REPORT TO SOLIHULL SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW REPORT (Mr S)

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Independent Author

1. Foreword by the Author

I was appointed by the Solihull Safeguarding Adults Board in December 2015 to assist them in the preparation of this Safeguarding Adult Review report. I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. I have also held senior Board level positions in the NHS and the voluntary housing association sector.

At the outset, I wish to record my thanks to all those who have assisted with the preparation of this report: the authors of the Individual Management Reports, the members of the Safeguarding Adult Review Panel and especially to the SSAB Business Team at Solihull Metropolitan Borough Council who have provided unstinting professional and administrative support.

2. Introduction

2.1 Mr S was born in Birmingham. Mr S was admitted to Solihull Hospital on 8th July 2015 following a drugs overdose of paracetamol, mirtazapine and co-proxamol. He had also consumed half a bottle of whisky. He was given treatment to reverse the effects of the overdose and was transferred to a medical ward for observation and continued care. Because of his clear, and continuing, suicidal intent, the hospital assessed that Mr S was at high risk of further self-harm and arranged for Mr S to be supervised, at all times, by a Registered Mental Nurse (RMN). However, as he was compliant with treatment and had mental capacity, Mr S was not made subject to an order under the Mental Health Act (1983).

2.2 In the morning of Monday 13th July 2015, RMN cover was not available and Mr S was able to leave the hospital.

2.3 At 09:46 hours on 13th July, West Midlands Police (WMP) were notified by Solihull Hospital that Mr S had left the hospital. WMP initiated a full scale missing person's enquiry. Mr S's body was found on Wednesday 2nd September 2015, in woods not far from the Hospital, having been missing for a period of 51 days. It is not known when he died but the extent of the decomposition of the body suggests that it may have been shortly after he had left the hospital. Mr S was found in circumstances consistent with suicide by suspension of a ligature around the neck (this being confirmed by the Senior Coroner at the Inquest)

2.4 On 9th September 2015 a formal request was made by WMP for there to be a formal Safeguarding Adult Review.

2.5 On the 28th October 2015, the Chair of the Solihull Safeguarding Adults Board (SSAB) decided that the criteria* were met for there to be a full Case Review into the circumstances leading to Mr S's death. It was also decided that the Safeguarding Adults Review (SAR) Panel which would lead the enquiries should

be independently chaired and the resultant report independently authored.

**NOTE: Section 44 of The Care Act 2014 sets out the criteria for a SAR*.

2.6 The SAR Panel included senior representatives from a number of agencies (please see Appendix 1 for details), supported by the SSAB's Business Manager, Development Manager and Management Assistant. The Panel received Individual Management Reports (IMR's) and presentations from the following:

- Birmingham South Central NHS Clinical Commissioning Group – On behalf of Mr S's GP surgery
- Heart of England NHS Foundation Trust*;
- Birmingham and Solihull Mental Health NHS Foundation Trust;
- Solihull Metropolitan Borough Council Adult Services;
- West Midlands Police.

**Three additional reports were also provided to the Panel by the Heart of England Foundation Trust; these reports having been requested by the Panel on certain points of detail.*

2.7 Mr S's immediate family were invited to contribute to the Review but did not do so.

2.8 The Terms of Reference for the Review are at Appendix 1. It will be noted that the purposes of a SAR are not to hold any individual or organisation to account. Other processes exist for that. The purpose is to try and establish what may have been done differently that might have prevented the tragedy and to learn lessons for the future.

3. Mr S.

3.1 For the majority of his life, Mr S lived in Solihull. At the time of his admission to Solihull Hospital on 8th July 2015, Mr S was living with his parents at an address in Birmingham. He had reportedly experienced a period of homelessness following the breakdown in his relationship with his long term partner. He was also in contact with his sister.

3.2 It is understood that Mr S had been in the long term relationship for a number of years. During their relationship, Mr S and his partner had a family. It is reported that Mr S's and his partners' relationship may have come to an end some time ago, although it appears they were still in contact with one another at the time of Mr S's admission to hospital.

3.3 It is also reported, by West Midlands Police, that Hospital records show that some two and a half years earlier, Mr S had attempted to drown himself. Further Police intelligence suggests that this drowning attempt may only have been some

four months before his admission to hospital on 8th July 2015. The SAR Panel has not been informed of the existence of any such records.

4. The Coroner's Findings

4.1 A Senior Coroner sat, with a Jury, to consider the circumstances of Mr S's death. The Jury concluded that:

Mr S died as a result of suicide contributed to by neglect due to the central issues in this case:

- *Lack of effective communication regarding his medical state on 10 July 2015 and what the plans were for the weekend;*
- *Lack of clear planning as to who was to cover the [RMN] 1:1 0n 13 July 2015;*
- *Lack of communication regarding who was watching Mr S before the RMN could arrive on the morning of 13 July 2015;*
- *Failure to adhere to [the] Management of Patients Who Self-Harm and Enhanced Observation Policy.*

4.2 Following our investigations, the Solihull Safeguarding Adult Review Panel would concur with these conclusions. The Coroner was aware that a Safeguarding Adult Review had been commissioned by the Solihull Safeguarding Adults Board and we trust that this report will build upon the Coroner's findings and provide vital learning points to prevent any future tragedies of this nature.

5. Background and Time Lines

5.1 The SAR concentrated on a very short time period, from the time of Mr S's overdose and admission to hospital on 8th July 2015 to 11th September 2015 when it was formally confirmed that it was his body which had been found some nine days earlier.

GP Involvement Prior to Admission to Hospital

5.2 The Panel heard from Mr S's GP Practice, that Mr S had first visited the surgery reporting anxiety and depression, due to the breakdown in the relationship with his long term partner and homelessness, on 12th December 2014. He was reviewed by the same GP (who had had prior mental health experience) every 4-6 weeks until the last face to face appointment on 8th May 2015. (Note: On one occasion, 3rd March 2015, Mr S failed to keep an appointment but did access another appointment some 3 days later). On the majority (and possibly all) of these six occasions the GP had asked Mr S about self-harm and suicidal ideation and, on each occasion, Mr S had denied these. Indeed, at the last appointment on 8th May, the GP records state that Mr S was "feeling *much better with medication, eating well, no suicidal ideation, no deliberate self-harm*". The news of Mr S's suicide came '*completely out of the blue'* for the GP: *"There was never any indication that this could have happened".* In hindsight it was possible to see that Mr S could not have been taking his medication correctly: he was only ever

prescribed one month's supply but had not returned to the GP for two months prior to his admission to Solihull Hospital in July. As there had been no particular concerns about Mr S's capacity and he had not been assessed as being at high risk, there had not been increased monitoring of whether he was requesting medication or not. In the circumstances that pertained in May and June of 2015, this is not unreasonable.

5.3 It should be noted here that on the day following Mr S's admission to Solihull Hospital (i.e. on the 9th July), a member of his extended family informed ward staff, in a written note, that Mr S had a history of irregular sleeping habits, extreme paranoia, numerous suicide attempts, a history of drug and alcohol abuse, lack of energy and appetite and complaining of 'his mind not stopping'. There was also a familial history of anxiety and Attention Deficit Hyperactivity Disorder. None of this had been disclosed to Mr S's GP in the preceding six months.

The Admission to Hospital.

5.4 On **Wednesday 8th July 2015**, Mr S was taken to Solihull Hospital by West Midlands Ambulance Service, arriving at the hospital at 11.55 hours. The ambulance crew had answered a call to assist a man who had taken an overdose of 50 paracetamol with a bottle of whisky and noted that "the patient had made previous suicide attempts by overdosing and drowning and had not spoken to his GP".

5.5 Observations were taken on arrival and treatment to help reverse the effects of the overdose was started. He was noted to be depressed and suicidal. It was also noted that Mr S had taken a quantity of mirtazapine and coproxamol in addition to the paracetamol and the half bottle of whisky.

Mr S in the Hospital Ward for continued clinical care

5.6 At 21.00 hours on 8th July, Mr S was transferred to a hospital ward-accompanied, appropriately, in view of his suicidal intent, by a Registered Mental Nurse (RMN). It is not clear who had requested the assistance of a RMN nor at what time that was done. It had been noted earlier, at the time of admission, that Mr S would need to be referred to the psychiatric assessment team, and the records suggest that the referral to the Psychiatric assessment team was made, by FAX, at 12.25 hours on the **9th July**. (Note - Solihull Hospital is not registered with CQC to provide mental health treatments. Where mental health support is required the hospital works closely with the local Mental Health Trust to secure the necessary specialist input – hence the referral to the psychiatric assessment team).

5.7 In the late afternoon of **Thursday 9th July**, Mr S was still expressing suicidal intentions but after a visit by his family, Mr S's mood had improved a little and he was expressing concerns about how his behaviour would impact on his sons.

5.8 At 10.00 hours on **Friday 10th July**, Mr S was seen by a medical Consultant who adjudges Mr S to still be depressed but now 'medically stable' and that a

Psychiatric assessment team review is required. [Note the use of the phrase 'medically stable' – we assume that this is different from 'medically fit for discharge'. This is discussed further below.]

5.9 Mr S was seen by the Psychiatric assessment team at 10.30 hours and changes to his medication were recommended. It was confirmed that Mr S must have 1:1 RMN supervision at all times and would likely require a psychiatric admission once deemed medically fit.

5.10 Mr S was seen by a Physician Associate later that same day: at 13.32 hours. The Psychiatric assessment team's recommendations were fully accepted: "to be observed at all times, psychiatric admission is likely, needs to be reviewed daily by Psychiatric assessment team and ward staff to let the Psychiatric assessment team know as soon as Mr S is medically fit for discharge".

5.11 At 16.47 hours, Mr S was seen by a consultant psychiatrist and a Psychiatric assessment team nurse. Mr S was still recorded as not medically fit for discharge: the consultant asked the Psychiatric assessment team to ensure that Mr S is seen by the on-call psychiatrist once he is deemed to be medically fit. At some stage after this, reportedly at 18.28 hours, staff from the Mental Health Trust complete the Assessment documentation.

5.12 At 16:50 Mr S was seen by a Locum SHO (Senior House Officer) who documented the targeted INR (liver function) range. (This would be a major factor in assessing if Mr S was medically fit for discharge). At 23.15 that evening, the INR was noted as being within the targeted range.

5.13 **Saturday 11th July**: Mr S continued to be supervised by an RMN. A member of the Psychiatric assessment team visited the Ward in the afternoon and learnt that Mr S was still not medically fit. It is noted that further liver function tests were awaited.

5.14 **Sunday 12th July**: Mr S's case notes were reviewed by the Psychiatric assessment team at 10.07 hours, but Mr S was not seen in person. Mr S was recorded as settled and compliant with 1:1 supervision. It was noted that the liver function tests are 'still deranged'. It was confirmed to ward staff that the psychiatric assessment team should be called once Mr S is 'medically fit/stable' for psychiatric review and discharge planning. Both hospital and mental health notes record this.

5.15 **Monday 13th July,** at 06.50 hours, it was recorded that Mr S had had a settled night. However, prior to this, at 02.30 hours, the Night Sister responsible for Solihull Hospital site, realised that there was no RMN rostered to come on duty at 07.00 to relieve the night RMN and maintain 1:1 supervision of Mr S. She contacted the appropriate outside agency who confirmed that a RMN would be made available but not until 10.30 hours. The shortfall in cover was brought to the attention of the 'first on' Sister at morning handover at 07.00 hours.

5.16 At 07.00 hours, at handover to the day nursing staff, it was noted that staffing levels, of the general nurses, was at the desired ratio. A staff nurse and a health care assistant were allocated to the bay in which Mr S, with others, was accommodated (Bay C). This particular bay was described as 'high acuity' due to the number of patients assessed as being at risk of falls. The staff were instructed to 'keep an eye' on Mr S but this was not clarified as constant supervision of him.

5.17 It would appear that the RMN who worked the night shift finished and there was no evidence of a documented handover to another ward nurse. There does not seem to have been an established practice that the RMN finishing shift would wait to be relieved by a colleague who was taking up the enhanced observation role. There is no record that the RMN or Ward staff discussed a plan regarding the lack of cover once the RMN finished. Reportedly, the ward Sister was distracted by a dispute with another night nurse over timesheets. However, the RMN's timesheet (signed by the 'first on' Sister) shows the shift finished at 07.30 hours, albeit there is nothing in the Ward records to show the RMN requesting to be relieved.

5.18 The Ward Manager (Senior Ward Sister) who arrived on duty at 07.50 – 08.00 hours reports that, at that time, a member of staff in a different coloured uniform was present on the Ward, in close proximity to Mr S's bed – the Ward Manager took this person to be the day RMN. The Ward Manager then left the Ward for duties elsewhere. The SAR Panel were unable to ascertain who the Ward Manager saw in the proximity of Mr S's bed.

Mr S's Departure from the ward

5.19 The Hospital Trust's IMR states that, the staff nurse in Mr S's Bay recorded that during the morning drug round Mr S attempted to leave the ward stating that he wanted a cigarette. He was told to wait until someone was available to escort him. He agreed to do this but said he would go to the toilet instead. The staff nurse in an adjacent bay (Bay B) then observed Mr S leaving the ward: she shouted after him but Mr S made no response. She immediately informed the staff nurse in Bay C of Mr S's departure and then left the ward to follow Mr S, but she could not find him. The staff nurse in Bay C made a check outside the ward and then informed the sister on call and site security.

5.20 A further report from the Hospital Trust, prepared at the SAR Panel's request, gives the timings during this critical period as follows:

- To the best of the staff nurses' recollection, it was at approximately 08.43 that Mr S's absence was noted.
- The drug round commenced at 07.57 hours and was suspended at 08.47 hours, due to the nurse being alerted that Mr S was missing.
- It was at 08.54 hours that security was notified that Mr S could not be found

- 08.54 – 09.10 hours (approximately): security take the necessary information and description and make checks using the available CCTV – security cameras are placed randomly along the main hospital corridors. There was no camera immediately outside the ward.

At 09.10 hours (approximately), security informed the ward that Mr S could not be located and they advised that the Police be contacted. At approximately 09:30, a nurse rang the police informing them that Mr S had been missing for some 30 minutes. The staff member followed the Missing Person Policy which directs them to contact the Police via 101. Reportedly, this call lasted 20 minutes during which time the nurse responded to a series of 20 questions asked by the police call handler.

5.21 At 09.31 hours, a psychiatric assessment team nurse contacted the Ward to see if Mr S was fit for discharge as the plan was to admit him informally to the Mental Health Trust. The nurse was informed by the ward that Mr S had left the ward twenty minutes previously and that there had been no RMN cover at the time. Ward staff also stated that they had attempted to contact the police but had not been able to do so as yet.

5.22 West Midlands Police (WMP) records show that the WMP Control room logged the first missing person call at 09.46 hours, informing them that Mr S had been missing for some 30 minutes. CCTV footage records were not available on the first two occasions when the police visited the hospital but on a further visit, at 17.15 hours, footage was available and in that Mr S was seen leaving the ward at 08.31, with a cigarette and at 08.32 leaving the hospital side entrance, heading for the smoking shelter.

The Police Search and other Subsequent Events

5.23 In view of the information received, West Midlands Police regarded Mr S as being at High Risk.

5.24 The search for Mr S continued throughout the day, in a wide range of locations, and from Police records, it is clear that the search was exhaustive and extensive and regarded as a major enquiry.

5.25 Within half an hour of receiving the notification that Mr S was missing, the Police informed Solihull Borough Council and asked them to monitor the town centre CCTV cameras for any sign of him. They also, within the first hour, dispatched officers to the hospital to make enquiries and to Mr S's home address to try to obtain any useful information.

5.26 Additionally, within the first four hours, the Police had:

- Taken action to identify any vehicles owned by Mr S;
- Visited Mr S's parents address and searched the address fully;
- Taken steps to identify Mr S's previous partner and to visit her;

- Requested West Midlands Passenger Transport to monitor if Mr S may be travelling on the bus network;
- Initiated work to identify if Mr S had a mobile phone and, if so, was he using it;
- Directed officers to search areas known to be frequented by Mr S, including canals and other waterways;
- Requested air support from the National Police Air Support unit – initially this was not provided as the helicopters were grounded because of weather conditions but fly-overs of relevant areas were conducted two days later;
- Searched the grounds of Solihull Hospital;
- Made enquiries of local taxi firms.

5.27 Concurrent to the above, the psychiatric assessment team were doing all they could to ready themselves should Mr S be found – psychiatric assessment team were informed (at 11.53 hours on 13th July) that Mr S was now regarded as medically fit for discharge from acute medical care – steps were therefore taken to be prepared to undertake a full assessment of Mr S under the Mental Health Act, when and if he were found. The psychiatric assessment team continued to keep in close touch with the police.

5.28 As part of the Police IMR process it was highlighted that on 19th July the Police Control Room received information from a witness who had come forward, after seeing a news item about Mr S's disappearance, saying that on 13th or 14th July (the exact date is unclear) she had seen a male walking along a dual carriageway, near to the motorway and away from Solihull Hospital. It is not clear when this witness contacted the police. Had this information been made available to the police search team on 13th or 14th July, it could well have changed the search area.

5.29 In the afternoon of the following **Thursday, 16th July**, at 15.03 hours, West Midlands Police received anonymous information that Mr S may be at an address in Dorridge. The Police contacted the admissions manager at the Mental Health Foundation Trust requesting that a Section 135 Warrant be obtained to enable them to enter the premises. [Under Section 135(1) of the Mental Health Act, the police can, on the authority of a Magistrate, enter premises and remove to a place of safety a person who is thought to have a mental disorder]. This information was passed, in turn, to the duty Approved Mental Health Professional (AMHP). However, as the precise address was not known, the AMHP could not proceed to seek the warrant. Possible other lines of action were considered but, again, the lack of a confirmed address made action impossible.

Despite further attempts that evening by the Solihull MBC Emergency Duty Team (EDT), the address could still not be established. It should be noted here that the EDT worker experienced some difficulties in relation to the police call handler's interpretation of the information sharing protocol. The following morning, **17th July**, the Police were able to confirm an address to the AMHP Duty Team at which Mr S may be – although this was not in Dorridge. It was agreed that a

Section 135 warrant would be sought – the Police offering to assist in the process. Solihull Magistrates Service no longer provide Section 135 warrants and a decision was made to seek the warrant from Telford Magistrates Courts. (It would have been usual practise to seek the warrant from the Birmingham Magistrates but as no appointments were available there, Telford was chosen as an alternative). However, in any event, the application failed as a result of technical difficulties in submitting the information electronically to the Telford Court but, later that day, the address was visited, initially by a psychiatrist and an AMHP and subsequently with the Police in attendance, but no trace of Mr S was found.

5.30 The Police search for Mr S remained an open enquiry until it was confirmed that the body found on 2nd September was his.

6. Analysis and Comment

6.1 It is appropriate reiterating here the Coroner's Jury findings into the circumstances leading to Mr S's tragic death:

Mr S died as a result of suicide contributed to by neglect due to the central issues in this case:

- *Lack of effective communication regarding his medical state on 10 July 2015 and what the plans were for the weekend;*
- *Lack of clear planning as to who was to cover the [RMN] 1:1 0n 13 July 2015;*
- *Lack of communication regarding who was watching Mr S before the RMN could arrive on the morning of 13 July 2015;*
- *Failure to adhere to [the] Management of Patients Who Self-Harm and Enhanced Observation Policy.*

6.2 This Safeguarding Adult Review serves to underline these findings but can also give some further analysis and recommend learning points for future practice.

6.3 **Communication Regarding Mr S's Medical State**. The SAR Panel considered, at length, if an earlier decision and communication that Mr S was considered medically fit for discharge would have made a difference. The phrases 'medically fit', 'medically stable' were both used, apparently interchangeably, albeit the two phrases could have different meanings. We also considered if the fact that Mr S was in the hospital over the weekend, when routine ward rounds are not carried out, was a significant factor. Our conclusions were that the Liver Function Test results fluctuated and, because of this, Mr S was not regarded, over the weekend, as fit for discharge and that, had the tests been consistently satisfactory earlier, steps would have been taken, on the Saturday or Sunday, to notify the psychiatric assessment team that Mr S was now clinically stable enough for the further psychiatric assessment to take place. There is a clear

need for absolute clarity on the meaning and use of the phrases 'medically stable' and 'medically fit for discharge'. The use of these phrases seemed to mean different things to both the mental health team and acute team. A joint review of the Service Level Agreement between the two agencies needs to address this and ensure clarity.

In addition, the SAR Panel would suggest that, as part of their joint review of the service level agreement in the light of Mr S's case, the hospital trust and the mental health trust should develop a policy whereby they jointly actively plan earlier for a patient's discharge. It appears that a full and formal mental health assessment is not undertaken until the patient is deemed physically fit - there could then be a problem finding the mental health services then adjudged to be required. In addition, consideration should be given to how someone with mental health needs in an acute hospital setting should be able to have both needs managed concurrently. Thought should be given to the role played by 1:1 RMN's – is it just a caretaking/supervisory role or could some therapeutic service be also undertaken?

6.4 **Absence of RMN Cover on 13th July**. Throughout his stay in the acute ward where his acute medical needs were well met (and previously in A&E) it had been recognised that Mr S was a serious danger to himself: hence why 24 hour RMN cover had been arranged from the outset. It was the failure to provide RMN supervision that was the critical issue on the morning of the 13th July.

This shortfall in staffing for the next shift was identified late. The normal process is for the Senior Ward Sister / or the Nurse in Charge who deputises for her by taking charge of the ward on each shift to review staffing for each coming shift and escalate to the site teams as early as possible any problems. Greater notice of staffing issues is desirable as it makes these issues easier to resolve.

The expectation at the Hospital is that any unfilled shift for the next working day should be identified by the nurse in charge of the ward and escalated to the Site Team before their meeting at 15.30 hours for their consideration/ support.

There is no evidence that the nurse in charge on the 12th identified the shortfall for the morning of the 13th and escalated it.

This led to the lack of cover being identified and addressed by the night sister, who could only obtain RMN cover from 10.30am onwards the following day.

The night sister reported this to the First on day Sister.

There are different accounts from the First on Day and Night Sisters of whether this was handed over for the day site team to address and no evidence was found that a review across site had occurred on the morning of the 13th to obtain cover for the period when there was no allocated RMN for Mr S.

- More timely escalation of the lack of cover on the 12th may have prevented the shortfall in cover between 07.30 and 10.30 on the 13th.

- Better communication at the site handover on the morning of the 13th may have led to another RMN on site being allocated to Mr S's ward between 07.30 and 10.30hrs.

- In addition, had clinical staff on the ward been following the Enhanced Observation Policy they would have recognised the need to escalate the lack of cover through their senior nurses to the site team.

  However, on the morning of 13th July 2015, the day Sister was busy from the very start of her shift: she had staff to deploy and also had to deal with a dispute about a timesheet with an agency nurse. Mr S's needs were, apparently, lost in this maelstrom of activity.

6.5 We cannot be sure at what time the night shift RMN left the ward. Her timesheet suggests that this was at about 07.30 hours but the Ward Manager reports that she saw someone 'in a different coloured uniform', who she took to be an RMN, in close proximity to Mr S's bed at approximately 07.50 hours. Suffice it to say that we can be reasonably certain that there was no RMN with Mr S by 08.30 hours and possibly substantially earlier. The issues arising from the failure to organise continuous RMN cover are addressed fully in the recommendations section to this report.

6.6 **Lack of communication regarding who was observing Mr S once the RMN had gone off duty.** By 07.00 hours on the morning of the 13th July, Mr S was nearing the end of his physical recovery but the continued presence of the night RMN on the ward, at that time, should have alerted staff to Mr S's continuing, high risk mental health needs. It can be anticipated that the general nurses on duty that morning are unlikely to have any particular knowledge or experience of working with seriously mentally ill patients but, to repeat, the continuing presence of an RMN on the Ward should have told them that he needed close supervision and oversight. At the start of the shift, the ward Day Sister had told staff to 'keep an eye' on Mr S but, perhaps because of staff/patient ratios, this fell short of the required enhanced observation.

The learning points here are picked up in the following paragraph – 6.7

6.7 **Failure to adhere to [the] Management of Patients Who Self-Harm Policy and the Enhanced Observation for Patient Safety Policy**. The Panel were unable to establish if the staff on duty on the Ward on the 13th July were familiar with/had received training in these policies. This seems unlikely as the Hospital Trust has acknowledged that there was 'a gap' in staff awareness of the policies and as will be seen from the recommendations and action plans further on in this report, this is an issue which is being addressed.

6.8 **Two Other Matters**

a) The Police Search: The actions taken by West Midlands Police to locate Mr S once they were informed that Mr S had left the hospital was thorough and exhaustive. The Police invested a considerable amount of time and resources into this search. From the outset, Mr S was considered a High Risk vulnerable missing person and remained so throughout the enquiry.

It is known that the first hour after a person's disappearance, the 'golden hour', is critical. As is clear from the detailed timelines given above, Mr S's disappearance was not notified to the Police for more than an hour. In addition, the details initially given to the Police were not accurate. The importance of prompt and correct notifications to the Police cannot be over stated. The Trust have subsequently informed the panel that delays in reporting Mr S being missing were down to not being able to get through to the Police on the designated 101 number.

West Midlands Police have fully reviewed the way in which the search for Mr S was conducted. Their recording systems have recently been upgraded, procedures are being reviewed and the use of new technologies to improve systems further is under consideration.

b) Matters Pertaining to the Seeking of the Section 135 Warrant:
In some respects, this is a side issue. The failure to obtain the Section 135 Warrant on the 16th/17th July had no bearing on the tragic outcome. But, it is clear that attention needs to be given to the existing information sharing protocol and to the processes and procedures by which warrants are sought: on the next occasion when such a warrant is required, timely and effective action may well be of the essence.

7. Recommendations

7.1 Each of the agencies who provided an Individual Management Report for this Review were asked to identify SMART (Specific, Measureable, Achievable, Realistic, Timely) recommendations to reflect their analysis of the events leading to Mr S's death.

West Midlands Police did not make any recommendations here. However, the SAR Panel noted and as stated in Section 6.8 a) above, the police have reviewed their actions and have taken, or are taking, actions to improve their practice.

The SMART recommendations, as they applied to single agencies, are as follows (it should be noted that some of the recommendations may have been completed at the time this report is published. Solihull Safeguarding Adults Board should assure themselves that all recommendations have been completed).

HEART OF ENGLAND recommendations for action –			
No	**What**	**How**	**By when**
1	Ensure appropriate risk assessments are completed and reviewed for patients presenting at risk of further self-harm	Head Nurse for Solihull Hospital to reiterate via meetings & communication importance of completing risk assessments. Audit to be undertaken to review if risk assessments are being completed	March 2016 May 2016
2	Reinforcement of the Enhanced Observation Policy to all staff on all wards across all 3 sites	Ward Sisters to ensure the policy and paperwork are communicated & paperwork completed	May 2016 The ward has already completed this
3	Consultant to reinforce with senior colleagues importance of discussing a shared management plan with psychiatry for patients that are admitted for self-harm requiring treatment.	Communicate to senior medical staff a request to ensure medically fit for discharge/assessment is clearly documented in a patients notes and management plan.	February 2016
4	Supervision and the understanding of requirements for 1:1 will be added to the competencies for shift co-ordinators.	Matron to develop and add to shift co-ordinator competencies.	February 2016
5	Lesson of the month developed to raise the awareness of the Enhanced Observation Policy, Management of Patients who Self Harm Policy and the Missing Persons Policy. This will cascaded to all staff.	Dissemination of lesson of the month via usual Trust wide channels.	February 2016
6	Reminder to all Senior/ Supernumerary Ward Sisters of the escalation process for any shortfalls in staffing and action to take to mitigate the risk	Head Nurses & Matrons to reiterate via the senior nurse forums of the importance to recognise and act upon any shortfalls especially if RMN required	May 2016

GP PRACTICE recommendation for action -			
No	**What**	**How**	**By when**
1	Surgery DNA (Did Not Attend)	to include more information	31st March 2016

	policy to be reviewed	around how to deal with DNAs for at risk patients	

The panel considered all the recommendations made by the agencies within their Individual Management Reports and following panel meetings, make the following recommendations to the Board. Some of these recommendations reiterate the actions identified by the single agencies above. It is accepted that, with the passage of time since the events of July 2015, a number of the actions recommended below will have already been actioned by those concerned. However, these are included here to provide a full record and to enable the SSAB to satisfy itself that all possible remedial measures have been fully implemented. (Recommendations relating to the HEFT Enhanced Observation Policy and Missing Persons Policy are a case in point: a Serious Incident Review was conducted by HEFT in 2015 and the SAR Panel have been told that appropriate ameliorative actions have already been taken.)

Recommendation 1

Having ensured that their Enhanced Observation Policy and Missing Persons Policy are fit for purpose, HEFT should

- Reinforce the Enhanced Observation Policy and Missing Persons Policy to all staff on all wards across all 3 sites.
- Ensure the competencies for shift co-ordinators incudes the requirement for them to fully understand the Enhanced Observation Policy and ensure this is covered in supervision and 1:1meetings.

Recommendation 2

- HEFT should review their Policy and Practices in relation to the escalation of staff shortages to ensure the safety of patients at all times, ensuring that all Senior/Supernumerary Ward Sisters are aware of the Trusts escalation process for any shortfalls in staffing and what action to take to mitigate the risk.

Recommendation 3

HEFT should take action to ensure that all staff are fully briefed on handover of patients' holistic care needs so appropriate care and supervision is provided.

Recommendation 4

HEFT & BSMHFT should review their SLA in relation to the Psychiatric Assessment Team. This review should

- Clarify what the roles and responsibilities of a 1-1 RMN should be – is it a 'caretaker' role or 'therapeutic' role and what records should be made and where these should be kept so that individual patient records provide a holistic record of a patient's physical care needs and mental health care needs.
- ensure there is clarification of the term(s) 'medically fit/stable' and that these are clearly understood.
- ensure greater multi-agency/joint working between HEFT and BSMHFT throughout a patient's stay in hospital
- ensure there is improved access and intervention for patients that require mental health services (acute in patient episode and community), early access rather than wait for time of crisis.
- Reinforce with senior colleagues importance of discussing a shared management plan for patients that are admitted for self-harm requiring both medical and psychiatric treatment.
- Ensure psychiatric assessments involve face to face interaction with the patient.

Differences in working practices between acute and mental health services could be explored within a "learning lessons/practitioners' forum" to aid future joint activities.

Recommendation 5
BSMHFT, MH Commissioners Local Authority and Police should ensure the mental health admission and assessment pathways are robust, sufficient and understood by all partner agencies.

Recommendation 6
SMBC with the Police (and others as appropriate) should review Section 135 procedures and/or establish a protocol to ensure the timely and appropriate applications for a warrant can be made. Roles and responsibilities for all relevant agencies should be clear.

Recommendation 7
SSAB should review local authorities (Dudley) strategic groups who meet to discuss vulnerable outstanding missing persons to consider if appropriate to Solihull. The objective of these groups is to ensure that all agencies share appropriate information. The sharing of this information enables agencies to conduct effective enquiries, with agencies sharing the management, ownership and actions of the investigation.

Recommendation 8
W M Police as a result of this review should take the opportunity to review and improve their electronic recording systems to ensure and encourage better recording on computer systems.

Recommendation 9
SSAB should satisfy itself that current Information Sharing Agreements are fit for purpose and that all agencies can demonstrate their staff comply with them, especially in relation to sharing information in emergency/urgent and out of hours situations.

It is anticipated that the Solihull Safeguarding Adults Board will require all agencies to report in detail on the progress made in implementing all recommendations in this report.

8. Closing Remarks

8.1 The panel has, from time to time, struggled around critical timing of events on the morning of 13th July 2015 about what happened. Indeed, there has been times when reports have conflicted with one another. However, it can be concluded that had continuous supervision been available for Mr S on the morning of the 13th July, then he may not have been able to leave the hospital and this tragedy may not have happened. Lessons to be learned are shown above.

8.2 It is to be hoped that not only the agencies directly involved in Mr S's care will learn these lessons but that like agencies, throughout the country, will review their practices and procedures in the light of this report to ensure that a similar train of events is not experienced elsewhere.

Robert Lake
May 2016

Appendix 1

Safeguarding Adult Review – Terms of Reference

Re: Mr S

1. Purpose

The purpose of the Safeguarding Adult Review (SAR) concerning Mr S is to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented Mr S's death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The Care and Support Statutory Guidance issued under the Care Act 2014 states the purpose of a Safeguarding Adult Review is not to 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council (14.139). However, Safeguarding Adult Boards are responsible for holding local organisations to account for how they safeguard and protect adults with care and support needs.

It is vital, if we are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs, their response will be defensive and their participation guarded and partial.

2. Principles

The following principles which incorporate the six safeguarding principles apply to this SAR:

- The focus of the SAR is learning and improvement across the partnership to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good

practice;

- The terms of reference have been drawn up to be proportionate;
- Mr S's family will be invited to contribute to this review;
- Solihull Safeguarding Adults Board is responsible for monitoring its progress and outcomes so as it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- It is expected that practitioners will be involved fully in the Individual Management Reviews and invited to contribute their perspectives;
- To secure real learning and improvement, organisations involved in this SAR are expected to 'tell it like it is'.

3. **Scope of Review**

The main scope of the SAR will cover the period of time from Mr S's overdose and admission to Solihull Hospital on 8th July 2015 to 11th September 2015 when it was confirmed the body found on 2nd September 2015 was Mr S. However, in relation to the General Practitioner's contact with Mr S the timeframe will be July 2014 – to the time of his admission to hospital 8th July 2015.

4. This SAR will specifically examine:

i. If there were ways agencies could have worked more effectively with regard to Mr S to safeguard him and others.

ii. Whether agencies could have communicated and shared information about Mr S's circumstances more effectively and whether this case raises any general concerns about difficulties in information sharing and communication.

iii. If there were legal routes that could have been taken by any of the agencies that would have had a positive impact.

iv. If there were any policy gaps that impacted on this case or on the action taken by organisations and agencies involved.

v. Whether there are any equality and diversity issues in relation to this case.

vi. If there were any culture, status or reputation issues that impacted on this case.

vii. Whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Mr S

In addition, the following Key Lines of Enquiry are required to be examined by the identified agencies.

a. Heart of England Foundation Trust and Birmingham and Solihull Mental Health Foundation Trust to report on the 1-1 supervision arrangements for Mr S to keep him safe throughout his stay at Solihull hospital and specifically on 8th July 2015.

b. Heart of England Foundation Trust to confirm the rationale for Mr S's care on a ward for respiratory conditions rather than a mental health ward.

c. West Midlands Police to confirm arrangements for undertaking 'safe and well' checks and how this was applied to Mr S

d. West Midlands Police to confirm their information sharing procedures and how this was applied in the case of Mr S – specifically on 16th and 17th July 2015 in relation to their interaction with Solihull Emergency Duty Team.

e. Birmingham and Solihull Mental Health Foundation Trust to report on an interaction recorded by SMBC which states 'Bed management and the Street Triage have been unhelpful'.

f. West Midlands Police to report on their involvement on 17th July 2015 with the s12 Doctor and the Approved Mental Health Practitioner.

g. Birmingham and Solihull Mental Health Foundation Trust to ascertain any support that may have been offered or provided to Mr S from the SIAS Service.

5. Information will be collated from the Individual Management Reports (IMRs) from the agencies listed in point 11 below and analysed by the Panel and Overview Report Author.

6. The SAR Panel will review and amend these Terms of Reference as required during the course of the SAR or as a result of the Coroner's Inquest. Solihull

Safeguarding Adults Board (SSAB) will be informed of any changes to the Terms of Reference.

The Panel

Solihull Safeguarding Adults Board has commissioned Mr Robert Lake as the independent author of the Overview Report and Executive Summary and Independent Chair of the SAR Panel.

7. Mr Robert Lake is independent of Solihull and all agencies involved in this case.

8. The Panel will be made up of:

Robert Lake Independent Chair and overview report writer
Luisa Blackwell, Named Professional for Primary Care/Deputy Designated Nurse, Solihull CCG
Nigel Sarling, WM Police
Sue Dale, Assistant Director, ASC, Solihull MBC
Anne Hastings, CEO Age UK
Brandon Scott-Omenka, CEO, Solihull Carers Centre
Catherine Evans, Head of Safeguarding, BSMHFT
Maria Kilcoyne, Head Nurse for Safeguarding HEFT

(Sue Walton, SSAB Business Manager – Advisor)
(Joan McHugh, SSAB Development Manager – Advisor)
(Lyn Skipp, SSAB Management Assistant – Minutes)

9. The Panel reserves the right to invite Solihull's Head of Strategic Commissioning (Mental Health) to a Panel meeting if required or any other expert as identified during the process.

10. **Individual Management Reports**

The following agencies are invited to contribute to the SAR by submitting Individual Management Reports (IMRs):

Heart of England NHS Foundation Trust

Birmingham and Solihull NHS Mental Health Foundation Trust

Solihull Metropolitan Borough Council – Adult Social Care

West Midlands Police

The IMRs should be carried out by someone who was not directly concerned with Mr S or his family, or the immediate line manager of the practitioner/s involved and are not Panel members of this SAR.

The IMRs should be completed in the format provided.

All IMRs must include a full chronology of significant events in the format provided.

Mr S's family will be informed of this SAR by the Independent Chair Mr Robert Lake with support from West Midlands Police following consultation with Birmingham and Solihull Coroner. Mr S's family will be invited to share their views via Robert Lake and West Midlands Police.

Timetable

The main timeline for this SAR will cover the period of time from Mr S's overdose and admission to Solihull Hospital on **8th July 2015 to 11th September 2015** when it was confirmed that the body found on 2nd September 2015, was Mr S. However in relation to the General Practitioner's contact with Mr S, the timeframe will be July 2014 – to the time of his admission to hospital 8th July 2015.

All IMRs and chronologies must be submitted to Solihull Safeguarding Adults Business Team electronically by: **19th February 2016**.

All agencies submitting an IMR and chronology will have the opportunity to present their findings to The Panel on **2nd March 2016**.

The Panel will, having considered the IMR's and chronologies and taking account of the agencies presentations, agree the SAR outcomes and final publication issues at a meeting on **14th March 2016**.

12. The Draft Overview Report will be available for all agencies to comment on inaccuracies week commencing **18th April 2016**. All agencies will have 7 working days to notify of any inaccuracies or concerns. The independent chair/author may amend the report or will detail the concerns raised and reasons why the report has not been amended.

13. The Panel will meet on **4th May 2016** to agree the final Overview Report and Executive Summary.

14. The Final Overview Report will be circulated to all Safeguarding Adults Board Members before week commencing **23rd May 2016**. Mr S's family will also be notified of the key findings.

15. The Independent Chair of the Safeguarding Adults Board will identify a SAB meeting to receive and discuss the Overview Report and Executive Summary, which will be presented by the independent chair/author, and the agreed recommendations. This may be an extraordinary meeting. This should be no later than the end of June 2016.

16. Once the report has been presented to Solihull Safeguarding Adults Board:

- All agencies involved with the SAR will take the Overview Report and Executive Summary through their own governance and accountability routes.
- All agencies involved with the SAR will debrief their staff.
- The Communication plan will be initiated.
- The action plan will be monitored by the Safeguarding Adults Board until it is completed.

Communications plan

17. All public or media enquiries will be managed by SMBC Communications team. All agencies, statutory, voluntary and independent, should re-direct any enquiries to the SMBC Communications Team.

18. The action plan will identify how all agencies should report the SAR through their respective governance routes.

Other issues

19. **Parallel Investigations**
There are two parallel investigations/processes that will impact on this SAR. They are
- Serious incident review being conducted by HEFT with BSMHFT and
- Coroner's Inquest with a jury.

20. **Legal Advice**
Solihull Safeguarding Adults Board and The Panel will take legal advice where it is required.

21. **General Advice**

General advice on Solihull's Safeguarding Adults Review procedure will be available from the SSAB Business Manager.

22. **Other Local Authorities**

At the time of agreeing these Terms of Reference there are no other Safeguarding Adults Boards with an interest in the case that this SAR is based on.

23. **References**

- The Care Act 2014
- The Care and Support Statutory Guidance issued under the Care Act 2014
- West Midlands Regional Best Practice Guidance – Safeguarding Adult Reviews
- Solihull Local Practice Guidance – Serious Case Reviews
- SCIE – Safeguarding Adult Reviews under the Care Act: implementation support.

These terms of reference have been agreed by Solihull Safeguarding Adult Review Panel and the SSAB Independent Chair and have been shared with SMBC Chief Executive and SMBC Director of Adult Social Services.