# Norfolk Safeguarding Adults Board Thematic Safeguarding Adults Review Malcolm and Joseph

# Improvement briefing

## What can we learn about working better together to reduce risks to citizens who may become in acute need of mental health hospital admission, given the limitations on bed availability?

### What have we learnt about ordinary work across agencies/partners in Norfolk?

Commissioning Safeguarding Adults Board: Norfolk

Independent reviewer: Dr Sheila Fish

Final 2 July 2026

# 1 Paying tribute to two much loved people

1.1.1 This Safeguarding Adults Review (SAR) is dedicated to Malcolm, a much loved father and to Joseph, a much loved son. Malcolm and Joseph did not know each other, neither do their families. They have nothing in common other than to have suffered mental health crises, meaning they required admission to an acute psychiatric hospital when none was possible.

In the time that followed, Malcom sadly took his own life. Joseph, thankfully, did not die but was impacted severely by self-neglect caused by his mental health crisis. With this SAR, we pay tribute to them both.

1.1.2 This review aims to derive systems learning from the tragedy of Malcom's death and the harm experienced by Joseph, through reviewing how agencies worked with them both preventatively in order to avoid either suffering an acute mental health crisis, and responsively when each required urgent admission to a mental health hospital but no acute beds were available.

1.1.3 The goal is to illuminate important areas where improvements are needed in order to make it easier for practitioners, clinicians and managers to manage the risks and minimise potential harms to citizens, of an insufficiency of acute mental health beds at the point of need, relative to demand, that is recognised in Norfolk as it is across the country.

1.1.4 Norfolk Safeguarding Adults Board (NSAB) and partner agencies, are then responsible for supporting and holding partners to account for the actions they take in response to the systems learning and reporting of this in the NSAB annual report.

1.1.5 As the independent reviewer, I hope this provides some assurance to both Malcom's son and Joseph's mother and wider family.

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# 2 Introduction

## 2.1 DECISION TO UNDERTAKE A THEMATIC SAR

2.1.1 Norfolk Safeguarding Adults Board (NSAB) determined to undertake a thematic SAR after receiving SAR referrals for two individuals: Malcolm and Joseph. Malcolm and Joseph did not know each other, and their lives were completely unconnected. Their circumstances and experiences were also very different in many ways. What the SAR referrals showed that they had in common was that there had not been mental health hospital beds available at points when both Malcolm and Joseph respectively, urgently needed to be admitted.

2.1.2 The coroner concluded that Malcom died by suicide while suffering from extreme distress. It was seven days after professionals requested a Mental Health Act Assessment (MHAA) in order to admit him to a mental health hospital.

2.1.3 Joseph thankfully did not die but was severely impacted by self-neglecting behaviours caused by a relapse of his paranoid schizophrenia, in the six-week period that professionals waited for a mental health bed to become available.

## 2.2 LEGAL MANDATE

2.2.1 The SAR was commissioned under Section 44 (4) of the Care Act 2014.

2.2.2 While both individuals had care and support needs, the initial scoping process did not evidence abuse or neglect as a direct cause of death / harm. However, the impact of the lack of mental health inpatient-based beds, leading to apparent issues with meeting needs while waiting for that acute care, was a significant concern. The SAR subgroup (SARG) therefore agreed to use the discretionary power under the Care Act to undertake this thematic SAR to consider these themes in more detail, to better understand the current situation and determine any system learning / action.

## 2.3 SUCCINCT SUMMARY OF BOTH CASES

### MALCOLM – TIME PERIOD UNDER REVIEW

2.3.1 Malcolm was only newly known to mental health services at the age of 72. This came about by chance due to hospitalisation for a diabetic crisis. His wife had died 18 months earlier, and 3 months earlier he had been newly diagnosed with diabetes. He was more open about his anxiety, low mood and a previous suicide attempt while at a second hospital in January 2024 due to a fall at home. Malcolm's son was also actively sharing his concerns about his father, in an effort to secure help for him. This triggered the involvement of the older people's mental health service Intensive Older Persons Service (IOPS), as well as a care package, in addition to on-going efforts by a social prescriber and care coordinator from the GP practice.

2.3.2 By February Malcolm's mental health state was declining further; he became more dishevelled, despondent, feeling everything was too much for him, sharing that he feels things are coming to an end, he had thoughts of wanting to die but was denying any plan or intent. He had become disordered and preoccupied with certain topics. Services to support his social engagement had fallen away because Malcolm did not engage and likewise a care package was in the process of being reinstated. Visits from the

district nurses were constant throughout, supporting Malcolm with his insulin administration.

2.3.3 When in March Malcolm became evidently more unwell, becoming hostile and evasive, IOPS increased visits to twice a day and requested via the Approved Mental Health Professional (AMHP) service a Mental Health Act Assessment (MHAA) with a view to urgent admission to a psychiatric hospital. The IOPS and AMHP service agreed not to progress to a MHAA until an inpatient bed was available. This was to avoid exacerbating Malcom's paranoia and risk him running away. IOPS continued to visit twice daily, and district nurses daily. Malcolm took his own life by drowning before a bed became available, seven days after the MHAA had been requested via referral to the AMHP service.

**JOSEPH – TIME PERIOD UNDER REVIEW:**

2.3.4 Originally from Yorkshire, Joseph was 48 years old and well known to mental health services with whom he had had involvement for over ten years. Joseph was supported by the Community Mental Health Team (CMHT) and funded under Section 117 to prevent mental health hospital readmission. He received regular depot injections for psychosis and had a diagnosis of paranoid schizophrenia. He also had been diagnosed with Huntingdon's disease but had no input from neurology services. His mother has always been an active, loving constant in Joseph's life. Joseph had his own flat, in a supported housing setting, for people with serious and enduring mental illness. He'd lived there for over four years. He was happy there and thriving.

2.3.5 Joseph's presentation began to change from January 2023. By May, the supported housing staff were escalating concerns to CMHT and adult social care, due to Joseph's on-going deterioration in self-care, apparent cognitive decline, engagement with staff and, by June, compliance with his medication regime. CMHT input was increased with Flexible Assertive Community Treatment (FACT) engagement. Adult social care describe trying to source residential care options, and source home care in the meantime. In July, when Joseph began appearing soiled with faeces and smelling of urine, and refusing all CMHT input including depot injections, the housing staff raised the need for a MHAA with a view to urgent admission to psychiatric hospital. CMHT anticipated a wait of four to six weeks at this point. Supported housing staff updated in his mother about the poor state that Joseph was in. Supported housing were desperate for who can help Joseph. They try to engage the GP around his physical health.

2.3.6 At the end of July CMHT requested an MHAA and, after triaging the referral, the AMHP service secure a S135(1) warrant for both the purpose of access and removal. This is not progressed because a place of safety is not available, nor inpatient bed. Almost daily contacts were made by the supported housing provider to CMHT, social care and AMHP with escalating concerns. CMHT visited every few days but was unable to gain entry to Joseph's flat, so mainly looking through the window. Joseph was increasingly soiled with episodes of aggression towards housing staff trying to support him. Joseph's family also began lobbying everyone they can think of, about how long Joseph has been waiting for admission. On 23 August the MHAA was progressed and Joseph was admitted to hospital, four and a half weeks after the referral was made to the AMHP service, requesting a MHAA.

## 2.4 A SYSTEMS BASED METHODOLOGY

2.4.1 Across multiple sectors, the evidence base suggests that a systems based approach provides the most useful learning from practice, to drive improvements. It is also reflected in the work led by the reviewer for this SAR, Dr Sheila Fish, over nearly two decades at the Social Care Institute for Excellence (SCIE) to support multi-agency safeguarding reviews in both child and adult safeguarding.[1]

2.4.2 A systems-based approach assumes that multi-agency working takes place in a complex, adaptive system. In such complexity, reviews of practice provide an invaluable opportunity to better understand ordinary practice in contemporary contexts. By this means, a systems approach uses a single case or cases to give a 'window on the system'[2] revealing how social and organisational factors, and complex systems dynamics influence what practitioners and clinicians do in direct work with citizens.

2.4.3 This approach uses the specifics of what happened and why in the index case or cases under review, to explore what is typical and usual. It moves from the 'case findings' of what went well and where engagement and outcomes were not optimum in terms of appropriateness, timeliness or quality, to draw out wider, generalisable learning about strengths and vulnerabilities in single and multi-partners social and organisational set-ups and ways of working. This wider learning can be distinguished with the terminology of 'systems findings' that identify what is enabling good practice and what is getting in the way and making it harder to achieve. These often stem from interactions between different parts and elements of our complex systems of health and care.

2.4.4 Using this methodology involves:

- Meaningful engagement with family members or equivalent
- Enabling collaboration with practitioners and managers involved at the time (Case group)
- Close working with strategic leads of involved agencies and services (Review team which in Norfolk is referred to as the Panel)

2.4.5 The approach encourages a concise, practical focus on learning relevant to improvement activity across partners and SAB assurance work

## 2.5 TERMS OF REFERENCE

2.5.1 In considering the two SAR referrals, Norfolk SARG recognised that the mismatch between availability and demand for mental health beds is a recognised systemic problem in Norfolk, as well as nationally.

2.5.2 The limited availability of mental health beds for those in acute need of admission is a well-rehearsed issue locally, as well as nationally, and one that is included as the focus of a large change programme that has been underway within Norfolk and Suffolk NHS Foundation Trust (NSFT).

2.5.3 In deciding the Terms of Reference for the thematic SAR, the SAR Subgroup wanted to avoid this review concluding with a repetition of what is already known: there is an insufficiency of beds at times they are needed. The lines of enquiry therefore focus

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[1] See: **SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews | The Learning Exchange (iriss.org.uk)**
**SCIE SAR Quality Markers March 2022 (lbbd.gov.uk)**

[2] Vincent, Charles ref

more on understanding this context, its impact and exploring how agencies might work better together in this compromised situation.

2.5.4 The questions set were:

- What is the current situation regarding adults waiting for acute mental health beds in the county?
- What is the impact (including cultural impact) on individuals, families, agencies and staff?
- Keeping the person central, what multi-agency responses can be put in place to manage risks and stop people coming to harm?
- What barriers do we need to overcome?
- What is the standard that we should aspire to?

2.5.5 The SAB is also keen that these insights are understood in the wider context and that the SAR achieves clarity about what the available data tells us.

2.5.6 The aim thereby is for the SAR to move beyond simply naming the problem of bed management and availability in acute psychiatric hospitals in order to provide partners with useful insights to inform improvement work.

## 2.6 SYSTEMS ORIENTED RESEARCH QUESTIONS

2.6.1 These are important questions that will be informed by the findings of this SAR but are not all answerable with a SAR methodology. What a thematic case review is well designed to shed light on is to reflect back ordinary practice and the conditions which produce typical ways of working.

2.6.2 These can be captured in a single, higher level systems-oriented research question, summarising the particular practice areas or 'window' (Vincent 2004) that our two cases can open onto our contemporary systems namely:

2.6.3

**Working with people who have identified mental health diagnoses or difficulties in Norfolk, meaning there is a chance they will experience, or already are experiencing a crisis that means they need urgent admission to psychiatric hospital.**

**What can we learn from Malcom and Joseph's experiences about what is helping and hindering better working together across agencies and professions in Norfolk, to support people in such circumstances, reduce risks and stop people coming to harm in a context where immediate admission to psychiatric hospital may not be, or is not possible due to waiting lists.**

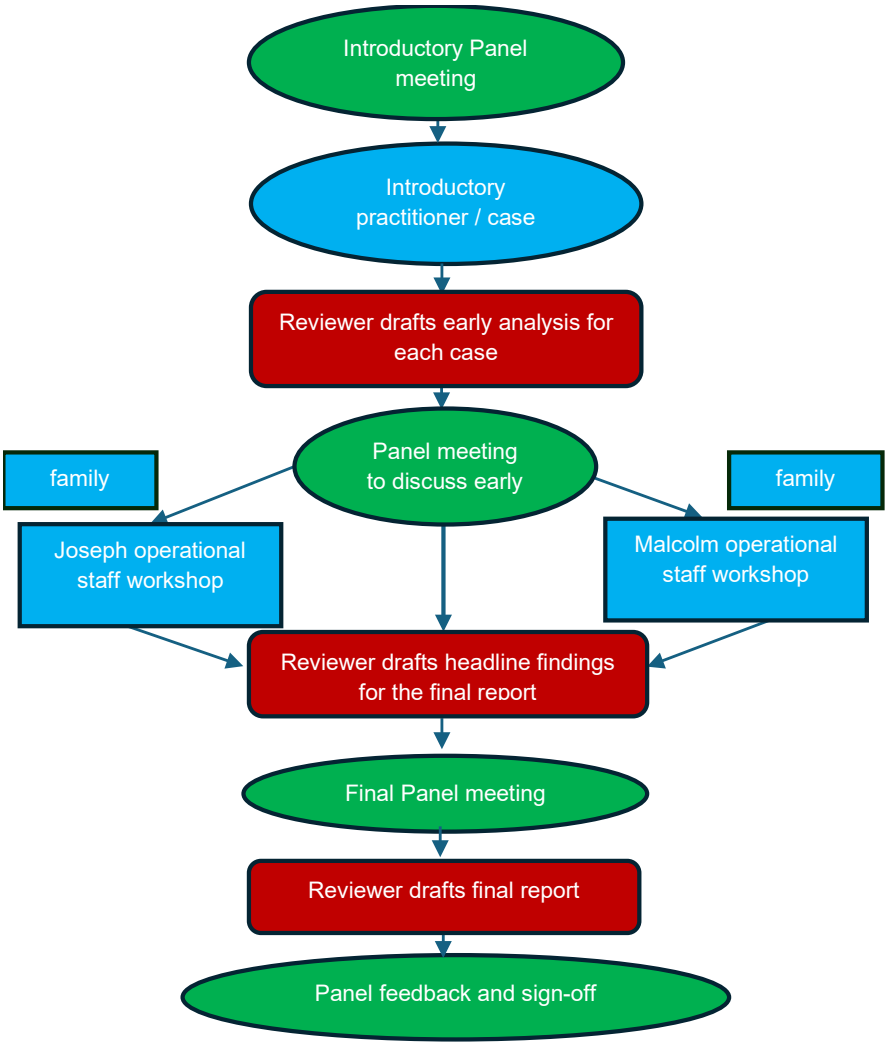
## 2.7 METHODS, TIMELINES AND PARTICIPANTS

### USING THE LEARNING TOGETHER SYSTEMS MODEL (FISH 2010) FOR A THEMATIC SAR

2.7.1 Earlier research by this author has shown that the title 'thematic SAR' is used to cover a range of different approaches. [3] The approach used here is captured in the schema below.

2.7.2 The graphic shows how that the process began with analysis and workshops with practitioners for each of the cases separately. From this basis, findings were then drawn together from both cases and presented and discussed together as systems findings related to this particular practice domain. The final report captures these systems findings and does not duplicate the case-specific analysis on which they are based.

**FIGURE 1. METHODS OVERVIEW**




[3] https://www.scie.org.uk/download/47701/?tmstv=1701249182

2.7.3 Analytically, the review has used the process and methods of the Learning Together model (Fish et al. 2010).[4] The development of Learning Together pioneered the use of a systems-based approach to reviewing multi-agency safeguarding practice. It is the most tried and tested approach to-date.

2.7.4 Practically, this means background reading of case related documentation is conducted, allowing the timeline to be divided into Key Practice Episodes (KPEs), and an early analysis of practice to be progressed. Analysing each episode in turn, in light of what has gone before (but not what comes after), is an aid to minimising hindsight bias. Early analysis of each KPE is supported with a consistent table layout, distinguishing evaluation of practice, from questions raised about the context, influencing contributory factors.

2.7.5 This early analysis then structures the multi-agency workshop per case. The aim is to involve key practitioners and clinicians who had been involved in the various KPEs, gain from them an appreciation of the 'view in the tunnel'[5] i.e. the rationale behind professional decision making and activity at the time and intended goals. In addition, the goal is to gain an understanding of the pressures and dilemmas faced on the ground.

2.7.6 The workshop is structured around the KPE analysis, allowing for those directly involved to check, challenge and amplify the detail. Discussions are anchored initially in the case and aim to then also broaden out to consider and how ordinary and usual responses seen in the case feature more commonly in everyday practice. From this evidence basis, draft systems findings are then drawn out and prioritised. They gain further check and challenge through discussion with the senior leads in the Review Team/ Panel who, ideally, bring wider evidence to bear in the refinement of these systems issues and their impacts.

### REVIEW TEAM/PANEL AND CASE GROUP

2.7.7 For this thematic SAR, a single review team/panel of strategic leads was brought together, while the 'case groups' were different for each case respectively, bringing together those who had had operational roles.

2.7.8 The Review team covered the following agencies/roles:

- East Coast Community Healthcare (ECCH), Deputy Director of Operations
- James Paget University Hospital NHS Foundation Trust (JPUH), Named Nurse for Safeguarding Children and Adults
- Norfolk & Waveney Integrated Care Board (N&W ICB), Deputy Designated Professional Safeguarding and Interim Associate Director of Mental Health, Adult Mental Health Strategic Commissioning Team
- Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), Director for Complex Health, Safeguarding and Professional Standards and Named Professional for Safeguarding Adults and MCA Lead
- Norfolk and Suffolk NHS Foundation Trust (NSFT), Head of Safeguarding Families
- Norfolk Constabulary, Community Policing and Custody
- Norfolk County Council (NCC), Adult Social Services Department, Approved Mental Health Professionals (AMHP) Team Manager

[4] **iriss.org.uk**

[5] Dekker, S (DATE) Field guide to accident investigation.

- Norfolk Integrated Housing and Community Support Services (NIHCSS), Contract Manager
- Suffolk and North-East Essex Integrated Care Board (SNEE), Designated Nurse Safeguarding Adults
- Suffolk Safeguarding Partnership. Interim Partnership Manager

2.7.9 Participation in the operational case group meetings for Malcolm and Joseph respectively, is summarised in Figures 2 and 3 below. Those teams invited but who did not attend are show in red. Difficulties faced in securing participation are noted in the methodological comment section below.

### INVOLVEMENT OF FAMILY MEMBERS

2.7.10 Family members of Malcolm and Joseph were both invited to meet with the reviewer and contribute to the review and agreed. I am incredibly grateful for the generous input from both Malcolm's son, and Joseph's mother and aunt. They both allowed me a much fuller understanding of their loved one's lives, including contextualising the time when their mental health deteriorated compared to earlier times, in a way that professional input did not. They also allowed me to appreciate their own experiences at the time, including of communication from services, as well as understanding their experiences of services subsequently.

2.7.11 The substance of their input is drawn on in appraisal of practice sections, and the presentation of the findings in the main body of the report.

### OUTCOMES FOR FAMILIES

2.7.12 When asked what they wanted from the SAR process, Joseph's mother responded promptly and clearly that she wanted two things:

- I want some sort of acknowledgement that things were not right.
- I don't want any other family to go through that.

2.7.13 Malcolm's son replied:

- This is the bit I don't want other people to go through: to learn for the first time, in an NSFT incident review report, without warning, that your loved one had been deemed sectionable under the Mental Health Act and had been on a waiting list for an emergency bed.

| **SAR family engagement points for NSAB consideration:** |
|---|
| • How will NSAB engage with both these families about how they can be given updates in response to the SAR findings and with time, assurances about change the SAR has secured?<br>• How might NSAB help Joseph's mother get the acknowledgement that she seeks about the excessive delay Joseph experienced in inpatient mental health care, and the impact on him and the wider family?<br>• How can NSAB help Malcom's son get acknowledgement of the harm caused by not having been told at the time, and the unconsidered way he was allowed to find out? |

**FIGURE 2. WORKSHOP PARTICIPANTS TEAMS/ROLES FOR MALCOLM**

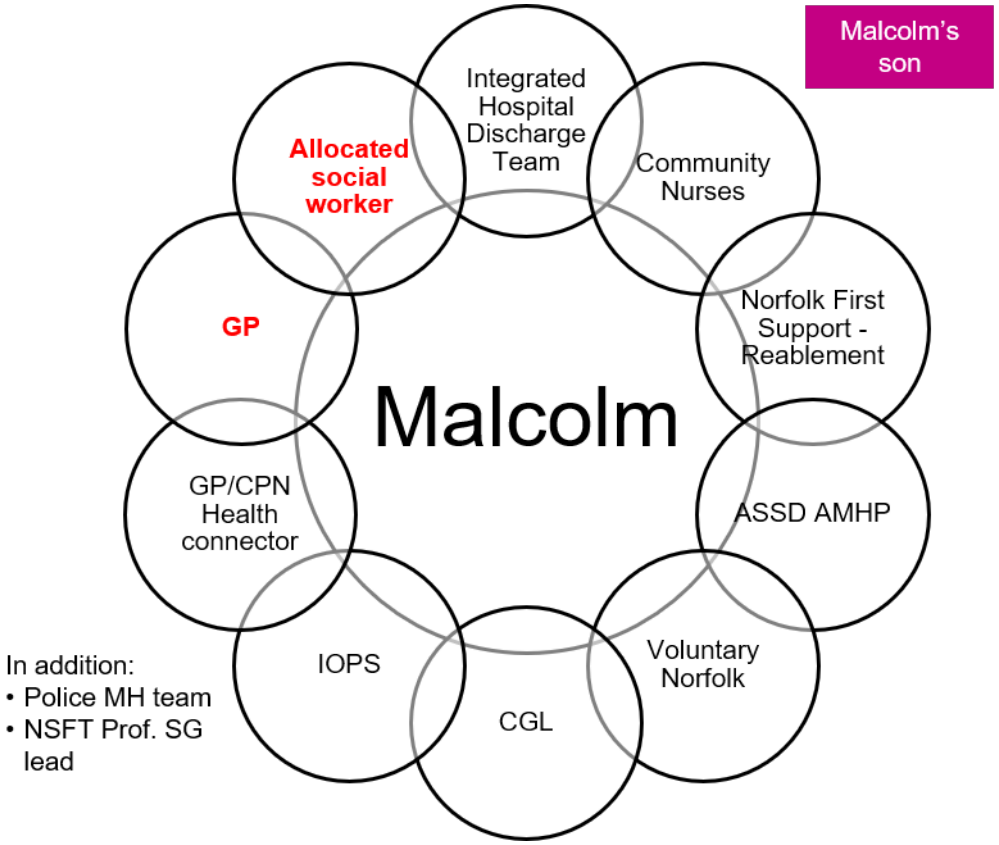
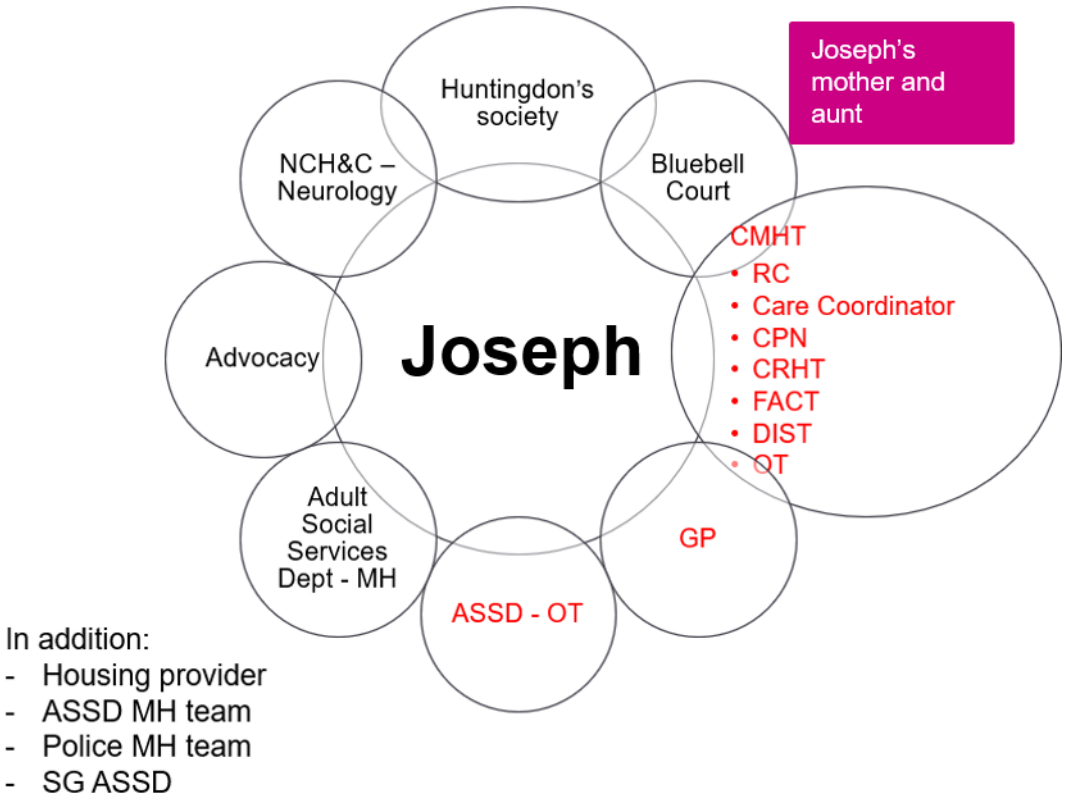



**FIGURE 3. WORKSHOP TEAM/ROLE PARTICIPANTS FOR JOSEPH**



## 2.8 METHODOLOGICAL COMMENT AND LIMITATIONS

2.8.1 The SAR process and methods have not run optimally.

2.8.2 There is useful learning to capture for reviewers as well as for SAR Business Unit / support functions about reassessing together, at the point of commissioning a proportionate review, whether the original 'data returns' that agencies submit provide sufficiently detailed information on which to base early analysis and workshops.

2.8.3 A lack of response from NSFT to requests for data toward the end of the SAR process has contributed significantly to the delay in completing the report, and outstanding gaps in understanding about the wider context of emergency mental health inpatient bed accessibility in Norfolk. Helpful senior involvement from the ICB did not follow through with support during the final requests for data.

2.8.4 Wider issues about NSFT's participation in the SAR process have been escalated via the NSAB Chair and are being dealt with separately to this report.

## 2.9 OUTLINE OF THE REPORT

2.9.1 In the next section, we turn to the substantive findings of the thematic SAR. This begins with a brief overview of the experiences of Malcolm and Joseph respectively, before setting the context and impact more widely, in line with the Terms of Reference.

2.9.2 Subsequently, the systems findings are presented. These are issues that need to be tackled in order that people who find themselves in circumstances similar to Malcolm or Joseph's, might receive a better response. They are illustrated with detail from the cases and further evidenced with wider intelligence.

# 3 OVERVIEW OF MALCOLM AND JOSEPH'S EXPERIENCES

## 3.1 INTRODUCTION

3.1.1 In this section, a brief appraisal of practice is presented of professional responses to Malcom and Joseph respectively. The articulates the independent reviewer's assessment of where practice was good and where it did not adequately address the person's needs, or was mistaken, given what was known or knowable at the time. It draws on the separate workshops that were facilitated to supplement detail from formal records, with direct input from operational staff who were or might have been involved, to establish the facts and understand something of the rationale for actions and decisions.

3.1.2 By the nature of SARs, and a thematic SAR in particular, the evaluation is not intended to be comprehensive. It aims to be targeted and sufficient to provide an initial evidence base from which to identify underlying systems findings. These findings are then presented in the following section.

## MALCOLM

## 3.2 BACKGROUND AND KEY PRACTICE EPISODES

3.2.1 The timeline for this SAR began with Malcolm's first hospital admission, early December 2023.

SUMMARY OF KEY PRACTICE EPISODES

| |
|---|
| EPISODE 1. **First hospital admission**<br>**(10-19 December 2023) 9 days** |
| EPISODE 2. **Support to Malcolm after 1st hospital discharge**<br>**(20 Dec – 11 Jan 24) 3 weeks** |
| EPISODE 3. **Second hospital admission after being found on the floor and not able to mobilise due to knee pain, and discharge planning.**<br>**(12-25 January 2024) <2 weeks** |
| EPISODE 3. **Support to Malcolm after hospital discharge**<br>**(26 Jan – 15 Feb) 3 weeks** |
| EPISODE 4. **Malcolm's mental state declines further and professional responses**. IOPS daily visits<br>**(19 Feb – 26 Feb. 7 days)** |
| EPISODE 5. **Escalation in Malcolm's presentation now hostile and evasive, IOPS decision to increase visits to twice a day and request MHA Assessment and responses to these circumstances.**<br>**(26 Feb – 03 March. 5 days)** |

## 3.3 BRIEF APPRAISAL OF MULTI-AGENCY SUPPORT FOR MALCOLM

3.3.1 *This is written in the historic present tense.*

3.3.2 Malcolm has had a very successful life, enjoying four to five holidays a year and is enjoying early retirement. He was not an easy person to get on with. He was very clever and could get people to think what he wanted. He liked to tie people in knots. Malcolm has not been known to mental health services during his life.

3.3.3 In March 2022, Malcolm's wife sadly dies. He has always relied on her to arrange the social side of their lives.

3.3.4 18 months later, in October 2023 Malcolm is newly diagnosed with diabetes. This means he has to newly manage medication (Metformin). He has been something of a 'functional alcoholic' most of his life and at this point stops drinking alcohol.

3.3.5 The timeline for the SAR looks at the deterioration that happens from this point onward, beginning with a hospital admission in December 2023. He is 76 years old at this point. It is three months since his diabetes diagnosis that he has his first hospital admission.

3.3.6 In this episode, covering the hospital admission and discharge, Malcolm's healed self-harm cuts are noted and he speaks to the Alcohol Care Team at length including about his struggle for many years with anxiety and his long history of dependent drinking. No acute mental illness is indicated as necessary at this point, so there is no referral to secondary mental health services.

3.3.7 In parallel, Malcom's son alerts social care to concerns about self-neglect and social isolation; Adult Social Care (ASC) expect these to be picked up through the hospital discharge process but they are not. Malcolm is therefore discharged after nine days, with a referral to community nursing for insulin administration twice a day but no package of care is considered or discussed with Malcolm.

3.3.8 The second episode of support over the following three weeks begins with the hospital discharge error being identified rapidly by the district nurses. However, Malcolm has now missed the fast track of the hospital discharge process and a new referral therefore needs to be made to adult social care and this is done. His GP prescribes anti-depressants, refers Malcolm to the Community Mental Health Team (CMHT) for counselling and health connectors and social prescribers visiting. None of this is effective because Malcolm wants companionship and to be taken places, and this is simply not on offer. He talks about respite care but this is not followed up. CMHT declines as they do not provide counselling and refer Malcolm on to the Wellbeing service. But they correctly identify the complexity of Malcolm's presentation, as he has recently been discharged, recently detoxed and has self-harmed, so they refer him back to CMHT.

3.3.9 After Christmas, in our third episode, Malcolm is readmitted to hospital after being found on the floor not able to mobilise due to knee pain. This is three weeks after this first hospital discharge. This time he talks much more about his earlier attempt to take his own life. He talks about feeling he cannot cope and overtly requests respite or residential care. Malcolm's son tells Mental Health liaison about the odd and paranoid thoughts his father has expressed, including believing the district nurses are just administering water not insulin as well as accusing his son of being in cahoots with mental health services to get him sectioned. Mirtazapine is restarted 20/01/2024 and, on discharge, Malcolm is referred to the Intensive Older People's Service IOPS) due to potential risk of suicide and self-harm. He is also discharged with a reablement care package. The district nurses continue to visit for wound care and insulin administration.

No partnership working is initiated at this point, to support preventative work to reduce the risk of Malcolm's situation escalating to a point where he may require inpatient admission – **this is explored further in Finding 2.**

3.3.10 The three weeks from mid-Jan to mid-February after Malcom's second discharge from hospital, forms the fourth episode. He is on antibiotics for his knee. No community support materialises because of what was requested in the referral. Malcolm's care package is cancelled because he is refusing support. This triggers a speedy Mental Capacity Act Assessment but there is then a three week wait for a Care Act assessment to re-commission a package of care.

3.3.11 Through this time IOPS visits daily. IOPS are focusing on Malcolm's symptomology in order to decide which medication needs to take priority and trying to adjust medication so that Malcolm does not feel groggy. They are working through the symptomology trying to ascertain whether his underlying issues are depression, paranoia or infection. Malcolm himself feels he is mad, psychotic and having delusional thoughts and believes he needs to be on antipsychotic medication due to his presentation. But the professional view at this point is to prioritise the low mood aspects of his presentation, not the suspicious / paranoid elements and therefore no anti-psychotic medication is prescribed. This is influenced by a misunderstanding that his wife died a year later than she actually did. His son is calling IOPS regularly, who are sharing updates with him.

3.3.12 IOPS are aware during this time that East Coast nursing are also going in but there is no real discussion across physical and mental health. Malcolm is engaging well with the district nurses, during their short visits, they find him very obliging.

3.3.13 Two months after Malcolm's first hospital admission, the last week of February, forms Episode 5. Malcolm's mental state is declining further. Now IOPS diagnosis is psychotic depression, secondary to bereavement reaction. Malcolm is started on the medication Venlafaxine but the next day he says it is giving him auditory hallucinations. IOPS try to reassure Malcolm by explaining that while this is a side effect, it will subside. IOPS note evidence of paranoia, with Malcolm saying he had thoughts of wanting to die but denying any plans or intent. He informs IOPS that he has stopped taking his medication. IOPS are noting Malcolm's presentation as remaining: low mood, anxious, paranoid, suspicious. His son calls IOPS very worried. IOPS reassures him that they are visiting daily and monitoring his mental state.

3.3.14 The final episode six covers just five days. Malcolm's presentation becomes hostile and evasive. IOPS decide to increase visits to twice daily and request a MHAA and assess risk of suicide as high. IOPS and the AMHP liaised closely and decided by mutual agreement not to progress the MHAA until conveyance to a place of safety can happen on the same day. Malcolm's paranoia about services is seen as intense. He has expressed reluctance at going to hospital. So they deem that the chances are high, that an assessment will otherwise trigger him to run away. No multi-agency meeting is called.

3.3.15 IOPS feel they have outlined the risks to Malcolm clearly, and they have updates daily as to bed management via the Admissions and Discharge Team meetings and Safety Huddles. So they felt then and continue to feel that systems of communication were working well – **bed-management processes are discussed further in Finding 4**. Their focus at this time is on encouraging Malcolm to take the medication Risperidone, because this is a quicker working medication.

3.3.16 They consider alternatives places of safety but rule them out due to Malcolm's paranoia. They also deem one-to-one staff observation as impossible for the same reason; it is likely to increase Malcolm's distress and agitation and negatively impact on this

engagement with them. For the same reason, they do not think it is a viable option to ask Malcolm's son to stay with his father, in Malcolm's house. IOPS do not tell Malcom's son that his father is awaiting a Mental Health Act Assessment or that they have assessed his risk of suicide as high - **this is explored further in Finding 3**.

3.3.17 Malcolm's son delivers shopping on Sunday 25th as he did every Sunday. But this Sunday, he leaves immediately afterwards, without going into his father's house, because his father appears very agitated when he opens the door. His son does not want to aggravate things. It is later this Sunday night that Malcolm drives his car to the Pier Hotel car park and walks toward the pier. He was found dead, washed up from the sea the next day.

3.3.18 With hindsight, Malcolm's son feels it is clear that his father's paranoia and rapid decline only started with the diabetes. The impact on him of not having been told at the time that his father was waiting for an inpatient admission, has been devastating.

## JOSEPH

## 3.4 BACKGROUND AND KEY PRACTICE EPISODES

3.4.1 The SAR selected one early timeline to understand practice linked to Joseph's early diagnosis of Huntingdon's. The main focus of the timeline for this SAR began January 2023 when cognitive deterioration was first noticed.

**Summary of KEY PRACTICE EPISODES**

EPISODE 1. **Joseph diagnosed with Huntingdon's disease and professional responses, two months after moving into Bluebell Court**

**(August 2018)**

EPISODE 2. **Virtual Care Assessment Review by ASC concludes with first talk about looking at potential residential options for Joseph**

**(January 2023)**

EPISODE 3. **Second ASC Review and first Psychiatric and pharmacy review completed, in context of cognitive deterioration and deterioration in self-care**

**(March 2023)**

EPISODE 4. **Further deterioration in Joseph's presentation, escalation of concerns by Bluebell Court with ASC and Community Mental Health Team (CMHT) and first refusals of engagement by Joseph**

**(May – June 2023)**

EPISODE 5. **Final escalation with request for Approved Mental Health Professional office to request a Mental Health Act Assessment and response (18 July – 23 August 2023)**

We are not looking at the conduct of the Mental Health Act Assessment and admission process

## 3.5 BRIEF APPRAISAL OF MULTI-AGENCY SUPPORT FOR JOSEPH

3.5.1 *This is written in the historic present tense.*

3.5.2 Joseph has a turbulent time after leaving home in his early thirties and moving from Yorkshire to Norfolk. He had always had self-soothing / stimming behaviours such as smacking his lips and pacing but had not required additional support or mental health services. With the distress caused by the breakdown of his second relationship, leading to Joseph experiencing homelessness, his mother helps him link in with a specialist housing association. Sometime later he experiences his first mental health crisis and is admitted to hospital under the Mental Health Act (MHA). Following discharge, Joseph's mental health again declines. He is again admitted under the MHA. The extent of his self-neglect and neglect of his living environment then is revealed and he loses his housing.

3.5.3 Joseph's need for supported accommodation is correctly identified and in June 2018, he moves into Bluebell Court, which provides supported accommodation for people with severe and enduring mental illnesses. Joseph has a diagnosis of psychosis and receives monthly depot injections from the CMHT. The medication regime and engagement and support from his support worker and the management of Bluebell Court are a success, and Joseph begins to have a life again.

3.5.4 Bluebell Court are regularly in touch with Joseph's mother. On finding out about a history of Huntingdon's disease in the family, Bluebell Court take the initiative of arranging for Joseph to be tested at Addenbrookes Hospital. The results are positive; he has Huntingdon's disease. While Joseph at this point is not showing any symptoms, the opportunity for psychiatric follow-up and reappraisal by his Responsible Clinician is not taken. The Responsible Clinician has not contributed to this SAR so it is unclear if this was considered. This means there is no forward planning about how his progressive neurological disease and his mental health illness might develop and interact. There is no early multi-agency plan or contingency planning to support the health, mental health and housing teams involved with Joseph. At this point, Joseph somehow also mistakenly falls out of the neurology clinic at Addenbrookes, which means he has no regular input from a neurology nurse whose expertise is key to recognising deterioration in Huntingdon's disease. The review heard of a long-standing and on-going chasm between neurology and psychology.

3.5.5 Over four and a half years later, in January 2023, Bluebell Court staff note changes in Joseph whereby he needs more support with daily living and managing his house. He is also becoming more withdrawn. The second episode of the SAR timeline begins. It is at this stage, that Bluebell Court staff note a marked decline in Joseph's engagement with the staff desk and think he has cognitively declined. They rightly trigger a care assessment review. This leads the social worker correctly to indicate that the time is approaching to consider potential residential options for Joseph. Input from neurology and Occupational Therapy (OT) is missing, and consequently so too is a professional overview of how Joseph is functioning cognitively and physically.

3.5.6 March 2023, our third episode, sees good communication between Joseph's allocated social worker and the housing support workers. Joseph's continuing deterioration is noted and the social worker agrees that Bluebell Court can no longer meet his needs. There is a delay in progressing residential accommodation options for Joseph due to the insufficiency of residential/nursing care options, who are equipped to take people

with neurological conditions and/or mental health illnesses. One placement is secured for Joseph, only for the setting to be closed down.

3.5.7 A psychiatric and pharmacy review is conducted by a Psychiatrist but does not take sufficient account of the current context of Joseph's decline, or Joseph's diagnosis of Huntingdon's disease. Later in the month, housing support staff escalate their concerns to CMHT, because for the first time Joseph's personal care is slipping and he is dishevelled and his clothes are dirty. The Responsible Clinician does not call a multi-disciplinary meeting, missing the opportunity to bring together both neurology and psychiatry. The Responsible Clinician has not contributed so it is not clear whether this was considered. At this stage, Joseph needs professionals to be thinking about his support needs in the present, as well as planning for further development of his Huntingdon's, especially given his need for anti-psychotic medication to avoid his mental health deteriorating. Assessments of Joseph's mental capacity around medication and self-care are pressing, given there are early indications of self-neglect in terms of hygiene and the episodes of forgetfulness he is now having around his medication.

3.5.8 Instead, Bluebell Court staff are directed to make a referral to Joseph's GP for Speech and Language therapy (SLT) and OT. The GP then rejects both of these applications in the mistaken assessment that the need was not clinically indicated. Input to this SAR indicate that the structure for accessing SLT is difficult and multiple attempts at referrals are often needed. No professionals escalate concerns about professional responses at this point.

3.5.9 Episode Four begins in May 2023. Bluebell Court staff's concerns continue to increase, especially now that there is an increase in times when Joseph is missing his medication. They rightly raise the need for an assessment of Joseph's mental capacity with adult social care as well as with CMHT. The CMHT review misinterprets Joseph's presentation as an issue of care needs, that they see as falling to adult social care to attend to. There is a missed opportunity to do a joint assessment of Joseph's mental capacity around personal hygiene and also around taking his mental health medication. ASC's usual practice is to conduct capacity assessments single agency and the newly qualified, Additional Support Year in Employment (ASYE) social worker is given a very precise task to complete and does not look beyond this. In addition, ASC relationships with one CMHT are well established, but Joseph is under another CMHT where adult social care do not have any personal relations to fall back on. As a result, Joseph's declining mental health and medication management is not sharply in view by those with mental health expertise.

3.5.10 The social care MCA assessment correctly deems Joseph does not have capacity around his self-care, but a significant delay follows in getting to a Best Interests Decision. This is caused by their trying to get an advocate involved, in line with Joseph's wishes.

3.5.11 No-one involved calls a multi-disciplinary meeting, even though it is approaching half a year since housing support staff began to be very worried about Joseph and ASC agreed that residential care options were now a priority. Concerns about self-neglect are noted in clinical records and Joseph starts to become non-compliant with his anti-psychotic medication but this does not trigger a multi-disciplinary meeting to be called - **this is explored further in Finding 2.** A stepped-up care provision is agreed from

Flexible Assertive Community Treatments (FACT) but the purpose of their support calls remains unclear to everyone involved.

3.5.12 Episode Five is the final episode in our timeline, beginning mid-July 2023. It begins with strong concerns about Joseph's deterioration being raised by housing staff with ASC and CMHT. For the first time, Joseph is smelling of urine and his trousers are soiled with faeces. They raise the need for a MHAA with CMHT but are told that there are no beds available for four to six weeks – **the on-going insufficient availability of mental health inpatient beds is discussed further in Finding 1**.

3.5.13 Over this five and a half weeks, between 18 July and 23 August, Joseph is seen not eating, only drinking alcohol, not taking his medication or allowing the antipsychotic depot injection to be administered, wearing the same soiled trousers, urinating and defecating on the floor of his flat. At this stage, a legal basis to intervene needed to be found in a timely fashion, to protect Joseph from the impact of self-neglect, and address the apparent relapse of his mental illness and impact of resultant self-neglect.

3.5.14 Housing support staff keep trying to engage with Joseph and encourage him to eat, change his clothes and take his medication. Joseph is increasingly soiled, and there are episodes of aggression towards housing staff trying to support him.

3.5.15 The CMHT Duty worker calls the AMHP services to request a Mental Health Act Assessment on 27 July. This is triaged and a s135(1) warrant is obtained on the following day, 28 July. There are no timescales for it to be executed because there is currently no place of safety i.e. Health Based Place of Safety or acute bed. On 30 July CMHT request an inpatient bed, while awaiting a place of safety to become available.

3.5.16 Despite the initial indication from CMHT of how long the waiting time might be, this is not revisited by CMHT or the AMHP service, in terms of the implications for Joseph. While the Crisis Resolution and Home Treatment (CRHT)/CMHT continue to have daily oversight of bed allocations and prioritisations, a multi-disciplinary meeting is not called to review, risk assess and consider options in light of the potential month or more that professionals can anticipate that Joseph may be waiting. Clinical leadership is not obvious at this point of crisis.

3.5.17 Bluebell Court are increasingly desperate, seeking out other partners who might work with them to help Joseph. They reach out to Joseph's GP, to police, to ambulance all to no effect because Joseph is not voluntarily allowing anyone into his flat. The supported housing staff are raising concerns almost daily with social care, safeguarding, CMHT and AMHP service. Joseph's family are incredulous. They also desperately reach out to everyone they can in a concerted campaign to try to escalate Joseph's situation and the increasing risks he is facing. They are worried he is going to die. **The gap of a system-wide escalation policy is raised in Finding 4.**

3.5.18 CMHT staff are visiting daily but Joseph will not let them in and engage voluntarily, and no Plan B is considered other than waiting for a bed to come free. Additional support from FACT similarly. Other attempts to escalate within mental health services create a circular loop between the CRHT and CMHT to no meaningful effect.

3.5.19 Joseph's mother continues to share her concerns and chase for updates. Supported housing provider likewise. They are not invited to contribute to the regular bed management meetings, to inform risk assessments and prioritisation of patients in the waiting list. **This is explored further in Finding 4.** On 23 August, resource of a psychiatric bed/place of safety is identified and the AMHP service is able to execute the warrant and conduct the Mental Health Act Assessment, and Joseph is admitted to an acute inpatient mental health ward. Joseph is emaciated, catatonic and the smell coming from him is overwhelming from faeces and urine, dried through into the fabric and his feet.

# 4 SYSTEMS FINDINGS

## 4.1 OVERVIEW OF SYSTEMS FINDINGS

4.1.1 Through this SAR we have identified and prioritised four systems findings. These are issues that make it harder for practitioners and clinicians to work together effectively to prevent and/or to respond to times of crisis for citizens with mental health problems, in a context where there is no guarantee that an inpatient bed will be immediately available.

**FIGURE 4. OVERVIEW OF SYSTEMS FINDINGS.**



## 4.2 FINDING 1 - AN ON-GOING INSUFFICIENT AVAILABILITY OF LOCAL MENTAL HEALTH INPATIENT BEDS

**On-going waiting lists for NSFT inpatient services, increases risks that local Norfolk citizens are unable to access timely and effective care, resulting in deteriorating health and impacting patient safety, outcomes and experience.**

### BACKGROUND

***Nationally***

4.2.1 The Kings Fund Mental Health 360 publication (February 2024), aims to provide a '360-degree' review of mental health care in England, focusing on services involved in providing assessment and treatment for people with mental illness, rather than those that may provide wider support. It focuses on nine core areas, bringing together data available at the time of publication with expert insights to help understanding of what is happening in relation to mental health and the wider context. One of the nine areas is acute mental health care for adults.[6] For our purposes it provides a national picture and context of acute inpatient bed availability. The last update was 21 February 2024 and forms the basis of the following section.

4.2.2 In summary, the total number of mental health beds in the country is at an all-time low, with current numbers at their lowest level since data collection began in 2010/11 (17,836). At the same time, the number of people getting to a state of mental health crisis in which detention is necessary has seen a marked trend of rising numbers. Since 2016/17, there has also been a 45% increase in the number of people detained by the police and removed to a place of safety under section 136 of the Mental Health Act.

4.2.3 Between 2016 and 2023 there was a 24% increase in the number of patients in hospital (The King's Fund, 2024). The average length of stay in an adult acute mental health bed has also increased; a stay of more than 60 days increased by 22% between June 2021 and November 2023. The causes are complex and may indicate either:

- missed opportunities to provide effective support earlier in the care pathway
- or inpatient 'bed days' taken up by people who are clinically fit for discharge who are delayed due to insufficient suitable community provision including housing and social care support and suitable accommodation.

4.2.4 Either way, this places increased pressure on available beds.

4.2.5 Bed occupancy has remained consistently over the maximum 85% level recommended by the Royal College of Psychiatrists (n.d.), since 2010/11 (Mental Health Watch, 2024). This means:

- both considerable delays for people who need to be admitted
- as well as likely compromises to safety and the quality of care once admitted.

4.2.6 It means people in mental health crisis are kept in inappropriate environments while waiting for inpatient beds to come free, including A&E, police cells or, as in our cases, at home.

4.2.7 The situation also creates a push for discharge to free up beds, and associated risks that people may be discharged too early. Community mental health teams can then end

[6] **Mental Health 360 | Acute Care For Adults | The King's Fund**

up supporting more unwell patients either because they are waiting for an inpatient bed or are discharged early.

4.2.8 There has been limited progress on reducing inappropriate out-of-area placements when patients are sent out of area because no bed is available for them locally.

4.2.9 In May 2025, the Royal College of Nursing conducted more recent research based on freedom of information requests to NHS trusts in England and evidence from senior nurses.[7] They focused on the extent of waits longer than 12 hours and also the number of people seeking help at A&E for a mental health emergency. The statistics obtained are likely to be an underestimate because only 26% and 52% of the 145 NHS trusts contacted provided figures. Nonetheless, this gives a more recent view.

4.2.10 They found that:

- at least 5,260 people a year in a mental health crisis wait more than 12 hours for a bed after a decision has been made to admit them – up from barely 1,000 in 2019.
- Some trusts that previously had no long waits for mental health patients now have hundreds.
- The number of people seeking help at A&E for mental health emergencies is rising steadily and reached 216,182 last year.
- The recruitment of mental health nurses has lagged far behind the rise in demand.
- The number of beds in mental health units has fallen by 3,699 since 2014.

**NORFOLK**

4.2.11 In February 2025, NSFT improved to the regulator Care Quality Commission's (CQC) grading of 'requires improvement' and exited the CQC Recovery Support Programme (formerly known as "special measures") that helps failing providers. Within the NHS England oversight scheme, it was also moved from segment 4 (mandated national intensive support) to segment 3 (mandated regional support and oversight).

4.2.12 As this report was being written, CQC published the results of its most recent inspection of NSFT, rating crisis services as remaining as "requires improvement" - with ongoing concerns around emergency referrals and staffing. The trust's community services for adults, in contrast, were rated as good.

4.2.13 These early improvements come against a history of being rated 'inadequate' four times by CQC over an eight-year period and being the first of its type to be placed in 'special measures' in 2015.

4.2.14 NSAB was keen for this SAR to understand:

- What is the current situation regarding adults waiting for acute mental health beds in the county? / what does available data tell us?
- What is the impact (including cultural impact) on individuals, families, agencies and staff?

[7] People in mental health crisis waiting up to three days in A&E in England | Mental health | The Guardian

### HOW DID THE ISSUE MANIFEST IN THE CASES OF THIS THEMATIC SAR

4.2.15 In both cases that form the basis of this thematic review, at the point that a Mental Health Act Assessment (MHAA) was requested, because professionals were of the view that the person's needs could only be met by an inpatient setting, there was no place of safety or hospital bed immediately available.

### IN MALCOLM'S CASE

4.2.16 On the 26 February 2024, an MHAA was requested for Malcolm. It was agreed not to progress this before an appropriate bed for potential admission had been secured. This was due to concerns that the assessment may exacerbate paranoia and increase risks. On the night of 3 March, Malcolm died by suicide. Counting the day the MHAA was made, Malcolm had waited seven days. Over this time his mental health had deteriorated. IOPS visited were increased to twice daily, but they are not a 24-hour service so could be no substitute for an inpatient setting. At the time of Malcom's death [March 2024] there were 13 patients awaiting beds.

4.2.17 Norfolk Coroner Jacqueline Lake said she believed action could have been taken that would have prevented Malcom's death.

4.2.18 The impact on Malcolm's son of knowing his father died a potentially preventable death has been compounded by only finding out after his death that he had been waiting for an emergency inpatient admission – this is discussed further in Finding 3.

### IN JOSEPH'S CASE

4.2.19 On the 24 July 2023, Bluebell Court supported housing staff first raised the need for a MHAA for Joseph with CMHT. They raised it again the following day, 25 July, and the request was triaged by the AMHP service who made an application for a Section 135(1) Warrant. This was issued on the 28 July but not executed immediately but on 23 August, at the point a place of safety became available. This was a wait of four and a half weeks.

4.2.20 As described in the appraisal synopsis, during this time Joseph was known not to be eating, to be only drinking alcohol, not taking his medication or allowing the antipsychotic depot injection to be administered, wearing the same soiled trousers, urinating and defecating on the floor of his flat.

4.2.21 While he did not die, the health impact on Joseph was significant. The AMHP who conducted the MHAA described, in the workshop for this SAR, how it is easy to be very detached over the phone but when she actually saw Joseph, she was really shocked. His was the worst case of self-neglect she had ever seen.

4.2.22 The impact on Joseph's elderly mother was also significant. 'Joseph was filthy. He had sores – looked like scabies. His stomach was also really distended. And he was incoherent. Non-responsive and non-communicative. He was only giving one-word answers,' she described. Three weeks with no sign of intervention, she and other family were warning professionals that they would have a death on their hands. The family campaign they instigated is described further in Finding 4. When describing their experiences to me as part of this SAR, Joseph's aunt turned to her sister, Joseph's mother and said: 'It nearly killed you'. 'I had to keep going,' Joseph's mum replies. 'But there were days I just sat and wept. We all did'. I would capture this impact as moral

injury – the psychological harm incurred from committing, witnessing, or being subject to actions that violate one's moral code.

4.2.23 One must assume that there is some negative psychological impact for all staff involved in this scenario. It was especially palpable from the supported housing staff and managers, who had known Joseph well for over four and a half years.

## HOW DO WE KNOW IT IS UNDERLYING NOT A ONE-OFF?

4.2.24 NSFT's patient safety investigation into Malcolm's death gave further details of the wider context of beds, demand and capacity as follows:

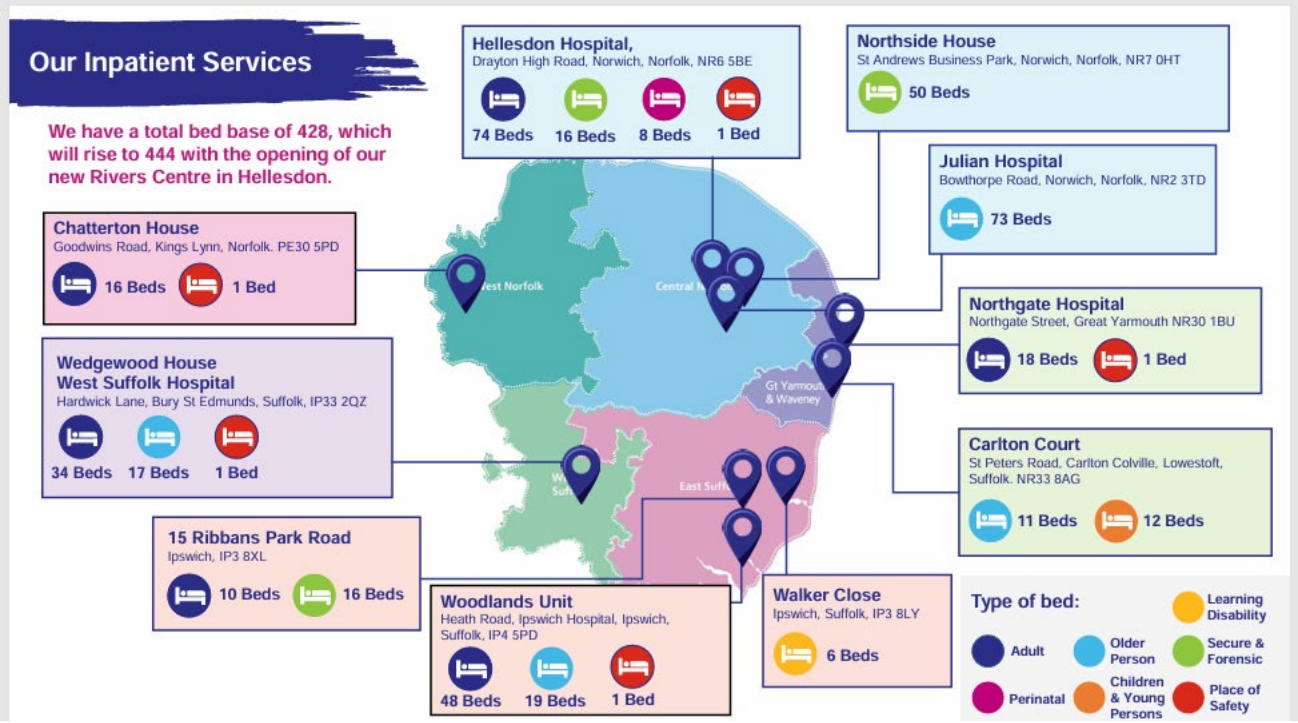
> The clinicians present on the panel advised that the process of accessing mental health beds is both chronically and acutely challenging.
>
> There are a significant number of bed requests across the Trust each day, which are managed via a daily bed management meeting involving wards and front-line teams. These meetings would see all potential discharges discussed with a review of each, 'red bed,' (a bed that while it may be vacant for a short period cannot be used) to identify demand and capacity.
>
> This pressure on capacity is reported to result in informal beds rarely being available the same day they are requested.
>
> The period during which this incident occurred saw the area working under Opel 4 level pressures, (the Operational Pressures Escalation Levels (OPEL) framework was developed to provide a universal approach to the communication of, and actions implemented from operational pressures).
>
> Known bed pressures from this period; on 25/02/2024, the week preceding the incident, there were 33 total bed requests across the whole of Norfolk and Suffolk, and the Trust had been on OPEL 4 since 21/02/2024.
>
> On 23/02/2024 the Trust went out for mutual aid to other Trusts related to the bed pressures, other private providers were full, NHS England was aware and had been part of the Mutual Aid (MA) request process.
>
> During this time other Trusts had also needed to escalate to the MA process.
>
> The Mutual Aid process is an agreed partnership between organisations to support each other at times of significant demand, the redeployment of staff between organisations as required during the COVID-19 outbreak being another example.

### *Absolute numbers of acute inpatient beds*[8]

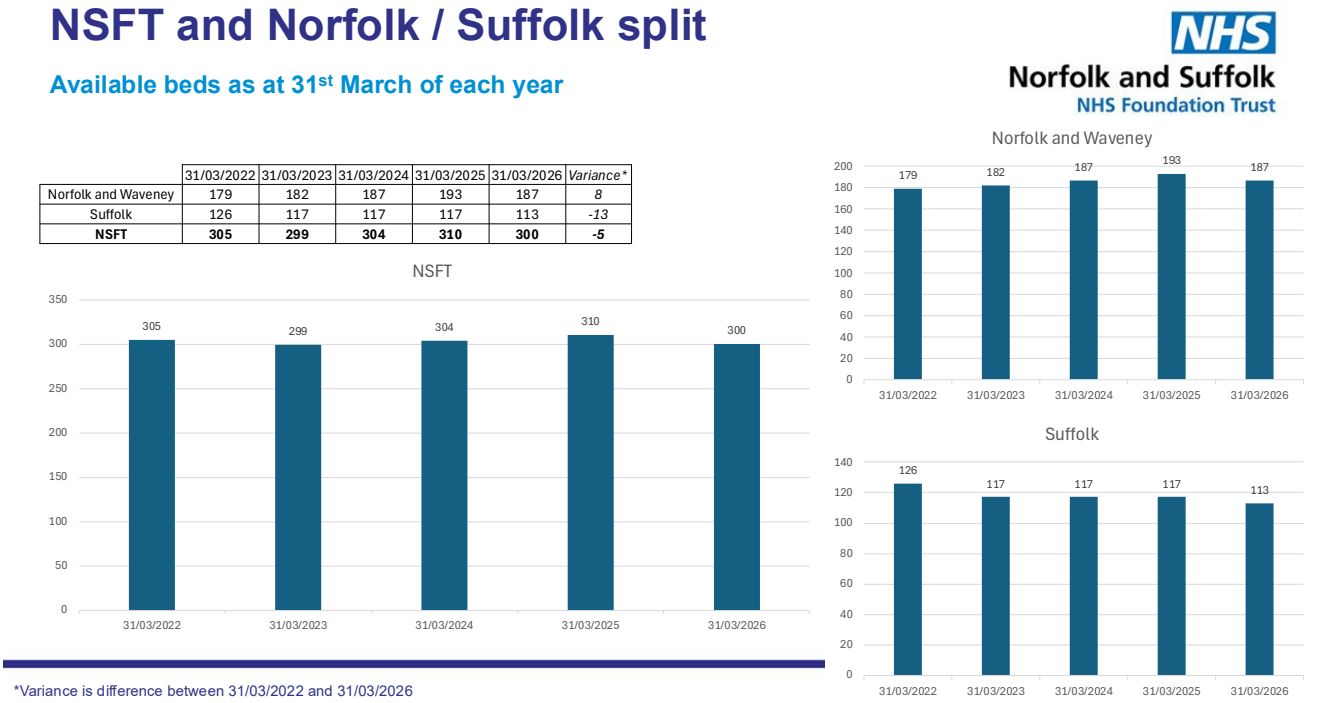
4.2.25 Relevant to the focus of this SAR, in terms of acute inpatient beds, NSFT's Clinical Strategy 2024-2029 (published in July 2024) states that NSFT has 428 inpatient beds, rising to 444 with the opening of the new Rivers Centre in Hellesdon – detail shown in Figure 4 below.

[8] Private hospital beds have not been considered

**FIGURE 4. NSFT INPATIENT SERVICES**




4.2.26 The slide provided by NSFT for this SAR indicates slightly lower numbers. This is likely explained by the data relating only to available adult acute and older peoples acute beds at 31 March over the four-year period 2022 to 2026:




| | 31/03/2022 | 31/03/2023 | 31/03/2024 | 31/03/2025 | 31/03/2026 | *Variance** |
|---|---|---|---|---|---|---|
| Norfolk and Waveney | 179 | 182 | 187 | 193 | 187 | *8* |
| Suffolk | 126 | 117 | 117 | 117 | 113 | *-13* |
| **NSFT** | **305** | **299** | **304** | **310** | **300** | *-5* |

4.2.27 The BBC Freedom of Information request found the number of beds available for sectioned patients at NSFT fell by 93 from April 2011 to a total of 481 in April 2014.[9] The subsequent ten years has, therefore, seen a further reduction by 37 beds.

4.2.28 Figures from NSFT show that, between 2011 and 2012, there was a slight increase in the number of mental health beds for sectioned patients at the trust. However, since 2012, the number has fallen.

***How many people wait in Norfolk***

4.2.29 Jacqueline Lake, Senior Coroner for the coroner area of Norfolk, wrote a Prevention of Future Deaths report for the Department of Health and Social Care following the inquest into Malcolm's death. This detailed as follows:

> At the time of Malcolm's death [March 2023] there were 13 patients awaiting beds. At the time of inquest [October 2024], there were 7 patients awaiting beds. There are peaks and lows with these numbers on a daily basis but overall there remains a shortage of beds.

4.2.30 Media coverage of another high-profile avoidable death supports this picture.[10] 4 July 2023 Christopher Sidle died by suicide after a misguided assessment sent him away rather than getting him swiftly admitted. On the morning of the fatal incident, Katie Sidle again tried to find a hospital bed for her brother. She was told 28 patients were awaiting an acute mental health bed at the time, her evidence submitted to the inquest said.

4.2.31 NSFT Board of Directors Meeting in public in July 2025 minutes state that:

> The Performance and Finance Committee were advised that there were 42 people waiting for a bed.

4.2.32 No additional data has been provided to the SAR, that would allow an evaluation of whether this is an exceptional peak in numbers, a worsening situation, or if there has been subsequent improvement.

4.2.33 The James Paget University Hospital shared data for the year February 2025 - February 2026 of mental health patients, with no health needs, that are waiting in the hospital (usually in the safe areas in the Emergency Department) for a mental health inpatient bed which is just a room with no windows. There is no therapeutic mental health care during this waiting time. The data shows 59 people affected over the year, waiting in total 130.6 days, and individually waiting between just under a single day and more than five days.

4.2.34 Contributors to the two workshops shared that their experience was that swift access to acute inpatient beds at points of need remained a significant concern to them, and was certainly not a thing of the past.

4.2.35 This would indicate the problem remains acute. However it may not be as acute for all population groups. Input at Malcolm's workshop suggested that the pressure is less for older people, and waiting times not as long. NSFT have not provided further data to the

[9] **100 mental health bed cuts concern in Norfolk and Suffolk - BBC News**

[10] Mental health trust failings contributed to Norfolk man's death, coroner finds | NHS | The Guardian

SAR, therefore I do not have further data with which to reflect on this. Further data is needed from NSFT and/or the ICB to understand the situation more precisely.

***How long are people waiting?***

4.2.36 In terms of how long people wait, the AMHP lead informed this SAR that historically there have been average waits of 56 days for an inpatient bed but more recently the wait was down to an average of six days.

4.2.37 No further data has been provided to the SAR, making it difficult to understand the situation with more specificity.

***Has NSFT Transformation Programme activity already addressed this issue?***

4.2.38 In the NSFT Board of Directors Meeting in public in July 2025, referenced earlier, the Performance and Finance Committee are also minuted as having asked how people were kept safe while waiting for acute inpatient admission. CD is minuted to have explained:

> "that the broader dashboard work would give more visibility of who was waiting and the clinical priority as it was not in one place at the moment".

4.2.39 This indicates that mechanisms to understand this issue are improving but not yet achieved.

4.2.40 In addition, adult mental health Urgent and Emergency Care pathways have also changed as part of the recent NSFT transformation programme, aiming at increasing crisis community alternatives to acute hospital admissions. The DHSC wrote to the coroner in Malcolm's case:

> "I am advised by NHSE/I that the Norfolk and Suffolk NHS Foundation Trust has increased capacity through the opening of four crisis house beds in Norwich, with plans to open two additional crisis houses in the coming months, as well as extra ward capacity for older people. This is expected to significantly enhance local bed capacity."

4.2.41 However, equating the opening of crisis houses to an increase in bed capacity should be treated with caution. Crisis community alternatives are neither necessarily registered with CQC, nor required to be staffed with qualified staff, nor are they suitable for people who are on waiting lists requiring emergency inpatient admission. Therefore they are not comparable to inpatient psychiatric hospital beds, and only impact indirectly on those in mental health crisis.[11]

**WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED**

4.2.42 Without the provision of additional data on admissions, waiting lists and waiting times, it is not possible to calculate how many people are affected by this lack of bed sufficiency for people needing emergency mental health hospital admission. Patient data calculated for the period 1 April 2024 to 27 March 2025, across NSFT there were:

- 1,842: Patients who had an inpatient stay[12]

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[11] See also: waiting-for-the-grown-ups-to-arrive.-dangerous-shortage-of-mental-health-beds-the-governments-deflection-of-coroners-warnings-and-normalisation-of-bad-practice-by-nhs-england--1.pdf

[12] **About us | Norfolk and Suffolk NHS FT**

4.2.43 This indicates something of the scale of the population group, a portion of whom might at some time potentially be affected by the lack of bed availability.

## WHY IT MATTERS

4.2.44 By the nature of mental health crises, there will always be people in such serious need and at such risk of self-neglect, suicide, accident or violence to others, that hospital admission cannot be avoided - or at least not avoided without serious risk. Within Norfolk and nationally, coroners' courts have repeatedly found that a shortage of mental health beds has been linked to people dying unnecessarily and avoidably. Such deaths continue.

4.2.45 In this situation, it is difficult to see how the principle of parity of esteem can be attained:

> In essence, 'parity of esteem' is valuing mental health equally with physical health. […]
>
> parity of esteem means tackling mental health issues with the same energy and priority as we have tackled physical illness.
>
> It is about changing the experience for people who require help with mental health problems.
>
> It is about putting funding, commissioning and training on a par with physical health services.
>
> And parity of esteem is about tackling and ending the stigma and prejudice within the NHS which stops people with serious mental health problems getting treated with the same vigour as if they had a physical illness such as, say, diabetes.[13]

4.2.46 Joseph's mother also made this exact point. She is in her early 70s and was still recovering from a fall at home when I spoke to her as part of this SAR. Due to the fall, she went to Accident and Emergency where she was told that there was a seven-hour wait to see a doctor, but they were not abandoned. While on a trolley in a corridor, she was treated with nothing but kindness and professionalism. She could hear doctors apologising to other patients saying, this is not how they like to treat patients, but that they would make sure they got the treatment they needed. Her leg was x-rayed and the doctor came and explained to her that she needed to be admitted but there were no beds. Again, they were not abandoned and there was never a sense that nobody knew what to do faced with this situation. They found an alternative placement for her. Initially she was reluctant to accept it because she thought it was a care home. The doctor arranged for the physiotherapist to come to her and provide further information about the setting and the benefits. She explained that, in contrast to a busy hospital, at the rehabilitation centre she would receive the treatment she needed every day. This allowed Joseph's mother to accept the suggestion.

4.2.47 She never felt rushed or dismissed. 'That's the level of care that everyone is entitled to,' she said, and Joseph was denied it 'when he was at his most vulnerable'. From mental health services 'there was no plan b and when we tried to share our concerns, we were dismissed, often with rudeness'. At the point there was not a bed available,

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[13] **NHS England » Parity of esteem – what are we trying to achieve?**

everything seemed to freeze. The lack of action to do something for Joseph was justified with the constant refrain 'there are no beds'.

4.2.48 There have been concerns about cuts to NHS mental health beds for decades but bed reductions have continued, leaving no 'flex' in the system. The current narrative is to reframe the issue as a problem of patient 'flow' rather than an insufficiency of beds. The Quality Committee Chairs' Report to the NSFT Board of Directors Meeting in public, in July 2025, states:

> The Committee noted that the outcome of the bed census had been reviewed at the Performance and Finance Committee, and this had highlighted issues around patient flow. It was felt that the issue was not a lack of beds but rather inefficiencies in flow and discharge processes, which were impeding clinicians' ability to place patients appropriately. The bed census report had revealed that 48% of patients were inappropriately placed, either out of Trust or within the Trust's own services.

4.2.49 This finding highlights that citizens on waiting lists for emergency inpatient admission, additional beds are needed in the short term, because, by definition, they cannot wait for solutions to 'flow' to be identified and secured.

4.2.50 The finding also draws attention to the wider ripples of harm caused by this scenario of waiting lists for emergency mental health inpatient beds, with staff and family risking 'moral injury' as they do the best they can for their client / loved one, in this compromised situation – the psychological harm incurred from committing, witnessing, or being subject to actions that violate one's moral code.

**FINDING 1. AN ON-GOING INSUFFICIENT AVAILABILITY OF LOCAL MENTAL HEALTH INPATIENT BEDS.**

**QUESTIONS FOR PARTNERS TO CONSIDER IN DETERMINING RESPONSES**

- What routine data does NSAB need to ask from NSFT to understand the changing situation regarding acute inpatient bed availability and waiting lists and times for Norfolk citizens?
- Is there a role for NSAB partners to gather additional evidence of citizen experiences and impact, in order to have an evidence base from which to review assurances provided?
- Findings 2, 3 and 4 speak to how partners across Norfolk can better come together in this context, to reduce risks to citizens. How can the NSAB enable and support better partnership working with NSFT?
- How would NSAB know if the situation had improved either in terms of routine understanding of the situation, or the timely accessibility of emergency inpatient mental health beds?

## 4.3 FINDING 2 - EMBEDDING MULTI-AGENCY WORKING AS A MENTAL HEALTH CRISIS PREVENTION STRATEGY

**The problem of inpatient mental health bed availability is well known but partnership working in Norfolk does not yet seem to be embedded strategically or operationally as a prevention strategy to catch any deterioration of a person's mental health as early as possible, in order to reduce the likelihood of high risk situations where someone urgently needs admission but no bed is available. This increases the chances that early**

**opportunities are missed when someone not previously known to mental health services presents, or when someone with a serious mental illness (SMI) shows signs of deviating from their care plan in significant ways, and/or their mental health is deteriorating.**

## BACKGROUND

### Partnership working of mental health services

4.3.1 NHS England Guidance (2023)[14] to support the commissioning and delivery of timely access to acute inpatient mental health care for adults and older adults proposes four core principles. These includes joined up partnership working:

> 'Inpatient services that work closely with a range of other services (see box below for examples) in a collaborative and coordinated way, are more likely to meet people's varied needs, contributing to improved experiences and outcomes from care and reducing avoidable time spent in hospital' (202).

4.3.2 The list of organisations indicated is significant.

**TABLE 5 KEY SERVICES FOR EFFECTIVE PARTNERSHIP WORKING IN INPATIENT MENTAL HEALTH CARE**

| | |
|---|---|
| • CRHTTs<br>• Community-based mental health teams<br>• Housing services (offering home adaptations and short- and long-term housing options)<br>• Carers support services<br>• Local authorities, in particular,<br>>Approved Mental Health Professional (AMHP) services,<br>>expert housing teams, and<br>>social care teams,<br>>incl. safeguarding specialists and<br>>those responsible for conducting assessments and arranging Section 117 aftercare (in partnership with integrated care boards (ICBs)<br>• Primary care<br>• VCSE sector organisations providing<br>>advocacy services,<br>>peer support,<br>>community crisis alternatives &<br>>reach services for specific groups, incl. people from racialised and ethnic minority communities<br>• Drug and alcohol services | • Pharmacy services<br>• A&E, psychiatric liaison and diversion services<br>• Services addressing sexual health and physical health needs (including community health, intermediate care and frailty services for older adults)<br>• Children and young people's mental health services<br>• Community learning disability services and specialist autism services<br>• Gender identity services<br>• Specialist trauma services<br>• Rehabilitation services providing advice and specialist intervention<br>• Financial support services providing advice on benefits and funding of ongoing care<br>• Employment support services<br>• Education services – including schools and further and higher education providers<br>• Criminal justice agencies, including probation and the police<br>• Independent sector providers (especially where people are placed in a non-NHS inpatient service) |

[14] NHS England » Acute inpatient mental health care for adults and older adults

4.3.3 The guidance stresses the collaboration required around both formulation and care planning:

> Both formulation and care planning work best when it is a collaborative process between the person, their chosen carer/s, the inpatient multi-disciplinary team (MDT) and representatives from partner services who know the person well and are involved in supporting the person (e.g. the person's named key worker, housing officer or advocate). An atmosphere of shared learning should be created, with equal value placed on the perspectives of each person involved (NHS England 2024).

4.3.4 While the guidance relates specifically to circumstances when it has been identified that someone needs to be, then is admitted and subsequently discharged, arguably these principles are as relevant to earlier circumstances. This might be when someone not previously known to mental health services presents or when someone with a serious mental illness (SMI) shows signs of deviating from their care plan in significant ways, and/or their mental health is deteriorating.

4.3.5 The NHS England guidance also includes a list of actions that can be taken to embed effective partnership working and also seem relevant to these earlier / other circumstances:

- Ensure there are clear pathways between services (e.g. between physical health and mental health services) and joint working arrangements are agreed with partner organisations, which include information on the management of transitions (e.g. from children and young people's inpatient services to adult inpatient services).
- Review the inpatient mental health pathway to understand how partnership working is currently functioning and how to strengthen it. For example, this could involve senior system partners and lived experience practitioners coming together on a quarterly basis to review performance data and local intelligence, assess where there are pressures across the pathway and identify actions to drive improvement.
- Integrate members of key partners organisations, for example, social workers and housing officers, as part of the ward team's staffing establishment.
- Ensure cross-service attendance at key meetings (e.g. care planning and discharge meetings, and other reviews). This should include representatives from the local CRHTT, the person's named key worker from the community-based mental health or learning disability team and any other key partners in the person's care (see box below for examples), as well as anyone that the person and their chosen carer/s feel it would be helpful to have in these meetings.
- Hold joint training between services that work with one another, where relevant, to understand the types of expertise that different services and professionals offer, as well as to reflect on and improve joint working processes. As an example, this could be used to share reflections about what more could be done to avoid escalation to admission, or to identify situations in which people are better cared for in the community.

### HOW DID THE ISSUE MANIFEST IN THE CASES OF THIS THEMATIC SAR

4.3.6 In neither the SAR lines of enquiry, or the cases for this thematic review, was system-wide partnership working evident either operationally or strategically as an approach to prevention, or as an evident priority to avoid escalation given the known system

vulnerabilities at points where urgent admission is needed. Further detail is given on each aspect in turn, below.

### IN THIS SAR PROCESS

4.3.7 When considering these cases in the context of on-going problems with availability at point of need of inpatient mental health beds, the focus was placed on how partnership working might be improved at the point of crisis (not earlier). This is important clearly, but there was no equivalent focus placed in the lines of enquiry on the effectiveness of partnership working **to prevent** escalation to points of crisis. However, the early analysis of both cases indicated that there had been opportunities for more effective prevention, this focus has therefore been added by myself, as the independent reviewer.

### IN JOSEPH'S CASE

4.3.8 The absence of the priority to partnership working as a prevention strategy is striking in Joseph's case because he has what NSFT describe as an 'extensive MH history' going back to February 2016, totaling approximately 1950 entries.

4.3.9 The NSFT information return for this SAR covered Joseph's diagnoses which included: Paranoid Schizophrenia, Huntingdon's Disease, unspecified psychosis, fatty liver disease, chronic alcoholism, OCD, anxiety, depression, history of overdose and acute MH inpatient admissions, history of harm to others.

4.3.10 During the time period of this SAR, Joseph was an outpatient subject to S.117, was active to a Community Mental Health Team (CMHT), and living at Bluebell Court, a 24-hour supported living placement.

4.3.11 After leaving home in his early thirties, Joseph had experienced difficulties in his marriage and relationships, with his mental health and his housing, experiencing periods of homelessness as well as inpatient admission under the Mental Health Act. It was at Bluebell Court, his mother described, that Joseph had really thrived.

4.3.12 She described how he made friends at Bluebell Court:

> 'There were activities. Staff loved him to bits. They were really supportive. He started going to Church under his own steam. They rang me every week and gave a synopsis of how Joseph had been. He even met the crew of Red Dwarf as part of a Norfolk Show Group - we and the staff were all on tender hooks! He was very happy there. He had a really good relationship with his support worker. They used to go to the cinema together. Bluebell Court kept Joseph for longer than they should have done. He's the longest person they've ever had. They said if he's happy, we will keep him. They did love him.'

4.3.13 This was, therefore, a real success story as regards support that worked for Joseph that had worked well for over four years. But that success for Joseph, belies the lack of engagement with partners by mental health services.

4.3.14 The first point of note is that there does not appear to have been any contingency planning for what to do **if** Joseph began to show ambivalence about accepting his anti-psychotic depot injections.

4.3.15 Secondly, Joseph's situation was significantly more complicated due to his additional, co-occurring diagnoses of Huntingdon's disease. However, broadly there does not appear to have been any acknowledgement of Joseph's Huntingdon's disease diagnosis by his Responsible Clinician or CMHT or of his schizophrenia diagnosis by

the neurological team at Addenbrooke's with whom he had annual reviews. Specifically, through the SAR we have not become aware of any review of Joseph's mental health formulation or care plan, in light of his Huntingdon's diagnosis. If there was, neither Joseph's supported housing, GP nor adult social care appear to have been aware of it.

4.3.16 This left staff in Joseph's supported housing, with least clinical expertise, in the driving seat. It also meant that all agencies were without a common script from which to plan their responses. There was no clinical guidance for non-clinical staff to understand what they may be seeing and how to engage Joseph in discussions and plans, no joint guide as to what kinds of deterioration to keep alert to, what the options of effective responses were, or roles and responsibilities in achieving them. There were no joint contingency plans for either Joseph's non-compliance with anti-psychotic medication, and/or cognitive decline or presentation with new psychiatric presentations potentially linked to the progression of his Huntingdon's.

4.3.17 This meant that despite support staff at Bluebell Court flagging concerns in a timely and determined fashion, responses were not optimum or coordinated.

4.3.18 CMHT seem to have responded initially to cognitive decline and not considered non-compliance with medication initially as a potential factor, nor considered contingency planning if that were to become an issue.

4.3.19 The GP appears not to have understood the context for the referral requested to SALT and OT, recommended by CMHT. We heard in the workshop that GPs play an important gate-keeping role for SALT services in the community, but anyone with a Huntingdon's diagnosis should never be rejected given the clear trajectory of potential issues.

4.3.20 No-one seems to have understood the important role of a neurology nurse once Bluebell Court were raising concerns, in order to help understand whether what Bluebell Court were concerned about in Joseph's presentation was a decline in his mental health, a progression of his Huntingdon's disease or a combination of both.

4.3.21 CMHT had MDTs but these did not include either adult social care or housing support from Bluebell Court. It still remains unclear what the CMHT plan was in response to Joseph beginning to refuse his depots. 'FACT support' we learnt in the workshop, is part of CMHT but a step-up, where the person is seen and reviewed more frequently. But it was not clear then, and remains unclear in the SAR, what FACT support actually entailed beyond 'eyes on' sightings of Joseph, or to what end. The support workers who knew Joseph best were not helped to understand what might be going on for Joseph, in the context of the comorbidity of Huntingdon's and schizophrenia and given no steer as to what they could best do to help.

4.3.22 There was no consideration of a mental capacity assessment in relation to Joseph's ability to make decisions about compliance with his medication. Adult social care explained that this would usually be undertaken by a medical professional so was not in their purview at the time. They focused only on Joseph's mental capacity about self-care and hygiene as they were looking to put in domiciliary care to minimise the risks at this time and maintain hygiene. It is unclear whether or how Joseph's Responsible Clinician, Consultant psychiatrist or CMHT were aware of adult social care's efforts to

find alternative accommodation for Joseph, or if this was also informed by their clinical input.

### IN MALCOLM'S CASE

4.3.23 Malcolm, unlike Joseph, was someone not known to mental health services, so the timeline available for partnership work as a preventative strategy was far shorter, yet nonetheless significant.

4.3.24 With hindsight it is clear that mental health professionals made a 'garden path error" of human reasoning,[15] focusing more on Malcolm's grief and less on the link between his diabetes diagnosis and detox from alcohol, as the driver of his mental health decline. In NSFT's SIR report, the date that Malcom's wife died remained wrong by a year, indicating that it had happened just six months earlier, when in fact it was already 18 months earlier, at that time. In contributing to this SAR, Malcolm's son stressed that he had regularly corrected professionals, but this plausible but inaccurate first assessment proved remarkably resilient to change. The IOPS team therefore were working on a differential diagnosis that meant it took longer for anti-psychotic medication to be started.

4.3.25 Similarly to Joseph, however, it is clear that there was no early bringing together of all involved agencies to work together in relation to Malcolm's mental health, and to contribute to monitoring or intervention at an early a stage as possible in order to prevent crisis. The community health team who were visiting Malcolm twice daily to support the administering of his insulin, were not aware of his suicide risk or aware to be alert to or share information with IOPS about particular presentations – particularly given the potential for insulin to be used in suicide.

4.3.26 IOPS were aware that the district nurses were going in and providing insulin and knew their own role. The view at the time was that there was nothing not working, so there was no need for partnership working. Input at the practitioner workshop for this SAR clarified that the norm for community mental health teams is usually to pull agencies together only when something in the plan is not working i.e. not preventatively.

### HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF IN THIS CASE

4.3.27 In written data returns and in workshops and meetings related to both of the cases for this thematic review, we have heard about positive improvements in NSFT bed-management processes (see Finding 3). We have heard about MDTs linked to the bed-management process, that include community mental health teams e.g. MS Teams Chat Group Admission and Discharge Team that takes place daily, and covers whether there are any inpatient beds, and presentation of anyone needing one. The IOPS team

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[15] *Garden path* problems are 'a specific class of problems where revision is inherently difficult since early cues strongly suggest [plausible but] incorrect answers, and later, usually weaker cues suggest answers that are correct' Woods and Hollnagel, 2006, p.75). Besides being influenced by the relative strength of cues, the worker is also hampered by the fact that data tends to arrive incrementally, not in a single, eye-catching batch. 'The vulnerability lies not in the initial assessment, but in whether or not the revision process breaks down and practitioners become stuck in one mindset or even become fixated on an erroneous assessment, thus missing, discounting or re-interpreting discrepant evidence' (Woods and Hollnagel, 2006: 75) (Munro 2008: 53).

also join a 9.00am daily 'Safety Huddle' concerning older people, which the Bed Management Team also join, where there is a brief discussion of patient flow.

4.3.28 But there was no indication in either case, or in wider discussions, that preventive partnership working was standard i.e., involving mental health teams and other agencies, such as housing, GPs, adult social care or safeguarding teams in contingency planning to catch early and avert deterioration in a person's mental health.

### WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.3.29 At any one time NSFT CMHT teams are working with 23,000 people across both counties at any given time.[16]

4.3.30 No intelligence has been identified for the SAR about whether NSFT partnership working preventatively is better in certain areas of Norfolk than others or outside Norfolk.

### WHY IT MATTERS

4.3.31 NSFT has been engaged recently in a significant transformation programme to tackle persistently poor CQC ratings, that appears to be beginning to deliver results for local citizens. There are significant large scale change programmes attached to the four priority areas of improving health, care, culture and value. It is understandable then that much focus has been internal and on coordinating intra-agency working. This finding draws attention to the benefits of also looking to system-wide collaboration with external partners both operationally and strategically, and the prioritisation of multi-agency working as a prevention strategy. This is vital while swift access to inpatient beds cannot be guaranteed for everyone who needs one, at the point they do.

4.3.32 This thematic review suggested that multi-agency sharing of mental health formulations and care plans, and tight collaboration in the creation of robust contingency plans for points where a person may become non-compliant with the care plan, or their mental health deteriorates, is not yet embedded or a tangible expectation or priority for practitioners and clinicians on the ground. Yet it holds promise for lessening the chances that people end up at their most vulnerable, at the most high risk area of system functioning.

| **EMBEDDING MULTI-AGENCY WORKING AS A MENTAL HEALTH CRISIS PREVENTION STRATEGY**<br><br>**QUESTIONS FOR PARTNERS TO CONSIDER IN DETERMINING RESPONSES** |
|---|
| • Does this finding resonate with all partners?<br>• To what extent does each partner agree that there is scope for tighter partnership working by community mental health teams to support the prevention of crises requiring emergency inpatient beds?<br>• To what extent is this in line with NSFT's change programme priorities? What does NSAB know about how well known or used the NSAB Complex Case Guidance is?<br>• Has there been any work to bring housing closer into partnership working locally, that |

[16] **(PDF) Norfolk and Suffolk NHS Foundation Trust model of Care Model of Care**

responses could build on?

- How would NSAB know if things had improved?

## 4.4 FINDING 3 - ORGANISATIONAL AND MULTI-AGENCY DECISION MAKING AROUND INFORMATION SHARING WITH FAMILIES IF A PERSON IS AT HIGH OR IMMINENT RISK OF SUICIDE

**The potential life and death consequences of decisions about whether to share information with family members, when someone is at high or imminent risk of suicide do not seem to be mirrored in NSFT's procedures for the Community Mental Health Teams or in multi-agency arrangements. Neither seem sufficiently clear or formalised, despite it being known nationally that best practice is widely poorly understood and not routinely applied by individual practitioners or clinicians.**

### BACKGROUND

4.4.1 Families have long raised concerns about the apparent reluctance of practitioners and clinicians to engage with them when a loved one is at risk of death by suicide (see the National Suicide Prevention Strategy for England 2012).

4.4.2 These are weighty decisions for professionals and consequential decisions for families. Family members can be left struggling with the unanswerable question of whether they could have made any difference, and saved their loved one's life, if only they had known.

4.4.3 Since 2014, updated in 2021, the 'consensus statement'[17] published by the Department of Health and Social Care has been available to inform practice in this domain. This was supplemented by the SHARE guidance, prepared by the Zero Suicide Alliance (ZSA)[18]

4.4.4 The DHSC consensus statement says:

> Confidentiality, consent and capacity are all issues which have rightly received a great deal of careful attention over the years. It is clear that, where the common law duty of confidentiality applies, practitioners will usually be under a duty to respect a person's refusal to consent to disclosure of their suicide risk if the person has the relevant capacity and they do not pose a risk to anyone but themselves.
>
> […] However, if a person is at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time.

4.4.5 The SHARE Guide states that

> Despite multiple innovations in a number of localities, best practice in consent, confidentiality and information sharing remains poorly understood and is not routinely adopted by many practitioners. Mental healthcare managers and practitioners are encouraged to review and consult the many resources and protocols which already exist and consider how these can be assimilated and adopted in their own settings.

[17] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention

[18] **SHARE: consent, confidentiality and information sharing in mental healthcare and suicide prevention - GOV.UK**

4.4.6 The Campaign to save mental health services in Suffolk and Norfolk, have also raised concerns about this issue. See Theme M: Family / Carer concerns ignored, in their recent report[19]:

> "Service users with psychosis and other of serious mental illness' (SMI) can become estranged from their families when presenting with paranoia, reduction in trust or lacking capacity. Some carers have experienced a defensiveness from the Trust, blaming parents or families by focusing on only the service users interpretation in psychosis and not recognising or documenting service user relationships when the service user is feeling better with healthy and improved relationships." (2024: 83)

4.4.7 The SHARE guidance emphasises management support in terms of giving practitioners the appropriate training and confidence to navigate the sometimes complex issues associated with consent, confidentiality and information sharing and the fundamental change in culture that this often requires away from an excessive default to privacy in all instances. It does not suggest ways in which this decision making can best be structured and arranged within or across agencies.

4.4.8 There are examples in other sectors where potentially life changing decisions are held at a higher level in the organisation – e.g. decisions to take a child into state care. Alternatively, where made closest to the person, arguably opportunities for check and challenge are important, and oversight arrangements need to be clear and robust. Currently SHARE only specifies that it is imperative that all conversations relating to consent and information sharing are fully recorded.

### HOW DID THE ISSUE MANIFEST IN THE CASES OF THIS THEMATIC SAR

4.4.9 Information sharing with their families was very different in Malcolm and in Joseph's case at the points of mental health crisis respectively. In Joseph's case, the housing provider brought his mother into the picture and attempted to leverage her role as part of the safety plan. In Malcolm's case, there was no information sharing with his son at the point of peak crisis and suicide risk. Yet both Malcolm and Joseph's experiences suggest that the process for making decisions about whether to share information with family members at times of crisis are not organisationally formalised in terms of procedure within single agencies, nor is there any multi-agency procedure in place to support such potentially consequential decisions.

4.4.10 Further detail is presented below first on Malcolm's experiences, then Joseph's.

### IN MALCOLM CASE

4.4.11 This systemic weakness suggested in this finding manifest with the greatest tragic impact in Malcom's case. This is how Malcolm's son ended the conversation with the me as independent reviewer:

> "Thank you. This is the first time I've been listened to. The first time anyone has asked how did it feel for the family? It impacts in the aftermath. On my processing."
>
> I still take umbrage with the lack of communication.

[19] A report of overlapping failures and unmet need within the care and treatment at Norfolk and Suffolk Foundation Trust using patient and carer experience October 2024 Website: https://norfolksuffolkmentalhealthcrisis.org.uk

> I would never want someone else to find out how unwell their loved one is in a report.
>
> I have to live with the fact that I walked away on that Sunday. The guilt is insurmountable. Would I have acted differently if I'd known he'd been deemed sectionable? I'll never know."

4.4.12 Malcolm's son described how after his father's death, he had been told there would be an incident review by NSFT and that he would have the opportunity to be involved and to ask any questions. In the event, the next he remembers knowing is being invited to an NSFT hospital to read the report. They were left alone for 20 minutes to read it. This was the first time he found out that his father had been deemed in need of assessment and admission under the Mental Health Act to a mental health hospital.

4.4.13 This was consequential because Malcolm's son and partner had been visiting his father weekly. Every Sunday they would take the bag of shopping round for Malcolm. On the Sunday 3 March 2024, they did the same. Malcom came to the door but would not let them in. He was clearly agitated. A few weeks earlier, Malcom had chased his son away and tried to hit him. So, wanting to avoid escalating Malcolm's distress, his son just dropped off the bag and said to his father that they would speak in the week. It was that night that Malcom died by suicide through drowning.

4.4.14 When Malcom's son asked why he had not been told, the explanation given was that he and his father were estranged, and his father had not given consent. Understandably, he found and still finds this unconscionable. He had been calling the CMHT / IOPS mental health team and sharing his concerns about his father's increasing paranoia. The last call was on the 25/02/2024, the day before a Mental Health Act Assessment was requested and IOPS visits were increased to twice daily in response to the high risk of suicide identified. Malcolm's son is still in disbelief, asking himself of mental health services: 'As he deteriorated, at what point do you stop taking him at his word [in terms of them being estranged and in terms of his consent]?'.

4.4.15 NSFT's Safety Incident Review report (07/06/2024) raises the same issue. It states that, recognising that the IOPS team is not 24/7 and is only staffed until 21.00, safety plans should be identified for outside of these times, offering guidance to service users and **where relevant those supporting them** on where help/support can be sourced if required. In Malcolm's case, it states:

> *In this case the service user was not able to engage in such discussions due to the acuity of the mental state. Further the dynamic of the relationship notwithstanding,* ***the record does not evidence the level at which discussion with the Son related to risk occurred****, beyond his concerns being further recorded in the combined assessment, most recently on 26/02/2024 (emphasis added).*

4.4.16 Further, the SIR notes that the Recovery Plan was basic and brief and not updated since 28/01/2024. This was noted as an oversight of a clinician relatively new in post. The combined assessment was updated more recently, on the 26/02/2024 was felt to

be of good quality, showing consideration of the presentation and risks known but, the report notes, it was not clear how widely this had been shared.

4.4.17 Overall the SIR concludes that 'These omissions did not impact the care in this case'. In the creation of this finding, the SAR takes a different view and raises questions about whether the way in which decisions are made currently, are optimum.

### IN JOSEPH'S CASE

4.4.18 In Joseph's case, the situation was different. Bluebell Court noted that one of the changes that had happened over the four and a half years that Joseph lived there related to his mother. Staff noted changes in Joseph whereby he needed more support with daily living and flat management (taking out rubbish, shopping and external cleaner), became more withdrawn such as not opening the door for daily meal deliveries, no longer attending groups or going out to the city with staff to watch films, or to collect his medication. He also stopped daily contact with his mother by phone, until he stopped calling altogether and withdrew consent for staff to speak with her (reasons unknown) about him. Joseph's wishes were respected but there was regular contact with his mother.

4.4.19 By the middle of the year, there had been further deterioration in Joseph's presentation, escalation of concerns by Bluebell Court, with adult social care and CMHT and first refusals of engagement by Joseph. Joseph's mother was also increasingly concerned and called Bluebell Court because Joseph was not answering her calls. Adult social care were then in contact with Joseph's mother about the best interests meeting, after they had deemed he did not have mental capacity in relation to decisions about his self-care.

4.4.20 Then in July, once the situation was in crisis, Joseph's mother had made contact and said they were going to visit. Due to consent having been withdrawn, Bluebell Court made the decision to explain that they may find the situation with Joseph to be distressing. With this, they effectively made Joseph's family part of the safety plan and escalation process during the long wait for a mental health bed to become available.

4.4.21 None of the mental health teams involved appear to have engaged directly with Joseph's mother in terms of what role she and family might play for Joseph in safety planning.

### HOW DO WE KNOW IT'S UNDERLYING NOT A ONE-OFF IN THIS CASE

4.4.22 Nothing in the NSFT SIR for Malcolm indicated that there is a specific formalised process for community mental health teams to support decision making about whether or not to inform family members/carers in an emergency, such as where a patient is deemed at imminent risk of suicide. It is part of safety planning which should involve the person and family members as appropriate.

4.4.23 The explanations given directly to Malcolm's son differ from the explanations shared as part of this SAR. Malcom's son was told it was a confidentiality issue. I was told that IOPS were aware that, as part of his mental health deterioration, Malcolm was increasingly paranoid about his son and therefore it did not seem wise to involve him more. Neither version was recorded, nor had oversight from a team manager or higher (as far as I am aware). Both factors underline that there seems to be insufficient formality to decision making in this scenario, given the weight of the decision at hand

and the compromised context in terms of timely access to inpatient mental health beds when identified as needed.

4.4.24 I, the reviewer, was not made aware until after the workshop, when I spoke with Malcolm's son, that he had not been informed that a MHAA had been requested, with IOPS visits stepped up to twice daily as professionals waited for a mental health inpatient bed to come free. Therefore I did not explore ordinary work further with those who took part in the workshop.

4.4.25 Turning to the multi-agency element of decision making now, similarly, nothing in the information provided to the SAR indicated that there is a multi-agency arrangement for informing or involving other involved partners in decisions about informing family members/carers when someone is at high or imminent risk of death by suicide. In Malcolm's case, IOPS did not liaise with community health district nurses who were administering Malcolm's insulin for his diabetes, nor with adult social care, or the GP. In Joseph's case likewise, there does not seem to have been any formality or multi-agency aspect to Bluebell Court's decision making about involving Joseph's mother as part of safety planning.

## WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.4.26 As part of the SAR, we sought to sought to understand the available data and develop an overall picture of the number of deaths by suicide linked to mental health, to identify where there may be opportunities to involve families and carers more effectively in prevention efforts.

4.4.27 The NSFT Board of Directors pack for July 2025[20] provides statistics for Norfolk on deaths of people known to mental health services. It is based on deaths notified to NSFT between 01/04/2024 and 31/03/2025. The data includes patients who died with an open referral to NSFT services, or who died within 6 months of discharge from NSFT, or had a contact or continuation note added to their record within the 6 months prior to their death and were considered to be under NSFT care following a manual screening process by NSFT.

[20] **NSFT board of directors pack**

4.4.28 This shows 126 people died with their cause of death categorised as unexpected unnatural, ranging from 6-15 every month. They represent 6% of all deaths, with the vast majority being natural deaths whether unexpected (46%) or expected (46%).

**Table 2 – Cause of death overview**

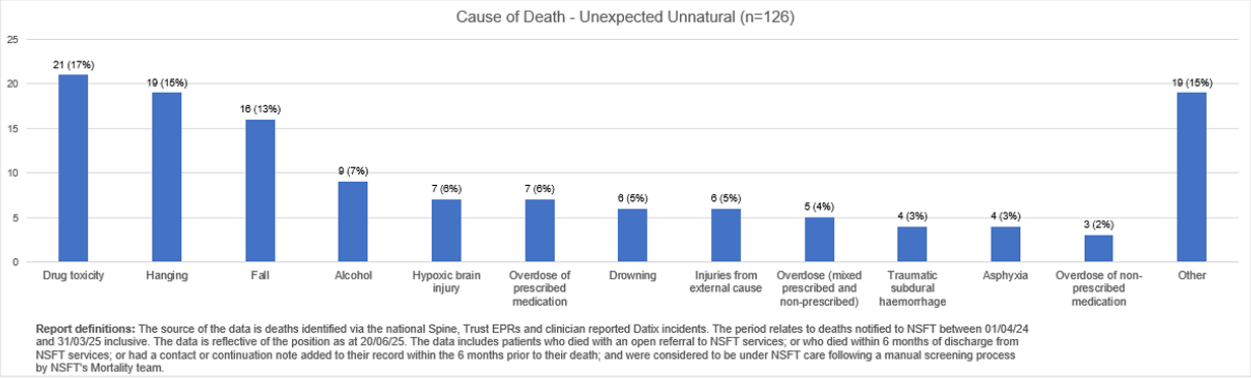
| Cause of Death | Unexpected Natural | Expected Natural | Unexpected Unnatural | Unable to Obtain | Awaiting cause | Total of deaths |
|---|---|---|---|---|---|---|
| Number of deaths | 934 | 927 | 126 | 9 | 40 | 2036 |

**Report definitions:** The source of the data is deaths identified via the national Spine, Trust EPRs and clinician reported Datix incidents. The period relates to deaths notified to NSFT between 01/04/24 and 31/03/25 inclusive. The data is reflective of the position as at 20/06/25. The data includes patients who died with an open referral to NSFT services; or who died within 6 months of discharge from NSFT services; or had a contact or continuation note added to their record within the 6 months prior to their death; and were considered to be under NSFT care following a manual screening process by NSFT's Mortality team.

4.4.29 Broken down by cause of death, the graph below shows from left to right drug toxicity; hanging; fall; alcohol; hypoxic brain injury; overdoes of prescribed medication; drowning; injuries from external causes; overdose (mixed prescribed and non-prescribed); traumatic subdural haemorrhage; asphyxia; overdose of non-prescribed medication and other.

**Chart 4 – Cause of death - Unexpected Unnatural**

Deaths relating to drug toxicity were the most reported causes of unexpected unnatural deaths.




4.4.30 From these statistics, it is not known how many were recognised as an emergency in which the person was at high or imminent risk of suicide. I am not aware of any data on whether carers were identified and recorded in these cases, or about decision making about whether or not to inform them (where it was known) of the person's crisis and/or involved them in the safety plan. The limitations identified by NSFT regarding the identification and recording of carers, might suggest this would be low. So while relative to all deaths of people in contact with NSFT is small (6%), 6-15 a month in Norfolk is

significant in terms of human suffering and loss, if carers have not had the chance to try to play a part in keeping their loved one safe through a mental health crisis.

4.4.31 Further information can be found in the audit of 961 suicides in Norfolk registered in 2014 to 2023, completed by Norfolk Public Health services – see **Norfolk Suicide Audit 2024**.

### WHY IT MATTERS

4.4.32 NSFT currently have a project focused on improving the recording of carer details on the patient safety record. This addresses the fact that recording of carer information in the Electronic Patient Record (EPR) is inconsistent and insufficient. Despite most patients having a network of family, friends or supporters who are likely to play a caring role in the person's life, the EPR does not contain the required information about these contacts, such as names, contact details, relationship and role, in a consistent way. A recent update on this project laid out the various risks this situation carries. Relevant to this finding, this includes:

- Important updates, crisis management, discharge or safety plans may not be shared with an appropriate person, leading to increased risk for the patient.
- In some cases, incorrect or absent information could lead to NSFT not being able to contact somebody in an emergency who could support with keeping a patient safe until help arrives.

4.4.33 This finding highlights the additional systemic issue around procedures for emergencies specifically when someone is at high or imminent risk of death by suicide, even where the carer information has been correctly identified and recorded. Without this, even where contact details for the 'related people' are known, there will be no reliability about decision making. The example given in the report is especially poignant:

> One parent shared with us, through the Think Family and Carer LiA project, that they discovered after the tragic death of their daughter by suicide, their contact information was not recorded in their daughter's records at all. They are clear that had they been contacted to advise their daughter's life was at risk, they would have made every effort to get to her and the outcome may have been very different. The opportunity to learn from this and provide a legacy of improvement has to be embraced and welcomed. (Board of Directors – in public pack – 31 July 2025

4.4.34 A legacy for improvement from Malcolm's experiences requires a wider focus, to include the next stage beyond consistent identification and recording. A formalisation of the process for determining when and when not to share the fact of an emergency and involved 'related people' in safety planning, to include internal oversight by the lead agency, as well as multi-agency information sharing with the opportunity this also brings for review.

| **FINDING 3 - ORGANISATIONAL AND MULTI-AGENCY DECISION MAKING AROUND INFORMATION SHARING WITH FAMILIES IF A PERSON IS AT HIGH OR IMMINENT RISK OF SUICIDE**<br><br>**QUESTIONS FOR PARTNERS TO CONSIDER IN DETERMINING RESPONSES** |
|---|
| • To what extent do partners agree with this finding about the need to formalise, and widen the partnership working around decision making about whether or not to inform and involve 'carers' when someone is at imminent risk of death by suicide linked to a |

mental health crisis?

- Is there any additional data from Healthwatch or other family campaigning groups that speaks to this issue?
- Is there any relevant or related improvement work currently underway or planned that a response to this finding could be added to?
- Does NSAB have an established approach to working up multi-agency procedures, that has co-production at its heart?
- How would NSAB know if things had improved?

## 4.5 FINDING 4 - MULTI-AGENCY INPUT INTO INPATIENT MH BED MANAGEMENT & SYSTEM-WIDE ESCALATION PROCESSES

**NSFT has focused on improving the visibility of people on the waiting list for inpatient mental health services, and rigour of the 'bed management' processes to determine the clinical priority of those waiting. This seems to work better when key teams involved with a person are NSFT (e.g. IOPS) but risks failing completely when key teams are social care, housing or other non-mental health services. The risks created are compounded by a lack of robust multi-agency, system-wide escalation protocols that can be used when there are long waits in A&E, challenges in locating inpatient provision for urgent admissions, and delayed discharges from hospital. This puts an unconscionable burden on family members who are forced to contrive their own campaigns in an attempt to be the voice of their loved ones.**

### BACKGROUND

4.5.1 NHS England Guidance (2023)[21] to support the commissioning and delivery of timely access to acute inpatient mental health care for adults and older adults includes a section on 'Arranging prompt access to the most suitable hospital provision for the person's needs'. It states:

> 'Arranging prompt access to the most suitable hospital provision for the person's needs: It is expected that when someone requires an admission, they will receive prompt access to the most suitable inpatient service that is available for their needs and begin receiving inpatient support as swiftly as possible'.

4.5.2 Where bed-occupancy rates are too high, this means the system does not have the necessary flex to accommodate urgent, unplanned admissions, creating waiting lists. 'Bed management' teams and meetings have therefore been developed to evaluate waiting lists against vacancies and attempt to determine who to admit first based on clinical priority and so ensure that individuals with the highest clinical risk receive urgent care.

4.5.3 NHS England's 'Inpatient Mental Health Improvement Guide (29 May 2025)[22] underlines that 'Regular communication with partners is a key part of maintaining flow

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[21] **NHS England » Acute inpatient mental health care for adults and older adults** Guidance to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible.

[22] **NHS England » Inpatient mental health: improvement guide**

through the system to ensure people get the right care at the right time'. However, I have not found any guidance that outlines more specifically what good practice looks like, or expectations, in terms of which partners or how they should be involved as part of bed management processes.

4.5.4 NHS England Guidance (2023)[23] goes on to outline expectations about escalations, if timely inpatient admission does not take place:

> **If someone is experiencing an unacceptably long wait for an inpatient bed** and this has not been resolved through routine processes such as bed management meetings, then **system-wide escalation protocols should be followed**. These escalation protocols should be **developed and shared with multi-agency partners** (e.g. local authority, police and A&E departments) and must be compliant with Section 140 of the MHA (https://www.legislation.gov.uk/ukpga/1983/20/section/140), which is a duty on local NHS commissioning bodies to provide every local social service authority with a list of hospitals that can receive urgent mental health admissions, and enable applications under the MHA, if necessary. **On a regular basis**, including after an escalation protocol has been activated, **multi-agency reviews should take place to help identify what more can be done to unlock capacity across the system** and help ensure that people can access inpatient mental health services in a timely way when they need them'.

4.5.5 The importance of collaboration across agencies is further underlined in a specific section titled 'Joined up partnership working'. The list of actions that can be taken to embed effective partnership working includes:

- Ensure there are clear pathways between services (e.g. between physical health and mental health services) and joint working arrangements are agreed with partner organisations
- Review the inpatient mental health pathway to understand how partnership working is currently functioning and how to strengthen it. For example, this could involve senior system partners and lived experience practitioners coming together on a quarterly basis to review performance data and local intelligence, assess where there are pressures across the pathway and identify actions to drive improvement.
- Integrate members of key partners organisations, for example, social workers and housing officers, as part of the ward team's staffing establishment.
- Ensure cross-service attendance at key meetings (e.g. care planning and discharge meetings, and other reviews). This should include representatives from the local CRHTT, the person's named key worker from the community-based mental health or learning disability team and any other key partners in the person's care (see box below for examples), as well as anyone that the person and their chosen carer/s feel it would be helpful to have in these meetings.
- Hold joint training between services that work with one another, where relevant, to understand the types of expertise that different services and professionals offer, as well as to reflect on and improve joint working processes. As an example, this could be used to share reflections about what more could be done to avoid escalation to admission, or to identify situations in which people are better cared for in the

[23] **NHS England » Acute inpatient mental health care for adults and older adults**

community.

- Develop clear escalation protocols with cross-agency partners, which set out when and how to raise issues to senior managers – the protocols should clearly identify where senior responsibility sits along with contact details to enable timely escalation to occur. Escalation protocols should exist for occasions when there are long waits in A&E, challenges in locating inpatient provision for urgent admissions, and delayed discharges from hospital. These protocols should be developed and maintained by the ICS, with input and agreement from NHS mental health providers and relevant partners included in the box below, who are key to the operation of the local pathway. More information about Section 140 compliant escalation protocols is set out in **this section of the guidance**.

### HOW DID THE ISSUE MANIFEST IN THE CASES OF THIS THEMATIC SAR

4.5.6 The contrast of experience in Malcolm and Joseph's cases, as relates to the experience of NSFT processes for managing waiting lists of people determined to be in acute need of mental health hospital admission, is illuminating.

### IN MALCOLM'S CASE

4.5.7 In Malcolm's case, IOPS was involved. Generically, IOPS provide additional, intensive support for a short period of time, to help service users in mental health crisis remain in their own home with as much autonomy and independence as possible. Once they identify that a person's needs can no longer be met in the community setting, they also request admission to hospital – as happened in Malcolm's case. They assessed Malcolm's risk of suicide as high, therefore increased visits to twice daily and requested a MHAA.

4.5.8 As described in the appraisal summary at the start of this report, the IOPS team were very positive about communication and collaboration during this time of crisis for Malcolm. They felt they were able to liaise closely with the AMHP and decided by mutual agreement not to progress the MHAA until conveyance to a place of safety could happen on the same day, due the assessed risk of Malcolm running away otherwise, in the waiting time.

4.5.9 They also described their input into the bed management process that followed, positively. They felt they had outlined the risks to Malcolm clearly, and these were accepted. They then received updates daily both via the MS Teams Chat of the Administration and Discharge Team, and their IOPS Safety Huddle, which the Bed Management Team join, allowing brief discussion of patient flow and risks to individual patients. They had understood at the time that there were three people waiting for one bed, and that Malcolm was to be the first. They did therefore not identify any need for escalation.

4.5.10 Input at the workshops suggested, poignantly, that this inpatient bed became available the day Malcolm's body was found.

### IN JOSEPH'S CASE

4.5.11 Joseph's case stands in stark contrast. Firstly, whether or what any step-up support was from mental health services was unclear. CMHT was visiting frequently, but as Joseph was not allowing them to come into his flat, their function appeared to others as merely having 'eyes on' Joseph. Joseph was described as being on FACT support also. FACT are part of the Crisis Response & Home Treatment Team (CRHT) service and a stepped-up care provision used if someone requires more intensive support and may be awaiting a referral to CRHT/CMHT or have been recently discharged from CRHT to

offer additional support and for ongoing observation. This support continued until Joseph's admission. What exactly it entailed or the benefits were unclear to other agencies. In early August CMHT staff made a referral to CRHT. This triggered an (internal to NSFT) MDT but there was deemed no role for CRHT at this time. Calls to the Crisis team were invariably transferred back to CMHT.

4.5.12 Both Joseph's family and Bluebell Court were calling everyone they could, including Adult social care, AMHP office, CMHT and the crisis team as time continued to pass, with their increasing concerns. They were also calling and emailing NSFT bed management. Pertinently, the supported housing provider was not part of nor had any opportunity to contribute directly to those bed management meetings.

4.5.13 The family described their response as 'starting the campaign'. They rallied the wider family, had a strategy and divided up roles to play to different family member's strengths and capacity.

4.5.14 As the weeks passed by, and without any formal escalation process to follow, the housing provider began to email senior leadership of the same agencies. Joseph's family did likewise, explaining to directors in adult social care, NSFT and NHS England the number of weeks that Joseph had been waiting.

4.5.15 Joseph's family also began to write to senior leaders and local politicians. In their view, change only happened when they threated to go to the media. Then their local MP wrote to the then CEO of NSFT, cc-ing the family. The next day Joseph was assessed and admitted.

### HOW DO WE KNOW IT IS UNDERLYING NOT A ONE-OFF?

4.5.16 In written data returns for the SAR and in workshops and meetings related to both of the cases for this thematic review, we have heard about positive improvements in NSFT bed-management processes. We have heard about MDTs linked to the bed-management process, that include community mental health teams e.g. MS Teams Chat Group Assessment and Discharge Team that takes place daily, and covers whether there are any inpatient beds, and presentation of anyone needing one.

4.5.17 But there was no indication in either case, or in wider discussions, about how non mental health related roles or teams are included in these mechanisms. The NHS England guidance cited in the background section to this finding, also does not appear to provide further detail.

4.5.18 Discussions as part of this SAR highlighted the existence of weekly meetings with the duty social work team to discuss high risk cases. Housing providers are part of these. The focus is on whether there been any deterioration for a person, whether there is anything more adult social care can do, whether any additional support can be arranged. But unlike IOPS safety huddles, NSFT bed management are not part of this duty meeting.

4.5.19 Conversely, neither adult social care nor housing appear to have opportunities to contribute to the NSFT bed management meeting. They are not clear what the criteria are for prioritisation.

4.5.20 The SAR has not heard any reference to knowledge of a system-wide escalation process that partners are expected and encouraged to use when there are delays to urgent inpatient admissions. It has heard that families resorting to communication with

local politicians and engagement with the media as the central means of advocating for their loved ones, in these circumstances.

### WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.5.21 It has not been possible within the constraints of the SAR to identify whether any data exists that would shed light on the number of cases where the key agency is not a mental health team or role, and is excluded from NSFT bed management processes.

4.5.22 Similarly, no data was provided on waiting lists for emergency mental health admission, so it has not been possible to identify how many people have been on a waiting list where the main agency involved was a supported housing provider.

### WHY IT MATTERS

4.5.23 NSFT bed management processes are clearly an important measure to mitigate the risks to citizens of not having access to urgent inpatient provision. Their success hinges on having the right information in order to be able to assess clinical priority and the right participants to provide adequate check and challenge to assumptions. Currently, key partner agencies are excluded from these discussions, increasing the chances of misinformed decisions that cause harm, sometimes linked to avoidable deaths.

**FINDING 4 - MULTI-AGENCY INPUT INTO INPATIENT MH BED MANAGEMENT & SYSTEM-WIDE ESCALATION PROCESSES**

**QUESTIONS FOR PARTNERS TO CONSIDER IN DETERMINING RESPONSES**

- How can partnership working in NSFT bed-management best be improved?
- What is the best way to progress the need for NSFT development of a clear escalation protocol with cross-agency partners, for use if someone is experiencing an unacceptably long wait for an inpatient bed and this has not been resolved through routine processes such as bed management meetings?
- How would NSAB know if things had improved?