lancashire safeguarding adults board

Safeguarding Adult Review

Overview Report

Adult J

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1. Introduction

1.1 The subject of this Safeguarding Adult Review (SAR) is Adult J who was found dead in his home on 27 February 2018 when the Police forced entry to the property. The cause of death was found to be 'Asphyxia by Ligature' and it is believed that Adult J took his own life. He was 41 years of age and lived alone in the property at the time of his death.

1.2 Adult J spent a period of time under the care of mental health services from December 2013 until March 2016 with a diagnosis of acute and transient psychosis. He was then discharged to the care of his GP and continued to receive anti-psychotic medication from the GP. Concerns about his mental health were raised by his ex-partner nine days before he died. These concerns were repeated during the intervening days.

2. The Review Process

2.1 A Safeguarding Adult Review was commissioned by Lancashire Safeguarding Adult Board (LSAB), following agreement at Lancashire Safeguarding Adult Review Sub Group in accordance with the Care Act (2014). Section 14 of the Care Act Guidance sets out the functions for LSABs. This includes a requirement to undertake reviews of serious cases in specified circumstances.

2.2 The methodology used was based on an adapted version of a Child Practice Review process introduced in Wales in 2013 and often referred to as the 'Welsh Model'. This is a streamlined, flexible and proportionate model of review that focuses on identifying key learning in order to improve service provision.

2.3 A Review Panel was established in accordance with guidance. This was chaired by the Deputy Head for Safeguarding Adults, East Lancashire Clinical Commissioning Group (CCG) and included representation from relevant organisations within Greater Preston CCG, Lancashire Care NHS Foundation Trust (LCFT), Lancashire Constabulary (the Police) and Lancashire County Council. Peter Ward was commissioned as Lead Reviewer for the review with support from the Business Coordinator to the SAB. Mr Ward has a background in Social Care and Safeguarding and is independent of the Lancashire Safeguarding Adult Board and all organisations involved in the review.

2.4 All relevant agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement. The agency timelines were merged and used to produce an interagency timeline. This was used to inform learning and identify areas for further exploration and consideration. The timeframe for the review was agreed as a 12 month period from 27 February 2017 until Adult J's death on 27 February 2018. Agencies were asked to also considered any significant incident relevant to this review but outside that timeframe. In reality the vast majority of the

relevant information relates to a nine day period immediately before Adult J's death.

2.5 An important feature of the 'Welsh Model' is that it enables practitioners who worked directly with the subject of the review and/or their family to actively contribute in identifying learning, good practice and recommendations. To that end, the Lead Reviewer held a Learning Event which was attended by practitioners from the agencies involved with Adult J and his family during the period covered by the review.

2.6 Another feature is that family members are invited to contribute to the review. Adult J's ex-partner, mother and sister were all invited to meet with the lead reviewer. They all decided that they did not wish to take up this offer but Adult J's ex-partner did provide a written submission that provides useful insights.

2.7 Since the death of Adult J, LCFT, the Police and the GP practice have formally considered aspects of the service provided to Adult J by these individual organisations. The lead reviewer has had access to the reports provided by LCFT and the GP practice and these have informed this report.

3. Factual Summary of Agency Involvement

3.1 Time Period 1; December 2013 to March 2016 – Involvement of Mental Health Services with Adult J.

3.1.1 Adult J's first contact with mental health services was in December 2013 when he was admitted to hospital acutely psychotic. During 2015 there were three more occasions when he was admitted to hospital whilst suffering from a psychotic episode. On each of these three occasions, the psychotic episode was precipitated by his non-compliance with medication.

3.1.2 Adult J was last discharged from hospital in November 2015 after which he received community mental health services until March 2016 and was then discharged to the care of his GP. During appointments that Adult J had with Practitioner 1 from the Complex Care Treatment Team in December 2015, it was identified that his mental health took approximately three weeks to deteriorate if he stopped taking his medication. It was also established that Adult J's ex-partner and mother were involved in his care and he wanted them to be aware of his situation so they could take suitable action if he showed signs of a relapse. Adult J's ex-partner was present at a subsequent appointment when his relapse signature was discussed.

3.1.3 A Care Programme Approach meeting took place in March 2016 prior to Adult J's discharge from community mental health services. Subsequently a discharge care plan was finalised by his care co-ordinator. Within this care plan it is identified that Adult J would be at high risk of relapse if he did not comply with his medication.

3.2 Time Period 2; March 2016 to Early February 2018 - Health Services Provided to Adult J Following his Discharge from Mental Health Services

3.2.1 Following Adult J's discharge from mental health services in March 2016 he was seen by his GP on one occasion. This was in January 2017 when he attended a routine annual mental health review. In January 2018, the GP practice sent him a letter asking him to make an appointment for his next annual review. Adult J did not respond to this letter and in early February 2018 a further letter was sent but this also elicited no response.

3.2.2 Between March 2016 and November 2017 Adult J collected prescriptions for his anti-psychotic medication. He did not collect any further prescriptions after November 2017 but the GP was not aware of this when the letters were sent asking Adult J to make an appointment for an annual review.

3.2.3 No other agencies had any contact with Adult J between his discharge from mental health service in March 2016 and the family raising concerns in mid February 2018.

3.3 Time Period 3; 18 to 27 February 2018 – Agency Responses to Concerns about Adult J's Deteriorating Mental Health

3.3.1 On Sunday 18 February 2018 Adult J's ex-partner contacted the Home Treatment Team (HTT) of LCFT[1] to raise concerns about Adult J's mental health and wellbeing. She described Adult J as behaving 'bizarrely and odd' and said she thought that he was not taking his medication and was relapsing in respect of his mental health. HTT Team Leader 1 tried to phone Adult J but did not receive any answer.

3.3.2 During the next eight days, Adult J's ex-partner, mother and sister made a total of 15 more calls to a range of services to express concerns about his wellbeing. Calls were made to ATT, the Police, the Council's Emergency Duty Team (Social Care), Adult J's GP and the school attended by Adult J's children. Relatives reported that Adult J had stopped taking his medication and that his mental health had deteriorated. He was described as acting 'bizarrely and odd' and bumping into people when riding his bike. He had told his ex-partner that he was hearing voices and was scared of these. Family members considered him to be a possible risk to himself and his family and stated that he had been aggressive in the past when unwell. The vast majority of calls were made by Adult J's ex-partner to ATT and the

[1] Community Mental Health Services in Lancashire are provided by Lancashire Care NHS Foundation Trust (LCFT). The Access and Treatment Team (ATT) is part of this service and comprises the Home Treatment Team (HTT) and the Specialist Triage, Assessment, Referral and Treatment Team (START). START is operational from 9:00 a.m. to 5:00 p.m. Monday to Friday and should provide a screening, triaging and signposting service for enquiries and referrals received during these hours. HTT is operational 24 hours/day, seven days/week and has various functions including assessment, gate-keeping and home treatment. Out of normal office hours, when START is closed, referrals are managed by HTT.

Police. (See Appendix 2 for a table phone calls received by agencies, from Adult J's family.)

3.3.3 On the morning of Tuesday 20 February 2018, police officers spoke to Adult J on the doorstep of his home. This was the only occasion during the period from 18 February onwards that anyone from any agency involved in this review spoke to Adult J or saw him alive. The Police visited his home on one other night but no-one answered the door. Practitioners from ATT tried to phone him on three occasions but received no reply. No other attempts were made to visit him at home although his GP planned to visit on 28 February 2018 having been contacted by Adult J's ex-partner in the late afternoon of 26 February.

3.3.4 Adult J's sister phoned the Police in the late afternoon of 26 February 2018 stating that she had not seen him for two days and was concerned for his safety. Police attended Adult J's house at 00:08 hours; his sister was also present. A decision was taken to force an entry into the flat due to the raised concerns for Adult J's safety. This was done and Adult J was discovered dead inside the house.

4. Thematic Analysis of Practice and Organisational Issues

4.1 Theme 1
Access into services and any barriers to access which impact on risk and patient experience

Access to mental health services via the Access and Treatment Team (ATT)

4.1.1 Mental health services did not open a referral in respect of Adult J until 27 February 2018, which was after he had died. In the previous nine days Adult J's ex-partner and mother had contacted the service seven times to express concern about his welfare (as outlined in paragraph 3.3.2) and to request assistance. During this same period Lancashire Police made a referral to ATT via the Multi-Agency Safeguarding Hub (MASH) and contacted HTT directly on two further occasions.

4.1.2 The absence of a referral was a significant barrier to the family accessing mental health services for Adult J because without one, the case was not seen as being active to the service. Consequently, every contact was treated in isolation as a one off contact and was closed down once a response had been provided. Several different practitioners were involved but they were all on duty and had limited time to seek detailed information from the records or from other agencies.

4.1.3 The Standard Operating Procedures (SOPs) relating to HTT and START state that all referrals must be triaged. They provide guidance around the triage process, including possible sources of further information such as key

agencies and previous referrals. However, because a referral was never opened, triage did not take place and no decisions were taken as to the appropriate pathway. Information gathered during the triage process would have informed the decision as to whether or not a referral was appropriate but the way the SOP is written, triage is only carried out once a referral is opened.

4.1.4 Point 5.1 of the SOPs relating to both HTT and START states that referrals can come from a variety of sources. This includes 'carers' which would include Adult J's ex-partner and mother, 'MASH' and 'other agencies' which would include the Police. Therefore this review has sought to establish why none of the calls resulted in a referral being opened.

4.1.5 Evidence suggest s that the main factors that drove the response of HTT staff, including their decision not to open a referral in respect of Adult J, were that he had not consented to a referral and that his ex-partner did not want him to know that she had made contact. On day 2 HTT practitioner 1 told Adult J's ex-partner that it would be difficult for the service to become involved due to a lack of consent from Adult J, on day 3 Home Treatment Team Practitioner 2 suggested she attempt to encourage Adult J to seek help via his GP or self-refer to START and on day 4 HHT 3 told the Police there had been no contact because it appeared Adult J did not wish to engage. The issue of consent is considered in section 4.2 below. On two other occasions HTT staff told the Police that contact had not been made with Adult J because he was not willing to engage.

4.1.6 A police officer, who had spoken to Adult J, told an HTT practitioner that Adult J <u>was</u> willing to engage. As lack of consent was the reason given by HTT for not opening a referral, this information should have resulted in one being opened. Instead, on two occasions the case was discussed in an MDT meeting the following morning and the information was sent to START. The transfer of the case from HTT to START is considered in paragraph 4.4.8.

4.1.7 The first five calls to mental health services from family members were made to HTT during the first three days of this time period. After the first of these, the HTT Team Leader tried to phone Adult J and left a voicemail message for him. This was the only time anyone from HTT tried to contact Adult J. The HTT Team Leader also left a message for the ex-partner to advise her of the action taken and made a note to inform Adult J's GP but this was never done (see paragraph 4.4.4). The Team Leader has not recorded the reason for planning to phone the GP.

4.1.8 On the other occasions that Adult J's ex-partner and mother contacted HTT, suggestions were made to them about other services they themselves might contact. There was a lack of consistency in the suggestions that were made which included suggestions to contact Social Care, the GP, the Police and to request a Mental Health Act assessment. None of the practitioners offered to phone other services on the family's behalf (see paragraphs 4.3.6, 4.3.7 & 4.5.1).

4.1.9 The first attempt by the Police to refer Adult J to mental health services was on 20 February 2019 and was by way of a Protecting Vulnerable People (PVP) report from Lancashire Police which was sent to the Multi-Agency Safeguarding Hub (MASH). This had been submitted on the advice of the Mental Health Action Line after police officers had undertaken a welfare visit to Adult J at his home that morning. In line with expected procedure this was triaged by MASH and promptly forwarded to ATT for the attention of START. This should have provided a way into mental health services for Adult J but it was not reviewed by anyone in START until seven days later, which was the day he was found deceased.

4.1.10 Point 5.5 of the START SOP states that "START will triage all referrals on receipt for urgency and risk." However, at the time the PVP relating to Adult J was sent to START, the process being used in the team to respond to PVPs was as follows:

- When PVPs were received they were printed by administration staff and placed in a tray.
- Every Wednesday START practitioner 3 triaged all the referrals in the tray.
- The practitioner would then write on the form what action needed to be taken and would pass the form back to the administration staff.
- If the specific practitioner was not in work the triage role would be undertaken by a different practitioner.

4.1.11 20 February 2018 was a Tuesday and, therefore, if the above procedure had been followed the PVP would have been triaged by START the following day. It is not clear why the PVP was not triaged that day but there are believed to be two possible explanations. Firstly, the printed version of the PVP has not been date stamped and there is no record of when it was received by Practitioner 3. Therefore, it may be that administration staff did not print the referral on the day it was received and it was not in the tray when Practitioner 3 undertook the triage. Alternatively, it may be that the PVP was in the tray but was not triaged by Practitioner 3. Practitioner 3 had been on leave the previous two days and had other appointments on 21 February 2018. Therefore she would have had limited time available to triage the referrals.

4.1.12 Irrespective of why the PVP was not triaged on day 4, the process of triaging PVPs referrals once each week was not compliant with the START SOP and was an unsafe system as high risk, urgent referrals could remain unscreened for a week even when the process worked as planned.

4.1.13 PVPs should state whether the service user has consented or if consent has been overridden but this was not included on the one concerning Adult J. When the PVP was triaged by MASH the words "this is a referral to mental health services" should have been written in the additional information box. This was also not done. Because of the delay in START before the PVP was screened these omissions did not make any difference. However, on another occasion they may be significant.

4.1.14 During a phone conversation in the early hours of 21 February 2018, a police officer asked about the possibility of a home contact but the HTT practitioner said there were risk concerns about a community visit to Adult J. This review has been told that these concerns were due to a previous occasion when Adult J had assaulted a paramedic. The Lead Reviewer does not regard the risk as an acceptable reason not to attempt a visit to Adult J. If the available information indicated that a visit was required, arrangements should have been made to undertake this visit in a way that minimised the risk, for example by undertaking a joint visit with the Police. This review has been told that HTT staff do sometimes undertake joint visits with police officers if a service user is considered to be a risk but this was not considered in this case because the service was not working with Adult J.

4.1.15 On both occasions that HTT forwarded information to START, the START response was to try to phone Adult J and to leave a message for him. As with HTT, a referral was not opened and no attempts were made to gather information from other sources, such as Adult J's GP. Leaving a phone message for Adult J was never going to elicit a response as his phone was broken (see paragraph 4.4.12). Even if Adult J's phone had not been broken it was not a robust response to just leave a message for him to phone back. It was believed that his mental health had relapsed and there were questions about his willingness to engage. A much more assertive response was required.

4.1.16 The final attempt that Adult J's ex-partner made to seek help from mental health services was a phone call to START on 23 February 2018. On this occasion she spoke to an administrator who took a message and passed this on to the START practitioner who was on duty. The practitioner considered the message and determined that the contact from Adult J's partner suggested minimal change in his circumstances. She concluded that there was higher priority work to undertake and left this message for a later response. Whilst it might have been correct that the information suggested minimal change in Adult J's circumstances, his partner had been expressing concern for six days and the only assessment of any sort had been one brief visit to the service user by the Police, who had then raised concerns. On this, and other occasions, ATT staff did not give any weight to the cumulative nature of the calls expressing concern about Adult J's welfare.

Access into Police services

4.1.17 Family members contacted the Police four times due to concerns about Adult J's wellbeing. Calls to the Lancashire Constabulary are graded for response as follows:

- Grade 1: Emergency Response with attendance within 15 minutes.
- Grade 2: Priority Response with attendance within 1 hour.
- Grade 3: Planned Responses with attendance within 48 hours.
- Grade 4: Telephone Resolution.

4.1.18 When incidents are reported to the Police, previous logs are cross referenced to the new log created, and a history of previous calls is available

to attending officers. Background checks are carried out by communications staff and relayed to attending officers. In cases of people suffering with apparent mental health conditions, previous history of that person should be taken into consideration when assessing the risk they present to themselves or others.

4.1.19 The first two calls were graded as grade 3; police officers visited Adult J's home within 10 hours of the call being made and in one case little more than an hour after it was made. The initial grading of these calls as grade 3 is considered to have been appropriate based on the information provided at the time.

4.1.20 The third call was made by Adult J's ex-partner on the evening of Sunday 25 February 2018. The ex-partner again reported concern for the safety of Adult J and said that he had stopped taking his medication. She explained that his sister had been to his home, Adult J had ripped the intercom system from the wall and she had been unable to gain access. However neighbours had reported hearing banging from his attic. The ex-partner added that this was a regular occurrence when Adult J had stopped taking his medication.

4.1.21 The police sergeant made the decision to refer the information to HTT in the first instance. Her rationale was that there were no immediate concerns for Adult J's safety to necessitate entry being forced and the Mental Health Service would be the best placed people to assess his mental health and establish if any further support would be required. A phone conversation between the Police and HTT identified that the HTT practitioner was unable to attend the property that night as he was working alone and that he had advised Adult J's ex-partner to contact Adult J's GP, who may be able to request a MHA assessment.

4.1.22 Following the discussion between the Police and HTT, the police sergeant graded the incident as grade 4. Therefore officers were not deployed and no attempt was made to see Adult J or check his welfare. The Police contacted Adult J's ex-partner and advised her to contact his GP in the morning, which was the same advice as she had been given by the Mental Health Service, and to ring for an ambulance if there were further concerns overnight. Key factors that influenced this decision were that the ex-partner had indicated that there had been previous occasions when Adult J had stopped taking his medication and had behaved in a similar way and there was no new information suggesting an immediate risk to Adult J or to anyone else. Furthermore, Adult J had displayed a lack of willingness to interact with Police or accept any offers of help on the 20 February 2018 and his presented behaviour / state had not been sufficient for any detention under the Mental Health Capacity Act, Mental Health Assessment, Breach of the Peace or Powers of Entry.

4.1.23 On balance, based on the information available to the Police that evening, the decision not to deploy officers appears reasonable. Although Adult J was clearly unwell, the information available to the Police did not suggest that he was an immediate risk to himself or others. It was reported that he had not

taken medication for in excess of two months and had previously behaved in the ways being described. It was reported that neighbours had heard noises from his attic which indicated that he was moving round inside his home. A high risk PVP had been submitted several days before and mental health services had advised the family to contact the GP the following day to request a mental health assessment.

4.1.24 The final call to the Police was made by Adult J's sister. Information provided by the sister included that Adult J had expressed thoughts of self-harm or suicide and that when she had visited his property she had been unable to gain access but had found a window ajar (it was winter and very cold outside). As with the first two calls this was graded as grade 3 and officers attended the property. There was no reply but the window was still ajar and neighbours said they had not heard Adult J moving around but that this was not unusual. Based on this information, the police officer did not consider there to be grounds to force entry. However, whilst officers were present Adult J's sister arrived at the property. She expressed great concern for his welfare and described his behaviour as "out of the ordinary". As a result of these concerns the officer decided to force entry to the property under Section 17 of the Police and Criminal Evidence Act 1984 (PACE). This is when he was found to have died.

Access to a Mental Health Act (MHA) assessment

4.1.25 During the evening of 20 February 2018, Adult J's ex-partner and his mother tried to access support by contacting the Emergency Duty Team (EDT) of Lancashire County Council and requesting that an assessment of Adult J should be carried out under the Mental Health Act 1983. This action had first been mooted as a possibility by HTT Practitioner 1 when she spoke to Adult J's ex- partner on the morning of 19 February. The following afternoon, HTT staff told Adult J's mother that they considered that a MHA assessment was necessary and gave her the contact number for EDT.

4.1.26 It is not known how HTT staff reached the decision, on day 3, that a MHA assessment was necessary as no mental health professional had seen Adult J. Even if a MHA assessment was appropriate the suggestion that Adult J's mother should request this directly did not comply with the relevant part of the HTT SOP (point 5.24.3) which reads as follows:

> *"If it is felt an assessment under the Mental Health Act 1983 (MHA) is required, ATT can refer to the AMHP (Approved Mental Health Practitioner) Hub. If the person is not known to ATT a conversation will take place regarding who should attend the assessment and/or provide a triage in order to consider with the AMHP whether home treatment is a viable option. The AMHP will arrange contact with the nearest relative as defined under Section 26 of the MHA 1983 and coordinate the attendance of appropriately trained Doctors, preferably one/s with prior acquaintance."*

4.1.27 This suggests that an HTT practitioner should have had dialogue with the AMHP during the afternoon of day 3 to discuss a way forward, rather than

suggesting that Adult J's mother should phone directly to request an assessment. This review has been told by staff from the AMHP service that they frequently receive calls from family members who report having been advised to phone and request a MHA assessment.

4.1.28 Even if it had been appropriate for Adult J's mother to request an assessment, the advice given to phone EDT was incorrect. During office hours Monday to Friday the AMHP service within the Council is responsible for undertaking MHA act assessments. At the time of these events, outside office hours the responsibility lies with EDT. Adult J's mother phoned HTT during the first half of a Tuesday afternoon. Therefore, if a MHA assessment was appropriate at that time, as HTT staff believed it to be, contact should have been made with the daytime AMHP service, rather than waiting until after 5:00 p.m. and contacting EDT. This would have enabled a quicker response and possibly a more effective one as during daytime more staff will be available and other services will be open.

4.1.29 Under the MHA 1983, the Nearest Relative, as defined by the act, is entitled to request a MHA assessment but other informal carers are not. An ex-partner is not a nearest relative and is not entitled to request an assessment. Therefore, the advice given by HTT Practitioner 1 to Adult J's ex-partner was incorrect. When the ex-partner phoned EDT to request a MHA assessment it was established that Adult J's mother was his nearest relative and that she would need to make this request. The ex-partner then had to contact the mother and ask her to phone EDT, which she did two hours later. Clearer advice from HTT about who could request a MHA assessment could have prevented this confusion and delay.

4.1.30 The social worker in EDT was responsive to the ex-partner and mother and liaised with the on duty AMHP. The outcome of these discussions was that a MHA assessment would not be arranged that night, because Adult J's whereabouts were not known but the request would be passed on to the daytime AMHP service to arrange an assessment the following day. It is considered that it would have been good practice for the EDT social worker to have passed the calls onto the AMHP to speak directly to Adult J's ex-partner and mother. This would have facilitated decision making and reduced the risk of important information being missed.

4.1.31 The duty AMHP saw the request for a MHA assessment the following morning and then looked at Adult J's mental health records held by LCFT. The most recent entry in the mental health record had been made at 10:15 that same morning and stated that the Police had contacted HTT overnight with concerns about Adult J's mental health and that the START team were to follow this up. The AMHP considered that follow-up by START was an appropriate way forward and preferable to a MHA assessment because it was the 'least restrictive option' as required by the MHA. Consequently he did not pursue a MHA assessment. He tried to phone Adult J's mother to inform her of this decision and left a voicemail message for her.

4.1.32 It may be that the AMHP was correct to consider the involvement of START as preferable to a MHA assessment. However, he did not talk to anyone in START to clarify what action they intended to take or to make them aware of his decision. Subsequently, the START practitioner made an unsuccessful attempt to contact Adult J by phone and then took no further action (see paragraph 4.1.15). Therefore, the request for a MHA assessment proved to be another unsuccessful attempt to access services.

Access to GP services

4.1.33 GP2 was responsive when the ex-partner phoned him on the afternoon of 26 February 2019. He spoke to her at that time and agreed to undertake a home visit. He decided not to visit that evening because he also received a call about another patient and he considered the circumstances to be a higher priority for a home visit. By the time this had been resolved it was 18:30 hours and he considered it more appropriate to undertake the visit when he was next in the surgery, two days later. One reason for this was that the visit could then be done in the daytime with extra support available if required. A second reason was on the basis of risk to the doctor doing a late visit in the dark with no support to a potentially violent patient who was declining medical assessment. GP2 took into consideration that the Police and mental health team were already aware of the problem, and at that stage there were no reported suicidal thoughts.

4.1.34 Adult J's ex-partner believes that the GP did not visit on the date agreed and it appears that she thought he was going to visit on the day of their discussion. GP2 states that he did not tell the ex-partner when he was going to undertake the visit but he accepts that he should have explained clearly to her that it might not be that day.

4.1.35 Whilst GP2 tried to be responsive to the phone call he worked in isolation which limited his capacity to provide a timely response. He did not consider contacting the Police or ATT to seek or share information about the ex-partner's call or to explore whether an earlier visit could be carried out.

4.2 Theme 2
Compliance with valid consent and the Mental Capacity Act

4.2.1 It is identified in Section 4.1 that a key reason for the mental health teams not becoming involved was that it was deemed that Adult J did not consent to their involvement. Records show that Adult J's ex-partner did tell practitioners that he would not engage or seek support and therefore it was reasonable for them to believe that he might not consent to services. However, as no-one from ATT saw or spoke to Adult J during this time, they were unable to confirm whether or not this was correct. Furthermore, on 21 February 2018 a police officer, who had spoken to Adult J two days previously, told HTT Practitioner 3 that he was willing to engage.

4.2.2 Even if it was correct that Adult J did not consent to receive support this should not necessarily have been a reason for services not to become involved. The Mental Capacity Act 2005 provides a framework by which an

individual's capacity to make a particular decision can be assessed and, in some instances consent can be overridden. Point 5.6 of the HTT Standard Operating Procedure (SOP) states that a person's "willingness or ability to engage" should be one of the factors considered when a referral is triaged but it adds:

> *"This however should not be a barrier to interventions. It is recognised that the lack of consent to engage may be part of the person's presentation and lack of insight and where this is the case an assertive approach to engagement must be considered. This will involve close liaison with existing services that are involved and family and carers where appropriate."*

4.2.3 The START SOP does not include such a statement, or any reference to lack of consent but the same principles should apply. The absence of any such statement appears to be an omission within the SOP.

4.2.4 Despite the guidance in the HTT SOP there is no indication that practitioners within ATT made any attempt to establish whether or not Adult J was a risk to himself or others or if he had capacity to make decisions relating to engagement. The learning review undertaken by LCFT found that HTT staff have always worked in the way described and were not aware of the engagement advice within the SOP.

4.2.5 Furthermore, as noted in paragraph 4.1.3, the SOPs refer to undertaking triage of all referrals. If this was followed to the letter the guidance about consent would only be considered after a referral had been opened but the reason for not opening a referral was the belief that Adult J would not consent.

4.2.6 In order to establish whether Adult J was willing to engage and/or if he had the capacity to make such a decision it would have been necessary for practitioners to talk to him. However, the belief that he was not willing to engage was used as a reason not to engage with him.

4.3 Theme 3
The extent to which care was person centred and responsive to Adult J and his family

4.3.1 Health Education England describes being person centred as:

> *"focusing care on the needs of individual. Ensuring that people's preferences, needs and values guide clinical decisions, and providing care that is respectful of and responsive to them."*[2]

4.3.2 The work undertaken with Adult J in December 2015 was person centred because it considered his particular circumstances and how he wanted to be supported. This included establishing that he was likely to relapse within

[2] https://www.hee.nhs.uk/our-work/person-centred-care retrieved 11 June 2019

three weeks if he stopped taking his medication and that his ex-partner and mother were important people in helping him to maintain his wellbeing.

4.3.3 When Adult J's care was transferred to the GP practice a standardised process was used to monitor his compliance with medication. This involves following up patients who have not ordered medication for between three and six months. Given Adult J's known relapse signature, it should have been evident that this process was inadequate and would not protect Adult J if he did stop taking his medication. It would have been appropriate for the GP practice to have put in place arrangements to flag non-compliance with medication much sooner in the case of Adult J.

4.3.4 There is limited evidence of practitioners in ATT who received phone calls from Adult J's family seeking information from elsewhere or checking the records held about him. Therefore the decisions made and advice given to the family was based on very little knowledge of Adult J's wider circumstances, wishes and needs.

4.3.5 The work undertaken with Adult J in December 2015 also identified that his ex-partner and mother were involved in his care and he wanted them to be aware of his situation so they could take suitable action if he showed signs of a relapse. The responses that his ex-partner and mother received when they contacted ATT suggest that staff were unaware of this.

4.3.6 Mental Health services are complex and complicated so family members may not be familiar with all aspects of the system. This can make it difficult for them to know who to contact and what to say. The responses given to Adult J's ex-partner and mother, when they contacted HTT and START for help and were advised to phone other services showed a lack of appreciation of their situation. Point 5.4 of the HTT SOP deals with self-referrals and states:

> *"To ensure that service users are not passed around between services the person taking the call will either address the concern directly or arrange for the call to be transferred to the relevant service."*

4.3.7 The Lead Reviewer believes that this guidance should also be applied to contacts from relatives.

4.3.8 Additionally, it can be upsetting and frightening if a loved one is experiencing a mental health crisis. At the Learning Event, Adult J's ex-partner was described as having been 'very upset' and 'distressed and worried about Adult J' during phone calls but this is not reflected in the case records or in the responses that were given to her. She also made it clear that she wanted someone to visit Adult J. During phone calls to services, Adult J's ex-partner expressed concern that he was a potential risk to her and her children. This was based on his previous history of behaving violently when unwell. There is no indication that practitioners considered the impact of this history on the ex-partner's capacity to interact directly with Adult J.

4.4 Theme 4
Information sharing and information gathering between and within agencies

4.4.1 Information sharing between the Police and HTT was generally appropriate during the nine day period when concerns were being raised about Adult J. This was facilitated by the police officer's use of the Mental Health Access Line after her visit to Adult J. However, this review has found several instances where information was not shared appropriately and relevant information was not gathered.

4.4.2 Staff in ATT did not gather appropriate or sufficient information about Adult J in order to make appropriate decisions about what action was required. One source of available information for Practitioners within ATT was the LCFT record for Adult J. Some staff within the service did view some relevant areas of Adult J's history, including previous risk assessments. However, his relapse care plan, which had been completed prior to his previous discharge from mental health services, was not viewed until 23 February 2018, five days after the first phone call from his ex-partner to HTT. Had the relapse care plan been viewed it would have shown that Adult J relapsed within a matter of weeks if he stopped taking his medication and also that he had made an advanced decision that he wanted his ex-partner and mother to intervene if he became unwell. Practitioners have told this review that when they are on duty they do not have time to look at detailed case histories due to the number of calls that are received. One practitioner stated that he looked at the records from the previous day but limited information was recorded.

4.4.3 Point 5.2 of the START SOP and 5.6 of the HTT SOP list six potential sources of information to help with triage. One of these is the "key agencies involved with the service user's care." Adult J had been discharged to the care of the GP two years previously and therefore the GP was likely to be a useful source of information. Furthermore, one of the concerns raised by Adult J's ex-partner during her phone calls was that Adult J was not taking his medication.

4.4.4 HTT Team Leader 1 recorded an action to inform Adult J's GP about the call she received from the ex-partner on 18 February 2018 but this did not happen. Day 1 was a Sunday, when the GP would not have been available and therefore Team Leader 1 allocated the task to be carried out the following day. The usual practice within the team is that this task would have been delegated to an administrator and overseen by a shift leader. The review has been unable to establish why there was no contact with the GP on this occasion. Because each contact was closed down, and there was no continuity as to who was dealing with contacts, no-one followed up to see if information had been gathered from the GP.

4.4.5 Subsequently no-one from any agency contacted the GP practice until 27 February 2018 after a referral was opened to the START team. Records do not indicate that anyone even considered contacting the GP during the

period between 18 and 27 February. If HTT staff had spoken to the GP practice on day 2 they would have been able to establish that Adult J had not collected a prescription for three months.

4.4.6 Several of the contacts made to ATT by the family and the Police were at times when the GP Practice would be closed but there were missed opportunities to contact the GP. This is another example of ATT staff not following the SOP because a referral had not been opened.

4.4.7 Combining the readily available information about Adult J's relapse care plan and the length of time that he had not ordered any medication gives what appears to be a compelling case to intervene with prompt and assertive action. However, even when his relapse care plan was accessed this information appears not to have been put together with the concerns raised by his ex-partner that he had stopped taking his medication.

4.4.8 On two occasions the HTT MDT considered overnight contacts that had been received from the Police. None of the attendees in the MDT meetings had had contact with Adult J or his family since the concerns had first been raised on 18 February 2018 and no-one viewed his history in the clinical record. Therefore, decisions were made with minimal information. On both occasions it was decided that HTT would pass the case to START. Adult J had a history of severe mental illness and if, as his ex-partner and mother were saying, he was suffering a relapse it was highly likely that he would require home treatment or a hospital admission. START would have been unable to provide these services and therefore it is likely that they would have had to pass the case back to HTT. Therefore, the decision to pass the case to START is questionable.

4.4.9 When Adult J's ex-partner and mother contacted the Council to request a MHA assessment, the AMHP viewed recent contacts within the LCFT care record. Having done so, he believed that action was being taken by LCFT mental health services. Consequently, he made a decision not to pursue a MHA assessment. The AMHP did not contact ATT to confirm whether they were going to take any action or to make staff at ATT aware of his decision not to arrange a MHA assessment. In addition, evidence suggests that the AMHP did not view historical referral information about Adult J.

4.4.10 Reviews often identify that practitioners are unable to access records from another agency, or even a different part of their own agency, due to incompatible computer systems or there being no permission to share. This is viewed as a barrier to good information sharing. During the Learning Event it was noted that the systems used by LCFT (ECR) and Adult Social Care (LAS) do not link together. AMHPs have access to both systems which is a good example of agencies working together to share information. It is, however, worth noting that in this case, the AMHP looked at the recent ECR entries and then assumed that START was going to become involved (see 4.4.9). He did not make direct contact with anyone in the service. This illustrates a potential risk when practitioners rely solely on written records.

4.4.11 When the GP received a phone call from Adult J's ex-partner he checked practice records regarding Adult J but did not liaise with any other agencies. Adult J's ex-partner told the GP about recent contact with mental health services. It would have been appropriate for the GP to contact ATT to find out more about what action they were taking. Such contact would have provided an opportunity for these services to share information and agree a course of action. It is of note that Adult J and the GP had never met one another so there was no previous relationship that might have helped the GP during a visit.

4.4.12 This review has also found two examples of miscommunication when information was shared, the first of which concerns Adult J's broken phone. In the early hours of 21 February 2018, HTT Practitioner 3 recorded that a police officer had told him that Adult J had broken his phone. Two days later START team administrator 1 recorded that the ex-partner told her that Adult J's phone was broken. Despite this information, START practitioner 1 left a phone message for Adult J on 21 February 2018 and START practitioner 2 left one on 26 February 2018. The record made by HTT Practitioner 3 was on the clinical record and should have been available for other staff to see. The record made by administrator 1 was a hand written note. This was not scanned into the clinical record until 27 February 2018 but, according to information provided by START Practitioner 4, it should have been in the duty tray the previous day and therefore should have been available for Practitioner 2 to see. This was important information as it meant there was no point anyone trying to phone Adult J. Therefore it should have been prominently recorded so that other practitioners dealing with the case would know the phone was broken. This review has been unable to establish why the practitioners in START remained unaware that Adult J's phone was broken.

4.4.13 The second example of miscommunication concerns family contact with the GP. When START contacted Adult J's GP on 27 February 2018, a member of staff recorded in the clinical record that Adult J had had a phone call with the GP on 26 February 2018. This record was incorrect as the GP had actually spoken to the ex-partner, not to Adult J. The START worker was also informed that the GP planned to visit Adult J on 28 February 2018, which was correct. No record was made of what future action was planned by START and, although this was not known at the time, Adult J had passed away before the phone call took place. Nevertheless, this miscommunication could have been misleading as it incorrectly gave the impression that Adult J was engaging with the GP. It is not known whether the information provided by the receptionist was incorrect or if it was recorded incorrectly by the START practitioner.

4.5 Theme 5
Inter-agency working relationships, professional challenge and escalation processes

4.5.1 This investigation has identified occasions when HTT staff advised Adult J's ex-partner and mother to phone other agencies. The advice as to which

agencies should be contacted was not consistent and staff did not offer to facilitate these calls. This was not best practice and the Lead Reviewer is left with a sense that the service did not want to engage with Adult J and was trying to pass the responsibility on.

4.5.2 The advice to the ex-partner and mother to request a MHA assessment is of particular note. The lead reviewer does not believe this was appropriate advice to give at that time as no-one from HTT had had any contact with Adult J. The first guiding principle of the Act is that 'the least restrictive option' should be used and that patients should not be detained under the Act where it is possible to treat them safely and lawfully without doing so[3]. When HTT advised that a MHA assessment was necessary they had not made contact with Adult J and had gathered little information. They had not even established whether he was willing to engage with services, let alone whether he had the capacity to make this decision. It is evident from information gathered during this review that there is a view, within the AMHP service, that families are often, inappropriately advised by HTT staff to make such a request. However, there is no evidence that the AMHP service appropriately challenged this advice. This suggests to the Lead Reviewer that work may be required at a management level to address this issue and to ensure that systems are in place for staff to escalate concerns if they believe that inappropriate advice is being given.

4.5.3 On two occasions the Police challenged HTT about why no mental health intervention had been provided to Adult J. These challenges were appropriate. After the second occasion it would have been appropriate to escalate these concerns to a manager within HTT.

4.5.4 There is no indication that any agencies ever considered undertaking a joint visit to Adult J's home. In paragraph 4.1.14 of this report it is suggested that a joint visit between HTT and the Police would have been appropriate when HTT used Adult J's history of violence as a reason not to visit.

4.6 Good Practice

4.6.1 A police officer appropriately sought advice from the Mental Health Action Line after speaking to Adult J. This resulted in a high risk PVP being submitted. The following day the police officer contacted HTT to see whether contact had been made with Adult J, she emphasised that he was willing to engage, informed HTT that he had broken his phone and asked about the possibility of a home visit.

5. Family Input to the Review

5.1 Adult J's ex-partner, mother and sister declined to meet the lead reviewer but Adult J's ex-partner has given written answers to written questions. This has provided a useful pen-picture of Adult J and insight into the difficulties

[3] Mental Health Act 1983: Code of Practice; Department of Health

that his ex-partner faced accessing services for him during the nine day period from when she first raised concerns until the time of his death.

5.2 Adult J's ex-partner described Adult J as a sporty and energetic man who had lots of hobbies and loved to be busy. He achieved well at school and worked hard as an adult. He lost his job because of the impact of the medication he was taking and went downhill as a result of this. Although Adult J and his partner were no longer in a relationship he remained involved with their children, whom he saw daily. He had a good network of support but after losing his job he started to withdraw. His ex-partner believes that he felt he was being let down by support services and that people did not understand what was happening to him. This left him feeling hopeless about himself and he could not see a way forward.

5.3 Adult J's ex-partner said that she requested numerous welfare checks and was told that Adult J could be sectioned under the Mental Health Act for an assessment. However this did not happen. The GP agreed to visit after the ex-partner raised concerns but he did not visit on the date agreed and, that night, Adult J was found dead when the Police visited to undertake a welfare check. Adult J's ex-partner feels that she could have given insight into the severity of his condition but that professionals did not listen to her and she was frequently told that she was not immediate family. She also believes that services did not meet timescales to address the deterioration in her ex-partner's mental health. She thinks that the following changes need to be made to improve services:

- Services need to recognise friends and partners, not just immediate family, because they often have more insight and contact.
- The Police and mental health services need to work together.
- Communication and multi-agency working need to be improved.
- Depot injections should be used more with non-compliant service users.
- There should be early intervention and assessment teams.

5.4 Adult J's ex-partner would like those involved to be held accountable and for people to be honest about how her ex-partner was let down. She would like to know that things will change so that this never happens again. She also wants to know how her children will be compensated for the loss of their father and the impact this will have on them in the future.

6. Conclusions and Learning

6.1 The system used in the GP practice for monitoring compliance with medication is not person centred. In the case of Adult J, it should have been evident that he would be likely to relapse if he did not take medication for approximately three weeks, so a monitoring system was required that would identify non-compliance much sooner than the three month timescale that was in place. In the case of patients with mental health problems, the relapse signature should be used to identify how quickly non collection of medication needs to be followed up.

6.2 Despite 10 contacts to the ATT service during the period from 18 to 26 February 2018, a referral was not opened in respect of Adult J until after he died. Not opening a referral was a significant barrier to the family accessing mental health services for Adult J.

6.3 HTT staff did not open a referral because they believed that Adult J had not consented to a referral being made and was not willing to engage with services. However, they did not clarify that this was the case because they never spoke to him.

6.4 HTT staff also did not consider whether there may be grounds to override consent due to a lack of mental capacity. The LCFT learning review gathered information which suggested that some staff in HTT were not sufficiently aware that there may be occasions when consent should be overridden.

6.5 Because a referral was not opened, triage did not take place and appropriate information about Adult J was not gathered in a timely fashion. In the case of Adult J, prompt access to his relapse care plan and his recent prescription history should have significantly raised concerns about his welfare. This should have highlighted the need for both a referral and a prompt and assertive response.

6.6 Case summaries and flags can be useful ways of ensuring that the most important information is readily accessible when staff look at case records.

6.7 Advice given by ATT staff to Adult J's family was inconsistent and did not show any appreciation of their situation. In the case of telling Adult J's ex-partner that she could request a MHA assessment, the advice was incorrect because she was not the Nearest Relative as defined by the Act. There were occasions when staff within ATT should have contacted other agencies themselves, rather than expecting family members to do so.

6.8 The decision that a MHA assessment was required was not supported by the descriptions of Adult J's behaviour and no-one from mental health services had seen him. An early visit to his home by staff from HTT would have been a more appropriate response in line with pursuing the principle of the least restrictive option. As there were health and safety risks for staff, this should have been a joint visit with the Police. There is no indication that this was considered.

6.9 Staff in START were unaware of key information that Adult J's phone was broken and consequently they tried to contact him by phone. This information had been recorded twice in the previous few days and would have been readily available to staff if they had read the recent records.

6.10 The system of screening PVPs weekly was an unsafe system that did not comply with the SOP. The system has now been changed and PVPs are screened daily

6.11 It is positive that staff in the AMHP service have access to LCFT records and that HTT staff have access to LPRES. However, in this case the AMHP relied on records when direct verbal communication with START was also needed.

6.12 The GP tried to be responsive to the phone call from Adult J's ex-partner but he worked in isolation which limited his capacity to provide a timely response. He did not consider contacting the Police or ATT to seek or share information about the ex-partner's call or to explore whether an earlier visit could be carried out. He was not clear with the ex-partner that he would not visit until two days after their call.

6.13 There is little evidence of professional challenge and escalation. The Police did raise concerns with HTT about a lack of action but this was not escalated to managers. The AMHP service did not raise concerns about what they considered to be inappropriate advice to request a MHA assessment.

7. Action Already Taken

7.1 Prior to this SAR being undertaken, agencies have learnt lessons from the circumstances of this case and have made some changes to practice. These are outlined in the following paragraphs.

7.2 The learning review undertaken by LCFT identified nine key lessons and made five recommendations. These recommendations address areas including the HTT SOP, processing and screening PVP reports and engagement with service users and potential service users, especially where there may be issues. Four of the recommendations have been fully implemented, a recommendation for the Network to consider reviewing and simplifying the format of the HTT SOP has been accepted and the review is currently being undertaken.

7.3 This SAR has been told that there is much better sharing of information within LCFT, including between START and HTT. The ECR system used by LCFT now includes LPRES (Lancashire Exchange Service) which enables HTT to look at information from the GP Practice such as what medication has been issued by the GP, the service user's diagnosis and GP summaries.

7.4 The Police now include more information on PVPs and there has been a reduction in the number being submitted to the ATT. The PVPs that are received by the ATT are screened every day rather than once each week.

7.5 Within Lancashire County Council there is now a dedicated 24 hour AMHP service which responds to all requests for Mental Health Act assessments under the Mental Health Act framework within Lancashire. This has produced a more robust service with improved communication pathways that enable callers to speak directly with an AMHP for information and advice at all times.

8. Areas which Require Consideration for Action

Lancashire Safeguarding Adults Board and its partners should consider how to address the following shortfalls identified by this review:

1. Monitoring and reviewing patients with mental health problems who are under the care of their GP, including monitoring of compliance with anti-psychotic medication and prompt intervention when non-compliance is identified.

2. The following procedural and practice issues with the ATT:
    a. Gaps and anomalies within the HTT and START SOPs, in relation to triage, opening referrals and consent;
    b. Staff knowledge of and compliance with the HTT and START SOPs;
    c. Staff knowledge of and compliance with the Mental Health Act and Mental Capacity Act;
    d. Information gathering and the use of case histories;
    e. Lack of face to face engagement with the subject of the review;
    f. Advising family members to contact other agencies, rather than taking ownership of the case or liaising with other agencies on the family's behalf.

3. A lack of professional challenge and escalation when practitioners consider that:
    a. A request for intervention has been inappropriately passed from one service to another;
    b. An agency has not responded to an appropriate request for intervention.

4. Practitioners and agencies working in isolation from one another, including an over-reliance on written records which suggest that action will be taken without confirming that this has actually been done.

Appendix 1 - List of Initials Used

AMHP – Approved Mental Health Practitioner
ATT – Access and Treatment Team
EDT – Emergency Duty Team
HTT – Home Treatment Team
MASH – Multi-Agency Safeguarding Hub
MDT – Multi-Disciplinary Team
MHA – Mental Health Act
PACE – Police and Criminal Evidence Act
PVP – Protecting Vulnerable People
SOP – Standard Operating Procedure
START - Specialist Triage, Assessment, Referral and Treatment Team

Appendix 2 - Table of phone calls received by agencies, from Adult J's family.

	HTT	START	Police	LCC EDT	School	GP
18/02/18	Ex-partner					
19/02/18	Ex-partner Ex-partner		Ex-partner			
20/02/18	Mother Ex-partner			Ex-partner Mother		
21/02/18		Ex-partner				
22/02/18					Ex-partner	
23/02/18		Ex-partner				
24/02/18			Ex-partner			
25/02/18	Ex-partner		Ex-partner			
26/02/18			Sister			Ex-partner