Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Leicester Safeguarding Adults Board

Safeguarding Adults Review

Executive Summary

'Bert'

Independent Author:
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Executive Summary

1. Introduction

1.1. This review considers the sad circumstances surrounding the death of Bert.

1.2. Bert had not previously been known to mental health services. He appeared to become acutely unwell to a point where he needed admission to hospital.

1.3. During the early hours of a Sunday morning, police were called to Bert's property by a neighbour. Following attendance, the police called for the assistance of the Mental Health Triage Car as they believed Bert to be in a mental health crisis. The Mental Health Triage Car attended and carried out an assessment and encouraged Bert to accept admission to hospital. As Bert was declining admission, arrangements were made for an assessment under the Mental Health Act 1983.

1.4. Unfortunately, there were significant delays in convening the Mental Health Act assessment. There were then further delays due to sourcing a bed and obtaining a warrant to gain re-admission to Bert's property.

1.5. Tragically, before this admission could be arranged, Bert left his house and died as a result of being involved in a six-car collision.

1.6. The agencies that contributed to the learning for this SAR were:

- East Leicestershire and Rutland CCG (ELRCCG)
- Leicester City Council (LCC)
- Leicestershire Partnership NHS Trust (LPT)
- Leicestershire Police
- Bert's cousin
- Mental Health Coordinator for the College of Policing and National Police Chief's Council
- Leicester Safeguarding Adults Board Manager
- Deputy Justice Clerk to the Magistrates

2 Summary of the Learning Points from the Review

2.1. Bert was experiencing high levels of distress due to his delusional beliefs. All professionals were concerned about his well-being and were trying to secure the care and treatment he was in need of but there were barriers that prevented this.

2.2 The range of crisis care available post-midnight is very reduced. This caused significant delays in convening the Mental Health Act assessment. This resulted in a long delay for Bert to be assessed under the Mental Health Act and had an adverse knock-on effect for police who were waiting with Bert.

2.3 There was substantial miscommunication surrounding the availability of a bed and then sourcing a bed. This was a major contributory factor. Had a bed been identified at an earlier stage, it *may* have been possible for Bert to have been conveyed to hospital immediately following the

assessment although it is acknowledged that it may still have been necessary to apply for a warrant to gain admission to Bert's property. The review highlighted the importance of effective bed management to enable accurate information about bed availability and a robust process to source a bed at the earliest opportunity when an admission is likely.

2.4 The review highlighted the importance of understanding different professional roles and responsibilities and the legal parameters in which professionals work. This enables clear communication of risk assessments and agreement over each partners' contribution to the risk management plan.

2.5. The review considered the period that Bert was left alone following the assessment while trying to arrange his admission. It is important not to make judgements based on hindsight knowledge of what then occurred. Given the information that was known at the time, it was reasonable to believe Bert was likely to remain in his house while a bed was sourced and a warrant obtained to gain admission to his property. There was however learning regarding the coordination and communication of this plan.

2.6. Given the factors at that time and resources available, it is unlikely that crisis care could practicably have been provided to Bert during this period. This was due to time of day, the four-hour standard response time by the Crisis Team and the fact that Bert was unlikely to grant admission to any services. However, the review identified that there is a pressing need for mental health services and social care to work together to agree interim care arrangements for people who have been assessed as requiring admission but for whom there is no bed available.

2.7. There is a need for a strategic, system wide partnership approach to mental health crisis care based on improved analysis and planning for inpatient bed provision as well as alternatives to admission. This work is underway through the Sustaining Transformation Partnership. There is a more immediate need to revisit crisis care provided out of hours. This relates to the capacity of services and the mechanisms that support professionals to work together to help people such as Bert who are in mental health crisis.

3. Conclusions

3.1. The review has examined the sad circumstances surrounding Bert's death. There was a convergence of factors that resulted in Bert's admission to hospital being delayed. Had these delays not occurred, it is probable that Bert's death in the car crash would have been averted.

3.2. The review also highlighted wider learning that though may not have made a substantive difference to Bert, nonetheless is important in reducing risks to others in similar circumstances.

3.3. The recommendations aim to help agencies act on the learning from this review to reduce risks for others in similar circumstances.

4. Recommendations

4.1 Since Bert's death, agencies have already made a number of changes that are relevant to the circumstances of this review, some as a direct consequence of the learning. LPT and LCC have also made some recommendations for their services. These are referenced in the appendix.

4.2 The author has taken these into account and made some additional recommendations for the partnership to take action on. The LSAB will seek assurance regarding how these recommendations have been acted upon

Recommendations

Learning Theme 1: Using Learning in Strategic Planning

Learning from this review should be used to inform the strategic work of the agencies involved, specifically:

Rec 1. LCC in their review of AMHP provision out of hours:

- Capacity of AMHP to meet the ADASS recommended levels
- Strengthening resilience of arrangements for access to AMHP
- Developing support for out of hours AMHPs including access to informed managerial assistance, policies and procedures and risk management tools
- Working with magistrates aimed at resolving any difficulties in access to magistrates out of hours.

Rec 2. LPT in the transformation of their service provision for acute care and crisis care and access to the service.

Rec 3. ELRCCG in leading the Sustaining Transformation Partnership mental health planning including crisis care and inpatient bed provision.

Rec 4. i) ELRCCG in reviewing the provision of section 12 Doctors
ii) ELRCCG will undertake a joint review of the current process/policies pertaining to availability Section 12 approved doctors.

Rec 5. For ELRCCG; LPT; LCC and Leicestershire Police to build on a collaborative whole systems approach to mental health crisis care. This includes commitment for consultation with partners where any single agency is proposing change (to procedures or resource) that may impact on the whole system's crisis care management.

Rec 6. For all relevant agencies to improve use of data on the involvement of police in Mental Health Act assessments. This will provide a clear evidence base to inform joint strategic planning and collaborative partnership working.

Learning Theme 2: Access to acute mental health inpatient beds

Rec 7. LPT and ELRCCG provide a joint report to LSAB regarding

- What changes to bed management arrangements have been made subsequent to Bert's death.
- Assurance of how these changes have improved outcomes.
- Data on delays in admissions to acute beds in the year post-dating Bert's death.
- Plans in place to further mitigate delays and timeframes for achieving this.

ELRCCG on behalf of LLR CGGs to notify the three Local Authorities in the LLR area; Leicester City Council, Leicestershire County Council and Rutland County Council, that LPT is the hospital identified to receive patients in cases of special urgency as defined in the Section 140 of the Mental Health Act.

ELRCCG will facilitate LPT and Local Authorities to produce a written operational agreement to describe how organisations will work together to keep people safe whilst awaiting an appropriate bed to be located.

Rec 8. LCC and LPT provide a report to the LSAB regarding the development and implementation of joint procedures to provide interim care and support to patients (assessed as requiring inpatient admission), who are awaiting a bed.

Rec 9. The LSAB should retain strategic oversight of matters that may give rise to safeguarding concerns including incidents where harm has occurred that may be attributable to lack of mental health service provision. This may include interface with mental health partnership board and with the Sustaining Transformation Partnership work streams where relevant to the safeguarding adult agenda.

Learning Theme 3: Training and Guidance

The agencies contributing to this SAR should consider what additional training and guidance is indicated from the learning, specifically:

Rec 10. Training and guidance for LPT on-call Drs and nurses, MHTC and crisis team: the need to begin the process of co-ordinating a bed at the earliest point i.e. as soon as there is reasonable likelihood that an admission will be required.

Rec 11. For agencies providing section 12 Drs in Leicester, to share learning from this review and reiterate the Code of Practice direction that 'it is not appropriate to encourage a person outside in order to use section 136 powers.'

Rec 12. For LCC and LPT, reiterating the importance of recording and adherence to organisational standards in relation to this.

Rec 13. Development of training and guidance for police, LPT Drs and LCC AMHPs in relation to risk assessments, roles and responsibilities during Mental Health Act assessments:

- developing understanding of how risk may be interpreted differently by the respective professional disciplines.
- increase understanding of roles and responsibilities of the respective. professional disciplines including the legal/professional constraints of their roles.
- develop tools and guidance to improve the clarity of communication and effective use of relationships during Mental Health Act assessments. Consider use of a shared framework that may support this process, for example applying the THRIVE mnemonic as a shared communication tool when involving police in assessments.

Sylvia Manson

Date: September 2018

Appendix 1: Recommendations made by agencies contributing to the review

Adult Social Care and Leicestershire Partnership Trust made recommendations and submitted action plans for their own respective agencies.

Leicester City Council - Adult Social Care Action Plan

What is the Recommendation?	**What is the desired Aim / Outcome from the recommendation?** What do we want to achieve?	**How will change be achieved?** What are the actions that need to take place?	**Lead agency and name of action holder**	**Key milestones achieved in enacting the recommendation**	**Timescale and Target Date** **DD/MM/YYYY**	**Progress (Long hand commentary & RAG)** If no progress recorded then note when the most recent request for update was made, to whom, and the proposed 'response by' **date given**
	Should this recommendation be enacted at a local or regional level?	*How exactly is the relevant agency going to make this recommendation happen?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation to be completed? What does the outcome look like? What evidence can demonstrate completion?*
Review safety provisions/support to EDT workers working alone between midnight and 8.30 am	Provide a safeguard for the AMHP.	Review the safety provisions for workers during this period and identify what further support is needed and how this might be provided	Adult Social Care	N/A	31.07.2018	Risk assessment completed re EDT working midnight – 8.30 am and procedure in place for undertaking visits during this time.
Provide training days to Duty managers to ensure they have some understanding of the	Improved communication between AMHP and duty manager to	Arrange training for EDT managers, and then regular updates on policy changes	Adult Social Care	N/A	30.09.2018	All EDT managers to have attended basic training on MHA

Mental Health Act and how it is applied in practice.	explore all possible and available options permissible under the Mental Health Act, as well as ensure local joint policies and guidance documents are understood and therefore adhered to.					
Annual training days/sessions for AMHPS concerning – de-escalation techniques, break-away and dealing with violent aggression and resilience training.	Equip the AMHP with skills to support de-escalation of service user behaviour but equally, to consider if the service users behaviour is threatening toward others or, just a response to poor mental health in which the service user is responding to unknown stimuli without intent of harm.	Arrange de-escalation training	Adult Social Care	Leicestershire County Council's Workforce Development Section has confirmed that it can offer this training	31.07.2018	De-escalation training available to all AMHPs in Leicester City Council
Review and update the *'Guidance to Leicester AMHPS when undertaking Mental Health Act assessments' where no bed has been identified'*. This should include guidance about risk assessing and recording of decisions	Provide clearer understanding of responsibility to follow these documents in practice and remove any potential confusion.	AMHP TL and HoS to review and revise the guidance	Adult Social Care	N/A	31.08.2018	Policy revised and presented to all AMHPs at an AMHP meeting. Copy of policy saved on Interface and sent out to all AMHPs and EDT managers

made. If an interim care plan is required, it should be written with the doctors present and delivered to either Crisis team or day-time AMHP team, and should include contingency arrangements.						
Regular discussions to be held to ensure that AMHPs are aware of policies and how these impact upon work	To ensure AMHPs have more than an awareness in applying local policy and guidance. This will assist in promoting confidence when dealing with a highly stressful & potential volatile situation.	Discussions on policies to be held within AMHP meetings. Reapproval interviews to specifically ask about use of policies	Adult Social Care	N/A	30.09.2018	Workers to be confident in using and able to explain their use of policies within their work. Reapproval interview notes and AMHP meeting notes to detail discussions and workers' understanding.

Leicestershire Partnership NHS Trust Action Plan

What is the Recommendation?	What is the desired Aim / Outcome from the recommendation? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Lead agency and name of action holder	Key milestones achieved in enacting the recommendation	Timescale and Target Date DD/MM/YYYY	Progress (Long hand commentary & RAG) If no progress recorded then note when the most recent request for update was made, to whom, and the proposed 'response by' date given
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level?	How exactly is the relevant agency going to make this recommendation happen?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted?	When should this recommendation be completed by?	When is the recommendation to be completed? What does the outcome look like? What evidence can demonstrate completion?
Services which do not have a 24/7 bed management service commissioned should review their policies and procedures to ensure that they are sufficiently robust and that staff with on call responsibilities are adequately supported.	Local	Through the relevant Safeguarding Sub Committee with oversight from the Trust Safeguarding Committee.	LPT	No	1st September 2018	Policies & procedures will be in place that are robust and provide support to on call workers.
Any review of policies and procedures should ensure that the process of sourcing OOA beds	Local	Through the relevant Safeguarding Sub Committee with oversight from the	LPT	No	1st September 2018	All on call workers will understand the process for sourcing OOA beds.

is clearly described with responsibilities apportioned to specific roles.		Trust Safeguarding Committee.				
Actions taken by on call staff should be recorded on the RIO clinical system to support good communication between all Trust staff.	Local	Through the relevant Safeguarding Sub Committee with oversight from the Trust Safeguarding Committee.	LPT	No	1st September 2018	There will be a visible record of all actions undertaken by on call workers.

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About the reviewer

The review was conducted by Sylvia Manson who is a mental health social worker by background and has many years' experience managing Health and Social Care services including responsibilities under the Mental Health Act.

Sylvia has held national roles with the Department of Health in relation to Safeguarding Adults, and led regional work in implementing the Mental Capacity Act 2005; Deprivation of Liberty Safeguards and Mental Health Act 2007. In addition to independent work, Sylvia is a specialist lay member and trainer for the Mental Health Tribunal

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