Devon Safeguarding Adults Board Vulnerable Adults Mental Health Crisis Care: Thematic Review

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Contents

1. Executive Summary

1.1. This review was commissioned by the Devon Safeguarding Adults Board (DSAB) to consider the quality of Mental Health Crisis Care for adults in Devon. The review relates to multi agency working and was commissioned to consider any underlying or cross cutting themes that existed within three cases that had occurred within six months of each other but were otherwise unrelated.

1.2. Transport in mental health crisis care was not a cross cutting theme in these cases, but was fundamental in one of the cases and, at the time the report was commissioned, was an unresolved issue in Devon, so it is included for consideration.

1.3. In the early stages of this review questions were raised about data sharing, communication, the delivery of home based crisis mental health care, and systems of joint agency working. Discussions held during the review have revealed effective underlying systems. That systems exist does not guarantee that all processes work; systems need to be developed, trained and explained.

1.4. The review period has coincided with significant national and local developments seeking to resolve the issues of mental health care for people in crisis. The Mental Health Crisis Care Concordat was signed at the national level in February 2014 and locally in December 2014. It is designed to deliver real change and to achieve this the agencies concerned have established an Action and Learning set of eleven leaders and service users to guide the process over its first 12 months.

1.5. In November 2014 a statutory regulation regarding the Duty of Candour was passed by parliament. This is a further positive step which should lead to an improved culture of openness and improved relationships with families when things do go wrong.

1.6. This review identifies, through the cases which instigated it, the importance of the current political and agency focus on Mental Health Crisis Care. It demonstrates the importance of agencies working together, and with families, to give levels of care consistent with the aspirations of the concordat and the obligations of the duty of candour.

2. Introduction

2.1. This review was commissioned by the Devon Safeguarding Adults Board (DSAB) to consider the quality of Mental Health Crisis Care for adults in Devon. The review relates to multi agency working and was triggered by three cases which occurred within six months of each other but are otherwise unrelated. The review did not seek to examine all aspects of mental health crisis care rather those that arise from the chosen cases.

2.2. Eight themes have been identified during the review as follows:

- The quality and timeliness of assessment at the point of crisis

- Inter-agency communication
- Sharing of risk information
- Colocation and informal information exchange
- Mental Health services discharge processes
- Joint agency training and understanding
- Multi agency participation in Root Cause Analyses
- Duty of Candour

2.3. Transport in mental health crisis care was not a cross cutting theme in these cases, but was fundamental in case C and is an unresolved issue in Devon so was included for consideration by DSAB.

2.4. During the course of the review contact was made with the families concerned. The family in Case C, relating to problems with patient transport, chose to engage with the process, the others preferred not to. Each of the families had been through a traumatic process linked to the mental health crisis care of their relative. Questions were apparent about the quality of communication to families before, during and after the crisis incident. In March 2014 the Department of Health published, "Introducing the Statutory Duty of Candour, a consultation on proposals to introduce a new CQC registration regulation"[1]. During the course of this review, in November 2014, Regulation 20 of the Health and Social Care Act 2008 was passed, making the duty of candour a statutory requirement for CQC registered bodies.

2.5. Each case was examined separately, by at least one agency. There was no link between the cases through geography, staff involvement or the clients themselves. The three cases were used in this review because they highlighted interagency communication and other issues in the field of mental health crisis care. Each case involved risk, serious harm or death.

2.6. DSAB intends to use these cases to learn from any cross cutting issues. It was agreed at a meeting of DSAB on 13th of May 2014 that the criteria for an Adult Serious Case Review were met in that:

- A vulnerable adult had died (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death.
- The cases gave rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.

3. Structure

3.1. Scope of the Review

The review identified the lessons gained from the initial agency reports on each case and further examined the cross cutting issues of the three cases. This included single and multi-agency involvement with the subjects. It was not intended to identify more lessons from the individual, but to focus on cross cutting themes. In the process some new areas for consideration in each case were identified.

3.2. Subjects of the Review

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295773/Duty_of_Candour_Consultation..pdf

The cases have been anonymised and are referred to by the letters below.

Case	Type	Incident Date
A	Suicide	2013
B	Murder	September 2013
C	Transport Dispute	January 2014

3.3. Limitations of the Review

The scope of the review was focussed on the issues cutting across some or all of the three cases, rather than any issues within the individual cases. The intention was for each case to act as a window into the system; the combination of the cases enabling a more thorough insight into mental health crisis care overall for adults in the county.

At the time of the review case B was the subject of criminal proceedings and awaiting trial. No attempt was made to interview staff or others mentioned in any of the three cases, nor to gather material other than that which was been provided to the DSAB or that was publicly available.

3.4. Methodology

The review was conducted in three phases, with reports submitted to the DSAB for their information and consideration at the end of each phase.

Phase 1: from 13 May 2014 to 15 July 2014
Currently available Individual Management Reports were reviewed, individual case issues were identified and any apparent cross cutting themes were examined.

Phase 2: from 15 July 2014 to 27 August 2014
Field work arising from Phase 1 recommendations. A series of conversations with senior policy officers from agencies concerned with single or multi agency working on Mental Health Crisis Care including:

- Police data sharing
- Mental Health Crisis Care
- Police Mental Health Liaison
- Acute mental health care and information sharing
- Development of multi agency protocols and concordat

Phase 3: from 27 August 2014 to 4 November 2014

Seeking meetings with family members of families affected by the cases. It was not possible to meet more than a small selection of family members, but those who were seen were able to put the work of different agencies into the context of their lived experience.

3.5. The Review Panel

The review panel consisted of senior professionals who were not themselves involved with the cases being considered.

Name	Role	Agency
Bob Spencer	Independent Chair	Devon Safeguarding Adults Board
Jim Connelly-Webster	Independent Reviewer	
	Detective Chief Inspector	Devon & Cornwall

		Police
	Safeguarding and Patient Safety Lead	SDT Clinical Commissioning Group
	Senior Probation Officer	Devon & Cornwall Probation Service
	Nurse Consultant Safeguarding Children and Adults	Royal Devon & Exeter
	Named Safeguarding Professional	South West Ambulance Service Trust
	Service Manager	Devon Partnership NHS Trust
	Senior Programme Manager (Transforming Community Services)	NHS North, East & West Devon Clinical Commissioning Group

The Review Panel met on these dates:

- 13th May 2014
- 15th July 2014
- 27th August 2014
- 4th November 2014
- 7th January 2015

Neither the Panel's Independent Chair nor the author of the overview report had any direct involvement with the professionals whose work was the subject of the review. The Chair of the panel has over 30 years' experience in policing and since concluding police service in 2009 has had experience as Independent Chair of several children's and adult's safeguarding boards. The Overview Report Author has experience as a senior police officer and since concluding police service in 2011 has had experience in the fields of education, health and partnership processes.

This thematic review is based on the documents received, conversations held with relevant policy leads and discussions with family members where this could be achieved.

3.6. Reflection & Bias

Given that qualitative research is inherently interpretive, the biases, values, and judgments of the reviewer are explicitly acknowledged so they are taken into account when reporting. In this case the review author has a background in policing (some within Devon and Cornwall Constabulary) and more recently in the fields of health, education and crisis management.

Awareness of the risk of finding false patterns is important. All of the cases involve clients with mental health crises, so it is to be expected that the Crisis Resolution and Home Treatment Team (CRHTT) features in several of them.

The nature of this review means that each case is being considered in the light of their eventual outcomes. Therefore hindsight bias is a challenge. While a course of action may appear in hindsight to have been better than that which was taken at the time, it is important to consider the knowledge held by the practitioner at the time. While recommendations may be made now, they do not imply, unless explicitly stated, any criticism of those concerned at the time.

4. The Mental Health Crisis Concordat

This review was commissioned soon after the publication of the Mental Health Crisis Concordat, launched by the Home Office and the Department of Health in February 2014[2]. The concordat sets out the principles and good practice that should be followed by health staff, police officers and approved mental health professionals when working together to help people in a mental health crisis. The issues raised in this thematic review broadly match those that the concordat has been established to address. This review's outcome may best be progressed through local structures established to develop the local response to the national concordat.

The concordat follows the refreshed Mandate for NHS England[3], which includes a new requirement for the NHS that "every community has plans to ensure no one in mental health crisis will be turned away from health services".

The national concordat was signed by 22 organisations including NHS England, the Association of Chief Police Officers and the Royal College of Psychiatrists. It sets out the standards of care people should expect if they suffer a mental health crisis, detailing how the emergency services should respond. The Concordat is focussed on three main areas:

- **Access to support before crisis point** making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** to prevent future crises by making sure people are referred to appropriate services.

The national concordat challenged local services to make sure beds are always available for people who need them urgently, and states that police custody should never be used just because mental health services are not available. It also stipulated that police vehicles should not be used to transfer patients between hospitals and encouraged services to get better at sharing essential 'need to know' information about patients which could help keep them and the public safe. Such issues feature strongly in these cases.

The Mental Health Crisis Care Concordat now requires that local areas ensure that:

- Health-based places of safety and beds are available 24/7 in case someone experiences a mental health crisis
- Police custody should not be used because mental health services are not available and police vehicles should also not be used to transfer patients.
- The number of occasions police cells are used as a place of safety for people in mental health crisis is to be halved compared to the level in 2011/12

[2] Mental Health Crisis Concordat downloaded from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

[3] Mandate for NHS England https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

- Timescales are to be put in place so police responding to mental health crisis know how long they have to wait for a response from health and social care workers. This is designed to ensure patients get suitable care as soon as possible
- People in crisis should expect that services will share essential 'need to know' information about them so they can receive the best care possible. This may include any history of physical violence, self-harm or drink or drug history
- In areas where black and minority ethnic groups are detained more frequently under the Mental Health Act, this must be addressed by local services working with local communities so that the standards set out in the Concordat are met
- A 24 hour helpline should be available for people with mental health problems and the crisis resolution team should be accessible 24 hours a day, 7 days a week

Following the publication of the National Concordat, agencies in Devon and Cornwall are now working on their own regional and local agreements to develop working together across services to improve care and potentially save lives. Within Devon and Cornwall this work is being undertaken by the Peninsula Mental Health Criminal Justice Agencies Group (PMHCJA), a sub group of the Local Criminal Justice Board. The PMHCJA is jointly chaired by NHS England and the Office of the Police & Crime Commissioner and is currently preparing the Local Concordat for signature by its members.

The Director of Operations and Delivery for NHS England (SW), has taken responsibility for drafting the Devon and Cornwall wide Crisis Care Concordat. A conference involving a number of key strategic partners entitled 'Call to Action for Mental Health in the Peninsula' was held by NHS England (SW) on 26th February 2014. The development of a localised concordat was discussed and agreed at this forum. Launched by Jim Symington (National Crisis Care Concordat Implementation Team) an action learning set has been set up with senior leaders from across Health and Justice Agencies. This group has committed to the Local Concordat and published a declaration statement in December 2014.

The group has also overseen the development of the November 2014 joint Police/NHS document entitled "Multi-agency Response to detention under the Mental Health Act 1983". This document has not yet been formally signed off but when it is it should address many of the issues regarding Places of Safety, communication, dispute resolution, and patient transport that arise out of this review.

The concordat declaration is being progressed into an action plan by a Learning and Action Set of eleven agency leaders and service users. This group will meet once every 6 weeks for approximately 12 months to enable the members of the Set to get to grips with the local issues and what needs to change. It will translate the experience of participants into a vision for improved mental health, providing the opportunity for understanding the perspectives of the various agencies and identifying and working through obstacles and opportunities for change to realise the Local Concordat.

5. Adult Mental Health Provision in Devon[4]

5.1 Adult mental health services in Devon are provided by the Devon Partnership NHS Trust, which was established in 2001. The trust has an annual budget of around £130 million and, at any one time, supports almost 18,000 people across Devon and Torbay. It is an NHS organisation that works closely with other health and social care providers across Devon to support the recovery of people with mental health needs. The trust employs around 2,500 staff and has around 100 staff assigned to it from Devon County Council and Torbay, including social workers and support workers. The trust serves a large geographical area with a population of more than 850,000 people.

5.2 Devon Partnership NHS Trust provides services for:

- Adults of working age and older people
- People with a learning disability
- People who are low in mood, stressed, anxious or depressed
- People with an eating disorder
- Those with alcohol and substance misuse issues
- Pregnant women
- People with gender identity issues
- People who need secure mental health services
- People with a personality disorder
- People with autism and Attention Deficit Hyperactivity Disorder (ADHD)

5.3 Adult Mental Health provision consists of community services as well as urgent and inpatient services. Community Mental Health service provision is made up of three mental health teams:

- Assessment
- Mental Health and Recovery for people with depressive disorders
- Psychosis and Recovery for people who tend to develop symptoms of psychosis when they become unwell

5.4 Urgent and Inpatient Care services are for those people with severe mental health difficulties, in crisis or experiencing severe distress and who may require a period of stay in hospital. People requiring specific dementia services receive care from the specialist Older People Mental Health Teams.

5.5 Urgent and Inpatient Care services include the hospital wards and the Crisis Resolution and Home Treatment Teams (CRHTT). Together they provide a 24 hours a day, 7 days a week service to care for clients with an urgent need or who are in a crisis, and for people who require a stay in hospital. When a hospital admission is needed, the CRHTT works towards minimising the length of stay, involving carers and families to ensure effective discharge arrangements are in place to support people.

[4] http://www.devonpartnership.nhs.uk/Adult-Mental-Health.65.0.html

6. Crisis Resolution Home Treatment Team (CRHTT)

6.1 Operating Policy

6.1.1 Two of the cases under review involve the work of the CRHTT. This section sets out their aims and role in the delivery of Mental Health Crisis Care.

6.1.2 The CRHTT's operational policy sets out the principles that guide their work as:

- Crisis Management, i.e. working through the crisis to the point of resolution.
- A holistic approach – based on a bio-psycho-social model of mental health.
- Empowerment of the individual in crisis.
- Psycho-education.

6.1.3 The CRHTT Operating Policy states that provision of service is centred on the needs and preferences of individual clients, their families and carers. The CRHTT seeks to respect people's right to dignity and choice. Their service attempts to reduce the effects of crisis by offering an alternative to hospital admission for seriously ill clients. It seeks to expedite recovery and maximise the quality of life. The service seeks to meet the needs of clients who are:

- Experiencing crisis as a result of serious mental ill health.
- Vulnerable or disabled to the extent that they need intensive or extended time for treatment and support.
- Who would otherwise be likely to require inpatient treatment
- And who are over the age of 16 years and not in full time education.

6.1.4 6.1.4 CRHTT seeks to work closely with other mental health services, primary care and the voluntary sector. It acts as 'gatekeeper' to acute inpatient beds and seeks to provide a service which is an alternative to hospital, 24 hours a day, 7 days a week.

6.1.5 Admission to an inpatient ward is one possible outcome of a crisis resolution assessment and is only used when all other options for management have been explored. The reasons for admissions will be recorded by the Crisis Team Assessor and used in the decision making process at Multi Disciplinary Team meetings, ward rounds and handovers as a client moves towards discharge.

6.1.6 Following initial contact a summary of the assessment and an initial care plan is given to the service user, the referrer and other professionals involved in the care provision. This summary document is posted to the referrer at the earliest opportunity, then a full copy of the assessment document is sent to the referrer on request. All assessment information will be recorded by the CRHTT assessing professional in the appropriate sections of the RIO electronic records system.

6.1.7 When the CRHTT accepts a referral they will endeavour to contact and see the client within an agreed time scale. If the referral is not appropriate for the CRHTT, the referrer will be given advice and guidance as to what services may be more suitable. This is the key factor in case A in that all processes post acceptance of referral are comprehensive and covered by detailed policy

but If the referral is declined, even following a brief telephone call, there is little policy or procedure that covers it.

6.1.8 Requests for acute inpatient beds, from whatever source are directed to the CRHTT. The Exeter, East and Mid Devon CRHTT is the sole route via which all admissions are made to mental health wards at DPT's Wonford House hospital.

6.1.9 The CRHTT should be contacted when a GP considers that a Mental Health Act assessment may be required. The evidence suggests that compulsory admissions can be reduced considerably when intensive home treatment is available as an alternative to hospital. If after discussion with CRHT, it is felt that a MHA assessment is still required, then this can be arranged in the usual way, by either the GP or CRHTT contacting the duty AMHP or, if out of hours, the Emergency Duty Team (EDT).

6.1.10 The CRHTT is the only route by which in-patient beds can be accessed. The CRHTT works closely with GPs to achieve a satisfactory plan that is in the service user's best interests, following a referral. If GPs wish to involve the community psychiatrist, the in-patient specialist psychiatrist or the duty consultant out of hours, then these doctors can be contacted via the hospital switchboard. The intention is that all consultant psychiatrists will support the fundamental role of the CRHTT in gate-keeping admissions.

6.1.11 The CRHTT operates a team working system which, in effect, means that every member of the team is aware of the issues concerning each client on case load and has a working understanding of their care plan and risk assessment. This should ensure that the client does not need to repeat his or her story at each contact.

6.1.12 The CRHTT operates a Primary Worker system, whereby each case is allocated to a senior member of the team, responsible for the care given to that client, the maintenance of records and lead on the client during case discussions and hand over. Clients are allocated to staff based on case load management principles, and where possible matching staff skills and expertise with the needs of individual clients.

6.1.13 The CRHTT provide a vital role in the coordination of mental health crisis care. The team follows national operational guidance. They are critical in managing risk when referrals have been made by GPs.

7. The Three Cases

Introduction

Each case is set out below. The details of a brief narrative, Root Causes and Initial Lessons Learned all come directly from the Root Cause Analysis (RCA) or Serious Untoward Incident (SUI) documents furnished by the relevant health authorities. The further issues identified in this thematic review have been developed through considering the RCA and SUI documents along with those provided by other agencies and any relevant discussions.

7.1 Case A 2013 Suicide

7.1.1 Brief Narrative

Details of this case have been redacted to ensure the anonymity of the case in accordance with the views of family members.

A woman, A, had been the victim of childhood sexual abuse. She attended her GP suffering from anxiety and depression. The GP made an urgent referral to the Crisis Resolution and Home Treatment Team (CRHTT). She spoke with the CRHTT, but was not in the end seen by them. She became distressed and stabbed herself, subsequently dying from her injuries.

7.1.2 Root Cause Identified

A reacted impulsively to acute internal distress; there were triggers apparent in her life and relationships, although the main trigger identified had occurred some 4 years earlier.

7.1.3 Initial Lessons Learned

(a) When people who are unknown to mental health services decline assessment, there is scope for more assertive follow up, for example the consideration of cold calling to attempt to establish rapport and improved knowledge of the person's situation.

(b) The rationale for decisions taken at the point of triage regarding response times should be recorded in the electronic screening tool.

(c) The rationale for actions taken regarding closure of a case where the person has declined assessment should be recorded in the electronic progress notes so that the narrative regarding the process is complete.

7.1.4 Personal Circumstances

A and her son lived with her mother. It is recorded that she had a difficult relationship with her ex-partner, the father of her son. Her family was well known to her GP surgery and she was described by her GP as a '*sensible and professional'* woman. She was described by others as a devoted mother to her son.

7.1.5 Mental Health History

In 2008, A had disclosed childhood sexual abuse; she made a statement to police and the perpetrator was charged. She was referred to a specialist counselling service at this time but she did not attend planned appointments; the reasons for this are not known.

7.1.6 Recent History and Recent Contact with Mental Health Services

A attended the GP surgery complaining of feeling stressed, in particular she was having problems sleeping. She talked of debt problems and a fear of making mistakes at work because of her levels of stress. She denied the presence of thoughts of self harm and she declined the offer of psychological therapies or medication.

A failed to attend a planned appointment with her GP for follow up 7 days later, instead she telephoned the surgery later in the day. During the telephone consultation she spoke of low mood, poor appetite and poor sleep and that she had made a self-referral to a counselling service.

At this time A was on sick leave from work; she said she felt too unwell to work because of her levels of anxiety and low mood but was worried about having to take further time away from the work place. She agreed with the GP that she would take further time off work with a phased return doing a shorter shift pattern. She denied any thoughts of self harm. The GP started A on Sertraline (50mg) anti-depressant therapy and emphasised that she should arrange a further surgery appointment for review.

Two days later at 1600 the GP made a referral to the Crisis Resolution and Home Treatment Service (CRHT) after A booked an emergency appointment slot. She was described as a young single women with a young son who was living with her mother. The GP explained that a week earlier A had attended the surgery complaining of low mood, anxiety and stress; the GP mentioned that A had taken only one dose of the anti-depressant medication prescribed earlier in the week. The GP said that she was presenting with panic symptoms and suicidal ideation; she was distressed and hyperventilating at times. It was mentioned that there was a previous trauma of childhood sexual abuse and that A had a difficult relationship with her ex-partner, the father of her son. The Senior Mental Health Practitioner advised the GP that based on the information contained in the referral that A would be contacted within 24 hours to set up an assessment. The Senior Mental Health Practitioner also recommended that the GP consider prescribing a small supply of diazepam between 2mg and 4mg up to three times a day as required.

At 14:10 the next day, the Senior Mental Health Practitioner from the CRHTT telephoned A to arrange a visit to carry out assessment at home; the plan was to visit her within the hour. A advised the Senior Mental Health Practitioner that, since meeting with her GP, she had shared her feelings with her family and that they were being very supportive; as a result she said she was feeling much improved. A said that she had been taking diazepam as prescribed and said this had helped alleviate the anxiety, distress and panic symptoms she was experiencing. A had also managed to sleep which she said had made a difference to her mental state. A stated clearly that she was no longer experiencing suicidal thoughts and declined the offer of assessment with the CRHTT service.

7.1.7 **Incident Description**

On that afternoon, within two hours of the telephone contact with the CRHT Team, A's mother came across her in the family home stabbing herself repeatedly and called for emergency assistance. At the time of the incident A's son was not in the house; he was staying with his grandfather. Documentation from the Emergency Department records A's arrival at the Emergency Department as 16:38. A died six days later after life support was withdrawn.

7.1.8 **Discussion and Analysis – Care and Service Delivery Issues**

7.1.8.1 **Precipitating Stresses**

In 2008 A disclosed to her GP that she had been subjected to childhood sexual abuse from the age of 12. She was referred for

counselling but it would appear she did not engage in the counselling process.

A had also mentioned that her ex-partner was reneging on his child care responsibilities for their son; she had disclosed to the GP that this had been causing her stress.

7.1.8.2 **Engagement**

The Senior Mental Health Practitioner with the CRHT Team telephoned A within 24 hours of receiving the referral from the GP. The Senior Mental Health Practitioner had just participated in the handover from the clinicians on the early shift and was planning the clinical work for the afternoon. Given that he had taken the referral from the GP on the previous day it was agreed that he and a female colleague would follow through the contact with A and an assessment time in the early afternoon had been earmarked. The Senior Mental Health Practitioner telephoned A to advise that, if convenient, an assessment would take place at her home address within the hour.

A answered the telephone immediately; she said that she had shared her feelings with her family, that they were proving very supportive and as a result she was feeling much improved. She said that she was also benefitting from the anti-anxiety medication, diazepam, that had been prescribed by the GP and in particular she had slept well. It would seem that the support from her family, the experience of sharing her thoughts and the use of medication had impacted substantially on the anxiety, distress, sleeplessness and panic she had been experiencing. The Senior Mental Health Practitioner reflected that A's tone, rate and volume of speech appeared to match the content of what she was saying; there was nothing to indicate that what she was describing was not what she was feeling.

The CRHTT had contact with A's mother, following the incident. She stated that she and A's sister were in the room at the time that A took the telephone call from the CRHT Team and witnessed the conversation. They confirmed that the mental state that A was describing to the CRHT Team was that which family members had observed. They related that A had spent a calm and relaxed day with family and seemed to enjoy the company of family and friends.

The family witnessed nothing on the day of A's death to give them cause for concern or suspicion that she was having thoughts of suicide; neither did the family think that A's behaviour was contrived to divert the family's attention from her true feelings. A's spoken words and her behaviour appeared congruent.

The GP mentioned during the RCA process that the consultation with A, on the day of the referral to the CRHT Team, was a little out of the ordinary. A had booked an appointment in the emergency clinic and attended with her mother. When she arrived A was in a very distressed state, she told the GP she felt so awful she had had strong thoughts of ending her life although she denied making suicide plans or thinking about methods. There was no evidence of

psychosis triggering the disturbance. The GP left the room to telephone the CRHT Team; when the GP returned, A looked the GP in the eye and said *'actually I'm feeling much better now', 'I think I will be all right'.* The GP was surprised by the marked change in A's presentation and had the sense that she was in effect declining further support, however she confirmed with A that the referral to the CRHT team had been made and that the team would be in touch. The GP recommended that should there be further deterioration A or her family should contact the on call GP or attend the Emergency Department.

7.1.9 **Triage and Response Time**

The Senior Mental Health Practitioner triaged the required response time after taking the referral from the GP. The Referral Screening field on the RIO electronic record was completed with details of the referral; a 24 hour response time was allocated to the referral rather than a more immediate response however the rationale for this was not recorded in the referral screening field. The response time was based on the information that was received from the GP; in particular the fact that A, while disclosing that she was experiencing thoughts of suicide, was not voicing plans to act on suicidal thoughts, had agreed to contact from the CRHT Team and had the support of her family. The Senior Mental Health Practitioner also discussed the decision making process with regard to response time with an experienced colleague.

The Senior Mental Health Practitioner recommended that A was prescribed a small supply of diazepam to assist in reducing her anxiety and distress in the short term. The Senior Mental Health Practitioner checked with the GP that the GP was satisfied with the planned response time of 24 hours. On the day following the referral, the Senior Mental Health Practitioner had planned a visit for 15:00; an appointment that, had A not declined, would have been within a 24 hour period of the initial referral.

7.1.10 **Risk Assessment**

A was not seen for assessment by the CRHT Team and so there is no related formal Risk Assessment documentation. At the time of her conversation with the Senior Mental Health Practitioner, when A declined the offer of assessment, she stated that her levels of distress and disturbance had been alleviated through sharing her thoughts and feelings with her close family, improved sleep, the support of the family, and through the use of medication. The Senior Mental Health Practitioner asked her specifically about any thoughts of suicide she may be experiencing and she stated clearly that thoughts of suicide had passed. The tone, rate and volume of speech appeared to match A's assertion that her mental state was improved; there was nothing to indicate that what she was describing was not what she was feeling.

Despite A's assertions that all was well, given that her improvement had not been sustained beyond 24 hours, the Senior Mental Health Practitioner recommended that the planned assessment go ahead; A, however, declined clearly and politely stating she did not feel a visit was necessary. While the Senior Mental Health Practitioner was aware that A's improvement had been swift, he was also aware that sharing a

problem as she had done with her family can prove particularly helpful at times of crisis. A had also told her GP on the previous day that her son was a strong protective factor and the GP had also mentioned the protective factors of the good support available from her mother and that she seemed able to confide in her mother.

Based on A's presentation at the time of the telephone call and the information that the Senior Mental Health Practitioner had from the GP, his clinical judgement was that he did not have further grounds to impose treatment – for example a Mental Health Act Assessment, or a 'cold call' to the house.

When A declined the offer of the CRHT Team intervention it would have been helpful for a risk formulation to have been added to the progress notes to demonstrate the rationale for the Senior Mental Health Practitioner's clinical judgement that there was no further action required by the Team – for example further details regarding the impression of mental state and capacity. It is clear from speaking with the Senior Mental Health Practitioner that these things were considered carefully but the clinical record does not fully reflect this.

As mentioned earlier in the section under 'Engagement' the family's experience of the improvement in A's mental state would appear to reflect that which informed the Senior Mental Health Practitioner's clinical judgement.

The Senior Mental Health Practitioner did not contact the GP on the day that A declined assessment. It was a Saturday and the Team would have had access to the out of hours' GP service only. The Senior Mental Health Practitioner confirmed that had he had concerns about A's decision to decline treatment he would have made urgent contact with a GP, as it was, his judgement was that he was able to complete his follow up letter, quickly describing the Team's contact with A and this would be a sufficient update given the circumstances.

Non-engagement is discussed as a matter of routine in the daily multi-disciplinary clinical meetings; the incident, occurred however only hours after the telephone contact.

7.1.11 **Safeguarding**

The Senior Mental Health Practitioner was aware from his conversation with the GP that A and her son lived with A's mother who was grandmother to A's son. The Senior Mental Health Practitioner was aware too, from his conversation with the GP, that the GP viewed the relationship between A and her mother as positive and supportive and that A had also stated that she was able to confide in her mother. ; A had told the GP also that her son was a strong protective factor. As described earlier in the report A in her telephone conversation with the Senior Mental Health Practitioner spoke of feeling much improved due to the support of her family and the fact that she had confided her anxieties in her family. The Senior Mental Health Practitioner's judgement based on the information from the GP and his conversation with A was that there was no requirement for safeguarding interventions.

7.1.12 **Involvement of Carers**

A lived with her mother who was providing support to her. A had visited the GP surgery with her mother on the day the referral was made to the CRHT team. It is clear from the comments made by A on the day she spoke with the Senior Mental Health Practitioner that she valued the support of her family. CRHT team interventions routinely involve family and carers in the clinical risk assessment process and recovery planning. When the Senior Mental Health Practitioner made contact with A, she spoke of an improvement in her mental state that appeared to be within the context of meeting with the GP, taking medication, having a good night's sleep, confiding in her family and feeling supported by her family. As stated earlier it has transpired that the family believed also that A had shown improvement that had been sustained over a 24 hour period and, as mentioned, family members were present when A was speaking with the CRHT team practitioner on the telephone and her account was congruent with that which the family had observed.

The Senior Mental Health Practitioner stated that A was very clear that she did not want contact with the CRHT team. The Senior Mental Health Practitioner did not specifically ask for A's consent to contact her family, however, he had the sense that contact with the family would have been in opposition to her wishes. The practitioner's clinical judgement was that he had no clinical grounds to impose treatment or make further intervention such as making contact with A's family.

7.1.13 **Medication**

The Senior Mental Health Practitioner, after discussion with the GP, recommended that the GP consider prescribing a small supply of diazepam. Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects. Diazepam can be used to calm severe anxiety and agitation that is disabling or is subjecting the individual to unacceptable distress as appeared to be the case for A.

7.1.14 **Further issues identified during thematic review**

7.1.14.1 This case involved a GP's surgery, the CRHTT, A and her family. Initial communications between the patient, GP and the CHRTT appear to be effective. The GP considered A's presentation and made a detailed referral to the CRHTT. There was an early assessment and timely response to the referral. The initial contact from CRHTT to the patient was a telephone call, this call reassured the CRHTT member that the crisis was over and the GP's initial treatment had been effective. It was also reported that the family members who were with her believed she was improving. Family members heard the phone call with the Senior Mental Health Practitioner and it was believed by the practitioner that they agreed with the outcome. Subsequent discussions indicate that the family were not so positive about the way forward.

7.1.14.2 There were appropriate grounds for the GP to make an urgent referral to the CHRTT, but when the patient declined the service during the initial telephone call with the CRHTT, the process appears to have ended. The CHRTT Terms of Reference have a clear policy on the treatment of cases that have been accepted, but

less so on cases that are declined. Once the case was declined by the CHRTT so many of the multi-disciplinary discussions that would take place prior to discharge from service did not occur.

7.1.14.3 A had been identified as being in crisis by her GP, this was followed up by a telephone assessment which identified that she was no longer in crisis. This appears to be a very fragile method of assessment, particularly so for people experiencing a mental health crisis. What dictates the method and timeliness of assessment for such cases?

7.1.14.4 There was no immediate follow up or communication back to the GP. The GP referred to the case as an emergency, the CRHTT took the case on, but after telephone contact they did not retain the patient on their caseload. A follow up discussion would have assisted the GP in planning continuing care. The Root Cause Analysis sets out the benefit of the CRHTT having such a conversation with the referrer.

7.1.14.5 The telephone call that the CRHTT member had with A left the worker with the view that she had no current suicidal ideation and in any event her child would be a buffer to any such action. This is a belief that has arisen in other reviews conducted locally. There is a strong reliance on the concept of children (or other factors) as a protective factor against suicide. The evidence base for this belief is not clear.

7.1.14.6 From this review and others it is apparent that people considering suicide can be effective at covering up their intentions. Devon Partnership NHS Trust provides its practitioners with Clinical Risk training that includes a combination of evidence based research around suicidal ideation and preventative measures. Practitioners receive updated information from local and national research including the NHS Safer Services site, Root cause analysis, National Confidential Enquiry into Suicide, reports from the South West Observatory and handouts providing practical steps when supporting somebody with suicidal ideation, including “do’s and don’ts”, questions that could be asked and suggested phrases to use. Identifying the precipitating factors, anything that may increase the likelihood of turning ideation into an act, will become part of the Formulation summary on the electronic record system and the training includes how to record this information. The content includes the importance of some of the statistics and influence of bias when assessing a person’s thinking in relationship to their presentation.

7.1.14.7 Practitioners have to make quick assessments on situations, based on their training and experience. The decision about the potential for suicide in a mental health crisis care case is a very difficult one and not one that is easy to make based on one telephone conversation.

7.1.14.8 In this case A either planned and concealed the plan, or took spontaneous action. It would appear that, unbeknown to the mental health practitioner who spoke to her, she was in significant

need of specialist services.

7.1.14.9 There appeared to be a concern about legal power and the ability to act without it. Not all actions require specified legal power, many can be carried out with the consent of the patient or using ordinary human interaction. Agencies do not need a legal power to make a home visit, albeit, if access was refused no entry could be forced without a legal power but it is highly unlikely that access would have been refused. The Root Cause Analysis sets out the concept of "assertiveness of follow up" when care is declined. Such assertiveness of follow up does not necessarily require a legal power.

7.1.14.10 Professional language can minimise and normalise people's lived experience. While it is necessary to use agreed terms and language to describe situations, in doing so the intensity of the patients experience can be lost.

7.1.14.11 The Root Cause Analysis is thorough and useful, however it considers single agency learning points rather than cross cutting issues. It is compiled with data from health professionals. There would be value in a degree of independent overview within the Root Cause Analysis process.

7.1.15 **Cross Cutting Themes from Case A**

- Interagency communication – the communication between CRHTT and the referring GP.
- Discharge protocols from CRHTT – for those clients triaged out at the first telephone call.
- Multi agency participation in the Root Cause Analysis Process
- The quality and timeliness of assessment at the point of crisis
- Use of client's own language in reports

7.2 Case B September 2013 Murder

7.2.1 Brief Narrative

This case relates to B, a 41 year old man with a history of amphetamine induced acute psychosis, alcohol residual psychosis and an 8 year history of opiate dependence. He had been seen by his GP and was regularly being seen by the Recovery and Independent Living Team. He was indicating levels of violence and disturbed behaviour. In February 2012 Police made contact with Churchill House, the mental health team in Honiton, this was instigated following concerns raised about his apparent deteriorating mental health. Police handed the information to mental health services and had no further involvement.

In 2013 a neighbour reported to police that he had shaved his head and bought a bayonet. No information was shared with other agencies by police. On the 26th of September 2013, he went to a pub, where he stabbed a random stranger with the bayonet, killing the man. He then calmly waited for the police to arrive.

7.2.2 Brief History

His first contact with Devon Partnership NHS Trust services was in 2005 following an amphetamine induced psychosis. He was supported in the community by the local Community Mental Health team and when stable was discharged back to his GP who continued to prescribe anti-psychotic medication.

He moved to Scotland to work offshore but had become mentally unwell and homeless. He was being treated at a methadone clinic in Aberdeen. He returned to Devon and was reviewed for opioid withdrawal with the Devon Drug Service in 2011. He was risk assessed and considered to be of no immediate risk to himself or others. It was noted that he would be at risk of deterioration if he became homeless. A treatment plan was developed and implemented.

In 2012 Police had received information from the NSPCC that B had called their helpline and appeared to be a risk to a young girl who lived opposite him. Police alerted the family and called mental health services. This led to an appointment with his GP in which he denied hallucinations or delusions. His medication was adjusted and police were informed.

B had been in receipt of care and treatment from the local Recovery and Independent Living (RIL) team until September 2011 when he was discharged back to his GP. At this time he was also in receipt of services from Devon Drug Services (DDS). DDS were aware that B had been in receipt of treatment from RIL and were aware that he had been discharged by the team; however as the teams use different electronic records systems, each team was unaware of the others interventions with him.

There is no written evidence of communication, such as letters or emails, between the RIL team and DDS; however the RIL team consultant psychiatrist stated that successful joint working between the two teams has taken place and considered that should B present with psychotic

symptoms DDS would contact the team for a referral. In addition he felt confident the GP would also contact the team if necessary.

B was supported with the detoxification programme by a drugs worker from DDS with the title of Care Coordinator. This title does not reflect the role of care coordinator in relation to the Care Programme Approach (CPA). B was not on CPA; however given the dual diagnosis B could be considered as complex, in which case CPA may have been appropriate. His care coordinator was experienced in working in addictions services, but did not have a professional qualification or specific training in relation to mental health. However she stated she would be able to see a change in his behaviour, and would seek advice if necessary. The care coordinator worked with the nurse prescriber working within DDS in order to address B's medication needs; the nurse prescriber liaised with B and the GP. There is no reference to B's previous history of psychosis being discussed; possible paranoia was not discussed.

The DDS care coordinator would normally see clients every three months, and a support worker would see him every six weeks in accordance with service protocol. However towards completion of the detoxification programme the DDS care coordinator had more frequent contact with B by telephone and with his GP to ensure compliance and address issues which arose in relation to medication and dosage of methadone. The level of contact could be questioned, especially whether telephone contact was the most appropriate method of interacting with B given his previous psychotic episodes which were possibly drug related.

Joint working took place with Devon Partnership NHS Trust (DPT) staff at Devon Doctors out of hours service, and the GP in February and March 2012 when it was established that B had deteriorated as he was not concordant with his medication due to experiencing gastric irritation. The GP saw B and prescribed a proton pump inhibitor to address his physical symptoms and encouraged him to take his medication. B stated he was keen to reduce his olanzapine to 10 mgs and the GP asked to see him again if he had problems and not to suddenly stop the medication with the plan to reduce the olanzapine to 15 mgs if he remained stable in the summer.

Joint working between the GP and RIL team in May 2013 resulted from a telephone call to the RIL team by B asking to see the consultant psychiatrist. An appointment was arranged for the following week. Following further communication with the GP and B it was established that the problem with gastric irritation had resolved but that B was having problems sorting out his disability living allowance (DLA). B declined a planned appointment as he said his abdominal pains had resolved. B was advised he may wish to contact Citizen's Advice Bureau to address his problems with DLA. An email was sent to the GP explaining the situation and stating the consultant psychiatrist would not see B unless the GP felt it was indicated.

B did not see his GP regularly, he would ask for repeat prescriptions; however it appears that he had last been prescribed olanzapine in February 2013. He had had appointments with his GP in July and August 2013; these had been to request night sedation whilst reducing his methadone on a detoxification programme. There is no evidence that B

was displaying any signs or symptoms of psychosis. .

B was in receipt of methadone withdrawal treatment from DDS, who were able to monitor his mental health. He appeared mentally stable and completed his treatment from DDS in August 2013 having successfully completed a detoxification programme. He failed to respond to a recovery check appointment on 25 September. This was discussed by the DDS care coordinator with the team and it was agreed he was to be discharged from the case load. This is not an unusual occurrence; following a detoxification programme people using services frequently decide they no longer wish to have contact with the service. Risk assessments and care plans in relation to the detoxification programme were in place and up to date. DDS workers state from their perspective B was not identified as having any psychotic signs or symptoms.

Reluctance to be followed up by services was not considered to be paranoid in nature neither were his paranoid feelings in relation to his GP. However methadone may have masked any psychotic symptoms. At no time were the problems in relation to medication considered to have a basis in psychosis; it was attributed to behaviour associated with people who misuse illicit and prescribed drugs. It would appear that staff normalised his behaviour. Any change in presentation by a person using services with a known mental health diagnosis should be followed up with a comprehensive risk assessment to either refute or confirm deterioration in a person's mental health. Drug screening would have identified any stimulant use which has been known to have previously contributed towards deterioration in B's mental health. It is unclear what level of drug testing was undertaken during the period of detoxification and whether any reported stimulant use was addressed.

All clinicians having contact with B during the months immediately preceding the incident state they considered him to be stable. Even though he had become agitated in July, he continued to appear stable with no psychotic signs or symptoms. The focus of the intervention provided by DDS was to facilitate his recovery from substance misuse, which they achieved through the supportive detoxification process which B was keen to complete. The focus of the DDS was not on B's mental health presentation.

B was arrested on a murder charge on 26 September 2013.

7.2.3 **Root Cause Identified**

Because there were Criminal Justice processes ongoing, no root cause was identified in the RCA process.

7.2.4 **Initial Lessons Learned**

a) When a person using services has contact with more than one Trust service, written communications should take place between both teams in relation to the person's care and treatment. When a person using services presents with dual diagnosis, joint planning meetings and joint risk assessments should take place in accordance with DPT's dual diagnosis protocol.

b) When there are changes in the behaviour of a person using drug services, who also has a history of mental health problems, a

comprehensive risk assessment should be undertaken to ascertain the cause of the change of behaviour.

c) Mental health services should not presume that drug and alcohol services have staff employed within the service with suitable professional qualifications or the knowledge or skills to monitor and respond to deterioration in a person's mental health

7.2.5 Further issues identified during thematic review

a) Information was received from a national charity that the subject had been making calls to their helpline. These calls were sufficiently worrying that police alerted a family who were subject of the calls.
b) Having received the information from the charity the police made contact with the Mental Health and Recovery Team, reporting that B may be at risk of harming himself or others. This was considered to be a "Grade B referral" meaning suitable for single agency response and once they are informed the case requires no further police action. That the police officer felt the need to make this contact should have been seen as a serious indicator of risk. Following this call B attended his GP and a follow up call was made to the police. This specific incident did not lead to any negative outcome, but the response to it appears fragmented, given the potential risk to a young person living opposite.
c) This case would not appear to meet the threshold for activating the Multi Agency Public Protection Arrangements (MAPPA) nor to work under the Potentially Dangerous Person (PDP) procedures. However, there were two groups of front line staff, one in the police and one within health that were dealing with this client who was sufficiently concerning to both that they were taking action in their own domain, but a holistic picture was not developed.
d) In 2013 a neighbour spoke with an officer in uniform and expressed some concerns that she had about B. She informed the officer that he had shaved his head and was in possession of a bayonet. She asked the officer not to do anything about the information she had passed but he informed her that he would pass on the information to the local policing team. The local policing team did receive a message to contact the neighbour, but not the original information itself. When contact was made the original information was not retold by the neighbour. It does not appear to have been placed into the police intelligence system by the original officer. The importance of the correct storage, assimilation and dissemination of information is clear.
e) The Devon Drug Service (DDS) Care Coordinator carried out a useful role, suggesting a three way meeting with GP, her and the patient. There was ongoing coordination by the DDS care coordinator. The key roles of the DDS care coordinator would have been to support B's detoxification programme for compliance and progress, link directly with the GP for prescribing and physical health checks, work with own nurse prescriber and support worker if allocated, monitor mental health and provide risk assessment and care plan. If mental health services were involved then there would be joint responsibility to support risk management and care planning.

7.2.6 Family Perspective

The family of the deceased preferred not to express a view to this review.

The mother of B said, "I feel that my son was failed by the system that was in place to help him. I am of the opinion that telephone consultations are of no use when assessing a patient with mental health issues. How can they be reassuring and gage the patient with no eye contact and no reading of body language as to how that person is really feeling.

Communication between all agencies should be shared so information can be viewed to assess the whole situation. Families should be involved to give support.

7.2.7 **Cross Cutting Themes – from case B**

- Communication: achieving effective coordination through inter agency communication and coordination.
- Sharing risk information between agencies

7.3 Case C January 2014 Mental Health Crisis Patient Transport

7.3.1 Brief Narrative

A 32 year old man with a history of mental illness had locked himself in the bathroom at his family home. His parents were concerned and called police for support. He was taken to the Royal Devon and Exeter emergency department with his parents for assessment, police provided an escort for the journey by following the ambulance. He was sectioned in A&E. Police assistance was requested to move him to an appropriate mental health facility. Police declined to give this assistance and a dispute ensued between police and health staff, leading to several days in which he was under a section, but was not taken to an appropriate location.

7.3.2 Root Cause Identified

a) Lack of police support in conveying patient
b) Slow response by specialist ambulances
c) Lack of effective communication between agencies and family

7.3.3 Initial Lessons Learned

The RCA reports that Police require refresher training in terms of their responsibilities under the Mental Health Act 1983 (2007) once a person becomes liable to be detained. This is a health defined lesson but is questionable. Police have a power under S136 of the act to take someone from a public place to a place of safety, if they think he or she needs immediate care or control. A 'place of safety' might be a police station, for example, but is nowadays mostly a hospital. This case does not deal with a person in a public place. Where a person is in their home or another private place, Section 135 of the act allows the police to gain entry to allow an assessment to be made, or to return someone who has left the hospital and is absent without leave. A warrant from a Magistrates' Court is required before this power can be used and the police must be accompanied by an approved mental health professional (AMHP) and in some cases, a doctor.

People can be held under Section 136 for up to 72 hours, during which time they should be seen by a doctor and by an approved mental health professional (AMHP). They may then be placed on Section 2 or 3 of the Mental Health Act, they may be admitted to hospital as an informal or voluntary patient, or they may be discharged.

This case involves different elements of the Mental Health Act 1983 at different stages. The initial call to the family home by police and ambulance service meant that because C was not in a public place, a magistrate's warrant would be required to detain him. Police were not able to use their powers. C was persuaded to go to hospital in the ambulance. At the hospital he was seen by a specialist medical team who were able to invoke Section 2 of the act, detention for assessment.

7.3.4 Family Perspective

Introduction

Case C deals with the difficulty of multi agency collaboration on the transport of a patient with a mental health crisis. The very type of situation that the mental health concordat has been established to resolve. The experience of the family was of dealing with the immediate crisis of their son, but then seeing different agencies fail to collaborate and exacerbating, rather than resolving the crisis.

In this case at least one of the parents had relevant professional experience of health service working in the field of mental health as well as both having the experience of supporting their son as he grew up.

Background
By the time of the incident C was 32 years old and had a history of mental health problems. He had been arrested some three years before the current incident, but his life was broadly stable, with support from his family.

Following the arrest his family took him to the GP and C was referred onto the STEP (Specialist Team for Early Psychosis) service. This service was redesigned in April 2014 and a similar function is now fulfilled by the Psychosis and Recovery (PAR) teams. The STEP team provided community care for 3 years. He was unwilling generally and had no insight into his own mental health; he did not agree he had a problem. He was placed on medication which seemed to help. His mother could tell when he wasn't well; for example shouting at people who were not there.

From Christmas 2013 he seemed to be on a downward spiral. He stopped taking his medication and refused to see his CPN. On one occasion he jumped out of a bedroom window when the CPN came, leading to another crisis.

The Incident
In January 2014 he had fallen into a severe crisis, he was convinced all the family were in grave danger and that the house had been wired up to explode. He had locked himself in the bathroom of the house and refused to come out. His mother was locked out of the house with her telephone and contact details inside.

C's mother's initial concerns were:

- Keep C safe
- Keep others safe
- Swiftly get C into Mental Health Services

She was not able to call for the Mental Health Crisis team because all her numbers were in the house. In any event, she felt that she needed police help. She did speak to the crisis team once the police were on scene. The team did not offer to come out, but advised that C should be taken to A&E or to a custody suite.

In dealing with hospital staff during the incident C's mother felt there was undue emphasis placed on his arrest 3 years earlier for being in possession of an offensive weapon, leading to an over interpretation of the risk he may have posed.

It would have been very helpful in this situation if there had been some pre alerting of the crisis team (CRHTT). 10 days earlier the CPN had talked to the STEP team and had briefed the crisis team about C's situation, but this information does not seem to have assisted in the process.

C wanted to be arrested but there were no grounds to do so. The ambulance crew and police, with family help, eventually persuaded him to go in the ambulance. In the end C did go in the ambulance with his mother and the police followed. The family arrived, with the ambulance at about 6.30pm and did not leave again until about 6.30am the following morning.

There was no one to meet them at the hospital at A&E and they went through the standard physical health A&E admissions procedure with standard questions and blood pressure tests. None of this seemed relevant in their situation. Once C was settled in A&E, the police left.

There was an A&E mental health liaison nurse but C wouldn't talk to them. A specialist MH liaison team consisting of two doctors and an approved social worker arrived. C was then sectioned but not medicated; his family feel that subsequent difficulties with transport would have been minimised if he had been given medication to calm him.

The nearest appropriate location for treatment was in Torbay so much of the night was spent trying to arrange appropriate transport. A series of attempts were made to get C, who was by now held under section, into a suitable treatment location.

His mother describes a catalogue of incidents, none involving violence, but all involving a reluctance by C to collaborate. He would not get into an ambulance and police would not assist with his transport. A specialist ambulance was called for, which had to travel from Bristol. When it arrived it was quickly damaged in an attempt to get C into it. At this time, some 12 hours after arriving at the hospital, a further secure ambulance was sought this time from Leeds. He was still under section but his parents decided it was time to take him home. There was a difficult situation in which the private ambulance crew made attempts to stop the family leaving, even attempting to pull the keys from their car.

He went home with his family, still nominally under the control of S2 of the mental health act. Attempts were made via the Mental Health Emergency Duty Team (EDT) to coordinate transport to Wonford House hospital in Exeter. A private ambulance was proposed but the family were willing to use their own transport. When the EDT arrived C had left the family home. There were several failed attempts to find and detain him. Eventually police forced entry into the family home and took C in a police van to Wonford House.

C is now at home and is well. Since this crisis he has been receiving treatment and his condition has improved greatly.

7.3.5 **What would C's family like to see?**
C's family do have experience of mental health provision and they are able to set out some of the key issues that they believe would improve the system:

- Routine support services (STEP) carrying out a briefing to crisis services (CRHTT) and better liaison between them
- The establishment of a care plan between STEP and CRHTT and the logging of that care plan electronically
- Is it feasible to call the Mental Health Services direct, rather than the Ambulance Service, when there is no medical issue?
- Why not use police vehicles for secure transport. What is the total cost of commissioning private secure ambulances? There is no good way of getting unwilling patients to hospital; pragmatically the police will get involved.
- Is it feasible to take people in NHS transport? If this case happened again, would it come to a different outcome?
- If the NHS did have secure transport, given Devon's geography where would you place it? How many vehicles would you need, where would you put them?
- Policy: when sectioned, suggest you sedate clients as standard. This will be an aid to transport. It is done in any event on admission to a psychiatric inpatient unit.
- Beware of communication and misinformation of client history.
- Ensure the links between NHS, family and client are open and effective.

7.3.6 **Further issues identified by thematic review**

a) The issue of mental health crisis transport is at the heart of the national concordat. While the national aspiration is clear, the local implementation is not. There is a clear expectation that the role of police will be minimised in the transport and the detention of people in mental health crisis, but in Devon and Cornwall the protocols are not yet complete and systems are not agreed.
b) While the conveyance of C in this case was a matter for the ambulance service, there was not the equipment or training available locally to achieve this. Ultimately the ambulance service is not equipped for non-compliant patients. The police are equipped but their use is inconsistent with the concordat as expressions of best practice.
c) The family were left largely unsupported during these difficult three days.
d) The SUI report focusses on the role of police in assisting in the transport of patients in mental health cases and the absence of police support in this case. The police appear confident that they have done all that is expected of them. Both the Peninsula protocol and the national guidance issue to police make it clear that transport of mental health patients is a matter for the relevant health authority. Even if the patient is violent the guidance indicates that appropriately trained ambulance staff provide transport. If the patient's behaviour is likely to be violent or dangerous, the police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, an ambulance service (or similar) vehicle should be used even where the police are assisting. (Code of Practice Mental Health Act 1983)
e) This case reveals that there is a lack of clarity about the exact roles and responsibilities of police and health staff in relation to mental health clients. The instructions to both agencies are clear in respect of overall responsibility and procedures, however there is a degree of flexibility and discretion in the policy to allow for transport of dangerous clients. This area of flexibility is tested at times of short resources. There is a mental health liaison process and an escalation process; they do not appear to have been utilised in this case.

f) The dispute regarding transport and police support for it is unresolved; both sides take a fixed view of their roles and the role of the other party. The family at the centre of this situation were poorly served while the health and police staff debated areas of responsibility. C and his family were left at the centre of this argument not receiving a coherent service.

7.3.7 **Cross Cutting Themes**

- Communication.
- Multi Agency or independent involvement in post incident review processes.
- Transport in mental health crisis care, while not cross cutting across other cases is fundamental to this case.

8. Cross Cutting Themes and Underlying Issues

	Case A	Case B	Case C
Quality and timeliness of assessment at the point of crisis	x		
Interagency communication	x	x	x
Multi agency participation in post incident review	x		x
Use of client's own language in reports	x		
Sharing risk information between agencies		x	
Transport in mental health crisis care.			x

8.1 The quality and timeliness of assessment at the point of crisis.

In case A the client had been identified as being in crisis by her GP. This was followed up by a telephone assessment which identified that she was no longer in crisis. This appears to be a very fragile method of assessment, particularly so for people experiencing a mental health crisis. It is not consistent with the very rigorous discharge process adopted by the CRHTT for people who have been accepted onto their caseload.

8.2 Inter-Agency Communication

In case B data was held within one agency that if shared with another may have assisted in the overall management of the cases. It is not clear though, to what extent it is practical or useful to share risk data on volume cases between agencies.

Communication is a challenge within any complex system, even more so between several different complex systems. There are many communication routes in place between police and mental health services, as well as with these agencies and others. The challenge is allowing information to flow effectively between practitioners, when the formal escalation routes may not be clear to them or appropriate in the circumstances.

Communication between police and health bodies operates at many different levels within their respective hierarchies, and deals with a wide range of issues. Multi agency working in mental health crisis care is supported by several layers of communication. At the top of the agencies there is the Peninsula Mental Health Criminal Justice Agencies Group (PMHCJA). This group is active and important, responding not only to the requirement to develop the local concordat but also to the October 2013 joint HMIC/CQC inspection of custody provision in mental health cases. This report entitled "Criminal use of police cells"[5], was an inspection of police facilities used for S136 detentions. The PMHCJA also created the multi-agency Section 136 Protocol that has been effective since April 1st 2010. It has created a range of other protocols including that dealing with information

[5] http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf

exchange.

The Peninsula Group has sub groups in Devon, Plymouth & Cornwall. Devon has its own sub groups of Torbay, Exeter, East & Mid and North Devon. There are also Mental Health liaison groups with Chief Inspectors as the Single Points of Contact within police Basic Command Units. These groups are able to consider specific incidents and learn from them.

Devon & Cornwall Police have a Mental Health Steering Group which has developed a mental health strategy and action plan. The force has suicide prevention strategies based upon national and local best practise.

Communication at the most tactical level, for example between front line PC and ambulance crew or nurses appears to be effective and positive, although not supported by clear and up to date operational protocols.

8.3 Sharing of risk information

The need for sharing data between agencies of all kinds relating to risk and safeguarding has been well rehearsed and has been at the heart of many Serious Case Reviews across the country. The tension between the need to share data when risk is apparent and the need to protect agency and personal data is a frequent theme.

Individual agency systems do not assist, with discrete and secure IT systems unable to talk to each other. Systems of human interactions and meetings have been established to support the necessary data exchange, within a regulated and auditable process. The Multi Agency Public Protection Arrangements (MAPPA) are well established having been developed originally to deal with sex offenders. The system is well known and a good basis for data sharing on high risk cases. Under the MAPPA framework the Potentially Dangerous Persons (PDP) protocols have developed data sharing to include a wider range of risk categories. The questions posed by the cases in this review are about data exchange in cases that do not meet the MAPPA or PDP threshold, where risks posed to the patient or public are not so clear.

The current guidance for the MAPPA process is set out in a 2012 Ministry of Justice document[6]. The guidance sets out 3 categories of offender who can be brought into the MAPPA process.

- Category 1 are registered sexual offenders.
- Category 2 are murderers or offenders who have been convicted of an offence under Schedule 15 of the Criminal Justice Act 2003 (serious sexual offences and offences of violence) and who has been sentenced to 12 months or more in custody, or having been so sentenced are transferred to a secure hospital, or is detained in hospital under S37 of the Mental Health Act 1983.
- Category 3 are other dangerous offenders; people who have been cautioned or convicted of an offence which indicates that she or he are capable of causing serious harm and who requires multi agency management. This might not be for an offence under Schedule 15 of the CJA 2003.

  Category 3 Offenders are most of interest to the circumstances of this review. This category contains offenders who do not meet the criteria for

[6] http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

either Category 1 or Category 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management. It could also include those offenders on a community order who are, therefore, under the supervision of the Probation Trust. To register a Category 3 offender, the Responsible Authority must:

- Establish that the person has committed an offence which indicates that he or she is capable of causing serious harm to the public, and
- Reasonably consider that the offender may cause serious harm to the public which requires a multiagency approach at level 2 or 3 to manage the risks.
- The person must have been convicted of an offence, or have received a formal caution or reprimand/warning (young offenders). In most cases, the offence itself will be of a clearly sexual or violent nature, although it need not be listed in Schedule 15 to the CJA 2003. There may, though, be some cases where only an examination of the circumstances surrounding the offence will indicate that the offender has a capacity for serious harm. This may show, for example, a pattern of offending behaviour indicating serious harm that was not reflected in the charge on which the offender was ultimately convicted. Although any agency may refer a case for consideration as a Category 3 offender, it is for the MAPPA Co-ordination unit on behalf of the Responsible Authority to determine whether the offender meets the criteria.

  The central question in determining the correct MAPPA level is: "What is the lowest level of case management that provides a defensible Risk Management Plan?" As risk can and will change, so the means of managing risk can and will change with it. MAPPA provides the framework within which changes can be effectively and consistently managed. The overriding principle is that cases should be managed at the lowest appropriate level, determined by defensible decision-making.

8.4 The Data Exchange Process in mental health cases

Public sector agencies in Devon have a well thought through process for sharing risk data in respect of risk linked to mental health. The protocol entitled, "Exchange of Information between Statutory Agencies in Devon and Cornwall in Relation to Potentially Dangerous or Mentally Disordered Persons" was developed in 2010 and has been agreed by the key health, police and local authority bodies across Devon and Cornwall. It is a comprehensive explanation of the powers to share data and those people established as Single Points of Contact (SPOC) between agencies. As an appendix it has a form MH1 that is used to request access to data held by another agency. The MH1 form and process allows for agencies to seek data from each other on people considered to be a risk to themselves or others. This form and process seems well known to specialists working in the field and is regularly used. It was quoted by both police and health service staff during discussions as part of the review. Since 12 April 2014 the Central Disclosure Unit of Devon and Cornwall Police has received 100 requests under the Information Sharing Agreement from three different health agencies, covering Devon, Cornwall and Plymouth. The form is used to a much lesser extent to request information from health bodies by police. The process allows for a rapid turnaround of data, with the ability to seek information within 2 hours if required. The form makes a request for data, but is by itself also a notification of a potentially risky person. While the request is taken by the police and actioned, the intelligence benefit that it poses is not utilised.

Each time an MH1 request is received by the police, it is sent to their Central

Disclosure Unit and an entry for inclusion in intelligence is made. This states that a request has been made and refers to the Central Disclosure Unit for further detail. None of the detail contained in the MH1 is cross checked against the information they hold about an individual.

If the police hold no existing nominal record relating to an individual when they receive an MH1 they do not create a new nominal record. Police provide a response to the originator dependant on the information they hold if any. Clarification is sought if the MH1 request does not state the reason for the request.

The protocol also allows for the proactive disclosure of data between signatory agencies in respect of a Potentially Dangerous Person. There is no record of this process having been utilised.

8.5 Colocation & Informal Information Exchange

While the Peninsula Mental Health Criminal Justice Agencies Group (PMHCJA), the Information Sharing Protocol and the liaison groups provide good levels of strategic and operational communication, there are a wide range of other systems, frequently based on colocation which allow for rapid sharing of information and improved understanding. These co-located groups have a very important role in improving overall coordination of response. Some of the key groups are described below.

8.5.1 Street Triage

The Street Triage Scheme which started in March 2014 is the most relevant to this review. Funding has been obtained from the Department of Health by the Devon Partnership NHS Trust (DPT) to provide this pilot service working with Devon and Cornwall Police. The service links with the existing custody liaison and diversion service.

This team operates from 8pm Thursday until 6am Monday every weekend. Two nursing staff work from the police control rooms at Exeter and Plymouth. These staff have full access to their DPT data systems, specifically RIO.

The remit of the team is to provide telephone advice and information to Police response units across Devon when they have a request for a call out to a person that may have mental health, learning disability, alcohol or substance misuse issues.

The team consists of two CPN's in each control room, this gives them the ability for one to leave and attend incidents with police response units. They are able to carry out triage, screening assessments and give information and advice to assist with decision making and disposal routes; they can carry out appropriate liaison and referral or signposting on according to identified need.

This project has external funding for two years. This scheme has the potential to make a significant difference to police and mental health services communications, for the good of patients.

8.5.2 Custody Liaison and Diversion[7]

In July 2013 North, Eastern and Western (NEW) Devon CCG in partnership with South Devon and Torbay CCG commissioned Devon Partnership NHS Trust and Plymouth Community Healthcare to deliver a one year Liaison and Diversion pilot to deliver services to police custody and courts across the county.

Liaison and Diversion services utilise mental health workers to identify people with mental health and learning disability related needs, when they come into contact with the Justice system. The aim of these services is to make sure that people get the treatment and support they need. Their remit is to:

- Provide timely screening assessments to those detainees and defendants presenting in criminal justice services (courts and Police custody) with suspected mental health, learning disability, alcohol or substance misuse issues.
- Give information and advice to criminal justice staff on how to manage those persons needs whilst they are going through the criminal justice system and make recommendations on disposal route.
- Signpost/refer person onto appropriate services according to identified need.

While this project was established with the remit set out above the staff are also a resource to the police to advise and assist with general concerns regarding mental health. This service has proven useful when the police have been looking for missing people with mental health concerns.

8.5.3 Custody Nurses

The custody nurse scheme is designed to provide a high level of medical care to all detainees in police custody. They also provide a useful communication role, gaining a good knowledge of the business models of both the police and health services. They have proven to be an effective informal communication channel.

8.5.4 MASH[8]

The Multi-Agency Safeguarding Hub (MASH) is the central resource for Devon receiving all child safeguarding and child protection enquiries. The MASH is aimed at the needs of children, not adults and is not designed to meet the needs of adults with mental health problems. That being said, it is a good example of how professionals are working together to bring a high level of interagency communication. The MASH is staffed with professionals from agencies including police, probation, fire, ambulance, health, education and social care. They share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm.

MASH staff gather information from every agency and use this to decide the most appropriate intervention to respond to the child's identified needs. Where appropriate, the MASH team is able to immediately trigger a response. The emphasis is on triggering interventions to the child or

[7] https://www.newdevonccg.nhs.uk/partnerships//partnerships-directorate-news/launch-of-liaison-and-diversion-service-in-devon/100431

[8] http://www.devon.gov.uk/mash.htm

young person and their family to prevent harm.

Working together in this way ensures that the agencies are sharing information and are able to respond to a child's needs quickly and efficiently. The MASH method has resulted in more effective and earlier identification of vulnerable children. It has reduced the number of different professionals being involved, while keeping the most appropriate professional to deliver interventions to meet the needs identified in any particular case. It has avoided unnecessary duplication and visits, and simplified processes. It has also improved communication between professionals.

8.6 Mental Health services (CRHTT) Discharge Process

The CRHTT Discharge process is directed by their operational policy. This policy is clear in respect of how a client is taken onto the service and clear about how they are removed from it. The triage process, by which the service decides if the initial referral is correctly made, is less clear and less well documented. In case A the detailed discharge protocol was not activated because the initial triage contact judged that the case was not a crisis, within the teams definition, it was therefore not taken onto the teams case load.

When a case has been taken on it is the Team's responsibility to ensure that clients are engaged with other mental health services (where these are appropriate), before the crisis service is withdrawn. Preparing for a client discharge includes planning and arranging a handover with the community team after the crisis is resolved, where this is appropriate. This may include conducting a joint meeting with a care coordinator. A relapse plan should be created. A discharge summary will be written which will provide information for the service to which care is handed to, the referrer and GP.

Involvement of those who use the service, their relatives and carers, is covered by the Trust Involvement Strategy. Promoting user and carer involvement is a central role for each Team member, both in their individual work, as part of the Team and as an employee of the Devon Partnership NHS Trust. Service users and their carers should be centrally involved in the assessment and care planning processes and an aim of the service will be to enable service users to make informed choices at all stages of their care.

Where a client is on the CRHTT caseload the decision to discharge is taken by a multi-disciplinary panel. The team meets twice a day and any discharge is considered at those meetings. In the morning meeting workloads are planned and identified, at the lunchtime meeting cases and their issues are discussed.

The question of discharge is then raised with clients at the team's next visit. If the crisis phase is over, but the client still needs support they will be referred to the community psychiatric team or others as necessary. If they are already receiving such care the CRHTT will speak to the care giver.

The discharge process is clear and comprehensive, the challenge is to bring the same level of rigour to the initial decision to accept or not accept cases onto the CHRTT caseload and, if they are not accepted, how is the hardback of responsibility to the original referrer achieved?

8.7 Joint agency training and understanding

During the review the benefit of joint agency training has been evident. There will

be many examples of courses that may be beneficial, one is detailed here as an example of a joint training product being utilised in NHS Cornwall.

STORM (skills-based training on risk management for suicide prevention) is intended for frontline workers in health, social and criminal justice services. STORM focuses on developing the skills needed to assess and manage a person at risk of suicide. The STORM package is designed to be flexible and adaptable to the needs of a service. Training is given with the goal of three members of staff receiving training to let them deliver STORM to the remainder of their organisation. There are packages based on both adult and child suicide prevention.

This is just one example of existing joint training; such training has duel benefits, it delivers the knowledge required and it helps to build relationships of trust between practitioners and agencies.

8.8 Multi Agency Participation in Root Cause Analysis or other reviews

The Root Cause Analysis (RCA) documents provided to this review were helpful and detailed. Each, however, was a health service view formed from the examination of health service documents or discussions with health service professionals. Each of the three cases involved interaction to some degree with other agencies, and all involved families. None of the RCA documents had other agency content or independent scrutiny, none of them had family involvement.

During the course of this review, the Duty of Candour regulation was passed. This will support an improved relationship with families going through such issues as examined by this review in the future. The exact relationship between the Duty of Candour in respect of patients and the Data Protection Act requirements in respect of families does not appear to be clear yet. This will require working through as the regulation is tested nationally.

It may be that the relevant Safeguarding Board's Serious Case Review sub group could offer multi agency scrutiny into post incident reviews of cases with multi-agency involvement that involve their constituent agencies.

The Root Cause Analysis/SIRI process would benefit from more independent scrutiny and, where there has been multi agency involvement in the incident, multi agency participation in the review.

8.9 Transport in MH Crisis Cases

Case C arose out of a dispute regarding mental health crisis transport. The current guidance for statutory agencies within Devon Cornwall and the Isles of Scilly is within a document entitled Section 136 Mental Health Act 1983, Operational Protocol for Devon Cornwall and the Isles of Scilly. Appendix 9 within it deals with patient transport.

The protocol sets out the responsibility of the Approved Mental Health Practitioner to arrange transportation and to undertake the risk assessment. The protocol states that SWAST are responsible for providing this transport. Para 2.4 and 2.5 sets out if the individual is considered to be a risk to him/herself and/or others, the police may be called upon to provide assistance, which may be in the form of a police escort within the ambulance. Para 2.5 states that the transported individual remains the responsibility of the AMHP until the patient has arrived at the receiving in patient unit.

Decisions to escalate transport plans are based on a risk assessment carried out

by the AMHP. It is only the high risk category which would trigger a police escort. High risk is described as; individuals with a relevant history of violence and/or pose a threat of physical injury to themselves and others or individuals who resist admission and are physically capable of doing so and need more than minimal physical restraint.

It is apparent that despite the 2010 protocol and the national concordat, effective local plans for the transport of medium risk patients are not yet clearly defined. It is also apparent that the definitions of medium and high risk are sufficiently wide as to allow for the type of differing interpretations seen in case C. The definition of high risk includes individuals who resist admission and are physically capable of doing and need more than minimal restraint. There is work currently underway within the PMHCJA group to resolve this and a new protocol was due for release before the end of 2014. This protocol is clear and helpful and will be a major step to resolving many of the issues that arose in this case.

8.10 Duty of Candour

In March 2014 Sir David Dalton and Professor Norman Williams published "Building a culture of candour, a review of the threshold for the duty of candour and of the incentives for care organisations to be candid". This work had been commissioned by the Minister for Care and Support following recommendations from the Francis Inquiry).

The Dalton/Williams report set out a range of recommendations designed to support candour in health care. It states that patients should be well-informed about all elements of their care and treatment and all caring staff have a responsibility to be open and honest to those in their care. It proposes that care organisations should have and sustain a culture which supports staff to be candid.

Government accepted the recommendations and in November 2014 they were brought into law in Regulation 20 Statutory duty of candour of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are:

- Care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout an organisation.
- The statutory duty applies to organisations, not individuals, though it is clear from CQC guidance that it is expected that an organisation's staff cooperate with it to ensure the obligation is met.
- As soon as is reasonably practicable after a notifiable patient safety incident occurs, the organisation must tell the patient (or their representative) about it in person.
- The organisation has to give the patient a full explanation of what is known at the time, including what further enquiries will be carried out. Organisations must also provide an apology and keep a written record of the notification to the patient.
- A notifiable patient safety incident has a specific statutory meaning: it applies to incidents where a patient suffered (or could have suffered) unintended harm that results in death, severe harm, moderate harm or prolonged psychological harm. Severe and moderate harm definitions are derived from the NPSA's Seven Steps to Patient Safety. Prolonged psychological harm means that it must be experienced continuously for 28 days or more.
- There is a statutory duty to provide reasonable support to the patient. Reasonable support could be providing an interpreter to ensure discussions are

understood, or giving emotional support to the patient following a notifiable patient safety incident.
• Once the patient has been told in person about the notifiable patient safety incident, the organisation must provide the patient with a written note of the discussion, and copies of correspondence must be kept.

The Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

9. Recommendations

9.1 The quality and timeliness of assessment at the point of crisis

Initial assessment is vital to establish the effective management of the case. Where a GP or other professional has made a referral to a crisis service an effective, timely response is vital. Telephone triage should not be considered sufficient. The effective disciplines used elsewhere in the CRHTT operating protocols should include initial contact and the decision making that defines whether a client is taken onto the service or not.

9.2 Inter-agency communication

A process should be devised and trained to allow and encourage the transfer of risk information between these two key agencies.

Formal negotiation and alerting processes exist, but the flow of risk information in routine matters is not effective. The MASH process in Devon has the potential of being a major step forward. The MASH process is designed for people under 18. Now that the infrastructure is built it may be possible to develop matching services for adults.

The Peninsula Mental Health Criminal Justice Agencies Group should sign off and agree the November 2014 joint Police/NHS document “Multi-agency Response to detention under the Mental Health Act 1983”, as soon as possible.

9.3 Sharing of risk information

The participating agencies should publicise the Inter Agency Data Exchange protocol, including the MH1 process, more widely.

The agencies should promote the range of risk data sharing mechanisms including MAPPA and PDP.

Police to consider the intelligence benefit from the questions in the MH1 form.

When a form MH1 is received by the police within the data exchange protocol, details should be added to the subject’s nominal record on the police intelligence system. If there is no existing nominal record, one should be created.

9.4 Colocation and informal information exchange

The current wide range of colocation and informal data exchange systems should be developed into an overall program of coordinated work. The extent of the current roles should be publicised.

9.5 Mental Health services discharge processes

Telephone Triage
When the CRHTT is making an initial telephone call to a potential client following a referral from a GP, the default position should be that a face to face meeting will follow rather than a telephone call.

Discharge
Consideration should be given to the methodology of the discharge of patients from specialist support services. A matching level of rigour should be given to the discharge as is given to the acceptance of B onto the specialist team's caseload. Entry onto specialist services client list requires specific referral from GP's or others. It is not done lightly. Removal from such lists appears to be easier, often utilising client self-diagnosis as a major factor. Removal from the specialist services list would merit information to, or consultation with, the original referrer.

9.6 Joint agency training and understanding

Devon Safeguarding Adults Board to audit the extent to which its constituent members are part of the Peninsula concordat process and to seek involvement.

Partner agencies to audit the range of joint training in respect of mental health crisis care, in conjunction with the Peninsula Mental Health Criminal Justice Agencies Group.

9.7 Multi Agency Participation in Root Cause Analysis

The Root Cause Analysis/SIRI process is thorough and clear, however the reports in this case are all single agency; they do not expand to include other agencies and do not have the benefit of independent non-health agency scrutiny.

Where there is the involvement of more than one agency with the potential for conflicting views, the establishment of multi agency involvement with the possibility of independent oversight for the process would add value. This is particularly evident in the investigation carried out into case C.

It is understood that work on a memorandum of understanding for multi-agency participation in root cause analysis, which had been initiated and drawn up by NHS Devon (Cluster PCT), was stalled when the CCG's and NHS England Area teams were formed, as there was an intention to develop a peninsula wide protocol by NHS Devon, Cornwall and Isles of Scilly Area Team. Further development of the memorandum to include multi-agency involvement and review of serious incidents involving a number of agencies should be considered by South Devon and Torbay CCG and NEW Devon CCG,

9.8 Transport in Mental Health Crisis Care

The joint police and health service protocol, drafted in November 2014 will resolve many of the disputes and uncertainties of the past. This was due for sign off in December 2014. If this is achieved it will be a major step forward.

10. Conclusion

At the start of this review questions were raised about data sharing, communication, the delivery of home based crisis mental health care and the systems professionals used in joint working. Discussions held during the review have revealed some effective underlying systems. That systems exist does not mean that all processes work; systems need to be promoted, trained and explained.

This review and its recommendations have the benefit of occurring at a time when there is a strong drive, initially nationally and now locally, to resolve the issues of mental health care for people in crisis. The concordat process is designed to deliver real change in this area. In December 2014 sixteen leading bodies concerned with the provision of mental health crisis care signed a joint declaration regarding the services they will jointly offer. The agencies established an Action and Learning set of eleven leaders and service users to guide the process from declaration to action over the next 12 months. This declaration and the work that flows from it will do much to resolve the issues in this review.

The establishment of the statutory regulation regarding the Duty of Candour in November 2014 is a further positive step which should lead to an improved culture of openness and improved relationships with families when things do go wrong.

This review identifies, through the cases which instigated it, the importance of resolving now, issues which have previously been unresolved despite a range of protocol and policies which were meant to do so.

11. Action Plan

Recommendation	Action to take	Lead Agency/Group	Key milestones achieved	Target date	Date of completion and outcome	Status (R.A.G.)
Recommendation 1 **The quality and timeliness of assessment at the point of crisis** Initial assessment is vital to establish the effective management of the case. Where a GP or other professional has made a referral to a crisis service an effective, timely response is also vital. Telephone triage should not be considered sufficient. The effective disciplines used elsewhere in the CRHTT operating protocols should include initial contact and the decision making that defines whether a client is taken onto the service or not.	To review the Crisis Response Home Treatment Team operating protocol to bring the initial contact following referral into the policy document. To make any decision not to take a referred client onto the CHRTT workload following a telephone call only highly unlikely and only if there has been discussion with the original referrer.	Devon Partnership NHS Trust (CRHTT)	TBC	September 2015		
Recommendation 2 **Inter-Agency Communication** Formal negotiation and alerting processes exist, but the flow of risk information in routine matters is not clear or always effective. The MASH process in Devon has	Devon to consider what processes should be developed to improve information flow in	Devon Safeguarding Adults Board	TBC	September 2015		

Recommendation	Action to take	Lead Agency/Group	Key milestones achieved	Target date	Date of completion and outcome	Status (R.A.G.)
the potential of being a major step forward. The MASH process is designed for people under 18. Now that the infrastructure is built it may be possible to develop matching services for adults.	cases outside the MAPPA/PDP regime. This might include the extension of the MASH process to include vulnerable adults or the further development of the Torbay ViST project.					
The Peninsula Mental Health Criminal Justice Agencies Group should agree, sign off and embed the November 2014 joint Police/NHS document "Multi-agency Response to detention under the Mental Health Act 1983", as soon as possible.	The Peninsula Mental Health Criminal Justice Agencies Group to agree and sign the protocol	Peninsula Mental Health Criminal Justice Agencies Group				
Recommendation 3 **Sharing of risk information** The participating agencies should publicise the Inter Agency Data Exchange protocol, including the MH1 process, more widely. The agencies should promote the range of risk data sharing	The process of MAPPA, PDP and the Mental Health Risk Management data sharing process for sharing data are all effective inter agency	Devon and Cornwall Police with the Peninsula Mental Health Criminal	TBC	September 2015		

Recommendation	Action to take	Lead Agency/Group	Key milestones achieved	Target date	Date of completion and outcome	Status (R.A.G.)
mechanisms including MAPPA and PDP. Police to consider the intelligence benefit from the questions in the MH1form.	approaches. The knowledge of their existence and use should be disseminated widely to operational staff When a form MH1 is received by the police within the data exchange protocol details should be added to the subject's nominal record on the police intelligence system. If there is no existing nominal record, one should be created.	Justice Group Devon & Cornwall Police		September 2015		
Recommendation 4 **Colocation and informal information exchange** The current wide range of colocation and informal data exchange systems should be developed into an overall program of coordinated work. The extent of the current roles should be publicised.	Map the range of colocation and partnership projects within the field of mental health crisis care and develop a strategy that encompasses them and allows for their overall development.	Devon and Cornwall Police with the Peninsula Mental Health Criminal Justice Group	TBC	September 2015		
Recommendation 5						

Recommendation	Action to take	Lead Agency/Group	Key milestones achieved	Target date	Date of completion and outcome	Status (R.A.G.)
Joint agency training and understanding Devon Safeguarding Adults Board to audit the extent to which its constituent members are part of the Peninsula concordat process and to seek involvement. Partner agencies to audit the range of joint training in respect of mental health crisis care, in conjunction with the Peninsula Mental Health Criminal Justice Agencies Group.	Audit membership and seek participation	Devon Safeguarding Adults Board	TBC	September 2015		
Recommendation 6 **Multi Agency Participation in Root Cause Analysis** The Root Cause Analysis/SIRI process should include multi agency participation and independent oversight in the review where there has been multi agency involvement in the incident. Where there is the involvement of more than one agency with the potential for conflicting views, the establishment of multi agency involvement with the possibility of independent non -health oversight would add value.	Devon Partnership Trust to develop policy and disseminate to their staff. Further development of the memorandum of understanding for multi-agency participation in root cause analysis to include multi-agency involvement and review of serious incidents involving a number of agencies should be considered It may be that the relevant Safeguarding Board's Serious Case Review sub	Northern, Eastern and Western Devon Clinical Commissioning group and South Devon and Torbay Clinical Commissioning Group	TBC	September 2015		

Recommendation	Action to take	Lead Agency/Group	Key milestones achieved	Target date	Date of completion and outcome	Status (R.A.G.)
	group could provide some multi agency scrutiny into post incident reviews of all kinds conducted by their constituent agencies.					
Recommendation 8 **Transport in Mental Health Crisis Care** The joint police and health service protocol, drafted in November 2014 will resolve many of the disputes and uncertainties of the past. This was due for sign off in December 2014. If this is achieved it will be a major step forward.	The Peninsula Criminal Justice Agencies Mental Health group to be asked to publicise the protocol through their constituent agencies	Peninsula Criminal Justice Agencies Mental Health group	TBC	September 2015		
Recommendation 9 **Duty of Candour** The exact relationship between the Duty of Candour in respect of patients and the Data Protection Act requirements in respect of families does not appear to be clear yet. This will require working through as the regulation is tested nationally.	To conduct research into the use of the Duty of Candour to work with families and carers when patients are deceased or incapable of receiving information	South Devon and Torbay Clinical Commissioning Group	TBC	September 2015		

12. Documents provided to the review

Document	Description	Comment
A1	Letter 27.8.12 SMHP CRHTT	
A2	ROOT CAUSE ANALYSIS 23.10.13	
A3	Appendix 2 Mental Health	Delivers Root Cause Analysis J2
A4	Appendix 2 Education	No substantive information
A5	Appendix 2 Education	No substantive information
A6	Appendix 2 Education	No substantive information
A7	GP Letter	
A8	Agency Chronology D&C Police	
B1	Appendix 2 GP	
B2	ROOT CAUSE ANALYSIS 8.12.13	
B3	Appendix 2 Mental Health	Delivers Root Cause Analysis K2
B4	Agency Chronology D&C Police	
C1	Appendix 2 GP 28.3.14	
C2	SUI 31.1.14	
C3	Appendix 2 MH Services 9.4.14	
C4	Appendix 2 RDE 9.4.14	
C5	Appendix 2 SWAST 3.4.14	
C6	Agency Chronology D&C Police	
C7	Operational Protocol CJA	
	CRHTT Operational Policy	