WALSALL SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review

Adult Andrew

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2018

Section 1: Introduction and background.

This report has been commissioned by Walsall Safeguarding Adults Board through its Safeguarding Adult Review Subgroup. It has been carried out in line with their Safeguarding Review Protocol and is in response to the death of a 33 year old man referred to in this report as Andrew (this name has been requested by his family) to preserve anonymity in line with the Safeguarding Adult Review guidelines.

Andrew was born in 1984 and for the past 9 years had travelled across Australia and New Zealand spending latter years predominantly in Thailand where he had spent more recent times learning to be a Buddhist monk.

Andrew arrived back in the country on a flight from Thailand on the 25th September 2017 to stay with his mother.

Andrew was detained by security staff at a UK International airport as he had been spotted in a grassy area away from the public having stripped naked saying he was very hot. It was believed that he may have been under the influence of drugs. This was later determined as not likely. Paramedics and on site police were contacted. It was established that Andrew had just returned from Thailand where he had been training to be a Buddhist Monk. He said he felt unwell and had stripped off out of public view and lay down on the grass to gain spiritual energy. Paramedics recorded Andrew's blood pressure and temperature which were raised and he complained of abdominal pain. Andrew acknowledged that removing his clothing was not acceptable in public and that he had done it as his Buddhist practice used this technique to help ailments. Following observations and worsening-advice given by the attending Paramedics and a mental health check by Police revealing he was not known to any services, he was released to the care of his brother who took Andrew to their mother's house.

Andrew remained at his mother's for five days and then decided to return to Thailand. He was dropped off by his family at the airport to catch a flight but he left and checked in to a hotel. Later that evening Andrew called the emergency control centre stating that he was hearing voices telling him to kill himself. It was recorded that he threatened to jump off the hotel roof. Following the arrival of ambulance and police services Andrew was taken to the Accident & Emergency department of a local Hospital where he subsequently left unnoticed. Andrew was later identified as the person found on the M6 carriageway and after medical interventions Andrew was later pronounced deceased.

The Coroner's Inquest in October 2017 confirmed death by significant trauma in keeping with the history that Andrew had jumped off the motorway bridge onto the motorway hard shoulder.

A scoping meeting was organised by Safeguarding Adults Board (WSAB) and held on 09/01/18. It was agreed that the criteria was met to undertake a Safeguarding Adults Review. A Panel was set up and a meeting arranged on the 29th March 2018 to set the terms of reference and methodology to be used in the review. It was agreed that the scope of the review would be the period 25th September 2017 to 1st October 2017.

I was appointed by the Walsall Adult Safeguarding Board in March 2018 to assist them in the preparation of this Safeguarding Adult Review report. I am an independent social care consultant

and qualified social worker with extensive experience of reviews, safeguarding services and investigations.

2. The Purpose and Terms of Reference for this Safeguarding Review is to:

a. Establish as far as is possible whether there are any lessons to be learnt from the circumstances of Andrews sad death and in particular about the way in which local professionals' and agencies involved, work together to safeguard adults at risk.
b. Review the effectiveness of procedures (both multi-agency and those of individual organisations).
c. Inform and improve local inter-agency practice.
d. Improve practice by acting on learning (developing best practice).
e. Commission an overview report which brings together and analyses the findings of the various reports (IMR) from agencies in order to make recommendations for future action.

This SAR will consider any lessons learnt by each agency and will inform a single interagency plan for implementation. Responsibility for driving through any required process for implementation will sit with the Chair of the Walsall Safeguarding Adults Board.

3. Methodology:

This Safeguarding Adult Review is undertaken using a hybrid methodology that analyses the complex circumstances that practitioners work in and provide opportunities for shared learning and lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and wellbeing of adults.

Key agencies were asked to nominate a senior member of staff to be a panel member and where agencies had significant involvement with Andrew they were asked to provide a detailed chronology of their contact with him and also conduct their own internal agency independent management review (IMR) and submit a report.

This was followed by the sharing of the written material in order that learning can be shared and analysed taking account of the views of the professionals that were involved at the time.

This process was planned to involve a round table Practitioner Reflection and Learning Workshop to ensure practitioner and first line manager involvement in the review. This planned methodology was amended during the SAR process owing to the inability of a key agency to be able to release practitioners for a frontline staff meeting. This has affected the author's understanding of why certain decisions were made and what factors may have influenced practice, particularly on the night/early morning that Andrew died.

IMR's were requested and submitted from:

The Ambulance Service

The Police Service

The Local Health Care Trust with responsibility for the Hospital

The Clinical Commissioning Group, Adult Social Care and Mental health services were included in meetings and sent an IMR request but as Andrew was not known to their service they did not submit a return.

Key areas of consideration included agencies to provide any relevant background information that would be important in setting the context for Andrew's situation.

The following key themes were determined to be addressed within each IMR.

1. Did practice within your service meet the required standard in this case? (Please expand on your answer providing evidence). Please comment on liaison between professionals and record keeping in the case specifically between Police and Ambulance and A&E, Emergency Services and Out Of Hours Crisis Team and Adult social care.
2. Please identify examples of good practice, both single and multi-agency.
3. Were agency actions in accordance with relevant legislation particularly mental capacity and section 136 Mental Health Act? Had staff had training on the changes to 136 regulations?
4. Were dynamic risk assessments undertaken at relevant stages of the incident?
5. Did the day or time of the incident impact on practice in this case?
6. Are staff suitably trained in recognising and managing risk of individual behaviours and presentations?
7. Please comment on why the Crisis Team were not involved in the incident on 30.09.17 to 01.10.17. What assessment process was used in determining whether the crisis team were contacted?
8. Were appropriate procedures followed? Any gaps identified in those procedures? Any training needs recognised?
9. Were appropriate assessments undertaken at relevant points and suitable action followed?
10. Were there any missed opportunities?

In addition further clarification was sought from the three organisations as follows;

Ambulance Service-

1. If a patient is threatening suicide but not violence and you consider that they would not stay within an A&E Department, where would you be able to take them and what measures would you put in place?
2. Please clarify why medical equipment for taking observations was not taken immediately in to the hotel.
3. Please clarify time of first call to services
4. Was further information about him taken from Andrew during the call to emergency services, such as family and where he lived?

Police Service-

1. Was Andrew's brother waiting at airport or did Police call him?

2. Did police officers attending the hotel know about previous airport incident?
3. Did the officers log record of conversation between the ambulance crew and police detail the reason for requesting a section 136 was because the ambulance crew assessed that Andrew was at risk of leaving an A&E department?
4. Given that both Health Trust and Ambulance Service IMR's consider that a section 136 should have been invoked, has or will a multi-agency discussion take place to clarify the powers to be used and situations it can or cannot be used- taking into account changes in this legislation?

Local Health Trust responsible for Hospital-

1. Was Andrew waiting to be seen by a mental health Doctor or the on-duty A&E doctor?

4. Panel Members and Organisations

Chair – Independent author

Adult Social Care

Local Health Care Trust

Clinical Commissioning Group

Police Service

Ambulance Service

Mental Health Trust

5. Key incidents within the scope.

From the material gathered and discussions at the Panel review meetings, it became clear that two incidents involving the agencies were to be covered within this Review:

Incident 1 at UK International Airport on 25/09/17.

Incident 2 covering the evening of 30/09/17 and early morning of 01/10/17.

6. Chronology of Incident 1. 25/09/17

On **25/09/17** at 07.52 hours the Ambulance Service received a 999 call to attend the Airport to an adult male identified as Andrew. He had been detained from an inbound flight from Thailand by security staff who contacted both ambulance service and on-site Police based at the airport policing unit. Andrew was attended to by both ambulance and police staff.

Security staff reported that Andrew had been observed in a grassy quiet area of the airport away from a public thoroughfare where he had removed his clothing and was laying down on the ground. Security staff had raised a concern that Andrew may be under the influence of unknown illicit drugs. The police incident log detailed that a police sergeant arrived at 08.04 hours and Andrew was already

replacing his clothing. It was noted that Andrew was wearing a tee-shirt and shorts with no pockets. The Ambulance Services sent an Advanced Paramedic accompanied by a Student Paramedic. Andrew reported that he had abdominal pain and observations taken showed he had a raised temperature and blood pressure. Andrew explained that he had removed his clothing as he had felt hot and had been lying down on the grass to re-charge his energy levels and cool down, a technique he said he had learnt whilst in training as a Buddhist Monk. The police IMR stated that *the practice of Tummo refers to the practice of inner fire meditation and is an established form of meditation within Buddhist teachings and is practised naked or with minimal clothing.* It was established by the sergeant that Andrew had spent a great deal of time in Thailand.

Andrew was monitored by the Paramedic staff who suggested the option of a hospital check on his physical health but he declined therefore they gave him advice on self-care and what to do if things got worse for him. Andrew informed the ambulance staff and police that he had realised that removing his clothing was not acceptable in public. He further explained that there were cultural differences from life in Thailand.

The police sergeant formed an opinion that the use of illicit drugs was not a causal factor in Andrew's activity. Andrew also denied any taking of illicit substances. Andrew had travelled in via Dubai where passengers and belongings are swabbed for the purpose of drug testing. It was noted by the Sergeant that this was further indication that it was unlikely that Andrew was under the influence of drugs. During this time the police carried out background checks including a mental health check with the Mental Health Triage team. The checks showed that Andrew was not known to mental health services. Andrew was left in the care of his brother who collected him from the airport and took him to his mother's home where it is known he stayed until the afternoon of 30/09/17.

7. Information from Andrew's mother.

The SAR Panel are very grateful to Andrew's mother for kindly agreeing to see the Independent Author and Safeguarding Board Manager on the 11/05/18. The following information was given at this meeting.

Andrew travelled across Australia and New Zealand starting in 2008. He worked part of the time and whilst there he undertook a charity bike ride to raise money for a Hospice Charity in the UK. He made plenty of friends. Whilst out in Australia he also travelled over to China and came home to his mother at times. When Andrew visited Thailand he had taken up meditation and found he liked it and later served in a monastery. During his time in the monastery Andrew was unable to be in touch as often and had no access to Skype as he had previously but would speak to his mother from time to time but there was no visual access. His mother explained that he would dip in and out of being in the monastery at first but after a time decided to become more involved and stayed within it for longer. Andrew's brother had spent time with him in Thailand. His mother said that Andrew sounded okay when she had spoken with him during his time away. Andrew decided in July 2017 to leave the Monastery and had contacted his mother for some money and told her he wanted to get his body fit by doing yoga and going to a gym and intended to stay in hotels during this time.

Andrew contacted his mother to say he was coming home and was expected back on the 25/09/17. His mother explained that it was sudden. They looked for suitable flights and his brother was to pick him up from the Airport.

Andrew's mother explained that when she first saw him she thought he looked unwell but she was not aware of the airport incident on the 25/09/17. Andrew told his mother that he did not feel well and said someone on the plane had been unwell. Andrew came home with few belongings and had no change of clothing. The partner of Andrew's mother went to purchase some clothes for Andrew. During the 6 days at his Mother's house she noted a couple of incidents, firstly when she was using a hair dryer Andrew requested that she stop as the noise was upsetting him. He was quiet and one night he was heard to be clicking on his bedroom light and when asked, he told his mother that he had experienced a bad night and was hearing a voice telling him to kill himself. His mother explained that Andrew had never told her before about hearing voices. Andrew's mother called the local GP who at first were dismissive so Andrew said to leave it as he didn't want to take tablets, so she cancelled the Doctor. Andrew went out for a walk with his mother and during this time he told his mother that he would go back to Thailand as he thought he would feel better out there and would return to the Monastery. They looked at flights and on the 30/09/17 his mother and partner dropped him off at the airport around 17.00 hours for the 20.00 flight.

Andrew's mother said she was unaware that he had not got on the flight and was informed of his death and circumstances by the Police. She explained that it was only at the Inquest that she found out what had happened leading up to Andrew's death.

From the information given at the Inquest Andrew's mother had a concern regarding the contact with Andrew, namely: why Andrew wasn't taken directly to the local mental health trust hospital. Andrew's mother explained that she felt that after she was informed of Andrew's death she had no information, no liaison officer or support. She explained she had written separately to the Police regarding her concerns.

8. Chronology of Incident 2 (30/09/17 to 01/10/17).

On **30/09/17**- CCTV showed Andrew being dropped off by a taxi around 18.45 and entering the local Hotel. He paid for three nights with cash and went to a room. The Coroner's Post Mortem Report detailed that around 20.00 hours Andrew ordered a snack.

At 22.20 the Ambulance control took a call from the hotel reception staff, they then put Andrew on the line. Andrew stated he was at the hotel and he was threatening to throw himself off the roof and needed to be locked up in order to stop him hurting himself. This call was categorised as a category 3 with a response time of 120 minutes available. A mental health triage car was contacted to complete a background check on Andrew at 23.59 – there were no records found for him.

An attempt of a welfare call was made by the Ambulance control room back to Andrew due to delay in ability to send an ambulance but was unable to get through. A further call was then received from Andrew this call identified that Andrew was threatening to harm others and this triggered the need for police attendance.

The Police record that they received notification from Ambulance control at 00.03 hours on 01/1017 this call records that Andrew had stated he was threatening to jump off the hotel roof, was suicidal and violent.

A double crew ambulance was dispatched at 01.06 who decided to stand by until police arrived as they had received information from control of Andrew's threat to others as well as himself.

As there was no estimated time of arrival for the police this first ambulance was needed elsewhere and cleared from the scene at 01.38.

The police categorised the incident as P2 denoting a priority response that requires an officer to be dispatched to the scene as soon as is possible or at least within sixty minutes of the original call. The police incident log records that at 01.08 hours information from forces control room noted that the ambulance crew will not be attending without police presence. The police log detailed problems in attempting to contact the hotel reception. Officers were not able to be dispatched within the sixty minute timescale.

The Ambulance service were advised that Police were on route at 01.43 but unable to give an estimated time of arrival. Police officers arrived at the hotel at 01.49 hours and attended to Andrew prior to the second ambulance crew arriving. The police contacted the Ambulance service at 02.28 saying they had been in attendance since 01.49 hours.

The police officers in attendance state that they quickly formed the opinion that Andrew was in need of medical assistance as he was *'displaying MH (mental health) issues'*. The police record states they saw Andrew in his hotel room and he was calm and compliant but with evidence of personal distress. Andrew confirmed to the officers that he had been waiting for an ambulance to arrive. The police log records that Andrew spoke about being a practising Buddhist monk and as such would not cause harm to another person or himself but he confirmed to the officers that he was struggling with voices in his head. In addition he complained of breathing difficulties and pain indicated to the heart region. The police have confirmed that their officer's checks would have featured the airport incident involving Andrew.

A further double crew ambulance arrived at 02.36 and saw Andrew in his room in the hotel with the police present. The ambulance crew state that they did not take their equipment in at that point owing to a reported potential for violence and they thought there may be a lack of privacy. The police officers report that Andrew was seen in his hotel bedroom which was not a public space.

The ambulance crew, consisting of two Emergency Technicians EMT1 & EMT2 undertook clinical examination and observations of Andrew including respiratory rate, blood pressure, oxygen levels. A mental capacity assessment was undertaken by the crew which is detailed as *Andrew failed* at that time. The ambulance crew recorded this on the electronic patient record. Communication skills were utilised to attempt to gain some history and the crew state that from the conversation and physical signs such as no eye contact they recognised that Andrew was experiencing a mental health crisis. It was recorded that there was no evidence of drug or alcohol use.

The Ambulance crew in attendance with Andrew informed the police officers present of their assessment of Andrew needing a mental health facility as no physical concerns had been identified. It was suggested by the ambulance crew that a section 136 be used by the police so that Andrew could go directly to the 136 suite at the local mental health hospital and receive an appropriate mental health assessment. EMT1 told the police his concern that Andrew may leave the General Hospital Accident and Emergency Department. This point was also relayed to the hospital as part of the handover of information.

A conversation between the police and ambulance crew took place regarding the legitimacy and ethical reasoning for use of a section 136 of the Mental Health Act in a hotel/hotel room. The police were stating that a section 136 could not be used as Andrew was compliant and in his hotel bedroom and interpreted this as his home (dwelling). It had been suggested by the attending ambulance crew that Andrew could be taken down to the ambulance (a public place) in order for the 136 to become permissible. The police officers refuted this idea stating it would be deceptive and as Andrew was expressing a willingness to seek medical help they felt that he was a person seeking voluntary mental health treatment.

The ambulance left the hotel at 03.08 and transported Andrew to the Hospital Accident & Emergency Unit. Andrew informed the ambulance crew that he wanted to be arrested and on being told he had done nothing wrong he attempted to assault the crew and grabbed the electronic patient record with an aggressive look. The ambulance crew had to stop on route to the hospital. Police were called once again, however due to the delay in police arriving and the close proximity to the hospital the ambulance crew alerted the Accident and Emergency Unit of the situation and arrived there at 03.22. Andrew was handed over to Security staff and the ambulance crew completed an incident report and gave a full clinical handover to the nursing team where it was documented on the patient record that it was felt Andrew was at risk due to his quiet demeanour and inability to make eye contact.

Andrew was seen in A&E at 03.32 hours by a staff nurse and Clinical Support Worker. The staff were aware that Andrew was hearing voices and that the ambulance crew had been concerned as he had tried to assault them in the ambulance. The staff reported there was no evidence of self harm and Andrew would not allow them to take observations. It was noted that his observations were all normal with the ambulance crew. Andrew was classified as 'green' category meaning he would be seen by a doctor at normal time. At 01.59 on 01/10/17 there were 32 patients in A&E, the average triage time was 298 minutes and average time to be seen by a doctor was 44 minutes. Andrew had been placed in a quiet room with two security staff. Andrew complained that he did not want to stay in the room and when staff asked him to wait to be seen by a doctor and mental health liaison team he was reported as being happy to wait. He told the staff member that he was feeling sick but declined the offer of a drink. At 03.40 (8 minutes later) the security staff approached the Clinical Support Worker asking if they could step down. The staff nurse agreed they could but would contact them if needed again.

At around 04.30 Andrew approached staff to say he wanted some fresh air outside. The nursing staff member agreed but checked with the receptionist that the security staff were still in the department. Reception staff confirmed that the security staff were dealing with another patient outside A&E therefore Andrew was allowed to go outside.

The advanced nurse practitioner reviewed the A&E card and went to the quiet room (known as mental health assessment room) at approximately 04.35 to see Andrew. Andrew was not in the room and so staff checked outside and with reception but Andrew was not found. Police were not called and the Trusts missing persons policy was not followed.

At approximately 06.00 hours the Police rang the A&E department to confirm whether Andrew had been to A&E earlier as a patient identified as Andrew had been treated following a suspected suicide attempt by jumping off the motorway bridge and was being transferred to the regional trauma

hospital. Staff were later informed that Andrew had died from his injuries. The advance nurse practitioner notified the hospital site manager and a clinical incident report was completed.

9. Key themes analysis and comment

1. ***Did practice within your service meet the required standard in this case? Please comment on liaison between professionals and record keeping in the case generally (specifically between Police and Ambulance and A&E, Emergency Service and Out of Hours Crisis Team and Adult Social Care.***

25/09/17: at the airport.

It was appropriate for both Police and Ambulance services to be requested to see Andrew and checks to be carried out. External background checks were undertaken such as any known dealings with Andrew by the Mental Health Team or any relevant police records held. Andrew's physical health was checked and monitored in line with routine procedures. Advice was given and options explored if Andrew felt any worse. In spite of the mental health check carried out there was no suggestion of mental ill health needs for Andrew by either service at this stage. It was appropriate for Andrew to be asked about any illicit drug- use and mental health at that time. The reasons for Andrew's behaviour within the airport was explored by both services. Andrew's response to the removal of his clothing was accepted as a credible motive albeit not acceptable in the location. It was determined that Andrew recognised the inappropriateness of his behaviour which added to the overall assessment process of discharging Andrew to the care and onward journey to his family.

It is difficult at this stage to see how either service in attendance could have carried out any further actions or enquiries. Reasonable steps were taken to ensure the health and welfare of Andrew. Both services were aware that Andrew being out of the country for a significant time would affect the likelihood of background health or mental health records. The ambulance service offered an A&E visit to check his physical care which Andrew declined which was within his rights to do so. Neither of the services noted that at any time during their assessment that Andrew lacked capacity.

30/09/17- 01/10/17: at the Hotel.

The Ambulance and Police services responded to Andrew's call for assistance via a control centre. A framework for grading calls and attendance within a stated timescale is used and response times are monitored.

Reasons have been given for delays incurred by both attending services. What is not clear is the effect these delays had on the mental well being of Andrew. It is clear that no harm came to any others during this period.

The first call on 30/09/17 to ambulance control at 22.20 came from the hotel and the phone was passed to Andrew. This first call had no suggestion of Andrew being a risk threat to others. Unfortunately owing to service demand on that evening there were no available ambulances to dispatch. The ambulance service attempted to make a welfare call to Andrew during the waiting time. A second call was received from Andrew was logged as *an individual who is saying he is hearing voices telling him to kill himself and others and would throw himself off the roof, identifying he needed to be locked up in order to stop him hurting others.* It was further logged- *patient stated he was going to be violent.* This clearly influenced the response whereby the police were asked to

accompany the dispatched ambulance. This is in line with procedures and safety protocols. The first ambulance was not until some 2 hours 56 minutes later at 01.06 (now **01/10/17**). The police record states that they were contacted for assistance to attend at 00.03 hours. This was logged as a Priority response P2 requiring a sixty minute arrival where possible. Their arrival took 1 hour 47 minutes. Andrew was first seen at 01.49 hours.

It is clear that the initial call suggested an urgency of need and a possibility of harm to Andrew and subsequent call suggested possible risk to others.

It is well documented nationally regarding the strains on all of the emergency services currently and during this particular period it was evident that the first ambulance was needed elsewhere as the Police had not arrived. They actually arrived at 01.49 hours 11 minutes after the first ambulance left and just under two hours of the call to them. Communication between ambulance and police was not effective during this period to enable an estimated time of arrival for police to be made.

Clarification was sought from the ambulance service regarding what the procedure would have been if a threat of violence was not reported and the sole referral was a threat of suicide and they assessed that the patient may not stay within and A&E environment. They stated that in such circumstances it would depend on the safety nets in place and patient capacity. The ambulance service have no direct access to mental health assessment units however they can leave a patient at home with appropriate support such as a relative and refer the crisis team to make contact with them at home. They could refer a patient to their GP or request their mental health triage car team to assess. Outside of these they have no real alternative but to take a patient to A&E with a full handover of concerns.

01/10/17.At the Hospital A&E Department.

The local mental health hospital is situated close to the local A&E hospital but does not allow for direct access for patients in Andrew's situation unless a section 136 has been used. Protocols from the Mental Health Trust responsible for the hospital request that patients are transferred firstly to A&E for a physical health examination and assessment prior to calling out or referring on to a mental health team. There is no opportunity for a patient who has no previous contact with the mental health service to and no assessed physical health needs to be seen primarily by a mental health professional.

EMT1 and EMT2 in the verbal handover in A&E informed staff that a mental capacity act assessment had been undertaken and recorded this in the Electronic Patient Record although it appeared that this was not referred to by the A&E staff on handover.

On arrival at A&E the ambulance crew followed their correct handover procedures and incident reporting. Information had been sent ahead regarding the violent outburst in the ambulance by Andrew. Security was alerted in line with any safety issues that may present on arrival of Andrew. A dedicated quiet room was allocated within A&E which is referred to as the *mental health assessment room.*

Further clarification by the author revealed that Andrew was waiting to see the A&E duty doctor and not an on-call mental health professional.

It is of concern that staff in A&E gave the reason for not contacting the police (when Andrew was noticed to be missing), was that he had been recorded as no fixed abode and interpreted this as homeless. Staff said that they had experienced that the police did not respond to notifications of missing persons' who are 'homeless'. I am pleased to say this has now been clarified and rectified within the Health Trust action plan and in addition the police response clarifies that this is not the case and all referrals are subject to a rigorous assessment called THRIVE+.

Before this SAR report was commissioned, the Health Trust had already organised and undertaken a Root Cause Analysis (RCA) Procedure in line with the reporting of a Serious Incident. They identified two main root causes as omissions in Andrew's care.

1. No mental health risk assessment document was available for use in A&E and therefore no way to assess the level of risk in relation to self-harm.
2. The second root cause was that the missing person's policy had not been followed, a primary search was undertaken for Andrew in and around A&E department, however Andrew could not be found and this was not escalated to the security team, the night manager or Police.

Following the RCA and its findings three clear recommendations for action for the Hospital were made. An action plan has been produced and a system that monitors and details progress and achievement.

The recommendations are as follows:

1. Development of a formal mental health risk assessment to be undertaken in A&E regarding patients risk to self and others to identify the level of risk and observation required.
2. Development of an observational plan established following Security stepping down.
3. Staff to enact the missing person's policy and notify Security and the Police when a patient is found to be missing from the department in line with the Missing Person's Policy.
4. Further clarification required regarding early referrals to crisis team when patients present to A&E with mental health issues and no known medical issues.

Further action was taken by the Trust and staff refresher training has been provided on suicide prevention and self-harm mitigation.

<u>Areas of Concern</u>

Andrew was waiting a long time before assistance arrived at the hotel. He was advised by ambulance control that there may be a long delay owing to the volume of calls that evening. He did not inform the control staff about any family locally that could be contacted. The further welfare call to Andrew from ambulance control was not answered by the hotel and so they were unable to have any further contact with him.

No other means of well-being support was able to be offered to Andrew whilst waiting such as the offer of a suicide help-line or to inform Andrew that calls may be made back to him during the waiting period to check on his well-being.

It is not known how the timescale of response affected the well being of Andrew. Knowing that the police would not be able to respond within the sixty minute response time attempts were made by forces control services to contact Andrew at the hotel but this was also logged as unsuccessful.

Knowing there was a threat of suicide and violence the response times for police and ambulance services differ greatly therefore making it difficult to co-ordinate the two services to arrive together.

It is concerning that the two services had differing procedural interpretation of when a section 136 is able to be used and the relevance of ambulance professional's outcome regarding the assessment of a person's mental capacity. This needs further clarification. It cannot be helpful in a situation such as Andrew's that clear differences of opinion about permissible actions amongst officers and crew continue to exist. (*This is addressed later in this report)*

Research for this SAR included the recently produced Local Agency Suicide Prevention Strategy. It is of note that Authorities were to produce such a document in 2017 following concerns nationally of increasing suicide trends. The strategy notes '*in recent years (2016) there has been a continually increasing rate (sic of suicide) in Walsall, which was higher than both the regional and national average rates.* This report has not linked this trend specifically to the care offered to Andrew but will in its recommendations suggest that the Strategy Group be made aware of the lessons learnt to inform future prevention work.

Staff interviews at the Health Care Trust suggested that the reason the police were not notified of Andrew as a missing person was that he had been identified as 'no fixed abode' and that they had a perception from previous incidents that the police had declined to search and would suggest that an ambulance was called.

The police dispute this assertion and their policy is to respond to calls and every call is subject to their risk assessment process THRIVE+ which identifies any risk to the individual to ensure the most appropriate responses are given, with a particular emphasis on identifying vulnerability.

a) Andrew was not of 'no fixed or abode' or homeless. The police have asserted that the hotel room was his abode. Further sensitive questioning may have revealed Andrew's mothers address or that of his brother that could have been used.
b) The belief by A&E staff that the Police do not respond to suicidal homeless patients leaving A&E is worrying and not in line with Police policies or actions. It is not good enough to have such a damaging view that results in calls not being made. Such views should be; reported, investigated and if founded, escalated.

2. Please identify examples of good practice, both single and multi-agency.

Assessments and approaches to Andrew at the airport showed sensitivity with consideration to his physical and emotional well-being. Ambulance and police services at the airport worked well

together with health and mental health needs explored and relevant checks carried out. It was recognised that Andrew's absence from the country for such a long period would have a bearing on his not being known to services.

Ambulance staff rightly questioned Andrew's capacity under the relevant legislation and recorded the outcome to be used in his assessment at hospital.

Consideration was given to providing Andrew with a quiet area and taking him there on arrival to the busy A&E environment.

Andrew was triaged on arrival rather than the waiting time of 298 minutes.

Security personnel were made available and present within A&E following the alert call from the ambulance crew regarding the violent outburst from Andrew.

3. Were agency actions in accordance with relevant legislation particularly mental capacity and section 136 Mental Health Act?

From the IMR's and subsequent discussions it was clear that the Ambulance service and Health Trust were of the opinion that police should have used a section 136 of the Mental Health Act for Andrew.

Relevant extracts of the Mental Health Act and Mental Capacity Act are as follows.

Section 136 – removal of mentally disordered persons without warrant

(1)If a person appears to a constable to be suffering from a mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons-

a) *remove the person to a place of safety within the meaning of section 135 or*
b) *If the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.*

(1A)The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place other than –

a) *any house, flat or room where that person, or any other person, is living or*
b) *any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more houses, flats or rooms.*

(1B) For the purpose of exercising the power under subsection (1), a constable may enter any place where the power may be exercised, if need be by force.

(1C) before deciding to remove a person to, or to keep a person at a place of safety under subsection (1) the constable must, if it is practicable to do so, consult-

a) *a registered medical practitioner,*
b) *a registered nurse,*
c) *an approved mental health professional, or*
d) *A person of a description specified in the regulations made by the Secretary of State.*

Mental Capacity Act 2005 –

Under the Mental Capacity Act 2005 (MCA), a person (aged 16 or older) lacks capacity in relation to a matter if, at the material time, they are unable to make a decision for themselves in relation to the matter because of an impairment or disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

A lack of capacity cannot be established merely by reference to:

- *a person's age or appearance*
- *A condition or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.*

Any question about whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities.

The ambulance service and police in attendance to Andrew at the hotel were concerned about his mental well being. On determining that Andrew did not need any physical health support the ambulance crew undertook what they refer to as a MCA assessment which is recorded and states that he failed it. Meaning they did not think that at that time Andrew had 'capacity' to make reasonable and rational decisions for himself. This was supported by the views of the police constable also in attendance.

The ambulance crew would have known of the high volume of calls that evening and how busy A&E department would be. They also voiced their concerns that Andrew was likely to leave A&E.

It is unfortunate that this point of learning from sharing information was unable to be explored as part of this SAR process, as one agency was unable to send their front-line staff to a learning workshop*.*

The ambulance crew suggested that it would be better for Andrew if the police used their powers under the Section 136 of the Mental Health Act. Their view was that Andrew could then be taken directly to the 136 suite within the mental health hospital. The police have responded to this in their IMR and state that – *on this occasion Andrew was contained within his hotel room, the place where he lived at that moment in time and that was considered a place of safety. It was recognized Andrew could hear voices in his head and for this he required specialist medical assessment and treatment yet, his overall behavior was not such that deemed it necessary for the officer to exercise the power to remove him from where he was. And so the decision is one which is based in law and is preservative ethical decision making processes.*

The police also refuted the idea of the ambulance crew to take Andrew to their ambulance and serve a 136 on there. A key issue for the police was that Andrew was willing and compliant to go with the ambulance to receive support.

Further legal clarification on the use of a 136 and definition of the room at the hotel as Andrew's home, was requested as part of this SAR. There has been case law regarding whether a hotel room could be entered by police for the purpose of a section 136. (R.v.Rosso (2003) this case has been updated in the light of the amendments to the Mental Health Act regarding Section 136 in January 2017. A summary of that decision why a section 136 **cannot** be used in a hotel room is:

… '*When you pay for a hotel room, you gain a right of occupancy over that room, subject to general terms and conditions in the hotel. It is known from case-law that warrants are required to enter hotel rooms and that hotel managers cannot over-ride that right of occupancy during the paid duration of someone's stay. Therefore no- you* ***cannot*** *use the new s136 in a hotel room as the person is regarded as living there, even if staying for one night and day. (Mental Health Cop- a Venn-Diagram of Policing, Mental Health and Criminal Justice. 07/03/17).*

The real issues emerging from this situation of where Andrew should be taken is not so much about the use of s136 it is more about the suitability of the assessment to take place in a busy A&E department. In addition, the timely and appropriate access to help and support for a compliant physically medically fit but mentally frail young man.

On arrival to the A&E department the handover from the ambulance crew to A&E staff involved both a verbal and electronic process. The lack of capacity assessment for Andrew was told to the staff and was detailed in the electronic record. Andrew was triaged but no dynamic risk assessments were undertaken despite the high risk associated with hearing voices telling him to harm himself or others. This failure has been dealt with earlier in the report and actions put in place to improve practice.

Areas of concern:

Ambulance crews are unable to directly access the mental health hospital when a suicidal patient has no physical need for intervention.

Misunderstandings exist amongst agencies and their legal representatives over the appropriate use of a Section 136.

This SAR has identified a lack of clarity over roles, restrictions and decisions to be taken in a 'best interest of the patient' scenario. There is a concern that front line staff are put in a position where pressure is on partner agencies to bend their powers to fit ongoing unsuitable provision. For example- timely and direct access to a mental health assessment and establishment for a willing and compliant patient should not rely on the use of the full force of a section 136.

It would have been interesting to consider what difference there would have been if a Triage car was available that night and went to the Hotel? This is covered later in this report.

Despite the RCA undertaken by the Health Trust and identifying the need for lead professionals at the Trust to hold discussions with representatives from the Mental Health Trust in relation to referral processes for patients presenting to A&E with mental health issues, this action does not appear to have been progressed.

Good practice:

The ambulance service has participated in the RCA with the Hospital following the incident. Education has been disseminated via clinical times to highlight the changes to the Police and Criminal Evidence Act in relation to section 135/136 of the Mental Health Act. Police officers are also in receipt of training to changes in respect of mental health regulations.

3. Were dynamic risk assessments undertaken at relevant stages of the incident (Incidents 1 & 2)?

The **dynamic** management of risk is about decision making. The **definition** of a dynamic risk assessment is- 'The continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident. In Andrews circumstances the assessment of risk related to his threat of suicide where risk factors can fluctuate markedly in both duration and intensity.

Both the police and ambulance services graded the call regarding Andrew whilst in the airport as a high priority and appropriate risk assessment of the situation was considered with the information available to them.

There was no concern during first call that Andrew posed a risk to others – ongoing risk analysis took place during second call when it was clear he wanted to harm someone else.

The ambulance crew were given information that Andrew had threatened harm to others and this significantly affected their decision on arrival at the hotel to wait for the police. The author noted that the control state they had had further contact with Andrew and knew he was conscious and talking to staff.

Areas of Concern

Both services identified difficulties in achieving response times owing to demands on the night. There is an unanswered question of the difference that might have been if a triage car had been available to see Andrew and provide mental health assessment and support.

A Mental Capacity Act assessment on Andrew was undertaken at the Hotel by attending ambulance crew. This information was handed over to receiving staff at the hospital and should have informed a further dynamic risk assessment process.

The Health Trust identified from their RCA that no dynamic risk assessments were undertaken for Andrew at any stage of his time within the A&E department. The RCA identified a serious gap in this area. The Trust has introduced a mental health triage assessment tool in line with the Royal College for emergency medicine standard. This was approved at the Trusts Divisional Quality Board on the 28/11/17.

The assessment tool assesses the risk of patients presenting with mental health issues. It requires staff to undertake a Mental Capacity Act assessment to determine a patient's capacity for best interest decision making. This also requires staff to complete a physical description of the patient, in order to inform police referrals following any patient that is identified as missing from the department.

5. Did the day or time of the incident impact on practice in this case?

The two incidents took place on a Monday and Sunday respectively which is outside of the Friday and Saturday peak demand time for police referrals but are considered a peak time for ambulance and hospital A&E referrals owing to primary care services being reduced at a weekend. The three services reported that there were delays which are a regular pattern however the staffing levels were within the accepted guidelines for each service.

6. Are staff suitably trained in recognising and managing risk of individual behaviours and presentations?

Much of this area is covered in questions 3&4. In addition, the Health Trust provided their A&E staff with Storm training which is about assessing suicide risk and self harm mitigation. They state that staff are suitably trained in recognising and managing risk of individual behaviours and presentations. The omissions that took place with their assessment processes for Andrew and detailed already in this report had a negative impact on ensuring that Andrew received the attention needed.

The joint assessment with ambulance staff and police on 25/09/17 evidenced an understanding of recognising and managing risk of individual behaviours and presentations where both physical health and the possibility of mental health were assessed as a cause of Andrew's behaviour.

Both the ambulance crew and police officers with Andrew at the hotel demonstrated understanding of risk and behaviours. They agreed that Andrew's priority need was for a full mental health assessment and support.

Ambulance staff receive mandatory training each year on Mental Capacity Act and Mental Health Act. This is completed by workbook and signed off as part of the development review process. In addition, staff receive regular written communication via 'Clinical Times' article and the changes to section136 had been communicated to staff to ensure awareness.

Police officer training is designed in close partnership with the college of policing and Approved Professional Practice (APP). For the purpose of research for this report I identified relevant APP guidance and subsequent good practice information on the use of Section 136 and places of safety utilised by Police across England. (*References in appendix)*

It is worth noting that current national research is concerned with the rising trend of suicides, especially for young men and there are reports by organisations such as the Care Quality Commission (*A safer place to be May 2017*) specifically around the locations of section 136 assessment units.

There are plenty of documents, surveys, good practice guides and specific training packages available for emergency staff training and ongoing refresher updates.

7. Please comment on why the Crisis Team were not involved in the incident on 30/09/17 to 01/10/17. What assessment process was used in determining whether the crisis team were contacted?

The ambulance service locally has access to a triage car. There is a second triage car covering the nearby city centre. The car(s) operated up to 02.00 hours (at the time in question) and included a mental health professional as part of its crew. Contact was made with the car by ambulance control at the time of the first call regarding Andrew. The car was in use and by the time it became available there was already an ambulance and police presence on route and they were closer than the triage car.

Neither the ambulance crew nor the police contacted the mental health crisis team. There are 'out of hours' numbers and duty call out mental health professionals via social care. The ambulance crew were pressing for the police to use their powers under a section 136 and the Police were satisfied that Andrew would be receiving attention from medically trained professionals at A&E.

It is worth noting again that it was stated that Andrew was fully compliant with being taken to a place to be assessed however the judgement of the ambulance crew was important in the assessment of risk that the A&E department may not be a secure enough place.

In A&E the author of the Trust IMR identified that the barrier to contacting the crisis team was that A&E staff needed to assess whether there are any physical medical needs first. Although Andrew

had complained of chest pain initially, following the ambulance crew assessment it was known before and on arrival that Andrew had no identified physical medical needs but assessed as lacking capacity and threatening suicide.

Areas of concern

It is of concern that from the information received for this report there is no clarity or confidence that the emergency services attending to people currently experiencing a mental health crisis such as Andrew had, in the night/early hours would receive a timely and appropriate mental health assessment in a safe and secure environment. Had an early intervention taken place there could well have been a very different outcome.

8. Were appropriate procedures followed? Were appropriate assessments undertaken were there any missed opportunities?

The questions relating to this section have been covered in the questions answered above and so I will not repeat these areas. The police have stated that all procedures were followed and did not identify any missed opportunities. I think that there is a danger of silo working for emergency service agencies in their understanding of the relevance and importance of each others' role in responding to and working alongside each other.

There is a line of thought that as Andrew had been assessed as lacking capacity, was he truly able to be compliant with the decision to go to A&E rather than use a section 136. This report is unable to clarify such an issue which is why the SAR process included a learning workshop for the staff involved to explore issues such as this one. It is disappointing that this was unable to take place.

Missed opportunities and use of appropriate assessments whilst Andrew was in A&E have been detailed in previous sections and where identified improvement action has taken place and monitored.

10: Recommendations and Action Plans

One of the purposes of a Safeguarding Adult Review is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and ensure that those lessons are applied in practice to prevent similar harm occurring again. As part of the Individual Management Review process the authors were asked to identify any lessons learned for their agency and to draw up an action plan accordingly. Two of the IMR's (Ambulance and Health Trust) identified areas in which their practice could be improved. In addition the Root Cause Analysis carried out by the Health Trust and included the ambulance service produced recommendations and an action plan. This is detailed in the body of this report.

I recommend to the Safeguarding Board that the Board note the Health Trust action plan and specifically require an update on the outstanding action of '*further clarification required regarding early referrals to crisis team when patients present to A&E with mental health issues and no known medical issues'. This must include the involvement of both the Clinical Commissioning Group and Mental Heath Trust.*

I recommend to the SB that the Strategy group producing the Local Suicide Prevention Strategy is made aware of this case review and they consider what is needed to enable effective multi agency working when threats of suicide are reported to emergency services and to include where people have had no known contact with mental health services.

I recommend to the SB that they consult with Suicide support organisations locally to determine what information/support can be offered to people waiting for an emergency service response to attend.

I recommend to the SB that they review and reinforce with the relevant agencies the importance regarding their attendance at meetings or learning workshops as part of the SAR process.

I recommend that the SB:

- Seeks assurance from the mental healthcare trust and hospital trust regarding the suitability of local provision for the assessment of patients threatening suicide with no physical medical needs taking place within A&E.
- In light of this review request that the relevant agencies review their arrangements for out of hours' mental health support including the Triage car availability for people threatening suicide and requiring mental health assessments.

Closing Remarks

It cannot be said definitively that Andrew's death could have been prevented or avoided. It could be thought that had Andrew seen a GP whilst at home or received timely mental health assessments and support (*on the night/morning of 30/09/17 & 01/10/17)* there may have been a different outcome.

A reality check on many of the issues from this SAR was the pressure on all of the emergency services that night .They work with competing priorities and the inextricable link to the mental health services and their capability and capacity.

Information from this SAR must serve to inform and improve the support for people in the future. This SAR details identified ways and lessons learned to make things work better.

Suicide is the biggest single killer of all men in the UK (*ONS Statistical bulletin 2014)* and they are three times more likely to take their own lives than women. Nationally there are a number of collaborations between police and national charities such as CALM (campaign against living miserably) and Samaritans to try and raise the awareness of male vulnerability and well-being. This initiative has recently been supported by HRH the Duke of Cambridge through the Coal Face Coalition (*the calm-before-the-storm 05/2016.)*

RESEARCH REFERENCES

- Public Health England –*Local Suicide Planning, a practice resource Oct 2016.*
- A&E is no place for suicidal patients-*The secret doctor The Guardian May 2015.*
- Care Quality Commission – *A safer Place to be, survey of health based places of safety for people detained under s136.*
- National Police Chief's Council (NPCC) –*Suicide prevention and response-August 2017.*
- APP College Police UK – *mental health vulnerability and illness/decision making.*
- NHS Digital data BBC news – *Steep rise in A&E psychiatric patients.*
- Walsall Suicide Prevention Strategy – *draft May 2018.*
- Mental Health Cop – *Hotels and R v Rosso.*