Hull Safeguarding Adults Partnership Board

SAFEGUARDING ADULTS REVIEW

Report into the death of Adult SEM who was found dead on the 25th July 2014

Report produced by Richard Proctor.

Independent Chair and Author.

May 2019.

Acknowledgements:

Hull Safeguarding Adults Partnership Board would wish to place on record their sincere thanks to the parents of SEM who worked closely with the board and Independent author. They provided valuable information and an insight into the life of SEM which was used in shaping and informing this review.

This Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied to the SAR Panel by those agencies who provided care and support for SEM. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.

This report reflects the combined views of the SAR Panel who have invested their time, commitment and expertise throughout this process. The input and professional support provided by the Safeguarding Adults Board Manager and Hull Clinical Commissioning Group Designated Nurse for Safeguarding Adults were invaluable throughout this process.

Table of Contents.

1. Introduction

All names in this report have been anonymised for publication and dissemination.

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and

c) the adult has died and the board suspects that the death resulted from abuse or neglect. (whether or not it knew about or suspected the abuse or neglect before the adult died).

The decision to undertake a Safeguarding Adult Review in relation to the tragic death of SEM was made on the 22nd June 2016 by the Independent Chair of the Board, this following consideration of the case and being satisfied that the criteria to undertake such a review was met.

Owing to parallel investigations the report was unable to be published until some years afterwards during which agencies involved and Hull Safeguarding Adults Partnership have progressed the learning and recommendations for improvement identified in this review.

Single Agency improvement plans and response to the questions raised were shared with SEM's parents so they may consider the findings and have awareness of the improvement activity that has been undertaken.

In response to the position provided by Humber Foundation Trust (HFT) as detailed on page 50 in relation to Supporting Families and the Duty of Candour SEM's parents challenged from what they described as their own lived experience.
Regarding supporting SEMs family, they described their experience of this as shambolic, lacked continuity, was devoid of empathy for the issues they were experiencing which they personally felt was predicated by an agency culture they described as "deny, delay, defend and deceive".

In relation to the response provided by HFT of the application of the Duty of Candour. the family held the view that whilst the Trust may claim to be compliant with the statutory duty of candour the reality of their experience was not as indicated where staff had neither the knowledge nor understanding of the requirements of this duty nor were compliant with its application.
https://www.gov.uk/government/consultations/statutory-duty-of-candour-for-health-and-adult-social-care-providers

Whilst the lead reviewer and author have the deepest of sympathy for the family, the examination and analysis of the issues are judged to be outside of the scope and purpose of this safeguarding adult review.
However, the views of the parents have been brought to the attention of HFT for them to consider and decide upon how they wish to respond.

Hence these issues raised have not been analysed further.

2.0 Service Involvement

The review was informed by information provided by the following agencies.

HFT	Humber Foundation Trust
YAS	Yorkshire Ambulance Service
CCG	Hull Clinical Commissioning Group
HP	Humberside Police
CHCP	City Care Health Partnership
HEYHT	Hull East Yorkshire Hospital Trust

3.0 Summary of events leading up to SEMs death.

3.1 SEM was born on the 22nd January 1992 and tragically found dead in her residential flat in Hull on the 25th July 2014 by Yorkshire Ambulance Service (YAS). The medical cause of death was mechanical asphyxia in combination with an overdose of Codeine and Nitrazepam following the taking of an overdose and placing a plastic bag over her head.
https://www.nhs.uk/medicines/codeine/
https://bnf.nice.org.uk/drug/nitrazepam.html
Following investigations into the circumstances of her death a narrative conclusion was recorded by the HM Coroner Professor. A narrative conclusion is a factual statement of the circumstances surrounding someone's death, without attributing the cause to an individual. In his narrative conclusion, the coroner ruled the failure to admit SEM to hospital was neglect and said “For avoidance of doubt, had SEM been admitted she would not have died that day”.

3.2 SEM had a long history of mental health problems, dating back to early childhood, spending prolonged periods in hospital both as an adolescent and adult. Consequently, she was cared for by Mental Health Services provided by the Humber NHS Foundation Trust (HFT). She received additional support from her local GP surgery and was a frequent attendee at the emergency department at Hull Royal Infirmary (HEYHT) following episodic self-administered overdoses of prescription and non- prescription drugs purchased online via the internet.

3.3 She was well known to the emergency services of the Yorkshire Ambulance Service and Humberside Police following occasions when she had taken overdoses of drugs or attempted other forms of self-harm.
However, despite the challenges her mental health condition posed to herself and agencies, she also had many positive aspects in her life including a caring and loving family, a keen interest in sport and had part time employment. She had a hopeful future and was looking at undertaking a catering or sports orientated course in September 2014.

3.4 SEM had an agreed care plan owned by HFT which indicated when the risks were heightened and there was a significant risk to her safety the care team could request, she be admitted to hospital for a brief period so that the risk could be managed and hopefully mitigated.

However, the review has established there were issues between HFT Crisis Resolution Home Treatment Team (CRHTT) and Community Mental Health Team (CMHT) around the formulation of the plan and a lack of clarity as to when and how the plan should be implemented when SEM presented in crisis.

3.5 On the 23rd July 2014 (two days prior to her death) SEM reported to HFT mental health workers she had taken a drug overdose for which she was treated for at the Hull Royal Infirmary emergency department (HEYHT). Here mental health workers assessed she had the mental capacity to make her own decisions and allowed her to return home.

On the 24th July 2014 (one day prior to her death) SEM met with mental health workers at Victoria House, owing to concerns for SEM's safety and welfare they requested in line with her care plan that she be admitted for short term residential care.

3.6 This request was declined by CRHTT at which point she informed them she had taken an overdose already and was transported to the emergency department at the hospital.
Following admission to the acute assessment ward she was eventually deemed medically fit to be discharged once an assessment had been undertaken by CRHTT with regards to her mental health.
At this time SEM requested she be admitted for short term residential care in line with her care plan.
This was declined by CRHTT owing to what they claimed to be a shortage of beds to accommodate her.
Information obtained later by the family originally unavailable to inform the review indicate that several beds were available at that time.

At this stage SEM became hostile refusing to engage in the assessment any further. CRHTT staff confirmed with hospital staff that SEM was refusing to engage and that she had mental capacity confirming they would contact her tomorrow.
https://www.legislation.gov.uk/ukpga/2005/9/section/1

3.7 Investigations undertaken subsequently by HFT identified no meaningful assessment was undertaken by the CRHTT staff in respect of SEM's mental capacity. Consequently, she was released from hospital and conveyed home by the police, all of these events happening in the early hours of 25th July 2014, with Police returning SEM home at 03:30 hours. Later that morning (25th July 2014 the date of SEM's death) SEM telephoned for an ambulance stating she intended placing a plastic bag over her head.
Around this time, SEM's mother began to try to contact SEM's HFT Care Coordinators. She had real concerns about SEM's low mood over the last 2 days and her increasing concerns around SEM's mental health.

3.8 Following numerous attempts to make contact, mother did speak to SEM's Care Coordinator and passed on her increased concerns regarding SEM. This was unusual as mother was aware of SEM's wishes that she did not speak to her mental health workers. SEM's parents describe how confidentiality appeared to be a barrier for HFT staff to receive vital information that would assist in her treatment and care. The "Triangle of Care Guide" developed by the Carers Trust is a therapeutic alliance between service user, medical staff and carer with the aims of promoting safety, support and sustaining well-being. Confidentiality is often seen as a problem area in creating a triangle of care.
https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health

3.9 Following the ambulance attendance, the CMHT also attended the address and spoke with SEM.
They contacted CRHTT requesting admission to a residential mental health setting in line with SEM's care plan as she was in acute crisis. CRHTT refused the request attributing a lack of beds again as the reason for refusing this request. SEM's risks

were escalating in the fact she had put a plastic bag over her head that day and was talking about her wish to die to the professionals in attendance.
It was finally agreed a gatekeeping assessment would take place with regards to SEM's admission at HFT Miranda House at 3.30pm that day. She was taken there by the CMHT staff accompanied by the police. Following assessment CRHTT refused to admit SEM justifying this decision owing to a lack of beds and their opinion that the risks she posed to herself were no different than normal for her.
This despite representations made by the CMHT staff and the police who were reluctant to take her home after witnessing her attempt to self-ligature whilst in her company at Miranda House.

3.10 They escalated their concerns to their immediate supervisor who joined them at Miranda House. The Police Sergeant discussed the case with CRHTT staff who stated that SEM's behaviour was a response to her needs not being met, that they had fully assessed her and did not identify any suicidal intention. This view was upheld and supported by a CRHTT Team Manager despite not speaking to SEM or the attending CMHT staff and made this decision without investigating the recent heightened safety concerns about SEM and her suicidal behaviour. This individual was also unaware of the fact SEM had been receiving psychotherapy for the last 2 years and that her psychotherapist thought hospital admission was appropriate.

3.11 The Mental Health Crisis Care Concordat was developed to support agencies to work together to establish a high-quality response to people with mental health problems in urgent need of help.
This review identified that where professionals have opposing views as to whether a patient should be admitted to hospital care that no formal escalation process existed to truly assess and test the case and where necessary seek guidance and advice from more senior members of staff.
This review identified none of these critical decisions, or the assessment of SEM's capacity were ever recorded.

3.12 Before discharging SEM, CRHTT staff informed her they would make contact later that day with her to provide reassurance. SEM stated that there was little point "As she would be dead by then".
SEM was then conveyed home by the police.

3.13 At 5.36pm SEM contacted the ambulance service to inform them she was intending placing a plastic bag over her head as she wanted to die. Owing to high levels of demand and confusion with regards to the incident classification the ambulance was not dispatched until 7.06pm arriving at 7.14pm. The call made by SEM was incorrectly classified as "psychiatric/suicide attempt" rather than "overdose/poisoning" which would have been the appropriate classification following SEM informing the call taker that she had taken an overdose.
On arrival of the Ambulance SEM was found dead with a plastic bag in situate over her head.

4.0 Pen picture SEM.

4.1 SEM was born on the on 22 January 1992 in Hull. Arriving two and a half years after her brother, she was the long-awaited daughter for whom her parents had hardly dared hope and they felt incredibly fortunate to have SEM, a happy and contented baby, to complete their family.

4.2 By the time SEM started school she was a confident, popular and outgoing child who excelled at everything she did. She set herself unnecessarily high standards and sometimes worried about getting things wrong. A change of school at the age of eight provided SEM with a new, stimulating and challenging environment, which she loved, and she threw herself into everything on offer. Highly organised, self-disciplined, focussed and competitive, she always gave of her very best.

4.3 It was here that her initial interest in music was nurtured and she loved learning to play the violin and playing in string groups, orchestras and performing at concerts. Having mastered the basics of the violin, she quickly wanted to expand her repertoire and pleaded with her parents for clarinet lessons. Clarinet mastered; she then became intent on learning the piano too.

4.4 Sport was another favourite and over time included hockey, netball, tennis, football, cricket, badminton (at which she played for Yorkshire), ice hockey and later, running and boxing. Her highly competitive nature and natural ability meant that she was assured of success.

SEM was also very creative, and she loved drawing, painting, photography and drama. This eventually saw her undertaking a two-year college course in Art, in which she gained a distinction.

4.5 As a person, SEM had many diamond-like qualities, in that she was multi-faceted, beautiful, brilliant, sparkling, precious and unique, with diverse facets and reflections. She had a chameleon-like quality and absorbed and adapted to a wide variety of environments. With a lightening wit, hilarious sense of humour and infectious smile, one carefully timed inappropriate joke or comment could make others weep with laughter.

4.6 Tragically, for SEM, life changed dramatically when she was in her mid- teens and began to develop a serious and potentially life-threatening psychiatric condition, an eating disorder. She struggled to cope with the horrendous mental and physical challenges this presented. From that point onwards, despite more positive episodes in her life, nothing was ever quite the same again and the shadow of her mental health issues was ever present, frustrating her ambitions, enthusiasm and enjoyment of life.

5.0 Methodology.

5.1 A Safeguarding Adult Review panel was established consisting of senior managers nominated by their agency with no previous involvement in the case, and authority to effect change in their own agency, meeting on several occasions.
Rather than establishing strict terms of reference to direct the review it was decided by the panel that learning would be best identified through the development of a series of questions to be answered by agencies in relation to their interaction with SEM.
SEM's parents were consulted in relation to these questions and given the opportunity to add or amend anything further. Following the consultation process eight questions (as detailed below) were identified as the key lines of enquiry and agencies invited to provide responses.

a) Was it appropriate for your agency to work with SEM and what factors helped with this involvement?
b) What were the challenges for your agency in working with SEM and how were these addressed?
c) Please comment on any areas of practice that were above expected levels
d) What are the possible influences on professional actions or decision-making?
e) What is your analysis of your agency's involvement?
f) What recommendations have resulted from this learning and when will these actions be implemented?
g) How will your agency ensure that these actions are firmly embedded into day to day practice?
h) What steps will you take to ensure that all frontline practitioners and managers within your organisation know about the lessons learnt from this review and will reflect and change their practice, if necessary, as a consequence.

5.2 It was acknowledged that YAS and HFT had already undertaken individual agency reviews to identify learning from practice following SEM's death.
Several improvement actions for these agencies had been identified and subsequently progressed.
Rather than purely revisiting these previous investigations, this review focusses on inter agency working and testing the system to assess what has changed several years later following SEM's tragic death.

6.0 Analysis of agency response to key lines of enquiry.

a) Was it appropriate for your agency to work with SEM and what factors helped with this involvement?

Humberside Police

In the majority of our contacts with SEM it was appropriate for the Police to be involved. There were some occasions when the Police were contacted by other agencies who were working with SEM or providing her with treatment that did not require Police involvement. On these occasions, contact was made due to previous incidents when SEM had been violent or aggressive.

Police utilised information from previous incidents involving SEM to assess risk and inform responses in dealing with incidents. This is evident on the occasions when SEM was reported as missing as Officers were directed to attend her home address initially, as this is where she was often found.

There is evidence within our contacts of engagement and communication with partner agencies in addressing the needs of SEM and responding to the incidents reported. This includes contact being made with SEM's Community Psychiatric Nurse and other Health Care professionals who were involved in the care of SEM.

Humber Foundation Trust

It was entirely appropriate for Humber FT to be involved with SEM's care for the reasons already identified. SEM had complex needs, a high-risk profile and the need for specialist psychotherapeutic input and consistent, long term community services pertinent to secondary care mental health services.

Yorkshire Ambulance Service

It was appropriate for YAS to be involved with SEM to provide emergency care through her calls to 999 or health advice from NHS 111. SEM was known to the Frequent Caller Manager due to the number of 999 calls she was making and to the local management teams in the Hull area. She was not flagged to the Safeguarding team as her involvement was with mental health services rather than support from Social Care. YAS did make two referrals to Adult Social Care in 2013 but it is not known what, if any, action was taken.

City Health Care Partnership

SM registered with the practice for general medical care. In order for SMs care to be maintained, having been removed from her previous practice she would need to be registered with a GP practice as soon as possible. The practice was the primary record keeper and therefore it was appropriate for the practice to liaise with other agencies to co-ordinate SMs care.

Hull East Yorkshire Hospital Trust

It was appropriate for the Trust to work with SM due to the number of attendances to the Emergency Department following episodes of self-harm. Documentary evidence from SEM's medical notes identifies that SEM required initial active treatment, observation, support and assistance to meet her mental health and physical care needs. This support and assistance included liaising with HFT Mental Health Care Team for specific support and guidance regarding the access of specific mental health services when required

b) What were the challenges for your agency in working with SEM and how were these addressed?

Humberside Police

The contacts that Humberside Police had with SEM were during times when she was in a crisis situation due to her mental health. There were some incidents when SEM was violent and aggressive and had to be restrained by the Police and on these occasions, SEM was arrested and taken into custody. However, on the majority of our interactions with SEM she was compliant and willing to engage with the Police.

In 2012 there were occasions when the Police had requested a member of the Crisis Team attend to help them deal with SEM, but staff were either not available or there was a delay in their ability to attend

(9/06/12 & 23/12/12). The delay in staff attendance to undertake an assessment of SEM on 9/06/12 resulted in Police resources engaged with SEM for nearly 12 hours with the final outcome being, that when SEM was finally assessed she was deemed at that time to be fit and well and was taken home by the Police. On another occasion (8/06/12) the Crisis Team contacted the Police to request the Police undertake a welfare check on SEM as they had no staff available to attend.

It is evident in Police incident logs that SEM's violence and aggression on previous incidents at time influenced agencies responses to SEM. The Ambulance Service contacted the Police to request assistance often detailing that SEM had a history of violence. On these occasions, it is recorded that the Ambulance Service would wait until the Police arrived before attending the incident to deal with SEM. From 2014 the Police start to decline to attend some incidents where they have been requested to attend, this decision is made on the fact that often Police presence is requested due to a presumption that SEM will be violent due to past presentations. On some of these incidents the Police have telephoned SEM to speak to her to assess her demeanour and then updated the Ambulance Service to help inform decision making. On one particular incident on 27/03/14 the Police declined to attend and as part of their decision-making use evidence from a call for service the previous day when information indicated she was violent but was calm and engaging with agencies. There has been a significant amount of work around Mental Health and raising staff awareness since our involvement in this case. The Force now has an Operational Lead and a Force Co-ordinator as well as an internal dedicated webpage for Mental Health. The webpage contains a wealth of information for all employees including guidance on legislation, conveyance of patients, restraint and risk, reference materials etc. The web page is also supported by a Mental Health App. In addition, there is now an electronic form to collate data from those cases dealt with under Section 135 & 135 Mental Health Act.

http://www.legislation.gov.uk/ukpga/1983/20/section/135

Training has been delivered to all front-line Officers as part of the Forces Professional Practice Days on Mental Health. A number of staff have been identified and trained as Mental Health Champions across all areas of Policing. These and other staff within the Organisation have also undertaken a number of external training courses in key areas of Mental Health

Humber Foundation Trust

Challenges and difficulties experienced by the practitioners

There were many challenges and difficulties experienced by the practitioners involved in the care of SEM throughout her care pathway with Humber FT.

SEM's high-risk presentations meant that various services would be involved with her care such as CMHT, Crisis Team, inpatient services, police, and ambulance services with the risk that care could be fragmented, and uncoordinated as various agencies responded to crisis.

It was identified in the serious incident (SI) that the lack of systematic documentation and the absence of 'fit for purpose' electronic record system meant that access to relevant assessments and information was compromised.

SEM presented with high risk and challenging behaviour and was inconsistent with her engagement with services.

SEM could be very challenging at times sometimes precipitated by not getting her needs met as she expected. SEM was also verbally abusive and threatening to staff at times.

SEM identified abuse of non -prescribed medication could impact on her presentation causing her to be disorientated, disinhibited and highly impulsive. This may have affected her capacity for rational thought at times as could her underlying mental health condition. Though capacity assessments did not appear to be formalised and there was an assumption of capacity there may have been times when this should have been more formally considered.

The Crisis Team did not appear to be engaged or aware of the multi-disciplinary multi-agency risk management plan which SEM had also signed up to which agreed a short-term admission if there were risk indicators.

The SI external investigation indicated that though there was attendance at the first multiagency meeting from Crisis Service Management the involvement was not robust, the second meeting was not attended and the notes and minutes from the meeting were not shared. The crisis team practitioners appeared unaware of any such agreed plan during interviews. This was identified in the SI report.

https://improvement.nhs.uk/resources/serious-incident-framework/

SEM had not had a review / assessment with a consultant psychiatrist for some time though her case was discussed in MDT.

https://www.evidence.nhs.uk/search?q=mdt%20working

SEM's hip injury had compromised her stress management process of taking regular exercise which then appeared to accelerate her self-harming behaviour as a coping mechanism. This had appeared to increase the volatility of her behaviour.
There were problems in overcoming the issue of communication with the family and the confidentiality concerns regarding SEM's refusal to share information with her family.

How these were addressed

A Care Coordinator had called a series of multi-agency multi-disciplinary meetings in February and March 2014 in recognition of the high demand that SEM could place on various services. The meetings then enabled an agreed Crisis Plan to be developed that could aid effective management of SEM when in crisis with all agencies aware and signed up to the contingency care plan.
There was a clear and agreed care plan in place, multi-agency multi-disciplinary following CPA guidelines and robust risk management.
Care coordinators were engaged in regular supervision with the psychotherapy team to help with the management of patients with a Borderline Personality Disorder. (BPD)
SEM was involved and aware of her care plan for brief admission in crisis.
The CMHT had advised the police that SEM's more challenging and aggressive behaviours could and should be addressed via the criminal route as SEM was deemed to have capacity and should take some responsibility for her more challenging behaviour. SEM was prosecuted in 2013 for an assault on a Consultant Psychiatrist.
The CMHT had supported SEM to access work and education and ongoing work on stress management was in place. All staff involved in SEM's care had had risk management training
SEM had explicitly stated that she did not want staff to give any information to her parents and family.
SEM had threatened legal action against staff if her confidentiality was breached.
There was an agreement in place to advise SEM parents if SEM left the inpatient units as she had sometimes made and carried threats against them. However, SEM's parents reported that this didn't always happen and also felt that the staff took a rigid view about confidentiality and interpreted this as not listening to their concerns.

Challenges and difficulties for Humber Foundation Trust

There was a lack of a clear strategy and clinical guidelines at that time for both CMHT and Crisis teams regarding the safe and effective management of patients with a BPD.

There was no specific training available at that time for suicide awareness.

There was no readily available electronic note system in the trust which could have aided communication between the services. The use of a limited electronic system (Lorenzo) combined with the use of paper notes stored within the relevant teams did not lend itself well to good inter team communication.

The risk assessment tool used at the time was a generic tool and did not allude to specialist risk areas such as suicide, self-harm and personality disorders.

There were bed pressures for acute admission services resulting in problems with access at times.

Supervisory systems in CRHTT were not of a good standard and the team itself was considered to be under resourced and on the risk register for the trust.

MCA training though available did not have a high take up rate at the time and staff had a limited awareness of MCA and safeguarding at that point.

How these were addressed

There are now a raft of improvements and actions in place which have addressed these issues.

Staff did have supervision both clinical and line management, but it was sporadic for CRHTT.

Staff had risk assessment training every three years.

The Crisis Team were gate keepers for the acute admission wards and worked closely with inpatient services to support discharge and explore alternatives for admission.

Staff could access some electronic notes and there was a policy to send notes manually as soon as a patient was discharged to the appropriate teams.

CMHT staff had access to specialist supervision from Psychotherapy services.

Engagement with services

SEM

SEM did engage with services well at times as exampled by her consistent therapeutic engagement with psychotherapy services a three and a half year period December

2010 – July 2014. SEM also had a positive therapeutic relationship with her care coordinator.

SEM had problems with engagement when in crisis when her demands could not be met and when she was under the influence of drugs. SEM could then be extremely uncooperative and challenging. SEM could refuse services and treatment even when there was a significant risk to her.

Other Professionals

The professionals involved in the care of SEM tried to balance the high risks presented by SEM and her need for independence and a life of her own. The long-term therapeutic engagement with SEM showed a high level of commitment to her care and there was evidence of many areas of improvement for SEM at times.

There were often testing situations for staff when dealing with someone as challenging and complex as SEM. SEM required a clear consistent approach with very clear boundaries and a sensitive awareness of her difficulties.

Yorkshire Ambulance Service

It is evident from the patient care records and notes made on call logs that, at times, clinicians had difficulties accessing mental health advice or services when SEM refused to be transported to the hospital following an overdose or was in crisis. The documents show that there were attempts to contact mental health teams for advice about what action the ambulance clinicians should take, or the clinicians were trying to make contact on SEM's behalf. These difficulties appear to have been a source of frustration for the attending clinicians who were trying to ensure that SEM received appropriate support when in crisis and must have been distressing for SEM who was trying to access help but felt she could not. Statements from the clinicians taken at the time indicate that at the time, clinicians felt that there was limited care pathways for patients suffering from mental ill health but who had capacity to refuse to be taken to the ED. YAS have since introduced a dedicated team of mental health professionals to the Emergency Operations Centres(EOC) who are able to provide advice and support for crews and either liaise with local mental health services or speak to the patient directly to ensure they receive appropriate care.

Had this team been in place at the time it may have improved communication between services and empowered clinicians to make decisions especially when assessing SEM's mental capacity to make decisions about her healthcare.

SEM met the criteria to be considered a 'frequent caller' to the 999 service; the threshold in 2013 and 2014 was 15 calls in a six-month period. The Frequent Caller Manager was aware of the volume of calls SEM was making and had taken steps to address this; at this time, it was policy and practice to inform the GP by letter about how many calls were being made, this was done. For some frequent callers the Frequent Caller Manager will work with other professionals to develop an Alternative Management Plan (AMP); this looks at ways that the amount of ambulances attending an individual can be reduced and a more appropriate level of care provided. This could involve triage by one of the Senior Clinicians in the EOC in conjunction with a care plan, referral to the police or to another primary care provider. The Frequent Caller Manager contributed to several MDT meetings about SEM between June 2013 and July 2014 where the amount of calls she was making was discussed and information shared about how SEM presented to the ambulance service or to NHS 111 and whether she travelled to hospital or refused transport. It was determined that SEM was a high-risk patient due to overdose and self-harm and therefore an AMP would not be appropriate for her and that when either she, or someone on her behalf, called 999 then she would be triaged as per normal protocol and the appropriate response sent.

The policy and procedure for managing frequent callers was followed and despite the high volume of calls made by SEM the decision not to introduce an AMP was correct. As evidenced in the chronology, a review of all 999 and NHS 111 calls shows that the majority of ambulances were dispatched to SEM correctly and they arrived promptly, and clinicians provided appropriate care by either taking SEM to the Emergency Department or contacting mental health services for her. The calls made on the 25 July 2014 have been fully investigated; YAS declared this as a Serious Incident however de-logged it following NHS Humber Foundation Trust conducting a Serious Incident Investigation; YAS contributed to this investigation but also completed an internal investigation to the delay on that day. The investigation into the delayed response of 99 minutes to the 999 call made at 17:35 found the root cause to be a high level of RED calls in the Hull and East Riding area at the time that resulted in a delay in responding to the 999 call made by SEM. YAS has a Demand Management Plan (DMP) in place to deal with situations where the demand in an area increases

unexpectedly and does not match the resources available to answer calls, the DMP was put in place to manage this demand and a paramedic was dispatched as soon as one became available. Calls received by the EOC are managed by Advanced Medical Priority Dispatch (AMPDS), this system is used by other ambulance Trusts in the UK and internationally.

https://www.firstresponse.org.uk/first-aid-az/3-general/first-aid/66-dialling-999

The caller is asked a series of questions and based on their answers a final coding is generated that determines the most appropriate ambulance response to be dispatched if needed. Further information about call coding can be found in Appendix 2. 999 calls are audited by a team within the EOC and are scored against the Performance Standards set by the International Academy of Emergency Dispatch (IAED). The audits are conducted using a system called AQUA and all aspects of the call, from verifying the address of the incident, to the order in which the questions are asked and the care advice, which is given at the end of the call, are audited. Calls are audited and graded as having 'High Compliance'; 'Compliant'; 'Partial Compliance'; 'Low Compliance' and 'Non-compliant'. These grades are calculated from four types of increasing deviation from the expected standard; starting from minor and increasing to moderate, then major and finally critical deviation.

1% of all EOC calls are audited in order to identify compliance with the protocols. In addition, any calls that have been identified through other channels within the Trust with a query over compliance i.e. complaints, incidents, etc., will also be audited. The outcome of the call audits is fed back to the call takers and where the calls have been found to have areas of non-compliance, action plans are put in place to monitor the individual's performance going forwards. The audit of the call made by SEM found the call to be non-compliant as the call taker selected the chief complaint as 'psychiatric/suicide attempt' rather than 'overdose/poisoning'; this would have been more appropriate given that SEM had told the call taker that she had taken an overdose. It is difficult to say whether this would have resulted in a different coding from the Green 2 response that was generated as key questions were not asked but it is unlikely the call would have resulted in a RED response as SEM was conscious and breathing. The call taker also ended the call when SEM asked if she could put the phone down, given the nature of the call and the information SEM had given the call taker, it would have been more appropriate for the call taker to keep SEM on the phone

in order to monitor her condition for any changes in her conscious level or breathing. While the call taker advised SEM to call back if her condition worsened best practice would have be to stay on the line, especially as SEM was alone. This was feedback to the call taker at the time and they understood the importance of remaining on the call with callers who have taken overdoses. The coding of SEM's final 999 call as Green 2 and way the call was handled was raised during the Coroner's Inquest into SEM's death where YAS was issued with a Prevention of Future Death Report.

YAS has taken steps to address the concerns raised by the Coroner by contacting the IAED informing them about SEM's death and providing information about the 999 call and in light of this asking for a review of the protocols relating to suicide attempt and overdose. NHS England are responsible for the decision about what type of call would result in a RED response, YAS has also written informing them of SEM's case and requested that they review also this.

City Health Care Partnership

SEM had been aggressive towards health care professionals, this posed challenges within the practice in terms of her management in regard to ensuring SEM's safety and that of the practice staff and patients. SEM was identified as at risk of self-harm and unplanned admissions in relation to her mental health condition and abuse of prescribed and non-prescribed medication.

In light of the challenge's SEM received five medication reviews between 2012 and 2014. Under normal circumstances patients would receive an annual medication review however in SEMs case she had 5 reviews.

https://pathways.nice.org.uk/pathways/medicines-optimisation/medication-review

SEM was sectioned twice within this timeframe and had several admissions to the acute inpatient mental health unit. SEM was under the care of HFT and had a Community Psychiatric Nurse (CPN) throughout her care at the practice, and copies of her mental health reviews and admissions were scanned into the patient electronic medical record. These reviews were seen by the GPs and any changes to medication or care were addressed in a timely manner. It is noted that SEM attended the practice on 9th July 2014 without a GP appointment, unfortunately at the time there was not a GP on site. SEM was requesting to see a GP and receive a prescription for pain relief. SEM became verbally abusive towards the administration staff which resulted in the police being called and her being removed from the practice. SEM had a history of

multiple overdoses and prescribing reflected this, as she was given a reduced number of days of medication.

Hull East Yorkshire Hospital Trust

There were a number of challenges in working with SEM. These include the following:
SEM was often unwilling to engage with medical and nursing staff or provide specific information regarding her current health which made effective communication problematic.
SEM was unwilling to disclose family details, specifically contact details and also did not consent to allow the staff to discuss their concerns with SEM's family and so were unable to fully support SEM.
SEM often left the Trust before medical assessment had taken place, self-discharged and left against medical advice, refused treatment and absconded on a number of occasions which made it difficult to provide the essential care and treatment that SEM required.
SEM's physical behaviour was very challenging at times which often required additional support from the Trust security team and Humberside Police Department.
SEM was often unwilling to speak and/or meet with the Humber FT Mental Health team whilst in the Trust and often left the hospital before they could meet with her.
SEM attended the Emergency Department multiple times, often on more than one occasion on the same day.

c) Please comment on any areas of practice that was above expected levels

Humberside Police

Due to the nature of Policing there is not one identified overall member of staff responsible for working with SEM. Those staff who did engage with her during the timescales of this review did so in a professional and ethical manner.
There is evidence of staff wanting to do the best for SEM and care for her needs to protect herself and others and engaging with other agencies to achieve this. On 23/02/12 a Supervisor records the following decision making when working with the ambulance service to try and get SEM to hospital –

'PC 1 does not have powers under S136 MHA and following a recent High Court ruling found that the Metropolitan Police Officers had unlawfully removed a person from a domestic premise to hospital under s.5 of the MCA. The ruling confirmed that the MCA confers no authority on the police to forcibly remove a mentally disordered person to a place of safety. She would not volunteer any friends and refused families help. As such I informed him to contact the emergency duty team (EDT) and make them take responsibility for coming to the address to assess her regarding mental health or welfare. If they were reluctant to do this then I stated that at present ECHR Article 2 in my mind is the ultimate consideration in our actions and that we should look to preserve life above all else.

https://www.echr.coe.int/Documents/Convention_ENG.pdf

If the ambulance staff believed that the quantity of tablets taken may result in death then I would be willing to trust a court to find me acting in the best interests of the female by using minimal force to make her attend hospital in an attempt to preserve her life.' Despite all of the above decision making the Police Officers present were able to talk to SEM and she eventually agreed to attend hospital on a voluntary basis with the ambulance service.

Humber Foundation Trust

Ongoing psychotherapy input for two years which had flexibility built in to ensure that SEM received increased input at times of crisis. The appointments were weekly but were occasionally twice weekly in times of greater need. There was an allocation of a second coordinator to ensure continuity of care in the build up to the first care coordinators retirement.

There was evidence of significant commitment of Care Coordinator A to the care of her patient and the attempts to highlight the risk that SEM posed to herself on the day of her death.

Care Coordinator A coordinated multi-agency meetings and took assertive steps to agree multi-agency plans to support and manage SEM when in crisis.

Consistent support from the CMHT throughout their involvement with SEM which involved increased appointments at times of crisis, support with therapeutic needs and practical issues such as education, work and housing

Yorkshire Ambulance Service

When SEM called 999 or NHS 111 stating that she had taken an overdose or that she was feeling suicidal, ambulances were sent and she was taken to hospital, this is appropriate and expected practice. On the occasions where there are delayed responses to SEM's call, she was contacted by a clinician from the EOC who further triaged her and ensured she understood what action she needed to take if she felt worse, again this is expected practice.

A review of the patient care records, calls and statements made by staff shows that SEM was treated with dignity and respect by both front-line clinicians and call handlers. Ambulance crews spent time with her making sure she was safe and when she did not want to go to the hospital, they stayed with her for hours contacting crisis teams and mental health professionals, this would be considered as going above and beyond what was expected. In July 2014, one of the clinicians who attended SEM and spent over two hours trying to access advice and support sent an email to YAS' Lead Nurse for Urgent Care raising concerns about the ability for crews to access mental health services and asking for more to be done about this. This shows a commitment of YAS staff to try and improve care for their patients and specifically at that time, SEM.

SEM's history of aggressive or volatile behaviour towards the emergency service often led to the police being called and the ambulance crew or rapid responder 'standing off' until it was safe for them to approach. As many of the crews had met SEM on several occasions, they did not always wait for the police to arrive as they clearly felt they were able to treat her while being safe, ensuring that SEM did not have to wait for care.

The call handler who took the NHS 111 call from SEM on the morning of the 25 July performed exceptionally well and kept SEM on the line and talking when she had said she felt suicidal and didn't know who else to call, the call handler arranged the ambulance and the police and stayed on the call until the ambulance arrived.

City Health Care Partnership

There is a consistency of care at the practice in terms of her seeing the same GP, apart from when this GP was on annual leave. The patient record had alerts on the home page to indicate her mental health status and the vulnerable nature of her health and wellbeing

Hull East Yorkshire Hospital Trust

There is documentary evidence in SEM's medical notes that the following good practice was carried out:

Capacity assessments were frequently performed, and capacity status documented. SEM was deemed to have capacity for all but one episode. Specific feelings, wishes and views of SEM were established and documented. Specific vulnerabilities and needs of SEM were recognised and recorded – this included the risks they posed to SEM and others.

Medical and Nursing staff frequently contacted the HFT Mental Health Care team for advice, support and guidance. Decisions made regarding the outcome for SEM following attending the Emergency Department were clearly documented. Specific risks regarding SEM's mental wellbeing were identified and recorded. Historical information, particularly regarding previous admissions and issues was utilised and documented. Mandatory Safeguarding training at the time of contact included guidance for mental health, mental capacity and adult SG. Trust policies and procedures were followed by staff.

d) What are the possible influences on professional actions or decision-making?

Humberside Police

Multi-agency working in terms of crisis work or longer-term interventions.

The review has already identified some of the challenges that are presented to the Police when agencies request assistance to deal with patients who have a history of aggression and violence but are currently not displaying this behaviour. All agencies are experiencing a reduction in terms of resourcing which impacts on the availability of front line staff and provision of services; therefore agencies need to ensure that decision making in responding to incidents or situations of crisis are undertaken on a risk basis taking into account all factors, including historical as well as those that are currently being presented. This was clearly evident on the incident on 27/03/14 when decisions were made by the Police not to attend an incident based on recent contact with SEM.

Humber Foundation Trust

Multi-agency working in terms of crisis work or longer-term interventions

Lack of joined up realistic plans for crisis management which meant the Crisis Team were unaware of SEM's specific needs and more importantly her changing presentation and heightened risk.

SEM's lengthy involvement with services and her continued presentation of risk and challenging behaviour meant that without a coherent plan of action and agreed boundaries, decision making could be flawed and not reflective of SEM's risk to herself.

Specialist assessment / referral for Forensic services - this was mentioned in 2013 and with her presenting risks, history of violent and challenging behaviour, may have been a way to further assess SEM's risk to herself and others in a secure environment.

Involvement of substance abuse services regarding SEM's abuse of prescription, non-prescription drugs and alcohol. This does not appear to have been fully acknowledged and without the specialist advice from substance abuse services in place, the decision-making process, particularly in crisis situations could be lacking in background awareness and knowledge of the effect substance abuse was having on SEM.

This could have influenced decisions and practice and a more robust risk tool may have identified this further.

Front Line factors (which may have influenced practice)

There was a lack of information from the family due to concerns around confidentiality.

No carer's assessment for the family which may have helped to high light concerns.

SEM's challenging behaviour and erratic engagement with services.

Poor communication between CMHT and Crisis team.

There was a lack of escalation of risk in any formal sense to a senior manager or the medical team.

Local Strategic factors

There were systems and capacity issues in the Crisis team which were being reviewed from an organisational perspective There was no trust guidance or strategy for the treatment of Borderline Personality Disorder the Suicide Prevention Policy was not current or inclusive of best practice

There were no specialist risk assessment tools relating to self-harm or suicide

There was little use through custom and practice of the medical team to support risk or reflective practice.
The thresholds for assessment and admission were not formalised. Police liaison was not effective
There were communication and cohesion issues with CMHT, and Crisis Services not helped by the lack of electronic systems and the mixed use of electronic and paper systems.
There were local issues with commissioning of services, increased funding requests for Adult Mental Health services and national issues with ongoing cuts to NHS budgets.
It has been acknowledged that the actions, assessments and competency demonstrated on the 25th July 2014 fell below expected standards of care.

Yorkshire Ambulance Service

Multi-agency working in terms of crisis work or longer-term interventions
The involvement of the Frequent Caller Manager ensured that information was shared across agencies and that a safe and appropriate plan could be put in place to manage SEM's calls to 999 and to NHS 111. The decision to always send an ambulance when she called 999 was made with all relevant information and this was correct and safest for SEM. The involvement of the Frequent Caller Manager ensured that other agencies were aware of this course of action. It appeared there were difficulties in ambulance crews accessing mental health services for SEM when she refused to travel to hospital, although it should be noted that she did agree to attend the ED most of the time. Multi-agency working with mental health teams has improved since the introduction of the mental health team in the EOC.

• **Family factors** (i.e. the characteristics of the family, the nature of concerns etc.
YAS did not have contact with SEM's family during this time frame but have engaged with them since her death.

• **SEM's behaviour**

SEM's behaviour often meant that the police attended with the ambulance crew both for the safety of the clinicians and for SEM. There were times when the ambulance would be instructed to 'stand- off' until the police arrived at her address. SEM told a member of the NHS 111 call takers that she was aggressive with the police but never with the ambulance staff, may the presence of the police, at times have made her aggressive behaviour worse although there were times when she was uncooperative or aggressive to YAS staff.

• **Worker/team/organisational issues**

During audits of the 999 calls there were some areas of minor deviation and non-compliance which did not impact on the outcome of the call. Action was taken with the individuals involved at the time.

• **Context** There were no factors related to context

• **Managerial issues etc.** There were no factors related to managerial issues

Local Strategic factors

• **Organisational structures**

The local structure did not impact on professional or individual decision making. Had there been a mental health professional in the EOC that could be contacted by either clinicians with SEM or the call takers on the phone then advice and support may have been accessed quicker and the frustration experienced by clinicians not happened.

• **Thresholds**

AMPDS does not allow call takers to decide the outcome of a 999 call once it has been coded. The exception to this is when a call is passed to 999 from NHS111, on the 24 July at 16:15 and 25 July at 10:30 the Green 2 responses were incorrectly overridden by the call taker and a RED ambulance response generated. This should not have happened and resulted in an inappropriate response being sent.

• **Culture**

The professional actions and decision making shows a caring culture where staff are prepared to spend time and effort ensuring they get the best and appropriate care when faced with difficult situations.

• **Commissioning**

There were no influences relating to commissioning

• **Tools and frameworks**

There was nothing specific relating to tools or frameworks

• **Staffing etc.**

Ambulances were staffed by appropriately qualified clinicians. The unexpected increase in demand on 25 July 2014 meant that there weren't enough ambulances to meet the demand on the 999 service rather than the area being under-staffed.

• **National/Government issues or Government policy**

YAS introduced a team of mental health professionals into the EOC as a commitment to the Crisis Care Concordant and continues to raise awareness of mental health issues with staff through regular update and articles in Staff Update

• **Management systems and regulations**

No issues relating to management systems or regulations

• **Expected Standards**

Calls were audited against national standards.

City Health Care Partnership

Multi-agency working in terms of crisis work or longer-term interventions

The GP attended a multi-agency meeting for SEM on 2nd October 2013 to co-ordinate and firm up the management plan and included the admission of SEM should she present seeking support and an admission would be facilitated.

Front Line factors (which may have influenced practice)

• **Family factors** (i.e. the characteristics of the family, the nature of concerns etc.
SEM had capacity and the records state that she did not want family involvement in her care.

• **SEM's behaviour**
SEM had drug seeking behaviour and reported accessing additional medication via the internet. SEM was also verbally aggressive towards health care staff and was presently under a 3-year conditional discharge for having assaulted psychiatrist and police.

• **Worker/team/organisational issues**
The Practice is a single-handed GP practice and SEM was seen by Dr Pinto unless he was on holiday therefore there was a consistency in her care.

• **Context**
The practice team and staff were involved in supporting SEM in accessing timely medical care.

Hull East Yorkshire Hospital Trust

Multi-agency working in terms of crisis work or longer-term interventions
The Medical and Nursing staff worked closely with Humber FT Mental Health team and followed their guidance regarding the provision of support for SEM.
There were delays in the Mental Health team's availability due to work pressures which was problematic External advice was sought appropriately and used to inform decision making for SEM.
Interactions with the Police were relevant and as per SEM's needs, including a specific protocol developed by the HFT MH team for SEM when she self-discharged.

Internal working was proactive, involving other teams when appropriate.

Front Line factors (which may have influenced practice)

• **Family factors**

SEM did not disclose any family details, specifically contact details and did not consent to allow the staff to discuss their concerns with SEM's family and so were unable to fully support SEM and meet her specific needs. There is no evidence of any communication with SEM's family by the Trust's medical and nursing staff. There is one recorded episode of care when SEM attended an elective appointment with her mother.

• **SEM's behaviour**

SEM's behaviour was very challenging and was often unwilling to engage with the medical, nursing and mental health staff. SEM often self-discharged against medical advice or left the department before assessment and/or treatment and often refused treatment which made it difficult to provide the care and treatment that SEM required. There is documentation that states SEM did not feel that the Humber FT Mental Health team were supporting her as she would like, and this potentially led to disengagement with that team.

• **Worker/team/organisational issues**

There is no evidence that SEM did not engage with Trust staff. There was no specific worker of team in the Trust that had a negative impact on SEM.

• **Context**

SEM attended the Trust for her physical and mental health needs as appropriate. The Trust is the main department locally for urgent health care needs.

• **Managerial issues etc.**

There was no evidence of issues with management, failure to escalate or non-compliance with Trust policies and procedures.

• **Local Strategic factors**

There is no relationship between SEMs attendances to the Trust and strategic factors. Staffing was appropriate to department levels. SEM was seen by appropriate level of staff on each occasion.
SEM was treated with equality and without prejudice on each occasion.

• **National/Government issues**
The MH Crisis Care Concordat (MHCCC) was not in place at the time.
https://www.crisiscareconcordat.org.uk/
However, SEM was treated within the realms of the Mental Capacity Act,
Mental Health Act and the legal framework adhered to. Following the introduction of the MHCCC, it is unlikely that there would be any changes to the Trusts management of SEM.
The care of SEM at the Trust was at the expected standards for someone with complex health care needs and was referred appropriately to the specialist services as applicable.

e) What is your analysis of your agency's involvement?

Humberside Police
Humberside Police responded in accordance with legislation and polices at the time in relation to all the incidents subject to this review. The recent contact prior to the death of SEM was referred to the Independent Police Complaints Commission in accordance with procedures requiring Police Forces to make referrals following the death of a person who has been in recent contact with the Police. The arrests of SEM were appropriate and in response to criminal offences that had been committed. On some occasion's restraint had to be used and the rationale for this was documented and presented to the Custody Sergeant. There were occasions whilst SEM was in custody that she was placed on cell watch, this was undertaken following a full risk assessment and to minimise any risk of her harming herself. There is evidence throughout our contacts that we have worked with partner agencies in responding to incidents, on some occasions, as described this has been challenging but the outcome has always resulted in SEM receiving the care and medical attention that she needed.

Humber Foundation Trust

To complete this review, the author has utilised SEM's notes from 2012, the Independent SI completed in 2015, the completed action plan implemented by the trust and the progress report in relation to the recommendations following SEM's death. There has also been discussion and feedback with the Director of Nursing, Clinical Director for Adult Mental health, Clinical operations manager, Assistant Director of Nursing Safeguarding and Patient Safety, Care Quality and Compliance Director and the Assistant Director of Quality and Nursing.

There has been a review of all relevant policies and procedures.

SEM was a complex and challenging young woman who had multiple difficulties which to an extent were being addressed by the services and acknowledged by the CMHT and the Crisis team. SEM's needs were recognised, and her risks identified as high regarding suicide and self-harm. An area where it is possible that SEM's needs weren't fully acknowledged was her dependence on and abuse of prescription and non-prescription drugs.

It is apparent it was not always recognised that there was an increased risk to SEM when under the influence of drugs and how this may have affected her capacity at times.

SEM's mental health was assessed frequently but there was a lack of a medical review from her own team for the last two years of her life though her care was discussed in MDT.

During the hours preceding SEM's death there was evidence that her mental health was not assessed to an adequate level, neither was there sufficient communication / discussion with clinicians who knew SEM well. The process also didn't take into account SEM's admitted drug consumption that day and the impact on her capacity and ability to keep her safe. The process itself was short lived and perfunctory and the primary issue appeared to be lack of bed space at that point. The lack of any medical review in these circumstances was another factor that did not fully acknowledge SEM's risk and the antecedents of increased risk i.e.; placing a plastic bag over her head. The family reported problems with communication and a lack of concern from services or awareness of their role in SEM's life. SEM had refused permission to the services to contact her parents or relay information, but the family felt that they didn't even have the chance to relay concerns and they were not kept in the loop as regards SEM

admission processes and discharges. The family felt that the risk to them from SEM was not acknowledged and that their input may have helped the service to understand more fully how their daughter was actually coping.

Under the 'Triangle of Care' guidance it would have been possible for SEM's family to relay information and concern about SEM without breaching her confidentiality. This would have been more supportive to a very concerned family and more helpful for staff to obtain a full picture of SEM's difficulties. Overall, SEM's consistent CMHT were well aware of her historical information and considered her care in context - this was, however, not bolstered by meaningful information from the family so may not have been a full and accurate picture.

Though there were meetings with the family during the earlier part of SEM's care there were always limitations and difficulties with incorporating their views.

The issue of confidentiality clearly concerned service staff who felt that their jobs would be at risk if they disclosed any information. A clearer understanding of the complexity of the confidentiality policy would have been helpful to the staff and family who felt unsupported in the process.

The relevant family history, cultural ethnic and religious identity of the family appears to have been acknowledged and considered.

The issue of whether the quality of judgments and decision making, the extent to which it focused on the needs of SEM and family represented appropriate professional standards and organisational guidance was addressed in the SI and clearly there were concerns particularly around the events of the day SEM died.

Localised issues on the day:

Risks were not explored in sufficient depth by the Crisis Team. Capacity was not formally assessed and there were clear risk factors regarding lack of sleep, effects of drugs in the system and recent events which had escalated the risk to SEM i.e. the attempt to put a bag over her head.

There was a lack of communication and cohesion between services and a prolonged and inadequate gate keeping process which did not understand fully the concerns or risk factors at that point.

Lack of a medical review for a young woman who was clearly stating she had intent to take her life and expressing her wish to use a method which was a very high risk – this had already been previously identified as an attempted action.

Crisis service ignoring existing concerns expressed by the CMHT and the agreed care plan that was in place to manage SEM in crisis.

Organisational issues:

System design and capacity of the Crisis Team, over reliance on individual assessments, lack of cohesive team discussion and communication with other services.

Record keeping which includes the lack of an electronic record system, splintered recording process i.e.; some paper some electronic and a lack of coherent access to updated records risk assessments etc. There was limited training for BPD and absence of a strategy and care pathway for this client group. The quality of judgments and decision-making process on the day of SEM's death were not of a good professional standard neither did they represent organisational guidance. However, the overview of her care during the last two years did evidence that there was a consistent and positive approach to decisions and judgments in the CMHT which were arrived at collaboratively.

Information regarding SEM and her family was shared appropriately amongst agencies and professionals and this was evidenced in multi-agency meetings in February and March 2014.

This included, Police, Ambulance service, A&E consultant, Psychiatrist, Psychotherapist and the Crisis Team clinical lead. All parties agreed an action plan that included a 72-hour admission for SEM if the risk were such that this was required. This is evidenced as good practice and in line with CPA policy and a high level of multiagency risk management.

However, this does not appear to have been fully acknowledged by the Crisis Team who were not present at the second meeting and did not receive the minutes from the meetings.

All Crisis Team practitioners during interviews felt that the plan had been developed in isolation and was not practical to implement. There is reference throughout SEM's notes to her capacity and she was indeed an intelligent and articulate young woman who would normally be considered to have capacity to make decisions. – The assumption of capacity is the cornerstone of capacity assessment and SEM had been identified as having capacity to make decisions regarding all aspects of her life. Therefore, unless there were reasons to doubt SEM's capacity to make decisions it

would not have been routine or indeed reasonable to formally assess SEM's capacity at every stage of her involvement with services and would have been at odds with the MCA to do so. However, there are exceptional circumstances when it would be reasonable to evidence capacity and when referencing it to identify that it has been properly assessed and documented on the appropriate paperwork. This would be for instance when SEM was refusing medical treatment for overdoses in the past or in this instance when she was stating her intent to take her life and she was considered to have capacity to leave and go home. In those circumstances a formal capacity assessment would have been an appropriate action particularly with the added concerns of recent threats and actual attempts to harm herself. SEM was actively asking for admission, so the Mental Health Act was inappropriate in those circumstances but the lack of documentation to show consideration of MCA in any formal sense in these high-risk circumstances indicated a lack of awareness of MCA and a lack of understanding of the risks involved.

https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act/

There was no evidence on those occasions of a formal assessment of capacity rather a much looser assessment of her mental state without a formulated risk management plan or protection / follow up plan.

'Assumption of capacity' is the overriding principle of capacity assessment. This states that a person is deemed to have capacity unless it is proved that they have an impairment or disturbance of mental functioning (such as an intellectual disability, dementia or other cognitive impairment, acquired brain injury or mental illness) and this impairment is sufficient to affect their capacity to make a particular decision. Clinicians should assess and diagnose such impairment before assessing capacity. The Act preserves the right of individuals without such impairment (and those with impairment who have capacity for the decision in question) to make unwise or risky decisions and it is emphasized that lack of capacity cannot be attributed simply because of appearance, condition, age, religious or cultural beliefs, and eccentric or idiosyncratic behaviour

Mental Capacity Act 2005

The quality of the recording and documentation was at times inadequate with poor recording of discussions, risk management, protection plans and particularly regarding

the Crisis Team interventions where there was a lack of meaningful documented assessments. The overall clinical notes did contain a variety of assessments and the psychotherapy notes contained detailed assessments and descriptions of therapeutic work.

Yorkshire Ambulance Service

YAS had a significant involvement with SEM in the period leading up to her death. The 999 calls were, on the whole, appropriately coded and an ambulance arrived within the expected time frame; areas of noncompliance were addressed with individuals at the time and remedial action taken. Clinically, ambulance clinicians took SEM to hospital when she allowed them to do so; when she refused her capacity to make this decision was assessed and clinicians spent time ensuring she was safe by either contacting other professionals for advice or informing the police.

It appears that she was treated with dignity and respect by both clinicians and call takers; they listened to her views and wishes and were concerned for her health and well-being. The introduction of the mental health team in the EOC would mean that clinicians and call handlers would be able to seek advice about mental ill health quicker, but this would not have an impact on the dispatching of an ambulance when an overdose had been taken.

The management of SEM's frequency of calls by the Frequent Caller Manager was appropriate, followed policy and procedure and was as safe as possible. There was an active engagement in information sharing to risk assess SEM in relation to the 999 calls and other agencies involved in her care.

YAS took appropriate steps to ensure SEM received help and medical attention following her overdoses and during times of crisis. Information was appropriately shared with other agencies through both the Frequent Caller Manager and by the clinicians who attended her.

The Serious Incident investigation supported by YAS into the delay of 99 minutes in attending the 999 call made by SEM at 17:35 on 25 July 2014 found the root cause to be due to an unexpected increase in demand in the area at the time meaning that there wasn't an ambulance to send to her. YAS continue to monitor demand and

staffing levels in each area and implement the Demand Management Plan when required to ensure that patients are kept safe at all times.

City Health Care Partnership

There were examples of very good practice. It is evident from the records that SEM engaged well with primary care, with her GP. She attended frequently over the two years and the records demonstrate she attended all her appointments and cancelled when she could not attend.

The records show periods of excellent continuity of care, which is evidenced by periods of frequent reviews of SEM. At times she was seen on a weekly basis by her GP.

On closer inspection of the records, there is documentation of the GP sending self-reminders as a prompt to review SEMs medical records, after notification of an overdose attempt. This shows a degree of involvement with the care of SEM, which is commendable. The records indicate a degree of rapport and trust between GP and SEM. Of particular note, the records indicate that one consultation with SEM lasted 45 minutes. However, there could be more emphasis in the GP consultations with regards to the cultural and religious identity of SEM. Furthermore, the documentation show that there is lack of discussion around her relationship and

psychosocial circumstances and the impact they have on her psychological wellbeing and the subsequent risk of further self-harm. It may be the case that the discussions occurred, but this is not reflected in the notes.

Another example of excellent practice is the multi-agency professionals meeting on the 2nd October 2013 at which the GP was able to attend. However, the records indicate that meetings between professionals of this type occurred only twice over the two-year period despite continued self-harm and presentation to the Emergency Department. The second meeting took place on 14 October 2013. Considering the complexity of her mental health and repeated number of contacts with ambulance services, accident and emergency and primary care there may have been benefit from more frequent meetings with a joint management plan determined.

Although there is evidence of liaison between the psychiatric services and primary care, in particular, pertaining to risk management of prescriptions, there is no documented evidence of discussions within the GP practice to minimize the risk of both further self-harm and violent behaviour.

The practice addressed the concern regarding prescriptions and gave prescriptions for a limited number of days for her psychiatric medication. There is no documented discussion of a joint management plan between the GP and SEM, to address her risk of further self-harm. NICE guidance on management of self-harm states that people who self-harm have a 50- to 100-fold higher likelihood of dying by suicide in the 12-month period after an episode than people who do not self-harm. NICE suggests constructing a joint management plan between the clinician and patient. However, the practice added an alert to her GP records that she is high risk of deliberate self-harm, and in June 2014 added SEM to the unplanned admissions register, a register of the top 2% of patients who are at risk of an unplanned admission. As a consequence, SEM would be involved in making a care plan as NICE suggests. Unfortunately, she took her own life before the plan was determined. A deliberate self-harm policy may have helped address this issue earlier.
https://www.nice.org.uk/guidance/QS34

The Practice received notifications from the Emergency Department at Hull and East Yorkshire Hospitals of overdoses taken by SEM and whilst this was recorded in the notes, there was often no action taken by the practice. The chronology indicates periods of time whereby the practice would receive successive notifications of deliberate self-harm, including in the months before her death. There was no documented action taken. There are many Accident and Emergency letters that come into practice and also the GP involved would be aware that SEM was under the Mental Health Team and that they too would be involved in her care and may have assumed that her A&E attendances would involve input from the Mental Health Team.
SEM was sent a letter by the practice of zero tolerance towards her behaviour following an incident at the practice in July 2014. SEM was clearly in crisis at that time, evidenced by her repeated deliberate self-harm over the preceding weeks and may have benefitted from a face to face discussion about the incident and assessment of her needs during the crisis period. The practice discussed the incident at a practice team meeting in July, as it is normal procedure that when police are contacted and an incident number is obtained, the patient can be removed immediately from the practice list. Datix web number, 11777, identified an action which was to discuss at a practice team to look at removal from the list due to the police involvement. The outcome of

which was documented, and it was decided not to remove patient from list at this time. (Datix, is the organisation's incident reporting system).

SEM was prescribed benzodiazepines medication over the two-year period and at times in conjunction with other sedative medication, and in the knowledge that SEM was supplementing the prescribed benzodiazepines with nitrazepam (a benzodiazepine) purchased from the internet.

There is no evident record in the notes of a discussion with SEM about the long-term risk of using benzodiazepines or a discussion regarding a plan to reduce the use of the medication. The Hull and East Yorkshire Prescribing Committee advise using the lowest dose of benzodiazepines for the shortest duration possible. NICE recommends that benzodiazepines are not offered for GAD (generalized anxiety disorder) in primary or secondary care except as a short-term measure during crises. The BNF states 'Benzodiazepines are indicated for the short-term relief of severe anxiety; long-term use should be avoided.'

The GP could have informed the police regarding the buying of drugs from the internet but not sure if this would have prompted them to take any specific action. The records do not indicate that the GP considered this course of action or not.

In relation to diazepam prescribing by GP1 short term increases from the dose of 2mg three times daily as needed were made as following:

4/1/13 increased to 5mg twice daily for 14 days only (Discharge medication request from Mill View on 26/11/12 had increased dose to 5mg bd.)

2/9/13 diazepam was increased to 5mg bd for 3 days.

13/9/13 diazepam was increased to 5mg once daily for 4 days only (I note in discussion with CPN on 12/9/13 he was advised not to make any changes to the medication regime)

Before and after any short-term increases in diazepam SEM was maintained on 2mg as needed.

https://www.nhs.uk/conditions/generalised-anxiety-disorder/treatment/

Hull East Yorkshire Hospital Trust

Effective documentation. It was clear in the nursing and medical notes that there was a care plan for SEM. It should be noted that since 2014, the Trust has introduced a

revised care plan which summarises episodes of care in one integrated record. Effective sharing of information where appropriate.
Utilised relevant historical information. Staff always referred to previous admissions in order to provide a holistic view of SEM.
Acknowledged recent attendances/actions which were considered and included in the overall plan.
Vulnerabilities and risks were recognised and actioned. The Trust does not use a specific tool for assessing Mental Health needs. However, the Trust hosts the Mental Health Liaison team and so access to specialist advice and assessments is available 24 hours a day.
MCA followed although the formal mental capacity assessment was not consistently performed and recorded.
The Trust works on the principles that patients have capacity unless there is reason to doubt this and in SEM's case, this was followed appropriately.
The Trust liaised and shared information with other agencies – Mental Health Team, Security, Humberside Police.
Incident reports were completed in line with Trust policies and procedures when applicable (such as restraint, security, absconding).
There are no reported Safeguarding Adult referrals for SEM. As SEM had other agencies already involved, it is unlikely that she would have met the threshold in a single episode of care. However, multiple admissions/contacts would trigger safeguarding concerns now and potentially a multi-professionals meeting commissioned by the Trust with all involved agencies.
Overall, the Trust involvement and care of SEM was appropriate to her needs

f) What recommendations have resulted from this learning and when will these actions be implemented?

Humberside Police
See Action Plan in Appendix

Humber Foundation Trust
See Action plan in Appendix

Yorkshire Ambulance Service

See Action plan in Appendix

City Health Care Partnership

See Action Plan in Appendix.

Hull East Yorkshire Hospital Trust

See Action Plan in Appendix

g) How will your agency ensure that these actions are firmly embedded into day to day practice?

Humberside Police

The escalation process and the availability of the Senior Manager has been included within the training delivered to front line staff. The escalation process is also contained within Operational Guidance.

Humber Foundation Trust

Lessons to be learnt

• All risk assessments must be completed following a systematic process that is inclusive and affords a protection plan for the individual. Assessment decision making should not be conducted in isolation but embrace current plans, views of the care coordinator, patient and family where possible. Assessments should not be considered in an isolated process.

• Staff should escalate high risk cases to managers and medical staff.

• Staff should always consider the involvement of family wherever possible in the care of a complex patient using the principles of the 'Triangle of Care'

• A carer's assessment should always be considered for families struggling to support a patient with complex needs.

• The trust must arrange appropriate support to families and staff and ensure that information is shared with the families following a distressing incident.

• Training for risk assessment must be up to date and the process should include specific risk tools for suicide and self-harm.

• Teams should be supported to work cohesively and embrace joint working and multi-agency risk management.
• Crisis management care plans agreed in a multi-agency forum should be upheld and adhered to whenever possible. These risk management plans should be realistic and communicated to all involved agencies.
• Supervision must adhere to the process and structures advised in the trust supervision policy.
Specialist supervision should be provided where needed to staff.
• Record keeping should be in line with policy and reflect the need for thorough contemporaneous note keeping including robust risk assessment and protection plans. Records should be accessible to all staff when needed.
All these points have been addressed via the action plans, the operational policy for CRHTT and embedded in the Transformation Plans.

Trust Action Plan

This is a summary position against the action plan:

All the agreed actions that have been implemented go through the Organisational Learning Report for the Care Group which is reviewed in the weekly organisational Risk Management Group. All actions have been implemented but ongoing learning and reflection continues to take place and inform continuous service developments with the Mental health care group.

Review of Crisis Resolution and Home Treatment Team:

The service has an ongoing Transformation plan which has been in place since 2014 and has implemented a number of transformational changes which includes delivering a more effective care pathway for people who are experiencing crisis.
These developments have seen an increased staffing over the evening and night time period within a Mental Health Response Service which is now integrated with Avondale acute admissions unit. Within the Mental health response service there is dedicated resources for delivering home based treatment following assessment either in crisis/ the community or following inpatient assessment, where increased home based support can be put in as a real alternative to admission or to support people being discharged from inpatient care. To support people experiencing emotional distress the trust in conjunction with Hull and East Riding Clinical Commissioning

Groups (CCG) has commissioned a crisis pad which provides a safe and supported space where people experiencing emotional distress can receive support and sanctuary as part of a preventative and supportive intervention when in crisis.
The Mental Health Response Team has a new operational policy in place supported by an increased leadership model which includes 24 -7 senior clinical support.
A clinical psychologist is in place to support the Mental Health Response Team with reflective practice groups, providing supervision and joint assessments to ensure best practice standards are delivered.
The operational policy includes: Enhanced function of daily MDT meetings with clear escalation and resolution process which includes access to both clinical and managerial support through on call systems and the supervisory process.
MDT review and reflective practice sessions have also been established within the service. The Mental Health Crisis Care concordat is well-established and the Concordat group which includes police ambulance, Within the Concordat there is an operation group which meets on a regular basis to ensure multiagency procedures are in place and supports effective communication and liaison between all agencies to support effect interagency working and routes of escalation.

Working with people with complex trauma/ personality disorder:

To support the development of a new clinical pathway and to benchmark current practice a clinical audit was carried out utilising the audit tool within the NICE (Clinical Guide 78) Borderline personality disorder:
https://www.nice.org.uk/guidance/CG78
Recognition and Management guidance. The audit was carried out in 3 selected teams within Humber NHS foundation Trust. The outcome of the audit supported the need to establish a specialist personality disorder service, as recommended by NICE, which would support the development of practice & care of patients experiencing this disorder. Since 2017 the trust has had in place a complex intervention service which comprises of complex trauma, personality disorder care co-ordination and treatment and the specialist psychotherapy service who are able to provide assessment and formulation, consultation /supervision, as well as case management and support for the most complex presentations. The personality disorder service provides complex care co-ordination and access to fully compliant Dialectal Behavioural Therapy (DBT)

which is recognised evidence based intervention for people experiencing self-harm and suicidal thoughts.

To further support evidence based intervention for people with complex needs the trust has implemented training across the community mental health teams and access to Mentalisation Based Therapy (MBT).

The Trust has commissioned training for borderline personality disorder for a number of years which has included training on formulation and management plans. The 3-day training course provides clinicians with a framework in which to understand and manage the relationship between the clients and the service providing their care and aiming to provide clinicians with the skills to assess risk at an individual level based on in depth formulation.

Training sessions were undertaken in November 2015, January 2016 and March 2016 with the January 2016 training being aimed specifically at team managers and services managers, so they were able to adequately support and supervise their teams in the management of complex patients.

As part of the development of a new clinical pathway, training needs were initially reviewed and a revised training plan was developed together with a quality improvement incentive scheme agreed with commissioners to commission and deliver the Personality Disorder Knowledge and Understanding Framework (KUF).

https://kufpersonalitydisorder.org.uk/

The KUF training was co provided by Leeds Personality Pathway development service and Emergence (Changing attitudes building lives). The KUF training aimed to provide staff with the underpinning knowledge and understanding required to work more effectively with service users with a diagnosis of borderline personality disorder and developing sensitivity to service user's experience. Training was undertaken from October 2016 following national and regional changes to the KUF training programme this package is no longer seen as relevant for the general adult population.

Alongside the KUF training the trust have developed a bespoke suicide and self-harm training package (SASH) which is supported by a handbook for clinical staff to support evidence based person centred practice. The training is designed to explore attitudes and understanding of self-harm and suicide and the training was co-produced and delivered by clinical staff and users by experience and has been in place since

early 2017. To reflect the changes in KUF programme the training has been reviewed with service users by experience and updated.

To date 350 front line staff have undertaken this training and as of 1st May 2019 98% of clinical staff within the mental health response team and mental health liaison team has undertaken the training.

Supervision:

The Trust has reviewed its existing supervision policy which has been approved and rolled out across the Trust. Training updates regarding the revised policy are in the training diary for all staff to access.

The Crisis and Home-Based Treatment Team which is now the Mental Health Response Service have revised its supervision structure to ensure appropriate clinical supervision is in place. This has been supported by the appointment of 4 band 7 clinical leaders as well as introducing reflective practice sessions and utilisation of a consultant psychologist within the team.

https://www.evidence.nhs.uk/search?q=reflective+practice+in+mental+health+nursing

As part of the transformation of this service supervision time has been identified for all practitioners within the team and is prepopulated in to each staff member's schedule of work (diary).

Electronic Records:

Humber FT now have a contemporaneous electronic patient record (EPR) which provides patient records to all staff providing direct care to patients. The EPR can be accessed remotely to provide virtual and face to face support an information, an example is the on-call medic can now see the record and from any location, this was not previously possible as the Trust were using paper records. The Mental Health Response Service can now access existing safety plans, care plans, FACE risk assessment and other clinical reports quickly and they also update the record in real time.

The Trust has secured NHS Wi-Fi in all its buildings. Staff have GOVroam so they can work at partner buildings and staff also have secure remote access so they can work from other locations and access the EPR.
We send all our communications electronically to GPs.
Our staff now have access to the Summary Care Record using our EPR.

Humber FT is also a wave 1 adopter of the Yorkshire & Humber Care Record and can now share patient information for direct care with other organisations as they join the Yorkshire & Humber Care Record.

To further improve patient safety Humber FT have started to implement electronic prescribing and medicines management (ePMA) across it Mental Health services in June 2019.

Confidentiality and patient and carer experience:
Humber FT has reviewed the confidentiality policy to ensure that there is clear guidance for staff regarding sharing information with relatives & carers. The Trust has appointed a Head of Patient and Carer Experience and Engagement and a Patient and Carers Experience Strategy have been developed and is supported by a Trust patient and carer experience forum. This group is chaired by the Medical Director and deputy chair the Head of Patient and Carer Experience and Engagement The group has developed a framework for improvement a key part of which is the commitment to work with carers to gather their story of the patient's history. This has now been rolled-out across the Trust.
The Trust has implemented a three year co-produced action plan to ensure the delivery of the patient and carer strategy. The trust is in the process of implementing the relatives stress scale to support the identification of carers in stress and identify appropriate support. To ensure carer support is embedded within the organisation a staff champion's programme is in place to ensure patient and carer experience is embedded within the teams.
In November 2018 the Trust implemented the Humber co-production network where partnering organisations across statutory service and third sector come together to support effective communication and partnership working.

Listening to carers is a key part of all new policy development and within the Adult Mental Health Care Group a 1-day training course has been developed and implemented around Family Inclusive Care co-ordination. The aim of this course is to enable practitioners to engage with families as a routine part of their care co-ordination role with clients and understand the principles of confidentiality and information sharing to assist rather than inhibit family inclusive practice.
A new standard operating procedure for information sharing with carers and significant others has been developed and is currently out for consultation.

Supporting Families:

Prior to the inquest an engagement lead was identified for the family to ensure that a single point of contact was available. The point of contact at this time was identified as the Care Group Director for Adult Mental Health. Following the inquest hearing the single point of contact was changed from the Care Group Director to Deputy Director of Governance & Patient Experience. The change in the named contact was made to reflect the current needs of the family and to ensure appropriate support was available to answer any unanswered questions the family may have.

Duty of Candour:

The Trust has implemented the statutory duty of candour requirements. A policy has been produced to provide information and guidance to staff. Training has been delivered through an external provider. The CQC declared the Trust complaint with the requirements of duty of candour when they inspected the Trust in April 2016.
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

MCA training and staff awareness:

MCA training is available to staff via an e learning programme and face to face training when required. . It covers; understanding the meaning of capacity and how to apply the test of capacity;

application of the 5 Principles of the MCA; application of the Best Interests checklist; recognising the importance of accurate recording & reporting; awareness of the Deprivation of Liberty Safeguards & the concepts of restriction and restraint; recognising the concept of Advance Decisions\Statement of Wishes and recognising other roles and the part these play within the MCA including Lasting Power of Attorney, Court of Protection, Deputies, Independent Mental Capacity Advocates (IMCAs) & the Office of the Public Guardian.

Compliance for MCA training in March 2019 trust wide was 85% which meets the agreed compliance

MCA reviews are undertaken throughout the trust for all clinical areas following an MCA audit and incorporate a review of MCA paperwork, recording of and quality of the MCA process. This is an effective method for testing the application and understanding of the process for clinical staff.

New MCA training specific to inpatient areas has been developed and will be available from August 2019 as face to face training for inpatient staff.

All clinical staff are required to undertake the revised Mental Health Act and Deprivation of Liberty training and undertake refresher training every 3 years.

MCA basic awareness level one leaflets has been distributed to all staff throughout the trust and there are regular updates from the safeguarding team via midday mail to all staff including practice notes and 5 minute focus for MCA.

Safeguarding:

Access to safeguarding support for all teams across mental health services including the Mental Health Response Service has been increased and is cited within the team's operational policy. The safeguarding team provide telephone support and advice to all teams 9 – 5 Monday to Friday and also provide support for any complex safeguarding cases., Advice and support can be provided on an ongoing basis for any complex safeguarding issue including MCA and Best Interest concerns. The safeguarding service offer development sessions to staff on a monthly basis , supervision on a one to one or group basis and support for any cases of concern which involve safeguarding . Humber safeguarding also offer advice regarding signposting, escalation of concerns, risk management and protection planning.

Compliance monitoring of safeguarding training is in place and monitoring is undertaken and reported by the Humber Safeguarding Team as part of the quarterly safeguarding reports which goes to the Trust Board & the Operational Management Group. Compliance for the Mental Health Response Team was 81% at the end of March 2019.The trust is fully compliant in all areas of safeguarding training with the new level three training expected to hit full compliance in October 2019.

Humber safeguarding has a full staff complement with an integrated safeguarding team covering adult and child safeguarding issues. There is a Named Nurse for Adult Safeguarding and also for Children's Safeguarding with 4 dedicated safeguarding practitioners and two part time trainers in place. Humber safeguarding have developed level three training for professional staff which has been available since April 2018 and also developed specialist training in the areas of self-neglect which is now available to all staff from March 2019... Humber safeguarding is involved and embedded within the trust risk management processes and SI review processes. In addition, all staff in the Trust has been sent basic awareness level one leaflets for Adult Safeguarding.

Patient Safety

Humber FT have produced and implemented clear procedures relating to the management of self-ligaturing which includes the safe removal of ligatures and use of ligature cutters. This procedure was agreed by the Quality & Patient Safety Committee in April 2016 and rolled out across the service with training for staff on the procedure and the use of ligature cutters. Training regarding ligature cutters has also been incorporated into the Basic Life Support/Immediate Life Support training which is a yearly refresher for staff.

All incidents of ligature are reported through the Trusts risk management system (Datix) and an audit of all Datix incidents relating to ligatures was completed in Quarter 4 in 2015/16 prior to the new procedure and training being implemented. And again in the same quarter 4 periods in 2016/17 to assure appropriate practice was undertaken

A review of the Management of Violence and Aggression policy has been undertaken to ensure practice remains current with national guidance.

A Positive Proactive Care Working Group was established and undertook a full review of all restrictive intervention policies linked to the review of restraint training. Following this a suite of policies will be introduced that cover all restrictive interventions e.g.

restraint, seclusion, long term segregation, mechanical restraint, chemical restraint (RT) and blanket restrictions.

To support this work a trust wide reducing restrictive interventions (RRI) group was set up so continuous motoring and service developments are in place to reduce restrictive practice. Alongside the RRI group a positive engagement team is now in place who contribute to the review of all restraints and incidents and support the training and development of all staff. As part of the patient safety strategy on violence and aggression, a review of training on managing violence and aggression was undertaken. This review has considered the Trusts current training, MAPA (Management of Actual or Potential Aggression) along with other forms of training approaches available and has recommended the continuation of MAPA. An audit of the use of restrictive interventions was carried out in Q4 of 2015/16 repeated in Q4 2016/17 since this time all incidents of restraint and seclusion are reviewed by the clinical team and reported through care group and trust wide patient safety forums.

Risk Training:

A review of the EGRIST risk assessment tool, document and process was undertaken by the Trust.

https://www.egrist.org/content/grist-solution

A Clinical Risk Assessment Reference Group was formed in October 2015 with terms of reference which includes three areas of priority. These are clinical risk training, clinical safety for health IT and the selection of an appropriate risk tool. The Adult Mental Health Care Group reviewed its existing mental health assessment and risk documentation on an ongoing basis and has introduced the Functional analysis of care environments (FACE) risk assessment which is a nationally recognised and accredited tool The Trust continues to review its risk management documentation and further work is continuing through the development of clinical pathways to identify disorder specific risk assessments which can be used following a global assessment of risk being completed. Specific risk assessments for self-harm and suicide have been included in the staff SASH handbook and within the SASH training. Trust wide generic Risk assessment training is also in place for clinic staff.

Yorkshire Ambulance Service

The mental health team in the EOC have been in place for over 12 months and their function and contact details are well known to all YAS staff and the pathway is well used. YAS have an Incident Review Group which meets fortnightly which review both individual cases where a process or pathway has not worker or incident where harm has been caused; the themes and trends that arise from these incident influence changes throughout YAS.

City Health Care Partnership

In future patients identified from high risk of Deliberate Self Harm (DSH) will be added to the unplanned admission register and this to be flagged on the home page of the electronic record. Patient will a have care plan added to the register and frequent reviews to be undertaken by the GP until the patient is stable &/or under regular CMHT review.

Practice pharmacist to do a search of patients on unplanned register who are at risk of DSH/overdose and ensure that current prescribing is in line with that advised by the CMHT and that regular medication reviews are being undertaken

Hull East Yorkshire Hospital Trust

Audit of practice - MCA documentation audit. Already in place so continuation of these audits.

3 G (Great staff, Great Care, Great Ward) Assessments.

Evidence of Trust Learning Lessons newsletter.

Medicine Health Group Quality Safety Managers to ensure actions are embedded by incident analysis, team meeting minutes and participation in audits.

Establishment of Safeguarding Adult database for patients who are frequent attenders and who may require multi-professional escalation

h) What steps will you take to ensure that all frontline practitioners and managers within your organisation know about the lessons learnt from this review and will reflect and change their practice, if necessary, as a consequence.

Humberside Police

The learning from this review will be embedded through the Forces Organisational Learning Group Meeting which is chaired by the Head of Professional Standards Branch. This meeting is attended by representatives from all Commands, including Community Policing, Specialist Policing and Communications Department.
Learning from this group raised with Senior Managers within the Organisation where necessary and disseminated to frontline Practitioners through representatives at the meeting and/or by the Marketing and Media Department through internal communications.

Humber Foundation Trust

The report findings have been shared with staff and the actions have been embedded into the transformation programme and have been the primary force behind the changes in triage, assessment, risk assessment and the structure of the team in line with secondary adult mental health services.
Practitioners and Managers are aware about the lessons learnt from this review which can underpin reflective practice and practice change if need be.

This is from a variety of methods:

Business Meetings
MDT
Peer Supervision
Development sessions – psychotherapy specialist supervision
Case feedback / practice discussion
Risk Management Training
Weekly team meetings
Daily MDT sessions
PADR
Clinical and Managerial Supervision

Yorkshire Ambulance Service

The individual clinicians and call takers who were involved with SEM in the time period running up to her death have been involved in the Coroner's process and are aware of the learning from her case.

YAS use anonymised case studies for the purpose of training, the good practice demonstrated by the call takers and clinicians who had contact with SEM will be shared in order to highlight the importance of treating patients with respect and dignity at all times.

City Health Care Partnership

The case is to be discussed with GPs, practice pharmacists and managers at an in-house learning event to gain further knowledge about the assessment and management of patients with anxiety and depression, and the management of patients with complex mental health issues.

The current policy on benzodiazepine/Z-drugs to be reviewed and is to be distributed to Hull GP practices.

Hull East Yorkshire Hospital Trust

Include in Safeguarding training – adult and child.

Learning lessons newsletter.

Briefings re policy changes, corporate email, trust websites.

Emergency Department team meetings.

Acute Medical Unit (formerly Acute Assessment Unit) team meetings

7.0 Conclusion

SEM's mental health often proved challenging to herself, family and professionals.
There was an agreed care plan which was to be implemented when she presented in crisis. Short term admission into residential hospital care was the agreed treatment and response during crisis.
Despite the existence of this plan and the expectations of SEM, her parents and her Care Coordinators, hospital admission was refused by CRHTT staff on the grounds that no beds were available.
Information obtained later by the family originally unavailable to inform the review indicate that several beds were available at that time.

This decision resulted in SEM being returned home by the Police, despite the attending officers expressing concerns about SEM's mental health and well-being, after witnessing her-self ligate within the hospital environment. Despite their concerns being escalated to their immediate supervisor, who discussed SEM's condition with the assessing CRHTT staff, they refused to admit SEM into the residential hospital environment. This in direct conflict with the care plan recommendations.
Within a short time of returning home SEM made a 999 call to Yorkshire Ambulance Service requesting assistance stating that she had taken an overdose and placed a plastic bag over her head in a bid to end her life. SEM's call was incorrectly classified which compounded by high levels of demand for service resulted in a delayed response by the ambulance which arrived an hour and 40 minutes later. Tragically on arrival of the ambulance SEM was found dead a plastic bag in situate over her head.

8.0 Recommendations

1. The Hull and East Riding Mental Health Crisis Care Concordat and Hull Safeguarding Adult Partnership Board should review the circumstances of this case; benchmark current multi-agency working practice and establish a system for agencies to escalate concerns to a senior health professional where there is a conflict of opinion regarding treatment.
This recommendation to be completed within 3 months.

2. The Hull and East Riding Mental Health Crisis Care Concordat and the Hull Safeguarding Adult Partnership Board establish a professional working relationship with regular liaison, so they work together to better safeguard adults suffering mental health issues. This recommendation is to be completed within 3 months.

3. Hull Safeguarding Adult Partnership Board to work in partnership with all 5 agencies involved within this review, to test the system and ensure their action plans are embedded in front line practice. This recommendation is to be completed within 6 months.

4. Humber Foundation Trust ensure all staff involved in the creation, ongoing management and action of care plans contribute where appropriate to their development and are aware of the location, content of the plan and expectations of the patient. This recommendation to be completed within 3 months.

5. Humber Foundation Trust to increase awareness and embed the Triangle of Care pathway into operational practice to facilitate, where appropriate, the receipt of confidential information provided by family and carers where patients are assessed to be in crisis. This recommendation is to be completed within 6 months.

6. Humberside Police to ensure specialist Mental Health advice is available to assist frontline officers in managing incidents that involve persons suffering with mental health issues and to provide them with confidence to challenge and

escalate concerns where decisions made by health professionals are felt to be inappropriate and against the best interests of the person in crisis. This recommendation is to be completed within 6-12 months.

7. CHCP to ensure GP Surgeries and GP practitioners have access to pathways for advice and a strategy to treat patients who are supplementing the intake of prescription drugs with additional drugs purchased via the internet. This recommendation is to be completed within 6 months.

All recommendations will be owned by Hull Safeguarding Adult Partnership Board under S45 Care Act 2014 and will be the subject of ongoing audit of compliance every 3 months.