

# Leicester Safeguarding Adults Board

## Safeguarding Adults Review

### ‘Bert’

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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 under the Mental Health Act 1983.
- 1.3. Tragically, before this admission could be arranged, Bert left his house and died as a result of being involved in a six-car collision.
- 1.4. 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.
- 1.5. The review also highlights learning that, although may not have made a substantive difference to Bert, nonetheless is important in reducing risks to others in similar circumstances.

### 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, Bert *may* have been conveyed to hospital immediately following the assessment. 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 entry. 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 – whether this is patients who are detained or being admitted as informal (voluntary) patients.
- 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.
- 2.8. The recommendations arising from this review aim to assist in this process.

## Main Body of the Report

### 3. Context of Safeguarding Adults Reviews

- 3.1 The Care Act 2014, requires Safeguarding Adults Boards to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together.
- 3.2 Leicester Safeguarding Adults Board (LSAB) commissioned an independent author to carry out this review. The author is an experienced chair and author of reviews and holds a professional background in mental health services and safeguarding adults. The author is independent of LSAB and its partner agencies.
- 3.3 The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again*'.<sup>1</sup> A SAR enables all of the information known to agencies to be seen in one place. This is beneficial to learning but must recognise that this benefit of hindsight was not available to practitioners at the time.
- 3.4. The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity.<sup>2</sup> The principles apply to the review as follows:

**Empowerment:** Understanding how agencies respected Bert's views and wishes within the confines of the Mental Health Act assessment.

**Prevention:** The learning will be used to consider prevention of future harm to others.

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<sup>1</sup> Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*

<sup>2</sup> Ibid

**Proportionality:** Understanding whether least restrictive practice was used.

**Protection:** The learning will be used to protect others from harm.

**Partnership:** Partners will seek to understand how well they worked together and use learning to improve partnership working.

**Accountability:** Accountability and transparency within the learning process.

## 4. Bert and the Background for this Review

- 4.1. Bert was a man in his mid-60's who lived alone in Leicester. Prior to the night of the assessment, Bert was not known to social care, mental health services or the police.
- 4.2. Bert's cousin has shared some information about him. Bert was a local man. He was a talented golfer and worked as a golf professional for many years until injury prevented it.
- 4.3. Bert was an only child and when his father died, Bert cared for his mother until her death eight years ago. Bert's cousin used to call him every Monday evening for a catch up. She describes him as a private man but a real character.
- 4.4. Although Bert had no close friends, he had a wide circle of acquaintances. He was in close contact with his neighbours and would regularly spend Christmas with them. Bert also went to visit old neighbours regularly.
- 4.5. Bert enjoyed being at home and had routines which he followed every day. Being a creature of habit, he didn't like travelling to places he didn't know, and it was very unusual for him to drive at above 30 mph.
- 4.6. Bert's life centred around a daily meal and soft drink at his local pub and making trips to the local betting shop to watch the sport, sometimes making a 20p bet. He was well known there and was described as 'happy go lucky', chatting to people and telling jokes. He was content with his life and loved watching all kinds of sport.
- 4.7. About two weeks before his death, staff at his local pub noticed that Bert was talking to himself. They contacted 111 and then a mental health charity but did not have enough knowledge of Bert for further enquiries to be made.
- 4.8. Two weeks later, Bert came to the attention of police and mental health services during the night. He appeared to be experiencing symptoms of psychosis. These symptoms included strongly held false beliefs (delusions) that were paranoid in nature. Bert was very frightened as he believed that he and others were under extreme threat from people including the IRA.
- 4.9. The events that followed on that night surround the assessment of Bert's mental health that involved Leicestershire Police, Leicestershire Partnership NHS Trust and Leicester City Council working together.
- 4.10. Very sadly, before Bert could be admitted to hospital he left his house in his car and was involved in a collision involving six cars. He died from the injuries he sustained.

- 4.11. This review explores the events leading up to Bert's death and the detail of how those agencies worked together to assess and try to meet his needs. Importantly, the review identifies learning and makes recommendation for change to reduce risk to others in similar circumstances.

## 5. Terms of Reference and Methodology

- 5.1 This SAR focuses on the events within the 24-hour period surrounding an assessment of Bert. The specific terms of reference are detailed in appendix 1, with questions grouped under the following headings:
- Personalisation and making safeguarding personal
  - Policies, procedures, local arrangements & protocol
  - Risk assessment
  - Systems & resources
  - Interface and joint working
  - Application of legal framework
  - Support and advice provided to practitioners
  - Organisational challenges
  - Good Practice
- 5.2 The methodology applied for this SAR drew on information from agencies' narrative reports and chronologies along with a learning event with all the agencies involved. This combined approach aids understanding of not just what happened, but why it happened and engages all in developing joint solutions.
- 5.3. It is important for SARs to try and gather views from those people who are closest to the person who is the subject of the review. The LSAB and Independent Author thank Bert's cousin for providing the background information about Bert for the review.
- 5.4. In order to protect Bert's privacy and dignity, identifiable information has been removed and a pseudonym of 'Bert' used. This pseudonym was chosen by his cousin.
- 5.5. The agencies that contributed to this SAR were:
- East Leicestershire and Rutland CCG (ELRCCG)
  - Leicester City Council (LCC)
  - Leicestershire Partnership NHS Trust (LPT)
  - Leicestershire Police
  - Bert's cousin
  - Chief Inspector Michael Brown, OBE, Mental Health Coordinator for the College of Policing and National Police Chiefs' Council
  - Lindsey Bampton, Leicester Safeguarding Adults Board Manager
  - Joanne Reed, Leicester Safeguarding Adults Board Officer
- 5.6. Detail on the context, roles and responsibilities of these agencies is contained in section 7. A glossary of terms is also available at page 42.

- 5.7. Information and views were also sought from the Deputy Justice Clerk to the Magistrates with agreement to share any learning points.

## 6. Summary of Events<sup>3</sup>

- 6.1. This section provides a summary of events. An analysis of these events follows in section 8.
- 6.2. Bert's cousin reported that approximately 2 weeks before Bert's death, staff in his local pub had noticed him talking to himself and generally behaving differently. The staff contacted 111 and then a mental health charity but did not have enough knowledge of Bert for further enquiries to be made.
- 6.3. Two weeks later, at **17:00 on a Friday** evening, the bed co-ordinator for the LPT Mental Health Services for Older People (MHSOP), provided an update report on the bed state to the staff with on call duties over the weekend. It appears from the electronic system that beds were available at this point. However, the information recorded on the handover document to on call staff is more ambiguous (this information is reviewed in more depth in section 8).
- 6.4. All subsequent events occurred during the Sunday night through to the Monday morning of that weekend.
- 6.5. **Monday 00:23** A neighbour of Bert's (not known to him) phoned the police. Bert was at their address saying he had been 'beaten up' and was too scared to return home. The neighbour thought Bert was shocked but did not need an ambulance.
- 6.6. Police attended within 15 minutes. Bert was distressed, believing he was being followed by the IRA. Police returned to his home with Bert, to check his property, and then contacted the mental health triage car (MHTC) as they believed he was experiencing an episode of mental illness.
- 6.7. The MHTC attended by **01:00** and began their assessment. The nurse from the MHTC felt Bert needed inpatient care and encouraged Bert to accept an admission. Bert refused and was upset at the nurse's suggestion that he may be experiencing mental illness. The nurse felt she should leave the property as Bert was upset with her. After discussion with on-call Consultant Psychiatrist, they agreed that Bert should be assessed for compulsory admission under the Mental Health Act 1983 (as amended 2007).<sup>4</sup>
- 6.8. The MHTC tried to contact the Council Emergency Duty Team (EDT) in order to locate an Approved Mental Health Professional (AMHP) to carry out the assessment. At **02:00**, having tried without success to contact the AMHP, MHTC phoned one of the Drs who was working with the AMHP on another assessment. The Dr initially responded that they would not be able

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<sup>3</sup> Note: There was some variation between each agency's recording of times when events occurred. Where variation occurs, the times used are taken from the police report as this was automatically recorded on the police computer whereas times provided by LCC were approximate and not recorded contemporaneously

<sup>4</sup> For ease the Mental Health Act 1983 (as amended 2007) will subsequently be referred to as MHAct

to attend and advised the MHTC they may need to defer the assessment to day-time. The Dr suggested the police could take Bert outside so that they could use their powers under sec 136 of the MHAct.<sup>5</sup> Police declined to do so as it was contrary to the Code of Practice and an abuse of the law.

- 6.9 At **02:00**, the MHTC shift had ended. The MHTC requested that the police officers remain with Bert until the AMHP and two Drs arrived and then leave. The MHTC nurse continued to try and make contact with the AMHP to hand-over information about Bert. After eighteen calls and emails, direct contact was made at **03:30**.
- 6.10. At approximately **04:50**, the AMHP and two Drs arrived at Bert's house. The AMHP and Drs requested the police officers remain as Bert appeared agitated. However, police decided it was not necessary for them to remain. The officers left the property at **04:52**. The AMHP recalls the police informed them that they would wait in their vehicle outside. However, the police dispute that they made this statement.
- 6.11. Bert subsequently became agitated, due to his delusional belief that the IRA would harm the officers. He locked his front door with the AMHP and Drs inside his house.
- 6.12. By **05:00** the Drs and the AMHP had completed their assessment. The Drs and AMHP agreed an admission was required. One of the Drs phoned LPT to try to secure a bed but was informed no bed was available. While making the phone call, Bert tried to grab the phone from the Dr, scratching his hand in the process.
- 6.13. Meanwhile, the AMHP phoned the police to inform them that Bert had locked them in and was preventing them leaving the house. The police officers were no longer outside the property. The police call taker informed the AMHP they would contact the officers and ask them to return. When the officers were contacted by the police call taker, they advised that Bert was of no threat and that the rear door was accessible as the key was in the door. The officer agreed to phone the AMHP back
- 6.14. Before the officer could ring back, at **05:12**, one of the Drs phoned the Police. The police officer's recall of this call was that the Dr reported '*false imprisonment*' and requesting police return '*so that they could leave the male as there was no bed available for him.*' Police declined to return. The police also recalled the Dr stating they would phone 999 to report being attacked. The officer briefed the control room Inspector.
- 6.15. At **05:49**, the AMHP and Drs team left Bert's house having located the key to his back door. Once outside Bert's house, the Drs completed a joint recommendation for admission to hospital under section 2 of the Mental Health Act. The AMHP was not able to complete the necessary documents to authorise detention as there was no bed identified.<sup>6</sup>

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<sup>5</sup> Section 136 of the Mental Health Act provides power to the police to remove a person from a *public place* to a place of safety if the officer considers the person is suffering from mental disorder and is in immediate need of care and control

<sup>6</sup> Detention under section 2 MHAct must be founded on 2 written medical recommendation – legal forms. Where the AMHP has decided criteria are met, they make an 'application' which results in the person being liable to be detained. However, the application must identify a specific hospital and AMHP can only write the application if a bed at that hospital has been identified.



- 6.16. The AMHP and Drs phoned the police to inform that they had left Bert's house. The police tapes of this call were that the AMHP and Drs felt at this stage that Bert posed a risk to others but would not harm himself. The AMHP's intention was to request the day time AMHP service to obtain a warrant to gain admission to Bert's house and, if necessary, to take him to a place of safety.<sup>7</sup>
- 6.17. The AMHP and Dr contacted their respective managers to inform of the incident. The Dr also informed the on-call nurse (bed coordinator) that the AMHP was planning to apply for a warrant during the day and that it may be a new assessment. This resulted in the on-call nurse putting a hold on sourcing a bed.
- 6.18. At **08:00** the AMHP liaised with the AMHP Head of Service to request the day service attend Magistrates Court to apply for a warrant under s135(1) of the Mental Health Act. The AMHP did not inform the day service that a valid joint medical recommendation was in place. The day service AMHP began the process of applying for a warrant and setting up a new assessment.
- 6.19. Later that morning, at **10:12**, Bert phoned the police to report that a violent incident was occurring outside his house. He kept on repeating a code word. The police control room contacted the MHTC and spoke with the nurse who had been with Bert the previous night. MHTC advised that the police should not attend as this was part of Bert's mental health issues and a warrant was being obtained to manage the situation.
- 6.20. At **10:51** an AMHP from the day-time service rang police to say a section 135 warrant had been granted. Arrangements were made for officers to attend Bert's house to use the warrant at **12:30** and for them to liaise with the MHTC.
- 6.21. At **11:07** police received a report that there had been a vehicle road traffic collision and an elderly male was trapped. On arrival at the scene, Bert had been trapped in a six-car collision. The air ambulance attended the scene but despite their best efforts, Bert died at the scene. May he rest in peace.
- 6.22. At **11:57** the LPT bed co-ordinator completed a referral for a hospital admission. The form stated that Bert was not safe at home and that he was a potential risk to others. It recorded that there were no 'functional beds' available.

## 7. Context

- 7.1. The events surrounding this sad incident related to the assessment of Bert's mental health.
- 7.2. From the information available, it appeared Bert was experiencing an acute episode of mental illness. This required further assessment in order to meet his mental health needs but also to secure his own safety and potentially the protection of other people due to the nature of his mental health needs at that time.

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<sup>7</sup> This is under section 135(1) MHAAct – described further in section 7

- 7.3. The majority of people with mental health needs are supported within their community by their family, friends and carers, primary care, specialist mental health services, social care and voluntary sector services.
- 7.4. The national demands on mental health services are well documented. In 2014, the Government introduced a concordat for all local services to work together to provide high quality services for people with mental health problems in urgent need of help.<sup>8</sup> Each area is required to have a Crisis Care Concordat. The Crisis Care Concordat Mental Health for Leicester Leicestershire and Rutland 2014, has a declaration statement.

*'We, as partner organisations in Leicester, Leicestershire and Rutland, will work together to put in place the principles of the national Concordat to improve the system of care and support so that all people in crisis because of a mental health condition, whatever their age, gender, sexual orientation, marital status, ethnicity, disability or race are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.'*

**The Crisis Care Concordat Mental Health for Leicester Leicestershire and Rutland Declaration statement 2014**

- 7.5. Leicester Leicestershire and Rutland have a range of services available to support people during periods of mental health crisis. These include (but are not limited to):

**Leicestershire Partnership NHS Trust (LPT)**

Crisis Team whose focus is to meet the needs of people experiencing an acute mental health crisis. The service operates 24 hours, 365 days of the year

Acute care inpatient provision – wards are defined for specific needs including separate provision for older adults with 'organic' conditions such as dementia and with 'functional' illness such as depression and psychotic illnesses. Availability of beds is coordinated through a bed manager.

Psychiatrists who, in addition to their day-to day clinical duties, provide on-call response to assess people under the MHAAct. This is referred to as 'section 12 approved.'

**Leicestershire Partnership Trust and Leicestershire Police:**

The Leicestershire Mental Health Triage Car (MHTC) is crewed by full time police officers with training in mental health and learning disability and senior Mental Health Nurses from the Leicestershire Crisis Team. The objective of the MHTC is to ensure that the most appropriate service is provided to the people in the community who may be experiencing difficulties or distress in connection with their mental health and/or learning disability.

MHTC operates between 1000-0200hrs every day of the week including bank holidays.

**Leicestershire Police**

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<sup>8</sup> HM Government (2015), *Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis 2014*, Available from: [https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353\\_Mental\\_Health\\_Crisis\\_accessible.pdf](https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf) [Accessed: June 2018]

Leicestershire Police have specific responsibilities defined under the MHAct Code of Practice including where a person may need to be taken to a place of safety, or where, in specific circumstances, police assistance may be needed to convey a person who has been detained under the MHAct to hospital.

### **Leicester City Council (LCC)**

Approved Mental Health Professionals (AMHPs) are a professional group of social workers and other qualified mental health professionals, trained to coordinate Mental Health Act Assessments with psychiatrists and other doctors, and make independent professional decisions about whether a detention in Hospital under the Mental Health Act is necessary. LCC has a statutory obligation to have sufficient AMHPs to provide a 24/7 service.

- 7.6. The Clinical Commissioning Group is responsible for ensuring there is sufficient beds available to meet the needs of the population and that there are sufficient section 12 approved Doctors. The Mental Health Act of Code of Practice states:  
*15.9 It is the responsibility of clinical commissioning groups (and the NHS Commissioning Board) to ensure that doctors are available in a timely manner to examine patients under the Act when requested to do so by AMHPs and in other cases where such an examination is necessary*  
East Leicestershire and Rutland CCG (ELRCCG) holds this delegated responsibility on behalf of the three CCGs covering Leicester, Leicestershire and Rutland.
- 7.7. Leicester Leicestershire and Rutland had a Crisis Care Concordat action plan designed to strengthen service provision and joint working for people in mental health crisis. Aspects of this plan are relevant to this review.<sup>9</sup> This work has subsequently been subsumed under the new structure of the Sustaining Transformation Partnership<sup>10</sup> – Mental Health workstream.
- 7.8. For some people, their mental health needs may require a period of inpatient assessment and treatment. For some people, the nature of their mental health need may mean they are not able or not willing to accept that they need care and treatment.
- 7.9. The MHAct is legislation that authorises compulsory detention. In relation to this SAR, the consideration was whether Bert needed to be detained under section 2, which authorises compulsory admission for assessment (followed by treatment) for a period of up to 28 days.
- 7.10. The MHAct also makes provision (where specific criteria are met) to apply to a magistrate for a warrant where necessary, to gain admission to a person's property in order to carry out an assessment. This is a warrant under section 135 (1) of the Act.
- 7.11. The MHAct requires assessments to be carried out by two Drs and an AMHP. The Drs may make a recommendation for detention and the AMHP decides whether to make an application (completion of the legal form).

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<sup>9</sup> Leicester, Leicestershire and Rutland (LLR) (2016), *LLR action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat*, Available from: <https://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/01/LLR-CCC-Action-Plan-7.1.15.pdf> [Accessed: June 2018]

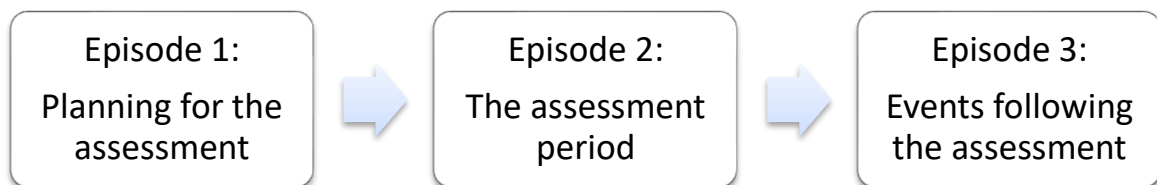
<sup>10</sup> NHS England (2018), *Sustainability and Transformation Partnership*, Available from: <https://www.england.nhs.uk/integratedcare/> [Accessed 5/7/18]

- 7.12. In order for the AMHP to be able to complete their application, a bed must have been identified as the AMHP must provide a named hospital on the application form. Where an application is made, this authorises the AMHP to convey the person to hospital, usually by ambulance and if necessary, assisted by police. If the person refuses entry to their house, professionals may apply for a warrant under section 135(2) to gain entry and then convey the person to hospital. Both section 135(1) and 135(2) are relevant to this review.
- 7.13. The Code of Practice<sup>11</sup> to the MHAct details guidance for those involved in assessing and conveying patients and is referenced throughout this report. The Code of Practice also describes the factors that should be taken into account during an assessment,<sup>12</sup> and requires adherence to guiding principles:



## 8. Analysis

This section provides an analysis of the events. The analysis is set out in three key episodes:



Section 9 then summarises the themes and learning arising from these episodes.

### 8.1. Episode 1: Lead up to the Mental Health Act assessment

#### 8.1.1. First Response

- 8.1.2. Bert's cousin informed the review that staff at Bert's local pub were concerned about him and had tried to contact services – through 111 and then a mental health charity. This was positive action taken by staff but unfortunate that as they had no other details about Bert, it was not possible for onward referrals to be made.
- 8.1.3. It is possible that, had mental health services been alerted to Bert's declining mental health at this earlier stage, intervention may have led to a different outcome for him. However, this is largely conjecture.

<sup>11</sup> Department of Health, (2015) *Mental Health Act 1983: Code of Practice*

<sup>12</sup> Department of Health Mental Health Act 1983: Code of Practice (2015) Chapter 14

- 8.1.4. The review did consider how accessible mental health services are to members of the public. Typically, the route is through the person's GP or through emergency services such as hospital Emergency Department or police.
- 8.1.5. Those attending the learning event acknowledged that navigating through the system may be difficult for members of the public – particularly if the person's GP is not known. The review was informed that LPT is currently going through a transformation and within this, are considering a single point of contact and self-referral. This would not have made a difference in Bert's situation, in the absence of any other information about him such as his address or GP. However it may well enable easier access and early intervention for others. The learning from this review should be used to inform this transformation work.  
**[Learning Theme 1: Recommendation 2]**
- 8.1.6. The review highlighted as good practice, the speed of the response by the police, attending Bert's neighbours house within thirteen minutes of the call.
- 8.1.7. Practitioners at the learning event discussed whether police had considered their powers under section 136<sup>13</sup> when Bert was moving between the neighbours house and his home so that he could have been taken to a place of safety. The police reviewers had viewed the body worn video from the officers and felt the situation was not clear at this stage and it was appropriate for the officers to go with Bert to check his house and then to call the MHTC to assess the situation more fully.
- 8.1.8. Those officers took a pivotal role during this first episode – staying with Bert for a total of over four hours; throughout the assessment by MHTC and then on their own for three hours while awaiting the arrival of the MHAct team. The officers remained with Bert due to welfare concerns for him.
- 8.1.9. The footage from the officers' body worn video demonstrated that they had built a good rapport with Bert and responded respectfully to him. They had been able to distract and redirect him when he was agitated. The officers were commended for their sensitive and skilled response.
- 8.1.10. The MHTC was also noted to have been responsive; both in the speed of attendance and the way the MHTC staff tried to engage Bert in an assessment. The MHTC nurse made efforts to encourage Bert to be admitted to hospital as an informal (voluntary) patient. This was appropriate in trying to involve Bert in his care in a way which was the least restrictive of his rights and freedoms. It is notable that when the MHTC nurse began to talk to Bert about his mental health needs and raised the prospect of admission, Bert became more agitated and asked the nurse to leave which the nurse respected.
- 8.1.11. The MHTC shift ended at 02:00hrs. However the MHTC confirmed that this did not influence their decision to hand-over to the police after their assessment.

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<sup>13</sup> Section 136 of the MHAct provides authority to the police to take a **person found in a public place**, who they believe to be suffering from a mental disorder and to be in immediate need of care and control to a place of safety in order to receive a mental health assessment (and then any necessary arrangements for their care)

### 8.1.12. Planning a bed for a potential admission

- 8.1.13. The Code of Practice<sup>14</sup> references the need for effective systems of bed management, communication and demand planning. It also requires liaison between the bed manager, assessing Drs and AMHPs to secure a bed.
- 8.1.14. The MHTC appropriately liaised with the on-call consultant psychiatrist to agree a MHAct assessment was needed. Those attending the learning event agreed it was at this stage that there needed to be a clear plan in place to confirm the latest accurate bed state. This gave the best chance of sourcing a bed at the earliest opportunity, giving time to be flexible and creative if there were limited options or no local bed available.
- 8.1.15. The view from a LPT representative at the learning event was that a bed is always available somewhere. Nonetheless, the message that was conveyed on that night to the on-call Dr and AMHP was that there was no bed. However, from subsequent enquiries, it appears a bed may have been available.
- 8.1.16. Information from the LPT report and the review learning event, highlighted significant gaps in the LPT bed management system at that time:
- 8.1.17. I. It was not consistent practice to initiate a bed status check at this first point i.e. when the MHTC first identified an admission may be required.
- 8.1.18. II. LPT had no out of hours bed manager. This meant the bed status was last updated at 17:00 on the Friday – this was 58 hrs earlier. The bed state could not therefore be assured as accurate. To get an accurate update, it was necessary for on-call staff to contact all relevant clinical areas for an update. There is no record of this occurring.
- 8.1.19. III. The electronic bed status record made on that Friday at 17:00hrs, indicated beds in Mental Health Services for Older People (MHSOP) *were* available. However, the format of the handover document was not clear and it could be interpreted that there was only a 'leave' bed i.e. someone who was inpatient but temporarily staying elsewhere, and that this was already on hold for another patient. There was ambiguity about whether any beds were in fact available.
- 8.1.20. IV. The roles and responsibilities to source beds out of hours were not clear. The bed manager on that Friday afternoon, had applied the LPT single operating procedure 'Escalation Process When Experiencing Capacity Issues.' As there were fewer than two beds available, the bed manager had notified the on-call manager and identified availability and contact numbers for out of area beds.
- 8.1.21. A LPT service manager confirmed it is the role of the out of hours on-call nurse to pursue out of area beds and for them to seek assistance if necessary. However this responsibility is not stated in the procedure. Accessing out of area beds requires approval at Director level. The Director was not contacted for approval. Securing an out

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<sup>14</sup> Code of Practice to the Mental Health Act Ch 14.89

of area bed is likely to be a lengthy process and difficult to achieve in the middle of the night.

- 8.1.22. V. There were barriers to having a whole system view of all beds available. Bert was new to the service and only in his mid-sixties. It may not have been necessary therefore to limit the bed option to the Older Adults wards. LPT confirmed they can if necessary use beds flexibly. However, the system at this time was that there was a separate bed manager for 'adults of working age' and then another bed manager covering older adults, learning disability and prison health. This limited the ability to look creatively and flexibly at options across the whole of the available bed stock.
- 8.1.23. LPT has subsequently revised their bed management structures and processes, moving to one system to manage all beds with a more senior manager managing this on-call. On-call workers now receive an updated bed state report every 24 hours, including over the weekend. The LPT report author has also made recommendations for LPT regarding the bed state report formatting and the out of hours co-ordination of MHSOP beds (appendix 2)
- 8.1.24. The review considered how data on bed availability had been used by ELRCCG in strategic planning for mental health services. As outlined in section 7, this is a duty under section 140 of the Mental Health Act and detailed in 14.78 of the Code of Practice.
- 8.1.25. ELRCCG confirmed these responsibilities had been delegated to LPT. ELRCCG is now receiving more detailed data regarding bed availability and delays in admission. This is informing their strategic planning through the Sustainability and Transformation Partnership – Mental Health. However, the quality of this planning is dependent upon receiving a full and accurate picture from all parties. LCC do have a reporting mechanism for delays in accessing beds, there is a question on the AMHP assessment. In this situation it didn't get answered as the assessment wasn't completed by the AMHP.
- 8.1.26. The findings from this review should be used by LPT and the ELRCCG to inform the development of the bed management policy, including ensuring there is a clear escalation policy where there is no bed availability. There is a need to evaluate the improved process and report data into the planning for acute inpatient provision.  
**[Learning Theme 1: Recommendation 2 and 3]**
- 8.1.27. **Convening a Mental Health Act Assessment**
- 8.1.28. There were significant problems in accessing the AMHP and in the timeliness of convening the MHAAct assessment. Between 01:00hrs to 08:00hrs, there is one AMHP and two on-call Drs covering MHAAct assessments in Leicester, Leicestershire and Rutland. This is a population of over 1 million. This time of night is also when the MHTC crisis service is not available.
- 8.1.29. This limited resource and the difficulty in contacting the AMHP had a significant knock on impact for the other agencies:
- I. for the MHTC nurse who worked hours beyond their shift, showing tenacity in trying to contact the AMHP to provide effective hand-over – the nurse is commended for this.

- II. for the two police officers who were waiting a further three hours with Bert once the MHTC had left. This had a significant impact on availability to respond to police operations.
- 8.1.30. For Bert, this meant over a period of nearly five hours, he had a total of seven strangers in his home and delays in response to his mental health crisis.
- 8.1.31. Agencies were all aware of how to contact the LCC Emergency Duty Team which was the access point for the out of hours AMHP. The problem was that there was no response from this number as at that time of night, the contact point was redirected to the AMHP's mobile. The AMHP's mobile was switched off for over 2 hours as they were already engaged in another assessment and therefore could not be disturbed.
- 8.1.32. This highlighted a number of concerns:
- I. LCC did not have resilient processes in place as a single point of contact to access out of hours AMHP
  - II. There was no robust system for others to know where the AMHP was, what other assessments may be pending, likely times of availability and how any competing work was being prioritised by the AMHP.
  - III. Concerns about lone working and safety of the AMHP in this role
  - IV. Resources: One AMHP on duty from 01:00hrs to 08:00hrs covering a population of approximately one million.
- 8.1.33. A recent publication<sup>15</sup> by Association of Directors of Adult Social Services makes various recommendations regarding the capacity of the AMHP

***An inner-city area of 250k population should have 33 full time equivalent daytime AMHPs, a shire county with a population of 1.1million would need 100 full time equivalent AMHPs.'***

ADASS 2018

- 8.1.34. It is notable that Leicester, with a population of 342,627,<sup>16</sup> has 23.1 full time equivalent AMHPS, (plus a locum AMHP for EDT) and includes covering the Leicester, Leicestershire and Rutland out of hours AMHP provision. This provision is supplemented by five Team Leaders who are available to cover in emergencies and carry out minimum assessments to retain their authorisation.
- 8.1.35. The provision of AMHPs was one area of action from the Leicester Leicestershire and Rutland crisis care concordat action plan in 2016:<sup>17</sup>

***'Crisis Care in the Community -***

*Work is undertaken to scope out the challenges and propose and agree the changes required.*

*Outcome:*

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<sup>15</sup> ADASS (2018), Top Tips for Directors on Approved Mental Health Professional (AMHP) Practice and Data , Available from: <https://www.adass.org.uk/top-tips-for-directors-on-approved-mental-health-professional-amhp-practice-and-data>[Accessed July 2018]

<sup>16</sup>2015 figures sourced from ONS mid-2015 population estimates

<sup>17</sup> Crisis Care Concordat Leicester, Leicestershire and Rutland (2016)



*There is provision of dedicated Approved Mental Health Professionals (AMHPs) that is sufficient to meet the needs of the population across LLR, especially in out of hour's periods.*

*There will be no circumstances under which mental health professionals will not carry out assessments because beds are unavailable.*

*Timescale for Completion 2015*

#### **Crisis Care Concordat Action Plan - 2016**

- 8.1.36. LCC had identified a need to review out of hours AMHP provision and has included actions to address these concerns within their report (appendix 2).  
**[Learning Theme 1: Recommendation 1]**
- 8.1.37. However, even had an AMHP been available, the AMHP would not have been able to carry out the assessment without the two on-call Drs who were also already engaged in the other assessment.
- 8.1.38. It is noted that when the MHTC eventually was able to speak with one of the on-call Drs, the Drs initial response was that the assessment would need to wait until the day-time as they were already involved in another assessment. The Dr's suggestion was for the police to take Bert out of his house so that they could then use their police powers under section 136 (being then in a public place). This is wholly unethical and contrary to the Code of Practice<sup>18</sup> and is an area to address in Drs training. Police declined to act on the Drs' suggestion.  
**[Learning Theme 3: Recommendation 11]**
- 8.1.39. At the learning event, LPT practitioners noted that it has become custom and practice for both out of hours on-call Drs to be section 12 approved Drs provided by LPT. However, the legal requirement is for one section 12 approved Dr. The other Dr can be a GP, providing expertise from a Dr who knows the patient.<sup>19</sup> In Leicester, Leicestershire and Rutland the Out of Hours GPs do not provide this role in MHAct assessments. If GPs were available, this would give provision for the two LPT on-call section 12 Drs to double their availability to cover assessments during times of pressure. However, ELR CCG informed the review that it was not feasible to use Out of Hours GPs at this time.  
**[Learning Theme 1: Recommendation 4]**
- 8.1.40. The pressure on all agencies' resources in these times of significant financial constraints is substantial. The ADASS publication<sup>20</sup> notes a 47% increase in the numbers of MHAct detentions in the last 10 years. Due to the partnership working required at point of admission, these pressures will have impacted on Health, Police and Social Care.

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<sup>18</sup> Department of Health Mental Health Act 1983: Code of Practice (2015) Ch 16.18

<sup>19</sup> The Mental Health Act (section12) sets out the requirements for two Doctors carrying out mental health act assessments. One must have special experience in 'diagnosis and treatment of mental disorder' this is typically a psychiatrist from the mental health Trust. The Code of Practice (14.73 – 14.74) states one Dr must have previous acquaintance of the patient – it is sufficient for this to be previous knowledge and could include accessing patient records. If the Doctor does not know the patient, it is preferable they are approved under section 12

<sup>20</sup> ADASS (2018), *ADASS Top Tips for Directors on Approved Mental Health Professional (AMHP) Practice and Data*, Available from: <https://www.adass.org.uk/top-tips-for-directors-on-approved-mental-health-professional-amhp-practice-and-data> [Accessed July 2018]

- 8.1.41. Some of the challenges that are relevant in the response to Bert, are replicated across the Country. The ADASS paper<sup>21</sup> also highlights common issues of concern including:
- I. transport problems
  - II. lack of beds
  - III. rising numbers of assessments
  - IV. lack of police resources.
- 8.1.42. The paper flags the importance of monitoring these issues and developing a whole system's response with collaborative working between the partners. The paper also recommends that safeguarding processes should be used to record concerns and be monitored at a strategic level. The findings from this review support this approach.  
**[Learning Theme 2: Recommendation 7, 8 and 9]**
- 8.1.43. The ELRCCG representative at the learning event confirmed that they are already engaged with partners through the Sustaining Transformation Partnership in developing these long term solutions. However there is also a need to develop more immediate operational solutions to the provision of crisis care during the whole of the out of hours period i.e. sufficient AMHPs and on call Drs and protocols to access crisis care in the event of no bed availability  
**[Learning Theme 2: Recommendation 8]**
- 8.1.44. The review author observed that there is a general lack of joint policies supporting the partnership work. This was also noted by the Chief Inspector, Mental Health Coordinator for the College of Policing, who attended the review. The author questioned to what extent there was a system-wide approach to policies and strategies, for example, whether policy or resource decisions taken by one partner agency, was adequately taking account of the knock on effect for other agencies.
- 8.1.45. It was noted that a review of all joint policies, procedures, protocols and guidelines was planned by March 2016 as part of the Crisis Care Concordat work.<sup>22</sup> The objective was to support effective partnership working.
- 8.1.46. The ELRCCG representative confirmed they had found practical barriers to keeping joint policies updated and signed off by all agencies. However, there was acceptance that partners need to be consulted and involved in the drafting stages of single agency's policies and strategies, where the proposed change is likely to impact upon them as partners in crisis care.  
**[Learning Theme 1: Recommendation 5]**

## 8.2. Episode 2: During the Mental Health Act Assessment

### 8.2.1. Decisions Surrounding Police Continued Involvement

- 8.2.2. There was considerable debate and different perspectives surrounding decisions about the police involvement throughout the MHAct assessment.

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<sup>21</sup> Ibid

<sup>22</sup> Crisis Care Concordat Leicester, Leicestershire and Rutland (2016)

- 8.2.3. The review explored whether due consideration was taken of the legal authority for the officers to remain in Bert's property.<sup>23</sup> It was confirmed that Bert was accepting of the officers being in his house and was more concerned about their safety if they left (due to his delusions).
- 8.2.4. Six points of decision making in relation to police involvement are summarised below:  
**Police Decisions:**  
**Decision 1:** Police first attendance and remaining with Bert while awaiting the AMHP and Drs  
 Episode 1: considered in 8.1 above  
  
**Decision 2:** Police remaining when the AMHP and Drs first attended  
**Decision 3:** Police returning in response to AMHP and Dr's request  
**Decision 4:** Police response when AMHP and Dr left Bert's property  
 Episode 2  
  
**Decision 5:** Police response to a call from Bert at 10:12hrs the following morning  
**Decision 6:** Police involvement in the execution of the section 135(1) warrant  
 Episode 3: considered in 8.3. below
- 8.2.5.       • **Decision 2: Police remaining when the AMHP and Drs first attended**  
 At point of the AMHP and Drs arriving, a number of different factors and tensions were in play that affected decisions about the police remaining.
- 8.2.6. On one hand from the police perspective:
- The officers had been at Bert's house for nearly five hours.
  - The officers were advised by the MHTC nurse to leave Bert once the MHAct team arrived. The police representatives at the learning event were clear that officers would put weight on that clinical opinion but would have made an independent decision.
  - The officers had felt it necessary to stay in order to mitigate the risk of Bert coming to some harm. The officers would not have been able to predict what form the harm could potentially take. However, they assessed generally that he was in mental health crisis and as such may engage in erratic behaviour which could bring him into harm's way, needed care and control and that mental health services (AMHP and Drs) were the correct people to take ownership of the situation.
- 8.2.7. On the other hand, the perspective from the AMHP and Drs was:
- Police officers had established a rapport with Bert and could aid his engagement with the AMHP and Drs in their role of carrying out an assessment.
  - Bert was unknown – he was agitated and unpredictable. The AMHP and Drs were skilled and knowledgeable in assessing risk with people with a mental disorder. Bert was clearly responding to delusions that may give rise to risks to others due to his belief he needed to protect himself – a flight or fight response. These risks would likely be amplified when questioned about his beliefs and suggesting hospital admission (as demonstrated with the MHTC nurse).

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<sup>23</sup> There is no automatic authority to enter or remain in a person's home. Had Bert objected to police or mental health professionals being on his property, they would have had to leave and applied to the magistrate's court for a warrant to gain admission.

- The ability to use restraint within a person’s own home is significantly limited – both in relation to the safe use of restraint (for the person and the professionals) and the lawful use of restraint.<sup>24</sup> (It should be noted that the police also had no legal powers at all to use restraint, unless Bert attempted to commit an offence).
- 8.2.8. The officers left Bert’s house. The LCC report refers to the police officers saying they would talk to their sergeant and would wait outside Bert’s house in their vehicle. This had given the AMHP some sense of security. However, it transpired that the police did not in fact remain. (It should be noted that the police officer strongly disputes having made this statement.)
- 8.2.9. Bert became further agitated when the officers left, believing they were going to be killed. He locked the door. Once the Drs and AMHP had agreed Bert should be admitted under section 2, the Dr used his phone to try to arrange a bed. As Bert became more agitated and tried to snatch the phone from the Dr, the AMHP realised the police were not outside the house.
- 8.2.10.       • **Decision 3: Police returning in response to AMHP and Dr’s request**  
This instigated the phone calls between the police and the AMHP and Drs. There was much reflection at the learning event about the content of these calls and the actions that followed.
- 8.2.11. The police reviewers had replayed their tapes from these phone calls. The police view was that Bert sounded calm and the police did not view the AMHP or Drs as under threat. The main issue during this first call was that they were locked in, so contact was made with the officers who had been with Bert. When Bert’s behaviours were described to these officers, their interpretation was that Bert was presenting in the same way he had when they were at his house. The officers did not feel this necessitated their return.
- 8.2.12. From the AMHP and Drs’ perspective, they identified that being in close confines to Bert presented great difficulty in what they were able to say. The AMHP had been trying to remain calm to avoid further escalation in his disturbed behaviour and this may have given a false impression to the police.
- 8.2.13. During a second phone call, the Dr tried to describe what was happening in the house i.e. being locked in and Bert having scratched his hand when trying to grab the phone. When the Dr relayed this to the police, they used phrases including ‘*false imprisonment*’ and ‘*assault*’. The officers felt this was misleading and exaggerated.
- 8.2.14. Within this phone call the Doctor also requested the police to return ‘*so they could leave as there was no bed available.*’ This was not appropriate for police to fulfil this role and further undermined the rationale for their involvement. Given the belief that no beds were available, the request would also have had the effect of tying up two officers for an undetermined amount of time and with no legal authority to be there.

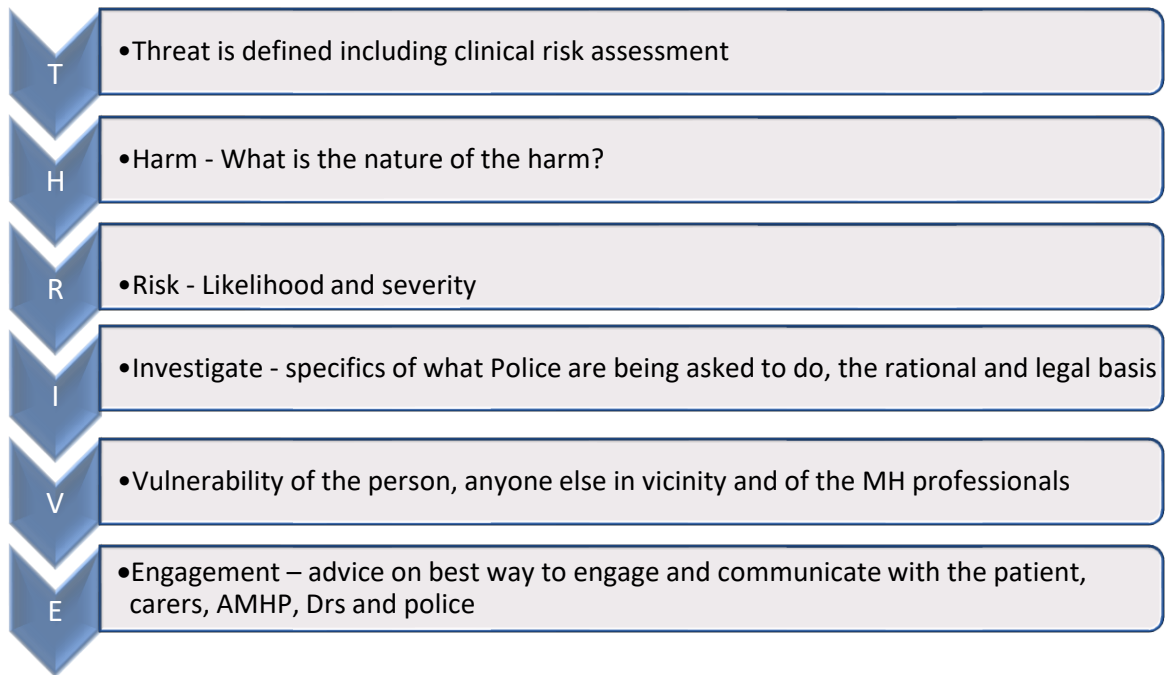
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<sup>24</sup> NICE (2015), *Violence and aggression: short-term management in mental health, health and community settings*, Available from: <https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-1837264712389> [Accessed July 2018]

- 8.2.15. From the AMHP and Drs perspective, they were feeling threatened by the situation and frustrated in their efforts to seek police assistance. Their view was that police were not listening to or respecting their judgement. The Dr's language was a way of trying to communicate and escalate the seriousness of their situation. In their view, Bert's presentation had changed by two trigger factors:
- the officers leaving Bert's house had raised his distress believing they were in danger
  - the MHAct assessment necessitated questioning Bert's thinking and raising the prospect of compulsory detention – all highly contentious areas for Bert and likely to increase his instinct for self-protection and risks associated with this. The AMHP and Drs were not in the position of being able to calm and divert Bert as the officers had done.
- 8.2.16. The AMHP and Drs felt these circumstances were not being taken into account.
- 8.2.17. The review noted that one of the actions from the Crisis Care Concordat action plan related to involving police in mental health crisis care.
- 'Crisis Care in the Community –***  
*'There will be a clear signed local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting and the approach to be taken when a police officer uses powers under the Mental Health Act to ensure prompt, efficient, organised and respectful partnership working under the Mental Health Act.'*
- Crisis Care Concordat Action Plan - 2016**
- 8.2.18. Learning from this review indicates there remains work to be done. Those at the learning event acknowledged that perhaps inevitably there may be different opinions about when it is appropriate to seek police assistance during assessments.<sup>25</sup>
- 8.2.19. LCC has also identified the need to introduce training for AMHPs on de-escalation techniques – this is now part of their training programme and is part of their own recommendations (appendix 2).
- 8.2.20. There was learning about the quality of communication between the parties involved:
- i) The need for police officers to clearly communicate they were leaving the site
  - ii) For AMHP and Drs to note police incident reference numbers in communications
  - iii) Inter-disciplinary communication: recognition that descriptions of behaviour have different meaning and connotations to police and to mental health professional e.g. 'agitation' may indicate associated risks to mental health professionals but be interpreted very differently by police
  - iv) The need for clarity when communicating specific risk factors
  - v) Clarity about what specific task is being requested of the police and that this is appropriate and lawful
- 8.2.21. At the learning event, police discussed the mnemonic police use nationally for decision making THRIVE (Threat, Harm, Risk, Investigation Vulnerability and Engagement). This mnemonic could usefully be incorporated into joint training and guidance to help develop a shared language and interpretation between partners when requesting police assistance. For example:

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<sup>25</sup> Over and above specified duties for the Police under section 135 and 136 Mental Health Act



**[Learning Theme 3: Recommendation 13]**

8.2.22. There was also discussion around the beliefs, myths, custom and practice issues that may get in the way of partnership working. Further work is needed to establish the facts surrounding use of police in all MHAct assessment for example: % of all MHAct assessments involving police; reason for police involvement; requests declined etc. This will provide an evidence base for the continued development of the joint strategic partnership.

**[Learning Theme 1: Recommendation 6]**

**8.2.23. Care Planning and Risk Management and Communication**

8.2.24. The review considered the care planning process and risk management once Bert had been assessed, including police involvement at this stage (Table 1, Decision 4: Police response when AMHP and Dr left Bert’s property).

8.2.25. While in Bert’s house, the Drs and AMHP had completed their assessments and agreed that Bert required compulsory admission to hospital. They then left Bert’s property as they felt unsafe to remain. This decision is supported by the LCC policy for AMHPs where no bed has been identified.<sup>26</sup>

8.2.26. Once outside Bert’s property, the Drs completed their joint medical recommendations. However, as outlined in section 7, in order for the AMHP to be able to complete the legal documentation that would authorise Bert’s compulsory admission, there had to be a hospital named on the section 2 application form.

8.2.27. As the Dr had been informed that no bed was available, the AMHP could not complete their legal documents and therefore there was no legal authority to convey Bert to hospital.

<sup>26</sup> Leicester City Council (not dated), Guidance to Leicester AMHPs when undertaking Mental Health Act assessments, where no bed has been identified.

- 8.2.28. The LPT report stated that even had a bed been identified at this stage, they believed this would not have made a substantive difference to the sad outcome for Bert. Their view was that as the AMHP had had to leave Bert's house, it was likely that the AMHP would still have needed to apply to the Magistrates Court for a warrant<sup>27</sup> to gain admission as Bert was likely to refuse entry to his house.
- 8.2.29. The review author does not accept this view.
- 8.2.30. The availability of bed may have made a difference. The LCC representative confirmed it is common practice for an AMHP to wait for an ambulance outside a person's property and to try and gain admission with assistance from the ambulance crew who are trained in this engagement work. The police also confirmed that if the request for their assistance was more clearly defined, i.e. to assist in conveyance of a patient liable to be detained, they would have considered this when deciding whether officers should be deployed. Their role in conveying patients is defined in the Code of Practice.<sup>28</sup> The presence of ambulance and police can help facilitate access (although there remains no right of entry without a warrant).
- 8.2.31. It is acknowledged that waiting for an ambulance can take some hours. The AMHP would have had to confirm with the ambulance service the expected wait time and consider this within their decision making. In exceptional circumstances, the police can convey a patient to hospital (though in this circumstance it is unlikely this would have applied.) The Independent Author has subsequently established that there were no particular operating pressures reported that night for the East Midlands Ambulance Service.
- 8.2.32. Had the ambulance been able to attend, there was still no guarantee of success as Bert may have refused admission to his property. However, if a warrant was then still needed, the knowledge that a bed was available would have been considered in weighing the urgency and value of applying for this warrant out of hours rather than delaying until the day-time.
- 8.2.33. What actually happened was a confused communication. The AMHP, believing there was no bed available, informed the Dr that they were intending to apply for a warrant under section 135(1) and that this may entail a new assessment (the Drs subsequently reported they did not understand why another assessment was being suggested and their recommendations were not being used). The AMHP's decision was to defer sourcing the warrant to the day-time AMHP service. The Dr shared this information with the bed manager who, it is understood, then put a hold on trying to source a bed (no records regarding requests for a bed were made by LPT until 11.53 but by this time, Bert had already left his house)
- 8.2.34. As referenced, reviews have the great value of hindsight. It is important to understand whether reasonable decisions were made on the information available rather than make judgements based on outcomes the professionals could not reasonably have predicted. However, the actions and decisions made by the AMHP surrounding the section 135(1) warrant do raise questions.

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<sup>27</sup> This warrant would be under section 135(2) of the Mental Health Act as Bert in this case, the section papers would have been completed and Bert would be 'liable' to be detained.

<sup>28</sup> Department of Health Mental Health Act 1983: Code of Practice (2015) Chapter 16 and 17

- 8.2.35. The records indicate the assessment had been completed. The AMHP has up to 14 days to complete their application after the assessment, i.e. to sign the legal document. The out of hours AMHP could therefore have completed the section 2 application once a bed had been found. Whether this was practicable, given the AMHP had been on duty all night, needs to be taken into account.
- 8.2.36. The purpose of the Section 135(1) warrant is to enter a person's property and if necessary remove the person to a place of safety with a view to making an application (i.e. detaining the person) or making other arrangements for their care. It is for use where it is believed the person is suffering from mental disorder but has not yet reliably been shown to be so.<sup>29</sup>
- 8.2.37. Applying for a section 135(1) warrant for an assessment that had already been concluded, was questionable. However it is recognised as a pragmatic approach and perhaps the best solution under the difficult circumstances. The warrant gave authority to take Bert to a place of safety, such as the hospital. This was a means of managing his care and containing risk while awaiting a bed. At that time, Bert could have been held in a place of safety for up to 72 hours.<sup>30</sup>
- 8.2.38. The expected practice was for the AMHP to weigh the options and risks. The AMHP must consider all circumstances and the requirements of the MHAct, the Code of Practice and overarching Human Rights including Article 2 (right to life associated with risk to Bert and others) and Article 5 (right to liberty).
- 8.2.39. The LCC report raised that an influencing factor was potential difficulties in obtaining a warrant out of hours. Applying for a warrant would need to go through the duty Clerk to the Courts. The LCC report author believed there was a widely held perception amongst AMHP's that they may be criticised for seeking a warrant out of hours in all but the greatest emergency. It is noted that the Deputy Justice's Clerk was not clear what this perception was based upon and was clear that although wherever possible, the Court would wish applications to be made in office hours, they operate an out of hours service as it is recognised that applications (such as in the case of Bert's circumstance) will need to have the facility to be made out of hours.
- 8.2.40. Although AMHPs act independently, they should have access to supervisory support as a consultation point. The AMHP's manager within the EDT was not themselves a qualified AMHP and had limited knowledge of the law or role of the AMHP. They were not therefore in a position to help the AMHP think through the pros and cons of delaying sourcing a warrant.
- 8.2.41. Had the EDT manager been a qualified AMHP, they may also have been able to provide support in applying for the warrant themselves, including managing any potential challenge from the Magistrate's Clerk. Given the pressures on the AMHP that night and the 'human factor' that a long and stressful night could have on decision making, it was reasonable to expect a greater degree of support from a manager. LCC has committed to providing briefings for EDT managers to enable them to provide a greater degree of support.

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<sup>29</sup> Referenced in Jones, R, (2016) *Mental Health Act Manual*, 19<sup>th</sup> Edn, London: Sweet & Maxwell, Ref 1-1329

<sup>30</sup> The law has changed and from December 2017, has reduced the time a person can be held in a place of safety to 24 hours.



LCC has made recommendations regarding support available to out of hours AMHPs and training for their managers (appendix 2). LCC should also work with Magistrates and AMHPs to resolve any barriers (or perceived barriers) to obtaining warrants out of hours.

**[Learning Theme 1: Recommendation 1]**

- 8.2.42. The LCC report highlighted that the AMHP did not make any records regarding their assessment or decision making surrounding sourcing the warrant. This is a significant omission and contrary to required practice. It is a learning point for AMHPs.

**[Learning Theme 3: Recommendation 12]**

- 8.2.43. Subsequent to the incident, the AMHP informed the LCC reviewers of the factors they took into account in deciding whether to delay applying for a warrant. The AMHP considered that the content of Bert's delusions meant he was more likely to stay in his house. The AMHP also felt that Bert may be more settled if given some space from professionals.

- 8.2.44. The Drs reflections following the assessment echoed this. They felt at the time that Bert was at high risk of unintentional harm to others but was at less risk toward himself, as he was in his own home. Their belief was that Bert would remain in his home due to the delusional belief that if he or anyone left his house, they would be killed by the IRA.

- 8.2.45. Given the information known at that time, these were reasonable views. However, the description given to the police at the time was less specific - informing the police inspector that Bert presented a risk to himself or others. This further highlights the importance of accurate communication regarding risk, recognising that the description of risk may be interpreted differently according to professionals respective roles and training i.e. risk associated with grounds for detention under the MHAct may be different to more immediate risks requiring a police response. The police at that stage (having questioned the description of 'assault' and the Drs wishes regarding this) felt there was no reason for them to attend. This was a reasonable judgement.

- 8.2.46. The review considered what alternative care plan was considered for Bert while awaiting the warrant and a bed to be made available. LCC does provide guidance to their AMHPs regarding steps to take when an assessment has completed but no bed is available.<sup>31</sup> The guidance states:

*'In situations where there is an indefinite wait for a bed to be identified, it is acceptable to leave the premises as long as your risk assessment identifies that it is safe to do so.*

*The decision to leave the premises and formulation of an interim care plan should be made in conjunction with the assessing doctors. That means letting bed management, or the crisis team know you are leaving the premises and if required, letting the police know that a person who is liable for detention has been left at an address alone.*

*If you do this, you need to record your risk assessment and rationale for doing so in your report and notify any relevant agencies that you have done so.*

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<sup>31</sup> LCC Guidance to Leicester AMHPs when undertaking Mental Health Act assessments where no bed has been identified

*You may then return to your base where you can continue to liaise with the responsible senior member of the Trust (i.e. bed management /unit co-ordinator/crisis nurse) in order to confirm when they have confirmed a bed.*

*When liaising with the Trust member of staff we ask that you share and agree the interim care plan with them which identifies when support from Health will be offered to the service user in the interim period (if applicable). You should record these discussions and the plan you come up with on your report.'*

**Guidance to Leicester AMHPs when undertaking Mental Health Act assessments where no bed has been identified.**

- 8.2.47. As noted, the AMHP and Drs liased with the police to inform that they were leaving Bert on his own. There was also liaison between the Dr and the bed coordinator – recognising it is the Drs responsibility to secure a bed<sup>32</sup>. However this communication did not appear to directly involve the AMHP. What is now known, is that there was mis-communication and mis-interpretation about the pressing need to continue to secure a bed. This resulted in the process of sourcing a bed being put on hold.
- 8.2.48. The extent of the interim care plan appeared limited to applying for a warrant which could then be used to take Bert to a place of safety. The review considered what planning is in place to support people who need to be admitted but awaiting a bed.
- 8.2.49. At the learning event, agencies considered whether the Crisis Team could have been an option to support Bert during this interim period. The Crisis Team have a standard response time of within four hours. They may be asked to try and engage with a person as an alternative to admission. However, the person has to be willing to engage with the Crisis Team – they have no rights of access or ability to enforce engagement.
- 8.2.50. This presents the dichotomy of people who may be at greatest risk to themselves of others, having no involvement, care or treatment during the period of awaiting a bed.
- 8.2.51. In Bert's situation the review agreed that it was not practicable to involve the Crisis Team in Bert's care between 05:00 and later that morning when the warrant was planned (although there was no records that this had been considered and discounted at the time). The priority needed to be securing a bed and obtaining the warrant.
- 8.2.52. The LCC report noted that the AMHP was not familiar with the LCC guidance for no bed availability.<sup>33</sup> The AMHP had access to all LCC policy and procedures but had not brought their laptop so was unable to access them via interface. Nor did they report on the length of delay in accessing a bed. This is a further learning point for the AMHP and for LCC in the support they provide to AMHPs.

**[Learning Theme 1: Recommendation 1]**

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<sup>32</sup> Department of Health Mental Health Act 1983: Code of Practice (2015) Chapter 14.77

<sup>33</sup> LCC Guidance to Leicester AMHPs when undertaking Mental Health Act assessments where no bed has been identified

- 8.2.53. LCC and LPT have identified the need to collaborate in providing interim care to people who are awaiting admission for an acute mental health bed following a MHAct assessment. They are seeking to develop a joint policy and protocol to support this. This needs to be progressed at pace.

**[Learning Theme 2: Recommendation 8]**

### 8.3. Episode 3: Responses following the Mental Health Act Assessment

#### 8.3.1. Coordination of Services

- 8.3.2. The LCC reviewer commented positively on the responsiveness of the day-time AMHP manager – taking immediate steps to begin the process of applying for the warrant. However, the out of hours AMHP had omitted to inform this manager that there were valid medical recommendations or made clear they had completed their assessment. Consequently, the day-time service understood they had to begin a whole new assessment.<sup>34</sup> LCC identified this as a learning point and the points raised in 8.2.41 regarding managerial support are also relevant here.
- 8.3.3. The review considered the response made to Bert when he phoned the police at 10:12hrs, voicing his delusional belief that there was violence outside his house and repeating a code word. The police decided not to attend having spoken to the MHTC nurse who had been involved with Bert the previous night. (Referenced in table 1 as Decision 5).
- 8.3.4. The review confirmed that from Bert’s presentation at this time, it was reasonable to conclude that there was no actual threat from others. Nonetheless, Bert may well have been very distressed by his beliefs and there remained the continued concern about risks to his own safety and to others – as defined in the criteria for seeking to detain him in hospital.
- 8.3.5. The review considered whether there was any role that the police or MHTC could have reasonably taken at this stage.
- 8.3.6. There was no communication between the MHTC nurse and the day-time AMHP service that were setting up the warrant and assessment. Had this call from Bert been communicated, the AMHP could have considered this information, re-evaluating the risks and their planning for the assessment.
- 8.3.7. Potentially there was an opportunity for the AMHP to use Bert’s call as lever to engage with him, or potentially consider involving the Crisis Team. This may have been useful had there been a further delay in obtaining or executing the warrant.
- 8.3.8. It was not until the learning event that the LPT reviewer was made aware of this call from Bert as though his call was logged on the police IT system, Bert’s call had not been recorded within the LPT clinical record – this was a point of learning for the MHTC.

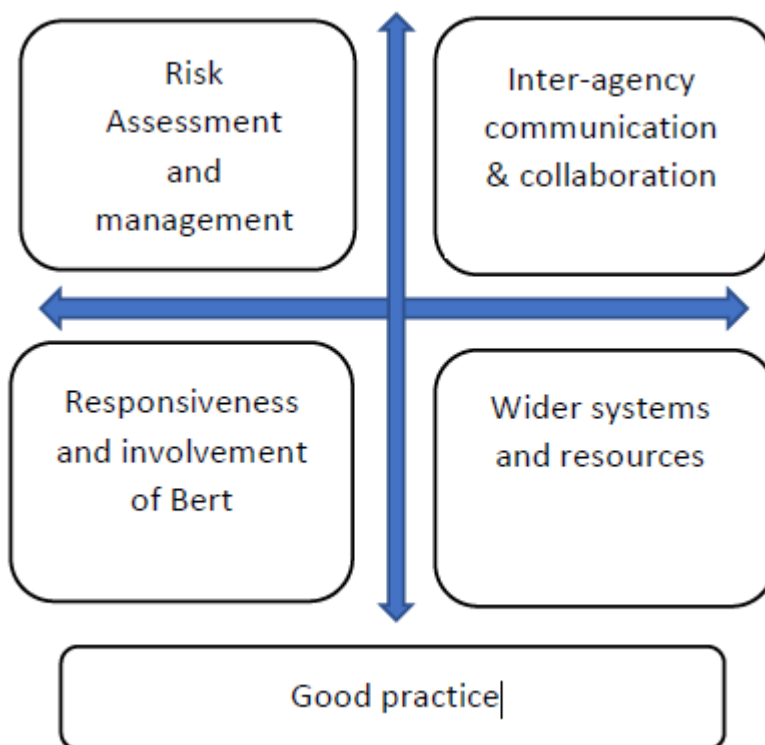
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<sup>34</sup> Note: a warrant under section 135(1) would have required an AMHP, one Doctor and a police officer to be present.

- 8.3.9. There was less than one hour between Bert making his call and then leaving his house in his car. It is unlikely therefore, that even had the MHTC contacted the AMHP, they would have been able to respond in time. There was no new information to suggest that the police should return. The presentation reinforced Bert’s mental health need that had been assessed by mental health services and a plan to obtain a warrant.
- 8.3.10. As identified in sections 8.2, further work is needed by the partnership in developing more robust and collaborative interim care plans where there is a delay in accessing beds.  
**[Learning Theme 2: Recommendation 8]**

## 9. Summary of Learning Themes

This section summarises the learning against interconnecting themes with good practice identified throughout:



### 9.1. Responsiveness and Involvement of Bert

- 9.1.1. As outlined in section 7, The Code of Practice describes the factors that should be taken into account during an assessment,<sup>35</sup> and requires adherence to guiding principles:

<sup>35</sup> Department of Health Mental Health Act 1983: Code of Practice (2015) Chapter 14

Least restriction,  
maximising  
independence

Empowerment  
and involvement

Respect and  
Dignity

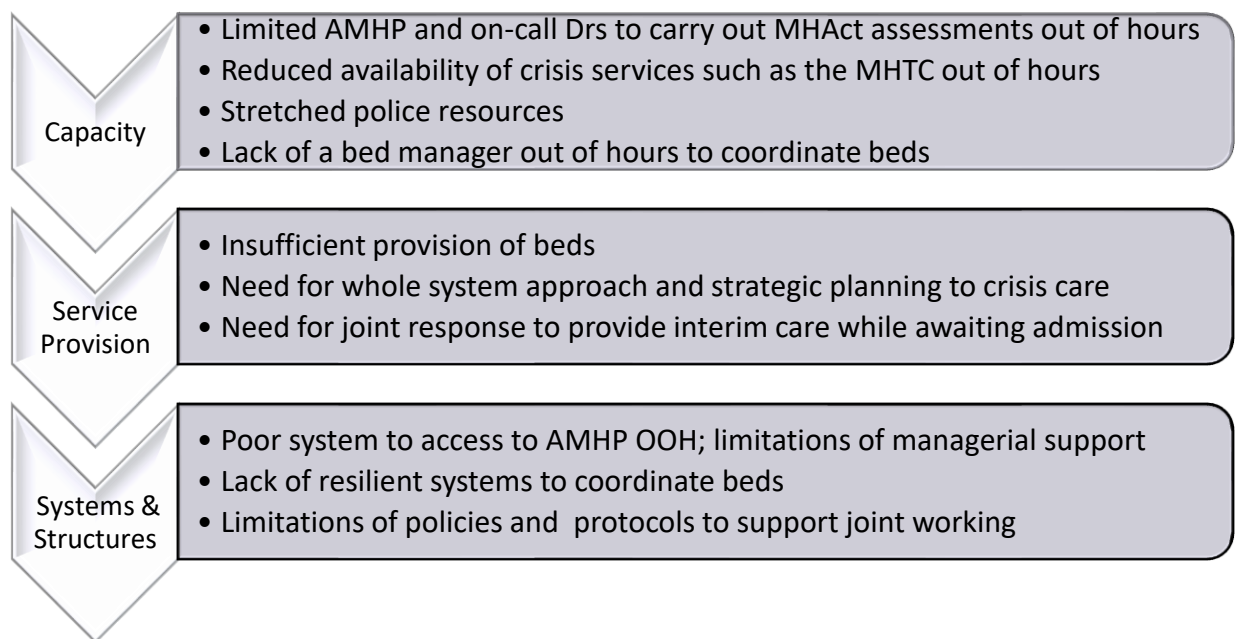
Purpose and  
Effectiveness

Efficiency and  
Equity

- 9.1.2. It is emphasised that all involved were working with Bert's welfare in mind. Involving Bert in his care remained challenging due to the nature of his mental health at that point. His thinking was consumed by his delusional beliefs and his fears for the safety of others due to these beliefs. This meant it is was difficult for the professionals to gather his views and wishes about his needs. There was also no background information available, (despite attempts to gather this by the MHTC), and no known family or friends to consult.
- 9.1.3. Within this context, there were notable actions to try and work according to the Code of Practice principles. This included:
- Police officers: responsiveness to Bert, skill in de-escalating, maintaining dignity and respect toward Bert, taking care not to use radios and phones in front of him as these frightened him.
  - MHTC, AMHP and Drs: seeking least restrictive options; trying to manage their respective assessments in a way that limited additional anxiety and distress for Bert.
- 9.1.4. A learning point was identified (section 8.1.38) in the suggestion to mis-use section 136 i.e. taking Bert outside so that police powers could be used. The Code of Practice specifically directs against this.

## 9.2. Wider Systems and Resources

- 9.2.1. The Code of Practice principles of 'Purpose and Effectiveness' and 'Efficiency and Efficacy' are relevant to considering the learning about systems and resources.
- 9.2.2. The partnership has some good systems to build on including the use of the MHTC which is a nationally respected inter-agency model that has improved response times to people in crisis and potentially averts the need for more restrictive care.
- 9.2.3. This review has identified significant learning relating to wider systems and resources



### 9.3. Inter-agency Communication and Collaboration

- 9.3.1. These deficits in the wider systems had significant impact on inter-agency working and risked undermining the good working relationships that had been built up over recent years. Professionals were trying to do their best in difficult circumstances but ‘the human factor’ of tired and stressed professionals resulted in strained relationships.
- 9.3.2. There was some notable good practice by those directly involved, for example the MHTC nurse who worked beyond their expected working hours to try and coordinate across the agencies.
- 9.3.3. There were also several crucial points of poor communication and collaboration that were substantial contributory factors:
- Mis-communication surrounding bed availability and the need to continue sourcing a bed
  - Lack of clarity in the communication between police, AMHPs and Drs regarding actual risks; roles and responsibilities in managing those risks – this became a barrier to a collaborative approach
  - Confused communication surrounding whether the Mental Health Act assessment had concluded or whether a new assessment was required
  - Limited evidence of collaboration in considering an interim care plan

### 9.4. Risk Assessment and Management

- 9.4.1. There was a shared view that night that Bert was very unwell and in need of urgent admission for further assessment and treatment. To that extent the risk assessment and risk management plan was clear – the need to progress his admission to hospital.
- 9.4.2. What was less clear was a shared view on risk management throughout and following the assessment period and the respective role that each partner could play, including the legal parameters for this.

- 9.4.3. Though for Bert, it may not have been feasible to provide alternative care while arrangements for admission were made, there is a pressing need for joint work by LCC and LPT to establish interim care arrangements to manage risk where admission is necessary but no bed available.

## 10. Conclusions

- 10.1. 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.
- 10.2. 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
- 10.3. The recommendations aim to help agencies act on the learning from this review to reduce risks for others in similar circumstances.

## 11. Recommendations

- 11.1. 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 detailed in appendix 2.
- 11.2. 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 reviewing the provision of section 12 Doctors out of hours 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

Sylman Consulting



Sylvia Manson

Date: September 2018

## Appendix 1: Safeguarding Adult Review Terms of Reference

Terms of Reference	
<b>1. PERSONALISATION AND MAKING SAFEGUARDING PERSONAL</b>	
1.1.	How did agencies work to understand Bert, respect his views and wishes within the confines of the Mental Health Act assessment?
1.2.	How did agencies focus on keeping him safe and at the centre of the intervention?
1.3.	How were family members/carers or others important to Bert involved and informed?
1.4.	Was practice sensitive to protected characteristics, as defined in the Equality Act 2010
<b>2. POLICIES, PROCEDURES, LOCAL ARRANGEMENTS &amp; PROTOCOL</b>	
2.1.	What single agency and multi-agency policies, procedures, local arrangements and protocol are relevant to this case?
2.2.	Were those involved with this incident (including frontline practitioners and managers to whom they went to for advice) aware of them? If not, why not? If so, were they followed?
2.3.	Are there any gaps identified in policies, procedures, local arrangements and protocol? Where they do exist are they fit for purpose?
2.4.	Consider policies relating to Mental Health Act assessments and policies relating to staff safety
<b>3. RISK ASSESSMENT</b>	
3.1.	What risk assessments were carried out in relation to decisions made throughout the events at the time of the incident?
3.2.	Were the risk assessments reasonable based on evidence and information available at that time?
3.3.	Did the risk assessments lead to effective risk management, utilising a multi-agency/multi-disciplinary approach?
3.4.	What worked well and what needs to improve?
3.5.	Were there any missed opportunities to provide earlier intervention to support Bert's mental health?
3.6.	How did agencies discharge their duty of care toward Bert and toward their colleagues?
<b>4. SYSTEMS &amp; RESOURCES</b>	
4.1.	What impact did systems and resources have upon this case including: i) availability of AMHPs and S12 doctors to carry out assessments in a timely way ii) availability of place of safety to carry out assessments under the section 135 iii) availability of inpatient beds if the outcome of the assessment is to make an application for admission? iv) availability of Magistrates when a warrant is to be requested
4.2.	What impact did this have on Bert?
<b>5. INTERFACE / JOINT WORKING</b>	

- 5.1. How effective is the interface and joint working between AMHP Team and the Triage Team? What worked in this case and what was the learning?
- 5.2. How are roles and responsibilities agreed and communicated between LPT/AMHP/Police (both prior to a Mental Health Act assessment being carried out and after the assessment)? Did this happen in this case? What needs to change?
- 5.3. What worked well in terms of organisational structure and culture related to joint working and what could be improved?

## **6. APPLICATION OF LEGAL FRAMEWORK**

- 6.1. Which pieces of legislation were relevant in this case? Was there any difficulty in interpreting or applying them and if so why?
- 6.2. Consider the following:
  - i) Did Bert. give consent to the AMHP and doctors being on his premises and if not, what legal authority was used for them remaining on his property?
  - ii) Had the AMHP / doctors been on the premises long enough to conclude a Mental Health Act assessment?
  - iii) Was there merit in applying for a warrant under sec 135 at an earlier stage, if necessary taking Bert to a place of safety to conclude the assessment?
  - iv) What are the arrangements for applying for sec 135 assessments out of hours? What were the reasons this was delayed until the next day?
  - v) What local guidance is in place for when an assessment has been made, admission under the Act is determined but the formal application cannot be made as no bed is identified?
  - vi) What changes in policy and practice for section 135/136 subsequent to the implementation of the Mental Health Act (as amended by Police and Crime Act)? Would this have made a difference in this case?

## **7. SUPPORT/ADVICE PROVIDED TO PRACTITIONERS**

- 7.1. Did practitioners experience any difficulties with obtaining appropriate support / advice during this incident? If so, what was the cause of these difficulties? If not, what facilitated this access?
- 7.2. Did practitioners seek advice from the most appropriate source? If so, what facilitated this? If not, what were the reasons?
- 7.3. Was appropriate advice provided? If so, what facilitated this? If not, what were the reasons?

## **8. ORGANISATIONAL CHALLENGES**

- 8.1. In what ways did each organisation's structural, financial, legal or policy challenges impact upon this case? Consider the impact of resources on the following:
  - Decision-making
  - The availability of care and support
  - Risk assessments
  - Workloads
  - Resilience
  - Access to guidance

## **9. GOOD PRACTICE**

9.1. What good practice is identified throughout this incident? What enabled this good practice?

## Appendix 2: Recommendations made by agencies contributing to the review

Adult Social Care and Leicestershire Partnership NHS 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
	<i>Should this recommendation be enacted at a local or regional level?</i>	<i>How exactly is the relevant agency going to make this recommendation happen?</i>	<i>Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?</i>	<i>Have there been key steps that have allowed the recommendation to be enacted?</i>	<i>When should this recommendation be completed by?</i>	<i>When is the recommendation to be completed? What does the outcome look like? What evidence can demonstrate completion?</i>
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 Mental Health Act and how it is applied in practice.	Improved communication between AMHP and duty manager to 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.	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
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 ' <i>Guidance to Leicester AMHPS when undertaking Mental Health Act assessments' where no bed has been identified</i> '. This	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

<p>should include guidance about risk assessing and recording of decisions 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.</p>						<p>out to all AMHPs and EDT managers</p>
<p>Regular discussions to be held to ensure that AMHPs are aware of policies and how these impact upon work</p>	<p>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 &amp; potential volatile situation.</p>	<p>Discussions on policies to be held within AMHP meetings.</p> <p>Reapproval interviews to specifically ask about use of policies</p>	<p>Adult Social Care</p>	<p>N/A</p>	<p>30.09.2018</p>	<p>Workers to be confident in using and able to explain their use of policies within their work.</p> <p>Reapproval interview notes and AMHP meeting notes to detail discussions and workers' understanding.</p>

## 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 overarching 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 is clearly described	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.



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.

## Glossary

**ADASS** Association of Directors of Adult Services

**AMHP** Approved Mental Health Professionals

**CCG** Clinical Commissioning Group, commissioners of local health care

**Crisis Care Concordat** The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis.

**EDT** Emergency duty team. A social services team that responds to out-of-hours referrals

**ELRCCG** East Leicestershire and Rutland Clinical Commissioning Group

**LCC** Leicester City Council. Responsibilities including Social Services and Approved Mental Health Professionals

**LPT** Leicestershire Partnership NHS Trust provide integrated mental health, learning disability and community health services for people across Leicester, Leicestershire and Rutland.

**LSAB** –Leicester Safeguarding Adults Board, statutory requirements under the Care Act 2014 – objective is assurance that local safeguarding arrangements and partners act to help and protect adults in its areas for whom safeguarding duties apply.

**Making Safeguarding Personal** - is a personalised approach that enables safeguarding to be done with, not to, people.

**Mental Health Act 1983 (as amended 2007)** is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

**Mental Health Act Code of Practice** provides statutory guidance to professionals in how they should carry out functions under the Mental Health Act.

**MHTC** mental health triage car is crewed by police officers and mental health nurses

**MHSOP** Mental health services for older people

**Safeguarding Adults** is used to describe all work to help adults at risk stay safe from significant harm.

**SAR** Safeguarding Adults Review, statutory reviews carried out under section 44 of the Care Act 2014

**Serious Incidents** Requirement within the NHS to investigated incidents using a specified framework.

**STP** Sustaining Transformation Partnership cover all of England and bring together the NHS and local councils to collaborate, plan and coordinate services to improve health and care.

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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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