Bristol Safeguarding Adults Board

Serious Case review Executive Summary

following the death of Simon Reynolds on 21 November 2014

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Contents

1. Executive Summary

1.1 The Bristol Safeguarding Adults Board (BSAB), commissioned a Serious Case Review (SCR) following the death of a 47year old man called Simon on the 21st November 2014. The BSAB received a formal request from the local Police Constabulary on 24 February 2015 for a SCR to be considered, and this was subsequently agreed and commissioned under the BSAB Serious Case Review protocol of 2009.

1.2 The SCR process formally began on 10th September 2015 following the conclusion of the Inquest into Simon's death in July 2015, and the appointment of a suitable Lead Reviewer.

1.3 This SCR was unusual in that it is focused on the events and decisions made during a single day (10th November 2014).

1.4 This review concentrated on a timeframe of 5 hours from 16.12pm to 21.24pm when Simon suffered a cardiac arrest, after choking on ingested paper a short time after being admitted to a Place of Safety (POS) unit. He was resuscitated and transferred to the Intensive Care Unit at a local Acute Hospital where he was cared for until his death on 21 November 2014.

2. A Serious Case Review (SCR)

2.1 The key purpose for undertaking a SCR is to enable lessons to be learned, enable future learning and development, and to determine if local agencies and professionals have worked effectively together in safeguarding a vulnerable adult. Professionals need to be able to understand fully what happened, and most importantly, what worked well, and what worked less well, and to identify any changes necessary to minimise the risk of such tragedies happening again.

2.2 The SCR was an anthology of information and facts gathered from all the known agencies that had been involved with Simon between 1 January 2013 and the date of his death on 21st November 2014, and this was described in the Terms of Reference (Appendix 2).

Family Involvement

2.3 This review must not underestimate the effect of this tragic incident on the members of Simon's family who remain understandably distressed. The author of this report wishes to convey their sincerest condolences to the family for the untimely death of their son and brother Simon.

2.4 The family have seen the full report and have made a number of comments. They were aware that he had been taking anti-depressants but would not agree that Simon suffered a period of mental illness.

2.5 Family members visited Simon day and night when he was in the Intensive Care Unit and were present at the Inquest into his death.

2.6 The family kindly sent some information about Simon and his life, which provided some insight to Simon as a person. He was described as a complex character who was artistic, musical and eloquent. Despite any difficulties he had with his personal life, he loved his family and always remained in contact with them.

3. Background

4.1 Simon had lived in in the local area for some years, having previously lived in the Midlands with his family. He had been seen regularly by his GP and received treatment for depression and anxiety. The last contact with his GP was in April 2014 when there were documented references to Simon's relapse and drinking alcohol after a long period of abstinence. However, there was no other information to explain what may have triggered Simon's return to alcohol use after such a long period of recovery. Simon's family confirmed that they were in regular contact with him and that he did not have any contact with mental health services, or a history of mental illness. They advised that Simon had started drinking alcohol again about six weeks prior to his death.

3.2 Summary of events on the day of 10 November 2014

Time	Event
16.12 hrs	A concerned member of the public called the police describing a male displaying 'bizarre' behaviour in the street. A male and female police officer responded to the call. It became clear to the officers that this man was experiencing a mental health crisis. Simon was described as being aggressive in nature, shouting in the street about 'death and hell'.
16.25hrs	A paramedic arrived to find Simon sitting on the pavement with his hands in handcuffs, which had been applied by police officers for Simon's own safety. During a handover from the police officers it was stated that they were aware of a previous history of mental illness, although this has not been confirmed as part of this review. The paramedic made an informed decision that Simon did not appear to have a physical or physiological cause of illness and that his primary complaint was an acute mental health crisis.
16.45hrs	The decision was taken by the attending police officers that Simon should be placed under Section 136 of the Mental Health Act, and that he would be taken to the Place of Safety.
16.48hrs	A referral phone call was made to the POS unit by the male police officer. As per POS protocol, the nurse in charge checked on the electronic patient records system for any prior contact with Simon, none was found. There were multiple verbal interactions between the police and the POS unit over the following hours until his arrival on the POS unit at 18.35hrs.
17.15 and 18.35hrs	On route to the POS unit, the police officers took Simon to his home address to arrange care for his dog. This was clearly causing some anxiety for Simon who continued to display erratic behaviour. Simon's flat was described as being in a poor state although it appeared to have been previously a well maintained flat, with photographs displayed on walls and units. The state of the flat suggested that there had been a recent deterioration in Simon's mental health and general wellbeing.
18.35hrs	On arrival at the POS the officers remained with Simon in a small waiting area until his admission was formalised, which did not happen for another two hours. The nurse in charge made a number of observations when Simon arrived on the POS, she was able to sit and talk with Simon, who was able to tell her some elements of his past medical history including the fact that he had stopped drinking 3 weeks previously. She

Time	Event
	described him as being 'dishevelled and underweight'. The nurse in charge of the unit described Simon, as being stressed, his mood appeared low but he was not tearful.
19.00hrs and 21.00hrs	A police officer remained with Simon in the waiting room for two hours prior to his formal admission to the unit. Simon's behaviour became increasingly erratic and he appeared to be experiencing hallucinations, head butting a wall and pulling at his teeth.
20.30hrs	The nurse in charge of the POS telephoned the duty doctor (psychiatrist) on call for advice, the doctor wanted to exclude any physical factors prior to a mental health assessment, and maintained that Simon should be seen in the Emergency Department (ED) to exclude any physical ailments. The nurse in charge agreed to contact Southmead Hospital ED to request an ECG, blood tests and a physical examination. The response from ED was that they were very busy and that there were 76 patients waiting to be seen (this information was incorrect).
21.00hrs	The police officers were told by the nurse in charge of the POS unit that they could now leave Simon in their care; the officers informed the unit staff that they would be returning to Simon's neighbour to check on the welfare of his dog and would telephone the unit later that night to reassure Simon. The police officers then left the POS unit. Simon was admitted to the bedroom closest to the nurses' station and assessed as requiring 10-minute observations. The nurse in charge commenced the nurse handover to night staff who had arrived on duty.
21.05hrs	Simon requested a pen and paper, the HCA (Healthcare assistant) sought advice from the registered nurse in charge who made the decision to agree to his request. A felt pen and paper was given to Simon by the HCA.
21.10hrs – 21.20hrs	An HCA entered the bathroom area of the bedroom after hearing a noise, Simon was found on the floor clutching a broken pen having attempted to cut his neck. The pen was removed and a superficial scratch was observed to his neck.
21.20hrs	An HCA noted that Simon refused to get off the floor and sit on the bed, he then started playing with his shoe laces. The decision was made to remove his shoes and laces, and these items were placed in the nurses' station nearby. It is worth noting that an individual cannot be directly observed when they are in the bathroom pod area without physically entering the bedroom. An assessment had been made by the nurse in charge that Simon did not warrant 1-1 observation and that 10 minute observations would be sufficient. Minutes later Simon was observed to be choking, the staff appropriately called for assistance activating the emergency call bell.
21.20hrs	At 21.25 hrs a 999 emergency call was made to the ambulance service by POS staff, and the resuscitation team called (provided by North Bristol NHS Trust). As this was a staff handover period, there was both late and night staff on the unit. The paramedics arrived at the same time as the NBT Resuscitation team on the POS and proceeded to remove a ball of paper from Simon's throat. Simon was resuscitated and transferred to Southmead Hospital at 22.30hrs. The lead clinician from the Resuscitation team was an Intensivist; therefore admission to the Intensive Care Unit was supported. An Intensivist is a doctor that works in the Intensive Care unit. Simon was cared for on the Intensive unit until his death on 21st November 2014.

4. The SCR Panel and Process

4.1 The Independent Chair of the SCR Panel was a retired Nurse Director who had experience of SCRs for both Adults and Children, and Domestic Homicide Reviews (DHRs). In addition, the Chair also has experience of conducting confidential investigations, including knowledge and experience of Safeguarding issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to safeguarding vulnerable people. The panel included representatives from the agencies detailed below who also provided IMR authors.

- Local Police Constabulary
- Mental Health NHS Trust
- Local Ambulance Service
- Local Acute NHS Trust
- Clinical Commissioning Group (CCG) on behalf of NHS England

4.2 The SCR Panel first met in September 2015 to discuss and agree the terms of reference (Appendix 2).

The Individual Management Review (IMR) process

4.3 The purpose of an IMR is to look openly and critically at individual and organisational practice, to establish whether any changes could and should be made and, identify how those changes will be brought about. Any significant concerns identified which relate to practice should be rectified as soon as possible to ensure that any similar incidents are not repeated. IMR reports were, in some cases, supplemented by face to face and telephone interviews between key staff and the SCR author.

4.4 All agencies involved were required to produce an individual management review (IMR) using a standard template provided describing their involvement with Simon on the 10th November 2014, including any actions taken. IMR authors met several times with the SCR Panel members and a draft overview report was completed by December 2015. This was submitted to the SAB SCR Quality Assurance subgroup prior to an extraordinary meeting of the SAB to present the findings and recommendations of the SCR for consideration and approval.

A Place of Safety (POS)

4.5 A crucial aspect of this event involved a Place of Safety (POS), commonly referred to as a Section 136 suite. Section 136 is one of many sections of the Mental Health Act 1983, Section 136 enables police officers to detain individuals for an emergency mental health assessment, and is entirely different to a criminal arrest.

4.6 ‘People in mental distress should be kept safe’ (Mental Health Crisis Concordat) utilising the least restrictive option available. It should also be the most appropriate environment to meet the particular needs of the patient.

4.7 A POS can be one of the following:

- A designated POS unit or
- An Emergency Department, (ED)

- A police cell - although this option should only be used in exceptional circumstances

4.8 A locally agreed 'Red Flag protocol' stated that the handover period from police to POS staff should take no longer than 1 hour. This was breached in this case. Other than the fact that the unit was busy with other admissions, POS staff had been advised of Simon's arrival several hours earlier, and no alternative explanation was offered by the Mental Health Trust for the delay in admitting Simon to the unit.

4.9 There was a clear communication breakdown between the ED and the POS unit despite an agreed 'Red Flag protocol' being in place between the ED and the POS unit. The ED staff did not appear to know of its existence.

4.10 This protocol was clearly misunderstood by medical staff in the local Acute Trust ED department who assumed that a medical review could be undertaken on the POS unit. The POS unit does not have the equipment or facilities to undertake a basic physical health assessment – for example, the taking of routine blood samples, or an ECG machine to perform a heart tracing. The local Acute Trust provided resuscitation services to the POS via a Service Level Agreement with the Mental Health Trust.

4.11 The alleged telephone call to the ED by the nurse in charge (POS) was not substantiated by the local Acute Trust IMR author, neither was the discrepancy in numbers waiting in ED at the time of the alleged call. There was no requirement at the time for calls to be logged in ED and it would be a useful exercise in the future to determine how well the 'red flag' protocol is used in practice. This could be monitored and evaluated by the SMAG (Strategic Multi-Agency Group). This is addressed by Recommendation 1 and 2.

The Inquest

4.12 An inquest hearing was heard on 15 July 2015 and concluded on 24 July 2015. All relevant professionals and members of the family were present at the jury inquest.

"The conclusion of the jury is that as a consequence of choking on paper which led to cardiac arrest, Simon subsequently died due to acute pneumonia, cachexia and chronic pulmonary disease".

4.13 Following the inquest, the Coroner contacted the local Mental Health Trust with a Regulation 28: Report to prevent future deaths. The Coroner raised concerns relating to staffing levels, training and patient observations. The local Mental Health Trust responded to the Coroner and reported that the POS staff were all up to date with their training, the observation policy was to be reviewed in line with national guidance, and staffing levels had been reviewed with their commissioners, increasing the number of registered mental health nurses from one to two per shift.

4.14 As part of this review, other POS unit staffing levels were investigated, with some units having 1-1 staffing for all individuals awaiting a mental health assessment. The SCR panel acknowledged that any increases in staffing would require negotiation between the Mental Health Trust and their CCG Commissioners.

4.15 The family expressed concern that Simon had already injured himself with a pen shortly after his admission, when he requested a pen and paper, and his shoelaces removed when he apparently stated he wanted to die. The local Mental Health Trust confirmed that a risk assessment was completed, and he remained alone in his room.

5. Agency involvement

The local Police Constabulary

5.1 The police were the main service involved with Simon's care and welfare on the 10 November up until his admittance to the POS at 21:00 hours. The officers demonstrated that they acted in Simon's best interests throughout the duration of their involvement with him. They acted with compassion in their dealings with Simon. It was clear that they were frustrated by the length of time it took for Simon to access a mental health assessment. One officer stated that, in their experience, it was the most significant mental health incident of their career. To place this in context, this officer had over 15 years in the service.

The local Ambulance Service

5.2 The local ambulance service were involved on two occasions on the 10 November, the first call at 16.11hrs when the police were with Simon in the street, and the second emergency call made by the POS staff at 21.25hrs when Simon had reportedly stopped breathing. The local Acute Trust's resuscitation team had been called and, as the mental health staff were handing over from day to night staff, there were more staff on duty than normal. The ambulance paramedics were advised they were not needed, however they were able to assist in transferring Simon to the ED at the local Acute Trust. This action demonstrated good multi-professional working.

The local Mental Health Trust

5.3 The local POS unit had been commissioned to have capacity for 4 individuals (including young people) and does not have resident or designated medical staff.

5.4 On reflection, an ability to take blood samples and a basic physical examination may have been extremely valuable to eliminate or confirm any doubts of any physical causes of Simon's presenting distress.

5.5 However, the delay in formally admitting Simon to the unit was unacceptable, as the unit had received prior notification of his arrival earlier that day. The reliance on the fact that the police officers were able to remain with Simon ensured that he continued to receive 1-1 support by police officers with no professional mental health training, with no apparent acceptance by the POS of any responsibility for Simon following his physical arrival on the unit. The local Mental Health Trust should have been working to the agreed Multi-agency Red Flag Protocol. This is addressed by Recommendation 1 and 2.

The local Clinical Commissioning Group (CCG)

5.6 The local CCG, as a commissioner, obtained Simon's GP records, for the purpose of this review, which provided limited medical information and some insight into Simon as a person, including his interaction with primary care services. Simon appeared to be appropriately monitored and received treatment for his depression and anxiety by his GP

with anti-depressants. He was referred to the Least Intervention First Time (LIFT) service (now known as Wellbeing services) for psychological assessment and support.

The local Acute Trust

5.7 The local Acute Trusts' involvement with Simon was limited to providing care in Simon's resuscitation and admission to their Intensive Care Unit on the 10th November 2014 until his death on 21st November 2014. It was unfortunate that a two hour window when Simon was kept waiting in the POS unit could not have been better utilised and the acute Trust provide support to the POS.

5.8 The SCR panel asked the local Acute Trust representative / IMR author questions relating to Simon's pre-admission history regarding blood samples taken for toxicology and X-rays or scans being done on admission to the ED or ICU. There was no indication that his pre-admission history had been considered. The local Trust IMR contained so little information about Simon and despite the panel formally asking about whether he had ever had any X-rays or scans to exclude any physical element pre-admission, no response was ever forthcoming from the local Trust panel member or their IMR author. The panel were also concerned at the paucity of information contained in the local Acute Trust IMR, with no information about the family visiting Simon during the time he spent on ICU or any communication with them, and multiple delays in submitting their IMR to the SCR panel on time.

Mental Health Crisis Care Concordat: the joint statement (2014)

5.9 The Mental Health Crisis Care Concordat was not fully embedded at the time of the incident. However, the document, in addition to the Red Flag protocol, had been agreed and signed up to by a large number of local and wider geographically located agencies. The following statement was extracted from the document:

"We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery. Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England." (MH Crisis Care Concordat 2014).

5.10 There is the opportunity here for all locally agreed protocols to be monitored and evaluated through the established Local Multi-Agency Group (LMAG) and SMAG. This is addressed in Recommendation 1 and 2.

6. Findings

6.1 It is unfortunate that, in this instance, there was little demonstrable evidence of support for the POS by the local Acute Trust. There was a two-hour window when Simon may have been able to be assessed in ED if that was made available. On reflection it is unknown if this may have changed the tragic outcome for Simon, however, the family are of the view that Simon would not have died if he had been seen in the local Acute Trust that day.

6.2 There was evidence of an apparent misunderstanding of the role of the POS by acute healthcare colleagues in ED, specifically in relation to the application of the locally agreed Red Flag protocol and the Mental Health Crisis Care Concordat, and not all professionals were aware of their roles and responsibilities as a result. This included a lack of escalation to senior managers to assist in resolving any practical issues.

6.3 There appeared to be differences in the interpretation of some agencies understanding of 'parity of esteem', and the need for greater collaborative working between mental health and acute services. This is addressed in Recommendation 3.

6.4 As part of this review, examples of other POS unit staffing levels and arrangements were examined. In some other POS units the time limit before an assessment must take place is restricted to 30 minutes, and all individuals admitted to POS for mental health assessments received 1-1 support until the assessment is completed.

6.5 Acute health colleagues had little understanding of the lack of medical cover and facilities available in the POS.

6.6 No evidence was found of what is described in the Red Flag protocol as 'intervention from a senior line manager to resolve issues' or that there should be a designated individual from all agencies to support front line practitioners. Telephone contact was made with on call managers who left communication with the acute Trust to the nurse in charge.

6.7 No Safeguarding Adult alerts were raised by POS unit to the local Social Services Safeguarding team or Commissioners at the time of the incident.

6.8 Although not in the terms of reference this report has not been able to examine the process of undertaking a MH assessment by Approved Mental Health Practitioners (AMHPs) in a POS, the process has been described, by those contributing to this report, as difficult and extremely time consuming, and not necessarily in the patients' best interests. A review of the MHA assessment and process would be beneficial in understanding reasons for delays in the system.

6.9 When there are delays in the process, the reasons need to be audited to be understood, and to identify any difficulties that may be systemic and could potentially delay the provision of timely emergency support.

Good practice

6.10 There was evidence that Simon's GP maintained regular contact and regularly reviewed him for his depression and anxiety

6.11 Simon was referred for psychology services LIFT (Least Intervention First Time) service by his GP

6.12 The attending police officers showed a caring, compassionate and supportive attitude towards Simon in making sure that his welfare was paramount and this included ensuring Simon's dog was cared for by a neighbour.

6.13 There was evidence of considered, pragmatic decision-making by the police officers and paramedics

6.14 The attending police officers were fully supported by their senior officer who agreed that the officers remain with Simon. He was not left alone until he was admitted to the unit.

6.15 Paramedics assisted in the transfer of Simon to the ED post cardiac arrest

6.16 The ambulance paramedics provided support on both occasions they were involved on the day, with evidence of collaborative working in Simon's best interests in their support of the police at the scene.

6.17 Despite being in a pressured environment, the POS nurse in charge demonstrated good decision making abilities and took appropriate actions and advice prior to Simon's admission, including contacting the on call manager for both advice and support.

7. Conclusions

7.1 The circumstances surrounding Simon's death were unusual in that Simon did not have a previous history of any mental health issues. The timeframe was condensed into an intense few hours during the course of one day rather than a longer period where more information may have been known about him. It was not known what may have triggered Simon's distress on this day, other than the fact he had started drinking six weeks prior to his death, and this SCR has not been able to provide an answer.

7.2 There was evidence of good practice, empathic and compassionate practice and support for Simon during the course of this SCR, particularly from the attending police officers who remained with Simon until he was admitted to the POS.

7.3 The review was able to highlight areas of practice and multi-agency work that requires review and evaluation especially in the treatment of acutely distressed individuals experiencing a mental health crisis in the community. Additional work is required to promote and evaluate the Mental Health Crisis Concordat and the multi-agency Red Flag protocol that was not fully implemented in practice at the time.

7.4 Despite ever increasing pressures on all aspects of the National Health Service (NHS), any individual experiencing mental health symptoms should be treated with the same integrity, dignity and respect as those experiencing physical distress.

8. SCR Recommendations

The following recommendations of the SCR are submitted to the Bristol Safeguarding Adults Board, as Commissioner, of the SCR for review, consideration and approval.

1 A thorough review is undertaken of the multi-agency Red Flag protocol across all signatories to include more specific detail in relation to its application in practice. The Red Flag protocol provides a solid framework for actions to be monitored and evaluated as necessary. The Strategic Multi-Agency Group (SMAG) and Local Multi-Agency Group (LMAG) to monitor and

evaluate the use of the Red Flag protocol, ensuring agencies respond as described in the multi-agency protocols and that designated senior managers are able to demonstrate that local issues are resolved in practice

2 Agencies signed up to the Red Flag protocol can demonstrate that it has been implemented effectively within their own agencies, and can demonstrate collaborative working with others. Ensure that front line staff are supported should escalation be necessary.

3 Agencies to ensure that Parity of Esteem is evident when dealing with people who are experiencing a mental health crisis

4 The Mental Health Act assessment pathway is reviewed and analysed to identify and understand the causes of delays and to make the necessary improvements to prevent unnecessary delays.

Single Agency Recommendations

While the BSAB maintain oversight of the progress of actions, for single agency recommendations it is the responsibility of the relevant agency to ensure this is enacted.

The local Mental Health Trust (in conjunction with Commissioners where necessary) to:

5 Ensure that admissions to the POS unit do not occur during the handover period and that an individual being taken to the POS unit is formally admitted within 30 minutes of arrival

6 Ensure that individuals admitted to the POS unit have 1-1 support until MH assessment has been completed, and to be more specific in their Red Flag protocol as to what constitutes a physical check when individuals attend POS for MH assessment

7 Review and strengthen the process for improved documentation of risk factors / assessment during the handover period, ensuring that risks are formally documented as evidence of informed decision making

8 Consider the need for urgent medical cover for the POS which will avoid the necessity to involve an ED unless absolutely necessary. Not all POS units are sited near an acute hospital. In this case resuscitation services were provided by a local acute trust using a Service Level Agreement (SLA)

9 Ensure that relevant safeguarding alerts made to the lead local Authority Safeguarding team and CCG Commissioners are in accordance with agreed multi-agency arrangements

10 Ensure that front line staff are supported should escalation within policies be necessary including auditing of relevant documentation to evidence this in practice

CCG Commissioners

11 To regularly review the performance and activity of the POS in relation to improved access for those people experiencing a mental health crisis

12 Review staffing levels with the Mental Health Trust in line with other units nationally, including capacity and patient flow within the POS

13 Assist with progression of electronic communication systems to enable Mental Health Trusts to electronically access GP and community records

14 Ensure that Red Flag protocol is thoroughly reviewed as part of the multi-agency SMAG following this SCR

15 Promote the use of the local Street Triage service pilot, and any evaluation / outcomes of the pilot to be made available to front line staff

Local Acute Trust

16 Local Acute Trust clinicians to take into account relevant pre-admission history and events to ensure that toxicology and medical examination are not excluded following admission

17 The status of a mental health crisis is viewed as an emergency by ED staff, and that physical review to exclude any physical ailments is completed as per the locally agreed Red Flag protocol

18 'Consultant to Consultant' referrals/ telephone calls from POS to ED are formally recorded including rationale for decision and outcome. For provider and commissioner to review this as part of wider S136 provision

19 Ensure that all ED staff are fully aware of the agreed working relationship between the POS and the ED including the red flag protocols for the diversion of individuals who require a physical examination. Audits to be used to evidence this to LMAG / SMAG

20 Ensure that both the Local Authority and Commissioners are aware of any Safeguarding alerts made

21 Ensure that IMRs are submitted on time, with evidence that internally senior overview and approval has been undertaken prior to submission to SCR

Appendices - Appendix 1

Glossary

AMHP	Approved Mental Health Practitioners
SAB	Safeguarding Adults Board
Clinician	Member of staff involved in patient care
CPR	Cardiac-pulmonary resuscitation (lung ventilation and chest compression).
Crash Team	A hospital-based team of doctors and supporting clinicians responded within the hospital to patients in cardiac arrest or requiring immediate life-saving procedures.
Differential diagnosis	An alternative condition that might have the same signs and symptoms as a primary medical diagnosis
ED	Emergency Department (hospital)
EDT	Emergency Duty Team
Hypoglycaemia	Low blood sugar level
ICU	Intensive Care Unit (hospital)
IMR	Internal Management Review
LIFT	Least Intervention First Time. The service is now known as the Bristol wellbeing therapy service
MH	Mental Health
Paramedic	Practitioner clinician registered with the Health Care Professionals Council as a paramedic.
PCR	Patient Care Record
POS	Place of Safety
Practitioner	Clinician with authority to make a decision about a patient care plan
S136	Section 136 detention under the Mental Health Act 1983
SCR	Serious Case Review
SOP	Standard Operating Procedure
SI	Serious Incident

Appendix 2

Terms of Reference (ToR)

The following ToR were agreed by the SCR panel as part of the Safeguarding Adult Board SCR process.

The purpose of a Serious Case Review is to

- Establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to Safeguard vulnerable adults
- Review the effectiveness of procedures
- Inform and improve local inter-agency practice\to improve practice by acting on learning

Simon's case had three distinct phases; an exploration of how agencies worked together and how decisions were made during each phase will provide essential learning to improve agency practice

This SCR will enquire:

1. How was the decision made by the agencies involved to convey Simon to the Place of safety?
2. How decisions were made by the agencies involved between the time of Simon's arrival in the POS at 7pm and his actual time of admission at 9pm?
3. How decisions were made by staff, involved with Simon, between 9pm and 11pm?

Timescale: From January 2013 until date of death 21st November 2014

Although the SCR panel will be focusing on a specific time period, any significant or relevant events in Simon's life should be identified to the SAR panel

We will work positively with Simon's family whilst learning lessons in order to prevent such a tragedy occurring again

The outcome of the SCR will be to produce learning that can be used by all agencies to ensure that:

- People experiencing a mental health crisis will be supported in safe and appropriate environments
- And, by agencies who can work confidently together in making decisions about their provision of care and treatment

Appendix 3

Places of Safety

In England, there are currently 164 POS units that cover varying populations (CQC national data December 2015).

The local POS unit is on a local acute trust site and managed by the local Mental Health Trust, it has four beds. Not all POS units share the same geographical location with an acute hospital. Commissioners are responsible for commissioning services that are fit for purpose, and ensuring that suitable arrangements are in place to manage multiple individuals, including sufficient staffing levels to ensure the safety of those waiting for or undergoing a mental health assessment.

This unit was commissioned on behalf of four local Clinical Commissioning Groups (CCGs) and opened in February 2014. There are a number of other POS units in the wider geographical area.

Police officers can use section 136 of the Mental Health Act to take a person to a POS from a public place when an officer believes a person is suffering from a mental health disorder and who may cause himself or herself further harm.

Following a Mental Health Act assessment a person may be sectioned using the Mental Health Act, voluntary treatment and support within the community, or nothing further may be necessary. In which case, the person is free to leave the POS. The person has rights under this section including legal advice and informing a relative / friend where you are.

Clinical Commissioning Groups (CCGs) are required under the Crime and Disorder Act 1998 to work in partnership with the police and other local responsible authorities in Community Safety Partnerships (CSPs).

In this case, the local POS unit was responsible for accepting both adults and young people. The protocol states that 'assessment arrangements be in place for ALL adults, and young people aged 16 and 17, and for under 16's within another adjacent area, who need to be removed to a POS'.

An Emergency Department as a POS

Whatever the circumstances of arrival, people in a Mental Health crisis should be provided with immediate care and access to adequate liaison psychiatry services to obtain necessary and ongoing support. Clear local multi-professional and multi-agency protocols and responsibilities should be in place.

Locally a Mental Health Crisis Care Concordat (2014), and the Red Flag protocol (2014), was signed by all local health & social care providers, mental health and acute Trust, Police and ambulance service providers to ensure that people suffering mental health crises have timely access to appropriate services within a POS.

There are two recognised levels of oversight for the operational management of these protocols already in place:

- The Local Multi-Agency Group or LMAG: and
- The Strategic Multi-Agency Group with a remit of undertaking an annual review (as a minimum) of the operation of this protocol.

Each partner agency has a designated operational manager with a responsibility for on-going operational or day-to-day oversight of the protocol to resolve any challenges or incidents surrounding the practical implementation of the protocol 'in a minuted forum' (LMAG).

An Emergency Department is not deemed an ideal location, as in the main, they deal with physical or life threatening events, and the 'Red Flag protocol' is clear that EDs should not be viewed as the first choice as a POS.