is described as very dominant in tone manner and voice and stating that he did not want the depot and would take his oral medication. However, his father was of the view, that he must have the depot as he was 'throwing his tablets into the bin'. F is persuaded to have the depot injection.

3.1.51 During this visit F says that, as he wants to see his girlfriend and would be gone for four months he wished to take his medication in tablet form. The CN confirmed with him that this was possible but that he would need to be organised. At this point F's tone manner and voice became more aggressive and he demanded that the CN and SW leave. Which they did.

3.1.52 26th November 2015, the GP sent a letter to the CMHT, chasing a follow up to earlier correspondence. The GP asked if the CMHT had seen F recently as there has been no response to the letter sent in August 2015. The final request was that the CMHT take on F's care as given the medication he was currently prescribed the

GP felt that they did not have the necessary skills to deal with this.

3.1.53 3rd December 2015, F's mother attended at her GP surgery and shared her concerns about F's behaviour. The GP sent a fax to the CMHT asking for an update as mother had attended at the surgery expressing concerns about her son.

3.1.54 4th December 2015, The GP sent an urgent letter to the CMHT advising them of F's mothers concerns about his behaviour. The GP also stated that the surgery was not clear who was reviewing F and that the last letter from them to the surgery was in May 2015. The GP requested an urgent assessment. Later, on the same day F's CC telephoned the GP and provided a verbal update on F's current treatment and status.

3.1.55 8th December 2015, F's case was discussed at the Mental Health Adult Treatment Team Meeting held at NPH. A team decision was reached that staff were not to conduct any more home visits and that F was only to be seen at NPH by 2 male members of staff. This was recorded on the eCPA (a computer based electronic Care Programme Approach system for care planning). The plan was for the CC to attempt to get F to attend at the NPH for the depot, which was due the following week. Father would need to provide transport.

3.1.56 10th December 2015, CC telephoned F's mother to arrange the visit. It was agreed that F would attend at the NPH on 17th December for the depot injection supported by his father. Mother said that F was behaving in the same way but was not violent.

3.1.57 17th December 2015, F attended at NPH as planned. He was described as aggressive on arrival. "Don't talk to me just give me the injection." The depot was administered as prescribed. F did not interact during the process and left NPH immediately afterwards.

14th to 18th January 2016

3.1.58 14th January 2016, F attended at NPH for his depot injection and for a review appointment with his Community Consultant Psychiatrist. F was quite angry but not physically or verbally aggressive. He accepted and had the depot injection - administered by two male members of staff, in accordance with the risk management plan. Present for the medical review were

CC, F and his father. F is reported to have 'conducted himself well' and F's father said that his son was 'generally doing well'.

3.1.59 F said that he was not taking his tablets, as they were hard to swallow but that he was happy to continue his depot injection. F shared his plans to visit his fiancée in the Philippines in the coming months. It was planned that some of F's medication be converted to liquid preparation. CC was to research how F's medication might be managed for an overseas trip. The outcome of the review was shared with F's GP in a letter.

16th January 2016

3.1.60 18:25 hours Sussex Police were called to the family home by F's mother who reported that her son had barricaded himself in his room and was taking Lemsip, Paracetamol and cough mixture. Before police had arrived, F ran from his home and an extensive search was commenced but F returned home at 20.25 hours the same evening. F told the police that he had taken the medication in order to sleep. An ambulance was called which took F and his mother to hospital.

3.1.61 21:58, F arrived at SRH A&E Department with a history of mixed overdose. He was seen by the Triage Nurse, who noted overdose and poisoning, and assessed that he was at moderate risk of self-harm and needed to be seen within an hour. Vital signs were taken, and he was placed in the Majors Department within A&E.

3.1.62 22:44, F was seen by a doctor in A&E bloods were taken and he was referred to the medical team for 'on-going care and psychiatric assessment'.

17th January 2016

3.1.63 F was admitted to the Emergency Floor at SRH in the early hours of the morning. The plan was for a review to take place later that morning

3.1.64 10:00 Consultant review found F medically fit for discharge. Note was made of the need for Psychiatric Review.

3.1.65 15:00 Mental Health Liaison Team (MHLT) assessment made by MHLN SRH A&E. F's presentation was described as 'blunted in thought, labile/blunted in affect'. He is further 'troubled by thoughts, but unable to provide clarity as to their content'. It is recognised that F's parents are concerned and are requesting admission to an AMHU although neither F nor his parents

describe previous indications of lapsing as in the previous Level 2 Risk assessment.

3.1.66 In view of F's parents' concerns and F's presentation at the time a referral was made to the CRHT with a plan to assess at home, the following day. This was agreed by all present. A risk assessment was completed with F and his parents and uploaded with full assessment to eCPA to inform the CRHT assessment/ review which was planned for following day. It was noted that the parents thought he required more support from the R&W team. F told staff that he would like to be at home with his parents and referred to the CRHT for increased home support to prevent a potential admission.

3.1.67 17:10, F discharged home in the care of his parents.

3.1.68 19:40, CRHT follow up phone call made. F when asked how he was replied, "Okay." But described as 'sounding low'. F was reminded that CRHT assessment at NPH was agreed for the following day. F agreed he was, "Okay" with the plan but when asked to make his own way to NPH he said, "No." There were reportedly no concerns that F would be able to keep himself safe until he was seen.

3.1.69 21:42, F contacted Sussex Police Control Room via 999. He told the Police Controller that he needed to go to hospital as he felt unwell and may do something bad to himself. The controller established that F was calling by mobile phone from the garden of his parents' home and that they were in the house. F told the controller that he did not want to go to hospital with his parents - he wanted to go by himself. The controller confirmed with F that his parents knew that he sometimes felt suicidal and that he wanted to go to Worthing Hospital. F told the controller that it was difficult and that he did not want to ask his parents. The controller again spoke to him about his parents being present and F stated that he would ask his parents to take him. Police did not attend.

3.1.70 21:54, F called the Sussex Mental Health Helpline (SMHH) stating that he needed admission to 'mental hospital'. He confirmed his name and date of birth before passing the telephone to his father. F's father reported that F was talking about taking a further overdose. The SMHH discussed with F's father that there was a CRHT appointment planned for the morning. The message from an earlier CRHT contact was reiterated namely that if F's mental health deteriorated he should present at the nearest A&E department. His father said that he might call an ambulance.

The SMHH telephoned both Crawley and Worthing Senior Nurse Practitioners to alert them to the call and F's possible attendance at A&E.

3.1.71 F called the ambulance service via 999. Suicidal ideation was identified and a plan to jump from a tall building stated. An ambulance was despatched, and F transported to WSHFT Worthing A&E arriving at 23:31. F arrived at Worthing A&E where SECAmb staff shared their concerns for F's safety and his threat that he will 'jump off a building if not given help'. F was seen and assessed by the nurse in charge and placed into a Majors cubicle near to the nurses' station.

3.1.72 23:37, a full nursing assessment was completed. This included an Emergency Department Mental Health Safeguarding and Risk Management Tool (SMART) and Vulnerable Adults Assessment Tool. F said that he had no suicidal intentions now, but 'wants to be seen and admitted by the Mental Health Trust'. F was alert and orientated in time and space. He was relaxed and collaborative with the assessment. He was triaged as Green on SMART Tool as no agitation or suicidal ideation displayed. His father was present during the assessment.

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3.1.73 01:28, F was seen by the A&E registrar who noted that F was seen one day ago at WSHFT St Richard's Hospital A&E Department for suspected overdose with suicidal ideations, that his case had been reviewed by the MHT and discharged with a plan for the CRHT to follow up today (18th January). F's father shared his concerns about his son's medications and concerns about possible side effects. He said that his son's mood had been very unstable and that as parents they feel unsafe at home. F's past medical history is noted: Depression: Bi-polar. Current observations are stable. On examination, the doctor notes that F lacks insight into his condition and is of 'labile mood.' A plan is agreed as follows:

- Observations stable
- Keep comfortable with food and fluids
- To be seen by Psychiatric Team for possible admission due to patient uncertainty and immediate family safety.

3.1.74 01:55, referred to Psychiatric Team on call assessment.

3.1.75 02:45, assessed by Senior Nurse Practitioner and on call doctor from Worthing AMHU at A&E. F stated that he believed he needed to be in hospital and wanted to voluntarily admit himself. His father supplied a brief mental health history over the last 4-5 years. On assessment, the assessors observed 'there appears to be little change in presentation' (since admission some 11.5 hours earlier). Described at the time as not distracted or floridly psychotic. F talked about having earlier thoughts of jumping from a height (whilst still at home). He also admitted to taking a cold remedy overdose as attempted Deliberate Self Harm (DSH) and not as previously stated just as a means of getting sleep. This changed explanation regarding the reason for the overdose was thought to be suggestive of increased risk.

3.1.76 During the assessment F denied any current suicidal thoughts or plans for DSH. F was described as fixed on voluntary admission, saying that he might try to end life if returned home and was not open to alternatives. The fixation regarding voluntary admission was linked to F's wish to have more freedom to come and go from the AMHU to be able to buy tobacco and smoke. Father also expressed concern at son returning home and his wife's ability to care for F at that time. F and father were told that there were no beds available within the Trust AMHUs overnight. This was in an apparent attempt to divert conversation /fixation on admission.

3.1.77 The decision was made not to admit, as F's presentation was not seen to fit the criteria for admission. The plan was to offer support to the parents prior to CRHT being able to assess the following day. It was agreed that F would be admitted overnight to WSHFT Worthing Hospital CDU. His father agreed to stay with him. The SNP discussed with Worthing CRHT if they were able to assess on behalf of Crawley as F's father had expressed his dissatisfaction with his son being expected to make his way to NPH for assessment with Crawley CRHT. This was not possible and so a request was made for F to be reviewed by Worthing Hospital's MHLT later that morning as presentation at that time did not demonstrate that he was clearly psychotic.

3.1.78 03:28, F transferred to CDU with his father - for psychiatric review later that morning.

3.1.79 07:00, F complained of increased agitation, appeared psychotic, increased verbalisation about pain, "pain inflicted on others." Registered nurse caring for F reported concerns regarding his behaviour to nurse in charge who arranged immediate transfer

back to Majors to maintain the safety of other patients in CDU. Security was informed.

3.1.80 08:00, seen by Psychiatric Liaison Foundation Year 1 (FY1) Doctor for SPFT who reviewed patient noting psychiatric history, documented in F's notes, that review of clinical need for admission would be completed when Psychiatric Liaison Consultant was present as this would allow two people to make the assessment and senior review. F was now described as 'euphoric and labile' in mood, laughing then tearful. He appeared to be responding to internal stimuli, eye contact described as, 'intense and preoccupied, distracted and worried'. Stated was reading FY1 Doctor's thoughts.

3.1.81 09:30 F was prescribed 5mg Olanzapine.

3.1.82 10:00 Decision to proceed with psychiatric admission '*F's mood appears volatile and changeable needing reassurance. F experiencing auditory hallucinations and delusional thoughts. He appears euphoric and distressed alternatively. Family cannot cope at home at present time*' Psychiatric bed requested through the SPFT manager based at Worthing A&E. '*Patient is wandering and needs assurance'*. F's father left A&E when decision was made to admit F. MHLN stayed with F ensuring he had food and fluids until he fell asleep in majors. MHLN asked the security guard to keep a watchful eye when she left (10:45).

3.1.83 10:20 Risk Assessment updated by Liaison Psych WDGH. On speaking to father, it appeared overdose masked how psychotic F was the previous day. Father stated F had informed him he was thinking of jumping from a high building. Given risks were greater-aroused, psychotic, sharing previous thoughts at home about serious deliberate self-harm, carers felt unable to keep him safe.

3.1.84 10:30 Liaison Psychiatrist discussed F's presentation with Crawley CRHT. Liaison Psychiatrist and MHLN state that at the time of F's assessment their main concern was his degree of psychosis; they did not raise concerns that he would do anything serious, he was very ill and their key concerns were being able to ensure that he had the correct treatment/medication. They concurred that F was asking for help and was accepting admission. Liaison Psychiatrist felt when asked that 1:1 observations (RMN Special) (See Appendices) at this stage could have been 'intrusive' and was not required.

3.1.85 10:45 A&E staff made aware of plans to admit, notes updated on eCPA. MHLN left to undertake another assessment.

3.1.86 11:00 the Psychiatric Liaison Consultant agreed that F now appears calmer and can be transferred back to CDU. No need for RMN Special 1: father remained with patient.

3.1.87 12:00 North West Sussex (F's) Bed Manager (BM) notified bed required for informal admission.

3.1.88 13:00 SPFT Trust wide bed call. F identified as 1 of 3 patients requiring a bed. The other two were detained under sections of the MHA.

3.1.89 13:00 CDU Sister notes that F is resting. His father has gone home to collect F's personal belongings. Closely observed by ED staff while father not present, F remained calm.

3.1.90 14:00 MHLN checked on F who was asleep. The MHLN noted that there were no concerns expressed by A&E staff.

3.1.91 14:30 – 16:45, the search for a bed continued. F'S BM confident bed would be identified.

3.1.92 15:30, father returned to CDU and sat with F. Father requests CDU sister that his son be admitted to The Dene, if possible. Sister advised F's father that she was unsure of the process for obtaining psychiatric beds (an area outside of her responsibility), so father requested to speak with the Psychiatric Consultant. The CDU sister telephoned the psychiatric team and left a message for them to call back, as soon as possible. Whilst on the telephone the Sister noticed that F had been walking about the CDU bay 1 and out into the corridor, she asked him if he felt agitated. He replied that he was calm. F settled back onto bed with father at his side.

3.1.93 16:03, vital observations recorded on F by Emergency Nursing Assistant (ENA). ENA who was sitting at a computer opposite F to input 4x sets of vital observations he had taken on patients in the bay.

3.1.94 16:15, staff later report that F sat bolt upright in the bed and said to father (who was sleeping next to him), I don't feel well, and the ENA seated near to F asked him, "Are you ok? Are you in pain?" F replied, "No I am okay," and lay back down on the bed and the ENA continued working on a computer.

3.1.95 16:18, record of staff and CCTV is that F jumped off the bed and walked to the doors of the CDU. The ENA immediately got up

and followed F asking him, “Where are you off to?” F replied, “Out of here,” ENA immediately woke F’s father and told him F had left the CDU via the right-hand corridor leading to the pharmacy.

3.1.96 16:22 ENA bleeped security and informed that F had left the CDU.

3.1.97 16:25 Security arrived at the CDU. F’s father returned unable to find his son. Security commenced search.

3.1.98 16:30 CDU sister phoned Psychiatric Liaison to report F had absconded and was advised to contact the police.

3.1.99 16:36 WSHFT make 999 call to SECAmb Category A Red to attend grounds at the back of Worthing Hospital for a young male not breathing.

3.1.100 16:39 SECAmb on the scene, trauma protocol initiated for F. F in traumatic cardiac arrest with a number of open fractures. Police were notified as treatment was taking place in a public place. Staff from the hospital cardiac resuscitation were also in attendance.

3.1.101 17:11, F declared deceased by hospital staff.

4 Analysis of Agency interaction with F

4.1 Sussex Partnership Foundation Trust (SPFT)

4.1.1 The Sussex Partnership NHS Foundation Trust provides mental health and learning disability services to the people of Brighton & Hove, East Sussex, West Sussex, Hampshire and Kent. Services include the provision of acute inpatient psychiatric care for adults and secondary mental health services provided by the Community Mental Health Team. Psychiatric liaison services provide mental health assessment and treatment for people who are inpatients in general hospitals or who may go to an A&E department and are in need of a mental health assessment. These are based at Royal Sussex County Hospital, St Richard's Hospital and Worthing. Crisis Resolution Home Teams (CRHT) are designed to provide safe and effective care in a person's own home if they experience a mental health crisis and would otherwise be admitted to hospital.

4.2 Summary of Involvement

4.2.1 F's GP initially referred him to SPFT in 2010 with a first episode of psychosis. Between this time and January 2015 F had five separate admissions to Adult Mental Health Units within SPFT. On two of these occasions he had support from the CRHT before transferring back to the Horsham Recovery and Wellbeing Team (R&WT). The SPFT core mental health service in the community is provided by a CMHT. Support from this service is provided by a CC. The service is currently referred to locally as the Assessment and Treatment Service (ATS), previously and for the period under review was known as the Recovery and Wellbeing Team (R&WT).

4.2.2 The CRHT is a distinct and separate service managed by Acute (inpatient hospital and A&E) Services. The CRHT is commissioned to cover 7 days per week across a longer day typically 07:30 - 21:00 with staff working on early and late shifts usually on a rotational basis. Caseloads for CRHT staff are defined to roughly 25 patients. Teams offer more intensive and more frequent input either to help prevent admission or to facilitate discharge in a structured way.

4.2.3 CRHT's and R&WT both use the same electronic patient record system (Care notes) and liaise regularly where a patient is known to both or requires the input of the other as appropriate.

4.2.4 SPFT records show that F had a diagnosis of:

- Asperger's syndrome (2013)
- Recurrent psychosis (2015, Care Plan)
- Paranoid schizophrenia (2015, CPA Assessment)

4.2.4 In F's case, the Care Coordinator (CC) was an Occupational Therapist and a member of the R&WT. He took over the case in January 2015 and was responsible for the formulation and delivery of F's Care Plan.

4.2.5 F was being managed under the Care Programme Approach (CPA); which framework is one under which mental health services assess, plan, co- ordinate and review the care of an individual with mental health problems or a range of related complex needs. It adopts a person-centred approach and covers all aspects of a person's wellbeing including housing, education, employment and leisure. Those receiving care under the CPA have a CC. The CPA was an appropriate framework in which to manage F's needs.

4.2.6 The Sussex Partnership Foundation Trust CPA policy sets out CPA principles including: *Assessment and care plans should address the range of service user needs. Risk management, crisis and contingency planning are integral to the process . . . assessing the needs of parents; dual diagnosis; physical health; housing; employment; personality disorder; history of violence and abuse; carers and medication.*

4.2.7 For most of the period under review F was in the community and being managed on a care plan by his CC. The care plans that we have seen (three were formulated through the period), lack sufficient background detail about F and his family and show only a very narrow plan of engagement. There is insufficient evidence of a holistic approach to intervention or clarity about objectives or timescales.

4.2.8 During the period under review there were two admissions to an AMHU and there was a further planned admission in progress at the time of F's death.

4.2.9 The first admission on the 1st January 2015 involved F being assessed and transferred under Section 2 of the MHA to The Dene Hospital. He remained under Section until the 28th January. A maximum of 28 days is allowed on this type of Section after which a further assessment and decision about treatment or

otherwise is required. In F's case, a decision was made that F would continue at The Dene as a voluntary patient. This decision appears to have been taken by The Dene without consultation with the CC. There is no record of either party seeking to contact the other about this important decision on the future status or content of F's hospital care. F remained a voluntary patient until his discharge back to his parents' home on the 3rd March 2015

4.2.10 The CC's role as a community based service was to ensure continuity of care for F's stay at The Dene by maintaining regular contact with F, his parents and hospital staff and to ensure that an agreed Care Plan was in place to support a successful discharge. F's stay at The Dene featured several extended periods of home leave. There is no record of the CC being notified of the dates of home leave. Although, the CC would have been responsible for a risk assessment concerning F's family home.

4.2.11 There are three recorded face-to-face contacts with SPFT staff during his stay at The Dene. Records of these meetings are limited in scope.

4.2.12 On the 17th February discharge was agreed following depot injections and arrangements for take away medication. F was now on the following prescriptions:

- *Paliperidone IM depot 100mg - this was a monthly intramuscular injection (injected into the upper outer quadrant of the buttock). It is an anti-psychotic drug.*

- *Procyclidine 5mgs (3 a day) - this is a drug to combat side effects associated with Paliperidone and is commonly used across Psychiatry for this purpose.*

- *Sodium Valproate liquid 5mls (twice daily) - this was prescribed as a mood stabiliser (rather than an anti-epileptic).*

4.2.13 Earlier in the year F was prescribed Clonazepam as an anxiolytic or for its calming properties, this was reduced over 6 weeks in May/June 2015. (This type of drug is best avoided for long term usage as can lead to tolerance and dependence.)

4.2.14 The agreement to discharge following the review on the 17th February was rescinded. This information does not appear to have been shared with SPFT, the CC only finding this out on

telephoning The Dene several days later. This appears to be poor practice by The Dene.

4.2.15 When discharge finally came on 3rd March 2015, there was no discharge meeting arranged which included the CC, who had only found out about the delay in discharge in a follow up telephone call to The Dene. The Care Plan in place was that which had been verbally agreed at the Discharge Planning meeting in mid-February. There was no updated written Care Plan made to reflect what had been agreed at the meeting.

4.2.16 The CC arranged a first meeting following discharge at F's home for 9th March (6 days after discharge). A Community Nurse (CN) was allocated responsibility for administering the monthly depot injections necessary for managing F's psychosis. The CC was an Occupational Therapist by training and background and not qualified to administer injections. Regular anti-psychotic depot injections are integral to F's Care Plan. On this first meeting following release the CC records that 'no evidence of psychosis is detected'.

4.2.17 Several days later, on 13th March is when F was admitted to WSHFT Worthing Hospital, following an apparent overdose of his oral medication. The attending Consultant Psychiatrist's impression was that there had been a relapse of his psychotic illness with possible secondary non-compliance with prescribed medication and illicit drugs.

4.2.18 F was assessed and placed on an MHS Section 3 of the 1983 MHA; he was described as 'acutely psychotic and distracted'. A bed was identified at 9:15 hours on 15th March and F was admitted to Worthing AMHU at 20.00. The gap between F being sectioned and his admission to an acute ward was just over 21 hours. A time, which exceeds by some margin the maximum, recently recommended for an admission to an acute psychiatric ward.[1]

4.2.19 A ward discharge meeting took place on 23rd March 2015 when the CC was in attendance. The GP was notified of discharge and the CC records a follow up appointment for 7 days. There is no record of an updated risk assessment or the proposed Care Plan.

[1] 'Improving acute psychiatric care for adults in England Lord Crisp October 2017.

4.2.20 Between his discharge from the AMHU in March and a Review with the Consultant Psychiatrist (CP) on 19th May there are four contacts involving F and the CC. Each of these contacts is at the family home when the CC is accompanied by the Community Nurse (CN) responsible for administering F's depot injection. The CC records of 7th April and 20th April indicate that F remained 'delusional'. On the second of these visits the CC noted that F is 'quite delusional, with paranoid content' and 'Functioning with day to day tasks'. There is no record of randomised drug testing taking place as had been referenced in the discharge Care Plan and had been a feature of F's most recent hospital admission. Similarly, there are no records of efforts to motivate or link F with services to support him with his Asperger's syndrome.

4.2.21 F and his father attended for a review with the Consultant Psychiatrist on 19th May 2015. The CC was not present. F reported that he was taking his medication regularly. There was no mention of an earlier concern that F had expressed to his CC (who noted that it should be picked up at this review) that the Clonazepam medication was making him 'very tired'. On mental examination, he was assessed as not presenting with active 'depressive/psychotic symptoms'.

4.2.22 The agreed Care Plan is noted as *'medication would continue and ongoing follow up with CC. The CP will see F again 'when required'*.

4.2.23 It is not clear from the records what 'follow up' by the CC entailed. However, as noted earlier a more detailed and holistic Care Plan which addressed some of the parental concerns (misuse of medication/use of illicit drugs) and contingency arrangements in the event of deterioration in health or social circumstances would have been appropriate.

4.2.24 There is no further recorded face-to-face contact with the CC until 17th December, a gap of seven months. Depot injections continued to be administered by the CN who undertook monthly home visits initially alone, but from October accompanied by a Support Worker (SW). The lack of face-to-face contact by the CC is concerning given his crucial role in planning and delivering the Care Plan.

4.2.25 The IMRs provided by the GP and SPFT record a series of efforts made by the GP to contact the CC. The GP had been properly informed of the agreed plan completed with F following his review with the CP on 19th May 2015. However, following separate visits made by F (10th August 2015 - when he disclosed

feeling suicidal whilst at work) and F's mother (3rd December 2015 worried about F's deteriorating mental health) the GP had written to the Mental Health Team requesting an update. The GP correspondence was noted and passed to CC. It was not until the 4th December (by which time the GP was requesting an urgent response), that the CC established contact and was able to verbally update the GP on F's Care Plan. This is poor practice on the part of the CC.

4.2.25 Between June and November there were seven contacts with the CN for depot injections. A visit in July was just four days after the incident recorded by Police, which described their attendance at Domino's Pizza store when F said he was suicidal. The CN does not seem to have been aware of this and there is no record in the logs until a letter written by F's GP was received by staff on the 10th August 2015.

4.2.26 The CN, in August, described F as subdued. By October his mother reported that F was not taking his oral medication and refused to receive his depot injection. Non-compliance with medication is identified as an important relapse indicator in SPFT's risk assessments. The parents were advised that if the situation becomes too strained they should call the police, Mental Health Support Line or contact A&E. There is no record of the CC being informed of these developments; however, there is an update to F's level 2 risk assessment, although this is not completed by the CC.

4.2.27 F's mental health and associated behaviour deteriorated. He was 'quite angry' when the next depot was administered at the mental health centre, only five days after an earlier home visit. In November 2015, the CN described F as aggressive and refusing his injection. The Depot was administered but only with difficulty and CN and the accompanying SW were asked to leave.

4.2.28 On 8th December 2015 at a Mental Health Team Meeting a decision was made to suspend home visits to F because of the risk to staff. The CPA plan was updated to note that F should only be seen at the centre and then always by two members of staff. F's father was to transport F to the centre. There is no record of account being taken of the risk to F's parents even though records made by the CN suggest that he was increasingly rude to his mother. It is known that F had previously threatened his mother with a knife, which he used to self-harm. This decision appears to have been made without the involvement of F or his parents/carers, the latter being informed of the change by telephone by the CC.

4.2.29 A review with his Community Consultant Psychiatrist (CP) took place on 14thJanuary 2016. The review was attended by the CC. F was described as being 'quite angry'. He told the CP that he was not taking his oral medication, as they were 'hard to swallow'. The Care Plan is recorded as 'agreed, documented' and shared with the GP. Notes suggest that the focus was on a proposed trip to the Philippines (planned for March) and on how his medication might be managed on the trip. There was also to be an investigation into some of F's medication being converted into liquids. The IMR indicates that none of the professionals involved had undue concerns about F's trip to the Philippines.

4.2.30 F's clinical history, misuse of oral medication, possible substance misuse and recent response to interventions involving the administration of his medication might together have given rise to serious concerns about the wellbeing of F on so extensive a trip. Those professionals present at the meeting raised none. There are similarly no recorded concerns about the continued wellbeing of F and his parents in the family home.

4.2.31 Three days later, on 17th January 2015 F was taken to WSHFT St Richard's Hospital with reports of a 'mixed overdose' when asked, F denied any thoughts of suicide and said he was not a risk to others. A full risk assessment was completed and documented. It was noted that the parents thought F required more support from the R&W team, also that on having stopped taking his medication (about three months previously), on recommencing he told his parents that he 'felt suicidal'. Non-compliance with medication and increased aggression had been factors in F's most recent previous hospital admissions.

4.2.32 Whilst at WSHFT St Richard's, a risk assessment was completed by a MHLN, a member of the Psychiatric Liaison Team. The risk assessment contained details of previous assaults by F on his father (in the company of professionals) and sister. These were thought be historical although there was 'some evidence of delusional ideation/paranoia towards his family'. The parents expressed their concern that they could not support their son with his mental health at that time. In denying that he had any thoughts of aggression it was also noted that F, 'became very distressed when questioned and did not want to share detailed thoughts'.

4.2.33 Following the assessment by the MHLN the decision was made to release F from hospital and for a review by the CRHT to take place the following day. In reaching this decision it was noted

that F was 'troubled by thoughts, but could not provide clarity as to content'. The parents were concerned and requested admission to an AMHU but that neither F nor his parents described relapse indicators as described in the L2 Risk Assessment. F's case notes were updated.

4.2.34 I have had sight of the L2 risk assessment completed in October 2015. This makes note of the ' . . . significant risks of this client group of dual diagnosis of Asperger's and Schizoaffective'. In assessing risk, staff are required to consider the five Ps - Predisposing, Precipitating, Perpetuating, Protective Factors and Presenting Risk/s to create a narrative of how these increase or decrease risk. The key factors noted for F were:

- long history of mental illness. In services for a while including EIS;
- number of admissions including 3 months at The Dene;
- dual Diagnosis;
- relapse signatures are that F becomes non-concordant with medication;
- can become psychotic but believe that he is well and
- sleep can be erratic and he becomes irritable.

4.2.35 Several of these indicators are static. The relevant dynamic factors include non-concordance with medication and evidence of psychosis. At the time of the assessment F was not displaying signs of psychosis.

4.2.36 F was discharged from WSHFT St Richard's Hospital at 17:10 on 17th January, back into his parents' care. The CRHT, as planned, make a follow up call to F two hours later.

4.2.37 Later F called the Sussex Mental Health Helpline to say that he needed an admission to mental hospital. On the same call F's father told the helpline that F was talking about taking a further overdose. F and his father were advised to attend for the CRHT assessment planned for the following day and to present at the nearest A&E if F's mental health deteriorated further - consistent with the advice given by the hospital MHLT.

4.2.38 Following this call the Mental Helpline operative contacted Crawley and Worthing Senior Nurse Practitioners to alert them to

the call. The service provided by CRHT operates through to mid-evening but is not a 24-hour service. Hence, the advice to contact the nearest A&E was consistent with the services then available in the area.

4.2.39 Later that same evening F arrived at WSHFT Worthing A&E Department. At 2:45 the following morning he was assessed by the Senior Nurse Practitioner from SPFT and on call Junior Doctor from Worthing Adult Mental Health Unit. F appeared fixed on voluntary admission, saying he might try and end his life if sent home and was not open to alternatives. He said his earlier thought of jumping from a high building were no longer the case.

4.2.40 F was requesting admission to AMHU, as were his parents. F's father said that he believed F needed to be in hospital and that he was concerned about his wife's ability to care for him 'at this time'.

4.2.41 A decision was made not to admit F, as his presentation did not fulfil the criteria for admission. The plan was to offer support to the parents prior to CRHT assessment planned for the following day. Accordingly, it was agreed with A&E staff that F would be admitted overnight to the hospital's CDU and that his father would remain with him.

4.2.42 At 08:00 the following morning F was moved to the hospital Majors area due to deterioration in his mental health. He was given 5 mg of Olanzapine (anti-psychotic medication) at approximately 09:30. The MHLN was in attendance and remained with F until he fell asleep around 10:00. The MHLN asked a hospital security guard to keep an eye on F, as she must leave.

4.2.43 At 10:20 the Liaison Psychiatrist (LP) updated the L1 risk assessment. On speaking with F's father, he noted that 'it appears the overdose masked how psychotic F was the previous day'. F's father informed the CC that F told him the previous day that he was thinking of jumping from a high building. The risk management plan was updated given risks were greater with F being aroused, psychotic, sharing previous thoughts of suicide at home about deliberate self-harm and carers felt unable to keep him safe.

4.2.44 An entry made by the MHLN and recorded in WSHFT Worthing Hospital notes at 10:30 reads that F has been seen *and 'we will proceed with admission. Family cannot cope at this time - carer*

breakdown. Mental health bed requested through Crawley CRHTT'.

4.2.45 The LP discussed F's presentation with the CRHT. When asked about the need for 1:1 observations for F. The LP felt that '1:1 observations at this stage could have been intrusive and were not required. Worthing Hospital staff were unaware of the alert on SPFT administration system, which indicated a potential risk to staff in relation to home visits.

4.2.46 At 11.00 F was transferred back to the CDU, as he now 'appeared calmer' his father accompanied him.

4.2.47 A referral for admission was made by the CC at 12.00 and a trust wide bed call put out at 13.00. F was identified as one of three patients awaiting a bed. The other two patients were detained under the Mental Health Act. With no formal protocol to identify vacant beds in other AMHUs, the plan was to identify a suitable patient to move to an integrated ward and in this way to free up a bed for F.

4.2.48 SPFT advise that there are many variables to consider when staff are making decisions about priority for a mental health bed, and that not being subject to the MHA status does not in itself determine the level of risk or priority. The implication being that F's voluntary admission was just one of many factors to consider. A further factor being that F was at A&E which was seen as a 'safer environment' than that of patients in the community. The availability of acute adult mental health beds is a national issue and there is recognition that waiting times may be lengthy.

4.2.49 The role of the Bed Manager (BM) seems to have been to create movement from other wards so that a male bed could be identified. A place at The Dene (requested by F's father) was not considered at this time because the possibility of securing a Trust bed remained feasible. A place at Worthing AMHU was available but discounted by SPFT as being outside the catchment area of F's local mental health team. Worthing AMHU was located in an adjacent area and as such would appear to have been the most suitable option for an earlier placement.

4.2.50 When F's father telephoned the CRHT at 14.00 to ask about the availability of beds and the possibility of F being placed at The Dene he was told 'private beds are only used if there are no beds available in the Trust AMHU, and that 'it was not confirmed via the Bed Manager if a bed would become available within

the Trust later in the day - due to patients being discharged'. F's father was told that as soon as a bed became available, the Liaison Psychiatrist would be informed. The father's preference for The Dene was noted and shared with the Bed Manager (BM).

4.2.51 At 15.30 F's father spoke with the CDU Sister and asked again if it would be possible for his son to be admitted to The Dene. The CDU sister was unable to assist, as she had not been updated by SPFT about progress. F's father asked to speak with the Consultant Psychiatrist. The CDU Sister telephoned the Psychiatric Team and left a message asking that they return her call as soon as possible. The position regarding bed availability and the likely timeframe for admission remained unknown to F, his father or the staff in the A&E CDU. This certainly caused anxiety to F's father and possibly also F.

4.3 Analysis of Involvement

4.3.1 The plan for SPFT staff working with F throughout the period of this review was to ensure that he received the necessary medication to manage episodes of Recurrent Psychosis and to engage with F and his family to support and address his mental health needs and reduce the need for hospital admissions. Whilst this was an appropriate plan it was very limited in scope and failed to take full account of his dual diagnosis - Recurrent psychosis/Asperger's syndrome and illicit substance misuse. Also missing were other important aspects of CPA planning for example: social inclusion and contingency planning.

4.3.2 The purpose of assessment in mental health is to enable the care team and the service user to develop a plan of action in specific areas to treat their mental health and manage the risks identified. Plans should be developed with the service user and their carer, and should be regularly reviewed. They should be person centred and focus on recovery. In F's case, overall assessment and planning was poor and lacked continuity between community services and acute hospital services.

4.3.3 There is one Care Plan on record completed by the SPFT CC in April 2015. The plan is limited in scope and background information about F and his family. A holistic person-centred approach would have been more appropriate. In each case many of the fields available for completion were not populated and the IT system generated this as 'unknown'. Although F and his parents were consulted with regard to Care Plans and reviews, there is no evidence that the CPA documents had been

shared with or signed by either F (the service user) or his parents/carers. This would have been good practice.

4.3.**4** Significant events should trigger an update to the risk assessment and care plan. There is no record of this happening after F presented to A&E in March following a suspected overdose. A risk assessment was undertaken when there were concerns about non-compliance with medication in October, although this generated no fresh information. When threats were made by F during a home visit by the CN in November, which led to cessation of home visits, there was no update to the risk assessment.

4.3.5 The CC ensuring that there was continuity of care through the frequent hospital admissions might have given increased reassurance to both F and his parents during those periods, when his mental health was at its worst. Similarly, having a consistent CC, who had developed a rapport and knew the family well, would have encouraged engagement and potentially also increased F's compliance with prescribed medication.

4.3.6 Throughout the review period F's treatment is essentially reactive. Aside from the administration of the Depot injections it is hard to see a consistent care plan to manage matters better for either F or his parents. Nor is there any ambition evident to improve F's lot by community integration, education or activities. The emphasis appears to be focused on managing his mental illness by medication.

4.3.7 The Author understands that the SPFT CC caseload was similar to that of peers and that the CC in question perceived the caseload to be high. On this basis caseload pressures on their own do not appear to account for poor care planning.

4.3.8 Formal CPA meetings were held appropriately with the Consultant Psychiatrist attending. SPFT advise that there is an expectation that CPA reviews are held at a minimum of annually. It is not clear in what circumstances an additional review may be required. For example, deterioration in mental health, non-compliance with medication and a request from parents/carers for review (reportedly asked for by them several weeks before one was scheduled, although not contained within SPFT case records), might all be reasons to bring forward or include an additional review.

4.3.9 There are two medical reviews with the Community Consultant Psychiatrist. The final one takes place on the 14/1/16 shortly

before F's final presentations at A&E. Overall, there is a presentation of professional optimism, which arguably fits with SPFT's strength based approach to treatment. However, this approach should not mean that individual difficulties or struggles are ignored. In my view a more balanced view would have been appropriate.

4.3.10 F lived with his parents who were his main carers. They supported him at home, transported him to appointments and maintained their contact when he was in hospital. They had to deal with unpredictable and frequently challenging behaviour linked to his mental health. The panel found nothing to indicate that they had been offered a package of support to assist them in their everyday dealings with F or that the risk to them had been considered and incorporated into the risk management plan. Risk management is a collaborative process which involves professionals but which also takes proper account of the views of carers.

4.3.11 It is suggested that the parents had not followed up on offers of additional help, however there is no documentation to support this, and the records of other agencies, notably the Police, the GP and Western Sussex Hospitals suggest numerous occasions when the parents were seeking help for F and were amenable to advice and interventions.

4.3.12 F's parents were consistent in describing his changeable moods and their concern for their own safety in the home. Bearing in mind their record of being his main carers and having witnessed his history of psychotic episodes little account appears to have been taken of their experience in reaching an overall assessment.

4.3.13 In discussing the failure to fully engage with F's carers or to provide them with a package of support, SPFT have told us that: *overall performance in terms of engagement with and support for carers has been unsatisfactory. The Trust has now made a strong commitment to implementing the Triangle of Care across all services, and has appointed a new Carers leader to take this work forward'.*

4.3.14 SPFT records show F's ethnicity as 'White British'. F was in fact of dual British and Filipino heritage. He lived in rural Sussex where the local ethnic make-up was 96% White British. It seems highly likely that he might have felt some sense of difference connected to his ethnic make-up. There is nothing to suggest that this was explored with him or that it was taken into account

in assessments and Care Planning. This finding applies to all agencies involved with F.

4.3.15 The GP was responsible for dispensing other medication and for F's general health and wellbeing. It was the responsibility of the CC to keep the GP informed of F's contact with them and there was a similar responsibility for the GP to share significant contacts.

4.3.16 The GP is notified of F's discharge from The Dene and prescribes medication to F on a monthly basis as recommended by the psychiatrist at The Dene. There is a similar notification to the GP following his discharge from WSHFT Worthing Hospital following his treatment for an overdose and his Section 3 MHA (March 2015).

4.3.17 There are however significant gaps in communication with the GP. Critically, communications from the GP are not responded to on two separate occasions. The GP forms an integral part of care planning and should be in possession of a copy of the Care Plan, including any contingency arrangements. Had the GP been in possession of the Care Plan he might have been in a position to offer reassurance to both F and his mother in their separate consultations with him.

4.3.18 F was: (i) not taking his medication; (ii) being delusional and (iii) possibly misusing illicit drugs. This was noted but generated no new activity, response or revision to the Care Plan.

4.3.19 The SPFT Serious Incident Report (SIR) says consideration should have been given to a referral to the Assertive Outreach Team, but: *'There was no evidence a referral to the Assertive Outreach Team (AOT) had been considered for Patient F, in view of his presentation, history of previous inpatient care/level of engagement with mental health services'.*

4.3.20 An Assertive Outreach Team (AOT) is a specialist teams with lower caseloads (typically 15:1) and are made up of health professionals who are able to manage long-term, severe and enduring mental health cases. This means that they are well placed to offer continuity of care and potentially through more consistent engagement. Recent discharges from hospital and difficulties in working with a Community Health Team are both reasons for consideration being given for transfer. A transfer may have been able to reduce the number of F's hospital admissions. The author similarly found nothing to indicate that this option had been discussed by those responsible for F's Care Plan. No referral

was made and F's eligibility or otherwise for more intensive intervention was not tested.

4.3.21 The events surrounding F's admissions to A&E on 16th and 17th January are protracted. F's parents voice their concerns at their ability to manage F's mental health and associated behavioural problems at that time.

4.3.22 The psychiatric assessment completed by the MHLN at WSHFT St Richard's, records that whilst F and his parents were requesting admission to an AMHU they do not 'describe previous relapse indicators (stated at L2 Risk assessment).

4.3.23 Relapse indicators for violence and suicide are considered when formulating a risk assessment at a time of crisis. The risk assessment was considered and updated by the MHLN with only historical aggression towards others at the time, with other risk factors not observed or denied by F. F is recorded as stating that he would 'like to be at home with his parents'. F and his parents said that they would like more support from the R&WT.

4.3.24 Although there were clearly indicators present to suggest an increased risk, these were balanced against protective features e.g. his parents/carers and that there was a package of support available in the community with potential for enhancement.

4.3.25 The decision was made for discharge back to F's parents' home and referral to the CRHT who's out of hour's service extended until 21:00 hours. Telephone contact was agreed by the CRHT with F, ahead of his appointment the following day.

4.3.26 Given that admission to an AMHU is regarded as a last resort and that both F and his parents were content to proceed on this basis the decision on balance appears reasonable. The professionals involved with F and his parents at the time are best placed to make this judgement having direct contact with all concerned.

4.3.27 *'The Trust is committed to ensuring that whenever inpatient care for individuals is being considered other options for treatment, in a less restrictive environment, must first be explored – hence the initial request for CRHT to assess offer home treatment as an alternative to hospital admission' (SPFT- Serious Incident Report).*

4.3.28 The contingency plan recorded in the risk assessment plan and recommended to F and his father in the follow up call with CRHT was to go to the nearest A&E if matters deteriorated. After F and his father spoke later with Sussex Mental Health Helpline, they

alerted local hospitals to his possible attendance. In the absence of any alternative 24-hour service this advice was appropriate to a further deteriorating situation.

4.3.29 When F and his father arrived at WSHFT Worthing Hospital A&E Department on the night of 17th January 2016; the initial view was that there was little change in F from his previous presentation at WSHFT St Richard's. It was noted that owning up to an attempt at deliberate self-harm was seen as an indicator of increased risk.

4.3.30 A suggestion that F's psychosis may have been masked/ diminished by his use of multiple cold medications raises the question as to how far practitioners were aware of this and should have taken that knowledge into account over the period when assessing.

4.3.31 The SPFT SNP and Junior Doctor from A&E agree that F should remain at the hospitals CDU overnight pending a further psychiatric assessment in the morning. The outcome of the initial psychiatric assessment had concluded that F did not fulfil the criteria for admission.

4.3.32 A further psychiatric assessment was made later that morning and F's mental state was observed to have deteriorated. At 10:00 the decision is made to find a suitable bed in an AMHU and for F to be admitted on a voluntary basis.

4.3.33 After his arrival at WSHFT Worthing A&E Department shortly before midnight on 16thJanuary until F's death some 17 hours later F experienced several moves between A&E and the adjacent CDU. Each move determined by deterioration or observed improvement in his mental health.

4.3.34 The IMR from SPFT records that F's father agreed to stay with him in the CDU because of the 'relatively small staff numbers and the alert regarding his potential risk of violent/aggressive behaviour'. WSHFT advise that the unit was fully staffed; however they were unaware of the alert on the SPFT records system.

4.3.35 Consideration was given to 1:1 supervision of F by a Registered Mental Health Nurse (RMN) Special but decided against. It is understood that: - *'The Mental Health Liaison Nurse and the Liaison Psychiatrist confirmed Patient F was not on one to one (1:1) observations. They both concurred as he'd requested help, had accepted admission and medication it was felt 1:1 observations could have been intrusive and X remained in A&E Majors at that time' (from SPFT SIR).*

4.3.36 The apparent reliance placed on F's father to monitor his son through most of this seventeen-hour period of uncertainty about admission seems onerous. It may be surmised that this "older parent" may already have been physically and emotionally exhausted by dealing with his son in crisis over a period of at least 24 hours. His ability to monitor under these circumstances and with the knowledge that there was a recorded 'alert' concerning his risk to staff is thus severely compromised.

4.3.37 The lack of information flowing back and forth between WSHFT and SPFT meant that hospital caring for F had no access to the MHLT notes. They were also unaware of the process for securing a mental health bed. This meant they were unable to offer reassurance, timescales or location to either F or his father. I understand that this is a situation that is unlikely to recur as SPFT now include the use of a shared information system with Western Hospital, as part of their CPA recording process.

4.3.38 With the decision made to identify a suitable bed at 10.00, the SPFT Bed Manager was contacted an hour later at 11.00 and the CRHT alert went out another two hours later, at 13.00, across the whole Trust to find a bed. We are advised by SPFT that there is a daily Trust wide bed call and numerous locality bed calls.

4.3.39 Each of the four Sussex localities has a Bed Manager (a Band 5 Administrator post) who carries out the local administrative tasks around bed management week day's 09:00 – 17:00. Initially when the need for a bed is raised the local Bed Manager works with the local Acute/Urgent Care Teams (wards/CRHT) to make a local bed available. In this case a local bed was available (Worthing AMHU) but not utilised as not served by F's local CMHT. The focus was on moving patients across units to free up a suitable placement. The criteria and decision making for a local mental health placement would benefit from a service review by SPFT.

4.3.40 The SPFT SIR addresses the timescale for identifying a suitable AMHU bed in the following ways:

- *'When there is no viable alternative to hospital admission the principle underlying processes is the individual will be admitted to the AMHU local to their home'.*

- *The review undertaken has identified there is no agreed process of how this is then escalated between the localities; presently there is no national standard regarding a 'time-*

*frame' in which a bed has to be identified for individuals assessed as requiring admission to a bed on an A*MHU (SPFT SI report)

4.3.41 There is a national shortage of Adult Mental Health beds and it is widely understood that waiting times for admission can be lengthy. The recently published Crisp Report (February 2017), 'Improving Acute Psychiatric Care for Adults' includes the following recommendation.

> *'A new waiting time pledge included in the NHS Constitution from October 2017 of a maximum four hour wait for admission to an acute psychiatric ward for adults or acceptance for home based treatment following assessment'*.

4.3.42 SPFT are mindful of the Crisp recommendation and working with their commissioners to respond to this pledge.

4.4 Learning Identified

4.4.1 In their Serious Incident Root Cause Analysis Investigation SPFT identify the need to: -

- Implement the Trust Care Programmed Approach (CPA) policy to ensure a thorough holistic review of patient care and clear documentation of the rationale behind decisions - *the Panel was not clear why Patient F had not been considered for a more assertive approach and felt the re-allocation of his care represented a missed opportunity for such a review*.

- Review the Acute Care pathway including bed management processes.

- External 'Tannoy' telephone ringer system

4.5 Recommendations

- CPA reviews to provide a thorough holistic review of individual's care / clearly document the rationale behind decisions involving carers' views (where appropriate) as key partners to the care planning process – as per Trust policy (Care Programme Approach policy)
- To undertake a thorough review of the Acute Care pathway to include Crisis Resolution and Home Treatment (CRHT) Teams and bed management / process

- Co-design of a more efficient bed management process with agreed standards for monitoring.

4.6 For further review:

1. *Process for accessing an acute adult mental health bed;*

2. *CRHT responsibilities regarding clinical updates/handovers/decision making;*
3. *CRHT responsibilities for ensuring accessible clinical input, clinical update inclusion in handover sheets;*

4. *CRHT decision-making in respect of gatekeeping and providing effective care;*

5. *Earlier capacity creation;*

6. *Patients identified for possible discharge to have their ward review accommodated in morning to support swifter bed management early in day;*

7. *Bed Management formalisation/standardisation across Sussex Care Delivery Services (CDSs);*

8. *Development of consistent protocols and clinical support for bed managers, a clear procedure for escalating concerns; consistent paperwork Standardised Bed Management record; to include support plan/ discussion/decisions/mitigation of risk whilst awaiting admission;*

9. *Development of a standard pro-forma across all CDSs – to include brief /essential information, reason/purpose for admission, risk management from point of referral to arrival on the ward and*

10. *Communication standards to keep patients/relatives (or carers)/third party service providers informed throughout the bed management process.*

4.7 General Practitioner (GP)

4.7.1 A GP is a medical doctor who treats acute and chronic illnesses and provides preventive and health education to patients. The Quality and Outcomes Framework (QOF) for GPs clearly sets out their responsibilities to have review systems in place in respect of individuals with bipolar disorders and psychosis.

4.8 Summary of Involvement.

4.8.1 F was first registered with GP's surgery in 2001. The GP was responsible for supplying F with his prescription for oral medication (Clonazepam & Epilim) and general health and wellbeing. F had seven consultations with his GP during the review period.

4.9 Analysis of Involvement

4.9.1 GP's actions in 'chasing' the CMHT appear primarily driven by response to seeing F. In this the GP was consistent in seeking information but gaps between these activities were over-long. There is little evidence of any sharing of records between MHT and the GP to ensure that either had full information to assist F. This meant the GP when attending F and his mother was unable to offer reassurance, as he was unaware of MHT level of involvement, if any. On the two significant occasions:

4.9.2 4th August 2015 when F told him he was sent home from work as suicidal and shared information about fiancée in Philippines and how to get her over here. He was sign-posted to the Citizens Advice Bureau, as GP seemed unaware as to whether CMHT was still involved. GP wrote to CMHT seeking clarification of current position.

4.9.3 3rd December 2016 Consultation with F's mother as F appeared unsettled, talking to himself. GP was only able to advise to contact emergency number – as still no response to earlier communications and unclear as to whom handling matter. The matter was escalated but four months had elapsed between these two events

4.10 Learning Identified

4.10.1 From the IMR: None.

4.10.2 From the Summary of Involvement in 16th October 2016; the importance of chasing up follow-ups/chasing concerns, to be discussed at regular significant event/clinical meetings.

4.11 The Dene Hospital – Burgess Hill – West Sussex

4.11.1 The Dene Hospital is a specialist private hospital providing secure services for people with mental illness in medium and low secure care environments. The hospital is part of The Priory Group of Companies. At the time of the Review The Dene was part of the 'Partnerships in Care' organisation. F was admitted to their acute male service under Section 2 of the MHA 1983.

4.12 Summary of Involvement

4.12.1 *F's admission to The Dene related to* his Recurrent Psychosis and reports from the AMHP that his behaviour at home was becoming increasingly challenging with violence towards his parents. The Dene's clinical programmes focussed on:

4.12.2 *Rehabilitation on-site and in the community and include programmes specifically focused on treating offending and challenging behaviours, minimising the risk to self and others.*

4.12.3 *Building skills to increase independence to promote people stepping down to care in the least restrictive setting appropriate to their health.*

4.12.4 *F was* treated at The Dene whilst under Section 2 of the MHA from 1st January 2015 until 28th January 2015 when his Section was rescinded. He remained as a voluntary patient at The Dene until his discharge home on 3rd March 2015.

4.12.5 Responsibility for F's treatment rested with the named Senior Clinician at The Dene. In F's case, this was a named psychiatrist, who was responsible for assessing the needs of the F whilst in hospital. It was a part of the psychiatrist's duty to rescind the section, if at any point F did not need to be detained. Good practice suggests that the decision be taken with the knowledge and input from the named CC.

4.12.6 In F's case, the Section 2 remained in place for the maximum period possible, 28 days. It was rescinded on the 28th January in favour of voluntary detention. Consideration was given to further detention under Section 3 of the MHA but deemed un-detainable.

4.12.7 Of his total period of stay (62 day), almost half (28 days) were spent on home leave with his parents. It seems clear from the records provided by The Dene have told us that many of the agreed periods of home leave were extended by agreement when F failed to return to The Dene on the due date. F's leave was agreed between F and his family and was reviewed by the medical team during weekly ward rounds. The Dene state that they sent details of these home leaves to the CC, but there is no record of this in their IMR or in information provided by SPFT. During his informal stay the lead clinician, F and his family are stated to have entered into an agreement that F would come back voluntarily if his mental state deteriorated. The author has been given no supporting documentation. Further the IMR does not answer the questions raised as to the how and when information should be shared with funders, local authorities, GP surgeries and other partners.

4.12.8 Staff at The Dene had considerable contact with F's father who collected and returned him to The Dene following periods of home leave. The hospital has advised us that responsibility for risk assessing the family home rests with the CC from SPFT.

4.12.9 Records from both The Dene and SPFT show that contact between these agencies was minimal and that the CC was unaware of the length of frequency of home leaves that were taken. This meant that staff at The Dene were wholly reliant on reports from F's father about the home situation and F's response to periods on home leave.

4.12.10 The summary provided by The Dene in their IMR describes F's adherence to his medication treatment plan, general and dietary health, ward observations and pattern of home visits through the period. He appears to have engaged in very few of the additional activities offered by The Dene as part of the recovery process.

4.12.11 An initial discharge CPA meeting took place on 17th February 2015. A decision was taken to discharge F, however because of events immediately after the CPA meeting (when it is understood F threatened to commit suicide if discharged home), a clinical decision was made which reversed the decision.

4.12.12 Notwithstanding the decision to rescind the planned discharge, F was on extended home leave from 20th February until his formal discharge on the 3rd March 2015. There was no formal discharge meeting, although information was shared between The Dene

and CMHT. Records from The Dene show that a plan to discharge F on the 24th February and to hold a discharge planning meeting were abandoned as F did not return from home leave.

4.13 Analysis of Involvement

4.13.1 There is no evidence of a shared care plan for F – despite requests for sight of this for review. Whilst The Dene's focus as stated includes: *Rehabilitation on-site and in the community.* It is hard to accept that the extent of his home visits (whether with parental support or not) is part of a coherent treatment plan. The result is F's being at home with no apparent input from The Dene for nearly half the period of his time under their care.

4.13.2 Leave from an AMHU should only be determined in consultation with the individual and within a formulated and agreed care plan.

4.13.3 Aside from the meeting on the Discharge Planning Meeting on the 17th February the panel has seen no evidence joint working and information sharing in order to show continuity of care between hospital and community provision.

4.13.4 The decision to reverse a decision to discharge is made by the lead clinician almost immediately following the meeting on 17th February. There is no formal record of the rationale for the decision and no notification made to the CC. In a practical sense F was on home leave between the 20th February until final discharge on the 3rd March.

4.14 Learning Identified

4.14.1 The IMR identified none, as there were no incidents during F's admission to The Dene.

4.15 Western Sussex Hospitals NHS Foundation Trust, St Richard's and Worthing Hospitals

4.15.1 Western Sussex Hospitals NHS Foundation Trust serves a population of over 450, 000 people across a catchment area covering most of West Sussex. The Trust runs three hospitals: St. Richard's Hospital in Chichester; Southlands Hospital in Shoreham-by-Sea and Worthing Hospital in central Worthing.

4.16 Summary of Involvement

4.16.1 WSHFT had three significant contacts with F during the review period.

4.16.2 March 2015 the first contact was when F was brought to WSHFT Worthing A&E Department by ambulance having been found unconscious at home. He was accompanied by his mother who briefed staff on his behaviour, her concern that F had overdosed on his medication and gave an account of F's recent medical history; including his admission to Langley Green Hospital and diagnosis of Schizoid-Affective disorder and Asperger's. F was treated for a mixed overdose and referred to the psychiatric team for a Mental Health Assessment. F was seen and sectioned under Section 3 of the Mental Health Act and was discharged from WSHFT Worthing Hospital to AMHU. F was subsequently followed up by SPFT.

4.16.3 16th January 2016 the second contact; F presented at WSHFT St Richard's Hospital A&E Department arriving by ambulance with 'mixed overdose'.

4.16.4 17th January he was seen assessed and referred to the Mental Health Team at 01:17. Later that morning at 10:00 F was reviewed by the A&E Consultant on the Emergency Floor and deemed medically fit for discharge, but awaiting a psychiatric review. At 15:00 F was seen by the MHLN. A risk assessment was undertaken which identified F as not presenting a risk to self or others. F did not express suicidal ideas at this point and denied making any preparatory steps. The summary on risk noted 'labile mood distress when asked re thoughts of self-harming or harming others'. There were further details of the known static risk factors including previous assaults on parents and a warning that F was only to be seen by two male workers.

4.16.5 The plan was for F to be discharged and for the CRHT to review F at home on 18th January and for them to contact F at home that

evening. F was discharged from WSHFT St Richard's at 17:10 on 17 January 2016.

4.16.6 The third and final contact with F came later on the night of 17th January through to 18th January. F presented at WSHFT Worthing Hospital A&E Department at 23.31 arriving by ambulance and accompanied by his father. F had indicated to Ambulance Staff and to his father that he would "jump off a high building if not given help".

4.16.7 F was seen an assessed by a nurse and triaged as moderate risk and placed into a Major's cubicle near to the nurse's station. Safeguarding and Managing Risk Tool (SMART) were completed as F admitted suicidal ideation. F told staff that he wanted to be admitted to an AMHU.

4.16.8 F was seen by the registrar on 18th January at 01.28 and referred to the Psychiatric on Call team at 01.55. He was seen by the Senior Nurse Practitioner (Psychiatry) and Psychiatric SHO at 02.55. The WSHFT IMR records, 'There were no mental health beds available and so the plan was for F to be admitted to the CDU overnight and for a review by the psychiatric team the following morning due to 'patient uncertainty and immediate family safety'.

4.16.9 F was transferred to the CDU at 03.28 and was in the company of his father. The Psychiatric Liaison reviewed F again at 08.00, Between 07:00 – 08:00 it was clear that F's mental health was deteriorating and that he appeared psychotic. F was transferred back to Majors, where there was increased staff ready to attend his clinical needs and the Liaison Psychiatrist was called.

4.16.10 At 10:00 the plan was for psychiatric admission and a bed was requested through the CRHT. F was given anti-psychotic medication and he appeared calmer, he was transferred back to the CDU where his father was again in attendance. It was noted by the CDU sister that F's father would like his son to be admitted to The Dene. The ward sister was unable to update F or his parents on progress with identifying an AMHU bed, as she was unaware of the process and unable to contact a member of the psychiatric liaison team. At 16:18 F jumped off the bed and left the CDU. A CDU member of staff who alerted his father and security observed his departure.

4.16.11 Hospital staff were unable to locate F. At 16:36 a call was made to SECAmb and the hospitals cardiac resuscitation team, to attend the grounds at the back of Worthing Hospital for F who

was not breathing. CPR was commenced and terminated at 17:10.

4.16 ***Analysis of Involvement***

4.17.1 F was provided with appropriate general nursing and medical care whilst a patient with WSHFT both in Chichester and Worthing A&E departments. Staff were able to elicit background history from F's parents and meet his immediate physical needs whilst he was waiting for psychiatric assessments. There was similarly appropriate application of Mental Health SMART tool and Vulnerable Adults Assessment Tool. Referrals made to psychiatric liaison and mental health teams for assessment were timely. The medical assessments made by hospital staff on arrival at A&E were timely and comprehensive as were those conducted prior to medical discharge. In each case appropriate referrals were made for a psychiatric assessment at the hospital. This is good practice.

4.17.2 WSHFT St Richard's Hospital found F medically fit for discharge, but final discharge to be subject to a psychiatric review.

4.17.3 F was received at WSHFT Worthing A&E Department some eleven and a half-hours after his discharge from WSHFT St Richard's Hospital. As at St Richard's Hospital staff attended to F's immediate needs and undertook relevant risk assessments. There followed a psychiatric assessment involving the Liaison Psychiatrist from WSHFT and SPFT.

4.17.4 A joint decision appears to have been made based on F's presentation (similar to when attending earlier at WSHFT St Richard's) and wish to be voluntarily admitted to an AMHU and denial of any suicidal intention and that F would be admitted overnight pending a further psychiatric assessment later that morning.

4.17.5 The admission was not without difficulty as there were concerns about F's behaviour based on information in the CRHT risk assessment. It was agreed that F would be admitted to the CDU and that F's father would accompany him (from the SPFT IMR). An entry in the WSHFT health records from SPFT confirms that this information was shared with F and his father. WSHFT were unaware of the alert on the SPFT administration system.

4.17.6 WSHFT advise that normal staffing levels in CDU are 2 trained nurses and one Health Care Assistant. Normal staffing levels in Majors in A&E are 4 trained nurses and one Health Care Assistant.

The moves between units were in each case determined by F's clinical condition.

4.17.7 The Root Cause Analysis (RCA) provided by WSHFT notes the concern expressed by nursing staff at WSHFT as to whether F should have had an RMN special provided and whether this would have prevented F from absconding. If mental health liaison identifies a patient who presents a potential risk, they will document that a special is required and A&E will organise a special. The Liaison Psychiatrist and the CRHT assessed this as not necessary as F was a voluntary patient and it was felt that 1:1 observations might be more intrusive. A clear rationale for not deploying an RMN for 1:1 observations is recorded in the SPFT IMR.

4.17.8 *The Mental Health Liaison Nurse and the Liaison Psychiatrist confirmed Patient F was not on one to one (1:1) observations.*

4.17.9 F made several moves between the A&E unit and CDU as his mental health deteriorated or conversely showed sign of improvement. The moves were necessitated by the need for more intensive treatment. However, they do raise a question for consideration by mental health and related services as to where is the most appropriate and safe environment to keep an acutely unwell patient with mental health needs where there is a delay in identifying a mental health bed.

4.17.10 The RCA notes that there is no clear pathway to guide decisions on the deployment of RMNs for the nursing team to ensure that they are supported with the care of a patient with needs like those of F i.e. recurrent psychosis and Asperger's syndrome.

4.18 ***Learning Identified:*** **Root Cause Analysis Investigation Report, WSHFT**

4.18.1 A clinical pathway needs to be agreed between WSHFT and SPFT as to the management of these patients whilst awaiting a mental health review bed. This would also support the requirements and decision-making around needs for specialising and observation of such patients. This should review the expected maximum time to transfer these patients to mental health beds and how to manage these patients if delayed beyond this and communication between the two Trusts

4.18.2 If a patient is seen by SPFT Psychiatric Liaison Staff in the A&E at Worthing a copy of their assessment should be printed and kept in the patient notes in order to promote patient safety.

4.18.3 Review of the WSHFT process in the management of persons found collapsed within the hospital grounds, outside of the buildings, to confirm responsibility of WSHFT staff and SECAMB.

4.18.4 Mental Health Board to be set up by WSHFT with key external stakeholders in order to promote patient safety.

4.18.5 Establish a clear pathway to guide decision making for the nursing team to ensure that they are supported with the care of mental health patients with complex needs similar to those of F.

4.19 *Sussex Police*

4.19.1 Sussex Police is the territorial police force responsible for policing the counties of East and West Sussex and Brighton & Hove. Its headquarters is in Lewes, East Sussex.

4.19.2 The role of the Police in Safeguarding Adults is initially to ensure the safety of the public, the safety of the vulnerable adult, investigating any offences suspected of being committed against the vulnerable adult and ensuring that Adult Social Care (ASC) are subsequently advised of the incident and the circumstances so that they can assess if any further assistance is required.

4.19.3 The Police inform ASC by completing a Single Combined Assessment of Risk Form (SCARF), which is then emailed to the appropriate ASC office.

4.20 Summary of Involvement

4.20.1 The Police were involved in four distinct interactions with F over the review period. All incidents were connected to F's mental health issues. Three were linked to hospital admissions and a fourth involved the Police responding to F's employers concern that F was threatening suicide.

4.20.2 1st January 2015, the first contact with F was when officers responded to a call from Mental Health services when F had absconded after being sectioned. The attending police officers did not complete a SCARF as Adult Services were also in attendance.

4.20.3 12th July 2015, the second contact was connected to the concerns of F's employer that he might commit suicide the next day. The attending officers spoke with F and liaised with his parents. They were satisfied that it was safe to leave F at home to await the arrival of his parents. The officers completed a SCARF, which was emailed to the relevant Adult Social Care office.

4.20.4 16th January 2016, in the third incident attending police officers conducted a search for F when it was believed he might have taken an overdose. F returned home of his own accord and the Police called an ambulance that conveyed him to hospital. The Police did not submit a SCARF, believing that Adult Social Care would be made aware by the hospital. A SCARF should have been submitted in these circumstances to ensure that Adult Social Care were aware of the incident.

4.20.5 17th January 2016, the police final contact with F during the period was when F himself made direct contact with the police via a 999 call. F was using a mobile telephone from his garden. He told the police controller that, 'he needed to go to hospital as he felt unwell and may do something bad to himself'.

4.20.6 In establishing F's circumstances, the police controller confirmed that F's parents were at home, that he sometimes felt suicidal and that his parents were aware of this. F told the controller that he did not wish his parents to accompany him to hospital and did not want to ask them. After further speaking to F about his parents being present F stated that he would ask his parents to take him. Police did not attend.

4.20.7 In each case the relevant incident logs had the outcome recorded on them.

4.20.8 18th January 2016, the police were also called by SECAmb to report on F's fall from the hospital roof and that he was in 'possible cardiac arrest in a public place and not breathing'. Police attended, the male was identified as F who was certified dead at the scene. It was suspected that he had fallen from a height and an investigation into his death was commenced.

4.21 ***Analysis of Involvement***

4.21.1 The police response to the incidents of 1st January 2015 and 12th July 2015 are timely with appropriate liaison with F's parents (12/7) and decision making in relation to the raising of a SCARF.

4.21.2 On 16th January 2016, the officers who attended incidents involving F ensured that appropriate care was provided. Submitting a SCARF would have been appropriate in the circumstances and consistent with the Sussex Police policy and procedures. It seems that because F was taken to hospital for assessment the police officers wrongly assumed that hospital staff and Adult Social Care staff who were on site would make the necessary notifications.

4.21.3 On 17th January 2016 F, himself made a 999 call and spoke with a Police controller. He told the controller that he wanted 'to cause himself harm'. Policy and guidelines issued to police staff are clear in identifying this as requiring a response that led to police attendance or failing this transfer for an ambulance to be despatched. (Grade 2).

4.21.4 Had the controller exercised 'professional curiosity' and probed still further it is possible that the response level might have been raised to the highest. (Grade 1). The author's assessment of what grade should have been applied to the incident was based on the limited information obtained by the controller.

4.21.5 The controller also failed to inform their supervisor of the call at the time that the call was being taken (as per police standard operating procedures and training). The controller then closed the incident log without it being independently assessed. This meant no SCARF was completed and no one else was aware of the call at this stage.

4.21.6 In their IMR Sussex Police advise that the controller who took the 999 calls from F on 17th January 2016 failed to provide the care required and did not follow their training, force policy or standard operating procedures. The controller should have obtained more information from F, interrogated police systems for other information and ensured that a police unit was dispatched to see F. This would also have alerted the controller to the fact that when F was unwell he could pose a threat to his parents whom he had assaulted in the past - threatening his mother with a knife that he then used to cause harm to himself.

4.21.7 By advising F to speak to his parents the controller both put the parents at risk and gave F further opportunity to harm himself. A police unit would have made a proper assessment of his needs. The controller also failed to inform their supervisor of the call at the time that the call was being taken. The police no longer employ the controller.

4.21.8 The call should have either had a police unit dispatched or should have been passed to the ambulance service.

4.22 *Learning Identified*

4.22.1 *IMR: None - on the basis that Sussex Police have addressed the issues identified in their IMR.*

4.23 *South East Coast Ambulance Service*

4.23.1 South East Coast Ambulance Service NHS Foundation Trust is part of the National Health Service (NHS). It responds to 999 calls from the public, urgent calls from healthcare professionals, providing NHS 111 services across the region. Calls are categorised by letter, according to their perceived urgency and have differing response times.

4.24 *Summary of Involvement*

4.24.1 SECAmb had five contacts with F over the review period:

4.24.2 1st January 2015, the first was a call from an Approved Mental Health Practitioner (AMHP) requesting transportation to hospital as F had been detained under the Mental Health Act 1983. The call was categorised as a category C call, meaning a target time for response of 60 minutes. The ambulance was not despatched during the target period due to 'higher priority 999 calls'. F absconded before an ambulance could be despatched. SECAmb made the police aware of the incident.

4.24.3 13th May 2015, the second contact followed a 999 call for attendance following a reported overdose. This was categorised, as a category A call meaning an 8-minute response was required. The response time was 15 minutes. F was found to be difficult to rouse and pre–alert information was shared with the hospital. As it was unclear what medication had been taken ambulance staff treated F with Naloxone (a drug to reverse the effects of opiates).

4.24.4 16th January 2016, the third contact with F. The call was made by the police who describe F as having taken a number of cold and flu remedies containing paracetamol, approximately one and a half hours earlier. The call was categorised as a Category C call with a 30 minute response time. A vehicle was assigned arriving at the scene within 36 minutes.

4.24.5 17th January 2016, the fourth contact was categorised as a Category C with a target response time of 30 minutes. This was a 999 call made by F who said that he was 'going to jump off a tall building'. A vehicle was assigned immediately and arrived at the scene in 15 minutes. Ambulance staff conveyed F and his father to hospital. They shared with hospital staff F's disclosures in relation to suicidal ideation.

4.24.6 18th January 2016, the fifth and final contact with F was in response to a call that a male had jumped from the top of a building within the hospital grounds. The call was categorised as Category A Red requiring an 8 minute response time. Two resources were on the scene within 3 minutes. Police were notified as treatment was in a public place. Medical staff from the hospital were also noted to be in attendance.

4.25 ***Analysis of Involvement***

4.25.1 SECAmb responded appropriately on each occasion, while acknowledging that target times were missed. If 75% of calls are to be dealt with within a target time it is to be expected that rural journeys will predominate within the 25% outside target.

4.26 ***Learning Identified***

4.26.1 *IMR None Identified*

4.26.2 *Training- SECAmb have recently employed a Mental Health Consultant Nurse to review mental health training and how the Trust interfaces with specialist services. This may identify areas where mental health response improves overall. SECAmb staff correctly employed good practice by passing on the appropriate information to the hospital, regarding F's suicidal ideation and threat to jump from a tall building.*

5 Review Recommendations

5.1 SPFT need to develop protocols to ensure the continuity of care between hospital and community, including where patients are placed out of area or with private sector providers, so that patient information is shared at the earliest opportunity.

5.2 The Trust Care Programmed Approach (CPA) was designed to ensure a holistic approach to patient care. This means involving all appropriate agencies and the provision of clear documentation for the rationale behind decisions. This case highlights deficiencies in the way the SPFT Care Plan was prepared and implemented. These concerns were also identified in a previous West Sussex Safeguarding Adult Review (SAR) in 2013 (Alan published by the SAB in 2016). SPFT should provide evidence to West Sussex Safeguarding Adults Board (WSSAB) that following service developments since the publication of the 'Alan' SAR, practice has improved to the required standard.

5.3 SPFT are committed to their 'Triangle of Care' programme (which is designed to ensure that carers' needs and their role are central to the planning process), SPFT should provide evidence of the plans and timescales for implementation and the outcome of their initial review of this approach to the WSSAB**.**

5.4 WSSAB need to ensure that all member agencies have in place suitable training to address cultural recognition,sensitivity and consider whether this training can be made available by the SAB.

5.5 SPFT need to review their implementation of their Reflective Practice[2] model to ensure that all practitioners are supported in their practice and the exercise of professional judgment.

5.6 SPFT and WSHFT need to develop a model of care, protocol and guidance for practitioners on the use of an RMN (for observations) in A&E. The resultant procedures should be fully implemented and subject to audit.

5.7 SPFT and WSHFT need to agree a clinical pathway and model of care for the management of patients waiting for a mental

[2] Reflective Practice involves the critical analysis of working practices to improve competence, promote professional development, develop practice generated theory, and help professionals make sense of complex and ambiguous practice situations (Cowdrill & Dannahy, 2009)

health bed as detailed in the SPFT Serious Incident Report. The pathway should include details of arrangements to consult with the patient and the patient's family/carers.

5.8 A&E departments are where the most serious and urgent medical emergencies are treated. The nature of their environment means that they do not always provide the most suitable therapeutic environment for someone who is mentally unwell. If a person is feeling paranoid, psychotic, distraught or suicidal, the environment can be detrimental, and potentially escalate symptoms. Commissioners should explore alternative emergency provision for acute mental health patients.

5.9 **GP**'s need to have clear escalation routes where they have concerns about service provision and attempts to raise concerns with the agency concerned are not satisfied.

5.10 **The Dene** Hospital need to develop protocols to ensure the continuity of care between hospital and community, so that patient information is shared at the earliest opportunity.

5.11 **The Dene** should review the processes and decision-making arrangements that apply to the granting of home leave, ensure that these satisfy the requirements set out in *S17 leave of the MHA and Ch 21 of the MHA code of practice and report their findings to the relevant commissioning body.*

5.12 **The Dene** need to provide all relevant agencies with comprehensive Care Plans which include detailed provisions for rehabilitation on site and in the community.

5.13 **Western Sussex Hospital Foundation Trust** to implement the recommendations found in the RCA report.

5.14 **Police** need to incorporate the importance of professional curiosity in practice into their staff training and supervision emphasising the need to probe and consider alternative interpretations for how a person is presenting to ensure their assessments are comprehensive.

5.15 **West Sussex SAB** to satisfy itself that the systems for ensuring that SCARF notifications made are robust and fully understood by police officers.

6 Conclusion

6.1 This report has highlighted some of the inherent challenges in managing complex mental health cases in the community and in ensuring continuity of care across inpatient mental health settings.

6.2 Responsibility for assessment, planning, coordination and review of F's Care Programme lay with the SPFT Care Coordinator. This review has found that the Care Plan for F was poor because it was limited in scope and aspiration. A more holistic assessment and package of interventions that supported F to integrate into his local community (reflecting F's ethnicity, interests and talents) would have added further support for his recovery. The absence of a Carer's Assessment or evidence of meaningful engagement with F's parents in key decisions such as the withdrawal of home visits and sourcing of a hospital bed, were omissions which further weakened the Care Plan and support for his recovery.

6.3 Holding the key-coordinating role, the CC was responsible for ensuring that all those involved with the care plan were communicated with, in writing and verbally as required either by the demands of a care plan or following significant events. In this case communication from the CC with the GP was not maintained and only limited contact was made with F and hospital staff when F was under MHA Section or as a voluntary mental health patient. Holding the key-coordinating role, the CC was responsible for ensuring that all those involved with the care plan were communicated with in writing and verbally as required either by the demands of a care plan or following significant events. In this case communication from the CC with the GP was not maintained, as required by the Care Planning process and only limited contact was made with F and hospital staff when F was under MHA Section or as a voluntary patient. Regrettably the CC contact with F and his parents was similarly, limited with gaps of several months without recorded contact, updated review or risk assessment following a significant event.

6.4 F was at home on leave for nearly half of his time at The Dean. There is no evidence of this taking place in the context of an agreed Care Plan or with any attempt to consult or inform the CC. Leave appears to have been extended in an *ad hoc* way without a clear process or rationale. There is no evidence of effective liaison or joint work with the community mental health services during this admission.

6.5 During the last year of his life, F was transported to A&E on several occasions following an overdose or because he was suicidal. The immediate medical care that he received from A&E staff was in each case, timely and responsive. Of concern in this environment are findings that relate to the flow of information from SPFT to WSHFT staff. Critically, in this case WSHFT staff had no access to F's mental health records or risk assessments and was unaware of documented concerns on the mental health team IT system about a potential risk to staff. The author understands that this situation has now been resolved and that each agency is able to share these notes. This is a welcome development.

6.6 Concerns remain about the timely access to a suitable mental health bed. The author recognises the difficulties both locally and nationally in securing a placement in mental health beds. In F's case there was a lack of transparency about how the mental health bed management process worked and poor communication with F's parents and WSHFT staff. The SPFT bed management process is now subject to review and change.

Glossary

A&E	**Accident and Emergency**
AMHP	**Adult Mental Health Practitioner**
AMHU	**Adult Mental Health Unit**
AOT	**Assertive Outreach Team**
AS	**Asperger's Syndrome**
ASC	**Adult Social Care**
ASD	**Autistic Spectrum Disorder**
ATS	**Assessment and Treatment Service**
BM	**Bed Manager**
CC	**Care Coordinator**
CDU	**Clinical Decision Unit**
CN	**Community Nurse**
CMHT	**Community Mental Health Team**
CRHT	**Crisis Resolution Home Team**
CPA	**Care Programme Approach**
DSH	**Deliberate Self Harm**
eCPA	**Electronic Care Programme Approach**
EIS	**Early Intervention Service**
ENA	**Emergency Nursing Assistant**
GP	**General Practitioner**
IM	**Intra-Muscular**
IMR	**Individual Management Review**
MHA	**Mental Health Act 1983**

MHAA	**Mental Health Act Assessment**
MHLN	**Mental Health Liaison Nurse**
MHLT	**Mental Health Liaison Team**
NHS	**National Health Service**
NPH	**New Park House**
OT	**Occupational Therapist**
RCA	**Root Cause Analysis**
R&WT	**Recovery and Wellbeing Team**
RMN	**Registered Mental Health Nurse**
SAB	**Safeguarding Adult Board**
SAR	**Safeguarding Adult Review**
SCARF	**Single Combined Assessment Risk Form**
SECAmb	**South East Coast Ambulance Foundation Trust**
SHO	**Senior House Officer**
SIR	**Serious Incident Report**
SMART	**Safeguarding and Risk Management Tool**
SMHH	**Sussex Mental Health Helpline**
SPFT	**Sussex Partnership Foundation Trust**
SW	**Support Worker**
TOR	**Terms of Reference**
USD	**Urine Screening for Drugs**
HSW	**Healthcare Support Worker**
WSHF T	**Western Sussex Hospital Foundation Trust**
WSSAB	**West Sussex Safeguarding Adult Board**

Appendices

Appendix 1

Terms of Reference

1. Were outcomes of assessments actioned and shared?

2. Were adequate steps taken to determine NW's Mental Health needs prior to his presentation at the hospital?

3. How were admission/discharge procedures implemented to ensure that F was appropriately transferred through agency support throughout the time of review?

4. Identify any organisational factors, including culture and capacity, which may have impacted on practice.

5. How effective was information sharing within your organisation, with other agencies and with the family?

6. Were the concerns of family members appropriately addressed?

7. How are processes and information around the availability of Mental Health beds identified and shared within your agency/with other agencies?

Appendix 2

Mental Health Act

Mental Health Act 1983 –Section 2 and Section 3

Section	What this section means	How long you can be kept under section
2	You can be detained if: you have a mental disorder you need to be detained for a short time for assessment and possibly medical treatment, and it is necessary for your own health or safety or for the protection of other people	Up to 28 days. The section can't normally be extended or renewed, but you may be assessed before the end of the 28 days to see if sectioning under section 3 is needed.
3	You can be detained if: you have a mental disorder you need to be detained for your own health or safety or for the protection of other people, and treatment can't be given unless you are detained in hospital You cannot be sectioned under this section unless the doctors also agree that appropriate treatment is available for you.	Up to 6 months. The section can be renewed or extended by your responsible clinician: for 6 months, the first time then for 6 months, the second time after that, for 12-month periods. There is no limit to the number of times the responsible clinician can renew the section 3. Your responsible clinician can also discharge you from your section before it comes to an end. If this happens, you are free to go home. If your mental health got worse again in the future, you could be sectioned and taken to hospital again, as a mental health team would assess you and make a decision then.

Extract From https://www.mind.org.uk

Appendix 3

1. Schizoaffective Disorder

a. Schizoaffective disorder is a mental illness that can affect your thoughts, mood and behaviour. You may have symptoms of bipolar disorder and schizophrenia. These symptoms may be mania, depression and psychosis.

2. Psychosis

a. Psychosis is a medical term used to describe hearing or seeing things that do not exist, or believing things that other people do not.

b. Common examples include hearing voices or believing that people are trying to do you harm.

c. You can experience psychosis for a wide variety of reasons. For example, it can be due to having a mental illness such as schizophrenia or bipolar disorder. It may be caused by drug use, brain injury or extreme stress.

d. There is no one single causes of psychosis but researchers believe that genes, biological factors and environment may play a part.

e. In the NHS, you should be offered medication and talking therapy to help with your symptoms.

f. To access treatment for psychosis, you usually need to have an assessment by specialist mental health services, such as the Community Mental Health Team (CMHT).

g. If you are experiencing very severe psychotic symptoms, you may need more urgent help such as going into hospital.

h. There are different perspectives on how we should deal with psychosis. This includes listening to the voices or trying to understand the meaning of the unusual beliefs.

3. Bipolar Disorder

a. Bipolar disorder, also known as bipolar affective disorder, is a mood disorder. It used to be called manic depression.

b. Bipolar disorder can cause your mood to change from high (mania) to low (depression).

c. Symptoms of mania can include: increased energy, excitement, impulsive behaviour, agitation and believing you have super powers for example.

d. Symptoms of depression can include: lack of energy, feelings of worthlessness, low self-esteem and suicidal thoughts.

e. You can also have psychotic symptoms if you have bipolar disorder.

f. There are different types of bipolar disorder.

g. There are different causes of bipolar including genetics and environment.

h. You can get medication and talking therapies for bipolar disorder.

Extracts from www.rethink.org

Appendix 4

1. Asperger's syndrome

a. Asperger's syndrome is a lifelong developmental disability that affects how people perceive the world and interact with others.

2. Autism is a spectrum condition. All autistic people share certain difficulties, but being autistic will affect them in different ways. Some people with Asperger's syndrome also have mental health issues or other conditions, meaning people need different levels and types of support.

www.autism.org.uk/about/what-is/asperger.aspx

Appendix 5

1. Role of the Care Coordinator

a. Works in partnership with people who have complex mental health and social care needs, and those supporting them;

b. Strives to empower people using services to have choices and make decisions to determine their wellbeing and recovery;

c. Integrates and co-ordinates a person's journey through all parts of the health and social care system;

d. Enables each person to have a personalised care plan based on his/her needs, preferences and choices;

e. Ensures that the person receives the least restrictive care in the setting most appropriate for that person;

f. Supports the person to attain wellbeing and recovery;

g. Ensures that the needs of carers/families are addressed;

h. Brokers partnerships with health and social care agencies and networks which can respond to, and help to meet the needs of the person who is experiencing mental health problems and

i. Care co-ordination is predicated on the principle that people, however vulnerable, should share in decision-making; that they are knowledgeable about themselves and the effect their conditions may have on their lives; and that they should be empowered and enabled to inform their own recovery.

Karen Hardacre, Care Co-ordination Core Functions and Competencies (PSE Consulting Ltd)

Appendix 6

1. Role of the Registered Mental Health Nurse (RMN)

Standing Nursing & Midwifery Advisory Committee (SNMAC) practice guidance on the safe and supportive observation of patients at risk (SNMAC 1999) observation is defined as "regarding the patient attentively, whilst minimising the extent to which they feel they are under surveillance."

Treatment of Patients with a Mental Health Disorder in an Acute Hospital Setting - Enhanced Observation and Support Policy –example from Mid Essex Hospital Services

The Consultant Psychiatrist will retain overall responsibility for their mental health care and treatment.

Additional mental health staff would be supplied on a 1:1 basis where clinical need and risk indicates.

'PROVIDING 1:1 OBSERVATION OF THE PATIENT

The staff member should position themselves at a safe distance between the patient and the door, but not blocking the exit.

The staff member's total concentration must be on the patient always.

The staff member is not responsible for the care or observation of any other patient.

The patient must not be left alone at any time. The staff member remains with the patient even during reviews by the medical team and/or other health professionals.

Issues of privacy and dignity are important but safety and security take precedence.

Ensure that the patient's immediate environment is safe and check the patient belongings for hazards.

Appendix 7

1. Sussex Police Policy and Procedures

a. Sussex Police Policy 785/2017 - Call Grades and Deployment Policy.

b. Grade 1: - Emergency - Immediate police attendance (Target time is a maximum of 15 minutes).

c. Grade 2: - Priority - Earliest possible police attendance (Target time is a maximum of 1 hour).

d. Grade 3: - Scheduled - Planned police response. (By appointment either at a Police Station or by a Police Constable or Police Community Support Officer (PCSO) attending at an agreed time).

e. Grade 4: - Resolution without Deployment - No further police action, information only or duplicate call or a police generated activity which does not require the controller to actively seek a unit for deployment.

f. The Sussex Police has a current policy specific to Vulnerable Adults, entitled 'Safeguarding Adults', Policy number 750/2015. It was last reviewed in October 2015 and is next due for review in October 2017. The policy sets out additional guidance, procedures and advice for officers and staff coming into contact with vulnerable adults at risk of abuse, which includes those at risk of abuse to themselves and self-neglect. This policy is in addition to all other Sussex Police policies which apply to people whether vulnerable or not.

g. Also, relevant to this review is Sussex Police Policy 785/2017 - Call Grades and Deployment Policy. The policy was last reviewed in June 2017, prior to that it had been reviewed in 2014 which was the version applicable during the period covered by the review.

Appendix 8

Sussex Partnership Foundation Trust

SPFT staff use a common framework for assessment

SUMMARY / FORMULATION OF RISK

Consider the five Ps - Predisposing, Precipitating, Perpetuating, Protective Factors and Presenting Risk/s to create a narrative as to how these increase or decrease risk
Using this framework enables the staff to consider a 360-degree view of risk that evolves and changes as time progresses and variables change or remain stable.

Leighe Rogers
Independent Reviewer