Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

Lewisham Safeguarding Adults Board Safeguarding Adults Review

Michael Thompson LSAB-SAR-002-2016

Report by:

Ian Winter CBE

Steve Chamberlain

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Contents

12th February 2018

Lewisham Safeguarding Adults Board, Safeguarding Adult Review

The family of Michael Thompson appreciate the investigation from Lewisham Safeguarding Adults Board into the death of Michael. We hope that this will go some way in helping to prevent future deaths of anyone, and in particular those suffering from mental health issues. Mental health is still very much misunderstood and feared even by professionals trained in roles to support vulnerable people.

Despite a difficult upbringing and past, and much regret for his previous action in early adulthood, Michael was a man devoted to his mother, three children and the grandson he got to meet. He did not get to meet his granddaughter born a year after his death.

He was the only child to his mother who continued to be saddened at his loss and gave up wanting to continue to live without him in her life. She passed away in August 2017 of heart failure at the age of 83.

We hope that those reading this report in order to gain learning and understanding, will appreciate that everyone deserves the right to live and for someone to act and advocate in their best interest when they no longer have the capacity to think and act for themselves.

The Family of Michael Thompson

Safeguarding Adults Review
Michael Thompson, 311 Downham Way BR1 5EN
Born: 08/01/56 Died: 04/03/16

1. Introduction

1.1 This review concerns the death of Michael Thompson (MT). At the time of his death MT was living in Lewisham in a flat that he lived in on his own. On 3rd March at around 10.59 a call was made to the London Fire Brigade (LFB) as smoke had been seen coming out of the window at MT's flat by a person driving past. LFB found MT unconscious. At 11.03 the London Ambulance Service (LAS) was called. The LAS attended and administered emergency treatment and MT was taken to University Hospital Lewisham ICU, placed on cardiac support and ventilation but he was declared dead at 16.32 on 4th March 2016. A post mortem on 7th March gave a provisional cause of death due to inhalation of fumes.

1.2 On the 2nd/3rd March 2016 emergency services had been called to MT's flat by family members and neighbours on 3 separate occasions (at 17.02, 23.45 and 02.15) because of concerns about his behaviour. It is the circumstances surrounding these contacts with services and subsequent decisions/actions taken that are central to this review.

2. Safeguarding Adult Reviews (SAR)

National Requirements

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

"(*1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—*

(a) there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases."

3. About this Safeguarding Adult Review (SAR)

3.1 This SAR was commissioned by Lewisham Safeguarding Adults Board (SAB) and managed by the Case Review Group.

3.2 A SAR was first commissioned in September 2016, however following consideration of the draft SAR report by the Lewisham Case Review Group in February 2017 it was determined that the review was not sufficiently independent and that a new SAR should be commissioned. The delay in convening and conducting this first SAR are unfortunate.

3.3 An independent reviewer was asked on 21st February 2017 to carry out a new SAR using materials gathered during the original review and any further information to clarify any areas and to establish actions and decision making. Revised Terms of Reference for the review were agreed by the Case Review Group on 3rd April 2017. The Terms of Reference are set out in Appendix 2.

3.4 This report is based on information provided from:

- Downham Family Medical Practice (GP Service)
- Independent Police Complaints Commission (IPCC)[1]
- Lewisham and Greenwich NHS Trust
- London Ambulance Service (LAS)
- London Borough of Bromley – Emergency Duty Team (EDT)
- London Borough of Lewisham – Approved Mental Health Professional (AMHP) Team
- Metropolitan Police Service (MPS)
- National Probation Service, Lewisham and Southwark Local Delivery Unit
- NHS 111 Service
- South East London Doctors on Call (SELDOC)
- South London and Maudsley NHS Foundation Trust (SLaM)

[1] At the time of writing the IPCC report was embargoed pending any further action by the Police. It has subsequently been concluded and matters dealt with as referred to at paragraphs 11.85 and 13.10.

3.5 The Care Act 2014 Guidance explains that the purpose of a review is to:

i. Develop learning that enables the safeguarding adults' partnership future.

ii. Ensure that lessons are learnt and lessons are applied to future situations to improve local practice, procedures and services together with partnership working in Lewisham to minimise the possibility of circumstances similar to this happening again.

iii. The purpose of the review is not to apportion blame or hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

3.6 Lewisham Safeguarding Adults Board will ensure recommendations and actions from Safeguarding Adults Reviews are implemented to ensure that learning from these are not lost but used to improve services and prevent further harm, abuse or neglect.

3.7 The following principles apply to all reviews:

- there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
- the individual (where able) and their families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- the Lewisham Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and
- Professionals/practitioners will be involved fully in reviews and invited to contribute their perspectives.

Back to contents

4. How this Review was conducted

4.1 The original SAR was commenced in September 2016 and initial material was gathered and analysed. Following a review by the new Independent Chair of the Safeguarding Adults Board (SAB) and the Case Review Group on 1st February 2017, this review was stopped because of potential concerns over the requirement for it to be fully independent of any of the agencies involved.

4.2 Some of the material from that review has been used as the basis of this new SAR, however all background details have been reviewed and new information has been sought where required.

4.3 It is acknowledged that this has meant a significant delay and time lag. The gathering of information and the memory of events has been more difficult.

4.4 The revised Terms of Reference (ToR) were agreed by the Lewisham Safeguarding Case Review Group on 3rd April 2017. The key questions from these ToR are included in this report as the basis for considering, in detail, the events of the 2nd and 3rd March 2016 and the decisions that were made.

4.5 Before that analysis it is important to consider background information regarding MT's involvement with health, social care and other services to determine any other contributory factors relevant to this SAR.

5. About MT and Background Information

5.1 MT was described as a 60-year-old Black British man of Jamaican origin. He had lived on his own in his current flat for around 5 years and had regular contact with his family. It is clear his family were important to him – and he to them.

5.2 Underpinning this history is MT's conviction for an offence of murder in 1977, for which he was sentenced to life imprisonment. MT was 21 years of age when he was convicted of this offence, it was not associated with any identified mental health issues; it was a stabbing incident believed to be gang related. He was released on life licence in 1992.

5.3 MT's mental health issues first emerged in 1996 when he was out of prison on life licence. As recorded by the Probation Service, he was arrested in October 1996 due to alcohol misuse and there were concerns regarding his lack of co-operation and rising concerns about public protection. He was recalled to prison. Subsequently MT was transferred to the Bracton Centre Medium Secure Unit for assessment under section 47 of the Mental Health Act 1983. In January 1997 MT was diagnosed with paranoid personality traits with a history of substance misuse and propensity to brief psychotic episodes under stress. MT was transferred back to prison in June 1997.

5.4 In 2004 MT was released from prison on licence and an assessment was carried out by the Bracton Centre Medium Secure Unit. MT was assessed as having no signs of active mental illness.

5.5 MT's licence was revoked again in December 2006 following an altercation with his mother but the Parole hearing held in May 2007 deemed this recall to be unjustified and he was released in September 2007.

5.6 In June 2008 MT appeared at court for offences of benefit fraud and he was sentenced to a Community Order with unpaid work of 70 hours which he completed in September 2008.

5.7 In January 2009 MT was admitted under Section 2 of the Mental Health Act 1983 to hospital (Ladywell Unit - a SLaM inpatient facility at University Hospital Lewisham) for assessment due to concerns about his aggressive behaviour. The police were called following an altercation with an ex-partner and use of alcohol. He was reported to be irritable, paranoid and hostile. A forensic psychiatrist confirmed the diagnosis made in 1996. No medication was prescribed. He was released from the unit in February 2009. SLaM records show that the only evidence of community follow up was a referral to a Community Opportunity Service, which was rejected by MT.

5.8 In January 2012 MT was again admitted to the Ladywell unit under Section 2 of the Mental Health Act 1983 after police were called because of concerns about self-neglect, disruptive behaviour and a flood in his flat. MT was formally assessed as having had a brief psychotic episode from which he recovered quickly. On 28th February 2012 MT was discharged and referred to the Assessment and Brief Treatment Mental Health Team. He had two post discharge follow ups where he was found to be symptom free and as having some insight into relapse indicators and the effect of cannabis use on his mental state. MT agreed to continue with prescribed medication (Olanzapine 5mg and Promethazine 50mg) under the care of his GP. Both MT and the team agreed that there was no need for further follow up with them.

5.9 Following MT's release from the assessment unit in 2012 he had contact with the Probation Service each month until April 2014 when the frequency of contact was reduced to every three months as he was assessed as posing a low risk of harm to the public.

5.10 During this period, the Probation Service's supervision with MT was focused on employment and he was engaged with Probation Education, Training and Employment (ETE) services, but they were unable to assist him in finding suitable employment. He was also introduced to an external ETE supplier, but they were also unable to help him. The Jobcentre placed him on a great deal of training, but his lack of work experience combined with his lethargic presentation meant that he had very little luck. It was acknowledged that he wanted to work but it was stated that he never demonstrated any strong motivation to secure a job. However, it was also acknowledged that this could have been linked to his apathy around being able to secure work due to the number of failed attempts.

5.11 Probation records indicate that MT cared for his mother who is elderly and has respiratory problems, but her needs were not deemed sufficient for him to become a full-time carer.

5.12 During the period 2012 to 2016 MT was not in contact with secondary health services. The last contact was in 2012, as detailed at paragraph 5.8 above with the Ladywell Unit, after which he was discharged to the care of his GP.

5.13 On 31 March 2015 MT attended a planned mental health review with his GP where it was found that his mental condition remained the same. The GP recorded that MT was a low suicide risk.

5.14 The last regular prescription was issued to MT on 5th June 2015. He did not collect any further prescriptions following this date.

5.15 MT was last seen by the Probation Service in January 2016.

5.16 On 12th February 2016 MT was seen by the Healthcare Assistant at his GP surgery for a hypertension review. It was noted that he was not taking his medication.

5.17 On 23rd February 2016 MT attended a scheduled mental health assessment with his GP. The GP assessed that his condition had improved. MT was adamant that he would not take his medication and the GP assessed that he had [full] mental capacity. The GP scheduled a mental and physical health assessment in two weeks' time.

5.18 In the information provided by Downham Family Medical Practice the GP recorded "*MT attended feeling well, he denied any on-going anxiety or stress. He denied any hallucinations or thought disorders but claimed to be a spiritual man who would never consider self-harm/suicide. He denied dangerousness and maintained good eye contact. His appearance and speech were euthymic. MT was adamant he would not restart his psychotropic and antihypertensive and I assessed him as having mental capacity to make those decisions (i.e. he understood the dangers of not taking his medication as he knew he could be sectioned and admitted against his will if he relapses with possible endangerment to himself and the public at large). He was able to retain this information and we discussed at length the implications and we agreed he would attend A&E if he became stressed or started hearing voices or felt suicidal or dangerous. We planned to assess his mental and physical health in 2 weeks and he was agreeable to this as a plan"*.

5.19 MT did have a history of brief and sudden psychotic episodes with no apparent clear cause, although use of illicit drugs and stress were suggested as a factor in previous reports. It is impossible to say for certain what the impact of continued use of psychotropic drugs would have been. The GP in this instance recorded that he had capacity and MT said he understood the risks and implications of not taking his medication.

5.20 The GP also recalls discussing the use of illicit drugs and alcohol and MT accepted drinking within normal recommended daily allowances. He denied the use of illicit drugs. The GP reports that MT was not in receipt of Substance Misuse treatment at any point.

5.21 At the time of this mental health assessment the GP did not consider that it was necessary to refer MT to mental health services as there were plans in place to review his mental and physical health in two weeks' time.

5.22 On 29th February 2016 MT's cousin contacted the GP expressing concern that MT was not responding to telephone calls by the family. The cousin was advised to visit MT and if concerned to take MT for a psychiatric review or get MT to contact GP for review/discussion regarding medication.

6. Events of the 2nd and 3rd March 2016

6.1 A summary chronology of events leading up to MT's death on 4th March are attached to this report in Appendix 3.

6.2 A detailed chronology is set out here with details and some comments. The issues raised by the events are fully discussed and analysed in Sections 7 to 12.

6.3 On Wednesday 2nd March at 15.00 MT's mother and two uncles went to MT's flat because they were concerned because they had not heard from him for approximately 6 days, which was said to be unusual. Using their key, they let themselves in. They reported that he seemed to be unwell and it appeared that possessions had been thrown around in the rooms. MT was vacant and non-communicative. At 15.23 one of the uncles called NHS 111. At 15.29 the NHS 111 "warm transfer" the call to a clinician (nurse) due to its complexity and at 15.49 the call is closed "*with a disposition for the caller to contact the Patient's GP. No safeguarding referral made".*

6.4 At 16.07 MT's uncle called NHS 1111 again. At 16.13 the call handler queued the call for a clinician to ring back (priority 1). At 16.25 the clinician contacted the uncle to reassess MT. At 16.37 the clinician decided an emergency ambulance was required for clinical reasons and requested the London Ambulance Service (LAS) to attend. No safeguarding referral was made.

6.5 LAS attended at 17.02 while the family were still present.

6.6 The family informed the LAS that MT was on medication for his mental health but had not been taking it for at least 3 months and they did not think he was under the care of any mental health team. The LAS crew suggested that MT should go with them to the hospital but MT refused any assessment. The LAS were unable to formally assess his mental capacity as he was uncommunicative but using the LAS Capacity Tool their assessment was that MT lacked the capacity to consent/make decision about attending hospital.

6.7 The LAS looked for paperwork to gain information on MT's medical history and found documents in the bedroom indicating he had previously been under the care of the Ladywell Unit and SLaM. While looking around the flat the LAS recorded that there was evidence of a small fire having been set as there were burnt papers on the floor in the middle of the lino in the kitchen. The LAS also found knives in the bathroom and bedroom, which with the knowledge of the family the LAS wrapped in a large tea towel and placed behind the boiler, out of sight or easy reach.

6.8 The family stated that MT had not expressed any intent to self-harm. There was no evidence of alcohol consumption or cannabis (no smell).

6.9 MT was verbally aggressive and refused any medical examinations or to go in the ambulance to the hospital. On the advice of the family, LAS staff vacated the property for their own safety but remained close by. The LAS officers then took detailed reports from the family, confirming some history of his mental health situation.

6.10 The LAS called the Police at 17.24 to assist them with transferring MT to the Ladywell Unit (a mental health unit) and MT's history of violence is recorded. The Police call handler queried the request and asked if a mental health assessment had taken place. The LAS response to this at 17.37 was "*MH crisis/Knives in premises/history violence*"

6.11 The LAS made a further call at 17.56 requesting police attendance. At 18.02 the police call handler questioned why the Police were required if the individual was being taken straight to a hospital. At 18.06 the LAS responded, "*Male not communicating/ Knives in the premises/ history of violence/ assistance required to transport to hospital*." The Police attended after this request.

6.12 The Police arrived at around 18.20 but did not enter the premises because the LAS advised that MT might react aggressively. The Police advised that there was nothing further they could do citing Section 136 of the Mental Health Act 1983.

6.13 Before the family left the scene, one of MT's uncles left his, and other family members', contact details with the Police and with the LAS who said that they would let them (the family) know what happened. The family left because one of the uncles needed to take care of his diabetic condition.

6.14 The LAS made contact with the out of hours doctors service (SELDOC). According to LAS the first call to SELDOC was at 19.03. The SELDOC call logs show the first call being received at 20.03. There is agreement that there was a chasing phone call from LAS around 21.00 after which the SELDOC doctor rang the LAS crew. The SELDOC call log times this contact starting at 21.35 and ending at 21.45.

6.15 The SELDOC call log shows that MT's details were updated on their system at 21.05 and 21.06.

6.16 At 21.35 the LAS spoke to the SELDOC doctor and passed on detailed information about MT. This included:

- Mental health history, including hospitalisation in 2012
- Not taking medication recently
- Evidence of a small extinguished fire
- Knives in the property
- History of violence
- Refusal to communicate or co-operate with assessment or to go to hospital
- Family members contact details

6.17 The LAS recorded that the SELDOC doctor's judgement was that it was not safe to come out on his own after hearing all the facts and as the police had left the scene by this time.

6.18 Following the conversation between LAS and the SELDOC doctor, LAS left the vicinity at around 21.45. LAS left with the understanding (assumption) that the SELDOC doctor considered the matter to be urgent and that he was going to liaise with the "mental health unit" (Ladywell). The paramedic statement states "*The GP said he wouldn't send anyone by themselves to deal with MT as he didn't think it would be safe to do so. He would pass the information to the Ladywell Unit and make it clear it was an urgent matter."* On that basis, they withdrew. Before they left LAS completed their paperwork in their vehicle and went back to the flat with the intention of leaving it there for the professionals visiting in the morning but felt it was unsafe to re-enter.

6.19 At 22.05 the SELDOC doctor contacted the Bromley EDT (AMHP) giving details from the Ambulance crew's call to SELDOC. The main details recorded by the Bromley AMHP in the Approved Mental Health Report timed at 22.05, records the following:

"*22.05 Ref 156889 Dr …. - family have not seen a relative for over a week – called ambulance – when arrived – verbally abusive paramedics afraid of him – family advised them to leave for their own safety and family too frightened to enter the property - is abusive – is on meds has not been taking it – MH concern. MT 08/01/1956 311 Downham Way Bromley BR1 5EN. Compulsory admission in 20/12/2015 - had not been in touch with family for week. Not engaging – threats – verbal abuse – police were there with ambulance – unable to intervene – risk to others? – There for a week – not attempting to go anywhere. Lewisham address recently moved – Downham medical practice CCG Lewisham. Nothing on RIO 207. Registered on Rio – no core assessment – no entries. Probably known to SLAM. Previously open to community team Bracton Service 2004 and forensic psychology assessment team Feb 2009. No entries on Rio on progress notes – nothing on core assessment or RA. Nothing on clinical documentation. CCG SLAM Lewisham. GP history Downham family Medical Practice 19/03/2009. Advised ring PLN Lewisham 0208 333 3478. 0208 333 3000."* There is no mention of knives, fire or family member contact details.

[The full report made by the AMHP is shown at Appendix 8. The reference to a compulsory admission on 20/12/2015 is incorrect. MT was actually admitted in January 2012. It must be assumed that this was an original case record or transcription error.]

6.20 The Bromley EDT logs also shows a call at 22.23 from the AMHP to the Psychiatric Liaison Nurse as follows:

"*22.23 hrs TCT (telephone call to) PLN* (Psychiatric Liaison Nurse) *who advised patient previously known to slam* (South London and Maudsley Hospital) – *no contact since 2012 – has had previous admission to Ladywell 2012 diagnosed – acute psychotic disorder - history of drug use. No contact since."*

6.21 The Bromley log then states there is a further telephone call to the referrer (SELDOC) as follows:

"FTC (further telephone call) to referrer – we discussed that as patient currently at home and has only shown aggression when being assessed that it could wait for him to be assessed during the day. Please can day team assess what

support/ assessment - this patient needs as family have become concerned about his lack of contact and his mental state appears to be aggressive?"

6.22 All of the above is taken from the composite summary of personal history in the Approved Mental Health Professional report as shown at Appendix 8.

6.23 SELDOC log records that final discussions took place between 23.07 and 23.12 between SELDOC and the Bromley emergency duty team (EDT) and this resulted in a decision that no further action would be taken out of hours and that this matter would be referred to daytime hour's services to the Mental Health Team. At this time, it is assumed to mean LB Bromley.

6.24 At 23.14 the SELDOC call log records *"Information outcome added – Mental Health check. Case triaged changed to urgent (to be seen in 24 hours)"*

6.25 A further call from a neighbour was made to the Police around 23.45 when it was reported that MT was throwing items of clothing out of his flat. The police visited at approximately 00.50 and according to the neighbour stayed for around 15 minutes. The Police determined not to take any further action based on information that Mental Health services were going to visit the next morning (3rd March). Refer to paragraph 11.84 and 14.9 which were amended following the conclusion of the IPCC investigation.

6.26 At 01.30 on 3rd March a further call was made to the LAS by a neighbour. The neighbour was not with MT at the time and it was determined no ambulance was required and the call was cancelled.

6.27 At 06.30 MT's neighbour called into the flat and spoke with MT on his way to work. He advised him to go to the hospital or to his mothers.

6.28 The referral from LB Bromley EDT to the day time services was progressed. At 09.00 on the 3rd March the Bromley EDT worker called the Bromley (day time) AMHP team. The team administrator checked the address and realised this was in fact a LB Lewisham address. Lewisham was contacted and the referral passed to them. The LB Bromley adult safeguarding report for LSAB states "*Referral sent to Lewisham (from Oxleas) and a conversation had at 10.09 between Oxleas AMHP and Lewisham AMHP. We understand when the referral was reviewed by the manager it was passed through to the Lewisham Response Team.*"

6.29 On 3rd March at 10.59 a call was made to the London Fire Brigade (LFB) as smoke had been seen coming out of the window at MT's flat by a person driving past. LFB and LAS attended and MT was found in the flat and unresponsive. Cardio Pulmonary Resuscitation (CPR) was performed and MT was transferred to University Hospital Lewisham (UHL). He was critically ill on arrival having suffered two heart attacks. He was transferred to Intensive Care Unit (ICU), placed on cardiac support and ventilation but he was declared dead at 16.32 on 4th March 2016.

Back to contents

7. Analysis, Comments and Learning Points

7.1 The chronology in Section 6 has been put together from the various reports and information received both from the material gathered for the original SAR and subsequent requests for further information and specific questioning as part of this SAR.

7.2 It raises a number of organisational learning and development issues, some questions that could not be resolved and areas of practice and procedure that require development and learning from this SAR to both improve and prevent the reoccurrence of some of these issues in the future.

7.3 It is of primary importance to not reduce this learning to organisational or bureaucratic analysis such that it loses sight of the individual concerned and the risks that he faced because of his recurring mental health condition. Ultimately this review is about an individual.

7.4 In summary, there are seven key process and practice issues that will be evident in this section. These are

- information exchange(s)
- response to the family
- risk analysis and decision making
- timely contact
- handovers between key professionals
- use of best practice
- candour and reporting

7.5 These are related to the events of the chronology, they are part of a narrative built on the responses of the key agencies involved and are broadly in the order in which the events occurred.

8 The Emergency Services

NHS 111

8.1 The call to NHS 111 first at 15.23 and then at 16.07 on 2nd March set in train the sequence of events for what happened on the 2nd and 3rd March.

8.2 While the history and diagnosis of MT's mental health condition was not available to NHS 111 at that time, it seems clear that his needs were primarily described as to do with his mental health state rather than any physical health condition.

8.3 Had MT been co-operative then it is likely that the very best an ambulance crew could offer would have been transport to a local A&E which may, or may not, have been appropriate.

8.4 Without MT's consent, transport to the mental health unit called Ladywell for the purpose of a psychiatric assessment would require a Mental Health Act (MHA) 1983 assessment and completion of section papers. In more urgent circumstances, a warrant under MHA 1983 Section 135(1) could have been

used. The warrant can only be obtained by an AMHP on application to a magistrate, and can only be executed by the AMHP with a police officer and a doctor in attendance.

8.5 Therefore, it is reasonable to conclude that an urgent referral to the AMHP duty service for the local authority where MT was (LB Lewisham) would have been more appropriate. In fact, had this occurred it was still within daytime working hours and may have avoided the protracted and inconclusive events during the rest of the 2nd March 2016.

Learning Point 1 - Referral to Mental Health Services

It is well-established that direct referrals are more effective at ensuring effective transfer of information, rather than a number of 'hand-offs' where errors of information or dilution of urgency can occur.

It would seem that the most appropriate action would have been for the NHS 111 or ambulance service to make direct contact with the AMHP daytime duty service.

This would have ensured that the professionals who had personally seen the person were able to provide first-hand information to the duty service, which would have inevitably helped with the risk assessment.

If this had occurred, the AMHP duty service would have been able to obtain contact details for MT's family, who had initiated the activity due to their own concerns. This would have enabled considerably greater knowledge of the risks and MT's current condition.

London Ambulance Service (LAS)

8.6 It is very clear that LAS paramedics on the ground did all they could during the time of their visit to gather information, secure some safety in the accommodation and pass on the relevant information so that co-ordinated action could follow.

8.7 In response to MT's refusal to go to hospital and the aggression he showed, the family were undoubtedly right to advise the ambulance crew to withdraw to prevent any escalation of the situation. Because of that withdrawal, the LAS paramedics decided to call the Police. This is referred to in paragraph 8.11 onwards.

8.8 The family then withdrew after the Police had arrived because one of the family members was diabetic and needed to eat/take insulin. MT's uncle recalled leaving his and the other family members contact details with both the LAS and Police and that the LAS crew said they would let the family know what had happened. It is clear that the LAS passed this contact information on to SELDOC as it was recorded in the subsequent SELDOC patient record (attached at Appendix 6). Family details were not recorded in the conversation between SELDOC and Appello (LB Bromley's call hander) at 21.55 (Appendix 14). The AMHP report (Appendix 8) makes no reference to any details of the relatives. Notwithstanding this, the AMHP then passed on the referral to daytime services on the basis of "*Nearest Relative (effectively)".* However, in a subsequent report from LB Bromley in response to questions for this SAR the

following statement is made, "*The AMHP does not recall receiving contact details from the doctor of MT, his family or his neighbours this would be required for any nearest relative request*."

8.9 In the event there was no follow up contact with the family after they left Downham Way at around 18.30 on 2nd March. The next contact the family had was when the Lewisham Hospital staff telephoned MT's mother around 17.00 on the 3rd March to inform her that MT was in their Intensive Care Unit (ICU). The lack of contact to either give or receive information in the ensuing 23 hours is not acceptable and is regrettable.

8.10 Contact with the family may well have clarified the urgency of the situation, and given the EDT AMHP, and/or subsequent daytime services, a clear and first-hand picture of MT's condition.

Metropolitan Police Service (MPS)

8.11 It is perhaps surprising that during the phone calls between LAS and the Police at 17.24 and 18.06 that an alternative course of action to contact out of hours duty AMHP (through an EDT) was not mooted. Nor was this discussed while the Police were at the property.

8.12 When the Police arrived and the situation was explained to them face to face by the LAS crew the police officers made it clear that they had no power to act.

8.13 There is no record of mental capacity in these discussions.

8.14 It is useful here to consider both section 136 of the Mental Health Act 1983 and the Metropolitan Police – Policing Mental Health Guidance V4. Key parts of these documents are included at Appendix 4 for reference. Section 136 was not available as MT was in his home and section 136 can only be used if the person is in a place "'to which the public have access".

8.15 It was clear from the outset that the Police were unlikely to be able to act and in light of the LAS experience it was unlikely that uniformed Police officers were going to be acceptable to MT.

Back to contents

Learning Point 2 - Referral to Mental Health Services, Identification of Risk, Especially Out of Hours

When dealing with situations that are primarily about the mental health or psychological wellbeing of an individual (which may be exhibited in a number of ways) the issue of Risk (to others and self) and Capacity should be foremost in professionals' evaluation of options.

Referral to designated mental health professionals (AMHP) whether during normal working hours or out of hours (EDT) should be considered?

This should be made clear in local guidance and at an appropriate time put into any revisions to the London wide Safeguarding (multi-agency) guidance.

London Ambulance Service and Police and Fire Service must be able to access a database that gives them the contact details of mental health emergency services as described above. This should also be reflected in local guidance and when appropriate London wide guidance.

9 Mental Capacity

9.1 In the original notes from LAS it states that MT *"did not have capacity to make his own decisions"*. The SELDOC report for this SAR states "*During the telephone conversation between the doctor and the LAS crew member, the LAS crew member stated that MT "might be lacking capacity". It was discussed how a LAS capacity form was attempted to be completed, but was difficult to assess capacity as he was not verbally communicating*."

9.2 While the consideration of LAS was not based on a full capacity assessment (as they state) it is very regrettable that the issue of MT's mental capacity (particularly to be able to take account of the risks he faced and ability to make sound judgements) seems to have been lost and not referred to in subsequent onward referrals. While it is difficult to assess capacity if the person is not communicating, but given the circumstantial evidence of his environment, combined with his failure to communicate this is a potentially significant alert to some form of mental disorder or impairment.

9.3 If the risks had been adequately communicated in onward referrals (knives, fire), combined with a view that he appeared unable to appreciate the severity of those risks that would have been important information to pass on, even without a fully completed capacity assessment.

Back to contents

10 SELDOC: Contact with SELDOC

10.1 After the withdrawal of the Police the LAS then contacted the out of hour's emergency doctor system called SELDOC.

10.2 A summary of SELDOC's role is included at Appendix 5. In summary, it is a GP co-operative company that provides unscheduled and out of hour's primary care services for people living in the area of, or registered with GP practices in its area of operation (Lambeth, Southwark and Lewisham). SELDOC "*aims to provide high quality clinical care for patients through local GPs or GPs who qualify to work for SELDOC by virtue of working at least 2 shifts per week as a GP in Lambeth, Southwark or Lewisham."*

10.3 In the event the call to the out of hours GP service (SELDOC) did not occur until 19.03 (according to LAS). Nearly two hours had elapsed since the ambulance first arrived.

10.4 The report from SELDOC times the first call to them at 20.03. A gap of three hours. It is not clear what was happening during this time.

10.5 From the reports received from LAS and SELDOC, the different timings for contact are as follows:

Contact between LAS and SELDOC on 2rd March 2016

LAS			SELDOC		
Time	**Description**	**Source**	**Time**	**Description**	**Source**
19.03	Call from LAS to SELDOC from paramedic's mobile phone	LAS signed response Paramedic statement to IPCC LAS Patient Record form			
20.07	LAS ring SELDOC chasing response	LAS signed response	20.03	First call from LAS to SELDOC	SELDOC response SELDOC additional information
21.00	Call back from SELDOC GP to LAS	LAS signed response Paramedic statement to IPCC	21.06	Second call from LAS chasing response	SELDOC additional information
21.09	Crew waiting for SELDOC ring back – have been waiting for 1 hour + Crew have called and have been advised GP to call shortly	LAS Call Log			

LAS			SELDOC		
			21.35 – 21.44	Call back from SELDOC GP to LAS	SELDOC additional information

10.6 As can be seen from the above there is a discrepancy in the timings provided by LAS and SELDOC. This refers to LAS stating that the referral to SELDOC was made at 19.03 with chase up calls at 20.07 and 21.00 – whereas the SELDOC records state that the first call was at 20.03 but agree that there was follow up call at 21.06.

10.7 These timings were queried with both LAS and SELDOC as part of this SAR. LAS confirmed their times as being correct and SELDOC confirmed their times as correct.

10.8 SELDOC stated "*If a previous call had been made to SELDOC, any subsequent calls would be logged against the original call (as with subsequent call from LAS at 21:06). There is no other clinical case with the same name or demographics as MT on the SELDOC computer system on the 02/03/2016."*

10.9 On the detailed LAS call log, there is an entry that reads "*21.09 awaiting SELDOC R/B – Have been waiting for 1 hours +. Crew have called back and have been advised GP to call shortly".*

10.10 It is impossible to resolve these two accounts. Whatever happened, this resulted in a delay of at least 1 hours 30 minutes in referral information being relayed between LAS (who were on the scene) and the SELDOC out of hours doctor.

The SELDOC categorisation of this call

10.11 Notwithstanding time discrepancies, the original referral from LAS to SELDOC resulted in an initial classification of Category C which was confirmed as "*all routine calls*" in the SELDOC additional information provided to this SAR.

10.12 While it is not possible to determine exactly what was said in the initial referral from LAS to SELDOC (whether at 19.03 or 20.03) it is perhaps surprising that this situation was categorised as "routine". The key factors known by LAS at that time were as follows:

i) NHS 111 determining that an ambulance should be called at 16.35.

ii) LAS insisting that police were required at 17.24.

iii) Specific concerns regarding MT's situation (knives, potential fire).

iv) Concerns regarding his mental state, aggression and non-compliance.

v) Deemed lack of capacity to make an informed decision.

vi) State of mind of MT's aggression and threats.

vii) Historical background information from the relatives.

10.13 It is of note that when SELDOC concluded their involvement at around 23.00 and the decision had been taken not to conduct an out of hours assessment (with Bromley EDT) SELDOC revised the categorisation to "*informational outcome added – Mental Health - Case triaged changed to urgent (to be seen in 24 hrs).*"

Referral of Information from LAS to the SELDOC Doctor

10.14 After one hour (21.06 according to SELDOC), or two hours (according to LAS), LAS made a follow-up call. The on duty out of hour's doctor for SELDOC called the LAS staff back at 21.35. From both the LAS records and SELDOC report, the doctor was given considerable detail, including MT's unresponsiveness, agitation and aggression, the knives that had been found and the evidence of a small fire setting of documents. It also included the information regarding MT's previous involvement with Ladywell Unit.

10.15 This account of the situation was relayed to the doctor at 21.35, some four and a half hours after LAS arrived at the property and five and a half hours after MT's uncle had contacted NHS 111 for the 2nd time.

10.16 SELDOC has confirmed that they have a standard policy for call handlers. It states calls received from a "Doctor or other healthcare professional" should be marked as "Urgent" (which it was not) with "Response Time for GP Contact" detailed as "As soon as possible – within 20 minutes". The call logged at 20.03 on 2nd March was marked as routine C. According to SELDOC's public website the duty clinician will make contact between 20 minutes and an hour depending on the seriousness of the condition.

10.17 Despite not being able to resolve the time of the originating call these timescales were not met. SELDOC should review their response times and take steps to ensure maximum compliance.

10.18 Following this discussion with the SELDOC doctor, LAS finally withdraw from the area around 21.45. They did so in the belief that the SELDOC doctor was making a referral to the mental health team on an urgent basis. Their report records as follows: "*The GP said he wouldn't send anyone by themselves to deal with MT as he didn't think it would be safe to do so. He would pass the information to the Ladywell Unit and make it clear it was an urgent matter."*

10.19 However, it is not clear that this decision had been taken and it was to be a further hour or more before the decision was taken not to conduct a mental health assessment that evening.

Back to contents

Learning Point 3 - Out of Hours (SELDOC) (a)

SELDOC should be asked to consider the method or triage used to categorise or designate calls and give clear guidance particularly around mental health or psychological conditions and risk.

The SELDOC policy of timescales for responding to calls should be reinforced and monitored carefully (this had been commented on by CQC in 2015).

SELDOC Referral to the Emergency Duty Team (EDT) at London Borough of Bromley

10.20 This next section is crucial in terms of the decision that was made not to visit MT and conduct either a mental health assessment or a Mental Health Act 1983 assessment that evening and to postpone any further action until normal working hours on the next day (3rd March).

10.21 The chronology in sections 6.19 – 6.23 sets out the key activities but it is important to explore in detail a number of factors that were present and the issues that arose in the decision making, firstly from the SELDOC reporting and their perspective.

10.22 It is important to consider these key events and exchanges from the Bromley EDT reporting and their perspective. There were limited case records (made at the time) from either agency. In the case of Bromley EDT the notes made of various conversations were written up by the EDT AMHP on his computer but his notes were lost when the hard drive failed and are irretrievable. The subsequent written reports are perhaps understandably different from each other, and both were written sometime after the events.

10.23 The referral from SELDOC was made to LB Bromley EDT. But MT was a Lewisham resident with a Lewisham GP. This was an understandable error in that ordinary web searches state that the post code is Bromley (BR) and both Downham Way and the GP practice on Moorside Road, comes up as being in Bromley. In fact, all of Downham Way is in the Downham Ward and is part of LB Lewisham although neither the post code nor an ordinary address search make this clear.

10.24 There was not a detailed check on the address at this point of referral but this error only came to light after 09.00 on 3rd March when the referral was passed from the Bromley EDT to the Bromley daytime services AMHP.

10.25 It is also clear from the report from SELDOC that the emergency doctor was not able to easily to find out who to refer on to. The SELDOC report states that the doctor *"asked the supervisor for the appropriate number to ring, given the patient's location, and although they did not have it, the doctor recalls being directed in the general direction which after several phone calls did lead to a referral. The doctor remembers that it was certainly not straight forward to get hold of anyone that night."*

10.26 As part of this review SELDOC was asked what information systems they have for doctors to use. Their response on 6th June was as follows "*On the computer system "Adastra", all clinicians have access to the "24-hour mental*

health helpline" for South East London (South London and Maudsley NHS Foundation Trust). There are also posters displaying the acute mental health pathways in every consultation. It is unclear why the doctor spoke with Bromley EDT (his previous statement states that he spoke with a Lewisham CPN?)". This is further confusion about the routing of the referral.

10.27 SELDOC have confirmed (paragraph 10.52) that the doctor was based at SELDOC headquarters in Dulwich Community Hospital. It is therefore difficult to understand why the Adastra system was not used and inexplicable why the doctor used his own personal mobile phone for the calls to and from the Bromley EDT AMHP rather than the telephones provided which have recording facilities.

10.28 The doctor finally contacted the Bromley EDT via Appello (the designated call centre for LB Bromley) and spoke with the AMHP worker at about 22.05.

10.29 In this first phone call SELDOC reports that their doctor took a good note of the information that the LAS crew provided and this is corroborated in their call log notes: In the SELDOC doctor's notes there is reference to:

- Mental health history, including hospitalisation in 2012
- Not taking medication recently
- Evidence of a small extinguished fire
- Knives in the property
- History of violence
- Refusal to communicate
- Family contact details

10.30 There is no mention of Mental Capacity.

10.31 SELDOC report that their doctor "*supplied all the information contained in the notes to the duty Approved Social Worker* (sic)" See also paragraph 8.8 and 10.22.

10.32 It is apparent that the doctor left the AMHP to follow up on other information and ring the Psychiatric Liaison Nurse in Lewisham and check electronic care records called ePJS (Electronic Patient Journey System).

10.33 The AMHP phoned the doctor back between 23.07 and 23.12 (from the SELDOC records).

10.34 From the SELDOC Patient Record it states, "*ASW has liaised with CPN and PLL* (Psychiatric Liaison Lewisham) *and they are referring to CMHT* Community Mental Health Team) *for assessment this morning as there is not sufficient evidence for a MH section tonight as patient has not shown any intent to leave the premises and only became threatening when house was invaded. ASW (*the AMHP) *has organised for MH visit in the morning. I have asked him to make sure the safety concerns are passed on".*

10.35 The Mental Health Act 1983 states in S13 (1A) b that if the local social services have reason to think that an application for admission in respect of a patient within their area may need to be made, they shall make arrangements for an approved mental health professional to consider the patient's case,

having regard to any wishes expressed by relatives or any other relevant circumstances.

10.36 Guidance states that consideration is not a one-off decision but should be reviewed in light of further information, and consideration should be given to obtaining a S135 MHA 1983 warrant in order to obtain entry to the property. Section 14.35 of the Mental Health Act Code of Practice states "*To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs*"

10.37 The point here is that as a person's needs change, then so will the risk and urgency and subsequently the rapidity of the response.

10.38 The Code also states:

a) Section 16.9 - Local authorities should ensure that guidance to AMHPs on how and when to apply for a warrant is also available to the relevant partner agencies (including the relevant local authority and police force).

b) Section 16.10 - Local authorities and hospital managers should ensure that there are procedures in place for obtaining warrants, both during and outside court hours.

10.39 The AMHP may have made a pro-active decision, based on the information.

10.40 As outlined elsewhere there is no record of a discussion between the AMHP and SELDOC GP at the time regarding relative's details, however as contained in paragraphs 11.44 and 11.57, according to a subsequent report from LB Bromley it states that the AMHP asked for further details of the family and the SELDOC GP did not have them to hand. The direct views of the relatives of MT who had been in the property with MT during the evening of 2nd March 2016, and had regular contact with him were therefore not considered as part of the EDT AMHP assessment. This information could be considered as crucial during the EDT assessment. Notwithstanding this the AMHP made the referral to daytime services as (effectively) on behalf of a Nearest Relative.

10.41 The Bromley safeguarding report (report of 26th June 2017) of this incident states that *'in line with EDT procedure and best practice a fully researched and planned assessment for the following day was the preferred outcome in this case.'*

10.42 Notwithstanding the information gaps, the outcome of the EDT AMHPs decision may still have been to defer the assessment to the next day in order that a fully planned assessment could take place. However, had a more robust approach to gathering information taken place the AMHP would have been in a more informed position to consider the decision to proceed to an assessment that night or defer to the following day. The issue of AMHP responsibilities are referred to further at paragraph 11.51 onwards.

10.43 The MHA 1983 and the code of practice sets out a clear framework for the AMHP in how to conduct Mental Health Act assessments. The EDT AMHP conducted the assessment and gathered information and concluded that the

assessment of MT could wait until the following day. If they concluded that an assessment under the MHA 1983 was required that night an application to an on-call magistrate could have been made by the AMHP to obtain a S135 warrant to gain access with police assistance to the property to conduct a MHA 1983 assessment.

Learning Point 4 – Obtaining a Warrant under S135

The EDT AMHP must be clear on the process of making an application for a S135 warrant out-of-hours:

- Telephone number of out-of-hours duty clerk
- Payment process for application
- Access to warrant documentation

Transferring the Patient Record

10.44 The Patient Record (as shown at Appendix 6) provided by SELDOC is a very important document, not least because it was completed on 2nd March.

10.45 This Patient Record was not transmitted to the Bromley EDT. In response to a question for this SAR, SELDOC have explained that this is because they "*would not routinely communicate clinical care records with outside organisations, with the exception of the patient's registered GP, unless specifically requested to do so at the time*."

10.46 It is very clear that the transmission of this document would have ensured that some crucial pieces of information were available directly, and without question, to the EDT AMHP. It would have assisted both decision making and the subsequent onward referral. This record was sent as required to MT's GP surgery on 2nd March in accordance with the National Quality requirements. The framework for out-of-hours GP care provision says a copy of all consultations with patients should be sent to the patient's registered GP by 08.00 the following working day. But it is also vital that the AMHP has all the relevant information made available to him/her. Without all the information, they risk working, as it were, with one hand tied behind their back.

10.47 The missing information is very significant particularly about factors of risk and the family details, which are central to any consideration of use of the MHA 1983 by an AMHP.

10.48 It would be helpful if there was a policy to exchange this information with AMHPs. This issue is referred to again in paragraph 11.57 in relation to Bromley EDT.

10.49 It is now impossible to know why crucial pieces of information were not recorded on the AMHP forms, though clear to SELDOC. This resulted in incomplete information being passed onto daytime services on 3rd March.

10.50 The telephone call from the SELDOC doctor was not made on SELDOC equipment and therefore was not recorded, contrary to SELDOC policy. In response to some further questions for this SAR received on 26th May 2017 SELDOC advised that, "*SELDOC policy is that all telephone calls relating to*

patient care are recorded. All telephone calls made from our office telephones are recorded as standard. We have examined the telephone call database three times, and have been unable to locate any recordings of calls between the doctor and Bromley EDT. Given the call is not recorded on the database, the call was not made using a SELDOC telephone. We have a policy of recording calls if a mobile telephone is used." It appears that the referral was made by their doctor using his personal mobile telephone." Why this was the case, which is at variance to SELDOC policy, has not been explained.

Learning Point 5 – SELDOC Recording Phone Call Policy

The SELDOC stated policy of using phones that enable the recording of referrals should be reinforced with all out of hour's staff. This usage should be monitored to ensure compliance. Where a personal mobile is used (and not recorded) the reasons for this should be stated.

10.51 In follow up to this SAR, SELDOC responded that "*We have been unable to contact the doctor to establish if there was any consideration of mental capacity in the discussion with Bromley EDT*." This is surprising as there are public records of this doctor's current surgery commitments in another area.

10.52 There is no explanation as to why the doctor was using his personal mobile telephone. SELDOC have further confirmed (6th June 2017) that the doctor "*was based at SELDOC headquarters at Dulwich Community Hospital for the shift in question. If a home visit was required, he would have been able to forward the case to three doctors on dedicated home visiting shifts during the evening time*."

10.53 Whatever the circumstances of this the Bromley service maintain that the following substantive items were not passed through to them:

i) Fire

ii) Knives[2]

iii) Contact details for family

10.54 The transmission to Bromley of the Patient record and a recorded telephone call, the latter of which is SELDOC policy, would have clarified this.

10.55 The most critical issue is, could this information, including contact with the family, have impacted on the decision not to visit and conduct a mental health assessment until normal working hours on 3rd March.

10.56 It is important to consider this decision making from the perspective set out by SELDOC. This is mainly contained in the report prepared by them in response to questions raised by those preparing the first SAR. This document gives a very strong emphasis to the view and opinion of the out of hour's doctor. This

[2] Following the Inquest in August 2017, transcripts of the telephone calls between SELDOC and Appello and then the Appello call handler to the AMHP (Appendix 14) shows that information regarding knives being on the premises was passed on. However this information is missing from the Approved Mental Health Professional Report at Appendix 8, which was the only record passed on to Lewisham.

report was written by the Patient Experience and Quality Manager and the Medical Director (dated 2nd September 2016). It states: *"It was considered unsafe for a visiting doctor to attend based on the information provided by the LAS paramedic. It would have been considered safe to attend as part of a formal section process with police, approved social worker and psychiatrist*, *which was the reason the doctor urgently referred the case to the Mental Health Team. The doctor feels that there was enough information to justify a section that night rather than liaising with the patient's GP for action the next day. The doctor feels that the information provided by the paramedic was sufficient to make the urgent mental health referral and that a further visit from a GP without the extra people needed to undertake a mental health act section would have presented an unacceptable level of risk to the clinician. The doctor would have been more than happy to arrange a GP visit as part of a section process with mental health colleagues and police that night, but the mental health team did not agree to organise a mental health assessment."*

10.57 It further states, the doctor *"would certainly have made a GP visit as part of a mental health act assessment but the doctor was not left with this option, having passed over all the information he had available*."

10.58 A lone worker of any description would be at risk visiting, particularly at night. It is evident that the police would be needed to undertake a MHA 1983 assessment not just for safety, but also to gain access and to ensure the ability to assess the person and remove to hospital if necessary (Section 135).

10.59 It is also clear from the Patient record that the doctor re-categorised the priority of the referral as urgent, requiring action within 24 hours.

10.60 The SELDOC service did not make any follow up contact with any of the family members nor is there any record of this being discussed between SELDOC and the Bromley AMHP.

10.61 This is unfortunate. The AMHP then progresses this to daytime services as a Nearest Relative (NR) request. It is surprising that the AMHP did not go to greater lengths to get the contact details of the relatives, either to speak to them that night, or alternatively to give the daytime service an easier task to contact them first thing in the morning. A primary element of this kind of referral.

Learning Point 6 - Making Safeguarding Personal and Follow-up with Families etc.

Follow up contact with relatives, referrers and carers should always be considered, and where appropriate followed up as a matter of good practice.

The key elements of making safeguarding personal (MSP) should always be considered both in relation to the individual concerned but also any other key individuals, especially when a serious incident has occurred.

10.62 As set out in paragraphs 10.56 and 10.57 above, the balance of the decision making as described by SELDOC was with the AMHP. In their report of 2nd September 2016 SELDOC make a number of points culminating in their final statement "*the doctor would certainly have made a GP visit as part of a mental*

health act assessment but he was not left with this option, having passed over all the information he had available."

10.63 It is difficult to reconcile the strength and tenor of these comments made in September 2016 with Patient Notes recorded by the out of hour's duty doctor at the time. These state, "*ASW* [Approved Social Worker] *has liaised with CPN* [Community Psychiatric Nurse] *and PLN* [Psychiatric Liaison Nurse] *and they are referring to the CMHT* [Community Mental Health Team] *for assessment this morning as there is not sufficient evidence for a MH section tonight as the patient has not shown any intent to leave the premises and only became threatening when house invaded. ASW has organised for MH visit in the morning I have asked him to make sure the safety concerns are passed on."*

10.64 These notes presumably made at the time by the doctor concerned do not seem to convey the strength of these later comments made by SELDOC staff.

10.65 As already indicated above and further developed in Section 11, there are very considerable differences between what is set out in the SELDOC reports to this SAR and the reports from LB Bromley to this SAR[3]. These are not minor matters. The EDT log completed on the night of 2nd March 2016 at 23.00 states: "*FTC to referrer – we discussed as patient is currently at home and has shown aggression when being assessed that it could wait for him to be assessed during the day*." However the subsequent reports from SELDOC and LB Bromley represent significantly different conclusions between the out of hour's doctor and the EDT AMHP. To some extent this may go to the very heart of any risk analysis and firm decision making. As stated elsewhere if there were differences between the AMHP and the out of hour's doctor it would have been better to have recorded them at the time. The net result of this was that one report (SELDOC) states that the AMHP was not prepared to conduct an assessment while the other (LB Bromley) says it was as a result of the doctor not completing an assessment.

[3] Please refer to Appendix 14 regarding recorded transcripts of the original referral discovered post Inquest in August 2017 for further information.

Learning Point 7 - Out of Hours (SELDOC) (b)

A clearer system for use of staff or out of hours doctors should be put in place to establish the responsible local council/social work services recognising that post codes may be misleading.

A database of clear out of hours/emergency services for local authority social work and mental health (AMHP) services should be available.

The policy of recording telecommunications/referrals should be reinforced with SELDOC doctors and personnel.

The transfer of patient records, particularly in relation to mental health referrals, to emergency duty teams or AMHPs should be reconsidered so that there is routine transfer of key information.

As a matter of good practice referral or other case notes should record any areas of disagreement or contentious issues.

So far as possible the timings of telephone calls/conversations should be recorded.

Risk factors and risk analysis should be considered in all referrals.

The issue of mental capacity, especially where this may be linked to risk, should be reinforced in guidance from SELDOC and become routine.

Back to contents

11 Bromley EDT

EDT AMHP Activity

11.1 The first call from SELDOC to the EDT AMHP was made at 22.05 on 2nd March 2016.

11.2 A short outline of the emergency duty team role is set out at Appendix 7.

11.3 This was the first contact with a mental health professional, some 6.5 hours after the first referral of MT to NHS 111 at 15.23. There had been previous possibilities of a referral to mental health services at 17.02 when the ambulance arrived and at 18.20 when the police arrived and at any time up until 22.00. This reinforces the need for information being available regarding the routing of calls from emergency or out of hour's agencies to mental health services.

11.4 EDT records state that the referral from the SELDOC doctor was at 22.05[4] on 2nd March, a follow up call from the Bromley AMHP to the Psychiatric Liaison Nurse in Lewisham and the follow up call to the SELDOC doctor sometime after 22.23, this is recorded on the Approved Mental Health Professional Report shown at Appendix 8.

11.5 This report was then used as the basis of the ongoing referral to daytime services. There are a number of issues regarding this report.

i) There is no mention made of the knives found in the house[5];

ii) There is no mention made of the evidence of a small extinguished fire;

iii) There is no record of the balance of any discussion regarding assessment need, risk factors;

iv) There is no mention/consideration of mental capacity;

v) There is no mention of differences of opinion between the AMHP and the doctor.

vi) There is no mention in this report that this is to be treated as a Nearest Relative referral (this was covered in a separate email from the AMHP timed at 23.41 on 2nd March 2016, however this email did not emerge as part of the SAR process until 28th June 2017.

11.6 It simply states "*we* (the AMHP and duty doctor) *discussed that as patient currently at home and has only shown aggression when being assessed that it could wait for him to be assessed during the day."*

11.7 This recording, presumably made at the time, bears little resemblance to the statements made in SELDOC's September 2016 report.

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[4] The transcript at Appendix 14, discovered after the Inquest in August 2017, makes it clear that the SELDOC doctor made contact with the Appello call centre at 21.55 on 2nd March. The Appello call centre contacted the LB Bromley AMHP at 22.00. The AMHP then rang the SELDOC doctor back at 22.05

[5] The transcript at Appendix 14 makes it clear that knives were mentioned to the Appello call centre and again when the Appello call centre passed the referral on to the LB Bromley AMHP

11.8 Subsequent to the final draft of this SAR, a transcript of the phone call from the SELDOC out of hour's doctor to LB Bromley's call centre (Appello) and then the call handler's call to the Bromley EDT AMHP on 2nd March 2016 was found in August 2017. This records what was originally referred from the SELDOC GP to Appello for further transmission to the EDT AMHP. The transcript records what was then transferred to the AMHP. It is now clear that the following items were not passed on in that conversation:

- Police had been in attendance and were unable to assist
- There was a history of violence
- Concern about MT's risk to other people
- There was no mention of the fires that had been sent in the flat in either phone call

11.9 This failure should be a matter of review in the expectation of the commissioned Appello service by LB Bromley. Notwithstanding the omissions there were then 2 subsequent telephone conversations between the 2 professionals concerned during which it would appear that the full information was not reviewed. The net result of this was that the AMHP report, that was then forwarded to daytime services on 3rd March, had gaps and omissions that may have had some direct bearing on how this referral was responded to after 09.00 on 3rd March.

11.10 The report received on 26th June 2017 has been relied on in this SAR which includes:

a) response to questions raised by the author of this SAR on *13th May, 24th May and 5th June 2017.*

b) the LB Bromley re-write/update of the report to the first SAR.

11.11 Submissions from LB Bromley to the Coroner's Inquest have not been seen in the preparation of this SAR, nor have any of the Inquest proceedings been used in this SAR as the author was not party to those proceedings.

11.12 The next section of this report has been prepared against this backcloth. It is noteworthy that despite the passage of time and the statement that the "s*taff involved in this incident, do not have a clear recollection of the details of this case"*, there is now very considerable detail and information in the retrospective accounts provided by LB Bromley.

11.13 The documentary information is contained in the AMHP report (at Appendix 8) and the copy of an additional email from Bromley EDT to Bromley day time services dated 2nd March 2016 and timed 23.41 which was provided to this SAR on 28th June 2017.

11.14 Any other LB Bromley records were reported as lost when the EDT AMHP's computer's hard drive failed and the records irretrievable.

11.15 The report from LB Bromley sets out their background to the situation:

"in line with EDT procedure and best practice a fully researched and planned assessment for the following day was the preferred outcome in this case as there was no medical recommendation provided by SELDOC."

"There was a final discussion between the doctor and the EDT AMHP where they agreed that MT could safely be referred for a full and properly co-ordinated Mental Health Act Assessment in the morning. That the patient was at home and currently showing aggression when being assessed meant that it could wait for him to be assessed during the day."

"The Approved Mental Health Professional considered the principles of the code of practice when making decisions under the Mental Health Act1983 in this case."

The following is noted about admissions to hospital:

2004 Bracton Services: Oxleas

2009 Forensic Psychology Team: Oxleas

2012 Ladywell in 2012: SLAM

2015 Compulsory admission: unknown"

"There is evidence of a discussion with the doctor but there was no evidence of risk assessment paperwork completed on our system."

"It appears from the notes we hold that the Duty AMHP gathered all the information he could from two professionals located at; Green Parks House, Duty Senior Nurse; Lewisham Psychiatric Nurse. This information gave a short summary of his mental health history but very little of his current circumstances. From the records we hold we can only surmise that the doctor was in contact with the police, London Ambulance Service and family. The AMHP was reliant on the doctor for information on the night and the doctor informed the EDT AMHP that he would not offer a medical assessment to support a Mental Health Act Assessment that night."

"We have established that the London Borough of Bromley EDT AMHP held the case until the morning as he believed it was a Bromley resident. The Lewisham Psychiatric Liaison Nurse who checked the records that evening did not challenge the presumption."

11.16 A 'Nearest Relative referral' was made in an email timed at 23.41 on 2nd March 2016, though this criteria for referral was not mentioned in the Approved Mental Health Report from the AMHP, nor was the separate email referred to.

11.17 In reviewing the documentation from LB Bromley, it is recognised that:

(i) Considerable time had elapsed since the events in 2nd/3rd March 2016.

(ii) The EDT AMHP concerned had been absent with prolonged ill-health and had undergone serious surgery. In the event the report to the original SAR had been put together from the records with input from the AMHP on duty. In June 2017 Bromley have recorded, "*the AMHP returned to work in April 2017 following major* health concerns *because of his hospitalisation and the length of time, his recall of the night in question is very poor.*"

(iii) The current situation is further hampered as Bromley have stated, "*The sources of information gathered are written up in the EDT log report dated 2nd March 2016. The various conversations had that evening, were written up by the EDT AMHP on his computer, but his notes were lost when the hard drive failed and are irretrievable. The report evidences the answer machine referral from Appello, several conversations with the doctor (SELDOC) the referrer, the Duty Senior Nurse at Green Parks House, Bromley and the Lewisham Psychiatric Nurse (PLN).*"

11.18 The central issue was the decision taken by EDT Bromley not to conduct any direct mental health assessment of MT on the evening of 2nd March 2016.

11.19 In considering this decision it is important to disentangle the contradictory reports from both LB Bromley and SELDOC and the very significant overlay and re-interpretation of the assumptions made. These reports, written after the event, provide considerable detail not evidenced by written records. In short, it is regrettable that both the SELDOC report and the LB Bromley report provide a great deal of additional but largely unsubstantiated "dialogue or interpretation" of actions and opinion.

11.20 What is absent in any reports are concrete and concise records of assessment, risk and clarity of next steps that can easily be followed.

11.21 Neither of these post-hoc reports (from LB Bromley and SELDOC) provide professional challenge or evidence of learning or development. The risk is that they seem somewhat laced with self-justification.

11.22 The subsequent report and response to further questions as part of this SAR raises a significant number of learning and development areas that require urgent and sustained consideration so that in the future where difficult and "on balance" decisions are taken they are both fully measured and the records, communications and onward referrals are clear and concise. Not least so that required next steps are able to be understood and responded to. This was not the situation in this instance.

11.23 To assist learning and development the rest of this section takes the report and analysis for Bromley and carefully considers it against practice, policy and Mental Health Act 1983 requirements. Where appropriate it points up the contrasts and some of the contradictions with the SELDOC report.

Further Details and Analysis of the LB Bromley Report

11.24 Because the report from LB Bromley contains considerable detail the section on the EDT referral is reproduced here. The policy and practice underpinning the role of the EDT is included at Appendix 7. The questions in the text refers to those asked of LB Bromley as part of information gathering as part of this SAR. It includes comment and cross reference to other reports. This is to support learning and development which is a fundamental purpose of this SAR.

Q: How does EDT establish if the referral is known to them and is a resident of the London Borough of Bromley?

11.25 "*EDT AMHP is not responsible for establishing if the referral is known to them and is a resident of the London Borough of Bromley. The London Borough of Bromley contracts out its out of hours calls to provider Appello, Oregon House, 19 Queensway, New Milton, Hampshire, BH25 5NN. It is their responsibility to establish if the referral is a resident of the London Borough of Bromley. Appello receives all out of hours referrals and screens addresses; they are responsible for checking addresses and passing the details of the referral onto the AMHP on duty. This is usually done by leaving a message on the answer machine*."

11.26 "*The AMHP progresses the referral based on this intelligence received and in this instance, did not recheck the address*."

11.27 "*Appello carried out an investigation into why their operator informed the wrong Borough and we were told that the operator did not check the postcode. The operator assumed the address was in the Bromley area and did not verify the postcode by using their system before taking action on the case. The address, 311 Downham Way, BR1 5EN is in the London Borough of Lewisham and the BR1 5EN postcode is a primarily residential postcode in Lewisham, London*."

11.28 "*The EDT AMHP called the Bromley team at 9.00am on 3rd March 2016 as per the procedure and their team administrator checked the address and understood it to be a Lewisham address. Lewisham community mental health services were contacted and the referral passed to them by the Bromley team*."

11.29 *"It was not until the morning of 3rd March that the error by Appello (not verifying the post code) was recognised."*

11.30 This was a regrettable error but, as noted at paragraph 10.23, where it is already clear that there are potentially confusing post codes, it is good practice to ensure local and standardised notifications in relevant records especially for out of hours.

Q: What information did EDT gather regarding Mr MT, and from what source did the information come from to inform their decision that the assessment for Mr MT could wait until the next day?

11.31 "*The sources of information gathered are written up in the EDT log report dated 2nd March 2016. The various conversations had that evening, were written up by the EDT AMHP on his computer, but his notes were lost when the hard drive failed and are irretrievable. The report evidences the answer machine referral from Appello, several conversations with the doctor (SELDOC) the referrer, the Duty Senior Nurse at Green Parks House, Bromley and the Lewisham Psychiatric Nurse (PLN)."*

Learning Point 8– Loss of Records

The loss of fundamental records is serious. Steps should be taken to ensure backup systems are in place especially where records relate to client based information and decisions that directly affect their care.

11.32 "*The information used to inform the decision came from the sources noted in paragraph 13* [of the original Bromley Report] *The doctor informed the EDT AMHP that the family had called the ambulance. They had taken this action*

because MT had not been in touch for a week. The doctor stated that the family told him MT was on medication, but he had not been taking it. The doctor explained that the police were there with the ambulance crew. MT verbally abused the ambulance crew and they were 'afraid of him'. The family were also too frightened to enter the property and advised the ambulance crew to leave for their own safety. The doctor informed the EDT AMHP that police had attended. He stated that MT had been there for a week and was not attempting to go anywhere and that the risk to others was noted. As there was no comprehensive history available from Dr, further phone calls were made to ascertain what other information may be available to EDT."

11.33 The report from LB Bromley received 26th June 2017 states, *"The EDT AMHP recorded his call made to Green Parks House Duty Senior Nurse who checked Oxleas records on RIO (patient database). There were no core assessments, or entries or progress notes; he was previously open to the Community Team Bracton Services 2004 and Forensic Psychology Team 2009. The nurse said South London Maudsley NHS Foundation Trust probably knew him."*

11.34 The error in post code allocation could have been resolved here. There was information that MT was known to SLaM (PLN) which could have alerted that MT was in fact a Lewisham patient.

11.35 "*The senior nurse told the EDT AMHP to call the Psychiatric Nurse at Lewisham. Telephone call made (22.23hrs) the PLN told the AMHP that South London Maudsley NHS Foundation Trust (SLAM) previously knew MT but there was no evidence of contact since 2012. MT had previously been admitted to Ladywell in 2012 and diagnosed with acute psychotic disorder and had a history of drug use*."

11.36 "*Neither was the AMHP able to ascertain who was MT's care coordinator or if he was under a home treatment or under a team that knew him. It was not thought that this information was necessarily unavailable, but that for whatever reason at the time of asking, the Lewisham PLN was unable to find it.*"

11.37 "*There was a final discussion between Dr and the EDT AMHP where they agreed that MT could safely be referred for a full and properly co-ordinated Mental Health Act Assessment in the morning. That the patient was at home and currently showing aggression when being assessed meant that it could wait for him to be assessed during the day. Dr had not seen the patient and without his medical assessment, no Mental Health Act Assessment could take place in any event. Given the requirement for a doctor to personally examine the patient the EDT protocol is to advise the duty doctor that we will not accept a referral for a Mental Health Act Assessment until this (personal examination) has been done and the doctor has assessed that an emergency admission is required*."

11.38 "*Dr advised that he had not seen the patient in the evening of 2nd March 2016 and had triaged over the phone. The fact the doctor had not personally examined MT supported the notion he did not think an admission under the Mental Health Act was required. He did not provide to the AMHP a medical assessment as required by 14.31 of Mental Health Act Code of Practice. In order to do so it is required in the MHA 1983 general provisions as to medical recommendation 1983 s12 (1) to be given by practitioners who have personally examined the patient. The application must be supported by two medical*

recommendations, given in accordance with the Act. Dr did not instruct the AMHP to request a section 135 from a magistrate."

11.39 "*The Approved Mental Health Professional considered the principles of the code of practice when making decisions under the Mental Health Act 1983 in this case*."

11.40 While this is correct there was a rather simple question to explore as part of the AMHP responsibilities: "who has seen the patient". It may have been asked but nothing is recorded.

Q: Was any attempt made to speak to Mr MT, his family or his neighbour?

11.41 "*The EDT AMHP did not speak directly with MT, his family or neighbour. The AMHP relied on information given to him on the evening of 2nd March 2016 by Dr. However, it is clear the doctor did not see MT that evening and the EDT AMHP was aware on speaking to the doctor, that he did not know much about the history of the patient and in order to assist day time team, the AMHP made enquiries initially to Oxleas and then to SLAM PLN. The doctor advised that he did not have the family's contact details to hand when asked. The AMHP was unable to obtain family details from SLAM PLN either. The AMHP does not recall receiving contact details from the doctor of MT, his family or his neighbours; this would be required for any nearest relative request. Dr did not provide to the AMHP a medical assessment as required by 14.31 of Mental Health Act Code of Practice. Apart from hospital records which appear to have had limited information, the referring doctor was the main informant*."

11.42 This whole section is central to the decision making and it is problematic. It is written with the benefit of the records (available now) and, it must be said, with considerable hindsight. The whole description and clinical/professional conclusion between this report and the SELDOC report vary in many respects.

11.43 Such divergence of conclusions in what was a very short space of time, and in some ways a relatively uncomplicated set of circumstances, is difficult to understand or reconcile.

11.44 There were medical records of MT from 2012 which included significant and pertinent detail of his condition and history. However, as there is no record of the conversations it is now impossible to know what information was given or what questions were asked. The patient records from SLaM would have shed considerable light on the decision making and could have been a key indicator to understanding MT's risks and needs.

11.45 Specifically, the following information would have been available in the SLaM records, which it is recorded the PLN accessed at 22.22 on 2nd March 2016:

i) MT had a history of infrequent but severe psychotic episodes, with no clear precipitating factors (suspicion of drugs and stress, but this is no more than conjecture in the notes.)

ii) When he gets unwell he gets very unwell - spent his whole 2012 admission in PICU, and for much of the first half of his admission he was in seclusion, and on 2:1 jobs.

iii) No evidence of suicidal ideation or actions in the past.

11.46 These factors should have been a critical part of the risk and decision making.

Learning Point 9 - NHS Trust Records

The issue of access to Trust patient records by out of hours (particularly AMHP) services should be looked into, notwithstanding there is no universal system for Trusts.

Risks to individuals (both patients and workers) are increased if these records cannot be accessed and this issue should be addressed.

11.47 Other concerns raised by the Bromley report are:

i) Was there any discussion about whether a doctor should see him that night? It would have been very difficult, but was it explicitly considered and an active decision made. If so it should have been recorded.

ii) This does not seem to be a description of a proactive AMHP who was deciding based on the information provided that a fuller assessment would be needed early the next day. This description suggests the AMHP is a rather passive member of the team, and can only proceed once the doctor has seen the person. In fact, the Code of Practice makes it clear that the AMHP has overall responsibility for coordinating the MHA 1983 assessment (S14.41).

11.48 It is not up to the doctor to ***instruct*** the AMHP to request a S135 from a magistrate. This is part of the AMHP's initial risk assessment duty under S13(1). This section requires the AMHP to 'consider the person's case' but, it must be said, does not require them always to go out immediately with all guns blazing.

11.49 Overall it is difficult to see the fit with the duty under MHA 1983 S13(1). The comments regarding the SELDOC doctor are a stretch in interpretation. This is an out-of-hours GP, who will inevitably not know the person. Again, this further implies the AMHP is passive in the decision-making, which is far from the role and function expected.

11.50 The AMHP has considerable leeway to exercise his professional judgement and cannot be instructed by others one way or the other.

11.51 However, it is important to note that S13(4) comes into play if the Nearest Relative requests an assessment for compulsory admission. The relative does not need to know the technicalities of the Act and the professionals should be able to interpret this, and it appears that ultimately in this situation the AMHP then did so, though the doctor was not made aware of this.

11.52 The requirements are the same irrespective of referrer (apart from nearest relative as described above).

11.53 Contact with the family was a significant gap. The LB Bromley report states. "*The AMHP does not recall being able to access family's contact details in this instance, but certainly would have recorded their comments if spoken to*."

11.54 It is inexplicable that the family details that were fully recorded in the SELDOC patient record form were "*not to hand*" when the AMHP asked for them. The

electronic transfer of the SELDOC record to the EDT would have solved this simply and immediately.

11.55 As stated in 10.49, the current position of routinely not transferring information from SELDOC should be urgently reviewed.

Q: Were EDT made aware of knives on the premises, any violent history and a "small extinguished fire' in the premises?

Q: If EDT were aware, did they share this information with any other agencies they were in contact with?

Q: If EDT were not aware, would having this information have influenced the decision that the assessment could wait until the morning?

11.56 *"There is no evidence in the records we hold that MT had knives on the premises or evidence of any violent history or that a 'small extinguished fire', on the premises was recorded in records the EDT accessed on the evening of 2nd March."* [6]

11.57 It is difficult to understand how these two main risk factors were not a priority in the referral. This was a central point in the SELDOC patient record. Transmission of this record would have solved this.

Q: As part of the decision-making process was a risk assessment undertaken/considered (i.e. risk to patient/professionals/others)?

11.58 *"There is evidence of a discussion with Dr, but there was no evidence of risk assessment paperwork completed on our system. The doctor's decision to refer MT for a Mental Health Assessment referral as opposed to a Mental Health Act Assessment referral was not a surprise to the AMHP. ("In deciding whether it is necessary to detain patients, doctors and approved mental health professionals (AMHPs) must always consider the alternative ways of providing treatment or care they need."* Code of Practice *4.13)"*

11.59 This section states the LB Bromley position that the doctor was not asking for a Mental Health Act 1983 assessment, not even for the following day. Just a mental health assessment.

11.60 The report from LB Bromley and the report from SELDOC cannot be reconciled on this very significant point.

11.61 The Bromley report submitted for this SAR states, "*When Dr was asked if he thought the patient required urgent admission or if there was an urgent need or if he was prepared to make a medical recommendation, he advised that his assessment was, he did not need to make a medical recommendation for urgent admission and neither that a formal Mental Health Act Assessment was indicated. (Under MHA 1983 Section 2(3) "An Application for admission for assessment shall be founded on the written recommendations in the prescribed form of two medical practitioners." and MHA 1983 Section 4(3), "An emergency*

[6] The transcript at Appendix 14 makes it clear that knives were mentioned to the Appello call centre and again when the Appello call centre passed the referral on to the LB Bromley AMHP.

application shall be sufficient in the first instance if founded on one or more medical recommendations.")"

11.62 These are clear and unequivocal statements, presumably made by the AMHP.

11.63 However, the report submitted by SELDOC states "*it was considered unsafe for a visiting doctor to attend based on the information provided by the LAS paramedic. It would have been considered safe to attend as part of a formal section process with Police, approved social worker and psychiatrist, which was the reason Dr urgently, referred the case to the mental health team. Dr feels that there was enough information to justify a section that night rather than liaising with the patients GP for action the next day. Dr feels that the information provided by the paramedic was sufficient to make the urgent mental health referral and that a further visit from a GP without the extra people needed to undertake a Mental Health Act section would have presented an unacceptable level of risk to the clinician. Dr would have been more than happy to arrange a GP visit as part of a section process with mental health colleagues and police that night but the mental health team did not agree to organise a mental health assessment.*"

There are clearly contradictory issues here about whether a mental health assessment or a Mental Health Act 1983 assessment was required. At the very least it is highly difficult that there are no records or notes now available to support and confirm the clarity of the statements made retrospectively in the 2 reports.

11.64 Ultimately none of these factors might have directly affected the decision to not take action that evening, however the lack of any record of disagreement, risk analysis and agreed conclusions is very concerning.

11.65 This then becomes more important as after these discussions the EDT AMHP determined to deal with this as a Nearest Relative (NR) referral (effectively) when it would have been necessary to report to the nearest relative referrer the reason(s) for not making an application in this instance.

Learning Point 10 – Support to Lone Workers on Record Keeping

There must be support to lone workers, whatever their discipline, to maintain simple concise notes of why decisions were taken and points of agreement and disagreement and next steps.

Q: How was the decision reached with SELDOC that MT could be left at home until the next day to be assessed?

11.66 *"The doctor as referrer and lead professional making the referral to EDT had discussed with police and ambulance crew who attended the scene. He advised he was aware of family's concerns and was not requesting a MH Act assessment and in the event, he had confirmed he would not be prepared to make a medical recommendation. This confirmed to the AMHP that he did not appear to think that urgent admission was required and therefore could only conclude that this was indeed a referral for a Mental Health Assessment by a professional. It is unusual for doctors to contact EDSW/AMHP to discuss a case that generates a follow up request for MH assessment from day teams. It*

appears from the notes we hold that the Duty AMHP gathered all the information he could from two professionals located at; Green Parks House, Duty Senior Nurse; Lewisham, Psychiatric Nurse. This information gave a short summary of his mental health history but very little of his current circumstances. From the records we hold we can only surmise that Dr was in contact with the police, London Ambulance Service and family. The AMHP was reliant on the doctor for information on the night and Dr informed the EDT AMHP that he would not offer a medical assessment to support a Mental Health Act Assessment that night."

11.67 While it is perfectly reasonable for any AMHP to set that opinion in the context of other information and all the considerations, as is their duty as an AMHP, it would have been far better if such a decision had been summarised in the referral document at the time.

Q: If EDT had established MT lived in the London Borough of Lewisham, was the report passed straight to Lewisham Community AMHP or did it go via Bromley day services?

11.68 "*We have established that the London Borough of Bromley EDT AMHP held the case until the morning, as he believed it was a Bromley resident. The Lewisham Psychiatric Nurse who checked the records that evening did not challenge the presumption. The referral was passed onto (Oxleas) Bromley day services and then passed to Lewisham later in the morning*."

Q: What time was the referral sent to London Borough of Lewisham?

11.69 "*The referral was sent to Lewisham (from Oxleas) and a conversation had at 10.09 between the Oxleas AMHP and Lewisham AMHP. We understand when the referral was reviewed by the manager it was passed through to the Lewisham Response Team. We understand that they then visited the property, but the fire was underway*."

11.70 In writing this SAR this matter was followed up more than once. Unfortunately, the specific Lewisham member of staff has been absent throughout because of ill health and family bereavement.

11.71 As referred to in paragraph 11.89 the Operations Manager in Lewisham categorically states that no visit had taken place and is completely at a loss to understand the basis of this record from Bromley. There was no visit undertaken according to LB Lewisham.

Q: *Is there anything else that Bromley EDT/AMHP would like us to be aware of?*

11.72 *On a personal note, the AMHP returned to work in April 2017 following major heart surgery. Because of his hospitalisation and the length of time, his recall of the night in question is very poor*."

11.73 "*In addition, a nearest relative request was made and this would require serious consideration in addition to presenting concern and request for assessment. The duty AMHP view was the lead professional did not believe that a Mental Health Act Assessment as an urgent necessity. It was also a clear request for a Mental Health Assessment, requiring a response from MH Services for a planned assessment as opposed to an emergency response. Due to the*

family's concern with the circumstances of the case and subsequent contact with the doctor, the AMHP thought that the referral should be responded to as a priority rather than being allowed to drift and so recommended it was given the "status" of a nearest relative request, even though it had come via the doctor. Hence his email to day AMHP team requesting this."

11.74 The email of the 2nd March timed at 23.41 that simply says, "*Please find attached a Nearest Relative (effectively) request for Mental Health ACT Assessment via DR MT",* and the Approved Mental Health Professional Report do not of themselves justify this retrospective comment from LB Bromley.

11.75 While it is impossible to gainsay the actual decision taken, there is insufficient recorded evidence of:

i) Considerations of risk

ii) Discussions of mental capacity

iii) Discussions of other options

iv) Agreed conclusions about next steps

v) Analysis of assessment factors

Learning Point 11 – Considering Mental Capacity

The issue of mental capacity should have been considered in all referrals or re-referrals as a part of assessing risk and options for action.

11.76 While it is possible that consideration of these factors would have made no difference to the decision later on 2nd March it could have made a difference to the information that was sent and the response to it during daytime hours on 3rd March.

11.77 However, it was clear that no individual worker should attend MT unaided.

11.78 Based on the information that the AMHP had and the circumstances that were explained to him by the SELDOC doctor the basic decision not to conduct a direct assessment on the evening of the 2nd March was not unreasonable. While that is a difficult conclusion, especially with the benefit of hindsight, that should not simply mean that there is not significant learning for the future.

11.79 As the chronology shows a further call by a neighbour was made to the Police at 23.45 on the night of 2nd March 2016 because MT had been throwing items of clothing out of his flat. The police visited at approximately 00.50 and the neighbour saw them enter MT's flat and thinks that they stayed for around 15 minutes before leaving the scene.

11.80 At the time of writing this SAR this Police visit to the property was the subject of investigation by the IPCC and there were on-going matters outstanding. The IPCC and the Metropolitan Police Service have now concluded their investigation and further action. It was agreed that three officers had a case to answer for misconduct, namely:

- An intervention opportunity which resulted in a failure to update the health service and MT's family members about concerns to his personal safety were missed.

- In addition, a sergeant failed to record an incident appropriately and failed to produce a detailed enough justification for withdrawing the officers.

The learning aspects were debriefed through a misconduct meeting where management advice was delivered.

11.81 The subsequent events that occurred at the property are set out at paragraph 6.29 and emergency services responded quickly and appropriately to the situation.

Learning Point 12 - Record Keeping for AMHPs in EDT

The record keeping at the EDT in relation to mental health referrals should be urgently reviewed. It should include:

- Mental capacity
- Risk factors to self or others
- Options for action
- Areas of discussion and/or disagreement
- Consideration of family, informal or formal carers or referrers' views which should be noted and wherever appropriate followed up

Where a decision has been made responsibility for the next steps should be properly set out.

EDT to Bromley Daytime Services AMHP and then to Lewisham AMHP

11.82 The referral from the EDT was sent electronically to LB Bromley daytime EDT service at 23:41 on 2nd March (the time the email was sent). Of course, it would not be picked up till the daytime service started at 09:00 on 3rd March (see paragraphs 10.23 and 11.32 regarding post codes).

11.83 The paperwork sent electronically consisted of:

(i) Covering email from the Bromley EDT AMHP to Bromley daytime AMPH team stating "*Dear Amhp's. Please find attached a Nearest Relative (effectively) request for Mental Health ACT Assessment via DR MT*." (Appendix 9)

(ii) The AMHP Report (Appendix 8)

11.84 LB Bromley's response also states "*The referral was sent to Lewisham (from Oxleas) and a conversation had at 10.09 between the Oxleas AMHP and Lewisham AMHP. When the referral was reviewed by the manager it was passed through to the Response Team. We understand that they then visited the property, but the fire was underway."*

11.85 The responsible Operational Manager in Lewisham disputes the account that a visit occurred and does not know the basis on which Bromley is reporting this.

11.86 The AMHP report, sent electronically to the LB Bromley daytime team on the evening of 2nd March 2016, was followed up at 09.00 the next morning by a phone call from the EDT AMHP. On realising that the referral related to a Lewisham resident, the LB Bromley daytime team forwarded the referral to LB Lewisham and followed that up with a phone call to Lewisham at 10.09. However, a more fundamental point is the nature and context of the referral.

11.87 The basis of the decision at around 23.00 on the 2nd March was that an assessment was best conducted when all resources could be in place the following morning.

11.88 The report ultimately sent to Lewisham is the AMHP report shown at Appendix 8. The important point is the final paragraph where it states: *"**Please can day team assess what support/ assessment - this patient needs as family have become concerned about his lack of contact and his mental state appears to be aggressive?**"*

11.89 This seems a rather more benign request to the AMHP on duty. It does not convey that this issue had been going on since at least 15.00 the previous day, nor any consideration of any identified risk factors of knives and small fire. It hardly accords with the report from Bromley, prepared after the event, that states **there should be a fully researched and planned assessment.**

11.90 Furthermore, the accompanying email from the EDT AMHP (to Bromley and then forwarded to Lewisham) is not referred to. This is the Nearest Relative request. When this email requesting Nearest Relative (NR) was chased down as part of this SAR process it was confirmed that it was received in Lewisham. However, it is not referred to in either the main referral document or any subsequent notes or records. This is not acceptable.

11.91 As mentioned before if the SELDOC Patient Form had been sent to the EDT it would have greatly enhanced the information then available to the Lewisham AMHP.

11.92 A situation that lacked pace and direction during the late afternoon and evening of the 2nd March continued in a somewhat similar manner on the 3rd March. By which time any responses were regrettably too late.

11.93 The requirements of mental health practice were inadequate with regard to the Nearest Relative referral, good information sharing which enables effective and accurate risk identification and subsequent analysis of urgency of response. This ties in closely with the concept of ***defensible decision-making*** for example in Hazel Kemshall[7] as follows:

- Appropriate levels of knowledge and skill
- Appropriate use of information

[7] *Good Practice in Assessing Risk: Current knowledge, issues and approaches*, ed. Kemshall H. and Wilkinson B (Jessica Kingsley 2011)

- Risk assessment grounded in evidence
- Communication with relevant others
- Risk management plan linked to risks and risk level
- Risk management plan delivered with integrity
- All reasonable steps taken
- Information collected and thoroughly evaluated
- Clear recording

Learning Point 13 – Determining Responsible EDT

A system for post code location should clearly take account of those that are likely to cause confusion, e.g. BR post codes that are in fact in the London Borough of Lewisham.

Learning Point 14 – Onward Referral Protocol for EDT

There should be an established protocol between adjoining boroughs for referrals from EDT to day and operational services. This must include both process and method and basic information requirements.

As a part of this there should be a clear record of the handover (timing, person/organisation and action required) by the sending EDT.

Back to contents

12 Lewisham

Lewisham Action 3rd March

12.1 According to the Operational Manager for the Lewisham Approved Mental Health Professionals Team, *"On 3 March 2016 I was not on AMHP duty but was in my office which is next to the AMHP office engaged with writing reports and catching up with my paper work. I may also have left the office but do not have a record of my activities for that morning. I checked my email at approximately 13:00 and found that I have been forwarded an email by a duty AMHP concerning MT that was originally sent from the London Borough of Bromley Out of Hours Duty Social Worker at 10:27 on 03/03/2016. I forward this email to the Assessment and Liaison Team at 13:07 to request that they arrange an urgent visit to MT to assess his needs and I followed this up with a telephone call to my colleague to ensure that he had seen the email, he informed me that he had seen the email and was making arrangements to carry out an assessment of MT's needs."*

12.2 While this delay is regrettable, it points up the need to have in place a clear protocol for handling out of hours (EDT) onward referrals that can be systematically dealt with, or a central AMHP duty email where communications can be picked up more reliably and rapidly. It is quite understandable that a manager or worker might not routinely see emails immediately but what if the person to which this email was sent had been on leave or out for the day. Would it not have been read until they returned? If the individual concerned has responsibility for seeing and managing a referral then steps should be taken to minimise delay.

12.3 The report by the Lewisham Team Leader of the Assessment and Liaison Service records that he received a call from the Operational Manager at around 14.00 on 3rd March regarding the referral, which he describes as "*it was slightly unclear as to where the referral had originated from as it had come second hand via an emergency duty team (EDT) social worker in Bromley."* He further states "*further examination of the report seemed to suggest that an out of hours GP had referred to an EDT social worker/AMHP in Bromley. From the report it is not entirely clear whether this doctor had actually seen the client, but at the time I was assuming not. The concerns appear to originate from the family of the deceased calling the London Ambulance Service (LAS) and reports that both family and paramedics were frightened/wary of MT because of abusive behaviour/mental health concerns*."

12.4 The team leader in discussion with the Operational Manager agreed that there needed to be:

i) Screening attempts (information obtaining to ascertain nature of difficulties and urgency).

ii) Probable assessment in the first instance by the Assessment and Liaison Service.

12.5 The Team Leader then set about this action recorded as follows:

i) Attempt to contact the out of hours GP (this was unsuccessful as the phone was not answered and he was unable to leave any voice mail message).

ii) Contact the local GP.

12.6 It is of concern that the email from the EDT AMHP referring this as Nearest Relative action does not appear in the subsequent documentation seen by this review. Despite raising this as part of this SAR nothing further has been forthcoming. There is a concern that the fact that this was a Nearest Relative referral was not recognised by the receiving service in Lewisham and acted upon on that basis.

12.7 The Team Leader records that the receptionist at the GP surgery (Downham Medical Practice) confirmed that MT's mental health review had been conducted by the GP on 23rd February 2016. There was no mention of the SELDOC Patient Form that it is stated was transmitted to the surgery before 08.00 that morning. The GP was out so the Team Leader left a message for him to call. In the witness statement to the Coroner the Team Leader then states, "*my plan then, was to await collateral information from the GP before deciding on the next course of action; i.e. review by the GP or an urgent home visit by our service."*

12.8 The Team leader then states *"The above plan was then, subsequently overtaken by events at approximately 15.51 according to my entry in the notes, I received an email from a social care lead; she had been informed by Police that MT had been admitted to the Intensive Care Unit at University Hospital Lewisham as a fire had been set at his home following a suspected suicide attempt*."

12.9 The referral from the Bromley EDT first arrived with the London Borough of Lewisham at 10.27 on 3rd March and the first concrete action to follow up did not occur until sometime after 14.00 on that day.

12.10 Some of the circumstances of this referral reinforce the issues played out overnight, as evidenced by:

i) The referral did not give all the available information.

ii) The attachment of the Patient Report from SELDOC with EDT papers would have greatly assisted.

iii) It is of note that notwithstanding the requirement of this SELDOC form being with the GP surgery by 08.00 (3rd March) it was not referred in the subsequent call to the surgery by the Lewisham Team Leader. At the very least this would have given contact numbers for the family.

12.11 The level of delay is unacceptable, not least because MT's situation had been going on since around 15.30 the previous day.

12.12 Notwithstanding that the referral from Bromley EDT was inadequate, as already set out in this report, it really does seem that the potential actions were very much a re-run of what had occurred the day before.

12.13 While of course in fact any action after around 10.00 on 3rd March would have had no material effect there is significant learning that must be followed up with a clear protocol for both the content of referrals and the process and responses to referrals, especially where there are underlying mental health concerns.

Learning Point 15 – Daytime Services Handling EDT Referrals

As there should be a clear transmission protocol from EDT there should be an equally and adequately resourced protocol for receiving and assessing referrals from EDT. This should include:

- consideration of risk
- additional information
- family contacts
- options set out
- additional contact e.g. telephone calls, emails, faxes recorded
- the basis of the referral

Back to contents

13 Duty of Candour

13.1 Comment has already been made regarding the importance of reporting to SARs in a way that demonstrates initial learning, insight and candour. Further work on this should be considered a priority, specifically the requirement on agencies of the Care Act 2014 Section 44(5) regarding reports to SARs as follows "*each member of the safeguarding Adults Board, must co-operate in and contribute to the carrying out of a review under this Section with a view to –*

a) identify the lessons to be learnt from the adult's case, and

b) apply those lessons to future cases".

Learning Point 16 – Candour Between Professionals

Alongside the Duty of Candour established in 2015 it is equally important that candour is also part of professional reporting.

Where there may have been disagreement this should be carefully recorded. Not to apportion blame but to set out, for all to see, in an open and transparent way how decisions may have been made and the balance of those decisions.

Similarly, reports written after a significant event should be written with openness and candour. Not to re-frame or re-balance discussions or decisions for which there is not accompanying information or evidence but as a candid report that recognises learning and development and indicates a good degree of insight and action.

Learning and development for those providing safeguarding reports on this professional duty of candour would be worth exploring to ensure compliance with Care Act 2014 section 44(5).

It is proposed that this issue should be followed up with the agencies under the aegis of the commissioning SAB to ensure that staff at all levels are supported to both respond to the specifics of this SAR but also to develop the responses required as part of safeguarding reporting.

14 Fulfilling the Terms of Reference

14.1 The revised Terms of Reference for this SAR were agreed on 3rd April 2017 by the Case Review Group. The methodology was based on system analysis and consideration of contributory factors and root causes.

14.2 The Terms of Reference set out 9 key questions (a-i) as a part of analysing the events and outcomes. Many of those are implicit in the narrative in Sections 7 to 12. For completeness those questions are set out here with further comments.

14.a Were there any delays in decision making and were these a potential factor in the incident on 3rd March.

14.3 The chronology is fully set out in Section 6 of this report and the detailed narrative in section 7 -12.

14.4 There were significant delays. These stem from:

i) Lack of available information about appropriate referral points;

ii) Lack of focus on this being a referral that might be best dealt with through mental health services;

iii) Breadth of thinking to consider alternate courses of action;

iv) Physical time delays in referral or responses.

14.5 These issues undoubtedly could have made a significant difference to good handover and engagement of the most appropriate and relevant services.

14.b Given the information available, was the decision not to conduct a MH Assessment on the evening of 2nd March reasonable. Was a full risk assessment carried out?

14.6 The decisions not to conduct a mental health assessment on the evening of 2nd March is set out in paragraph 10.56 to 10.57 from a SELDOC perspective and from paragraph 11.40 to 11.41 from the Bromley AMHP EDT perspective.

14.7 Based on the information that the AMHP had and the circumstances that were explained to him by the SELDOC doctor the basic decision not to conduct a direct assessment on the evening of the 2nd March was not unreasonable. While that is a difficult conclusion, especially with the benefit of hindsight, there is considerable learning to be worked on for the future.

14.8 There was no recorded risk assessment carried out.

14.9 The visit of the Police at 00:50 on the morning of 3rd March has now been the subject of management action by the Metropolitan Police Service where the learning aspects were debriefed through a misconduct hearing where management advice was delivered.

14.c Did the referral of MT to Bromley EDT (rather than Lewisham EDT) have any impact on decision making on 2nd March.

14.10 There is no evidence that the referral to Bromley EDT rather than Lewisham EDT had any real impact on the decision making on 2nd March.

14.11 The issue of determining postcodes is fully covered in the text of the report.

14.d Were there any undue delays in the referral from EDT services to daytime services on the 3rd March.

14.12 As set out at paragraphs 11.86, 11.88 and 12.9 there was a delay of an hour and a half because this referral first went to Bromley daytime team service and then on to Lewisham. The key factors here were more to do with the material provided to Lewisham. There were delays in Lewisham responding and beginning to work on the referral. These are fully covered in the text.

14.13 Learning Points set out in the next section pick up a number of these points.

14.e Take into account any findings from the IPCC report when available.

14.14 In light of the process of the IPCC report being current it would be inappropriate to comment further, save to say that once these processes have concluded it is important not to lose any learning in relation to MT and the way in which decisions and an individual's risk are considered.

14.f Consideration of relevant legislation (Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS))

14.15 There is reference to legislation in paragraphs 8.4, 8.14, 10.35, 10.36, 10.58, 11.50(ii), 11.51, 11.52 and 11.64. Appendix 4 summarises the relevant areas for consideration.

14.g Safeguarding guidance (both London wide and for individual agencies)

14.16 The pan London Multi-Agency Adult Safeguarding Policy and Procedures are an extremely important element of trying to ensure consistency of practice and agency responsibilities. They contain very considerable and helpful guidance for professionals and agencies. It would be impossible for such wide based guidance to cover every single eventuality or circumstance and to try and do so would mean that they are in a constant state of revision or amendment.

14.17 No protocol exists either locally or pan London to deal with out of hours mental health assessment that requires urgent daytime team response and this is an unfortunate gap in providing adequate follow-up and response in which further action should be developed.

14.18 However, there are areas that could be highlighted so that when any reviews or amendments are being considered and the findings from SAR's across London and elsewhere are being analysed these pointers could be taken into consideration.

Learning Point 17 - Inter-Agency Referral to Mental Health Services especially AMHP

The interface between emergency services particularly the police, ambulance services and out of hours GP services and their referral to mental health (AMHP) and EDT services needs some clarification and further advice.

This should include where there may be requests for Mental Health Assessment, Mental Capacity Act assessment or other discussions and decisions regarding mental health situations.

14.h Any other relevant policy or practice guidelines for individual agencies and any national advice or guidance.

14.19 There are a number of pointers to policy or practice at local level set out in the learning points. There are no major indicators for national guidance or advice.

14.i Was Making Safeguarding Personal (MSP) considered at any point.

14.20 MT's situation was not, at the time, a safeguarding referral. That is not to say that the risks to him were not serious. His situation at that time was directly due

to his mental health condition and the need for main stream services to respond accordingly.

14.21 As already set out, engagement with his family once they had left Downham Way was inadequate. Their involvement would not only have kept them informed but they could in turn have given valuable information that was missing in the ultimate referral to AMHP services.

14.22 The fact that the EDT AMHP placed the referral as Nearest Relative (NR) meant that they should have made contact with relative a high priority, which it was not. There is no evidence that the relatives' details were passed from SELDOC to the Appello operator. Further, it is stated that the out of hours GP did not have them to hand when asked by the AMHP. The code of practice and Act in relation to Nearest Relative should have been followed.

14.23 It is not clear what liaison there was with the family after MT's death and there should have been at the very least an offer of follow-up in the spirit of good practice and the key elements of Making Safeguarding Personal.

14.24 The family members were approached during the conduct of the first SAR and approached again during this SAR. They said that they wished to deal with any issues through the Coroner Court. This decision is respected. However once this SAR is signed off by the SAB they should be offered an opportunity to discuss its findings in an appropriate way.

Back to contents

15. All Learning Points

15.1 For ease of reference all the learning points referred to in the preceding text are brought together here so that they can be re-produced for learning and development activity.

Learning Point 1 - Referral to Mental Health Services

It is well-established that direct referrals are more effective at ensuring effective transfer of information, rather than a number of 'hand-offs' where errors of information or dilution of urgency can occur.

It would seem that the most appropriate action would have been for the NHS 111 or ambulance service to make direct contact with the AMHP daytime duty service.

This would have ensured that the professionals who had personally seen the person were able to provide first-hand information to the duty service, which would have inevitably helped with the risk assessment.

If this had occurred, the AMHP duty service would have been able to obtain contact details for MT's family, who had initiated the activity due to their own concerns. This would have enabled considerably greater knowledge of the risks and MT's current condition.

(Para 8.1 – 8.5)

Learning Point 2 - Referral to Mental Health Services, Identification of Risk, Especially Out of Hours

When dealing with situations that are primarily about the mental health or psychological wellbeing of an individual (which may be exhibited in many ways) the issue of Risk (to others and self) and Capacity should be foremost in professionals' evaluation of options.

Referral to designated mental health professionals (AMHP) whether during normal working hours or out of hours (EDT) should be considered?

This should be made clear in local guidance and at an appropriate time put into any revisions to the London wide Safeguarding (multi-agency) guidance.

London Ambulance Service and Police and Fire Service must be able to access a database that gives them the contact details of mental health emergency services as described above. This should also be reflected in local guidance and when appropriate London wide guidance.

(Para 8.11)

Back to contents

Learning Point 3 - Out of Hours (SELDOC) (a)

SELDOC should be asked to consider the method or triage used to categorise or designate calls and give clear guidance particularly around mental health or psychological conditions and risk.

The SELDOC policy of timescales for responding to calls should be reinforced and monitored carefully (this had been commented on by CQC in 2015).

Para 10.5 –10.17)

Learning Point 4 – Obtaining a Warrant under S135

The EDT AMHP must be clear on the process of making an application for a S135 warrant out-of-hours:

- Telephone number of out-of-hours duty clerk
- Payment process for application
- Access to warrant documentation

(Para 10.38)

Learning Point 5 – SELDOC Recording Phone Call Policy

The SELDOC stated policy of using phones that enable the recording of referrals should be reinforced with all out of hour's staff. This usage should be monitored to ensure compliance. Where a personal mobile is used (and not recorded) the reasons for this should be stated.

(Para10.50)

Learning Point 6 - Making Safeguarding Personal and Follow-up with Families etc

Follow up contact with relatives, referrers and carers should always be considered, and where appropriate followed up as a matter of good practice.

The key elements of making safeguarding personal (MSP) should always be considered both in relation to the individual concerned but also any other key individuals, especially when a serious incident has occurred.

(Para 8.8 – 8.10, 10.40, 10.60)

Back to contents

Learning Point 7 - Out of Hours (SELDOC) (b)

A clearer system for use of staff or out of hours doctors should be put in place to: establish the responsible local council/social work services recognising that post codes may be misleading.

(Para 10.23-10.27)

A data base of clear out of hours/emergency services for local authority social work and mental health (AMHP) services should be available.

(Para 10.26 -10.27)

The policy of recording telecommunications/referrals should be reinforced with SELDOC doctors and personnel.

(Para 10.50)

The transfer of patient records, particularly in relation to mental health referrals, to emergency duty teams or AMHPs should be reconsidered so that there is routine transfer of key information.

(Para 10.45 – 10.49)

As a matter of good practice referral or other case notes should record any areas of disagreement or contentious issues.

(Para 10.56 – 10.57)

So far as possible the timings of telephone calls/conversations should be recorded.

Risk factors and risk analysis should be considered in all referrals.

(Para 10.47, 10.49, 10.53, 10.58, 10.65)

The issue of mental capacity, especially where this may be linked to risk, should be reinforced in guidance from SELDOC and become routine.

(Para 10.30, 10.51)

Learning Point 8 – Loss of Records

The loss of fundamental records is serious. Steps should be taken to ensure backup systems are in place especially where records relate to client based information and decisions that directly affect their care.

(Para 11.34)

Learning Point 9 - NHS Trust Records

The issue of access to Trust patient records by out of hours (particularly AMHP) services should be looked at.

Risks to individuals (both patients and workers) are increased if these records cannot be accessed and this issue should be addressed.

(Para 11.48 – 11.49)

Learning Point 10 – Support to Lone Workers on Record Keeping

There must be support to lone workers, whatever their discipline, to maintain simple concise notes of why decisions were taken and points of agreement and disagreement and next steps.

(Para 11.61-11.69)

Learning Point 11 – Considering Mental Capacity

The issue of mental capacity should have been considered in all referrals or re-referrals as a part of assessing risk and options for action.

(Para 10.30, 11.5, 11.79)

Learning Point 12 - Record Keeping for AMHPs in EDT

The record keeping at the EDT in relation to mental health referrals should be urgently reviewed. It should include:

- Mental capacity
- Risk factors to self or others
- Options for action
- Areas of discussion and/or disagreement
- Consideration of family, informal or formal carers or referrers' views which should be noted and wherever appropriate followed up

Where a decision has been made responsibility for the next steps should be properly set out.

(Para 11.5, 11.6, 11.69)

Learning Point 13 – Determining Responsible EDT

A system for post code location should clearly take account of those that are likely to cause confusion, e.g. BR post codes that are in fact in the London Borough of Lewisham.

(Para 10.23, 10.24)

Back to contents

Learning Point 14 – Onward Referral Protocol for EDT

There should be an established protocol between adjoining boroughs for referrals from EDT to the day and operational services. This must include both process and method and basic information requirements.

As a part of this there should be a clear record of the handover (timing, person/organisation and action required) by the sending EDT.

(Para 11.90 – 11.97)

Learning Point 15 – Daytime Services Handling EDT Referrals

As there should be a clear transmission protocol from EDT there should be an equally and adequately resourced protocol for receiving and assessing referrals from EDT. This should include:

- consideration of risk
- additional information
- family contacts
- options set out
- additional contact e.g. telephone calls, emails, faxes recorded.
- the basis of the referral

(Para 12.3 -12.13)

Learning Point 16 – Candour Between Professionals

Alongside the Duty of Candour established in 2015 it is equally important that candour is also part of professional reporting.

Where there may have been disagreement this should be carefully recorded. Not to apportion blame but to set out, for all to see, in an open and transparent way how decisions may have been made and the balance of those decisions.

Similarly, reports written after a significant event should be written with openness and candour. Not in any way to re-frame or re-balance discussions or decisions for which there is not accompanying information or evidence.

Learning and development for those providing safeguarding reports on this professional duty of candour would be worth exploring to ensure compliance with Care Act 2014 section 44(5).

It is proposed that this issue should be followed up with the agencies under the aegis of the commissioning SAB to ensure that staff at all levels are supported to both respond to the specifics of this SAR but also to develop the responses required as part of safeguarding reporting.

(Para 10.53, 10.56, 11.21, 11.22)

Learning Point 17 - Inter-Agency Referral to Mental Health Services especially AMHP

The interface between emergency services particularly the police, ambulance services and out of hours GP services and their referral to mental health (AMHP) and EDT services needs some clarification and further advice.

This should include where there may be requests for Mental Health Assessment, Mental Capacity Act assessment or other discussions and decisions regarding mental health situations.

(Para 8.5, 8.11)

Learning Point 18 - The Mental Health Crisis Care Concordat- Improving Outcomes for People Experiencing Mental Health Crisis

The Concordat should be used as a basis for the action planning and learning and development from this SAR.

As a part of this the local area(s) should urgently consider the development of a Local Mental Health Crisis Declaration as suggested in the Concordat.

(Para 16.6 – 16.8)

Back to contents

16. Conclusions

16.1 The SAR process as a whole has taken a long while to conclude and this does not help in relation to the memory of those involved or locating some of the records.

16.2 This should not detract from the importance of the key messages and the learning which are still entirely relevant to all the agencies that were involved and should be followed up with urgency and immediacy regardless of the length of time this SAR has taken.

16.3 It is clear that MT's state of mind was a major factor in his untimely death on the 3rd March. It is impossible to tell exactly what factors (root causes) may have impacted on him.

16.4 There was perhaps a cumulative effect of a number of factors that did not result in more urgent and responsive action on either the 2nd March and then on the 3rd March.

16.5 There is good reason now to look carefully at the handling of the referrals and handovers of all mental health referrals from:

- London Ambulance Service (LAS)
- Metropolitan Police Service (MPS)
- SELDOC service
- Emergency Duty AMHP
- Daytime service LB Bromley AMHP
- Daytime service LB Lewisham AMHP

16.6 It is of considerable concern that there was not a single mention in any of the reports made to either the first SAR or this SAR regarding the Mental Health Crisis Concordat[8] . The circumstances, needs and requirements of MT on the 2nd and 3rd March 2016 were significantly manifest in the areas covered by the Concordat. The key issues of working together, sharing information, high quality responses and supporting from one service to another are cornerstones of the Concordat. The vision for the Concordat states:

"*We must also recognise that in too many cases people find that the services do not respond so well. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises.*"

16.7 Most presciently the vision continues:

"*Where there are problems they are often as a result of what happens at the points where those services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another."*

[8] Mental Health Crisis Care Concordat, Department of Health February 2014

16.8 The Concordat offers a framework, already agreed between all the agencies that should be the basis of learning and development from this SAR. There should be, as a starting point, a commitment to developing a Local Mental Health Crisis Declaration as an outcome from this SAR, the first step being to agree a timescale and process for its completion.

Learning Point 18 - The Mental Health Crisis Care Concordat- Improving Outcomes for People Experiencing Mental Health Crisis

The Concordat should be used as a basis for the action planning and learning and development from this SAR.

As a part of this the local area(s) should urgently consider the development of a Local Mental Health Crisis Declaration as suggested in the Concordat.

16.9 Record keeping was often difficult to follow and the handover of the referral was disjointed or unclear. Difficult decisions were not underpinned by a framework of good information exchange, an analysis of risk for the individual themselves, the public and to evidence of consideration of options.

16.10 While this may not have altered the outcome in this situation, this is not a sequence of events that should be allowed to occur again in this way.

16.11 It is of note that all the points raised in the SAR have little to do with the resources that were deployed or that were available. Nor was it to do with inadequacy of legal frameworks or practice guidance.

16.12 Not considering MT's mental capacity, as a key part in the decision whether or not to assess his mental health, was regrettable. The combination of an individual's capacity and the risks that they face should always be a part of the balance of decision making.

16.13 The policy not to routinely transmit patient referral records to colleague professionals (especially out of hours) needs to be reviewed in the interest of patient care and assisting risk analysis and decision making.

16.14 While the SLAM notes were accessed at 22.22 hours on 2nd March 2016, they do not seem to have been fully used. The Trust should consider the barriers to proportionate, relevant and necessary sharing of MH Trust patient records out of hours by members of staff in the Trust.

16.15 Lone workers (out of hours) should be supported to keep concise, timed and accurate notes of their actions and decision making and recording areas of disagreement or contrary views.

16.16 Staff responsible for reporting after the incident to a SAR or any other reporting should be supported to develop open and transparent approaches. Most importantly to indicate that learning and development is a key part of the activity so that time is not lost. The lack of insight apparent from some of the key agencies needs some careful consideration by senior managers/clinicians as a point of organisational development following this SAR.

16.17 All staff face tremendous challenges in the work they do and this is often amplified during out of hours working, isolated working or other pressures.

It is the role of organisations and managers to support front line staff in their complex and difficult tasks.

16.18 This SAR is ultimately about Michael Thompson and the circumstances of his untimely death. It is vital that all the agencies involved commit to learning lessons, refining practice and process and ensuring that those who may face similar and difficult circumstances in the future are given the support and help they need.

16.19 Staff too need advice, guidance and the tools to do their difficult, complex and sometimes contradictory jobs especially where they may have been called on to analyse risk and make decisions with imperfect information often in isolated or lone working conditions. They too face risks.

16.20 As part of learning and development for the agencies concerned, the staff involved directly in the circumstances of this SAR should be offered appropriate opportunity to discuss its learning and development and be adequately supported.

Back to contents

APPENDICES

Back to contents

Appendix 1

Report for the SAB Panel

3rd April 2017

Lewisham Safeguarding Adults Board

MT Safeguarding Adults Review

Terms of Reference

Summary of events

On Wednesday 2nd March 2016, the London Ambulance Service (LAS) was called to the address of MT by his relatives. They had visited MT because they had not heard from him for approximately 6 days, which was said to be unusual. They reported that he seemed unwell and it appeared that possession's had been thrown around in the rooms. MT appeared vacant and non-communicative.

LAS attended at 17.02. MT was verbally aggressive and refused any medical examinations or to go in the ambulance to go to hospital. On the advice of the family, LAS staff vacated the property before the Police arrived for their own safety but remained close by. The LAS officers took detailed reports from the family, confirming some history of mental health needs and contacted the out of hours doctors service (SELDOC). According to LAS the first call to SELDOC was at 19.03.

The LAS called the Police at 17.24, when the Police arrived they did not enter the premises and advised that there was nothing further they could do.

At around 22.00 the LAS left the property. Before they left LAS completed their paperwork in the vehicle and went back to the flat with the intention of leaving it there for the professionals visiting in the morning but felt it was unsafe to re-enter.

Final discussions at around 23.07 between SELDOC and the Bromley emergency duty team (EDT) resulted in a decision that no further action could be taken out of hours and that this matter would be referred during normal duty hours to the Mental Health Team. Based on that information, LAS left the area. The exact nature, timing and extent of these contacts and the risk analysis and decision making requires further examination.

A further call from a neighbour was made to the Police around 23.45 when it was reported that MT was throwing items of clothing out of his flat. On this occasion, the Police determined not to take any further action based on information that Mental Health services were going to visit the next morning (3rd March).

Following a referral to the Police of this whole incident, the Independent Police Complaints Commission (IPCC) initiated an investigation, the terms of reference of which were agreed on 22nd March 2016.

At 01.30 a further call was made to the LAS by a neighbour. The neighbour was not with MT at the time and it was determined no ambulance was required and the call was cancelled.

On 3rd March at around 10.59 a call was made to the London Fire Brigade (LFB) as smoke had been seen coming out of the window at MT's flat by a person driving

past. LFB found MT unconscious. LAS attended and administered emergency treatment and MT was taken to University Hospital Lewisham ICU, placed on cardiac support and ventilation but he was declared dead at 16.32 on 4th March 2016.

The SAR

The purpose of a SAR is set out in section 44 of the Care Act 2014. There are some circumstances under which the Safeguarding Adults Board must arrange for a review. In these circumstances, the following applies:

"A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult,"

A SAR in respect of MT was commenced in September 2016 and following review of the draft report by Lewisham Safeguarding Adult Review Panel it was determined that this report was not sufficiently independent and therefore that the SAR should be restarted. Hence these revised ToR.

As noted above, immediately after the incidents on 2nd and 3rd March, the IPCC decided to investigate the actions, decision making and considerations regarding the Police attendance at MT's address on those dates. While separate from the SAR, it is important to consider any findings of the IPCC.

In June 2016, the Coroner determined that the circumstances of MT's death met Section 7(2) of the Coroners and Justice Act 2009 which requires a jury to be summoned. The preliminary dates for the Inquest's final hearing are 10th July to 18th August 2017.

It is anticipated that the SAR will be concluded by the end of June 2017.

Proposed Methodology

The approach taken in this SAR is based on system analysis as this allows for both a detailed examination based on the chronology and can consider direct service delivery actions, decision making, adherence to good practice, legal requirements and relevant policy.

In addition, and in light of MT's involvement with mental health services, consideration of any contributory factors (root cause analysis) will be considered.

This methodology would then allow for key learning to be identified and recommendations regarding policy and/or practice to be highlighted.

Back to contents

Terms of Reference and Areas of Enquiry

1. Consider in detail the events of the 2nd and 3rd March 2016 to identify the actions and decision making of all professionals/agencies that were involved in those events, and to consider any outcomes having regard to:

    a. Were there any delays in decision making and were these a potential factor in the incident on 3rd March.

    b. Given the information available, was the decision not to conduct a MH Assessment on the evening of 2nd March reasonable. Was a full risk assessment carried out.

    c. Did the referral of MT to Bromley EDT (rather than Lewisham EDT) have any impact on decision making on 2nd March.

    d. Were there any undue delays in the referral from EDT services to normal hour's services on the 3rd March.

    e. Take into account any findings from the IPCC report when available.

    f. Consideration of relevant legislation (Mental Health Act (MHA) and Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS)).

    g. Safeguarding guidance (both London wide and for individual agencies).

    h. Any other relevant policy or practice guidelines for individual agencies and any national advice or guidance.

    i. Was Making Safeguarding Personal (MSP) considered at any point.

2. Review and outline the previous history of MT and his involvement with mental health services or other health, social care or community services to establish whether or not there are any linkages with the events of the 2nd and 3rd March.

3. To specifically consider the mental health review that was conducted by the GP on the 23rd February 2016.

4. To further attempt contact with MT's relatives regarding the SAR and, as far as possible, to gain their engagement.

The context of the above is to ensure that the key principle of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

To assist in the examination of Mental Health law, Mental Capacity Act or guidelines and practitioner requirements, specialist advice will be sought from Steve Chamberlain (Practice and Mental Health Act advice and expert).

The preparation of the SAR will refer to all existing material, reports and correspondence. Where necessary revisiting some of this material may be required and new or further information will be sought.

It is anticipated that a final draft of the report will be completed by the end of June 2017.

Ian Winter CBE
16th March 2017

Back to contents

Appendix 2: Biographical details of SAR authors

Ian Winter CBE

Ian has over 40 years' experience at local, regional, national and international level in health and social care. He was the Director of Adult and Children's Services in a large shire county, pioneering work on re-ablement, care management and integrating learning disability and mental health services.

Ian led an in-country assignment for the Royal Government of Cambodia, securing substantial World Bank funding for Healthcare.

He served for 6 years as senior civil servant in the Department of Health as regional director for London and other national projects.

Following this he worked on an integrated response to the Winterbourne View abuse scandal and researched and produced the national stocktake of progress which was used as the bench mark for further action.

Ian has advised Safeguarding Adult Boards on their development and has authored other Safeguarding Adult Reviews.

He has provided consultancy support to local authorities and led Peer Challenges on behalf of the Local Government Association.

He is the independent Chair of Transforming Care Partnership Board for Learning Disability Services for services in Oxfordshire and is the independent Chair of the Children's Safeguarding Board in Barking and Dagenham.

Ian was awarded a CBE for services to social care in 2012.

Expert Mental Health advice and information was provided by:

Steve Chamberlain

Steve Chamberlain is a trainer and independent social worker, having left local authority employment in summer 2014. He qualified as a social worker in 1983 and trained as an Approved Social Worker in 1987.

Since 1990, he has worked in adult social care and mental health. He practiced as an ASW/AMHP until 2013 and was a London Borough AMHP lead from 2001 to 2013. During 2013/14 he managed an inner London assessment and care management service.

Steve was a borough MCA lead until 2008. He was seconded to the Department of Health as London implementation lead for MCA/DoLS until 2011. He trained as a Best Interests Assessor in 2009 and continues to practice. He has delivered training since 1998, mainly on mental health and mental capacity issues. Steve has been chair of the national AMHP leads network since 2011.

He has been involved with two SCRs after adults with a history of mental ill health killed their children, and is undertaking Safeguarding Adults Reviews for local authorities under the Care Act 2014.

Appendix 3 - Chronology

Date/time	Event	Source
1977	Murder conviction	SLAM fact finding report
1992	Released on licence	SLAM fact finding report
	4 year gap	
1996	Recalled to prison due to concerns about mental health. Assessed at Bracton Medium Secure Unit (MSU) under S47/49 of Mental Health Act 1983. Diagnosis of: • Paranoid personality traits • History of substance misuse • Propensity to brief psychotic episodes under stress GP record refers to diagnosis of cannabis induced psychosis Transferred back to prison.	SLAM fact finding report and Probation report GP notes Probation report
2004	Released from prison on licence. Was assessed at Bracton MSU – no sign of active mental illness. No medication prescribed. MT to report to the Probation Service on a quarterly basis.	SLAM fact finding report GP notes
	5 year gap	
2009	Police called to ex-partners address. MT admitted to hospital for assessment under S2 of MHA 1983 for approximately 4 - 5 weeks. Diagnosis made in 1996 confirmed. No medications prescribed. Released 6th February 2009.	SLAM fact finding report Probation report
	3 year gap	
Feb 2012	Taken by Police to hospital (Ladywell Unit) under S136 – which was converted to a S2. SLAM states admission dates as 11 Jan 2012 to 28 February 2012. Assessed as having had a brief psychotic episode. On discharge from hospital referred to the Assessment and Brief Treatment (ABT) Mental Health Team. 7 days after discharge assessed as being symptom free. This is confirmed in a 2nd re-assessment follow up – date not given. MT and the team agree that there is no need to continue with the ABT and MT agrees to continue the prescribed medication under his GP's supervision. GP response says diagnosis of Acute Transient Psychotic Disorder made on discharge.	Lewisham & Greenwich NHS Trust doc SLAM fact finding report GP notes

Date/time	Event	Source
March 2012	Contact with Probation is every month from this discharge.	SLAM fact finding report Probation record
1 May 2012	Mental Health Services discharge MT. Last contact with SLAM. There is no further contact re MT until the incident on 2nd/3rd March 2016.	SLAM fact finding report Bromley AMHP Report
	2 year gap	
April 2014	Contact with Probation moves from monthly to every 3 months - MT was assessed as posing a low risk of harm to the public.	Probation record
	1 year gap	
31 March 2015	GP MH meds review. Condition the same. Low suicide risk.	GP notes
5 May 2015	Last time regular prescription issued: • Olanzapine (5mg daily) • Promethazine Hydrochloride (25mg daily) • Amlodipine (10mg daily)	GP response letter
	8 month gap	
20 Jan 2016	Last contact with Probation.	Probation record
12 Feb 2016	GP – essential hypertension review by Natalie Holiday (Healthcare Assistant). Not taking medication.	GP notes
23 Feb 2016	Scheduled GP MH meds assessment. Assessed as condition improved. MT adamant that he will not take any of his medications. Assessed as having capacity. MT states he will attend Ladywell Unit if he feels unwell/any anxiety/stress. Planned to assess mental and physical health in two weeks.	GP response
	2 day gap	
25 Feb 2016	Last contact with family on 25th February 2016.	LAS Patient Form
	4 day gap	
29 Feb 2016	MT's cousin phones GP. MT not responding to mother/family calls for about a week. Cousin advised to check on MT at home and if any concerns to take MT for psychiatric review or get him to contact GP.	GP notes
2nd March 2016	**2 day gap**	
15.00	Family members (mother and 2 uncles) visit MT at his flat. They have a key to enter. They ask a neighbour (Mr Smith) to assist them in communicating with MT as he is not responding to them.	Police statement by neighbour and uncle

Date/time	Event	Source
	On entering flat the neighbour reports that MT was on the sofa, slumped but conscious but incoherent. Flat not in state that MT usually kept it.	
15.23	Uncle calls NHS 111.	NHS 111 call log
15.29	Call is warm transferred to a Clinician (Nurse) due to its complexity.	NHS 111 call log
15.49	Call is closed with a decision for the caller to contact the Patient's GP. No safeguarding referral made.	NHS 111 call log
16.07	Uncle calls NHS 111 again.	NHS 111 call log
16.13	Call handler begins triage.	NHS 111 Call log
16.15	Call handler queues call for a clinician ring back (Priority 1).	NHS 111 Call log
16.25	Clinician contacts caller to reassess patient.	NHS 111 Call log
16.37	Clinician reaches final disposition of emergency Ambulance for Clinical Reasons and requests LAS attendance to scene. No safeguarding referral made.	NHS 111 Call log
17.02	Ambulance arrives: • MT refuses any assessment • Evidence of a small fire having been set • No evidence of alcohol consumption or cannabis (no smell) • Number of knives in different rooms – hidden by ambulance staff with family's knowledge Family advise of history of violence and poor mental health. LAS unable to assess capacity as MT is not communicative. Their assessment at time is that MT lacks capacity to consent/make decision about attending hospital. Capacity Tool paperwork was completed and attached to the Patient Form. Patients Best Interests form completed "requires MH assessment and medication and place of safety". Action: SELDOC GP called. Police attended.	LAS log LAS Patient Form LAS Signed response
17.24	Ambulance staff call for Police assistance. Before police arrive, the family advise ambulance staff to leave the flat for their safety.	LAS call log Statement by Paramedic to IPCC
17.37	The Police call handler queried the request and asked if a mental health assessment had taken place. The LAS response was "*MH crisis/Knives in premises/history violence*"	LAS call log
17.56	Further call by LAS for Police attendance.	

Date/time	Event	Source
18.02	Police call handler questioned why the Police were required if the individual was being taken straight to a hospital. At 18.06 the LAS responded, "*Male not communicating/ Knives in the premises/ history of violence/ assistance required to transport to hospital*". The Police attended after this request.	LAS call log
18.20	Police arrive but do not enter flat. They speak to the family and ambulance staff. Police determine that they cannot assist.	Statement by Paramedic to IPCC
18.48	Call received into 111 by on scene Paramedic – wishing to speak to out of hours doctor regarding mental health concerns. 18.50 After seeking advice, call handler advises paramedic to contact OOHs directly and provides contact number. 18.54 Call is closed by Senior Clinician as it had been queued in error. The on-scene paramedic had accepted responsibility for calling OOH direct.	NHS 111 call log
Before 19.00	Time unknown. Family leave before the Police depart. Family leave their contact details with both the LAS and Police.	Uncle's statement to IPCC
19.00	Police leave. Records that MT not sectioned and family arranging assessment tomorrow. Left premises as MT not violent and LAS in process of arranging MH Assessment through his GP/MH Duty Team.	MPS initial briefing note
19.03	Ambulance staff call SELDOC using mobile phone. This call time is recorded in the LAS signed response. LAS are clear that contact with SELDOC was made at 19.03 and 20.10.	LAS signed response, LAS Patient Report Form, further information provided by LAS as part of this SAR
20.03	SELDOC call log states the first call from LAS received (Operator Eleanor).	SELDOC summary, SELDOC patient record Additional SELDOC provided as part of this SAR
20.06	SELDOC triage the case as a routine C (Routine C Category is a described as "all routine calls" on the SELDOC call handling policy. No further details are described in the policy.)	SELDOC summary Additional SELDOC info to IW
20.07	Ambulance staff waiting for SELDOC to ring back, so they ring again.	Paramedic statement to IPCC

Date/time	Event	Source
21.00 approx.	SELDOC GP rings paramedics back and says he would be referring MT to MHT and on judgement felt not safe to come out on his own after hearing all factors as the police had left the scene by this time. SELDOC time this conversation at 21.35. In paramedic's statement to IPCCC SELDOC said they would not send anyone by themselves as didn't think it safe to do so. He would pass info onto Ladywell Unit and make it clear it was urgent.	LAS signed response Paramedic statement to IPCC
21.05	Patients details updated on SELDOC system.	SELDOC summary
21.06	Patients demographic changed on SELDOC system. Also next call from LAS to SELDOC.	SELDOC summary Additional SELDOC Info to IW
21.09	Entry in LAS call log is at 21.09 LAS crew waiting for SELDOC ring back for 1 hour +. Crew have called back but advised GP to call shortly.	LAS call log
21.35 – 21.45	Contact between LAS and SELDOC.	Additional SELDOC info to IW
21.45	Ambulance crew leave. (Handwritten note records 21.45 as time "event ended") They are unable to leave paperwork at the flat. They record in their notes that SELDOC are referring to MH Team.	LAS call log Paramedic statement to IPCC
21.55	SELDOC doctor contacts LB Bromley call centre Appello.	Appello transcript
22.00	Appello call handler calls Bromley EDT AMHP.	Appello transcript
22.05	Bromley EDT contacts SELDOC. SELDOC doctor gives details from Ambulance crew's call to SELDOC.	Bromley AMHP Report
22.23	Bromley EDT AMHP advised by Senior Duty Nurse at Green park House to call Lewisham Psychiatric Nurse (PLN) at Lewisham. PLN told the AMHP that MT was known previously to SLAM but no contact since 2012.	Bromley Safeguarding report
23.07	Consultation advice by SELDOC doctor.	SELDOC summary
23.07 – 23.12	Final discussion between SELDOC, EDT and AMHP. Decision is that more appropriate for assessment to be done in the morning when there are resources available (including police). SELDOC doctor thought that it was of sufficient urgency for assessment to be done that night.	SELDOC summary
23.14	"Information outcome added – Mental Health check. Case triaged changed to urgent (to be seen in 24 hours)."	SELDOC summary

Date/time	Event	Source
23.45	A ground floor neighbour calls resident in flat 309 (Mr Smith) because personal items have been discarded in the corridor by MT. Person in flat 309 calls the police.	Neighbour's information to SAR author. Neighbour's statement to IPCC
	3rd March 2016	
00.50 approx.	Police arrive. They report that MT is having a crisis. No action taken as MT is "going to the hospital for assessment in the morning" Police stay for approximately 15 minutes.	IPCC ToRv2 MPS Initial Briefing Note Neighbour's statement to IPCC
02.15	Neighbour (who is unknown) calls for an ambulance. The caller is not with MT. There are no details of what the problem is and the call is cancelled as ambulance not needed. LAS Chronology (Final) says this call was received at 02.15.	LAS Chronology (Final)
06.30	Neighbour from flat 309 (Mr Smith who also rang the police at 23.45) goes into MT's flat through open front door. MT is "not with it".	Neighbour's information to SAR author
09.00	Bromley EDT worker calls and refers MT to Bromley daytime AMHP. Administrator checks the address and realises it needs to go to Lewisham.	LB Bromley report adult safeguarding review
10.09	"Referral sent to Lewisham (from Oxleas) and a conversation had at 10.09 between Oxleas AMHP and Lewisham AMHP. When the referral was reviewed by the manager it was passed through to the Response Team"	LB Bromley report adult safeguarding review
10.27	Email from Bromley's Out of Hours Duty Social Worker arrives in Lewisham AMHP Operational Manager's inbox.	Statement by Lewisham Operational Manager
10.59	Emergency services called by passing motorist as smoke seen coming out of MT's window.	LAS Chronology (Final)
11.03	MT taken to University Hospital Lewisham.	LAS Chronology (Final)
13.00	Lewisham AMHP Operational Manager checks emails. Sees a forwarded email from a duty AMHP concerning MT that had originally been sent from Bromley Out of Hours Duty Social Worker at 10.27.	Statement by Lewisham Operational Manager
13.07	Lewisham AMHP Operational Manager forwards the email to the Lewisham Assessment and Liaison Team to request an urgent visit to assess MT. This was followed up by a phone call to check the email had been received.	Statement by Operational Manager

Date/time	Event	Source
14.00	Team Leader for Lewisham Assessment and Liaison Service receives phone call from Lewisham AMHP Operational Manager regarding the forwarded referral.	Team Leader's statement to Coroner
afternoon	Lewisham Assessment and Liaison Team contact MT's GP. Ask the GP to ring back with information and to decide on next course of action.	SLAM fact finding report Team Leader's statement to Coroner
15.51	While waiting for the GP to ring back the Team Leader received an email from the social care lead informing him that MT has been admitted to ICU following a fire that had been set. Records states it was a suspected suicide attempt.	Team Leader's statement to Coroner
17.00 approx.	Family contacted by hospital staff to inform them that MT was in their ICU.	Statement by MT's uncle
	4th March	
16.32	MT declared dead by doctors at ICU University Hospital Lewisham.	Lewisham and Greenwich NHS trust

Back to contents

Appendix 4 – Legislation and Guidance

Metropolitan Police - Policing Mental Health Guidance version 4

Dealing with spontaneous mental health incidents on private premises

The 'Metropolitan Police - Policing Mental Health Guidance version 4, Dealing with spontaneous mental health incidents on private premises" states a *'Police supervisor must take a lead on such spontaneous incidents'* and that the supervisor must *"'Consider risks to officers, to the mentally ill person and to others nearby together with the powers available"*

The guidance provides specific instances where in particular circumstances police may enter a property without the use of a warrant:

- *'Where there is evidence of a criminal offence justifying entry under S17 PACE to arrest for that offence'.*
- *'Where a breach of the peace is in progress or anticipated justifying entry in order to make an arrest'.*

Breach of the peace is further defined as, *'Whenever harm is done, or is likely to be done to a person, or, in his presence to his property, or, whenever a person is in fear of being harmed through assault, affray, riot or other disturbance. – Usually there must appear to be an imminent risk of assault to a person for a breach of the peace power to be used."*

Additionally, where there is a genuine belief that a person lacks capacity and is likely to *'imminently commit suicide or seriously self-harm'* police can enter under S17 PACE and should restraint be required S 5/6 Mental Capacity Act 2005 should be considered as necessary to prevent serious injury or death.

Section 136 of Mental Health Act 1983

However, case law R (Sessay) v South London and Maudsley NHS Foundation Trust [2011] EWHC 2617 (QB) states that S135 and S136 Mental Health Act 1983 (MHA) are the exclusive powers available to police officers to remove persons who appear to be mentally disordered to a place of safety.

Sections 5 and 6 of the Mental Capacity Act 2005 do not confer on police officers authority to remove persons to hospital or other places of safety for the purposes set out in sections 135 and 136.

The MHA 1983 provides a complete statutory code for compulsory admission to hospital for non-compliant incapacitated patients, so the common law doctrine of necessity does not apply during the period in which a patient is being assessed for detention under the Act. If there is urgent necessity to detain then the S4 procedure should be followed.

Back to contents

The police guidance goes on to include circumstances where police attend incidents not as serious as above and it is unlikely that power to enter and deal without consent would be available. Advice provided where an AMHP is not present is to either:

- *'Refer the person to the AMHP and leave the premises'*

Or

- *'Persuade the owner of the premises (quite possibly the person with mental illness) to permit police to enter the premises and request the AMHP urgently attend'.*

Section 13 (1A) b of Mental Health Act 1983

The Mental Health Act 1983 states in S13 (1A) b that if the local social services have reason to think that an application for admission in respect of a patient within their area, they shall make arrangements for an approved mental health professional to consider the patients case - having regard to any wishes expressed by relatives or any other relevant circumstances.

Guidance states that consideration is not a one-off decision but should be reviewed considering further information, and consideration should be given to obtaining a S135 MHA1983 warrant in order to obtain entry to the property.

Back to contents

Appendix 5 - SELDOC Role

SELDOC (South East London Doctor's Cooperative Ltd) is a GP (General Practitioner) co-operative, run as a mutual not-for-profit company limited by guarantee. SELDOC's duty doctors are highly valued and are integral to the delivery of high-quality clinical services in accordance with the expectation of SELDOC's commissioners.

SELDOC provides unscheduled and out-of-hours primary care services for people living or registered with GP practices in the area its opted-in GP surgery members operate from, as well as other areas it has contracts for. SELDOC operates a clinical service from 18:30 to 08:00 Monday to Friday, and 24 hours over weekends and Bank Holidays, until 08:00 the next working day.

SELDOC aims to provide high quality clinical care for patients through local GPs or GPs who qualify to work for SELDOC by virtue of working at least 2 shifts per week as a GP in Lambeth, Southwark or Lewisham.

A Service Level Agreement (SLA) is signed before any GP works for SELDOC. The SLA ensures that all parties are aware of their responsibilities and commitments to each other.

In summary, the SLA states that:

- Whilst undertaking work as a SELDOC duty doctor, the GP is an independent contractor
- All SELDOC duty doctors are required to comply with the General Medical Council "Duties of a Doctor"
- All SELDOC duty doctors are required to comply with the requirements of revalidation"

Back to contents

Appendix 6 – SELDOC Patient Record

This information has been extracted from the SELDOC Patient Record.

Case Date: Wed 02 Mar 2016 **– Case No:** 24249 **– Case Type:** Advice

Page 1

Patient Name: Michael Thompson

Sex: M

Date of Birth: 08 XX 19XX

Current Address: 311 Downahm Way

Reported Condition: Symptoms: p.t. mental health crisis

Receive Time: 20:03

Advice Time: 23:07

Advice End: 23:12

Latest Advice Details:

Mental Health Patient with psychosis

Has not been in contact with family for a bout a week.

Non-compliant with his medicines

Was in hospital in 2012

Not been taking meds lately

Does not seem to be under MH team

There was evidence of a small extinguished fire

And knives

Police attended but unable to assist under regulations

History of violence

Still standing at the window

Paramedics had to evacuate premesis for their safety.

Became verbally aggressive and family advised crew to get out for their safety.

Family fearful to enter.

Refuses to communicate with crew/police.

Does not sound safe at all for a GP visit.

Ther are knives scattered in the premesis.

Will speak to MH Team.

Page 2

Family have a key – XX (Family contact details withheld)

Also Uncle XX - (Family contact details withheld)

It is not a safe environment there is a risk of serious harm visitng individuals as assessed by the crew who had to rapidly evacuate in fear for their safety.

Efforts to track down OOH MH Team…

Passed details to Bromley Out Of Hours.

Spoke with ASW Bromley.

Explained the situation.

They are thinking as he is not going out of his house and the aggression was triggered by people invading his house uninvited, there may be recourse ot sort this out in the day when more resources are avaialable.

Will liaise with MHT to ascertain whether still under MHT initially and come back to me to formulate a plan.

Call back 2307

Was last open to service 2004 and forensic 2009

Spoke with PLN Lewisham

Was in Ladywell Unit for ? drug indcuced psychosis

ASW has liaised with CPN and PLL and they are referring to the CMHT for assessment this morning as there is not sufficient evidence for a MH setion tonight as the patient has not show any intent to leave the premises and only became threatening when house was invaded.

ASW has organised for MH visit in the morning I have asked him to make sure the safety concerns are passed on.

Back to contents

Appendix 7 - Bromley Emergency Duty Team

The Emergency Duty Team (EDT) offers an emergency response to referrals for social care (for children, adults and mental health) that are made between 5pm and 9am on normal working days, at weekends and Bank Holidays. The Emergency Duty Team is a single officer service, responsible for prioritising between the tasks involved in responding to referrals.

Mental health services are not provided directly by the local authority and arrangements exist under a section 75, Oxleas NHS Foundation Trust is our mental health provider.

i. All referrals for Mental Health Act Assessments will be rung though by the referrer, either via the EDT contact centre or directly on the EDT AMHP's mobile.

ii. All referrals should be logged onto the EDT log on the one Bromley, whether they have been accepted or not.

iii. In co-ordinating Mental Health Act Assessments, the duty AMHP will make decisions in line with the Mental Health Act Code of Practice.

iv. All assessments carried out leading to admission would be followed by an outline/ interim report which should be recorded onto Rio.

v. All decisions to or not to assess, would be clearly documented on the relevant systems namely Rio and Carefirst (where the person is known to social services) and any follow up actions clearly documented.

vi. Liaise with on call SPR/ Psychiatrist and DSN following requests for Mental Health Act Assessments out of hours.

vii. Full AMHP Reports and other necessary paperwork to be completed within reasonable timeframes following the EDT shift and ensure these are uploaded in a timely fashion on to Rio. (Rio is the Oxleas client database).

Out of Borough patients: EDT will consider requests for Mental Health Act Assessments for patients in custody or in the local 136 suite at Green Parks House (Princes Royal Hospital site) who are not Bromley residents. However, requests for patients from Bexleyheath area or who have been picked up in the Bexleyheath locality should be referred to Bexley EDT by the DSN's.

For other patients, picked up in neighbouring local authorities who end up in Green Parks House, it is good practice to liaise with the responsible areas and consider whether it is appropriate to transfer patients back to their area on S.136. Each case should be considered individually, taking into account all circumstances.

General principle and working practice of unplanned community mental health assessments out of hours is that the doctor would have discussed what known risk factors that were readily accessible at the time on record - (risk assessment information on electronic records) that may have been known - the patient's current mental state and presentation.

Back to contents

Policy and Practice

What is the Bromley EDT policy/practice on carrying out unplanned community MHA assessments out of hours? If there are such policy/practice agreements please send a copy for review?

Local authorities are responsible for ensuring that sufficient Adult Mental Health Professional's (AMHP) are available to carry out their roles under the MHA 1983, including assessing patients to decide whether an application for detention should be made. The London Borough of Bromley to fulfil its statutory duty, must have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.

The out of hours Emergency Duty Team (EDT) is responsible for carrying out unplanned community MHA assessments out of hours. The service offers an emergency response to referrals for social care (for children, adults and mental health) that are made between 5pm and 9am on normal working days, at weekends and Bank Holidays. The Emergency Duty Team provides one duty social worker, who is responsible for prioritising between the tasks involved in responding to referrals. The responsibility of the duty AMHP is to meet the duties under section 14.35 of the Code of Practice including assessing patients – when requested in accordance with the code of practice and protocols.

A protocol exists between the London Borough of Bromley EDT and Oxleas NHS Foundation Trust (community mental health service arrangements are managed under a Section 75 agreement) for the management and handover of cases to daytime services. A summary is below;

(i) The referrer will telephone through all referrals for Mental Health Act Assessments, either via the EDT contact centre or directly on the EDT AMHP's mobile.

(ii) All referrals should be logged onto the EDT log on One Bromley, whether they have been accepted or not.

(iii) In co-ordinating Mental Health Act Assessments, the duty AMHP will make decisions in line with the Mental Health Act Code of Practice.

(iv) All assessments carried out leading to admission would be followed by an outline/ interim report, which should be recorded onto RIO (Oxleas' electronic record/data base).

(v) All decisions to assess or not, would be clearly documented on the relevant systems namely Rio and Carefirst (where the person is known to social services) and any follow up actions clearly documented.

(vi) Liaise with on call SPR/Psychiatrist and DSN following requests for Mental Health Act Assessments out of hours.

(vii) Full AMHP Reports and other necessary paperwork to be completed within reasonable timeframes following the EDT shift and ensure these are uploaded in a timely fashion on to Rio. (Rio is the Oxleas client database).

General principle and working practice of unplanned community mental health assessments out of hours is in line with section 14.31 of Mental Health Act Code of

Practice. The application must be supported by two medical recommendations given in accordance with the Act. In practice, the doctor must see the patient and should have discussed what known risk factors were readily accessible at the time on record - (risk assessment information on electronic records); that may have been known - the patient's current mental state and presentation. In line with EDT procedure and best practice, a fully researched and planned assessment for the following day was the preferred outcome in this case as there was no medical recommendation provided by SELDOC.

Does the above policy/practice differ if service users/residents are known/unknown to AMH/ASC services?

The practice does not differ if service users or residents are known or unknown to the EDT services.

EDT will consider requests for Mental Health Act Assessments for patients in custody or in the local S136 suite at Green Parks House (Princes Royal Hospital site) who are not Bromley residents.

For other patients, picked up in neighbouring local authorities who end up in Green Parks House, it is good practice to liaise with the responsible areas and consider whether it is appropriate to transfer the patient back to their area on Section 136. Each case should be considered individually, taking into account all circumstances. Requests for patients from Bexleyheath area or who have been picked up in the Bexleyheath locality should be referred to Bexley EDT by the DSN's.

Back to contents

Appendix 8

APPROVED MENTAL HEALTH PROFESSIONAL REPORT

Client name: Michael Thompson 08/01/1956 311 Downham Way Bromley BR1 5EN **DoB** XX/XX/XXXX

Date of Assessment: 02.03.2016 **Rio No.**

Name of Referrer: **Dr X** **Team Responsible** **Please select**

Assessment venue: **na** *(if other please state)*

Status at time of referral

Outpatient ☐ **Not known to Service** ☒ **CTO/SCT** ☐

Inpatient ☐ **Informal** ☐ **Formal** ☐ **Section**: 1

Nearest Relative Details

Name: **ns** **Relationship:**

Address:

Post Code: **Tel No.**

NR contacted: **Yes** ☐ **No** ☒ **Statutory letter sent :** **Yes** ☐ **No** ☒

Brief summary of personal history:
To include: Social/Family background information, Safeguarding issues; Educational/Occupational; Forensic History (if applicable); Financial; Psychiatry History (brief summary)

22.05 Ref 156889 Dr XXXXXXX 078014XXXXX family have not seen a relative for over a week – called ambulance – when arrived – verbally abusive paramedics afraid of him – family advised them to leave for their own safety and family too frightened to enter the property - is abusive – is on meds has not been taking it – MH concern. Michael Thompson 08/01/1956 311 Downham Way Bromley BR1 5EN. Compulsory admission in 20/12/2015 - had not been in touch with family for week. Not engaging – threats – verbal abuse – police were there with ambulance – unable to intervene – risk to others? – There for a week – not attempting to go anywhere. Lewisham address recently moved – Downham medical practice CCG Lewisham. Nothing on RIO 207. Registered on Rio – no core assessment – no entries. Probably known to SLAM. Previously open to community team Bracton Service 2004 and forensic psychology assessment team Feb 2009. No entries on Rio on progress notes – nothing on core assessment or RA. Nothing on clinical documentation. CCG SLAM Lewisham. GP history Downham family Medical Practice 19/03/2009. Advised ring PLN Lewisham 0208 333 XXXX. 0208 333 XXXX. 22.23 hrs TCT PLN who advised patient previously known to slam – no contact since 2012 – has had previous admission to Ladywell 2012 diagnosed – acute psychotic disorder - history of drug use. No contact since. FTC to referrer – we discussed that as patient currently at home and has only shown aggression when being assessed that it could wait for him to be assessed during the day. Please can day team assess what support/ assessment - this patient needs as family have become concerned about his lack of contact and his mental state appears to be aggressive?

Circumstances leading to assessment: (should be included in AMHP referral)

see above

Details of Client interview:
(include assessment of clients mental state, discussion with relevant others including recommending Doctors). Record assessment of client's capacity to make particular decisions.

see above

Consultation with Nearest Relative:

see above

Significant Risk Factors:

see above

Outcome of Assessment

Please can duty Amhp assess?

Approved Mental Health Professional: XXXX

Base/contact details: EDT

Date: 02.03.2016

Back to contents

Appendix 9 - Email from Bromley EDT AMHP to Daytime AMHP

From: XX@bromley.gov.uk
Sent: 02 March 2016 23:41
To: 'BromleyCentralAMHPTeam BromleyCentralAMHPTeam'
Subject: Thompson Michael 02.03.2016

Dear Amhp's

Please find attached a Nearest Relative (effectively) request for Mental Health ACT Assessment via DR Michael Thompson.

Best Regards

XX
EDSW

Back to contents

Appendix 10 - Letter to Family, 9th June 2017

Mrs XX
Flat XX XXXX Court
XX Road
Catford
London
SE6 XXX

Friday 9th June 2017

Dear Mrs XX

Re. Mr Michael Thompson, 311 Downham Way, BR1 5EN, DOB 08/01/1956

I am the new Independent Chair of Lewisham Safeguarding Adults Board. You may be aware that, prior to my appointment, the Board decided to commission a Safeguarding Adult Review regarding your son Michael. Upon my appointment, I have reviewed progress on this review and decided to commission an Independent Reviewer, Ian Winter, to complete the review. He is an experienced reviewer and has considerable expertise in adult social care.

By way of background, Safeguarding Adults Boards arrange Safeguarding Adult Reviews when there is concern that partner agencies could have worked more effectively to protect the adult. The purpose of the review is to determine what relevant agencies and individuals involved in the case might have done differently that could have prevented harm. This is to ensure that lessons can be learnt and applied to future cases to try to prevent similar harm occurring in future. It is not to hold any individual or organisation to account.

In addition to seeking information from managers and practitioners that were involved in the case at that time, the Safeguarding Adults Board must provide families with the opportunity to contribute. I have found this part of the process invaluable in getting an insight into how the person concerned may have experienced services. You may have received a similar request previously. I am inviting you again to offer your views on how professionals and agencies worked with your son. I would therefore like to invite you to meet with me and Ian Winter to discuss your experience of services and how they worked with your son.

We are happy to meet with you both at a time and place that is most convenient for you. We are happy to meet you in your home or at Lewisham Council offices, whichever is more convenient for you. I look forward to hearing from you.

Yours sincerely,

Professor Michael Preston-Shoot
Independent Chair, Lewisham Safeguarding Adults Board

Back to contents

Appendix 11 Contributory Factors and Root Cause Analysis

There were three significant factors in MT's history; his past history of mental illness, a conviction for murder and his non-compliance with medication. Additionally there were two significant risk factors on the evening of the incident, large knives found scattered around flat and evidence of a small extinguished fire in his kitchen. All agencies held some of the information but no single agency held all of the information which hindered services seeing the full picture.

There appeared to be a lack of direct or comprehensive communication between professionals at the scene and those professionals making decisions about further action. Little attempt was made by police to gather full information and no attempt by EDT to contact the family or LAS to gather information and further contact details.

In summary the analysis using Root Cause Analysis (RCA) tools and techniques shows:

Area of Concern:

PATIENT FACTORS	INDIVIDUAL/STAFF FACTORS	TASK FACTORS
Patient lived alone. Was known to have had a previous admission in 2012 for transient psychotic illness.	Following further concerns raised by neighbour police attended the property but did not take any further action.	NHS 111 made contact with LAS for an ambulance to attend patient rather than an AMHP. LAS called Police for assistance rather than refer to an AMHP. Long delays in response or originating call to the out of hours doctor (SELDOC). SELDOC doctor did not have clear information about EDT (AMHP) contact. The post code (Bromley) was not checked for the actual Borough boundary. EDT did not conduct a risk assessment or formulation on the information they had gathered specifically in relation to MT's health, his safety or the protection of others.
Previous conviction for murder in 1978.		
Not been taking medication since June 2015.		EDT did not speak to family to gather information and obtain their contact details to follow up later as required.
MT was uncommunicative and agitated apart from verbal abuse towards ambulance crew.		The records in the NHS Trust had valuable background information about the patterns of MT's mental health condition.
MT had knives on the premises and there was evidence of a small		This does not seem to have been considered in the decision not to assess on the night of 2nd March. SELDOC/AMHP and EDT did not appear to conduct a robust risk analysis and options for action. No consideration of mental capacity other than by the LAS. The SELDOC patient report did not convey what was later stated as the doctor's strong view that an assessment visit was required.

PATIENT FACTORS	INDIVIDUAL/STAFF FACTORS	TASK FACTORS
extinguished fire in flat.		The response on receipt of the referral from Bromley was delayed and not comprehensive.
Following departure of family and LAS MT had discarded items in the communal hallway and reported as having 'trashed' his premises.		The second visit of the Police needs to be considered once the IPCC findings are available.
TEAM & SOCIAL FACTORS	**WORKING CONDITION FACTORS**	**COMMUNICATION FACTORS**
		• All services did not know about MT's forensic history. • No access to GP records. • SELDOC did not know how to contact the EDT team. • There is a discrepancy between what SELDOC said that they handed over to EDT and what EDT reported in their log. • NHS 111 or LAS did not consider a direct referral to EDT (or AMHP) services. • EDT did not communicate that if there was a change in circumstances that professionals and or family could re contact them and decisions could be reviewed. • EDT believed that SELDOC was at the property and had spoken direct to MT's family which was not the case. • There are differing expectations between services regarding whether a mental health assessment, Mental Health Act assessment or an assessment of support needs MT required. • The referral from Bromley EDT to Lewisham 3rd March did not indicate sufficient urgency or clarity of purpose. • The fact that this was a Nearest Relative (NR) referral from EDT to daytime services was not recognised.
EQUIPMENT FACTORS	**EDUCATION & TRAINING FACTORS**	**ORGANISATION & STRATEGIC FACTORS**
		The contractor commissioned by LB Bromley did not carry out relevant checks to identify the correct EDT service. Reports for Safeguarding Adult Reviews from agencies should be candid and record any initial learning and development to give confidence that there is a level of insight that will help to develop practice.
CAUSAL FACTORS/ROOT CAUSES		
No specific root cause.		

Adapted and amended from the original SAR

Appendix 12 - Documents Used as Part of Original SAR and New SAR

The primary sources of information used to inform both the original SAR and this SAR were:

GP:

- MT's medical notes dating back to 31st March 2015.
- Practice response to specific questions put as part of the original SAR.

LAS:

- Copy of all notes taken during their call out to the scene.
- Chronology of ambulance calls.
- LAS response to specific questions as part of the original SAR.

London Borough of Bromley EDT:

- Approved Mental Health Professional Report.
- EDT response to specific questions put by as part of the original SAR.

London Borough of Lewisham:

- London Borough of Lewisham SAB Timeline.

Lewisham & Greenwich NHS Trust:

- Response to questions put as part of the original SAR.

London Fire Brigade:

- Response to questions put as part of the original SAR.

MPS:

- Initial Metropolitan Police Service briefing note.
- IPCC Terms of Reference.
- Copy of witness statements of ambulance attendant, neighbour, MT's uncles.

SELDOC:

- SELDOC Patient Record.
- SELDOC response to specific questions put as part of the original SAR.

SLAM:

- South London & Maudsley NHS Foundation Trust – Fact Finding Report
- Copy of draft report to Coroner completed by Lewisham AMHP operational manager.

Oxleas NHS Trust Information Governance Team:

- Response to questions put as part of the original SAR.

Telephone contacts by original SAR authors with:

MT's Mother:

- 11th October 2016. Did not want to meet or provide information to assist with the original report and declined further contact.

MT's Uncle:

- 20th October 2016. Did not want to contribute to the original report.
- Informed investigator he had spoken to police and provided information to them.
- He did not want further contact.
- IPCC shared statement made by MT's uncle as part of the original SAR.

MT's Neighbour:

- 24th October 2016 agreed to speak by phone, and provide information/statement as part of the original SAR.
- Neighbour did not want to meet face to face.
- IPCC shared police statement made by neighbour as part of the original SAR.

In addition to the above, the following were also obtained as part of this SAR:

GP:

- Conformation from GP as to what report was received from SELDOC on 2nd March 2018.

LAS:

- LAS response to additional specific questions.
- NHS 111 timeline of calls on 2nd March 2016.

London Borough of Bromley:

- Bromley EDT response to additional specific questions.

MPS:

- Confirmation from the MPS on the progress of the IPCC. Information relating specifically to the second visit to MT by MPS was unavailable due to IPCC investigation.

Probation:

- Telephone discussion with Head of Lewisham and Southwark Probation on 3rd May 2017.
- Record of MT's contact with the Probation Service.

SELDOC:

- SELDOC responses to additional specific questions.

SLAM:

- Telephone discussion with Lewisham AMHP Operational Manager as part of this SAR on 5 June 2017.
- Response to specific questions put to the Lewisham AMHP Operational Manager as part of this SAR.
- Statement of Lewisham Response Team Manager to Coroner requested as part of this SAR.
- Patient records from 2009 and 2012.

Family:

- Further contact was offered to the family as part of this SAR on 9th June 2017 (a copy of which is attached as Appendix 10).

Legislation and Guidance:

- Mental Health Act 1983 and Code of Practice
- Mental Capacity Act 2015
- Metropolitan Police – Policing Mental Health Guidance
- *Good Practice in Assessing Risk: Current knowledge, issues and approaches*, ed. Kemshall H. and Wilkinson B (Jessica Kingsley 2011)
- Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis, Department of Health and Concordat Signatories February 2014.

Back to contents

Appendix 13 - Additional Information and Outcome of Coroner's Inquest held 10th July to 9th August 2017

Inquest Verdict

An Inquest into MT's death was opened on 20th April 2016. In June 2016, the Coroner determined that the circumstances of MT's death met s7(2) of the Coroners and Justice Act 2009 which requires a jury to be summoned. The Inquest's hearing took place between 10th July and 9th August 2017.

There was a narrative verdict as follows:

"Based on the evidence we have heard and received we conclude that Mr Thompson's death was an ACCIDENT – 'Consequence of an unintended act or omission'

Mr Thompson's death was probably contributed by succession of failings in terms of a number of significant errors and omissions by all services in his care.

Contributory factors include:

- The first GP's failure to act on information received on 29th February 2016 delaying treatment for the deterioration of his mental state which could have possibly prevented his death.
- Steps were not taken to identify immediate risk and emergency health assessment thereby delaying the identification in providing the care.
- Lack of adequate assessment of threat and risk of harm to others by not accurately updating the Merlin who attended at 18.19 on 2nd of March 2016.
- Failure to communicate effectively between the different health providers supporting mental health issues, sharing accurate information among their own Borough and their staff.
- Failure to pass on accurate information between police officers who attended @ 00.50 on 3rd of March 2016 and the Ambulance Service, the AMHP, out of hours GP and the family.
- SELDOC and AMHP failed to respond and follow the correct pathways due to administration and communication errors and the non-identification of the correct Borough.
- The AMHP was not as proactive in maintaining effective communications with the family".

Additional Information Post Inquest

A transcript of the telephone referral between the SELDOC out of hour's doctor and Appello (LB Bromley's call centre) on the 2nd March 2016 at 21.55 and the consequent telephone referral between Appello and the LB Bromley AMHP at 22.00 were discovered. Those transcripts are attached at Appendix 14 to provide a complete record.

This transcript is a significant document and it is unclear why this was not uncovered earlier given that:

1. LB Bromley had launched an investigation into the Appello referral as part of the post code mix-up.

2. The fact that referrals are recorded must be a known element of the contract between Appello and LB Bromley.

3. That LB Bromley were specifically asked to confirm that the issue of knives etc. were not passed on from the out of hours GP.

While this new information may not have made any material difference to the decisions, it is of concern that the existence of these transcripts took so long to come to light.

Back to contents

Appendix 14 – Transcripts of telephone calls to and from Appello (LB Bromley's call centre) on the evening of 2nd March 2016

"Please see the transcript below, from the call at 21:55 hours on 02/03/16

Call received from SELDOC on the London Borough of Bromley out of

***hours telephone line*;**

Appello operator – "Hello you are through to the London Borough of Bromley Council, how can I help"

SELDOC – "Hello it is err SELDOC here the out of hours doctors service we are just trying to track down the number for the out of hours mental health service. Is that something you might have?"

Appello operator – "Err it's not something I can pass across, but, it is something I can get them to call you on".

SELDOC – "yeah that's fine".

Appello operator – "sorry tell me again, what is your name?"

SELDOC – "It's Doctor XXXXXXX here"

Appello operator – "Doctor XXXXXXXX and what's your call back number?"

SELDOC – "020"

Appello operator – "yep"

SELDOC – "8XX"

Appello operator – "yep"

SELDOC – "XX6"

Appello operator – "And what's happening, what do you need the Support Worker for?"

SELDOC – "There's a psychotic patient who err the Ambulance visited and they had to evacuate for fear of their safety. Err the patient has a history of violence and compulsory mental health admission back in 2012, but, from what we can see has not been taking his medicines and not under the medicine that Mental Health Team since then. Um the family became concerned, because, they hadn't heard from this person for about a week, err so the Ambulance went down and found them acting very strangely, threatening, abusive, and literally ran out of there fearful for their safety. Um so they're concerned that this individual is a threat to others".

Appello operator – "okay"

SELDOC – "Hence they've passed it on to us. Obviously, it's not safe for us to visit given the details that we've been passed. Err the Police were in attendance with the Ambulance, but, weren't able to assist either, err, so I'm just passing on to Mental Health to see if we can come up with some kind of plan, either tonight or tomorrow to get something sorted out for this chap".

Appello operator – “Okay”

SELDOC – “because he does sound quite dangerous”. There’s a history of violence”.

Appello operator - “Sorry I’m quiet, I’m just typing this all up.”

SELDOC – “No that’s alright, and the Ambulance noticed lots of knives in the premises”.

Appello operator – “What’s the gentleman’s name?”

SELDOC – “MXXXXX TXXXXXX [SELDOC spells the surname for the operator] – TXXXXXX”.

Appello operator - “do you know his date of birth?”

SELDOC – “I do, XXXXXX 19XX”.

Appello operator – “And what’s his address?”

SELDOC – “XXX DXXXX Way”

Appello operator – “DXXXX is that one word?”

SELDOC – [SELDOC spells XXXXX] “DXXX yep”

Appello operator – “DXXXXX Way, Bromley

SELDOC – “BR1 XXX”

Appello operator – “Okay got it. I’m gonna ring the Social Worker now um and ask him to give you call back and you two can work it out/ what’s gonna happen next”.

SELDOC – “That’s fine, that’s fine”

Appello operator – “Alright?”

SELDOC – “yep. Actually I tell you what, I’ll give you my mobile number cause then they know where I am in the office so they can get me more quickly. So I’ll give you my mobile, you ready?”

Appello operator – “Yep”

SELDOC – “07XXXXXXX8”

Appello operator – “Lovely. Alright Doctor, I will pass that across to him now.

SELDOC – “Alright then. Bye”

Appello operator – “Bye”

Transcript of the call between the Appello operator and the London Borough of Bromley Duty Social Worker on the 2nd March 2016 at 22.00 hours.

Duty Social Worker – "Hello"

Appello operator – "Hi C [*name withheld for data protection purposes*], it's X at Bromley"

Duty Social Worker – "Hi X"

Appello operator – "Cor you're busy tonight"

Duty Social Worker – "I am yeah, its [indiscernible speech] non-stop"

Appello operator – "And I've got another one for you"

Duty Social Worker – "Okay bear with me a sec, [typing in background] [indiscernible speech] yep fire away"

Appello operator – "Okay, Job reference is 156"

Duty Social Worker – "Yeah"

Appello operator – "889"

Duty Social Worker – "Yeah"

Appello operator – "Doctor has called me, his name's Doctor [*doctor's name withheld for data protection purposes*]"

Duty Social Worker – "Yeah"

Appello operator – "Call back number is 07"

Duty Social Worker – "Yeah"

Appello operator – "[*number withheld for data protection purposes*]"

Duty Social Worker – "Yeah"

Appello operator – "[*number withheld*]"

Duty Social Worker – "Yeah"

Appello operator – "08"

Duty Social Worker – "Yeah"

Appello operator – "Basically, what's happened is um, family member's haven't seen a relative of theirs for over a week so they were concerned, they called him an Ambulance, the Ambulance attended. When the Ambulance got into the property, they left for fear of their safety, because, he was behaving violently, um, he had knives in the premises, very abusive so they've left um so the Doctor's saying well I can't go round either, because, he's obviously got mental issues um he is on medication, but, it looks like he hasn't been taking it um, so it's a mental health assessment?"

Duty Social Worker – [typing in background] “Okay” [typing in background]

Appello operator – “The gentleman in question”

Duty Social Worker – “Yeah”

Appello operator – “His name is Michael Thomson”

Duty Social Worker – [typing in background] “Michael Thomson, yeah”

Appello operator – “Date of birth is the XX of the XX 19XX”

Duty Social Worker – “Yeah” [typing in background]

Appello operator – “His home address is 311”

Duty Social Worker – “311”

Back to contents

Appendix 15 - Glossary

	Term	Explanation
A	A&E AMHP	Accident and Emergency Approved Mental Health Professional
B		
C	CPR CAD CMHT CPN	Cardio Pulmonary Resuscitation Computer Aided Dispatch Community Mental Health Team Community Psychiatric Nurse
D		
E	EDT ETE	Emergency Duty Team Education, Training and Employment
F/G/H		
I/J	IPCC ICU	Independent Police Complaints Commission Intensive Care Unit
K		
L	LAS LFB LSAB	London Ambulance Service London Fire Brigade Lewisham Safeguarding Adults Board
M	MCA MHA MPS MSP	Mental Capacity Act 2005 Mental Health Act 1983 Metropolitan Police Service Making Safeguarding Personal
N/O	NR	Nearest Relative
P	PLN PLL	Psychiatric Liaison Nurse Psychiatric Liaison Lewisham
Q		
R		
S	SLaM SELDOC SAR	South London and Maudsley NHS Foundation Trust South East London Doctors On Call Safeguarding Adults Review
T		
U/V	UHL	University Hospital Lewisham
W		
X/Y/Z		

Back to contents