Independent investigation into the care and treatment received by Mr B Trust ref: E239434

October 2025

Report advisory notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and serious incidents. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where it is relevant to quote the opinion of a psychiatrist or doctor or where a specific act has been documented. We do advise caution for those who may be triggered by reading information which might be distressing, particularly, and ask that they are helped to read this report in a safe and supported way. This report contains detailed information on self-harm. Limitations exist on the extent of publication of such information.

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Conveyed to: NHS England East of England
On: 28 October 2025

First published: **5 November 2025**

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Our Final Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of Mr B. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

Contents

1 Executive summary

Incident

1.1 Mr B was a 50-year-old man who had been living with secondary progressive multiple sclerosis (MS) for over 20 years and was living in a care home.

1.2 On 27 May 2023, Mr B left the assessment unit of Brook Meadows House (BMH) where he had been living since 10 June 2022, and travelled to Kent, where he ended his life.

Background and brief mental health history

1.3 Mr B had contact with multiple agencies between April 2021 and May 2023 and moved between areas, which impacted on the continuity of care provided to him, particularly for the treatment of MS which he was diagnosed with in 2002.

1.4 He faced several factors which identified him as being at higher risk of suicide than the general population. He was a middle-aged man, diagnosed with depression, and he had MS. Mr B had a previous significant self-harm event in April 2022, via a high-risk method; this also increased his risk.[1] Mr B told those caring for him that he wanted to end his life and he would use the same method.

1.5 Mr B found living through the COVID-19 pandemic hard. Those who had known him a long time reported a change in his personality. His marriage ended and he left the marital home in March 2021. His relationship with his child reportedly became strained.

1.6 Following a period of crisis in spring 2021, when he was using cocaine and changing accommodation frequently, Mr B was seen by mental health services and was prescribed an antidepressant. Mr B's transient living arrangements made it difficult for him and services to remain in contact.

1.7 Mr B's life became more settled when he found accommodation in Southend, near family and friends, in June 2021.

1.8 He saw a neurologist in early 2021 and was referred to a neuropsychiatrist because there were concerns about changes in his behaviour.

1.9 A consultant neuropsychiatrist assessed Mr B in June 2021. They identified that Mr B had some cognitive deficits which could be the result of the MS. The neuropsychiatrist found that Mr B's mood was much better than it had been at the time of referral by the neurologist. In line with good practice, the neuropsychiatrist gathered collateral[2] information from Mr B's mother which confirmed that his mood had improved.

1.10 Mr B continued to be prescribed antidepressants by his GP. He referred himself for Talking Therapies[3] twice in 2021 to help him with his depression (although decided in January 2022 it was not for him).

1.11 Mr B's mother contacted the Essex Partnership University NHS Foundation Trust (EPUT) crisis line to raise concerns about Mr B on 12 April 2022. There is no record of what the concerns were or what action was taken in response. On the morning of 13 April 2022, Mr B attempted to end his life in Kent and the attempt resulted in life-changing injuries.

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[1] Suokas, J., Suominen, K., Isometsä, E., Ostamo, A., & Lönnqvist, J. (2001). Long-term risk factors for suicide mortality after attempted suicide - findings of a 14-year follow-up study. Acta Psychiatrica Scandinavica; Acta Psychiatr Scand, 104(2), 117-121. 10.1034/j.1600-0447.2001.00243.x

[2] Collateral information is information gathered about a patient's mental health history, their presenting problems, and how they usually are, from other people who know the patient.

[3] The NHS Talking Therapies programme was developed by NHS England to improve the delivery of, and access to psychological therapies for depression and anxiety disorders https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

1.12 Mr B was admitted to King's College Hospital (KCH) where he was treated for his injuries: his leg had to be amputated and he had an injury to his hand. When medically stable, Mr B was transferred to an acute surgical bed at Mid and South Essex NHS Foundation Trust (MSE), in May 2022.

1.13 Mr B was in ongoing pain. His mobility was severely impacted; he needed a wheelchair and had to learn to walk again. Mr B became severely depressed and experienced flashbacks.[4] Across both inpatient stays, he was cared for on continuous observations and seen by the mental health liaison team (MHLT)[5] at South London and Maudsley NHS Foundation Trust (SLaM) while at KCH, and by EPUT while at MSE. The EPUT MHLT changed his antidepressant medication and increased the dosage shortly before he was discharged.

1.14 Mr B's lease on his flat ended while he was in hospital, and he was identified as homeless. Mr B was admitted to the assessment unit at BMH, a care home which provides personal care, on 10 June 2022. Discharge to assessment was a new model of care for the Southend on Sea City Council ("the council") and Southend Care Ltd. Southend Care Ltd is a company owned by the council, which was set up to deliver care and support services. Southend Care Ltd is the registered provider that runs BMH.

1.15 The model of care was that people were placed on the assessment unit at BMH for a maximum of six weeks for reablement; this would be expected to end for Mr B at the end of July. The focus was on physical reablement, with occupational therapy (OT) and physiotherapy staff who attended BMH providing active rehabilitation and medical input from a GP. However, Mr B remained at BMH until the events of June 2023. An application for accommodation had been completed by his care coordinator in March 2023, with supplementary information requested and submitted in May 2023. The reablement team were no longer involved with Mr B as his physical reablement was complete. There was no fixed date for discharge.

1.16 On discharge from MSE in June 2022, the MHLT at EPUT referred Mr B to the Southend Recovery and Wellbeing Team (SRWT),[6] the community mental health team (CMHT). He was identified as having complex needs and placed on the Care Programme Approach (CPA). CPA is a defined package of care for people with mental health problems, where people with complex needs are assigned a healthcare professional to coordinate their care.[7]

1.17 Mr B was seen in outpatient clinics and his mood was noted to fluctuate. All involved in his care reported that Mr B openly talked about thoughts to end his life when he was more mobile. He was frequently in pain and was on long-term opiate[8] analgesia.

1.18 The consultant psychiatrist (CP) amended Mr B's antidepressant medication, adding a second treatment in August 2022. Mr B was referred to the adult community psychology (ACP) service in October 2022 and started a psychological awareness programme (PAP) of three sessions in January 2023.

1.19 Mr B's GP noted in February and April 2023 the level of risk that Mr B might make a further attempt to end his life. They alerted SRWT when BMH care staff alerted them to his mood (in April 2023). His level of risk was also noted by SRWT and ACP as Mr B presented with a fluctuating mood and shared with staff his thoughts of suicide.

[4] A flashback is a vivid experience in which you relive some aspects of a traumatic event.

[5] The team provides specialist mental health care in a physical health setting, enabling Emergency Departments and wards in the general hospital to assess, manage and support mental health problems as they present or arise among people being cared for within the general health pathway.

[6] The Southend Recovery and Wellbeing Team is an EPUT service which provides community mental health provide long-term support and care planning across health and social care. The team is made up of psychiatrists, nurses, social workers, psychologists, occupational therapists, psychologists, employment specialists, and support workers.

[7] CPA has since been replaced by the Community Mental Health Framework.

[8] Opioid analgesics are usually used to relieve moderate to severe pain. Repeated administration may cause dependence and tolerance. Regular use of a potent opioid may be appropriate for certain cases of chronic non-malignant pain.

1.20 Mr B's mood became progressively worse when plans for his discharge from BMH took shape. Although there was no confirmed date for his discharge, his care coordinator had completed applications for housing in March, with supplementary information submitted in May 2023. This coincided with the anniversary of his first attempt to end his life.

Context and national guidance

1.21 The aim of this report is to help improve the delivery of care for people who are at risk of self-harm. This section sets out the guidance relating to transition of care between settings, care for people who have mental health needs and are at risk of self-harm in the community, and care for people with depression and chronic physical illness.

1.22 National Institute for Health and Care Excellence (NICE) guidance[9] on the transition of care between inpatient mental health settings and community or care home settings social care sets out the importance of a collaborative, planned discharge which involves the person and their family, so the person does not feel their discharge is sudden or premature.

1.23 Where a person is identified as having an ongoing need for care following discharge from hospital, section 74 of the Care Act (2014)[10] sets out the duty of an NHS trust to plan for their discharge, involving the person and any carer.

1.24 Local authorities have a full rehousing duty if an individual is eligible on the basis of immigration status, homeless or threatened with homelessness, in priority need, and unintentionally homeless.[11]

1.25 Adult safeguarding and homelessness: Experience-informed practice (2021),[12] informed by learning from safeguarding adult reviews, identified nine important areas which must be considered when working with individuals who are homeless:

- Person-centred approach, keeping in contact
- Concerned curiosity
- Exploring non-engagement and repeating patterns
- Understanding the person's history
- Exploring the impact of trauma and adverse experiences
- Thorough mental capacity and mental health assessments
- Thorough risk and care and support assessments
- Thinking family
- Seeing transitions as opportunities

1.26 Department of Health and Social Care (DHSC) guidance in 2022 described four pathways of discharge from hospital.[13] Mr B was identified as being on pathway 2 which is 'discharge to assess' (D2A). D2A is where people who are considered medically optimised[14] for discharge and do not require an acute hospital bed (but may still require care services) are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community

[9] Transition between inpatient mental health settings and community or care home settings (NICE) National Guideline NG53, National Institute for Health and Care Excellence, 2016

[10] The Care Act (2014)

[11] Homelessness Code of Guidance for Local Authorities HM Gov 2018, updated May 2024

[12] Adult safeguarding and homelessness: experience informed practice, Local Government Association and Association of Directors of Adult Social Services, 2021

[13] Statutory guidance: Hospital discharge and community support guidance DHSC, 2022 updated 2024

[14] To be medically optimised is the point at which care and assessment could be continued at home or in a non-acute setting or the patient is ready to go home.

setting. Fundamental to D2A is the idea that comprehensive assessment (including assessment under the Care Act, 2014) will take place out of hospital to allow people time for recovery before making choices about their longer-term care and support.

1.27 National guidance published in 2022[15] recognised the importance of awareness that moving to independent accommodation in the community with tenancy responsibilities can be an extremely challenging, stressful, and isolating experience for some people. It set out the need to work with people to assess the risks associated with their new living arrangement, while also recognising their strengths, and planning ways to mitigate the risks.

1.28 MSE had a discharge policy in place (Management of Joint Discharge from Mid and South Essex NHS Foundation Trust, October 2021) which was in line with national guidance.

1.29 There is national guidance on how people with mental health needs are cared for in the community which is the Care Programme Approach (CPA). This guidance describes the approach used in mental health care to assess, plan, review and coordinate the range of treatment, care and support needed for people in contact who have complex care needs. NHS England have since made changes and introduced the community mental health framework (which will replace CPA), which services are in the process of adopting. During Mr B's period of care, he was identified as having complex needs and therefore needed to receive care under CPA.

1.30 EPUT's CPA policy sets a standard for six-monthly reviews of care and identifies triggers for professionals' meetings including transitions such as moving and any increase in risk.

1.31 The contract (undated) between Southend on Sea City Council and Southend Care Ltd who run BMH sets out the details of the model of care which was being provided in the assessment unit. BMH are contracted to deliver a short-stay care provision (up to six weeks) using a therapy-led model of support (What Matters to Me approach), based around recovery and support for self-management with emphasis on what matters to the individual. The focus is on active recovery. The contract describes the model as one which "*moves away from the traditional illness/condition focused delivery model to a more person-centred approach with an emphasis on the outcomes that matter to the individual rather than focusing on task completion*."

1.32 The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[16] (University of Manchester 2023) reported there were 68,357 suicides in the general population in the UK between 2010 and 2020, an average of 6,214 deaths per year.

The Five Year Forward View for Mental Health (The Mental Health Taskforce 2016)[17] found that most people who took their own life had been in contact with a health professional, usually a GP, in the month before their death. More than a quarter (28 per cent) of suicides were among people who had been in contact with mental health services within 12 months of their death.

1.33 NCISH (2021)[18] identified key risk factors among middle-aged men who had taken their own lives which are set out in the table overleaf:

[15] Integrated health and social care for people experiencing homelessness NICE guideline [NG214], National Health and Social Care Excellence, 2022

[16] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester.

[17] The Five Year Forward View for Mental Health: The Mental Health Taskforce, 2016

[18] Suicide by middle-aged men. National Confidential Inquiry into Suicide and Safety in Mental Health: The University of Manchester, 2021

Figure 3 - Comparison of key risk factors of suicide in middle aged men

Table 2: Comparison of key risk factors from study sample, by available general population figures.

Variable	Sampled middle-aged men (%)	General population figure (%)
Unemployment	30%	4.5%
Deprivation	25%	20%
Divorced/separated	21%	5%
Alcohol misuse	36%	20%
Drug misuse	31%	7%
Physical health condition	52%	34%
Mental health diagnosis	66%	15%

Source: Suicide by middle-aged men. National Confidential Inquiry into Suicide and Safety in Mental Health: The University of Manchester, 2021

1.34 There is a national competency framework[19] for people working with adults and older adults. It identifies competencies including ability to work within and across organisations, an ability to coordinate case work, and collaborative assessment and management of suicidality. The framework describes several actions to help keep people at risk of self-harm or suicide safe, including:

- a safety plan
- sharing plans with others
- reducing access to lethal means or means of self-harm
- providing the best available evidence-based treatment to meet the needs of that person

1.35 A report on risk management by NCISH (2018) identified the importance of a shared approach to managing risk to strengthening the standards of care.[20] "*The management of risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and onward referral are all managed safely.*"

1.36 There is national guidance[21] which sets out the treatment for patients with depression. The guidelines identify that the most effective treatment option for severe depression is individual cognitive behavioural therapy combined with an antidepressant medication. Where there is a limited response to treatment, the dose of antidepressant medication can be increased and/or a second antidepressant medication can be added (e.g. mirtazapine).

1.37 National guidance[22] on recognising, assessing, and treating post-traumatic stress disorder (PTSD) aims to improve quality of life by reducing symptoms of PTSD such as anxiety, sleep problems and difficulties with concentration. It also aims to raise awareness of the condition and improve coordination of care.

1.38 There is national guidance[23] on the care of people who have MS. These highlight the importance of a multidisciplinary approach to the care of people living with MS, with access to a range of

[19] Self-harm and Suicide Prevention Competence Framework Adults and Older Adults, National Collaborating Centre for Mental Health (2018)

[20] The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: The University of Manchester, 2018.

[21] Depression in adults: treatment and management, NICE Guideline NG 222, National Institute for Health and Care Excellence, 2022

[22] Post-traumatic stress disorder NICE guideline [NG116]

[23] Multiple sclerosis in adults: management NICE Guideline NG 22, National Institute for Health and Care Excellence, 2022

professionals who can support them and with a single point of contact. The guidance highlights the need to be mindful of the impact of pain on the mental wellbeing of people with MS.

Key findings

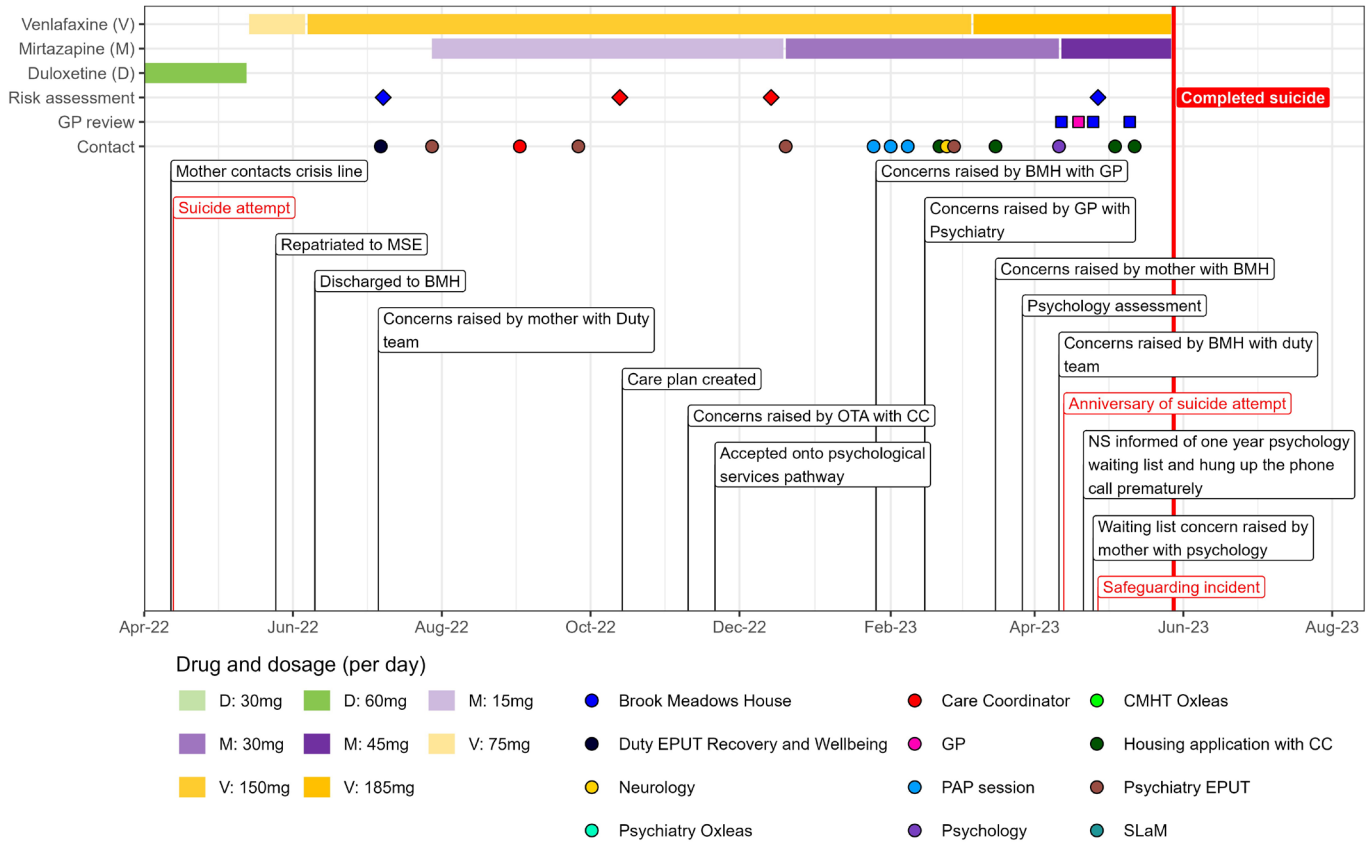
1.39 In summary, from our review there were a number of factors which were likely to be impacting Mr B's mood:

- He was frustrated by limitations on his physical ability to be independent and he was worried that his mobility would not improve.
- He was concerned about potentially being isolated in a flat, and living in mental health supported living environment, which he had no choice over.
- There was a long wait for individual psychological work.

1.40 Although different services raised concerns about Mr B's mood and his intention to end his life, the investigation has identified several factors which impacted the effectiveness of managing Mr B's risk and treating his depression.

1.41 The chart below provides a picture of the key events in Mr B's life prior to May 2023, his medication timeline and dosage, and the engagement of the key teams he was involved with.

Figure 1 - Significant events in Mr B's life



1.42 The table shows, in our view, the antecedent events, when concerns were raised about Mr B, and the delays he faced in the last year of his life:

- Concerns were raised by family at the point at which he should have been discharged from BMH.

- There was a four-month delay in creating a care plan, from his referral to SRWT.
- The care coordinator was informed of concerns about Mr B's mood in November 2022 by OT staff at BMH.
- There was a four-month delay before Mr B was referred to psychology by SRWT.
- Four weeks after he was referred to psychology, he was accepted onto the service.
- The specialty doctor 1(SD1) increased the dose of mirtazapine[24] in December 2022 and asked psychology to prioritise Mr B and look at providing trauma work. Two weeks later, Mr B was offered and accepted a three-session, virtual psychological awareness programme (PAP) which started in January 2023.
- After leaving the third PAP session before it started in February 2023, Mr B requested and was offered an assessment for individual psychological therapy which took place at the end of March 2023.
- BMH staff asked the GP in February 2023 to see Mr B as they were concerned re his mood; the GP contacted SRWT who arranged an expedited appointment with the psychiatrist and increased his dose of venlafaxine.[25]
- Mr B's care coordinator applied for housing for Mr B in March 2023.
- BMH contacted the duty team to raise concerns in April 2023; this was the day before the anniversary of Mr B's first attempt to end his life, and in response to his mother's concerns.
- Psychology services contacted Mr B to explain that his assessment would be discussed, and the outcome would be shared with him.
- Psychology contacted Mr B two weeks later to tell him he had been accepted for individual therapy and that he had been placed on a waiting list that would be about 12 months; Mr B hung up.
- Mr B's mother contacted the duty team to raise concerns about the long wait for psychology; she was told there is no prioritisation.
- BMH raised a safeguarding alert and requested a mental health assessment by an approved mental health professional (AMHP)[26] on 28 April 2023 because Mr B had been buying painkillers off the internet and said he intended to end his life when he left BMH.
- The GP increased Mr B's dose of mirtazapine after discussion with SRWT.
- Mr B had his last contact with mental health services on 4 May 2023 when he saw his care coordinator who discussed the further information that had been requested for Mr B's housing application.
- Mr B saw the GP and they discussed physical health needs on 10 May 2023.
- Mr B left BMH and ended his life on 27 May 2023.

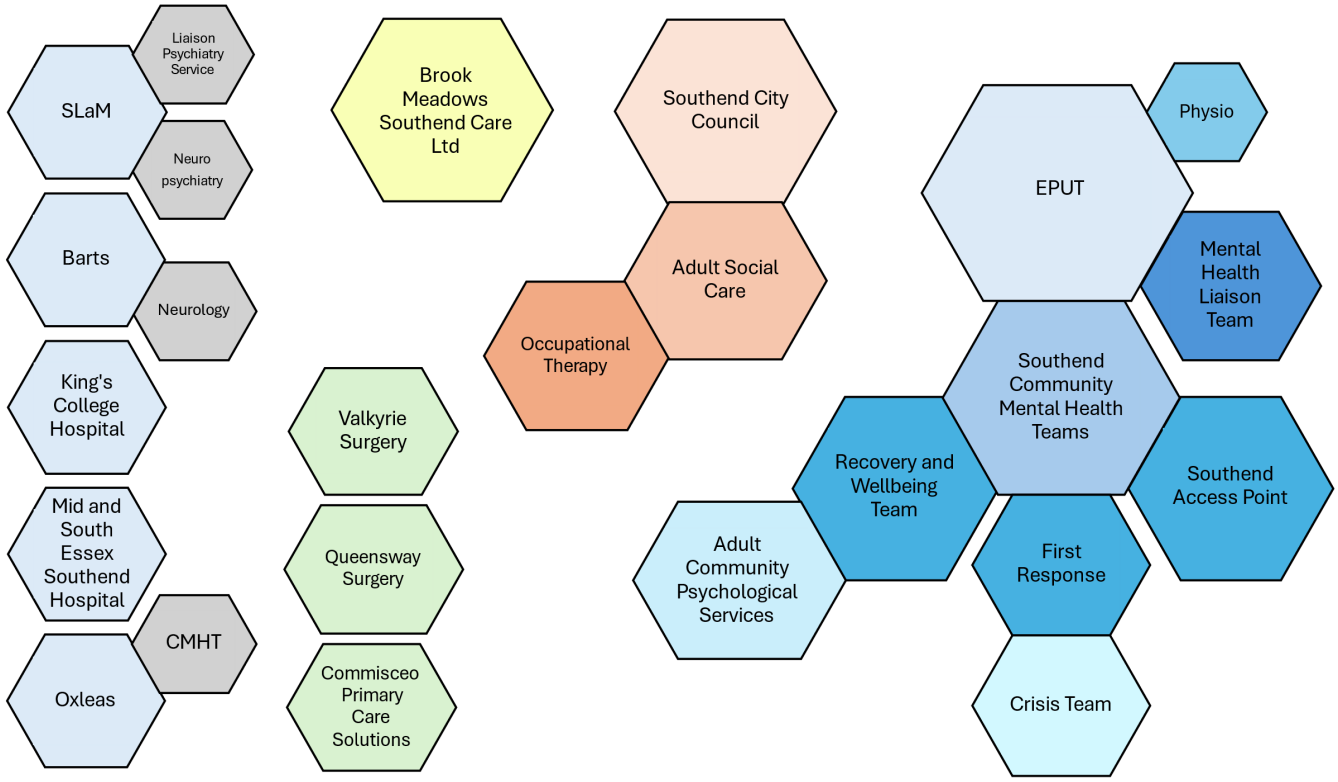
[24] Mirtazapine is an antidepressant medicine used to treat depression and sometimes obsessive compulsive disorder (OCD) and anxiety. It works by increasing noradrenaline and serotonin levels in the brain.

[25] Venlafaxine is an antidepressant from a group called serotonin and noradrenaline reuptake inhibitors. It works by increasing noradrenaline and serotonin levels in the brain.

[26] An approved mental health practitioner is a professional who has been approved by a local authority to carry out certain duties under the Mental Health Act.

1.43 The table below shows a schematic of the organisations and their services which engaged or were involved with Mr B in the last 18 months of his life.

Figure 2 - Services involved in the care and treatment of Mr B between April 2021 and May 2023



1.44 It is clear from the above that:

- There were a large number of services involved in Mr B's care, and several teams within EPUT.
- Effective systems for sharing information would be essential to ensure that all health and social care professionals had the necessary information to plan care.
- It would be essential that each health and social care professional was aware of their role and responsibility in delivering care to Mr B.

Collaborative working to manage risk

1.45 Risk information was not effectively shared among those involved in Mr B's care to enable effective management of risk.

- Information relating to Mr B being nursed with continuous observations and diagnosed with MS was not included in the discharge referral to the local authority.
- Safeguarding concern was shared with a generic access team email and with the mental health team involved in Mr B's care.
- Concerns voiced by Mr B and his mother, and BMH, about the long wait for individual psychological therapy, and Mr B's potential to act impulsively, were known to psychology but not shared with all of his mental health team.

1.46 Risk assessments and supporting care plans were not completed in a timely way, did not contain all the information required to reduce risk, and were not shared among all those who were involved in Mr B's care. Risk assessments were not updated to include all risk factors and incidents.

1.47 There was a gap between what people involved in Mr B's care thought was happening for him, and what was happening. Examples of this include:

- Mr B was able to leave BMH when he wished, when it was recorded in his risk assessment and his psychology assessment that he had to be accompanied when he left BMH.
- The CP recorded that Mr B needed weekly care coordinator visits, and there are records of three face-to-face contacts.
- The CP wrote that Mr B was to be referred to psychology after their first clinic contact, and GP2 recorded that Mr B was receiving counselling, but Mr B was not referred to psychology until the clinic letter sent in October 2022, had not completed the psychological awareness programme (PAP) and was awaiting assessment for individual therapy.
- The safeguarding incident was being case managed by the community mental health team (CMHT).

1.48 Teams worked in silos which meant risk information was not shared. In turn, no team involved in Mr B's care had all the information necessary to assess risk and take action to mitigate it. Although the need to collaborate with all professionals involved in Mr B's care was included in plans written in clinic letters, this collaboration did not happen. It was not identified that this was not happening by any of the teams involved in Mr B's care.

1.49 Within EPUT, information relating to risks was not shared within the team. Records and assessments were not written up at the time of contact, which meant that the team did not have all relevant information to work with.

1.50 When concerns were raised, systems were not effective to confirm that action had been taken in response. BMH reported a safeguarding incident on 28 April 2023: the local authority contacted EPUT and were told that the concern would be case managed. This did not happen, although the information was shared with the mental health team involved. None of the professionals involved in Mr B's care called a professionals meeting to share concerns, agree plans and identify roles and responsibilities.

1.51 Changes of care provider, and handover and referral processes impeded the continuity of care that Mr B received.

- Mr B had three different GP services during his stay at BMH.
- The referral for neurology was initially rejected and took several months to be accepted.
- Mr B's referral for psychology was not made in writing and accepted until October 2022.

1.52 There was no mental health presence at the reviews run by the GP services at BMH. We heard that the medical reviews at BMH were focused on responding to requests and following up actions from other professionals.

Care Programme Approach (CPA)

1.53 Mr B did not receive care in line with CPA. There was a delay in allocating a care coordinator, and first contact. There were no planned reviews of care in line with EPUT policy which requires reviews at least every six months, and at points of transition.

1.54 A professionals meeting was not held for Mr B, despite meeting the criteria set out in Trust procedure, e.g. he was changing accommodation. As Mr B's move into independent

accommodation was in hand, it would have been helpful for all to meet to agree plans and share information.

Capacity in community health teams

1.55 The Recovery and Wellbeing Team in Southend struggled to recruit and had a high turnover of staff, particularly care coordinators. To mitigate the risk, the team relied heavily on the use of temporary workers employed via an agency.

1.56 We heard that there were differences in caseloads between teams in Essex, and that Southend had more complex cases, and seasonal variations with increased demand in the summer. This further impacted recruitment and turnover rates of staff.

1.57 Mr B was seen by clinical associates in psychology,[27] overseen by clinical psychologists. Mr B was placed on a psychological awareness programme before he was assessed for individual therapy. There were long waiting times for individual psychological therapy. We were told that this was because psychology was not commissioned in line with national guidelines.

Collaborative working to deliver care

1.58 The health and social care professionals involved in Mr B's care were not working together effectively to ensure that there was a shared understanding of his care needs, across physical and mental health and social needs. This meant that each team who provided care for Mr B had separate records and meetings to plan care.

1.59 While each team considered and identified Mr B's needs and risks, there was no collaborative working to ensure that these were responded to effectively. Risks were raised and referrals were made, with little evidence of these being followed up, shared and therefore included in holistic care plans.

1.60 There were no multidisciplinary team (MDT) meetings to set out roles and responsibilities of all professionals involved in delivering the care. Teams worked in isolation, which meant that information was not shared effectively to coordinate care. It also meant that there was no sharing of knowledge and skills to strengthen the response to Mr B's needs. The Southend Wellbeing and Recovery Team (SWRT) did not support BMH with their risk management.

1.61 There was no recovery care plan in place, which meant that there was no clear description of his needs nor a support plan describing how, and by whom, these needs were to be met.

1.62 The lack of multi-professional meetings/reviews meant that roles were not clear and understood, to ensure that all teams were working together to deliver care.

1.63 The lack of a multi-professional approach meant not all professionals who could contribute to Mr B's recovery were included in the planning of his care. EPUT had no contact with the neurology team and therefore there was a lack of specialist input into care planning and coordinated working to support Mr B's complex needs. Information relating to the potential neurological changes were not considered in risk assessment and care planning.

1.64 He did not receive care in line with best practice for severe depression or for the trauma he had suffered. Mr B was not able to access individual psychological therapy. There were delays in his referral to psychology and once accepted there was no prioritisation of the referral. No effective actions were put in place to support Mr B once placed on the waiting list.

1.65 There were no recorded internal mental health meetings involving psychology and SRWT to discuss Mr B's care needs and plan how to support him while he waited for individual therapy. The GP service believed that Mr B was receiving counselling when he was still on a waiting list.

[27] Clinical associates in psychology provide psychological interventions under the supervision of a fully qualified practitioner psychologist

1.66 When Mr B moved between services, the process for handing over his MS care did not work. Mr B's GP had to refer him back, this was rejected and the referral had to be resubmitted. Following his admission to BMH, Mr B again had to be referred to the service.

Record keeping

1.67 Records were not always completed accurately or shared with other agencies. This meant that up-to-date information was not always available or clear to those delivering and making decisions about Mr B's care. Therefore, decisions relating to Mr B's care were taken without access to all the information that was available.

1.68 Mr B's discharge assessment, completed by the Mid and South Essex NHS Foundation Trust's (MSE) discharge team, did not include all necessary information, including information related to his MS diagnosis, that he had been cared for on continuous observation, and that his dose of antidepressant had been doubled shortly before discharge.

1.69 Risk assessments and care plans were not completed in line with Trust policy. Contact records were not always written up at the time of contact.

1.70 Contact notes were taken at the time of the psychological assessment for individual therapy but did not include all the information, such as the Quality of Life scores that had decreased. The report for the psychological assessment was completed ten weeks later, which was two weeks after Mr B's death. The assessment did note that it was completed after Mr B's death. There was no comment on the decrease in Quality of Life scores since the January assessment undertaken by psychology.

1.71 A conversation between GP3 and SRWT was not recorded in EPUT records and did not include the name of the healthcare professional in GP records.

1.72 Contact notes from Mr B's last meeting with his care coordinator on 4 May 2023 were not completed until 31 May 2023. It was not recorded within the entry that the notes were being made after Mr B's death. The care coordinator had emailed Mr B on the morning of 30 May 2023, requesting further information for his housing application, which had been requested on 10 May 2023. The care coordinator was informed of Mr B's death by police later that morning.

Impact of COVID-19

1.73 For most of the period of the review, COVID-19 policies relating to different ways of working were no longer in place. Mr B had struggled personally during lockdown. It is documented throughout his contacts with psychology services, at Therapy for You and at PAP, that he expressed a preference for face-to-face contact. He had appointments virtually and face to face in 2021.

Recommendations

Trust/organisation recommendations

Recommendation 1: Risk management

There were delays in completing risk assessments and supporting care plans. These did not include all necessary information, including risk factors, a formulation of risk, and a supporting care plan with a crisis and contingency plan. They were not updated to reflect new risk incidents and information. Each team had their own risk assessment and risk information was not shared between teams, which meant that no one had a complete picture of the risk and therefore what actions were needed to reduce them.

All organisations must assure themselves that they have an effective shared risk management information system in place which supports:

- effective sharing of risk information, so that teams can work collaboratively and produce up-to-date risk assessments and support plans which clearly identify routes of escalation
- recording and sharing of actions taken and their impact, so that all system partners are assured that effective action has been taken in response to risk
- the involvement of the individual and their family/carer so that their concerns and opinions are heard and can contribute to risk management
- having processes in place which look at the quality of risk assessments and care plans, so that they are used to effectively support people using services

Recommendation 2: Responding to concerns

When a safeguarding concern was raised, there was no process to confirm whether the agreed actions had been taken and whether they were effective in safeguarding the individual.

EPUT, Southend on Sea City Council, Brook Meadows House and Commisceo Primary Care Solutions must have a system in place which provides a notification when actions have not been taken and assurance that:

- when safeguarding concerns or alerts are raised, actions are taken
- outcomes of actions and their impact are assessed and recorded and shared with all relevant parties

There was no recorded outcome of Brook Meadows House's request for a Mental Health Act assessment by an approved mental health professional (AMHP). There was no record of whether the request was passed on to an AMHP to consider, or any record of any decision or action in response to the request.

Southend on Sea City Council must be assured that:

- requests for an AMHP mental health assessment are managed in line with statutory requirements
- records of decisions are kept demonstrating the actions taken

Recommendation 3: Care coordination

There were delays in EPUT allocating a care coordinator to Mr B although his complexity and risk were recognised. Some cases are held by the duty team as there is insufficient capacity to allocate a care coordinator. There is a high turnover of staff in the community mental health team, with a reliance on a temporary workforce with varying skills and experience. Not all staff had completed the training identified as essential for their role.

We were told that there is a difference in the demand and complexity of caseloads between community mental health teams. The risk had been identified on the service's risk register, but this had not led to effective actions to reduce the pressures on the team.

EPUT must:

- evaluate caseloads for acuity and volume and develop a plan so that staff are working with equitable workloads
- evaluate local capabilities and training needs for complex case management and develop a plan to address any gaps so that staff have the right knowledge, skills, supervision and mentoring to perform their roles
- assure itself there is effective monitoring of which cases are held by the duty team, that risks are being managed effectively, and that people are allocated a care coordinator as soon as possible

Recommendation 4: Psychological therapy

Mr B had severe depression and was suffering from flashbacks following the trauma of the first attempt to end his life. Mr B stated a preference for face to face contact, and wanted individual therapy. Mr B's needs for psychological therapy were not met. This was due to a number of factors:

- **there was a delay in referring Mr B for psychological treatments**
- **poor communication between psychology and the SRWT**
- **lack of capacity in the psychology team led to Mr B being placed on a waiting list of 12 months**
- **no prioritisation of need of the waiting list**
- **the psychological treatment that was planned was not in line with NICE guidance NG222 and NG116**

EPUT must review its processes for referral into psychological services to ensure that:

- people using the service are aware that they can access individual therapy without first having to attend the psychological awareness programme
- the referral process is fit for purpose and monitored by the leadership team, and that level of risk is considered
- people's preference for how they engage with services (virtually or face to face) is considered

- staff understand what psychological therapies are available, and how to refer people to them
- referrals clearly indicate which pathway is being requested
- access to psychology is equitable across the Trust; EPUT and the integrated care systems (ICS) must identify any shortfalls in capacity in the commissioning of psychology across their footprint and work together to ensure that it meets national guidelines
- suitably qualified and experienced staff deliver psychological therapy for depression as a first line of treatment in line with NICE guidance
- they work with psychology staff to develop a system to upskill others in the community mental health team to mitigate the long waiting times for psychological intervention

Recommendation 5: Integrated care of physical and mental health needs with a long term condition (MS)

The link to the neurology service was lost and Mr B was not re-referred for MS care before discharge from MSE, which impacted on collaborative working to meet his physical and mental health needs. Mr B was placed in an assessment unit in a residential care home where there were strong links with physical reablement services but not mental health services and no neurology input; this meant that there was a lack of clarity between EPUT services and BMH about how care was being provided.

EPUT, MSE, Southend on Sea City Council and BMH must assure themselves that:

- all health and social care professionals understand the scope and limits of the services each team offers
- the model of care and delivery meets the needs of people placed there and staff have the knowledge, skills and capabilities to meet the needs of people placed there
- there is a link to the specialist services to meet the needs of people placed in the assessment unit
- there is an effective escalation system to flag where there are challenges in collaborative working and solutions can be found to ensure that service users' needs are met

Some aspects of care and treatment were not delivered in line with best practice as there was no integrated care of physical health and mental health; each team of health and social care professionals delivered care in isolation. Information that might have helped ensure joined-up delivery of care was not routinely shared. There was no consideration of the impact of MS and long-term prescription of opiates on Mr B's mental health.

All organisations involved in delivering care should assure themselves that:

- multidisciplinary meetings are arranged to plan care which considers all the care needs of the individual
- the roles and responsibilities of all health and social care professionals involved in delivering care are agreed
- multidisciplinary reviews of delivery of care are carried out at agreed intervals and in response to risk
- care and risk plans are developed and reviewed regularly by the multidisciplinary teams and the service user to monitor their efficacy

A compounding factor in this case was that he was lost to services. Mr B moved frequently and specialist nurses were not able to handover as they did not know his permanent address.

- specialist nurses should review their processes for transferring care between services to reduce the risk of patients being lost to services when they move

Recommendation 6: Record keeping

Records were not always kept up to date, with delays between contacts and their assessments being written up, which meant that information was not available to all involved in care. Additions made post-death were not always clearly identified.

EPUT needs to:

- ensure that reasons for posthumous access to records are defined in the record keeping policy
- assure itself that all records, including contacts with partner agencies, are being recorded in line with expected practice

Recommendation 7: Discharge

When Mr B was discharged from MSE, the discharge policy and best practice were not followed. The planned second discharge planning meeting was not held as Mr B was discharged before it happened. Not all relevant information was included in the referral information.

MSE, the council and BMH must ensure that:

- complex discharges are managed in line with policy
- all required referrals are completed before discharge and care transitions
- the discharge assessment includes all necessary information
- the patient and carer are meaningfully involved in the discharge process to enable a comprehensive and effective discharge plan

Good practice

1.74 We identified good practice by the mental health liaison psychiatrist at EPUT as they contacted the neuropsychiatrist from SLaM to gather information and check arrangements for handover of neurological care. They presented Mr B's case at a multidisciplinary SRWT meeting shortly after Mr B was discharged into the community, as they recognised his needs were highly complex and they wanted to ensure a timely and comprehensive handover.

1.75 Although Mr B was no longer open to the SLaM neuropsychiatrist, he provided support to Mr B's friends and family when they were concerned about him, by contacting teams who were involved with Mr B.

2 Investigation

Incident

2.1 Mr B was a 50-year-old man with secondary progressive multiple sclerosis (MS). He took his own life on 27 May 2023. He had left the care home where he was placed after he had sustained life-changing injuries following an attempt to end his life a year earlier.

Approach to the investigation

2.2 NHS England (Midlands and East of England region) commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent multi-agency review into the care and treatment provided by the NHS and other relevant agencies to Mr B. Niche is a consultancy company specialising in patient safety investigations and reviews. The independent investigation follows the NHS England patient safety incident response framework (PSIRF).[28] The terms of reference for this investigation are given in full in Appendix A.

2.3 Below is a list of services who contributed to this review.

- Essex Partnership University NHS Foundation Trust (EPUT)
- Mid and South Essex NHS Foundation Trust (MSE)
- South London and Maudsley NHS Foundation Trust (SLaM)
- King's College Hospital (KCH)
- Valkyrie Surgery (VS)
- Queensway Surgery (QS)
- Commisceo Primary Care Solutions (CPCS)
- Southend City Council (SCC)
- British Transport Police (BTP)

2.4 We reviewed a range of information relating to the care and treatment of Mr B which included care records, correspondence, policies and procedures. We met with staff from some of the organisations who provided care to Mr B and would like to thank all the organisations for their support during the investigation. We were unable to speak to Mr B's care coordinator during our review because they have left the Trust. EPUT told us they no longer work in the NHS. We have not been able to meet neurologist 2 during our review.

2.5 British Transport Police's contact with Mr B was in response to both incidents. Following the first attempt to end his life, BTP shared a risk assessment form with his GP.

2.6 The draft report was shared with the organisations involved in the review. This provided an opportunity for the organisations that had contributed significant pieces of information, and those we interviewed, to review and comment on the factual accuracy of our report.

2.7 The draft report has been subject to legal review.

2.8 The terms of reference include the development of a learning document for wider circulation; this will be provided separately to this report.

[28] The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety, NHS England, 2022

Contact with Mr B's family

2.9 We spoke with Mr B's mother and his brother. NHS England had asked them to comment on the terms of reference at the start of the review. Their comments and questions were incorporated into the terms of reference. They wanted to know why nobody asked Mr B where he was going when he left BMH.

2.10 Mr B's mother provided a helpful document which detailed events in Mr B's care.

2.11 We have heard that Mr B was able to come and go from the care home as he pleased. Staff told us, and records showed, that he did go out: sometimes on his own, sometimes with friends, or to visit friends and family. As it was so normal for him to go out, on the day he ended his life nobody asked him where he was going. We were told that sometimes they would have a chat about his plans but not always. Mr B appeared fine to staff on the morning he left; he was asked to wait until he had had his morning medication, which he did, and then he went out. His family do not agree that he went out much on his own.

2.12 Mr B had capacity to make decisions and unless there was a concern about his capacity, the home had no powers to prevent him from leaving. Mr B did not need to tell staff where he was going and it is highly unlikely that he would have shared his plans.

2.13 We would like to offer our sincere condolences to Mr B's family and thank them for their assistance.

2.14 We shared the report with Mr B's mother, brother, and former wife who shared the report with his daughter. Mr B's mother does not agree that Mr B went out much on his own. His mother and brother are very angry about what happened to Mr B. They described his care as "*having more holes than a colander*." His mother feels that the long wait for psychological therapy and then being told there was a further 16-month wait had impacted Mr B's mental health. Mr B was also worried about leaving BMH and where he was going to be living. She had considered contacting her MP to raise concerns about his care.

2.15 His mother and brother told us about how Mr B's death had impacted them. Mr B was a much loved brother who was an important part of his brother's life and he is much missed. Mr B's mother has lost a son who she tried very hard to advocate for. Whenever she raised concerns, she was always worried that it would have repercussions for Mr B, which added to her distress and concern for Mr B. His mother said that she felt that the care home did a good job under the circumstances, but they were not supported by the other services. It is her view that some of the care he received was "*negligent*".

Structure of the report

2.16 Chapter 3 of the report sets out the methods we used to analyse the evidence to identify the five main themes.

2.17 These main themes are then reported on in chapters 4 to 8. In chapter 9 we comment on the impact of COVID-19. Chapter 10 contains our conclusion.

2.18 The detailed chronology of Mr B's care is set out in Appendix C.

3 System thinking to analyse data

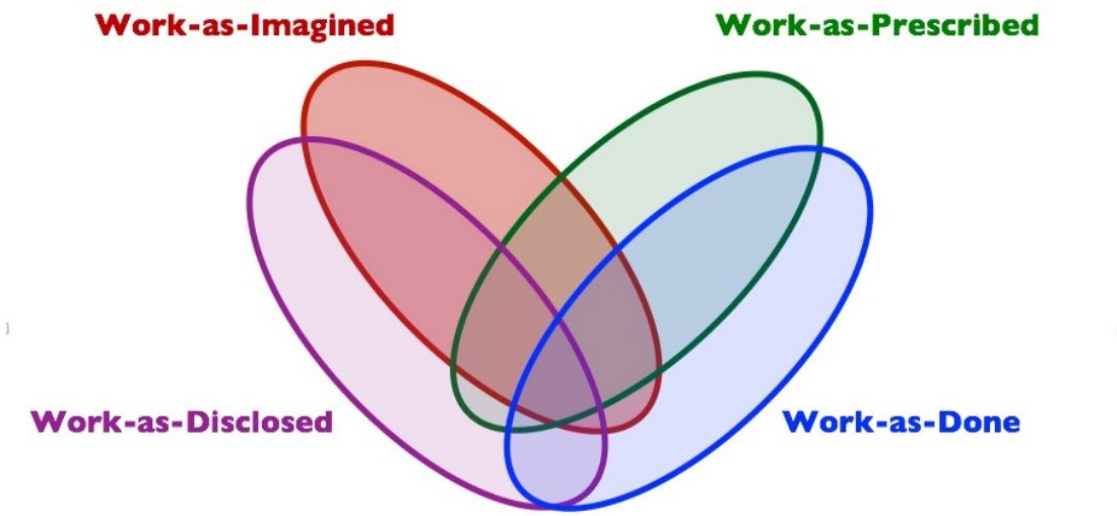
3.1 NHS England replaced the serious incident framework with PSIRF in 2022 to increase focus on understanding how incidents happen, including the factors which contribute to them. Systems Engineering Initiative for Patient Safety (SEIPS) is a framework that has been developed which prompts users to look for interactions rather than identifying a simple linear cause.

3.2 Human factors is concerned with managing the capabilities and limitations of people in the workplace, making it as easy as possible to do the work required. The Chartered Institute of Ergonomics and Human Factors identified that "*Human Factors is far more than error or incident analysis, but rather about focus on rigorous, elegant, evidence-based solutions to problems and building resilient systems that enable people to do the right things, every time.*"[29]

3.3 Its importance in responding to patient safety incidents is clearly set out in PSIRF.

3.4 It has long been accepted that how people think that work is done (work as imagined) and how work is actually done (work as done) are two different things. Steven Shorrock in The Varieties of Human Work (2016)[30] builds on this and identifies that there are four important factors to consider when things do not go to plan. Work as prescribed relates to how work is set out to be delivered, in guidelines, policies and procedures. Work as disclosed is what we tell people we have done, either in written records or verbally.

Figure 4 - The Varieties of Human Work (Steven Shorrock)



Source: Blog Humanistic Systems, The Varieties of Human Work, Steven Shorrock

3.5 The delivery of quality care requires a complex system of design, decisions, controls, monitoring, training, risk management, culture and assurance. In Mr B's case the systems in place were not effective in ensuring that the care that Mr B received was always in line with national guidance and organisational policies.

3.6 To do this, we used human factors principles. These helped us understand the complexities of delivering health care by better understanding how people act, and how they interact with each other. Acknowledging the complexities helped us to avoid coming to simplistic cause and effect

[29] Human Factors and Healthcare Evidencing the impact of Human Factors training to support improvements in patient safety and to contribute to cultural change: A report for Health Education England by the Chartered Institute of Ergonomics & Human Factors, 2019

[30] Blog Humanistic Systems, The Varieties of Human Work, Steven Shorrock

conclusions. It also helped us to identify themes and make recommendations aimed at bringing about the changes needed.

3.7 From talking to people, reviewing care records and reviewing documents such as policies and procedures, we have analysed Mr B's care using this human factors approach. The diagram on the following page shows that there were clear differences between what people thought was happening and what was actually happening.

3.8 This also highlighted the lack of communication between organisations and the lack of opportunities to work together, with very little opportunity to disclose what work was being done in a multidisciplinary setting. Our analysis can be seen in the diagram on the following page.

3.9 We have identified the following themes:

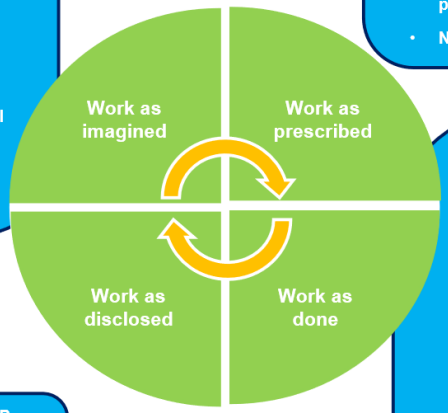
- collaborative working to manage risk
- Care Programme Approach
- capacity within community health teams
- collaborative working to deliver care
- record keeping

3.10 In chapters 4 to 8 of the report we look at each theme in more detail, our findings and the evidence to support them.

Figure 5

- The care coordinator is visiting NS weekly and monitoring risk.
- The efficacy and side effects of medication are being monitored by the care coordinator and the GP.
- NS was having psychological input.
- All teams that were supporting NS were working together to share information and inform care.
- A request for a mental health/AMHP assessment would result in a formal response such as a multi professionals discussion.
- Following the decision to case manage the safeguarding concern, risk would be responded to by the mental health team.
- All involved aware of the changes in risk relating to increased mobility, trigger of leaving BMH and long wait for individual psychological therapy.
- In 2022, the IAPT service informed GP that NS had shared suicidal thoughts during a call which he felt could be managed in the community.
- Contacts and assessments were being recorded at the time they happened and included all necessary information.

- EPUT's risk management policy requires that a risk assessment is put in place, which has been developed with input from the patient, family and carers and that risk information was being shared between all care providers.
- EPUT's Care Programme Approach policy requires six monthly reviews of care and identifies triggers for professionals meeting including transitions, increase in risk.
- NICE guidance 222 Depression in adults: treatment and management guidelines set out that people with severe depression should receive antidepressants and psychological therapy.
- NICE Guidance 138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services
- NICE Guidance 220 Multiple sclerosis in adults: management



- NS was receiving counselling according to GP records in relation to NS sharing suicidal ideation.
- The safeguarding concern was being case managed and urgent action being taken.

- The care coordinator completed a care plan which did not contain information relating to risk and was focused on NS's accommodation and physical needs.
- CPA was not followed. There were no reviews of care involving NS, his mother and those involved in his care.
- No professionals' meetings were called at transition points such as the planned move from BMH.
- Risk assessments were completed on CPA documentation: the care plan was completed on non CPA documentation.
- While there was a risk assessment completed, its quality was poor, without a formulation and supporting care plan.
- NS was seen for three recorded face to face contacts by his CC between June 2022 and May 2023.
- NS first attended and participated in two of the three PAP sessions in January/February 2023.
- Delays in being assessed for individual psychological therapy and a one year wait for therapy once NS was assessed in April 2023.
- Both the care coordinator and psychology document that NS's risks are mitigated by being unable to leave the care home unaccompanied.
- No CPA review meeting was held throughout the period.
- NS received combined antidepressant therapy but no CBT.
- Effects and side effects of antidepressants were not routinely assessed and recorded.
- Lack of multi-disciplinary care plans which involved all professionals involved in NS's care, including GP, neurologist and set out roles and responsibilities, and a medication management plan.
- GP tried to contact NS in response to letter from Therapy for You, but NS did not respond.
- The safeguarding concern was not responded to by the mental health team involved in NS's care.
- There were delays in writing up contact and assessments. Records did not include all the necessary information.

4 Collaborative working to manage risk

4.1 There were several areas where the care that was delivered to Mr B in response to his risk did not align with national guidance on managing risk:

- delay in allocating a care coordinator and then the first contact being made
- once a care coordinator was allocated there was a delay in completing a risk assessment
- treatment of Mr B's depression
- an effective formulation of risk
- care plans to mitigate risk
- the creation of a safety plan
- sharing of plans with practitioners involved in Mr B's care and what their role was in supporting Mr B to be safe
- the involvement of Mr B and his family in the risk management process, particularly when they raised concerns

4.2 A shared system approach was not being followed to safely manage the risk to Mr B. During our review of records and talking with people who were involved in his care, we learned that while each organisation had processes and guidance in place to manage risk, these were not effective in ensuring that Mr B received the care he needed to mitigate risk.

- All risk events were not shared with those involved in his care.
- The risk assessment did not include all the required information.
- A risk formulation was not completed.

4.3 The lack of a shared risk assessment and management plan which set out strategies to support Mr B, signs when his risk increased, details of what might trigger an increase in his risk, and roles and responsibilities, meant that people supporting Mr B were working separately, with no one person or organisation in possession of all the information needed to support Mr B. The risk process was not used effectively.

Effective response to risks

4.4 We saw evidence that where risks were raised with others, the act of raising the concern was not followed up to check that action was taken or effective. Examples include:

- need for expedited mental health appointment
- safeguarding referral
- increase in antidepressant therapy
- increasing mobility
- known trigger of leaving BMH
- Talking Therapies raising concerns with GP service 1 re Mr B's suicidal thoughts in 2022
- Mr B's mother raising concerns with the crisis team in April 2022 prior to Mr B's first attempt to end his life
- Mr B's mother raising concerns about the impact of the wait for individual psychological therapy
- deteriorating outcome scores between January and March 2023

4.5 The risk assessment was not shared by EPUT with the GP or BMH. Mr B's consent would have been required, but this is not recorded as being sought. This was a missed opportunity to identify what other people's concerns were, understand how Mr B's mood was currently, share what signs to look for in relation to side effects and mood elevation, as well as flag if there was a drop in Mr B's mood. This would have been helpful for BMH, a care home that predominantly provides dementia care.

Risk assessment as an inpatient

4.6 A risk formulation is defined by the National Collaborating Centre of Mental Health (2018) as, "*A collaborative process between a person and one or more mental health professional(s) to understand the person's mental health needs. During a formulation the professional will draw on psychological theory, social, environmental and biological factors to develop a series of working hypotheses and formulation of need, including an initial diagnosis*."

4.7 While being cared for by the MHLT, the Trust risk assessment tool was not used. Non-nursing mental health professionals we spoke with shared that nurses and care coordinators completed risk assessment tools, and EPUT guidance for community mental health teams stated that the care coordinator should complete this. There was no guidance on how the MHLT should manage and record risk. We were told that the team struggled to recruit nurses to the MHLT.

4.8 The assessment completed by the discharge team at MSE did not include all the information relating to Mr B's risk. It did not mention that Mr B had a diagnosis of MS or that he had been cared for on continuous observation. The discharge team recorded that they requested the continuous observation to be stopped as Mr B would not be able to be discharged while on that level of observation.

Discharge into the community

4.9 The liaison consultant psychiatrist (LCP) presented Mr B's case to the CMHT who would be supporting Mr B soon after his discharge. This was driven by her concerns about the complexity of his case. This was good practice. The LCP also wrote to Mr B's GP to inform them that he had been referred for care coordination.

4.10 Once Mr B was discharged into the community, there was a delay in assigning a care coordinator to support Mr B. This led to his mother contacting the duty team on 6 July 2022 as she was so concerned about his low mood. He was seen by a member of the duty team on 7 July for a mini mental state examination (MMSE). Mr B rated his mood as 1/10 and that he had thoughts of ending his life. Mr B's risk to self was rated as high as he stated that he could be impulsive. It was documented that Mr B was 'bedridden' following surgery. The duty team informed staff at the care home, although it was not recorded who was told. There is no record of a risk management plan being created with a safety plan or any consideration of potential risks in the environment. There is no record of any other action in EPUT records. BMH staff noted that Mr B was to be assigned a case worker and that they were to call them if Mr B was in crisis.

Risk assessment at Brook Meadows House

4.11 BMH created the first risk assessment for Mr B relating to his risk of suicide on 8 July 2022, following Mr B's review by the duty team. This identified that Mr B was to have hourly checks day and night, staff were to provide reassurance, and share any concerns with other staff immediately and at handover. It contained the contact number for the Southend Recovery and Wellbeing Team (SWRT)). The risk assessment did not contain sufficient information on how to identify risk. BMH staff would have benefitted with support from the CMHT in identifying what signs to look for in terms of Mr B's risk, as well as considering potential risks in the environment which Mr B could use to self-harm.

4.12 BMH's risk assessment was updated in April 2023 following Mr B's purchase of paracetamol for pain and the concerns that Mr B was planning to end his life when discharged from BMH. The

updated risk assessment set out an agreed approach with Mr B to open all packages he ordered. It did not identify how any risks not related to purchases were to be managed.

Risk assessment EPUT

4.13 EPUT's risk assessment policy[31] and underlying procedure[32] were ratified in 2019 and were due for review in April 2023, but this was extended to August 2023. While this means that it had not been updated in line with the most recent national guidance, it supports the principles of establishing a therapeutic relationship with the patient, assessing and formulating risk. It sets out the priorities for managing risk, including:

- the use of an appropriate tool that helps predict the likelihood of a risk occurring
- the creation of a safety plan
- treatment (e.g., psychological care, medication)
- supervision (e.g., help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others)
- include the views of others involved with the patient in their view of risk

4.14 A care plan should then be developed in collaboration with the person, and with their carer if the person consents, which sets out the interventions that will support their recovery, as well as the key professionals and practitioners involved in their care. A safety plan should be developed with the person. The procedure defines the safety plan as a written list of coping strategies which are prioritised and sources of support that patients can use during or before a crisis, with the aim of providing a list of potential coping strategies and a list of individuals or agencies that can be contacted. It flags that where there is continued and difficult risk to manage, a professionals meeting could be called. A professionals meeting is where professionals involved with an individual come together not only to share information, but also to help determine and agree a plan moving forward.

4.15 Trust policy says the risk assessment should be completed within 24 hours (it does not detail whether this is within 24 hours of admission or of acceptance of patient in the community) and be reviewed at least every six months and more frequently where risks are fluctuating. For community patients, "… *risk assessment must be reviewed as considered necessary by the clinical team, however the care coordinator is responsible for ensuring reviews are undertaken, as set out within the Care Programme Approach (CPA) and Non CPA Policy and associated guidelines at a minimum of 6 monthly CPA reviews.*"

4.16 Mr B's first risk assessment using the Trust risk assessment was written on 13 October 2022 by the care coordinator. We were told that this was in response to a prompt from their mentor who had identified that one was not in place.

4.17 The care coordinator did not complete the risk assessment in line with Trust policy. It did not include:

- all relevant information, such as the potential impact of MS on Mr B and his impulsivity
- the views of Mr B's family and carers
- responses to all the prompts, which would have identified risk factors such as increased mobility
- all relevant information from all available sources
- a formulation of risk which clearly identified triggers and protective factors, signs of increasing risk and a treatment and management plan to reduce the risk

4.18 The care plan did not outline strategies to support Mr B and did not include a safety plan. It was completed on non-CPA documentation and focused on Mr B's accommodation needs after

[31] Clinical Risk Assessment and Safety Management Policy, EPUT, ratified July 2019

[32] Clinical Risk Assessment and Safety Management Procedure, ratified July 2019

discharge into the community. A safety plan should be a co-produced, personalised plan that includes practical ways to help keep a person safe. This should include strategies that are known to help the person during times of distress, details of people or services to contact during a crisis, or reducing access to means to harm oneself. EPUT's CPA procedure sets out that the care plan should include a contingency plan. None of this happened in Mr B's case.

4.19 With Mr B's consent, the risk assessment and care plan could have been shared with others who were involved in his care so that they were aware of how they could support him in times of distress. This did not happen.

4.20 Mr B's risk assessment was updated on 14 December 2022 by his care coordinator. This risk assessment had more information and included information relating to the increased risk as Mr B was more mobile and would be able to act on his plans.

4.21 However, the risk assessment was still incomplete. There was no reference to the potential impact of his MS diagnosis on his risk as there is a link with impulsivity. Mr B had himself disclosed in July 2022 that he sometimes acted impulsively. There was no reference to the need for support for the flashbacks Mr B was suffering following his attempt to end his life.

4.22 The document identifies that Mr B was at risk of suicide, deliberate and accidental self-harm, falls, risk of injury to self through moving and handling, and risk of or actual perpetrator of domestic violence. For the risk of domestic violence, it was recorded that no safeguarding referral was made because Mr B did not want to disclose information about his previous relationship breakdown. There was no record of how the risk to his child was considered.

4.23 Protective factors were identified as his child, his mother, and that Mr B wanted to return to his previous job and to maintain regular contact with his care coordinator. The NSPCC[33] advises that "*A child should not be seen as a 'protective factor' in the treatment of a parent with a mental health problem, as this does not sufficiently recognise the child's needs or safety."*

4.24 The final summary of risk notes that Mr B was taking antidepressant medication, which was not preventing his suicidal thoughts, and that due to these suicidal thoughts and intent, Mr B had been referred to psychology "*where he may benefit from a good recovery to reduce his thoughts*."

4.25 Risks were not formulated in line with national guidance. No safety plan was produced.

Updating risk documents

4.26 There are no records which indicate that there was a consideration of the anniversary of Mr B's first attempt to end his life. When risk incidents happened, these were not recorded in Mr B's records and did not lead to a review of the EPUT risk assessment or a multidisciplinary review of care.

4.27 As noted previously, BMH night staff discovered (on 27 April 2023) that Mr B had bought paracetamol for the pain he was experiencing during the night. Mr B told staff that he had bought paracetamol off the internet.

4.28 BMH staff took several actions on 28 April 2023:

- raised a safeguarding concern with the local authority about Mr B purchasing paracetamol, refusing to hand it over and declaring that he would end his life after he was discharged
- highlighted that Mr B had capacity, could leave the home at any time, and could access his bank account
- set out that Mr B had a plan to end his life when he left BMH
- emailed the council informing them that Mr B needed a mental health assessment by an AMHP
- agreed with Mr B, and updated his risk assessment related to suicide, to include that he must open all packages in front of staff

[33] Parents with a mental health problem: learning from case reviews, NSPCC, 2023

- informed Mr B's mother, with Mr B's consent, about the incident and that he had agreed to open all packages in front of staff

4.29 Although the risk assessment at BMH was updated, it did not include actions that would mitigate all the risks such as purchasing paracetamol when he went out, nor consider other risks within the home or when he left the home. The risk assessment and management plan could have been strengthened if there had been support and input from the mental health team.

4.30 In response to the safeguarding referral, Southend City Council contacted EPUT via the safeguarding email address to ask whether Mr B was known to EPUT mental health services. EPUT safeguarding confirmed that he was known to them and asked the council to share the referral. Once received, EPUT told the local authority that the safeguarding concern would be case managed by the team involved rather than through a safeguarding process. They informed the council of this decision and said they had copied in the relevant mental health team (the access team) "*for their information and urgent action.*" The council closed the safeguarding enquiry. There was no record of the outcome of the case management.

4.31 Staff we spoke with at EPUT were not aware of this incident. The contact was not recorded in Mr B's EPUT care records, nor in the timeline that EPUT compiled immediately after the incident. We identified the contact from the local authority records.

4.32 There is no record of Mr B's risk being escalated within EPUT. BMH care records show that they were monitoring how he was feeling and daily records state that hourly checks were completed.

4.33 Following this safeguarding incident, Mr B's next contact with mental health services was on 4 May 2023. Mr B, along with his mother, attended a meeting at the Taylor Centre with his care coordinator. The record of this meeting was not entered onto the electronic record system until 31 May 2023, after Mr B's death. This is not in line with Trust record keeping standards. There is no reason recorded for the late entry or that they were being entered after Mr B had died. The record details accommodation needs only and what was needed from Mr B to complete his application for accommodation. There was no record of discussion of his mental health, any exploration of any concerns about Mr B moving out of BMH, and no discussion of the recent safeguarding incident.

4.34 This was Mr B's final contact with mental health services.

4.35 Mr B was seen by GP service 3 (Commisceo) on 10 May 2023. The focus of the appointment was his physical health problems. There was no discussion re Mr B's mental health. In interview we were told that Mr B engaged with the GP, there were no concerns about his mental health in Mr B's presentation, and Mr B did not raise any concerns.

Effective use of information from previous contacts

4.36 From previous contacts with mental health and neurology service, there was information available which could have been used to inform the development of holistic risk assessments and treatment plans.

4.37 The following paragraphs set out some of the information that was known to services.

4.38 Mr B and his mother attended the Valkyrie Surgery (GP1) on 1 April 2021 as she was concerned about his mental health and felt he needed to be cared for in a mental health hospital. Several things had happened which had led Mr B's parents and friends to be concerned, including:

- the breakdown of his marriage
- becoming homeless after leaving the family home and renouncing any claim on the marital home
- an incident in March 2021 when he was found bloodied in a hotel with black eyes; Mr B was admitted to a medical ward via the emergency department for a short period of time
- Mr B accessing his parents' bank account (access had been set up some years before) and taking money

4.39 Mr B told the GP he did not need mental health support, apologised for taking money from his parents, and said he would not do it again. The GP explained that, without his consent, and as Mr B was not at the threshold for being treated under the Mental Health Act (MHA) 1983, then mental health care could not be forced upon him.[34]

4.40 A neuropsychiatrist at South London and Maudsley NHS Foundation Trust (SLaM) wrote to consultant neurologist 1 (at KCH) on 23 April 2021, outlining an assessment of Mr B which was the result of a discussion at an MDT meeting with consultant neurologist 1 (KCH). To gather information, the consultant neuropsychiatrist had spoken with several people who knew Mr B, including his family, friends and estranged wife. The neuropsychiatrist was unable to speak with Mr B himself, as he did not answer his phone. The assessment concluded that there was no immediate risk to Mr B, but the consultant neuropsychiatrist was sufficiently concerned to draw up a plan of care which was:

- the local crisis team to visit and assess Mr B, and to take into consideration how the MS diagnosis may affect presentation
- to consider assessment for detention under the MHA, again flagging that people with frontal lobe damage (which Mr B had because of his MS) can perform well in interview and test settings, despite marked impairments in everyday life. This is known as the 'frontal lobe paradox'. The assessment should also check his plans for caring for himself as he was a vulnerable adult, with a significant risk of ending up homeless
- to suggest specific screening tools to assess cognitive function, that are sensitive to subcortical damage (such as verbal fluency checking for the presence of preservative errors, recall and attention)
- to set out a potential placement if he was detainable at the Lichman Unit[35]
- liaison with a local GP (Mr B was in Kent) to arrange assessment

4.41 The assessment concluded that there was a two-year decline in Mr B's mental state. It outlined a plan to refer to the crisis team for assessment and consider inpatient treatment in a mental health unit if needed.

4.42 Mr B was seen virtually on 6 May 2021 by a psychiatrist from the Complex Care Team at Oxleas NHS Foundation Trust who referred him for an assessment by the community mental health team, which was completed on 18 May 2021. Mr B denied any suicidal ideation, saying he had not had any since he had visited his brother in April 2021. Mr B expressed hope for the future. No risks from others were identified. Mr B shared that family and some friends felt that he had been exploited in the financial settlement he had agreed with his estranged wife. The assessment team felt he had capacity to make financial decisions. In consideration of Mr B's MS diagnosis, and in line with NICE guidance,[36] the team discussed with Mr B about appointing a lasting power of attorney[37] in the future. Mr B disclosed that he had been using cannabis for 30 years and that he continued to use it as he felt it helped with his MS symptoms. He also vaped cannabis oil with THC.[38]

4.43 The outcome of the assessment was:

- Mr B did not need escalation to crisis services.
- Mr B did not appear to require a package of care for activities of daily living.

[34] Mental Health Act (1983). This is a law that applies to England and Wales which allows people to be detained in hospital if they have a mental health disorder and need treatment. You can only be kept in hospital if certain conditions are met.

[35] a 15-bedded inpatient ward located at the Bethlem Royal Hospital. This is a specialist neuropsychiatry inpatient unit offering multimodal assessment and treatment by a multidisciplinary team of experts.

[36] Multiple sclerosis in adults: management NICE guideline [NG220]:National Institute for Health and Clinical Excellence, 2022

[37] If you are 18 or older and have the mental ability to make financial, property and medical decisions for yourself, you can arrange for someone else to make these decisions for you in the future. This legal authority is called lasting power of attorney.

[38] Cannabidiol (CBD) / Tetrahydrocannabinol (THC) vape products: CBD oil is legal to sell in the UK, and this includes the sale of CBD vape juice. However, UK law dictates that any CBD oil sold must contain no detectable THC.

- The team were to email his employer for clarity re employment status.
- A professionals meeting was to be arranged.
- Mr B was to remain in zoning[39] so that his care was discussed.
- The team would need to consider the needs of the friend with whom Mr B was staying, if they made contact.
- Initiate safeguarding process regarding potential financial exploitation relating to sale of house.
- If Mr B was to move out of the area, a transfer of care may be required, upon personality changes secondary to MS.
- Mr B remains vulnerable and short-term monitoring may be beneficial; lasting power of attorney may be a long-term measure if this is not in place already.

4.44 Mr B saw the consultant neuropsychiatrist at SLaM on 25 June 2021 following the assessment in April 2021. The assessment included all the areas outlined in the plan following the April assessment, and identified that Mr B had some cognitive deficits which could be the result of MS. The neuropsychiatrist found that Mr B's mood was much better than it had been at the time of referral and previous review. In line with good practice, the consultant neuropsychiatrist had gathered collateral information which confirmed that Mr B's mood was improved. The report states that the CMHT were to follow up with Mr B. This did not happen.

4.45 Mr B self-referred in July 2021 to the NHS Talking Therapies service provided by EPUT, Therapy for You. Therapy for You sent Mr B a letter on 17 July 2021 stating that following the recent assessment, Mr B had agreed that the service was not for him and that he was discharged from the service. We were told that Mr B was signposted to Relate. We have not seen records to confirm this.

4.46 Mr B self-referred again in October 2021 to Therapy for You. They arranged telephone/virtual sessions with a Step 2 practitioner.[40]

4.47 Therapy for You wrote to Mr B's GP surgery (GP1) on 3 November 2021 after undertaking an assessment the same day. The letter set out that Mr B had disclosed suicidal thoughts and plans in the last two weeks, which Mr B felt could be managed in primary care services. The letter went on to say that the Therapy for You practitioner had advised Mr B to attend the GP for a review.

4.48 The GP wrote to Mr B on 5 November 2021 saying "*We received a letter from Therapy 4 U. Please make an appointment to speak to a GP if you have concerns about your mental health*." There was no response from Mr B.

4.49 Mr B had a telephone consultation with GP1 on 12 November 2021 which focused on a referral to the neurologist for the treatment of his MS. There is no record of a discussion about Mr B's mental health or the antidepressant treatment and care he was receiving.

4.50 We were told, but have not seen the records, that Therapy for You tried to contact Mr B on 13 December 2021 but there was no answer. On 21 December 2021, a risk review call was booked on 11 January and as the service was unable to speak with Mr B, a text was sent to confirm the appointment. The risk review call was attempted on 11 January 2022 but Mr B cancelled it. Two further unsuccessful attempts were made to book risk review calls on 18 and 21 January 2022. On 25 January 2022, Mr B called Therapy for You and stated he no longer required input as he had opted for private treatment.

4.51 Therapy for You wrote to GP1 on 25 January 2022 informing them that Mr B was discharged as he had stated he no longer needed the service.

[39] Zoning is a system which identifies the level of support needed. Patients are split into red, amber, and green zones and are discussed to ensure management plans are in place.

[40] The Step 2 programme of NHS Talking Therapies provides a range of interventions to people with mild to moderate anxiety and depression.

4.52 Mr B had a telephone consultation with a neurologist on 25 March 2022. He was informed that he did not qualify for MS treatment under NICE guidance.[41] He was offered the opportunity to be put forward for a clinical trial which would require him to have a magnetic resonance imaging (MRI) scan.[42]

4.53 Mr B's mother called the NHS 111 Mental Health Crisis Response Service[43] on 12 April 2022 at 5.28pm. The team took Mr B's contact details and noted that Mr B had a history of mental health issues. There is no record of what action was taken or what advice was given. The section which records whether the call was passed to the crisis team was not completed.

4.54 NICE guidance sets out the importance of clear and timely exchange of patient information between healthcare professionals, particularly at the point of any transitions in care. This did not happen in Mr B's case for the care of his MS. Although Mr B was initially diagnosed with MS in 2002 and had been under the care of a neurologist for a long period, when he moved out of the area, the system in place required Mr B to be referred in by his GP, even though Mr B had been admitted to MSE in 2021 and his MS diagnosis accepted.

4.55 Between March and May 2021, Mr B was spending time in Essex and Yorkshire, staying in hotels and with friends and family. This created difficulties in providing continuity of care. He was contacting several services to get repeat prescriptions for his medication. Mr B signed a lease on a flat in Southend in May 2021 and was there until his lease ended during his admission to KCH in April 2022.

4.56 Records show that Mr B was requesting a referral to a neurologist via his GP from June 2021, which implies that his care had not been transferred between neurology services. A referral to MSE was made and subsequently rejected in October 2021, as it did not include sufficient information relating to when Mr B was diagnosed.

4.57 This led to further delays for Mr B accessing specialist support for his MS, as well as the referral having to be resubmitted. It was suggested to Mr B by GP1 that Mr B himself contact his former neurology team to assist with this. Mr B was successfully referred by GP1 and had a lumbar puncture at Barts Health NHS Trust ('Barts') in April 2022. This was the week before Mr B's first attempt to end his life.

4.58 During Mr B's inpatient stay in MSE in May and June 2022, there is no evidence staff sought to identify who was providing neurological care for Mr B or referring while an inpatient. If complex discharge guidance had been followed, this could have been acted upon. The referral to social services for placement did not include information about Mr B's MS diagnosis.

4.59 The delay in mental health input was flagged by GP1 who also contacted the mental health services to alert them to Mr B's need for mental health input. Similarly, the prosthetics team highlighted the lack of care coordinator on 11 August 2022, and the lack of neurology consultant for MS care, and no MS specialist nurse involvement. In view of Mr B's identified risk, the receiving community consultant psychiatrist requested that Mr B have a care coordinator who was skilled at managing people with complex needs.

4.60 It is clear that different organisations had information that would have helped those involved in his care produce person-centred risk assessments and care plans. Mr B's long-term use of cannabis was not explored and considered in his care plan, or any potential impact if he were to stop using it. The thorough review by the SLaM neuropsychiatrist and the Oxleas Complex Care Team also contained information that would have helped those involved in his care to better understand and respond to his risks.

[41] Siponimod for treating secondary progressive multiple sclerosis Technology appraisal guidance Reference number:TA656, National Institute for Health and Clinical Excellence, 2020

[42] Magnetic resonance imaging, is a non-invasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles, and blood vessels.

[43] EPUT's adult crisis mental health phone line is available 24 hours a day, 365 days a year and is accessed by calling 111 and selecting the option for mental health crisis for immediate and specialist support.

5 CPA

5.1 The Care Programme Approach and EPUT's policy for its implementation set out how care should be organised. This includes regular reviews, at least every six months, to assess whether the care is meeting the needs of the patient. Mr B was under the care of several services between April 2021 and May 2023. There are examples where transition between services worked well and examples where Mr B's moving between addresses led to difficulties for him accessing services.

5.2 During his admission at MSE, Mr B was low in mood, hopeless, and unhappy to have survived the attempt to end his life. He disclosed that he was experiencing flashbacks of the incident which were very distressing. Multiple sclerosis had already prevented Mr B from participating in the sports that he enjoyed, such as golf. The loss of his leg, and injuries to his hands, meant Mr B could not imagine living independently again.

5.3 The MHLT consultant psychiatrist was involved in Mr B's care for a short period of time before he was discharged into the community. They took several actions to manage Mr B's risk:

- arranged for psychological interventions to be provided by a member of the MHLT
- increased the dose of antidepressant, venlafaxine, to 150mg a day on 7 June 2022 in response to his presentation
- requested an MDT discharge meeting to agree a coordinated care plan to follow discharge
- contacted the neuropsychiatrist who had seen Mr B in 2021 to discuss care
- advocated for Mr B's preference of discharge destination

5.4 During this time, Mr B was told by the discharge team member that as he was homeless, he needed to complete his own application for accommodation. This distressed Mr B and his mother. At this point Mr B was recovering from a major operation, severely depressed and voicing his unhappiness at having survived the suicide attempt and experiencing flashbacks of the incident. He was on morphine for pain relief, was considered at high risk of another suicide attempt, and was being cared for on 1:1 observation.

5.5 Following discharge, Mr B openly shared when he was feeling low, his thoughts of suicide and what his plan was to end his life. His plan was dependent on several factors including increased mobility, moving out of BMH and living independently. The opportunity to share this information between professionals and consider how Mr B could be best supported was not taken.

5.6 We were told that the psychology team and the SRWT were based in the same building which helped with communication. However, the psychology team and the SRWT had separate meetings to discuss cases, although a psychologist would attend the SWRT meeting. Mr B was not referred to the psychology team until October 2022.

5.7 The weekly recovery and wellbeing team meeting was an opportunity to present cases and discuss with other professionals. Mr B was presented once by the MHLT on his discharge from MSE. No records are available of this meeting. A proforma for the meeting has now been produced, to ensure discussions and actions are captured.

5.8 Once the discharge destination was known, nobody involved in his care called a professionals meeting for all involved in his care (rehabilitation, neurology, BMH, mental health, social worker, occupational therapy and physiotherapy) where risk information could be discussed and shared and roles and responsibilities confirmed, and alternative approaches considered such as the use of assertive outreach/crisis teams.

5.9 This was a missed opportunity to explore what was happening with Mr B, share ideas and test out how care was being delivered and how Mr B was progressing.

5.10 Mr B attended an appointment with a community psychiatrist (CP2) on 27 July 2022. They completed a thorough assessment, including consideration of the role of MS in his presentation and concluded he was at a "*very high risk of completing suicide*", describing Mr B as "*very depressed*", and at risk of a possible manic relapse which required monitoring because of the change in antidepressant and previous history. Mr B told CP2 that when he was physically able (that is, when he received a prosthetic leg) he would try to end his life by the same method.

5.11 CP2 emailed the CMHT leads and their manager on 28 July 2022 to request that Mr B was allocated a care coordinator as soon as possible who "*sees him weekly, work with the supported accommodation and other care agencies involved so we pick up if there is any change in mobility and risks. He cannot be managed by duty only at all.*"

5.12 A care coordinator was allocated to Mr B on 1 August 2022. Mr B's first contact with a care coordinator, on 2 September 2022, was 12 weeks after he had been discharged from hospital. Mr B had not been an inpatient in a mental health service, which would have required contact from community mental health services within seven days according to the Trust's CPA procedure. He was identified as having complex needs and was at risk of repeating attempts to end his life. This was recognised and he was placed on CPA. A risk assessment was not completed until 13 October 2022, 17 weeks and 6 days after discharge.

5.13 We have seen records of two further face-to-face contacts with the care coordinator; the record of one of these contacts was completed after Mr B's death.

5.14 The CPA care was not provided in line with Trust policy and best practice:

- CPA documentation was not completed at the start of care.
- Documentation was not well completed and lacked important information.
- CPA reviews did not take place.
- Professionals meetings were not called.

5.15 These deviations from policy and best practice were not identified by assurance processes and meant that professionals were not able to meet and discuss Mr B's care and treatment plans. Had this happened, there may have been a better understanding of Mr B's risks and needs, as well as of how work was actually being done.

6 Capacity within the community health team

Care coordinators

6.1 There were several factors which impacted on the allocation of a care coordinator once Mr B was discharged into the community:

- As the liaison team did not know where Mr B was to be discharged to, and therefore which community team they would sit under, there was no opportunity to ensure a care coordinator was allocated at time of discharge.
- There was a chronic shortage of permanent, skilled, experienced care coordinators in the Southend community team, due to low retention of staff, and difficulties recruiting due to high and complex caseloads as identified in the service's risk register.
- When the care coordinator was allocated, the understanding was that Mr B's needs related to accommodation, rather than his complex needs relating to his physical and mental health needs.

6.2 Nationally, between April 2021 and June 2023, the vacancy rate for mental health nurses was between 9.2% and 10.6% with a peak of 11.7% in Q1 and Q2 2022/2023. For the East of England region, the figure was nearly double, between 17.2% and 19.4%, with a peak of 23% in Q1 2022/2023.[44]

6.3 Staffing was a risk for SRWT throughout the period this review examined. (See table 6 below). The December 2022 risk register detailed that four Band 6 (care coordinator level) had been recruited and started. Gaps in controls of the risk were identified as:

- increasing levels of complaints
- high turnover of staff
- difficult to retain permanent or agency staff
- gaps in social worker provision impacting section 75[45] provision
- poor quality agency staff meant that managers' time was taken up with performance management

Figure 6 - showing the risk score for staffing in Southend Recovery and Wellbeing Team

File name	Initial Risk Score	Current risk score	Target Timescale	Key action - Identified (Y/N)	Key actions - By when and who (Y/N)
Care Unit Risk Register MSE - July 2022 (no update Aug)	16	12	Aug-22	N	N
Care Unit Risk Register MSE - November	16	12	Aug-22	Y	N
Care Unit Risk Register MSE - December	16	12	Aug-22	Y	N
Care Unit Risk Register MSE Jan 23 NJ	16	12	Aug-22	Y	N
Care Unit Risk Register MSE Feb 23 v3	16	12	Aug-22	Y	N
Care Unit Risk Register MSE March 23 v5 SB	16	20	Sep-23	Y	Y
Care Unit Risk Register MSE April 23 v1	16	20	Sep-23	Y	Y
Care Unit Risk Register MSE May 23 v2	16	20	Sep-23	Y	Y

Source: EPUT risk register data

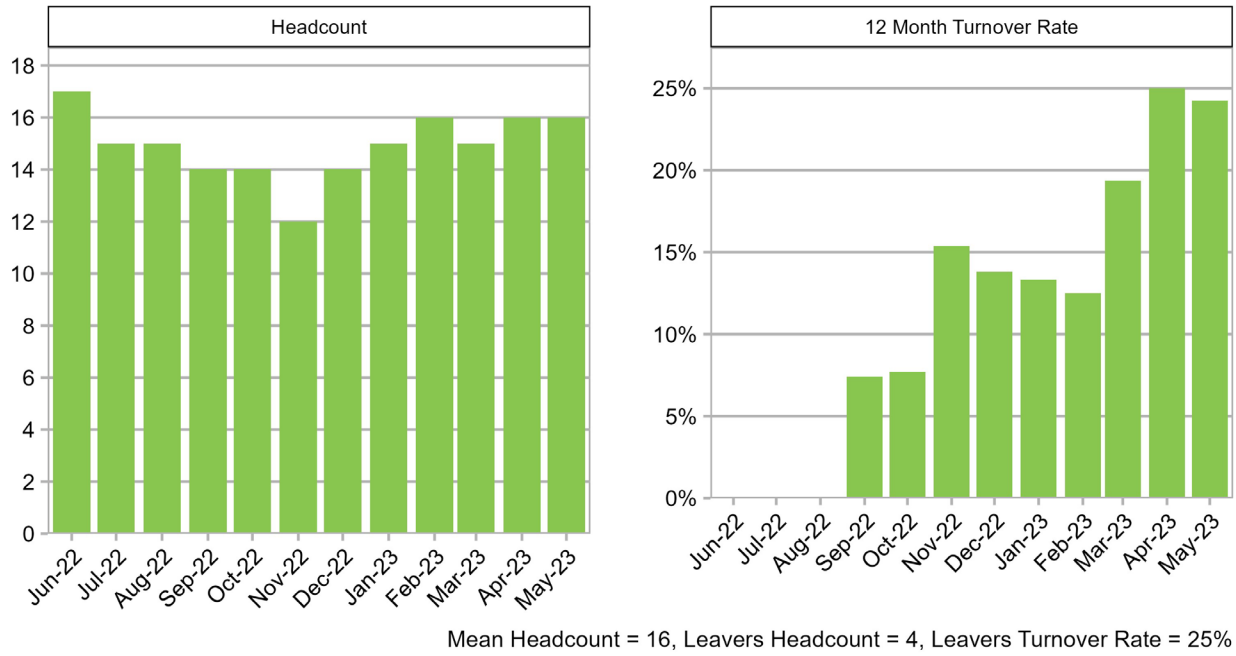
[44] NHS Vacancy Statistics England, April 2015 - June 2023

[45] Partnership arrangements made under section 75 of the National Health Service Act 2006 Act enable at least one NHS statutory body (ICBs/NHS England or NHS trusts/foundation trusts) and local authorities (LA) to collaborate across a range of the LA health-related functions and NHS health functions as prescribed within the regulations.

6.4 By May 2023, the risk score had risen to 20, with the risk entry noting that Band 5 and Band 6 staff were particularly hard to recruit and retain, with more agency than permanent care coordinators.

6.5 There were also real challenges in recruiting Band 6 agency staff. At exit interviews, staff were citing high caseloads, complex and risky cases, and an increase in abuse from patients as reasons for leaving. We heard that there were differences in caseloads between CMHTs, with Southend having the largest caseloads of up to 35 and other teams having 10. We heard that demand for the service fluctuated seasonally with a large increase of population in the summer.

Figure 7 - Showing the headcount and staff turnover rate for Southend Recovery and Wellbeing Team between June 2022 and May 2023



Mean Headcount = 16, Leavers Headcount = 4, Leavers Turnover Rate = 25%

Source: EPUT staffing data

6.6 We were told, and have seen evidence, that some people who needed a care coordinator were not being allocated one as there were not enough available. Those considered lower risk were managed by the duty team. While mitigating the risk of no contact from CMHTs, this approach does not provide continuity of care for people using services and may impact on the quality of care delivered. Mr B was seen by the duty team in July 2022, in response to his mother's call, and the community consultant identified that Mr B was too complex and risky to be managed by this approach.

6.7 Staff turnover can impact on the stability of the team and continuity of care. The risk register for SRWT identifies that there were issues with the level of performance of some staff and that performance managing those had added to the pressures on the team. High turnover increases pressure on those who must induct and support staff.

6.8 Providing training to staff is one of the ways that organisations ensure that staff have the knowledge and skills to perform effectively in role. EPUT provided care coordinator training to staff in that role, via course '364 Care Programme Approach and Co-ordinator', which needs to be completed every three years. In the current team, of 11 staff eligible, 8 had completed this training. For clinical risk, 13 of the 16 currently employed in the team are up to date with clinical risk training.

6.9 We have been unable to speak with the care coordinator for Mr B as they had left the Trust. We asked for details of whether they were substantively employed or on a temporary contract, and details of their training. This information was not provided.

Psychology

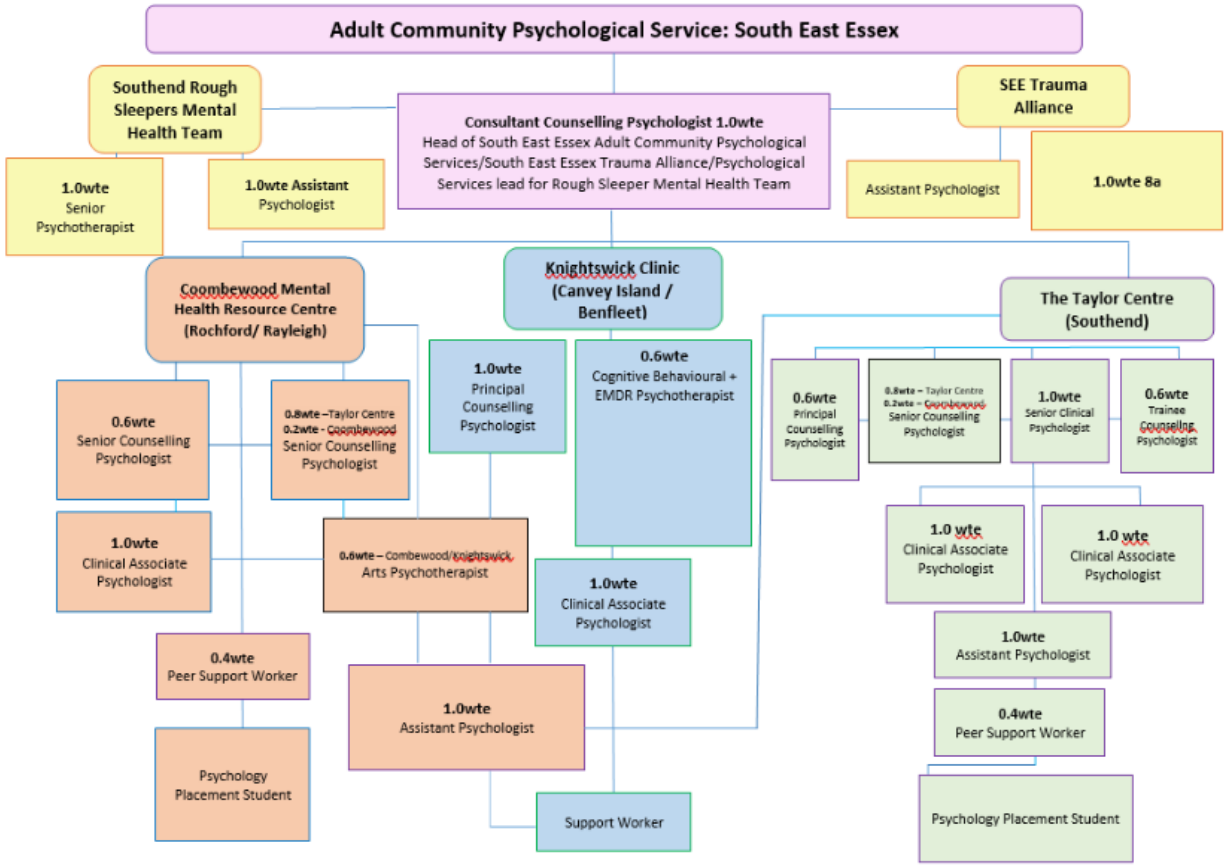
6.10 National guidance for severe depression rates treatment with cognitive behavioural therapy and an antidepressant as the most effective.

6.11 We were told that to offset the waits for psychology interventions, psychology staff provide ad hoc training to mental health practitioners to augment their skills. This did not happen in Mr B's case. There is no framework which describes which service users would benefit or what ad hoc training was available.

6.12 The Trust Board papers for May 2023 rated access to psychology as red on the Trust scorecard.

6.13 The Trust is geographically spread and is commissioned differently by integrated care systems within the Trust's footprint. We were told that in SRWT there is 0.5 of a psychologist post. Below is the psychology staffing structure provided by EPUT.

Figure 8 - Psychology staffing structure for South East Essex



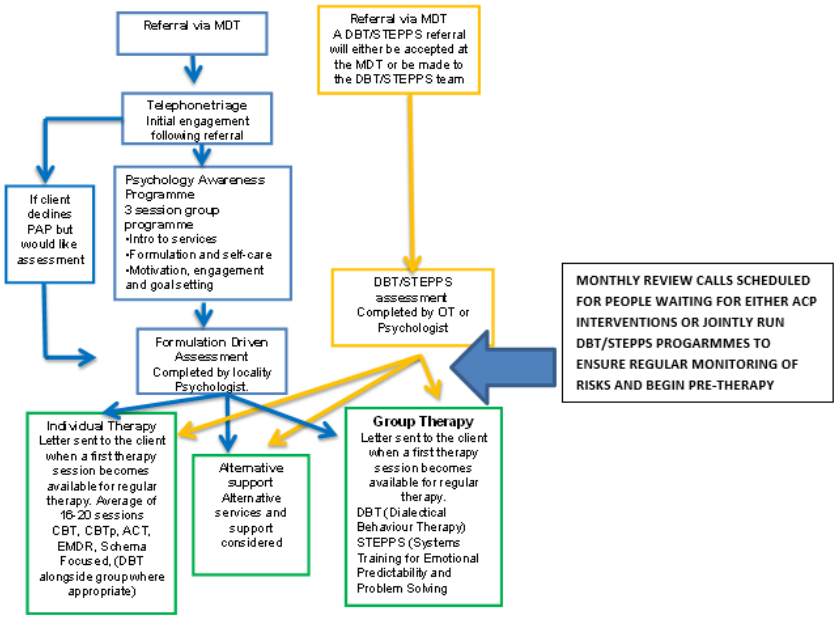
Source: Anonymised ACP East staffing structure

6.14 We were told in interview that the waiting list for individual therapy has been steady at one year, in 2023 and 2024. In May 2023, the psychology department was in the process of amending its approach to supporting people on the waiting list. They introduced monthly calls for those without a care coordinator and three-monthly calls for those with a care coordinator. We were also told that these calls were considered part of the therapeutic offer; however, there was no continuity in the delivery of the call, and this was not planned for in the updated process we reviewed.

6.15 In response to a request about waiting times and access, we were told that "*The service works to a nominal access target of being offered a first phase intervention in the form of a Psychological Awareness Group and a formulation focused specialist psychological assessment within 12 weeks of a referral being accepted."* If the person declines the PAP, they can have a formulation focused specialist psychological assessment without attending the PAP.

6.16 The diagram below sets out the routes to psychological services via an MDT referral. Mr B followed the blue route.

Figure 9 - Pathway to psychology



Source: EPUT psychology response to Niche questions document

6.17 The need for psychology was identified in a clinic letter following Mr B's appointment in 11 July 2022. The letter had not been copied to psychology.

6.18 In Mr B's case, the psychology team identified the first date of referral as 25 October 2022 via an outpatient letter to the GP, copied to the psychology team.

6.19 A letter was sent to Mr B accepting his referral on 21 November 2022. He was offered three group sessions on a virtual PAP, which started in January 2023. Mr B attended and participated in two of the three sessions. Mr B joined the third session but left, saying he was struggling with MS symptoms. The practitioner called him after the session to check on him. He asked to be referred for individual therapy and was told he would be assessed for this.

6.20 Mr B attended an individual psychological assessment in person on 27 March. Clinical features of hopelessness and low mood were reported in the context of both physical health and mental health. Clinical outcomes were repeated. Mr B scored 7/80 on the ReQoL[46] (a measure of quality of life) indicating a very low level of experienced quality of life. He scored 124/180 on the OQ45,[47] with 63 or more indicating experiences of clinical significance across the domains of mood, anxiety, risk, and functioning. Both scores were worse than those in January taken at the time of the first PAP. This assessment was written up on 7 June 2023, after Mr B's death, and therefore was not available to his wider mental health team at the time the assessment was completed. The deterioration in outcome scores was not shared with his care coordinator.

6.21 BMH contacted the SRWT duty team on 11 April 2023 to raise concerns that Mr B was distressed waiting for the outcome from his psychology assessment. They also highlighted concerns from Mr B's mother that Mr B may act impulsively. The duty worker passed the call to the ACP service who called Mr B back on the same day. They advised Mr B that his assessment was being completed and would be discussed with colleagues to develop a treatment plan. The clinician told Mr B that there would be a lengthy wait for the therapy. They told Mr B that they would continue contact with

[46] ReQoL is a Patient Reported Outcome Measure (PROM) that has been developed to assess the quality of life for people with different mental health conditions. A PROM is a questionnaire that patients complete about their health.

[47] The Outcome Questionnaire (OQ-45.2) is measures important areas of functioning (symptoms, interpersonal problems, social role functioning, and quality of life) that are of central interest in mental health.

him while he waited and offer support. In line with the process that had been put in place to support people waiting for individual therapy, this would have been three-monthly calls as Mr B had a care coordinator. The ACP noted that no immediate risks were identified "*in the context of a chronic risk profile characterised by hopelessness and fluctuating despair."* This contact was not shared with the care coordinator, or the wider mental health team.

6.22 Psychology called Mr B on 21 April 2023 to tell him the outcome of his psychological assessment. There was a discussion with Mr B about the individual therapy he was to be offered which was acceptance and commitment therapy (ACT) and/or narrative therapy.[48] The interventions that were planned were not in line with NICE guidance NG225 and NG116. Mr B appeared hesitant but accepted the sessions. He expressed concerns about waiting for the therapy to start and prematurely ended the call. This discussion was not shared with Mr B's care coordinator or other members of the mental health team.

6.23 Mr B's mother called the duty team on 25 April 2023 to express her concerns re the waiting time for individual therapy. A clinical psychology assistant gained Mr B's consent to speak with his mother and called her back. Mr B's mother highlighted her concerns about him waiting for psychological therapy when he had previously made a serious attempt on his life, and she continued to have concerns about him. She asked if Mr B could be prioritised. Alongside validating her concerns, the importance of service access being equitable for everyone with high level needs was explained. Psychology also told his mother that the wider mental health team were supporting Mr B. Mr B's mother was informed that he would have access to regular review contacts from the ACP team while he waited for therapy. Details of this contact was not shared with Mr B's care coordinator or wider mental health team.

6.24 The report of the psychology assessment was not completed and added to Mr B's clinical records until 7 June 2023, which was two weeks after Mr B's death. We were told this was due to staff sickness.

6.25 We asked about how the ACP service manages the waiting list and were told that the service "*does not prioritise some referrals above others in order to ensure parity of access for everyone accepted for a psychological intervention. This is due to everyone that meets service thresholds presenting with complex mental health needs with associated risks and impact on functioning. When somebody's needs clearly warrant additional input sooner than therapy can begin the team seeks to work closely with other professionals already involved with somebody's care. Through offering consultation and sharing recommendations for current care plan support people's psychological needs can be responded to more regularly through contacts already in place with others in the team. In addition, everybody waiting for an individual or group psychological intervention has a scheduled session with an assistant psychologist or a clinical associate in psychology every 4 weeks. These sessions support early and ongoing safety planning, pre-treatment work and consistent skilled contacts until such times that people can commence weekly sessions."*

6.26 We reviewed the process in place. There were two levels of contact, depending on whether the person waiting had a care coordinator (contact three-monthly) and those with no care coordinator (every four weeks). Mr B would have received three-monthly contact. This may not have been sufficient for Mr B as he was very worried at the prospect of waiting, as evidenced by the calls to the duty team by BMH and his mother, and Mr B hanging up prematurely when psychology called him.

6.27 Psychological therapies combined with antidepressants are the most effective treatment for severe depression. In this case Mr B was very motivated to access individual psychological therapy. Nationally, access to psychological interventions is impacted because of capacity issues. In Mr B's case, this was further impacted by:

- the delay in the referral

[48] Narrative therapy focuses on storytelling and exploring the person's past experiences, while ACT is focused more on identifying overly involved thinking patterns, enabling individuals to be more present and mindful in the moment.

- having to attend PAP before assessment for individual therapy, as the option for being assessed without PAP attendance was not offered
- no flexibility in the management of the waiting list

7 Collaborative working to deliver care

7.1 There are several factors which impacted Mr B's continuity of care:

- frequent moves by Mr B in early 2021
- the large number of teams involved in Mr B's care
- the referral process into neurology services
- lack of use of hospital's own clinical records

7.2 Prior to Mr B's first attempt to end his life, we have identified effective liaison between neurology and neuropsychiatry, which led to a timely assessment of Mr B's risks and referral, and further assessment of Mr B's needs in the community. This involved three separate services: KCH, SLaM and Oxleas.

7.3 Following Mr B's assessment by the Oxleas Complex Care Team, it was agreed that Mr B did not need further support. He moved to Southend shortly after this and his antidepressant treatment was continued by GP1.

7.4 There are several areas where the management of Mr B's depression did not match with national guidance for the treatment of depression.

7.5 During 2021 and 2022 Mr B was receiving repeat prescriptions of antidepressants from primary care services. Mr B was not asked to attend the surgery for the GP to assess whether the prescribed antidepressant was working, or to monitor any side effects that he might be experiencing.

7.6 On discharge from MSE, the second planned discharge meeting was cancelled as Mr B had already been discharged. Mr B was not referred for MS services before discharge; this impacted on collaborative working to meet Mr B's physical and mental health needs. Mr B was placed in a service where there were strong links with physical reablement services but not mental health services, which meant that there was a lack of clarity between EPUT services and BMH about how care was being provided.

7.7 Mr B was not seen by a neurologist for eight months after he was discharged from MSE. When he was seen, he was referred for specialist physiotherapy. There was no one professional identified as the lead to coordinate care for MS in line with national guidance.

7.8 There was no established structure to facilitate effective collaborative working of the health and social care professionals involved in Mr B's care, which meant that teams were working in isolation and not sharing information, knowledge, and skills effectively.

Social care setting

7.9 The assessment unit at BMH was a new model for delivery of care, designed to assist with timely discharge from acute hospital and provide reablement before people return home or go to other accommodation. There were no inclusion or exclusion criteria to ensure that the skills of the staff were matched to the needs of the people being placed. We heard of strong and effective working relationships between MSE, the council and BMH.

7.10 We were told that inclusion and exclusion criteria were not needed, as there was a process for assessing referrals, with the opportunity to accept or decline the referral. This would depend on the quality of the information provided. In Mr B's case, important information was not included in the referral to the council from MSE, including the fact that Mr B had been nursed with supportive observations while a patient, and that he was living with MS.

7.11 All people with capacity who are placed in a care home have the right to come and go as they please and this was set out in BMH policy. For security reasons, there was fob access to the care home with service users asking staff to open the door for them. We heard that Mr B frequently left the building independently, to visit family, go to the shops, and visit friends he had made in BMH.

Staff at BMH were trained in the Mental Capacity Act (MCA) and staff we spoke with were confident that if they were concerned about Mr B's mental state, they would have stopped him from going. From interviews and care records, it was clear staff knew Mr B well. When he was feeling low, he generally stayed in his room.

7.12 There was no written process for what staff needed to do when people were leaving the site. Following this incident, the service had implemented the Herbert protocol, which is a form developed in Essex and contains a list of information to help the police if the person goes missing, including: medication required, mobile numbers, places previously located and a recent photograph.

7.13 The target length of stay at the assessment unit was a maximum of six weeks (42 days), with OT, district nursing and physiotherapy provided into the service. These services had been well set up to support people, with a strong presence at BMH, which provided an effective and joined up reablement service for Mr B.

7.14 This same approach was not in place for people's mental health needs. We were told that EPUT had not been involved at the setup of the model. Records show that there was confusion among the mental health team supporting Mr B as to what BMH were able to do in relation to restricting his liberty. In the psychological assessment, it is recorded that Mr B had told the clinical associate psychologist that he was unable to act on his suicidal thoughts as he was not allowed to leave BMH unaccompanied (this was not accurate).

7.15 Mr B had been staying at BMH for 11 months at the time of his death. We were told that this was because of a shortage of suitable housing. Between June 2022 and May 2023, the average length of stay at BMH exceeded the 42-day target in six of 12 months, which reflects the challenges of facilitating discharges from BMH.

7.16 While Mr B's stay exceeded the target, he told many people that he felt safe at the service and formed good relationships with staff. In fact, he was very worried about the transition from BMH to independent living.

Primary care services

7.17 Mr B had three different GP services during his stay at BMH:

- GP1 - who he had registered with when he moved back to Southend and who kept him on their patient list until January 2023 even though BMH was out of their catchment area.
- GP2 - who Mr B was transferred to in January 2023.
- GP3 - from March 2023 when the contract for the assessment unit was transferred to them.

7.18 GP services are contracted to provide care into a residential care home, which generally has a low turnover of people and a similar range of needs. GP2, the commissioned GP service at BMH, felt that the contract did not reflect the extra support needed for the assessment unit. This was because of the high turnover of service users, with a wide range of needs, including some disturbed behaviour. They believed that the assessment unit needed a care home which provided nursing care to meet those needs and raised this with the commissioners of the service. This led to the contract for the assessment unit being moved to GP3.

7.19 The process for accessing the GP while in the assessment unit was for BMH staff to flag patients for review when there were concerns, or the GP service could initiate contact in response to contact from other healthcare professionals. There was no formal handover between services, and all had access to the electronic GP records. For GP3, however, there was an issue for prescribing for patients who were already open to GP2. There was a system to overcome this, but it involved extra effort for repeat prescriptions.

7.20 These changes in GP services could have led to Mr B's difficulty in sharing how he was feeling, but there is no evidence of that, with Mr B able to tell primary medical services staff during reviews how depressed he was and what his plans were. While all three services escalated concerns, there is no

evidence that they checked that the concerns were responded to. None of the GP services requested a professionals meeting or spoke with the community consultant. While GP3 recorded that they spoke with a member of staff at the Taylor Centre in April who instructed them to increase Mr B's mirtazapine dose to 45mg, there is no record of who was spoken with, and there was no follow up to check how Mr B was responding to this change.

7.21 Primary care services were the healthcare professionals who had most regular contact with Mr B during the period of this review. There were examples of processes in place which increased workload for all, and impeded access to services.

7.22 Communication between GP services and EPUT generally happened by email, with EPUT sending clinic letters with actions for GPs, usually relating to medication changes and monitoring. This communication was never followed up to see if actions were taken or to seek GPs' views of Mr B's presentation.

7.23 It would have been helpful in this case if GPs had requested further input from mental health services and requested a professionals meeting. This would have provided the opportunity for all professionals to be clear on their roles and responsibilities in relation to Mr B's care.

Neurology

7.24 Once Mr B was accepted by neurology services when back in Southend, neurologist 2, who is based at Barts, was responsive, providing advice and seeing Mr B quickly. There was an example where GP2 and GP3 and neurology worked together effectively to access services and support Mr B to agree to have an MRI. Neurologist 2 also referred Mr B for specialist physiotherapy.

7.25 The transfer of neurology care was not managed effectively at discharge by MSE so as to prevent loss of contact and reduction of care for Mr B.

7.26 Mr B had been receiving neurology input since his diagnosis with MS in 2002. When he moved to Southend, his care provider changed. In July 2021, Mr B requested that GP1 refer him to neurology. In November 2021, Mr B requested again that GP1 refer him to neurological services. GP1 explained that the referral had been completed but rejected as it did not contain enough information. A referral was accepted in early 2022, when he was seen by neurologist 2. He was informed that he did not qualify for treatment with medication but could be put forward for inclusion in a clinical trial.

7.27 Mr B attempted to end his life in April 2022. There is no record of neurological service input when Mr B was repatriated to MSE. There is no record that Mr B's change of address to BMH was shared with the neurology service provider. There is no evidence that a person was identified to coordinate Mr B's MS care in line with best practice. This could have been supported by the care coordinator, but there is no evidence that the care coordinator acted upon the request from consultant psychiatrist 2 to liaise with neurology services. There is no evidence of contact between neurologist 2 and mental health services. This was a missed opportunity for ensuring that the care being provided considered the impact of MS as well as his mental health needs.

7.28 BMH records show that GP1 referred Mr B to neurology in October 2022 and that he was waiting for an MRI scan. In December 2022, the SD1 sent a clinic letter following a psychiatry appointment stating that the GP was to investigate a follow-up appointment for neurological care for Mr B.

7.29 Mr B was referred to neurology in January 2023 by GP2 who had taken over his primary care. Neurology provided advice for treatment of MS symptoms to the GP within a week of contact and arranged a clinic appointment for Mr B. He was seen in clinic in March, where he declined an MRI which was needed for inclusion in a clinical trial. Neurologist 2 arranged for specialist physiotherapy and copied in the specialist MS nurses to the letter.

7.30 The neurologist wrote to the GP to update after clinic. GP3, who were now providing primary care services into the assessment unit at BMH, followed up with Mr B. GP3 talked to Mr B and explored with him why he did not want an MRI scan, which Mr B said was because he felt claustrophobic in the scanner. GP3 suggested that there may be an opportunity to have the scan under sedation. The discussion was followed up on May 10 when Mr B agreed to have the MRI.

7.31 Mr B failed to attend an appointment with the specialist neurology physiotherapists on 28 April 2023. The physiotherapist tried to contact Mr B two weeks later to follow up his non-attendance, but Mr B did not answer the call.

7.32 The systems in place to manage transfer of care for Mr B's neurological care were not efficient and were not person-centred. This led to delays in accessing specialist care and delays over administrative processes for busy referrers to navigate. Once accepted by the service, care was responsive and supportive, with evidence of effective working with GPs. There was a missed opportunity for mental health services and neurology to share information and work together to support Mr B.

8 Record keeping

8.1 Records were not always completed accurately. Mr B's discharge assessment did not include all the required information, including information related to his MS diagnosis, that he had been cared for on continuous observation and that his dose of antidepressant had been doubled shortly before discharge.

8.2 Risk assessments and care plans were not completed in line with Trust policy. Not all prompts were responded to and not all risk information was included. See EPUT risk assessment paragraphs 4.16 to 4.28 for further detail.

8.3 We heard that when Therapy for You wrote to GP1 to inform them that Mr B had suicidal thoughts which he felt could be managed in the community, GP1 was not clear on what was being asked. GP1 did try and contact Mr B. Since this date, GP1, who reported a positive relationship with mental health services, said they had raised the issue with EPUT and letters that they received now made clear what action they were required to take.

8.4 Contact notes were taken at the time of the psychological assessment for individual therapy, but did not include all the information, such as the Quality of Life scores that had decreased. The report for the psychological assessment was completed ten weeks later, which was two weeks after Mr B's death. The assessment did note that it was completed after Mr B's death. There was no comment on the decrease in Quality of Life scores since the January assessment undertaken by psychology.

8.5 GP3 recorded that they had spoken to the Taylor Centre, where SRWT was based, in April 2023 and were advised to increase the dose of mirtazapine for Mr B. The record did not include the name of the doctor who gave the advice. There was no record of the discussion in EPUT records.

8.6 Contact notes from Mr B's last meeting with his care coordinator on 4 May 2023 were not completed until 31 May 2023. It was not noted within the entry that the notes were being made after Mr B's death. The care coordinator had emailed Mr B on the morning of 30 May 2023, requesting further information for his housing application, which had been requested on 10 May 2023. The care coordinator was informed of Mr B's death by police later that morning.

9 Impact of COVID-19

9.1 For most of the period of the review, COVID-19 policies relating to different ways of working were no longer in place. Mr B had struggled personally during lockdown.

9.2 We heard, and records have shown, that Mr B was seen in person as well as virtually during 2021. Following his first attempt to end his life, Mr B had all mental health clinic appointments face to face. In contrast, PAP was delivered virtually, as was Therapy for You. Mr B's assessment for individual therapy was face to face. It is documented throughout his contacts with psychology services, at Therapy for You and at PAP, that he expressed a preference for face-to-face contact.

9.3 Ward reviews at BMH by primary care services were face to face.

9.4 There is no evidence that COVID-19 impacted on how Mr B's care was delivered. Psychology services are the service who provided most services virtually, and Mr B's personal preference was not responded to.

10 Conclusion

10.1 Mr B was a middle-aged man, with many factors which placed him at high risk of a further suicide attempt. Following his first attempt to end his life, he was placed in an assessment unit in a care home which was set up to provide reablement for up to 6 weeks before moving to permanent accommodation. Mr B ended up living at the care home for 11 months.

10.2 There were multiple services involved in Mr B's care, however the potential network that was available to support Mr B was not effectively used to meet his needs:

- There was no community psychiatric nurse input.
- There was no mental health occupational therapy input.
- Recovery support workers were not engaged in his care.
- Crisis teams were not used when Mr B became more distressed.
- CPA was not used effectively to bring together all those involved in his care.

10.3 Healthcare professionals worked in silos, without the benefit of roles and responsibilities being clearly defined and understood. There was a belief that Mr B's emotional needs were the responsibility of psychology alone.

10.4 Silo working meant that the residential care home staff were left to manage the day-to-day risks. They raised concerns via a safeguarding concern, but this was not dealt with effectively and nobody had oversight of the response. When concerns were shared with psychology, these were not shared further.

10.5 Mr B's care illustrates the importance of effective MDT working and effective systems for oversight of the quality of care. This would have flagged up when risks were escalating, and when care was not being delivered in line with policy; and it would have allowed for holistic consideration of the impact of the care on Mr B, by placing him at the centre of care.

Appendix A - Terms of Reference

Independent Investigation into the Care and Treatment received by Mr B Trust Ref: E239434

Background to the Independent Investigation

In May 2023 Mr B left the residential home where he had been living at 07.45 hrs. Mr B was noted to get into a taxi, which staff noted was not the normal routine, residential home staff attempted to contact Mr B on his mobile however there was no answer.

The family reports that they were not informed by the care home that Mr B had gone missing until midday. They suggested they call the taxi company to find out where he had gone. They told them what taxi company they normally used and gave them the contact details. The destination was Orpington where Mr B had made a previous attempt at ending his life, the home also contacted Essex Police.

British transport police informed Mr B family and the residential home that Mr B had taken his own life that morning.

Purpose of the Independent Investigation

- To independently assess the quality of the NHS and Local Authority care and treatment provided against best practice, national guidance, and organisational policies.
- To identify opportunities for learning that may be applicable on a local, regional, or national basis.
- Preliminary gathering of information to develop a timeline was undertaken by Mid and South Essex Integrated Care Board, Essex Partnership University NHS Foundation Trust, Commissioners and Primary Care Services. Due to the large number of services involved the Mid and South Essex Integrated Care Board have asked NHS England to commission an Independent Investigation into the care and treatment of Mr B.
- This investigation will focus on the care, treatment, communication between services, discharge arrangements, and availability of services within Essex, Kent, and London.

Terms of Reference

- The following Terms of Reference have been reviewed at the formal initiation meeting and agreed with the family.
- Compile a full chronology from 2021 of Mr B's contact with the following.
  - Mental Health
  - Primary Health Care
  - Acute Hospital
  - Neuropsychiatry
  - Local Authority services including residential home
  - Police forces including British Transport Police
  - Any further services that may come to light, across the localities of Essex, Kent, and London to determine if healthcare needs and risks were fully understood
- Review the risk assessments and management plans of Mr B held by all organisations along with mitigations to manage any physical and mental health risks presented.
- Review discharge planning from both London and Essex acute hospitals in line with Provider Guidance, National Policy, and best practice including referrals and/or re-referrals into appropriate physical and mental health community-based health and local authority services.

- Review the quality of inter-service liaison, communication, decision making and planning between organisations - did collaborative working take place for the totality of care provided.
- Review the availability of services able to support Mr B in the community and determine whether there were any missed opportunities to engage, listen to and support Mr B.
- Review the appropriateness of the care and treatment of Mr B in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review any impact that the Covid-19 Pandemic may have had on the care and treatment provision.
- The family have asked for the investigation to explore why the staff did not ask Mr B at the time where he was going, rather than attempting to contact him after he left.
- Involve the family to the extent of the family's wishes, in liaison with Essex Partnership University NHS Foundation Trust Family Liaison Officer and other identified support organisations.
- Provide a written report to NHS England that includes measurable (SMART) and sustainable recommendations for the providers, integrated care boards, local authorities, and NHS England as appropriate.
- Produce a learning document, suitable for sharing with other providers both regionally and nationally on the key learning from the investigation.

Timescale

- The investigation process starts when the investigator receives the Provider(s) documents, and the investigation should be completed within 6-9 months thereafter.

Initial steps and stages

- NHS England will:
- ensure that the family is informed about the independent investigation process and understand how they can be involved, including influencing the terms of reference
- arrange an initiation meeting between the trust, health and local authority commissioners, investigator, and other agencies who are involved in this investigation
- scope if any safeguarding statutory investigation is underway and consider bringing into scope of wider independent investigation

Outputs

- NHS England will require monthly updates and these to be shared with the ICB and provider(s).
- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations that have been coproduced with the effected organisations, having been legally and quality checked, proofread, and shared and agreed with participating organisations and the family (NHS England style guide to be followed).
- At the end of the investigation, to share the report with the Provider(s) and meet Mr B's family to explain the findings of the investigation.
- If required, presentation of the investigation report to NHS England, ICB and Provider Boards and to staff involved in the incident. Delivery of learning events/workshops for the Provider(s), staff, and commissioners if appropriate.
- A briefing document of key learning points that can be shared with the Regions, and the wider NHS.

Appendix B - Documents reviewed

We have reviewed a wide range of documents from the services involved in Mr B's care. This included care records, communications, policies, and procedures. A full list is available on request.

Appendix C - Detailed chronology of Mr B's care and treatment

April 2021 to April 2022

Mr B and his mother attended GP1 on 1 April 2021 as she was concerned about his mental health and felt he needed to be cared for in a mental health hospital. Several things had happened which had led Mr B's parents and friends to be concerned, including:

- the breakdown of his marriage
- becoming homeless after leaving the family home and renouncing any claim on the marital home
- an incident in March 2021 when he was found bloodied in a hotel with black eyes and was admitted to a medical ward via the emergency department for a short period of time
- Mr B accessing his parents' bank account (access had been set up some years before) and taking money

Mr B said that he did not need mental health support, apologised for taking money from his parents and said he would not do it again. The GP explained that, without his consent, and as Mr B was not at the threshold for being treated under the MHA, then mental health care could not be forced upon him.[49]

A neuropsychiatrist at SLaM wrote to consultant neurologist 1 (at KCH) on 23 April 2021, outlining an assessment of Mr B which resulted from a discussion at an MDT meeting with consultant neurologist 1. To gather information, the consultant neuropsychiatrist spoke with several people who knew Mr B, including his family, friends, and estranged wife. The neuropsychiatrist was unable to speak with Mr B himself, as he did not answer his phone. The assessment concluded that there was no immediate risk to Mr B, but the consultant neuropsychiatrist was sufficiently concerned to draw up a plan of care which was:

- the local crisis team to visit and assess Mr B, and to take into consideration how the MS diagnosis may affect presentation
- to consider assessment for detention under the MHA again flagging that people with frontal lobe damage (which Mr B had because of his MS) can perform well in interview and test settings, despite marked impairments in everyday life. This is known as the 'frontal lobe paradox.' The assessment should also check his plans for caring for himself as he was a vulnerable adult, with a significant risk of ending up homeless
- to suggest specific screening tools to assess cognitive function, that are sensitive to subcortical damage (such as verbal fluency checking for the presence of preservative errors, recall and attention)
- to set out a potential placement if he was detainable at the Lichman Unit[50]
- liaison with a local GP (Mr B was in Kent) to arrange assessment

The assessment concluded that there was a two-year decline in his mental state. It outlined a plan to refer Mr B to the crisis team for assessment, and to consider inpatient treatment in a mental health unit if needed.

Mr B was seen virtually on 6 May 2021 by a psychiatrist from Oxleas NHS Foundation Trust. They referred Mr B for an assessment by the complex mental health team, which was completed on 18 May 2021. Mr B denied any suicidal ideation, saying he had not had any since he had visited his brother in April 2021. Mr B expressed hope for the future. No risks from others were identified. Mr B shared that family and some friends felt that he had been exploited in the financial settlement he had agreed with his estranged wife. The assessment team felt he had capacity to make financial decisions. In consideration of Mr B's MS

[49] Mental Health Act (1983) This is a law that applies to England and Wales which allows people to be detained in hospital if they have a mental health disorder and need treatment. You can only be kept in hospital if certain conditions are met.

[50] a 15-bedded inpatient ward located at the Bethlem Royal Hospital. This is a specialist neuropsychiatry inpatient unit offering multimodal assessment and treatment by a multidisciplinary team of experts.

diagnosis, and in line with national guidance, the team discussed with Mr B about appointing a lasting power of attorney in the future. Mr B disclosed that he had been using cannabis for 30 years and that he continued to use it as he felt it helped with his MS symptoms. He also vaped cannabis oil with THC.

The outcome of the assessment was:

- Mr B did not need escalation to crisis services.
- Mr B did not appear to require a package of care for activities of daily living.
- The team were to email his employer for clarity re employment status.
- A professionals meeting was to be arranged.
- Mr B was to remain in zoning so that his care was discussed.
- The team would need to consider the needs of the friend with whom Mr B was staying, if they made contact.
- Initiate safeguarding process regarding potential financial exploitation relating to sale of house.
- If Mr B moved out of the area, a transfer of care may be required, upon personality changes secondary to MS.
- Mr B remains vulnerable and short-term monitoring may be beneficial; lasting power of attorney may be a long-term measure if this is not in place already.

Mr B saw the consultant neuropsychiatrist at SLaM on 25 June 2021, following the assessment in April 2021. The assessment included all the areas outlined in the plan following the April assessment, and identified that Mr B had some cognitive deficits which could be the result of MS. The neuropsychiatrist found that Mr B's mood was much better than it had been at the time of referral and previous review. In line with good practice, the consultant neuropsychiatrist had gathered collateral[51] information which confirmed that Mr B's mood was improved. The report states that the CMHT were to follow up with Mr B. This did not happen.

Mr B self-referred in July 2021 to the NHS Talking Therapies service provided by EPUT, Therapy for You. The NHS Talking Therapies programme was developed by NHS England to improve the delivery of, and access to psychological therapies for depression and anxiety disorders.[52] Therapy for You sent Mr B a letter on 17 July 2021 stating that following the recent assessment, Mr B had agreed that the service was not for him and that he was discharged from the service.

Mr B self-referred again in October 2021 to Therapy for You. They arranged telephone/virtual sessions with a Step 2 practitioner.[53]

Therapy for You wrote to Mr B's GP surgery 1(Valkyrie) on 3 November 2021 after undertaking an assessment the same day. The letter set out that Mr B had disclosed suicidal thoughts and plans in the last two weeks, which Mr B felt could be managed in primary care services. The letter went on to say that the Therapy for You practitioner had advised Mr B to attend the GP for a review.

The GP wrote to Mr B on 5 November 2021 saying "*We received a letter from Therapy 4 U. Please make an appointment to speak to a GP if you have concerns about your mental health*." There was no response from Mr B.

Mr B had a telephone consultation with GP1 on 12 November 2021 which focused on a referral to the neurologist for the treatment of his MS. There is no record of a discussion about Mr B's mental health or the antidepressant treatment and care he was receiving.

[51] Collateral information is information gathered about a patient's mental health history, their presenting problems, and how they usually are, from other people who know the patient.

[52] https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

[53] The Step 2 programme of NHS Talking Therapies provides a range of interventions to people with mild to moderate anxiety and depression.

Therapy for You wrote to GP1 on 25 January 2022 informing them that Mr B was discharged as he had stated he no longer needed the service.

Mr B had a telephone consultation with a neurologist on 25 March 2022. He was informed that he did not qualify for MS treatment under NICE guidance. He was offered the opportunity to be put forward for a clinical trial which would require him to have a magnetic resonance imaging (MRI) scan.[54]

Mr B's mother called the NHS 111 Mental Health Crisis Response Service on 12 April 2022 at 5.28pm. The team took Mr B's contact details and noted that Mr B had a history of mental health issues. There is no record of what action was taken or what advice was given. The section which records whether the call was passed to the crisis team was not completed.

Mr B tried to end his life and sustained life-changing injuries on the morning of 13 April 2022. He was admitted to KCH for emergency treatment and surgery. KCH referred Mr B to the MHLT from SLaM in line with NICE guidance (National Institute for Health and Care Excellence, 2022a).

The SLaM liaison team assessed Mr B and created a plan of care for him, which included:

- 1:1 supportive therapeutic observation where Mr B was continuously observed by nursing staff to reduce the risk of self-harm
- a change of antidepressants from duloxetine[55] 60mg to venlafaxine 75mg once a day
- lorazepam[56] (a medication for anxiety) was changed to clonazepam[57]

Mr B was receiving patient-controlled analgesia (morphine) which Mr B said was also helping with his anxiety.

When Mr B was medically optimised and his transfer to MSE was agreed (as this was nearer where he was living at the time of the incident) SLaM MHLT proactively contacted the EPUT liaison team to provide a handover of care to the team. This was good practice.

25 May 2022 to 27 May 2023

Mr B was admitted to MSE on 25 May 2022. The doctor who admitted him recorded that no discharge letter from KCH came with him. However, there were nursing records from KCH in the case records provided. The MHLT had shared information about Mr B with the new liaison team prior to his admission.

Mr B was seen by the MHLT team on 25, 26 and 30 May 2022.

The surgical team caring for Mr B assessed him as medically optimised for discharge on 29 May 2022. This meant Mr B no longer needed care in an acute setting.

On 1 June 2022 there was a meeting with those involved in Mr B's care, in line with national guidance. This included representatives from the discharge team, the ward, the surgical team, and the MHLT. The record made by the MHLT details the MDT decision that Mr B did not require inpatient mental health care and that his mental health needs could be met in the community. It was noted that Mr B was not engaging with nurses and rehab at the hospital "*due to lack of motivation*." These notes record that Mr B's preference was to be admitted to an inpatient rehabilitation facility.

The plan was:

- discharge team to contact social services for interim placement

[54] Magnetic resonance imaging, is a non-invasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles, and blood vessels.

[55] Duloxetine is a medication used to treat depression and anxiety.

[56] Lorazepam belongs to a group of medicines called benzodiazepines. It's used to treat anxiety and sleeping problems that are related to anxiety.

[57] Clonazepam belongs to a group of medicines called benzodiazepines. It's used to control seizures or fits due to epilepsy, involuntary muscle spasms, panic disorder, and sometimes restless legs syndrome.

- refer to inpatient rehabilitation
- not for psychiatric admission/community psychiatric care to be provided on discharge
- current medication to be monitored but not increased yet as there are other factors involved
- care package to be put in place on discharge
- to meet again the following week on 8 June 2022
- continue to provide psychological support while on admission

In the plan there was no record of any discussion about:

- the risks to Mr B
- the 1:1 supportive observation that was in place, and whether they would need to continue post-discharge

A note made by the discharge team states that there was a brief discussion with the consultant psychiatrist about Mr B's mental health needs and that they said that Mr B "*has suicidal thoughts but is not at immediate risk because of that*." They also suggested an inpatient rehabilitation bed for Mr B as his main concerns were mobility and discharge destination. Mr B was homeless at this point. The discharge coordinator informed Mr B of the plan.

On 2 June 2022, there was a ward round by the trauma team who noted that the discharge team nurse informed them that Mr B "*does not meet the criteria for placement as he has full capacity and needs to sort his accommodation issues himself. She will inform mental health team to withdraw one on one supervision as he is not a high risk patient and cannot be discharged if that is still in place*." It continued that the family members would be given contact numbers to "*sort his accommodation*" and that social care would only intervene if they were unsuccessful.

Supportive 1:1 observation continued and noted that Mr B was distressed at times, low in mood and experiencing spasms in his leg.

On 4 June, records show that there was no registered mental nurse to carry out 1:1 observation on the day shift. This was escalated, and the risk mitigated as the Mr B's bed was in front of the nurse's station. Mr B's mother told staff that she was not happy that Mr B had to find his own accommodation and that she did not believe that he had capacity to do this.

There is no record of a discussion or assessment by a professional of Mr B's capacity. On the night of 4 June, Mr B told the registered mental health nurse (RMN) providing 1:1 observation that he would rather not be here and wished that he could go to sleep and not wake up. The RMN offered reassurance and said that there was support for him.

Mr B told a nurse on 6 June 2022 that his mood was "*very low*". The RMN recorded that Mr B appears low in mood, no suicidal ideation, and unhappy with the discharge plans shared with him by the discharge team. There was no entry in the notes re the visit by the discharge team.

The council agreed on 7 June 2022 that Mr B was eligible for services under the Care Act 2014[58] and that he would be placed on the discharge to assessment pathway.

Mr B was seen by a member of the MHLT on 7 June 2022, following two failed attempts the day before, as Mr B had been asleep when they had visited. Mr B's mood was described as low, he was experiencing intermittent suicidal thoughts, felt helpless and unsupported in the hospital and he "*regrets not dying*." He repeatedly said "*I don't want to be here*" as he felt his situation was impacting his mother's health. The lack of clarity about his discharge was also causing him concern. Two rating scale scores (PHQ9[59] score of 24

[58] Care Act 2014

[59] It is a tool used to monitor the severity of depression and response to treatment.

and GAD[60] score of 16) both indicated Mr B was experiencing severe depression and anxiety. Risk to self was noted as low "*as there is no intent or plan at the moment. However, he continues to express suicide ideas.*" The notes continued that Mr B lacked motivation to do anything as he was preoccupied with on getting into a rehabilitation ward and starting walking school. Mr B's appetite and sleep were poor. The plan was for the OT to speak to Mr B re plans, and increase his antidepressant venlafaxine from 75mg once a day to 150mg once a day.

The planned MDT to discuss discharge on 8 June was postponed until 10 June.

Mr B had 1:1 supervision overnight from an RMN on 8 June 2022.

On 9 June, it was decided to discharge Mr B to BMH, a care home. Discharge to assessment was a new model of care for the council and Southend Care Ltd. The model was that people would be placed on the assessment unit at BMH for up to six weeks. While there, their active rehabilitation would be supported by OT staff and physiotherapy provided by council staff, and their medical needs met by a GP service.

Mr B was discharged from MSE on 10 June 2022.

Mr B was accepted for care coordination by the SWRT on 14 June 2022, following a referral from MHLT because of "*ongoing suicidal thoughts with plans to end his life as he is able to move, severe depression and a role for multiagency coordination*."

Mr B's first contact with the CMHT was on 7 July 2022 when he was seen by the duty team. This was instigated following contact from Mr B's mother who was concerned about Mr B's suicidal thoughts. The duty team completed a mini mental state examination (MMSE). His risk was rated as high. There is no record of actions taken at that time in response to the assessed risk, other than telling BMH staff about his low mood and thoughts of suicide.

Mr B attended an appointment with CP2, a community consultant psychiatrist on 27 July 2022. They completed a thorough assessment, including consideration of the role of MS in his presentation and concluded he was at a "*very high risk of completing suicide*." They described Mr B as "*very depressed*," at risk of a possible manic relapse which required monitoring because of the change in antidepressant and his history. Mr B told CP2 that when he was physically able (i.e. when he received a prosthetic leg), he would try to end his life by the same method.

CP2 emailed three CMHT leads and copied in their manager on 28 July 2022 to request that Mr B was allocated a care coordinator as soon as possible who "*sees him weekly, work with the supported accommodation and other care agencies involved so we pick up if there is any change in mobility and risks. He cannot be managed by duty only at all."*

CP2 wrote to GP1 and copied to the care coordinator (though none yet allocated), that Mr B was to be referred to psychology. It does not state who is to refer.

CP2 acknowledged that there was a staffing crisis and referred to an MDT meeting where the mental health liaison psychiatrist (MHLP1) had presented Mr B's case, shortly after his discharge to BMH. CP2 highlighted that there was no current plan of care for Mr B after being assessed as high risk by the duty team on 7 July 2022, and he had not been seen by mental health services since.

CP2 was sent a letter on 4 August 2022 stating that a care coordinator had been allocated and would attempt to contact them in the next two weeks for handover of care. The letter requested that if CP2 or Mr B had not heard from the care coordinator within two weeks, they should contact the duty team.

CP2 sent a letter to the GP on 9 August 2022, copied to the care coordinator, outlining the plan of care which involved treatment with antidepressants, close monitoring of Mr B's risks by the care coordinator including 'high mood' and for a referral to psychology. The care coordinator was to confirm with the care home that they were supporting Mr B with taking medications and checking for side effects.

The care coordinator saw Mr B for the first time at BMH, accompanied by a healthcare assistant, on 2 September 2022. The care coordinator had contacted BMH to ask for Mr B's contact number to arrange.

[60] This is a tool used to measure level of anxiety.

This visit took place four weeks after they were allocated Mr B and not in line with the request from CP2 who had asked for weekly visits and close monitoring of Mr B's mobility as his risk would increase when he became more mobile.

The care coordinator spoke with a member of the OT staff first and then with Mr B. The member of staff detailed Mr B's progress and how much he enjoyed walking school and that the BMH physiotherapist was going to go to walking school with Mr B the following week so that they could learn how to support Mr B with his mobility. They shared that Mr B had been visited by his child and his mother twice. The care coordinator noted that BMH was under the impression that Mr B was going to transition to a rehabilitation unit. The notes record that there was no rehabilitation place for Mr B, but it is unclear whether this was shared with him or BMH staff.

Mr B described the progress he had made in his mobility and being able to transfer into wheelchair independently. He shared that he was not able to focus on the future, but he was well supported by his family and friends. He described the guilt he felt towards his child after what his first attempt to end his life.

Mr B's mood was described as euthymic, which meant Mr B was displaying a normal range of emotions. Risk was identified as "*none presenting at this time*." The plan was recorded as:

- Keep in regular contact with his care coordinator.
- Keep working with walking school.
- Try to get more visits from therapy dogs (staff member had said Mr B had enjoyed the visit).

The care coordinator had the contact number of Mr B's mother and reminded Mr B that if he felt distressed, he could call the duty team, or if out of hours, he could contact the NHS Helpline 111.

Mr B was seen in outpatient clinic by a psychiatrist at the Taylor Centre on 26 September 2022. Records show that Mr B was eating and sleeping well, identified things which helped his mood and talked about how he spent his day. He described a great relationship with his child, that he had seen his sister-in-law and his child, and talked about his business. He had no thoughts of self-harm "*but stated that 6 weeks ago it was much different from now.*"

Mr B disclosed that he had smoked cannabis at the weekend and asked the doctor not to inform BMH. The doctor discussed the risk of impact on his mental health that smoking cannabis could have, and he said it was a one-off thing and he would not do it again.

The plan was for:

- a referral to psychology (via the clinic letter being copied to them)
- medication to be always supervised by his accommodation and to stop clonazepam
- care coordinator to monitor closely, due to risk, and liaise with neurology and prosthesis team
- review again in 12 weeks' time

A clinic letter was sent to the GP, copied to the care coordinator and to psychology as a referral.

The care coordinator completed a risk assessment using the EPUT form for patients on a CPA 'Assessment of Safety and Risk Issues' on 13 October 2022. This was sparsely completed, lacked detail, and failed to respond to the prompts in the form about using the person's own words and about consideration of risk factors, such as any well-formed suicide plans and preparation, hopelessness, chronic physical illness, and pain. Under summary of risk, they recorded "*Living alone after discharge due to loneliness and falling*."

The summary of Mr B's risk formulation was one sentence referring to Mr B having visitors, which potentially was a protective factor.

Carers at BMH described Mr B's mood as low at the start of November 2022.

A member of the OT staff contacted the care coordinator via email on 10 November 2022 to raise concerns about Mr B's low mood. Carers had found Mr B on the floor. They informed the care coordinator that Mr B had shared "*suicidal thoughts*" and spoken to them "*about wanting to be dead. He feels at a loss and cannot see himself 1 leaving Brook Meadows and 2 Fending for himself independently."*

They reported that Mr B was making progress with his mobility and had an appointment at the prosthetic clinic on 16 November 2022. They stated that Mr B had been trying to contact the care coordinator for several weeks and requested a call to Mr B that day from the care coordinator or the duty counsellor.

The care coordinator recorded that they tried to contact Mr B and BMH without a response. They spoke with Mr B's mother who said that Mr B was OK. The care coordinator asked her to inform Mr B that they would contact him the following day at 10am. There is no record of the call or any other actions relating to the information shared. The risk assessment was not updated.

According to BMH records, Mr B mood fluctuated in November 2022, with periods where his mood was recorded as low. There was no recorded contact with his care coordinator. His mood improved at times when he spent time with other people in the assessment unit, talking and watching TV, and in response to support from care workers.

Mr B's risk assessment was updated on 14 December 2022 by his care coordinator. The document identified that Mr B was at risk of suicide, deliberate and accidental self-harm, falls, risk of injury to self through moving and handling, and risk of or actual perpetrator of domestic violence. For the risk of domestic violence, it was recorded that no safeguarding referral was made because Mr B does not want to disclose information about his previous relationship breakdown. There is no further detail.

Protective factors were identified as his child (who was under 16), his mother, and that Mr B wanted to return to his previous job and to maintain regular contact with his care coordinator.

The final summary of risk noted that Mr B was taking his antidepressant medication, but this was not preventing his suicidal thoughts, and that due to these suicidal thoughts and intent, Mr B had been referred to psychology "*where he may benefit from a good recovery to reduce his thoughts*."

There was no safety plan included, no risk management plan, and no evidence that this was shared with others involved in Mr B's care.

Mr B was seen in clinic by SD1 at the Taylor Centre on 20 December 2022. He had attended thinking he was seeing a psychologist when the appointment was with a psychiatrist, SD1. Mr B was informed that psychology would call him over the telephone for a triage assessment.

The doctor noted that Mr B has thoughts of suicide two to three times a week and had no immediate plan or intent to act on these thoughts. He was experiencing flashbacks in relation to his previous attempt on his life. It was noted that he felt "… *he can keep himself safe while at the care home and looked after by staff but has thoughts that he will attempt to repeat the suicide attempt if he is physically able to do so.*" Mr B had been attending walking school, practising with his prosthetic leg, but was frustrated by falls. Mr B requested an increase in medication. The doctor made a plan:

- to increase the dose of mirtazapine from 15mg to 30 mg at night
- to request prioritising the psychology referral
- care coordinator to continue to monitor mental state and risk and early signs of elated mood
- care home to continue to support with activities and manage his medication
- to review in 12 weeks

Following this appointment a clinic letter was sent to the GP, copied to the care coordinator and psychology to prioritise referral.

Psychology contacted Mr B on 5 January 2023 to tell him there was a place available on the PAP which was three sessions of 90 minutes online, starting on 25 January 2023. Mr B agreed to join. He said that he would prefer face-to-face therapy.

Mr B attended the first programme as planned on 25 January 2023 and joined in the discussion. He said that he was asking for therapy and wanted to get better. Via the chat function, he shared that he preferred face-to-face appointments. No risks were identified.

Mr B attended the second PAP session on 1 February 2023. He shared that he had recognised that he needed to want to get to better, to be able to work towards his goals further. No risks were identified.

A letter was sent from the neurologist at Barts to his GP on 3 February 2023 giving advice on antispasmodic medication in response to a request they had made.

The third and final session of PAP was on 8 February 2023. Mr B joined the start of the call but as the session started, he wrote in the chat function that he had to leave as "*his MS was bad.*" A member of the psychology team called Mr B after the session and wrote that Mr B did not report any imminent risk to self or others and reported he was "*OK*" but struggling due to his MS. Mr B felt that he needed counselling and the process for this assessment was explained. He was reminded of the numbers to call in a crisis and Mr B said he had them. There is no record that this was shared with his care coordinator, or others involved in his care. Mr B was to be invited for assessment for individual therapy.

Mr B was seen by a physician's associate on 16 February 2023 in the GP weekly review at BMH. They were concerned about his low mood and suicidal thoughts, and the risk that he might act on these thoughts when he left BMH. They contacted the consultant psychiatrist and ask them to expedite the appointment, which was made for 27 February 2023.

At this expedited appointment with the consultant psychiatrist (CP) and specialty registrar (SR), Mr B shared that he thought about repeating the attempt to end his life every day and that his immobility stopped him. The specialty registrar noted that they both (the doctor and Mr B) acknowledged that this had been going on for some time and that Mr B wanted to get better. It was noted Mr B had no active intent or plans to end his life.

The plan of care was:

- increase venlafaxine to 187.5 mg in the morning
- care coordinator to continue to monitor mental state and risk and early signs of elated mood
- care home to continue to support with activities and manage his medication
- Mr B to engage in psychology as already under way (he had not been assessed for individual therapy at this point and there had been no discussion about leaving his last session of PAP)
- review in 12 weeks

A clinic letter was sent to the GP, who was no longer involved in his care, and copied to the care coordinator and psychology. Mr B's risk was identified as high, contained by being in the care home.

The care coordinator saw Mr B and his mother at BMH on 21 February 2023 to complete Mr B's application for accommodation.

Mr B was seen in clinic by a neurologist from Barts who then wrote to his GP1 (who was no longer his GP), asking the GP to increase the medication for his leg spasm, tizanidine[61] from 2mg weekly up to 8mg, and to increase mirtazapine from 15mg to 30mg (the SD1 had already increased to 30mg in December 2022). An MRI was requested, and Mr B was referred to neuro-physiotherapists at MSE. The letter was copied to specialist MS nurses at the neurology department at MSE and to Mr B.

[61] Tizanidine is a medication which is used to relax muscles. It relieves spasms, cramping, and tightness of the muscles caused by medical problems, such as multiple sclerosis or certain injuries to the spine.

BMH care notes documented that Mr B was having trouble sleeping and complaining of pain and spasms in his legs throughout March 2023. His mood as mainly described as low.

Southend Council followed up the housing application being completed by the care coordinator on 13 March 2023, as Mr B was no longer receiving reablement input, which meant that he was in a position to move on. Mr B's risk assessment was not updated, although Mr B had repeatedly told of his plans if he was to leave the care home. No CPA or professionals' meeting was planned. There is no record of this being discussed with others involved in his care.

Mr B's mother raised concerns about Mr B's low mood and his leg spasms with BMH staff on 15 March 2023, who arranged for him to be reviewed in the GP ward round the following day. At this review, there is no record of what the view was of Mr B's mood, but it was noted that Mr B was under mental health services and receiving counselling (he was not). It was noted that Mr B's dose of venlafaxine was 150mg a day which had been increased to 187.5 mg on 14 March 2023 following the instruction from the psychiatrist.

Mr B had a telephone call with psychology on 17 March 2023 as part of his assessment for individual therapy. No risks were identified, and a face-to-face appointment was arranged for 27 March 2023.

Mr B was seen again during the GP weekly review on 23 March to discuss the changes in medication suggested by the neurologist. It was noted that mirtazapine had already been increased to 30mg. Mr B agreed to the changes. There is no record of discussion about his mood.

Mr B attended his psychology assessment for individual therapy on 27 March 2023. Mr B disclosed that he had thoughts of suicide every day. He was in pain, which was affecting his sleep. Mr B identified a goal of wanting to live and to live a normal life, although understood that there were physical barriers in the way of this. He was unable to identify what would have to change for him to want to live. Mr B completed two questionnaires to rate his functioning (Outcome Questionnaire OQ-45[62] and ReQol-20[63]). His scores had worsened in both since he had completed them before his first PAP session. This was not reflected in the notes. The impending anniversary of his first attempt to end his life is not discussed with Mr B or identified in the records as a significant date. This was not discussed with the others involved in his care. No professionals meeting was planned.

The plan was to discuss Mr B with the psychology team and contact him in due course.

The practice providing GP services into BMH changed on 28 March 2023. Services were now provided by GP3. Mr B had been experiencing poor sleep and pain in his legs overnight. He was reviewed by GP3 on 29 March 2023. He told the GP his mood was still low, and that he had a plan to end his life when he left BMH. He had no plan to act on this while he was at BMH. The plan was to review his mood and medication in one week.

Mr B was incontinent on 2 April 2023 and staff at BMH assisted him with a shower. His mood was persistently low, with Mr B expressing that he wished he did not wake up, and his sleep was poor.

On 11 April, two days before the anniversary of the first attempt, BMH called the EPUT duty team to share their increasing concerns about Mr B's low mood, suicidal ideation, and his mother's worries that he may act impulsively. Staff reported that Mr B had been waiting for the outcome of his recent assessment by psychology. The duty team emailed the psychology team who assessed him. There is no record that they copied in the care coordinator or consultant.

Mr B was called on the same day by psychology who explained to him that the process of discussing assessments and formulating a treatment plan can take "*a couple of weeks*." They also explained that the long Easter weekend would have impacted this further. They explained that if Mr B was to be offered

[62] The Outcome Questionnaire (OQ-45.2) is measures important areas of functioning (symptoms, interpersonal problems, social role functioning, and quality of life) that are of central interest in mental health.

[63] ReQoL is a Patient Reported Outcome Measure (PROM) that has been developed to assess the quality of life for people with different mental health conditions. A PROM is a questionnaire that patients complete about their health.

therapy, he would be placed onto a lengthy waiting list, but that they would be happy to explore with him about what might be helpful for him in the meantime, for example coping strategies.

Mr B was reviewed by GP3 on 12 April 2023. Mr B was very low in mood, experiencing pain in legs and poor sleep. GP3 recorded that they had contacted mental health services at the Taylor Centre who had advised them to increase the dose of mirtazapine to 45mg. It was noted that the Taylor Centre were arranging therapy for Mr B. The details of who GP3 spoke with was not recorded in either the GP or EPUT records.

13 April 2023 was the first anniversary of Mr B's first attempt to end his life. Mr B continued to experience poor sleep and pain in his legs throughout April. On 17 April Mr B was assessed by the neuro-physiotherapists and given some exercises to help reduce leg spasms.

Psychology informed Mr B on 21 April 2023 of the outcome of his assessment and that he had been placed on the waiting list for 1:1 intervention. Mr B agreed to be placed on the waiting list (of approximately a year) but was concerned about the lengthy wait. Mr B was told he could contact psychology via his care coordinator. Mr B ended the call prematurely. This was shared with others involved in his care. No risks were identified, and he was placed on the waiting list for narrative/ACT. The report of the assessment was to follow.

The psychology team spoke with Mr B's mother on 25 April 2023 as she was concerned about the impact the long wait for individual therapy on Mr B, and asked whether he could be prioritised. His mother was worried about him because of his current presentation and previous suicide attempt. His mother was informed that people were seen in date order, and that he would get check-in calls while waiting on the list. The call finished with his mother going to check whether Mr B would consent to her speaking with his care coordinator. This call was not shared by psychology with his care coordinator.

Mr B was seen by GP3 on 25 April 2023. The focus of the review was Mr B's physical health, and they gave dietary advice and discussed Mr B's reluctance to have an MRI scan - as requested by the neurologist - due to his anxiety. The GP suggested that the MRI could take place under sedation and agreed to write to the neurologist to suggest this.

Mr B wrote to his care coordinator on 26 April 2023 to request a meeting with his mother, so that they could discuss future plans.

Mr B was distressed and in pain overnight on the 26 April 2023. Staff attended his room and discovered that he had his own supply of paracetamol from the internet. He had taken two doses of 1g that day because of the pain he was experiencing and refused to hand the medication to staff.

BMH staff updated Mr B's risk assessment on 27 April 2023 to require Mr B to open all packages in front of staff (this does not mitigate the risk of Mr B buying paracetamol when he is out on his own), they informed GP3, who requested that a member of BMH staff spoke with Mr B on the dangers of taking unprescribed medication.

BMH took several actions on 28 April 2023:

- They raised a safeguarding concern with the local authority about Mr B purchasing paracetamol, refusing to hand it over and his declaration that he would end his life after he was discharged. Within the referral they set out that Mr B had capacity, could leave the home at any time and had access to his bank account.
- They informed Mr B's mother, with his consent, about the incident and that he had agreed to open all packages in front of staff.
- A director of BMH emailed the council informing them that there was a "*pressing"* need for an AMHP/psychiatric assessment to mitigate risks to Mr B and protect the home's CQC registration.

In response to the safeguarding referral, Southend City Council contacted EPUT via the safeguarding email address to ask whether Mr B was known to EPUT mental health services. EPUT safeguarding confirmed that he was and asked the council to share the referral. Once received, EPUT confirmed that the

safeguarding concern would be case-managed by the team involved rather than through a safeguarding process. They informed the council of this decision and stated that they had copied in the relevant mental health team (the access team) "*for their information and urgent action*." The council closed the safeguarding enquiry. Staff we spoke with at EPUT were not aware of this incident. The contact was not recorded in Mr B's EPUT care records, or in the timeline that EPUT compiled. It was only detailed in the council records and emails between the council and BMH.

Mr B did not attend a physiotherapy appointment at the hospital on that day.

Mr B and his mother attended a meeting at the Taylor Centre with his care coordinator on 4 May 2023. The record of this meeting was not entered onto the electronic record system until 31 May 2023, which is not in line with record-keeping standards. There was no reason recorded for the late entry or that they were being entered after Mr B had died. The record discussed accommodation needs only and what was needed from Mr B to complete his application for placement. There was no record of discussion about his mental health or anxieties about his move, and no discussion about the recent safeguarding incident.

Mr B's sleep continued to be disturbed by pain and he was reviewed by the GP on 10 May 2023, with a focus on pain. There was no discussion about mental health or consideration of whether the raised doses of antidepressants were having an impact, detailed in the notes.

The council confirmed on 10 May 2023 that Mr B's application for accommodation had been accepted but further information relating to Mr B's financial situation were needed.

The physiotherapy department at MSE tried, but were unable, to contact Mr B and his mother on 12 May 2023 about his non-attendance at his appointment.

Mr B was reported as being more settled in mood, according to the records from BMH between 13 and 26 May 2023. He reportedly had less disturbed nights and had enjoyed visits from his mother and watching football in the lounge.

Mr B was reported as unsettled at the start of the night shift on 26 May 2023. Staff gave him paracetamol for pain, and he then settled and slept well.

Mr B was reported as being in a good mood on the morning of 27 May 2023. He asked to go out at the start of the shift and was asked by staff to wait for his medication before he left, which he did. Mr B often went out on his own, particularly at the weekend. As Mr B had capacity, and there were no concerns about his behaviour, he was allowed to go out unaccompanied. He had not talked about ending his life to staff at the care home throughout May 2023.

The care coordinator contacted the GP surgery on 30 May 2023 to tell them that they had been informed about Mr B's death.

The psychology assessment report for individual therapy was completed on 7 June 2023. The report started with a statement saying that the report was in progress and that it was being completed and uploaded following Mr B's death.

Appendix D - Glossary

ACP	adult community psychology
ACT	acceptance and commitment therapy
AMHP	approved mental health professional
BMH	Brook Meadows House
CC	care coordinator: this is a person who is assigned to coordinate care where people have complex needs. They can be a health professional or an allied health professional.
CPA	Care Programme Approach
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
EPUT	Essex Partnership University NHS Foundation Trust
GAD	generalised anxiety disorder
ICB	integrated care board
ICS	integrated care system
KCH	King's College Hospital NHS Foundation Trust
LCP	liaison consultant psychiatrist
MCA	Mental Capacity Act
MDT	multidisciplinary team
MHA	Mental Health Act
MHLT	mental health liaison team
MMSE	mini mental state examination: this is a commonly used set of questions for screening cognitive function.
MRI	magnetic resonance imaging: a non-invasive medical imaging test that produces detailed images of almost every internal structure in the human body, including the organs, bones, muscles, and blood vessels
MS	multiple sclerosis (MS): a condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation, or balance. It is a lifelong condition that can cause serious disability.
MSE	Mid and South Essex NHS Foundation Trust, which provides acute health services including surgery and neurology
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health: a research programme into suicide prevention in clinical services, which aims to improve safety for all mental health patients. It provides evidence to support service and training improvements and, ultimately, to contribute to a reduction in patient suicide rates and an overall decrease in the national suicide rate.
NICE	National Institute for Health and Care Excellence: it produces guidelines which make evidence-based, best practice recommendations. Implementing these helps to improve patient safety and reduce the risk of harm across the health system.

OT	occupational therapy
PAP	psychological awareness programme
PSIRF	patient safety incident response framework
PTSD	post-traumatic stress disorder
RMN	registered mental health nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SLaM	South London and Maudsley NHS Foundation Trust
SMART	specific, measurable, achievable, relevant, and time-bound
SPMS	secondary progressive multiple sclerosis is a stage of multiple sclerosis (MS) which comes after relapsing remitting MS for many people. With this type of MS, disability gets steadily worse.
SWRT	Southend Recovery and Wellbeing Team

Appendix E - Services involved in Mr B's care

ACP	adult community psychology service in EPUT, made up of a range of psychological practitioners who provide a specialist psychology service to adult service users
Barts Health NHS Trust	a group of hospitals which provide the neurology service into MSE
BMH	Brook Meadows House, a care home which provides residential care and assessment beds post discharge from hospital
BTP	British Transport Police, a specialised force who police Britain's railways, providing a service to rail operators, their staff, and passengers across the country
EPUT	Essex Partnership University NHS Foundation Trust, which provides several services: mental health, community health, learning disability and social care
KCH	King's College Hospital NHS Foundation Trust, which provides acute health services including surgery and neurology
MHLT	mental health liaison team: they provide mental health assessments and advice for in-patients in acute trusts. They offer advice and support to colleagues within the acute trusts.
MSE	Mid and South Essex NHS Foundation Trust, which provides acute health services including surgery and neurology
Oxleas NHS FT	Oxleas NHS Foundation Trust which provides community health care such as district nursing and speech and language therapy, care for people with learning disabilities and mental health care such as psychiatry, nursing, and therapies
PAP	psychological awareness programme, a three-week programme in a group that meets online on MS Teams. The programme covers how psychological therapy is delivered, readiness for engagement, and the variables most likely to support optimal outcomes.
SLaM	South London and Maudsley NHS Foundation Trust, which provides mental health services in London and some specialist national services
Southend on Sea City Council	the local authority responsible for funding Mr B's care
SRWT	Southend Recovery and Wellbeing Team, which provides long-term support and care planning across health and social care. The team is made up of psychiatrists, nurses, social workers, psychologists, occupational therapists, psychologists, employment specialists, and support workers.
Therapy for You	the team delivering talking therapies within EPUT

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