SAFEGUARDING ADULT REVIEW OVERVIEW REPORT INTO THE DEATH OF RICHARD IN FEBRUARY 2024

PARMINDER SAHOTA: INDEPENDENT REVIEWER

COMPLETED: MAY 2025

Contents

Family's Dedication to Richard

This report uses real names for Richard and his family members at the family's request.

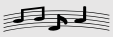
Kind and gentle soul,
Tortured by your own demons,
You fought so hard not to give them control,
And to not give them reason.
Worthless,
Unloved,
Pathetic,
And Weak.
All names they'd torment you with.
We'll never truly understand your pain and struggles Rich,
But know this…
You were loved,
You had worth,
You were strong at times most of us would've crumbled,
You were not pathetic,
You were my Uncle Rich!
You taught me that kittens couldn't actually swim!!
Vinegar was needed on everything!
Scratch cards were only for you to win!
And Peppa Pig has now taken over my life
That was your only sin!
You were a victim of your own self.
But rest easy now Rich,
It's time to let those thoughts disappear,
And finally find peace without any fear.
We'll all keep our memories of you dear,
We love you Rich.
Sleep tight hairy melon, sleep tight John boy.

Heather, Richard's niece

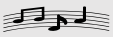
'My Brother'
As kids, we lived together
We fought, we laughed, we cried.
We did not always show the love
That we both had inside.
We shared our dreams and plans
And some secrets too.
All the memories we share
Is what bonds me now to you.
We grew to find we have a love
That is very strong today.
It's a love shared by our family
That will never fade away.
You are my brother not by choice
But by the nature of our birth

I could not have chosen a better one
You were the best on earth.

Alan



'When the night is cloudy
There is still a light that shines on me
Shine on until tomorrow, let it be.'



Richard, your life was precious, and your death is unfathomable to those you've left behind. Your mother, your brother, your sister and all your loved ones are extremely proud of how you carried on through your struggles and your adversities. As we commit your body to be cremated, we do so in the knowledge that you are now at absolute peace, and in the knowledge that your star will continue to shine. You will not be forgotten, Richard. You are deeply loved, and this will always be so. Rest in peace.

Elaine, Richard's sister

Preface

The Independent Chair and Review Panel express their sincere condolences to everyone impacted by Richard's death and thank them for their support and contributions.

Richard's family has requested that real names be used; therefore, no pseudonyms are used for Richard or his family members.

A Safeguarding Adult Review (SAR) is a multi-agency statutory review designed to determine what the relevant agencies may have done differently to prevent harm or death. It is essential to establish the potential knowledge that can be derived from Richard's death and for agencies to understand the circumstances so that these lessons can be realised and widely distributed to support future safeguarding practices.

The chair thanked the panel and individuals who provided chronologies, material, and reports for their time, patience, and cooperation.

The chair expresses gratitude to the family for supporting the review and helping to ensure that it appropriately portrays Richard's life.

"As a family we are distraught at the loss of Richard, he was truly loved by us all and was a kind, thoughtful Son, Brother, Uncle, and person who fought bravely against the inner increasingly hostile world inside his head. We were proud of him."

"Richard never complained about anything, and that generosity and kindness of his soul was ridden over rough-shod by some of the very people who should have cared for him."

"Rest in peace Richard you were loved more than your inner thoughts ever allowed you to understand."

1.1 Introduction

1.1.1 The review was initiated in response to the death of Richard in February 2024. In February 2024, Avon and Somerset Constabulary referred Richard to the Keeping Bristol Safe Partnership (KBSP) to consider a SAR.

1.1.2 The Safeguarding Adults Board (SAB) has a statutory duty to organise a SAR when the following criteria under Section 44 of the Care Act 2014 are met:

a) An adult with care and support needs has died, and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect.

b) When there is reasonable cause for concern about how the Board, its members, or others worked together to safeguard the adult.

Board members must work with and contribute to the SAR to identify lessons learned and ensure they are shared and used in the future.[1]

1.1.3 Richard was fifty-three at the time of his death. He lived in a supported living flat and received four hours of weekly support from the Milestones Trust, which supports adults with learning disabilities and mental health to live their best lives.[2]

1.1.4 Richard experienced anxiety, social phobia, a fear of social situations,[3] hallucinations, a false perception of objects or events involving the senses: sight, sound, smell, touch and taste[4] and psychotic depression.[5]

1.1.5 In December 2023, Richard was detained under the Mental Health Act (MHA 1983): Section 2: "*A patient may be admitted to a hospital and detained there for a period not exceeding 28 days.*"[6] due to auditory hallucinations (hearing voices) that directed him to take his own life. Richard was admitted the next day to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and discharged seven days before his death. His family believed he was not ready for discharge.

1.1.6 In February 2024, Richard's upstairs neighbour contacted the Milestones Trust on two separate occasions, reporting having heard Richard shouting and banging the night before his death. The service coordinator (Milestones Trust) contacted the mental health crisis team (AWP), 101 (non-emergency police), and 111 (non-emergency medical support). The crisis team recommended that the service coordinator contact 999. *[Richard's family reported that the crisis team advised the service coordinator not to disrupt them as they were all in a two-hour training.]* The

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[2] https://www.milestonestrust.org.uk/
[3] https://www.nhs.uk/mental-health/conditions/social-anxiety/#:~:text=Social%20anxiety%20disorder%2C%20also%20called,big%20impact%20on%20your%20life.
[4] https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/feelings-and-symptoms/hallucinations-hearing-voices/
[5] https://www.nhs.uk/mental-health/conditions/psychotic-depression/#:~:text=Symptoms%20of%20psychosis,-Having%20moments%20of&text=The%20delusions%20and%20hallucinations%20almost,risk%20of%20thinking%20about%20suicide.
[6] https://www.legislation.gov.uk/ukpga/1983/20/section/2

service coordinator was unclear whether Richard required emergency medical assistance, so no call was made to 999.

1.1.7 The following day, Milestones Trust support workers discovered Richard deceased.

1.1.8 Avon and Somerset Constabulary were informed of Richard's sudden death by the South Western Ambulance Service NHS Foundation Trust (SWAST).

1.1.9 The coroner's conclusion:

"The Deceased died from self-inflicted wounds to the neck whilst suffering an acute psychotic episode."

1.2 Purpose, Aim and Scope of the Safeguarding Adult Review

1.2.1 The primary objective of a SAR is to enhance practice and encourage learning rather than to re-examine or assign responsibility.

1.2.2 The Care and Support Statutory Guidance[7] emphasises reviews are

"To promote effective learning and improvement action to prevent future deaths or serious harm occurring again."

1.2.3 The objectives include establishing:

- To look at the systemic safeguarding system
- To consider how agencies worked together
- To consider the context in which decisions/processes took place
- To consider changes in practice/ legislation
- To identify areas of good practice
- To identify systems learning that can be used to improve future practice

1.2.4 The panel agreed that the review should focus on Richard's life from **February 2023 to February 2024**.

1.2.5 Agencies should also include details and an analysis of any significant events or incidents outside of the period that may be relevant.

1.2.6 The family agreed with the timeframe; however, they believed the primary focus should be on the period from Richard's admission in **December 2023** to his death.

1.3 Richard

1.3.1 The family kindly shared their dedication and the below with the chair.

[7] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

1.3.2 Richard didn't communicate very much about his deeper feelings about things. But he certainly expressed a lot of love to the people he cared about, not so much through words, but through his actions.

1.3.3 Richard's family has talked a lot about how thoughtful he was. The presents he bought for people were always very personalised, and it was obvious to the recipients of his gifts that Richard had really thought about the person he was giving the gift to.

1.3.4 Richard was generous and patient with people. When his neighbours and carers learned about his death, they all said how kind he was. We know that he had real struggles with his relationship with himself, but to other people, Richard was a very easy-going, mild-mannered person.

1.3.5 Richard's mum, Jackie has talked about how easy Richard was as a baby and a young child. He had lots of friends at school, he was popular as a kid and Richard's sister, Elaine remembers that there were always friends knocking on the front door for him when they were young.

1.3.6 Richard was shy underneath his popularity though, and he could sometimes be easily influenced and easily led.

1.3.7 Alan and Elaine have both said that maybe Rich struggled to maintain his outward appearance to the world. It's possible that there was a tension between who Richard really was – or who he really felt himself to be – and who other people saw him as. He had a lot of anxiety, especially in social situations, but boys tend not to talk very openly with each other about that kind of thing, so maybe Richard created a bit of a mask for himself as he got older and more self-aware.

1.3.8 But there were things in Richard's life that brought him a lot of joy. As a young person Richard had lots of interests. He got really into the cycle speedway and used to go to the speedway, which he was really good at. He was always interested in cars and bikes and often his dad Pete would help him out tinkering with engines and parts. Richard loved fishing as well.

1.3.9 There were family holidays and during these holidays Richard had a knack for always seeming to find money on the floor of the arcade they went to. He was lucky like that.

1.3.10 But when he was in his mid-twenties, life started to become more difficult for Richard. He moved back in with his mum and dad. Richard's dad, Pete did his best to support Richard, but of course, this was a hard time for everyone, there's no denying that.

1.3.11 Richard always found it very difficult to talk about his feelings, this is just part of who he was. And when his dad died suddenly in 2019, Richard didn't talk openly about his sadness about this. But Richard kept going and, over time, he managed to come back to himself again, and his life got better.

1.3.12 *Richard loved the outdoors, and he got a volunteering position at a Farm, which he really enjoyed. And this volunteering position led to a job through the Brandon Trust, working on the ride-on lawnmowers. Richard loved this job. It suited him really well. And he was pretty devastated when he lost this job.*

1.3.13 *But still, Richard kept going. He was a man of routine. He'd take his mum shopping every Saturday, arriving at her house 7:30am on the dot each week. And, every Tuesday he'd visit Jackie as well, arriving at 10am sharp. Richard and Jackie would watch This Morning together and, as soon as it was over at 12:30, Richard would get up and go home. These routines of Richard's no doubt helped him to feel safe and in control in the midst of his inner world, which was becoming a more hostile place for Richard.*

1.3.14 Richard had the following diagnoses:

1. Schizophrenia is a mental disorder that is distinguished by impairments in social interactions, emotional responsiveness, perceptions, and thought processes.[8]
2. Depression is a prevalent mental illness that influences an individual's thoughts, emotions, and behaviours.[9]
3. Agoraphobia, an anxiety disorder in which the individual experiences intense fear in a public or crowded environment, and the potential for escape is challenging.[10]
4. Obesity is abnormal or excessive fat accumulation that poses a health concern.[11]
5. Type 2 Diabetes is a chronic condition with elevated blood sugar (glucose) levels.[12]
6. Hypertension, which is high blood pressure.[13]

1.3.15 As of January 2024, his prescribed medication was as follows:

1. Olanzapine, an anti-psychotic medication[14]
2. Paroxetine, an antidepressant medication[15]
3. Ramipril to treat hypertension[16]

1.3.16 Richard's interactions with AWP ranged from April 2010 to May 2018. His next contact with AWP was his admission in December 2023.

1.3.17 Richard had contact with Adult Social Care (ASC) in 2016 when he received his initial Care Act Assessment, which is the Local authority's duty to assess a person's care and support needs.[17] In the same year, he was assessed under the MHA by an

[8] https://www.nhs.uk/mental-health/conditions/schizophrenia/overview/
[9] https://www.nhs.uk/mental-health/conditions/depression-in-adults/overview/#:~:text=When%20to%20see%20a%20doctor,on%20the%20way%20to%20recovery.
[10] https://www.nhs.uk/mental-health/conditions/agoraphobia/overview/
[11] https://www.nhs.uk/conditions/obesity/
[12] https://www.diabetes.org.uk/about-diabetes/type-2-diabetes
[13] https://www.nhs.uk/conditions/high-blood-pressure/
[14] https://www.nhs.uk/medicines/olanzapine/
[15] https://www.nhs.uk/medicines/paroxetine/
[16] https://www.nhs.uk/medicines/ramipril/
[17] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs

Approved Mental Health Professional[18] (AMHP) authorised by Bristol City Council ASC to perform specific responsibilities under the Mental Health Act and subsequently admitted to the AWP mental health unit.

1.3.18 Richard's penultimate care episode with AWP was between December 2016 and May 2018. The Bristol Mental Health Community Rehabilitation Service works in partnership with Second Step, AWP, and Missing Link[19] commenced support during his inpatient stay and was discharged in May 2018.

1.3.19 At the end of this episode, Richard resumed paid and voluntary work, attended activity groups with the AWP Bristol Active Life initiative,[20] and continued his recovery by moving back into his flat. His medication was discussed, and he was signposted to the MIND social anxiety group.[21]

1.3.20 In 2017, 2021 and 2023, ASC provided Richard with additional Care Act assessments. ASC funded his low-level support, four hours of weekly care support with the Milestones Trust since 2016. However, Milestones Trust had worked with Richard since 2012. This was still in effect at the time of his death.

1.4 Contact with Richard's family

1.4.1 The chair met with Elaine, Jackie, and Brother-In-Law Pete on 25.09.24. They shared the following:

1. **AWP Patient Safety Review** dated April 2024 (Incident Number 184162)	Commissioned following the family's complaint. The review (Incident Number 184162) disappointed the family, which determined no learning. They believed this was disrespectful to Richard and the family, and they and the chair agreed that there is always learning potential, even if it is incidental. Additionally, unlike in Incident Number 192587, the names of the patient safety review attendees and people involved were missing.
2. **AWP Patient Safety Review** dated August 2024 (Incident Number 192587)	Related to inaccurate medication dispensed on discharge.
The family reported being uninvolved with the reviews and had to escalate the request to receive the reports. Overall, the family believed the 'duty of candour' (an obligation upon trusts to be open and honest with patients, service users, and their families when something goes wrong that appears to have caused or could lead to moderate harm or worse in the future)[22] was not achieved. The family felt that AWP did not communicate with them effectively.	

[18] https://www.legislation.gov.uk/uksi/2008/1206/schedule/2/made
[19] https://www.second-step.co.uk/our-services/recovery-mental-health/community-rehabilitation/
[20] https://www.wesport.org.uk/custom-content/uploads/2017/01/BALP-Leaflet_A4.pdf
[21] https://bristolmind.org.uk/support_type/anxiety/
[22] https://www.gov.uk/government/calls-for-evidence/duty-of-candour-review/duty-of-candour-review#:~:text=In%20November%202014%2C%20the%20government,first%20serve%20a%20warning%20notice

The Coroner commented that he was surprised that no learning was to be determined, as all other reports listed something.	
3. **AWP Inpatient Discharge Summary to the GP** dated 30.01.24	The medication dosage on discharge was incorrect.
4. **AWP Progress Notes** from 26.12.23 – March 2024	• The family reported receiving this on the morning of the inquest. • The notes were perceived as helpful by the family as they provided information regarding Richard's inpatient stay. • The family questioned the content of the progress notes, which the Terms of Reference in the SAR will explore.

5. The coroner's bundle file, which included the following:

1. Statement of Identification	2. Identification Statement	3. Neighbour's Statement
4. Postmortem Report	5. Family Statement	6. Police Report
7. Toxicology Report	8. South Western Ambulance Service NHS Foundation Trust (SWAST) Statement	9. Mental Health Report
10. GP Report	11. Support Worker (Milestones Trust) Statement	12. Milestones Trust Statement

6. Bristol City Council Preventing Suicide in Bristol Annual Report.

7. Email communications between the family and:

1. AWP	2. Avon and Somerset Police	3. finance
4. Bristol City Council Safeguarding Team	5. Second Step[23] (Specialist Suicide Service)	6. Brighter Places (Housing)
7. AWP Patient Advice and Liaison Service[24] (PALS) and Complaints	8. Coroner	9. Milestones Trust

1.4.2 The family felt that the contact with Richard's bank was exceptional.

[23] https://www.second-step.co.uk/#:~:text=Welcome%20to%20Second%20Step,make%20their%20future%20their%20own.
[24] https://www.awp.nhs.uk/contact-us/patient-advice-and-liaison-service-pals

1.4.3 The family reported that the coroner had answered most of their questions. Some of the outstanding queries for the SAR to consider were:

1. Section 2 was rescinded, and the family was not involved. Communication with the family throughout the admission was poor.	2. Duty of Candour not fulfilled by AWP.	3. Inaccurate medication dispensed on discharge.
4. The support worker called the crisis team and was told they were in training for two hours and not to be disturbed.	5. Why was Richard discharged from the crisis team?	6. Richard was known to become mentally ill during his birthday (December). Did AWP note this, and what was the care plan/crisis contingency plan?

1.4.4 The chair informed Elaine and Pete of the progress and communicated with them throughout the SAR. Both felt involved throughout this.

1.4.5 The chair informed them of the delays caused by AWP, and they felt this further reinforced AWP's lack of compassion and "failure to fulfil their duty of candour." The family added that this demonstrated "utter disrespect."

1.5 Methodology

1.5.1 The chair implemented a hybrid model integrating root cause analysis[25] and the learning together model[26] to conduct the SAR.

1.5.2 The initial panel meeting was held on 07.10.24. The Key Lines of Enquiry (KLOES, Section 3.1), contact with the family, and the reason for the referral were all discussed and agreed upon. Following the panel agreement of the KLOES, the family received the KLOES, which they accepted on 15.10.24.

1.5.3 The panel shared their engagement with Richard at the meeting, and the following agencies were requested to complete chronologies and respond to the following:

1.5.4 **Adult Social Care**

1. AMHP Paperwork	2. Care Act Assessment/Carers Assessments[27] (as applicable)

[25] https://www.healthinnowest.net/toolkits-and-resources/quality-improvement-tools-2/root-cause-analysis/#:~:text=Root%20Cause%20Analysis%20(RCA)%20is,that%20led%20to%20the%20problem.
[26] https://www.scie.org.uk/safeguarding/children/case-reviews/learningtogether/
[27] https://www.legislation.gov.uk/ukpga/2014/23/section/10

3. Copy of Section 42(2) Enquiry[28]	4. Response to applicable KLOES

1.5.5 Avon and Wiltshire Mental Health Partnership NHS Trust

1. Care Plan and Risk Assessment	2. Prescription Chart
3. Crisis and Contingency Plan	4. Response to applicable KLOES

1.5.6 GP Practice

1. Copy of the medication review	2. Response to applicable KLOES

1.5.7 Milestones Trust

1. Care Plan and Risk Assessment	2. Response to applicable KLOES

1.5.8 The agency's information and the material the family shared were analysed to substantiate the SAR.

1.5.9 The second panel meeting on 21.11.24 discussed the agency information.

1.5.10 On 14.01.25, the third panel meeting discussed the first draft overview report. The report is expected to be a comprehensive, candid, and truthful review of the circumstances intended to inform learning and influence change.

1.5.11 The fourth panel meeting was postponed because AWP had not submitted the requested information. The chair subsequently escalated the issue to the SAB chair.

1.5.12 The approved report was shared with Elaine and Pete on 19.03.25, and they identified areas requiring further enhancement and correction, which were subsequently addressed and incorporated into the final version.

1.5.13 Recommendations for improvement will be outcome-focused and Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART). The SAR panel considered and agreed on the learning points, which have been integrated into an action plan (Appendix I).

1.5.14 On 24.04.25, the final report and action plan were sent to relevant agencies for final comments before submission to the Keeping Adults Safe Board for sign-off.

1.5.15 The KBSP published an electronic copy of the overview report on the local KBSP web page on 27.08.25. The KBSP members were sent a copy of the final report and a

[28] https://www.legislation.gov.uk/ukpga/2014/23/section/42#:~:text=42Enquiry%20by%20local%20authority&text=(2)The%20local%20authority%20must,so%2C%20what%20and%20by%20whom.&text=(d)having%20money%20or%20other%20property%20misused.

professional learning briefing to discuss at their relevant forums, share learning, and, where appropriate, shape priorities and work programmes.

1.6 Review Panel

1.6.1 The attendance of the appropriate independent management representatives at the panel meetings is essential for an effective review. The panel is responsible for providing rigorous oversight, challenging the information presented, and making an honest, diligent, and thorough effort to learn from the past.

1.6.2 The following agencies and independent panel members constituted the SAR panel:

Agency	Role
Avon and Somerset Constabulary	Detective Chief Inspector and Head of the Major Crime and Statutory Review Team
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Significant provider of specialist mental health services.	Professional Lead Safeguarding Adults
Bristol City Council (BCC) Adult Social Care (ASC)	Head of Service
Integrated Care Board (ICB) Representing the GP Practice	Deputy Designated Nurse All Age Safeguarding
Milestones Trust	Senior Operations Manager
North Bristol NHS Trust (NBT) It provides hospital and community healthcare to Bristol, South Gloucestershire, and North Somerset residents. It is a regional centre for neurosciences, plastics, burns, orthopaedics, and renal.	Safeguarding Lead
South Western Ambulance Service NHS Foundation Trust (SWAST)	Safeguarding Specialist
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), which includes The Bristol Royal Infirmary (BRI)	Deputy Head of Safeguarding

1.7 Parallel Reviews

1.7.1 AWP conducted two patient safety reviews:

1. AWP Patient Safety Review dated April 2024 (Incident Number 184162).

1.7.2 The review concluded that no learning was gained from the death, and no recommendations were issued.

2. AWP Patient Safety Review dated August 2024 (Incident Number 192587).

1.7.3 The review determined the following learning and recommendations:

1. *Add prompt to ward round summary – If discharging, check the TTA (to take away) form and discharge summary correlates with current prescription and any recent changes to medication.'*
2. *'Remind staff that a minimum of 48 hours is required before requesting TTA's, ideally 4-5 days.'*

1.7.4 BCC ASC conducted a safeguarding enquiry under Section 42 (2) of the Care Act 2014 (Appendix II). The enquiry was initiated by Richard's family's concerns following his death regarding his care while under AWP and potential risks to others.

1.7.5 The enquiry was completed by the Named Professional Adult Safeguarding at AWP on 18.03.24 and overseen by the Safeguarding Adult Team at BCC.

1.7.6 No other reviews were undertaken.

1.8 Key Lines of Enquiry (KLOE)

1.8.1 The review is intended to identify the lessons from Richard's contact with agencies and to implement those lessons to prevent safeguarding-related fatalities.

1.8.2 The critical question to be addressed by the review is:

What insights can agencies learn regarding support for individuals experiencing an acute mental health crisis?

1.8.3 The SAR panel agreed on the following areas to be addressed in this review (section 3.1 contains the full KLOES):

1. Assessment and Support
2. Admission, Treatment and Discharge
3. Risks

1.9 Chair and Author of the SAR

1.9.1 Parminder Sahota is an experienced independent chair/author with over eleven years of safeguarding and domestic abuse expertise.

1.9.2 Parminder has committed more than 20 years to the NHS as a Mental Health Nurse, specialising in crisis intervention and delivering care and treatment for adults with personality disorders. She was the Director of Safeguarding Children and Adults and served as the Domestic Abuse and Prevent (counterterrorism) Lead for an NHS Trust. Additionally, she is a Best Interest Assessor (Mental Capacity Act 2005).[29]

[29] https://www.legislation.gov.uk/ukpga/2005/9/schedule/A1/part/4/crossheading/best-interests-assessment

1.9.3 She completed training in the Patient Safety Incident Response Framework[30] in 2023, a method used to review incidents within the NHS. In 2024, she completed the updated Home Office review training course for Domestic Homicide Review Chairs.[31]

1.9.4 In 2024, she enrolled in a new course for Safeguarding Adult Reviews, which the Social Care Institute of Excellence[32] facilitate.

1.9.5 The training reinforces her status as a qualified professional for conducting reviews.

1.9.4 Parminder is independent of all agencies involved and had no prior contact with Richard or his family.

2.1 Key Events

Pre-Admission: April 2023 – December 2023

17.04.23

2.1.1 The GP practice clinical pharmacist reviewed Richard's medication (Olanzapine 15mgs, Paroxetine 40mgs, Piriton 4mgs and Ramipril 2.5mgs). Richard reported taking the medication as prescribed, not experiencing any side effects, and feeling *"stable"*.

2.1.2 Richard was observed to have gained weight since the last recording in December 2021, and his weight was twice that of the typical healthy range. He reported that he did not consume alcohol and smoked twenty 'roll-ups' (tobacco) daily.

13.06.23

2.1.3 The GP practice nurse conducted a medication review with Richard, recommending a low-sugar diet and advising Richard to reduce the consumption of sweet biscuits and exercise daily, if feasible. On 17.04.23, the original medicines review recommended blood tests for Ramipril. The pharmacist ordered blood tests on 10.05.23. On 13.06.23, a practice nurse saw the blood results and added this outstanding information from the earlier review, categorising it as a medication review.

21.12.23

2.1.4 Richard's employment was terminated, and he disclosed to AWP that he had neglected to take his medication.

2.1.5 ASC was notified of Richard's redundancy at the Brandon Trust[33] in December 2023, he was placed on a waiting list for priority allocation.

24.12.23

[30] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[31] https://aafda.org.uk/training/home-office-funded-dhr-chair-training
[32] https://www.scie.org.uk/
[33] https://www.brandontrust.org/jobs/our-roles/being-a-support-worker/?gad_source=1&gclid=CjwKCAiAzvC9BhADEiwAEhtlN_Lz1GQYUm5AVv3CXz5bI0-UxNXRT8eGiriSKeIn47QyfR9kcwHHFRoCbCsQAvD_BwE

2.1.6 Elaine visited Richard at home and observed that his mental health had declined. Richard was incoherent and did not respond normally when she revisited him that day. She discovered that Richard was hearing voices that were instructing him to harm himself.

2.1.7 Elaine contacted the AWP crisis team, who recommended that she call 999.

2.1.8 The SWAST crew arrived and was greeted by Elaine at the door. Richard was seated on the bed in a dimly lit room. Richard did not exhibit any indications of self-harm; however, he was contemplating self-harm. He was agitated and mumbling bizarre ideas with delusional thoughts (delusions are characterised by an individual's firm conviction that something is false).[34]

2.1.9 He had disordered motor activity (uncontrollable or involuntary bodily movements or actions), speech, thinking, mood, affect (expression of emotions or mood), and confused conversation. Richard appeared to be experiencing anxiety and fear.

2.1.10 The paramedic communicated with AWP, who recommended that the crisis team assess Richard at home; however, if he were unsafe at home, he would need to be transported to the hospital with the assistance of the police. With Elaine's encouragement, Richard reluctantly agreed to attend the hospital. An uneventful journey was documented, and Richard appeared to be less agitated.

2.1.11 AWP medical history recorded, Richard was diagnosed with schizophrenia and experienced command hallucinations.

25.12.23

2.1.12 Richard was transported to BRI via ambulance and assessed under the MHA.

2.1.13 Richard appeared perplexed and distracted during the MHA, and his hygiene was recorded as poor. He was challenging to engage with, as he seemed engrossed in thought and discussion. He presented with poor eye contact and spent most of the MHA silently muttering to himself.

2.1.14 He appeared distressed and low in mood. He responded with monosyllabic responses when he did respond. His thoughts were assessed by listening to the words he spoke to himself. He appeared self-deprecating and referred to "something bad" having happened but could not provide additional details. He reported that he had been unable to sleep for several days and was hearing voices. He also reported command hallucinations that told him to kill himself, which the MHA determined put him at high risk.

2.1.15 He was subsequently detained under Section 2: MHA and remained at BRI until his admission to AWP.

Admission to AWP mental health ward 26.12.23 – January 2024

[34] https://www.nhs.uk/mental-health/conditions/psychosis/symptoms/#:~:text=in%20the%20mouth-,Delusions,they%20have%20power%20or%20authority.

26.12.23

2.1.16 Richard was admitted to the AWP mental health unit (approximately thirty miles from his home, as there were no beds locally). He stated that he had ceased taking his medication and had lost his job one week before Christmas.

29.12.23

2.1.17 Richard reported that the voices (auditory hallucinations) had decreased and speculated that discontinuing his medication may have contributed to him feeling “this way”. He stated that he had taken paroxetine for years and was experiencing a slight improvement in his mood.

05.01.24

2.1.18 Richard stated that he was not a talkative individual and, therefore, preferred to remain in his room. He reported that he was eating and sleeping well and denied any intention to cause harm to himself or others. He was not experiencing any hallucinations or paranoia and remarked that his medications were satisfactory. He stated that he did not feel fully prepared to return home.

16.01.24

2.1.19 Richard reported that he experienced a "breakdown" and required time to recuperate. He perceived recovery as the ability to return home and, with any luck, seek employment. The period leading up to Christmas was particularly challenging for him, and his subsequent job loss was a substantial source of stress. He reported that his work as a gardener and groundsman and interaction with others were enjoyable.

2.1.20 He stated that he discontinued his medication because he was unable to care for himself due to the above. He said that he was comfortable with his medication regimen and was compliant with it; however, he had occasionally decreased the dosage of olanzapine. He stated that the voices had deteriorated significantly over time. His mental health deteriorated because of the voices' advice to harm himself.

2.1.21 In the discussion, he stated that the voices were still present, albeit at a reduced volume. He was reluctant to engage in a conversation regarding their nature and content. On direct questioning, he stated they did not tell him to harm himself, and he had no thoughts of harming himself. Nevertheless, he reported feeling hopeless about the future and experiencing a depressed mood at the time. As a result, he believed that he required additional time to recuperate.

2.1.22 When queried about returning home, he expressed concern about being alone, not seeing anyone, and potentially finding himself in a situation requiring readmission.

18.01.24

2.1.23 Richard reported that his mood was okay; however, he was experiencing fatigue. He noted that he continued to hear the voices, which were not disagreeable or negative. He consented to remain on the ward with his status as "informal"

(**voluntary admission, formal detention rescinded**), stating that he was unprepared to return home. He mentioned he was happy to talk with his family and friends and was uncertain whether his mood would be okay if he returned home.

19.01.24

2.1.24 The Occupational Therapy (OT) staff attempted to engage Richard in a conversation regarding employment support. Although he accepted a leaflet, he hesitated to engage in further discussion.

23.01.24

2.1.25 Richard was not talkative and stated that he still experienced voices but was not agitated.

2.1.26 Richard informed the OT staff on two separate occasions that he was not in a state to converse regarding specialised employment support. He had reviewed the leaflet and consented to a subsequent conversation.

24.01.24

2.1.27 Richard expressed his reluctance to use the communal toilet on the ward due to his aversion to leaving his room in the presence of other excessively boisterous patients. When asked why he was deferring to engage with occupational therapy or going off-ward with staff, he stated that he is typically a private individual and is not particularly social, even at home.

2.1.28 He stated that he was *"not too bad"* and that his mood was satisfactory. He noted that the voices were still present but were silent and did not cause him any distress. The voices did not express any negative sentiments or instruct him in any way. He refuted any intention to harm himself.

2.1.29 He expressed anxiety regarding his return home, as he was concerned about the potential consequences of a recurrence of the negative situation. He was amenable to receiving support from mental health services, family members, and support workers. He said he would inform his mum or support workers if he sensed the deteriorating situation. He stated that his relationship with them was positive.

2.1.30 He expressed his wish to resume cooking; he was informed that his progress on the ward had reached a halt, and it was suggested that his home might be the optimal location for him to continue his recovery and resume his desired activities, such as job hunting. In some respects, Richard agreed with this. He expressed a wish to interact with individuals with whom he was more familiar, an activity he had been unable to engage in on the ward.

2.1.31 Richard was enthusiastic about gardening and groundwork. He was satisfied with his medication and was willing to continue taking it after his discharge. He agreed to his family's involvement in planning his discharge.

2.1.32 The ward multi-disciplinary team (MDT) reported:

"Psychosis significantly improved. As a result, the risks present at admission have been reduced considerably. Ongoing features of depression are now likely exacerbated by the ward environment and distance from family/support at home. It is unlikely to improve further in this environment. Willing and able to accept community-based support around mood, psychosis and general support. Has the capacity to agree to this."

Seven days before Richard's death, he was discharged from the AWP mental health ward.

2.1.33 Elaine and Pete participated virtually in the ward round. The family handed in a letter asking about the discharge process, including a request for a Care Act Assessment review, ongoing social work support, and about six other related questions; to date, no reply has been received.

2.1.34 Richard stated that he was unaware of how he was doing on the ward but was feeling relatively well after resting and relaxing. He preferred to remain private and refuted any intention to cause harm to himself or others.

2.1.35 Richard stated that he was uncertain about his post-discharge objectives but was happy to see his family and support worker.

2.1.36 Richard expressed his continued reluctance to be referred to employment support. He stated that he needed to be more informed of the support available, which was subsequently clarified to him.

Post Discharge

Day after discharge

2.1.37 The AWP crisis team met Richard face-to-face, and he stated that he was not experiencing any intrusive thoughts and had no intentions of harming himself or others. He confirmed that he had the contact numbers for the crisis and recovery teams and would contact them if necessary.

2.1.38 Richard's assigned AWP Care Coordinator (CCO, also known as a key worker) saw him at home; he was described as cooperative, concentrating well, and responding appropriately and coherently. He stated that he had a restful night's sleep and had no intentions or plans to end his life or harm himself.

Four days before Richard died

2.1.39 The crisis team's initial home visit to Richard was unsuccessful.

2.1.40 They returned the same day, and Richard was reported to be agitated and did not feel like a visit. He refuted intrusive thoughts and notions of harm to himself or others. He said he was doing well and was pleased to see his CCO.

2.1.41 AWP handed over responsibility to the Milestones Support worker as Richard felt more comfortable with that (this was outside the agreed discharge plan and not communicated to the family).

Two days before Richard died

2.1.42 The crisis team called Richard, as agreed, by phone; they received no response and could not leave a message.

The day before Richard died

2.1.43 Jackie contacted the CCO to voice her concerns regarding Richard. Richard had assured her that he was in good health; however, she could hear him conversing with himself after they had concluded their phone conversation earlier that day. She had visited him the previous day and was uncertain whether he was eating, as the food she had brought earlier in the week was still present. She stated that Richard's refusal to permit professionals entry was indicative of a relapse.

2.1.44 She was concerned that Richard had not been seen by anyone since the day following his discharge. The CCO clarified that they had seen Richard three days after discharge and disclosed that they intended to visit him in the afternoon.

2.1.45 Richard met with the CCO. He was observed to be murmuring words under his breath. He disclosed that sleep was inadequate and declined to elaborate. Richard did not wish the CCO to remain for an extended period. He appeared to be preoccupied and was not maintaining eye contact. He stated that he was taking his medication and had eaten a meal that day. Richard was unable to engage in a comprehensive assessment of his mental health and was not enthusiastic about the prospect of the CCO visiting him the following day.

2.1.46 The CCO consulted the crisis team due to Richard's lack of engagement and his observation of a shift in presentation. The CCO referred him back to the crisis team for additional support due to concerns regarding his change in presentation. The crisis team advised the CCO to conduct a further assessment of his mental health and subsequently establish a referral. The CCO intended to perform an additional visit the following day.

2.1.47 Milestones on-call night staff contacted the AWP Response Line.[35] They were concerned about Richard, as a resident who resided beneath him had contacted them after hearing him scream and shout since 21:00. Milestones indicated that Richard was not engaging with them. The AWP Response Line worker stated that Richard's CCO visited him that day and expressed some concerns. Consequently, the CCO intended to see Richard the following day.

2.1.48 The AWP Response Line worker recommended that Milestones' staff contact 999 to request an ambulance if they were concerned about him and believed that emergency support was required. The response line worker said they would send an email update to Richard's CCO and the crisis team, which they did following the call.

[35] https://remedy.bnssg.icb.nhs.uk/adults/mental-health/247-mental-health-support/

The day of Richard's death

2.1.49 The CCO and a colleague arrived at Richard's address and were greeted by the police. The police informed them of an undisclosed incident and informed them that they would not be able to see Richard.

3.1 KLOE and Analysis

3.1.1 The panel agreed on which agencies must respond to each KLOE.

Assessment and Support, responses from AWP, BCC and Milestones Trust

3.1.2 **AWP:** Richard was not in contact with AWP from May 2018 until his admission in December 2023. He was under the care and treatment of AWP from December 2023 to his death in February 2024.

3.1.3 **BCC:** BCC funded Milestones Trust to provide outreach community support for Richard from 2016, which remained in place at the time of his death.

3.1.4 BCC was the responsible authority for completing Care Act Assessments; the last assessment took place in March 2023. At the time, no increase in his support was required as he remained well.

3.1.5 BCC's last contact with Richard was the MHA assessment in December 2023, when he was detained under the Act and admitted to the AWP mental health unit.

3.1.6 **Milestones Trust:** They were Richard's landlord and provided community outreach support.

3.1.7 According to the Local Government Association publication, the local authority where the patient was an ordinary resident is responsible for assessing and addressing eligible care and support needs under the Care Act upon discharge from the hospital[36].

3.1.8 People with mental health problems may be eligible for social care and support if they meet specific criteria under the Care Act (2014).

3.1.9 Care and Support Statutory Guidance, Chapter 6: Assessment and Eligibility:[37]

"The assessment aims to identify the person's needs and what outcomes they want to achieve to maintain or improve their wellbeing. The outcome of the assessment is to provide a full picture of the individual's needs so that a local authority can provide an appropriate response at the right time to meet the level of the person's needs."

[36] https://www.local.gov.uk/publications/ordinary-residence-guide-determining-local-authority-responsibilities-under-care-act-0#leaving-hospital
[37] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

"The assessment will support the determination of whether needs are eligible for care and support from the local authority and understanding how the provision of care and support may assist the adult in achieving their desired outcomes. An assessment must be person-centred, involving the individual and any carer the adult has, or any other person they might want involved."

KL0E 1: Did the Local Authority receive a request to conduct a Care Act Assessment for Richard? If so, when did this occur, what was the outcome, and did this follow the guidance?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.4 AWP did not refer Richard to BCC for a Care Act Assessment during his admission or discharge. AWP did not inform ASC that Richard was discharged.

3.1.5 The ASC support plan, developed in March 2023, clearly identified Richard's required support, and it was evident that the assessor had considered all aspects of Richard's life.

3.1.6 As per the Government Association publication, ASC was expected to be informed of the discharge plan and the potential need to review the Care Act assessment to establish whether additional community support was necessary.

Bristol City Council Adult Social Care

3.1.7 In 2016, Richard received an initial Care Act Assessment, which determined that he satisfied the eligibility requirements for care and support. He received further assessments in 2017, 2021 and 2023.

3.1.8 A Care Act Assessment must be conducted with the participation of the adult, their carer, or someone they nominate.[38] Milestones and Richards' family were not part of the assessment process. However, the assessment was completed with the Brandon Trust, and a detailed support plan was developed.

3.1.9 It is reasonable to anticipate that ASC would be aware of the change in Richard's circumstances, as they conducted the MHA in December 2023. However, no Care Act assessment was reviewed or referred to ASC to reassess Richard's care and support needs upon discharge.

KL0E 2: How were person-centred care practices implemented? Did agencies consider Richard's wishes and goals?

[38] https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-3-assessing-needs-and-determining-eligibility

3.1.10 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Part 3, Section 2 discusses person-centred care.[39] It stipulates that service users must receive care and treatment as per the following:

(a)be appropriate,
(b)meet their needs and
(c)reflect their preferences.

3.1.11 The Act establishes the requirements for the "registered person" (concerning 'regulated activity', which is associated with the provision of health and social care)[40] to provide person-centred care.

3.1.12 It asserts that a registered person must collaborate with the individual, which includes making reasonable adjustments to support and assist the individual in making informed decisions about their care and treatment options, including how they wish to manage them.

3.1.13 It is also crucial to consider the individual's capacity to consent, and they or a person lawfully acting on their behalf must be involved in the planning, administration, and review of their care and treatment. Health and social providers must ensure that individuals who make decisions have the legal authority or responsibility. However, when appropriate, they must adhere to the Mental Capacity Act 2005, which mandates the consultation of others, including carers, families, and/or advocates.

3.1.14 The Care and Support Statutory Guidance and NHS England further emphasise the following:

"In carrying out a proportionate assessment, local authorities must have regard to: The person's wishes and preferences and desired outcomes."

Care and Support Statutory Guidance

"Being person-centred is about focusing care on the needs of the individual. Ensuring that people's preferences, needs and values guide clinical decisions and providing care that is respectful of and responsive to them."

NHS England[41]

3.1.15 The Act, Guidance, and NHS mandate that all regulated services provide person-centred care.

3.1.16 The primary perspectives of person-centred treatment were emphasised in the British Journal of Psychiatry.[42]

[39] https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/9
[40] https://www.legislation.gov.uk/ukdsi/2014/9780111117613#:~:text=but%20in%20regulations%2012%2C%2014,on%20of%20a%20regulated%20activity;
[41] https://www.hee.nhs.uk/our-work/person-centred-care
[42] JPsych Int. 2020 Aug;17(3):65–68. doi: 10.1192/bji.2020.21

"Person-centred care focuses on the patient's history, strengths, values, beliefs, etc., not merely to inform decisions about diagnosis and treatment but to help them live the life they wish to lead"

3.1.17 The review highlighted that safeguarding the individual's autonomy is essential to implementing person-centred decision-making methodologies in mental health care. Shared and supported decision-making are the most frequently discussed person-centred approaches to decision-making in mental health care.[43]

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.18 AWP states:[44]

"Through all our services, our multi-disciplinary teams work with our patients and carers to develop person-centred care plans, ensuring everyone is treated as an individual."

3.1.19 During Richard's admission to the AWP mental health unit, he spent most of the time in his room and did not engage in conversation with staff. He required staff to prompt him to understand his views and wishes, was able to articulate a decrease in distress associated with the voices and was amenable to taking his medication.

3.1.20 Richard did not wish to discuss employment support, which was acknowledged, and he was advised to explore this again with the OT staff.

3.1.21 Richard could not clearly articulate his future objectives and generally agreed with the discharge plan despite having previously expressed reservations about discharge, specifically the recurrence of how he felt on admission. This is explored in KLOE 6.

3.1.22 Milestones Trust support workers had a longstanding relationship with Richard, and following the Act, Guidance, NHS England, and research, their involvement would be crucial. Milestones Trust stated they were not invited to participate in Richard's care plan while under AWP.

3.1.23 AWP obtaining Richard's consent to communicate with Milestones could have strengthened the development of a person-centred and shared decision-making process. Furthermore, the support plan developed by ASC further defined Richard's needs and the methods by which they could be satisfied, including indicators of his mental state relapse.

3.1.24 Milestones work with individuals when the local authority contracts them, indicating the individual's consent to assessment and care needs fulfilment. Milestones share information with relevant professionals as needed for care, in line with the Service Line Agreement and without requiring consent under GDPR, based on Common Law Duty of Confidentiality and Caldicott Guardian Principles. If Richard could not

[43] https://doi.org/10.1080/01612840.2023.2288181
[44] https://www.awp.nhs.uk/our-services

consent due to illness, contact could still occur to enhance his person-centred care and ensure safe discharge.

3.1.25 AWP determined that Richard would benefit from being closer to his family and support. His advancement was believed to have reached a plateau in the ward environment.

3.1.26 The involvement of Richard's family is the subject of KLOE 9.

3.1.27 AWP recognised Richard's pursuits of gardening, cooking, and spending time with his family. Nevertheless, they also stated that Richard was hesitant about the discharge and needed help articulating his objectives.

3.1.28 The absence of critical stakeholders, ASC and the Milestones Trust resulted in a lack of person-centred care and diminished opportunity for shared decision-making.

Bristol City Council Adult Social Care

3.1.29 Richard's last ASC interaction was the MHA assessment.

Milestones Trust

3.1.30 Milestones Trust's support is based on the Recovery Pathway documentation. It is an outcomes-focused approach. People can see their development, improve their motivation, increase their confidence and self-esteem, strengthen their resources, and move on to greater independence.

3.1.31 The Recovery Pathway Support Plan and Recovery Star, completed by the Milestones Trust with Richard on 01.08.23, were shared with the panel. The support plan was written in the first person, signed by Richard and emphasised the objectives and support he identified.

3.1.32 The plan is a good example of person-centred and collaborative decision-making.

KL0E 3: What support was provided to Rich, and how frequently was it reviewed?

Bristol City Council Adult Social Care

3.1.33 BCC funded Milestones Trust to provide Richard with four weekly financial and tenancy support hours. Richard was able to meet his care and needs. The support plan identified the following:

1. *Making a Positive Contribution: Richard enjoys gardening and working with animals but needs support to engage in voluntary work and his allotment group. He works two days a week at Ground and Gardens and volunteers at Elm Tree Farm (Brandon Trust), which are essential for his mental health recovery. Richard can access his community independently and values being*

treated fairly and recognised for his contributions. Ongoing support and encouragement are crucial for Richard to reduce the risk of relapse and maintain his engagement with his interests and responsibilities, including supporting his mother.

2. *When Richard is Unwell: Richard's chronic mental illness affects his confidence and leads to social withdrawal. His low mood and self-esteem often prevent him from engaging in activities and socialising, requiring extra support during these times.*
3. *Ongoing mental health recovery: Richard has a car and can access his community independently when well, but he currently needs support due to a decline in his mental and emotional well-being.*
4. *Managing and maintaining nutrition: Richard is independent with eating, drinking, and meal preparation. He primarily heats ready meals and can make dishes like steak, chips, or roast dinner. He is aware of healthy eating and should continue to make healthy meal choices.*
5. *Past issues when Richard has been unwell: Richard tends to self-neglect due to lacking motivation. He requires prompting to maintain a healthy dietary intake; without it, he may overeat and gain weight or not eat enough and lose weight, which affects his health and well-being.*
6. *Maintaining a habitable home environment: Richard is independent in cleaning and maintaining his home. He can shop for food and collect his medication on his own. He receives 4 hours of 1:1 support from Milestones to help with his tenancy, budgeting, benefits, correspondence and accessing community facilities.*
7. *Developing and maintaining family or other personal relationships: Richard visits his mum regularly, and she supports him with decisions and worries. He also has a brother and sister in Bristol whom he occasionally sees when they are at their mum's.*
8. *Using necessary facilities or services in the local community, including public transport and recreational facilities or services: Richard can independently access local facilities and shops and uses public transport to travel around Bristol. He regularly walks to visit his mum, taking her shopping, which he finds therapeutic. Richard has a bike and a car.*

3.1.34 The plan demonstrated a person-centred approach and identified the support he needed and the aspects of his life that he enjoyed, including areas that indicated a relapse in his mental health.

3.1.35 The chair emphasised that the plan is good practice and requested that the ASC panellist inform the author of the support plan.

Milestones Trust

3.1.36 Milestones Trust exclusively provided financial tenancy support in two two-hour weekly sessions, typically scheduled in the mornings on Mondays and Thursdays. However, the schedule could be modified according to Richard's needs.

3.1.37 The support plan identified the following:

1. Managing Mental Health: *"To manage medication independently."*
2. Physical Health and Self-Care: *"To be healthy and fit and to have lost some weight."*
3. Living Skills: *"To help me have a better understanding of my correspondence and have confidence in speaking on the phone independently."*
4. Social Networks: *"To feel more confident in myself and make new friends."*
5. Work: *"To improve my skills and feel more educated and part of society."*
6. Relationships: *"To make new friends."*
7. Responsibilities: *"To maintain and sustain my tenancy."*
8. Identity and Self-Esteem: "To have gained confidence and to be able to say what is on my mind."
9. Trust and Hope: *"I would like to be seen as a member of the community. My dream is to work with animals."*

3.1.38 Milestones Trust supported Richard in achieving the plan's objectives during their visits.

Admission, Treatment and Discharge, responses from AWP, BCC and GP Practice

3.1.39 **AWP:** Richard was admitted to AWP in December 2023 and discharged in January 2024. Upon discharge, he was prescribed Ramipril, Paroxetine, Olanzapine, and Niquitin. The dosage of Paroxetine was incorrect. The coroner addressed this matter, and a medical doctor informed them that Richard's mood would not have been significantly affected.

3.1.40 **BCC:** Richard was detained under Section 2: MHA in December 2023. He presented with severe psychotic symptoms and a mental health diagnosis of recurrent depressive disorder.

3.1.41 **GP Practice:** Richard had not seen his GP in the years preceding his death. However, he received two medication reviews within the review period. In the following weeks, he was requested to conduct blood tests and blood pressure readings at home. He was reported obese, the diagnostic threshold for Type 2 diabetes, and had slightly elevated cholesterol and marginally elevated blood pressure. His cholesterol, weight, and diabetes were addressed through dietary recommendations, and he was prescribed blood pressure medication.

> *"Anyone prescribed antipsychotics or mood stabilisers (regardless of diagnosis) should also have their physical health monitored from initiation of these medications in line with British National Formulary guidelines or summary of product characteristics."*
>
> NHS England[45]

[45] https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/#:~:text=Anyone%20prescribed%20antipsychotics%20or%20mood,of%20product%20characteristics%20(SmPC).

"Blood lipids and weight should be measured at baseline, at 3 months (weight should be measured at frequent intervals during the first 3 months), and then yearly with antipsychotic drugs. Patients taking olanzapine require more frequent monitoring of these parameters: every 3 months for the first year, then yearly."

NICE, British National Formulary guidelines[46]

Common side effects of Olanzapine (may affect up to 1 in 10 people). This includes putting on weight or an increase in your appetite. An uncommon side effect (less than 1 in 100 people) can increase the amount of sugar in the blood and can sometimes lead to diabetes.

NHS Medicines[47]

3.1.42 **Milestones Trust:** They provided Richard community outreach support before and after admission.

KL0E 4: What consideration was given to the potential risks of Olanzapine to Richard's physical health? Did the GP collaborate with AWP to discuss alternative medications to mitigate risks?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.43 Information from the discharge letter dated 19.04.18:

"You [Richard] were offered a review and possible medication change. This is because your current anti-psychotic, Olanzapine, can result in users experiencing increased appetite and a tendency to gain weight. You did not wish to consider changing medication and may speak to your GP about this in future."

3.1.44 Richard's records contained no discussion or communication concerning Olanzapine and Richard's physical health between AWP and his GP following Richard's discharge in January 2024.

3.1.45 According to the British Medical Journal, patients who are administered Olanzapine are at an elevated risk of developing diabetes in comparison to those who are administered conventional antipsychotic medications.[48]

3.1.46 A non-significant increase in risk was observed among patients taking the antipsychotic risperidone. The British Medical Journal authors suggested that doctors should, therefore, consider the metabolic consequences (A process that controls how the body creates and uses energy. The consequences refer to the potential risk of heart disease, stroke and type 2 diabetes),[49] of antipsychotics, as weight gain and disruption of glucose metabolism are potential mechanisms for the association between diabetes and antipsychotic use.

[46] https://bnf.nice.org.uk/drugs/olanzapine/#:~:text=Blood%20lipids%20and%20weight%20should,the%20first%20year%2C%20then%20yearly.
[47] https://www.nhs.uk/medicines/olanzapine/
[48] https://doi.org/10.1136/bmj.325.7358.0/a
[49] https://www.nhs.uk/conditions/metabolic-syndrome/#:~:text=Complications%20of%20metabolic%20syndrome,disease%20and%20type%202%20diabetes.

3.1.47 A case study revealed the necessity of an increased awareness of the generalised metabolic effects and risk of diabetic ketoacidosis associated with antipsychotic medications to establish a safe treatment plan for patients.[50]

3.1.48 Richard's admission in December 2023 would have provided the opportunity to address his physical health and his prescription of Olanzapine.

3.1.49 According to an article published in Psychiatric Times, *We strongly advise that atypical antipsychotics, including Risperidone and Aripiprazole, be considered when initiating drug therapy in prospective diabetic patients, as they do not appear to pose a significant risk of diabetes*.[51]

3.1.50 According to the Mental Health Foundation, physical health issues significantly elevate the likelihood of developing mental health issues, and the reverse is also true. They also report research that individuals with mental health problems are more likely to develop preventable physical health conditions, such as heart disease.[52]

3.1.51 Richard was recognised as a smoker and was prescribed medication as part of the smoking cessation plan. During his admission, he had also disclosed his aversion to leaving his room and venturing outside, which consequently restricted his ability to engage in physical activity.

3.1.52 Physical health must be considered to support and prevent physical health conditions. This includes ensuring that mediation does not exacerbate the risk of poor physical health and providing guidance on improving physical health through diet and exercise.

GP Practice

3.1.53 The practice did not document any specific discussion regarding the physical health risks of Olanzapine or GP collaboration with AWP, where alternative medications to mitigate risks were discussed.

3.1.54 As per the recommendation in the article published in the Psychiatric Times, it is necessary to raise awareness and ensure that GPs are supported in prescribing anti-psychotic medications that may increase the risk of poor physical health. This includes collaborating with psychiatrists.

KL0E 5: Did the MHA assessment follow the legislation and Statutory Guidance Code of Practice: MHA 1983, and what information was obtained to substantiate the decision?

3.1.55 An MHA assessment is performed to determine if someone should be detained in a hospital for the treatment of a mental disorder.

[50] https://doi.org/10.1016/j.aace.2023.10.006
[51] https://doi.org/10.4103/0976-3147.143182
[52] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/physical-health-and-mental-health#:~:text=Physical%20health%20problems%20significantly%20increase,condition%20such%20as%20heart%20disease.

3.1.56 MHA assessors consist of a registered medical practitioner, an AMHP, and a Section 12 approved doctor (Section 12 approved doctors are those approved by the Secretary of State under Section 12(2) MHA, where they are described 'as having special experience in the diagnosis or treatment of mental disorder.'),[53] typically a psychiatrist.

3.1.57 The AMHP is obligated to investigate the social aspects of the individual, including their living environment, the available support, and their ability to support themselves.

3.1.58 These areas were explicitly identified in the support plan developed in response to the Care Act Assessment in 2023. This included the support method that Richard would use to sustain his recovery and when he would require support in the event of a relapse. The plan would be accessible to the AMHP to facilitate their comprehensive assessment.

3.1.59 At his admission in December 2023, the support plan was consistent with Richards's relapse indicators. This further demonstrates this as an accurate record and comprehension of Richard's needs.

3.1.60 The assessment of the individual's physical and mental health is the responsibility of the doctors.

3.1.61 The assessors must consider all available treatment alternatives, consult with the family as necessary, and address the individual's perspectives.

3.1.62 The AMHP determines whether hospital admission is the most effective care and treatment method. The two doctors must also agree with this decision.

3.1.63 The AMHP is responsible for informing the "nearest relative" (the nearest relative under the MHA is the person who is highest on a list of relatives defined in the Act), the doctors conducting the MHA, the CCO as relevant, and the GP, as well as determining whether to proceed with the section and providing the individual with justification for their decision.

3.1.64 The code of practice outlines the procedures for fulfilling professional obligations under the Act and delivering safe and high-quality care.[54]

3.1.65 The code's five overarching principles are:

1. Least restrictive option and maximising independence
2. Empowerment and involvement
3. Respect and dignity

[53] https://www.kcl.ac.uk/research/availability-of-section-12-approved-doctors#:~:text=Section%2012%20approved%20doctors%20are,Care%20Quality%20Commission%20(2018).
[54] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

4. Purpose and effectiveness
5. Efficiency and equity

Bristol City Council Adult Social Care

3.1.66 The AMHP is a lawful assessment that follows the MHA principles. The outcome was detention under Section 2, as the presentation reflected that this was needed to ensure appropriate care and treatment for Richard.

KL0E 6: What care and treatment were administered to Richard by AWP between December 2023 and February 2024, including facilitating his recovery in the community, developing care plans, identifying risk assessment/management, and creating a crisis/contingency plan in collaboration with Richard and others (as appropriate)?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.67 On admission to the ward, the following plan was recorded:

- The nursing staff observed Richard every 15 minutes to support his safety on admission.
- Nursing staff to administer Richard's medication.
- Richard's physical observations are to be monitored weekly.
- Richard to maintain contact with family and for information to be shared as per his consent.
- Richard is to be supported towards discharge through the Care Programme Approach (CPA, a framework which ensures that services and healthcare professionals work together to meet your needs)[55] meetings with CCO and family.
- Richard to have authorised periods of leave from the ward.
- Richard is to be offered 1:1 meetings with staff.
- Richard to access additional support from staff as required.

Medication

3.1.68 Richard's medication significantly influenced his treatment on the ward. Historically, he was treated for an extended period with paroxetine and olanzapine. Ramipril was also historically prescribed for hypertension. Upon his admission to the ward, he was prescribed high-potency nicotine patches.

- 27.12.23: Olanzapine 5mg, Paroxetine 30mg and Ramipril 2.5mg.
- 11.01.24: Olanzapine 10mg, Paroxetine 30mg and Ramipril 2.5mg.
- 16.01.24: Olanzapine 15mg, Paroxetine 40mg and Ramipril 2.5mg.
- 23.01.24: Olanzapine 15mg, Paroxetine 50mg and Ramipril 2.5mg.

[55] https://www.awp.nhs.uk/patients-and-carers/leaflets-and-resources/patient-and-carer-information-leaflets/conditions-and-treatments/care-planning-approach-cpa#:~:text=The%20Care%20Programme%20Approach%20(CPA,you%20to%20meet%20your%20needs.

3.1.69 Medication has been discussed in KLOE 4.

Employment Support

3.1.70 The ward OT staff attempted to engage Richard in a conversation regarding employment support, identified during the ward round on 19.01.24. The staff engaged in a discussion regarding the "Individual Placement and Support" approach[56] (IPS). Richard accepted the leaflet that explained IPS but was hesitant to engage further. Nevertheless, he agreed to a further review with the OT.

3.1.71 The day before his discharge, Richard was offered a referral to IPS, which he declined. Nevertheless, he consented to retain the leaflet if he changed his mind.

3.1.72 The Royal College of Occupational Therapists states that OT enhances health and well-being by facilitating engagement in occupations, which are daily life activities, roles, and routines. OTs acknowledge that participation in meaningful occupations can foster good mental health, aid in recovery, and enable individuals to attain personalised outcomes, including caring for themselves, engaging in work and leisure activities, and contributing to the community.[57]

3.1.73 The Journal of Psychiatric and Mental Health Nursing published an article on service users' perspectives on acute mental health ward activities.[58] The following themes were identified:

1. Lack of activities, Dissatisfaction and Boredom
   Richard was observed to spend most of his admission in his room. He had disclosed his interests to AWP, which included gardening and cooking. At the time of Richard's admission, these activities were unavailable.
2. The values/benefits of activities: Psychological Well-Being, Social Connectedness and Physical Health.
   The Milestones Plan highlighted these benefits; had AWP collaborated with them, it may have been feasible to support Richard in pursuing his objectives during admission.
3. Barriers to Engagement: Ward Environment, Restrictions and Wellness.
   Richard stayed in his room because of the ward environment. A therapeutic environment is essential for fostering a safe environment and engaging patients.

3.1.73 The activity or clinical appropriateness determines the location of OT activities, which may be in the service user's room, kitchen, or outdoors. Additionally, access to work is available. Richard stated he wished to remain in his room as he preferred his company.

[56] https://ipsgrow.org.uk/about/what-is-ips/
[57] https://www.rcot.co.uk/file/1805/download?token=dA7ez-G9#:~:text=Occupational%20therapy%20aims%20to%20improve,Prevention%20and%20Health%20Promotion
[58] https://doi.org/10.1111/jpm.12595

3.1.74 This area could have been strengthened if AWP had collaborated with Milestones Trust to maintain the objectives of the established community support plan. Furthermore, Richard had articulated his interests, and his engagement with them may have facilitated his interaction with the MDT.

Risk Information, Assessment and Management

3.1.75 AWP completed the following:

- **25.12.23:** Staff were unable to engage Richard in the assessment process. Richard had previously been documented as having stabbed himself in the abdomen when he was unwell and had broken glass, resulting in cuts to his hand. Richard was observed responding to unknown stimuli. The plan was for Richard to remain in BRI overnight for a review by the psychiatric liaison service the following morning.
- **26.12.23:** Admission to the AWP Ward. Pete was reported to have called an ambulance on 24.12.23 after discovering Richard rocking on his bed, speaking in an unusual voice, and responding to command auditory hallucinations to kill himself. His front door was left open, and a knife was discovered next to his bed. Richard did not engage with the assessment and responded to auditory hallucinations during his assessment in BRI.

3.1.76 AWP records indicated that Richard appeared more settled and engaged with the staff. The initial record occurred during Richard's admission and was associated with his feeling settled and increased engagement with staff compared to his previous admission. The second record was on 31.12.23, indicating that Richard was calm and settled in the presentation.

3.1.77 He was unable to recollect the events that transpired before his admission. He acknowledged that he had experienced a "major breakdown" and was experiencing worsening depression and auditory hallucinations over the past month.

3.1.78 The reports from Milestones and the family indicate that Richard's job loss was a significant stressor, potentially contributing to his decline in mental health, which led to his admission.

3.1.79 He disclosed that he had neglected to take his medication due to forgetfulness rather than any concerns or experiencing side effects. He stated he was happy to take the medication.

3.1.80 Richard's forgetfulness was influenced by depression and the disruption of his routine.

3.1.81 He described auditory hallucinations as a single male voice that had been present in his life since childhood. Recently, this voice had been directing him to harm himself while also occasionally expressing affectionate sentiments towards him. He did not disclose any intentions to end his life or self-harm.

3.1.82 The NICE guidance[59] on treatment options for acute psychosis (hallucinations) recommends the use of oral antipsychotic medication, which Richard was prescribed before admission and was increased during his inpatient stay, as well as psychological interventions. The documentation did not suggest that psychological interventions were discussed or considered.

3.1.83 AWP reported that a referral to psychology was not made, as Richard was receiving support from the occupational therapist, part of the psychology team. The chair acknowledged that the two methodologies are distinct. OT emphasises the development of independence through practical interventions, while psychology employs talking therapy to address the underlying thoughts and emotions that contribute to poor mental health.

3.1.84 The crisis and contingency plan were last updated in March 2018.

3.1.85 A crisis plan prevents the likelihood of an individual's mental health deteriorating. It should identify the social network and be centred on the service user. Additionally, the contingency plan should specify the interventions, actions, and responses that will follow.

3.1.86 Richard disclosed that he had experienced a "major breakdown" and that his auditory hallucinations and depression had escalated. He stated he had become forgetful, which resulted in him neglecting his medication. The documentation did not indicate that this had been explored to consider the potential causes. Consequently, it would be challenging to develop a care and treatment plan that would effectively mitigate the risk of relapse.

3.1.87 Richard had additionally disclosed that he had heard a male voice since childhood, and it had recently directed him to harm himself. The documentation did not specify the strategies Richard had previously used in response to the voice or whether he would benefit from psychological interventions in conjunction with mediation to improve his coping responses.

3.1.88 Suicide is a behaviour, not a condition. Any given individual cannot be accurately predicted at a single point in time to end their life by suicide. Suicide is typically the result of a multifactorial process, during which vulnerability to suicide may develop over several weeks, months, or years.[60] Consequently, it was crucial to understand Richard's circumstances before admission, determine whether they persisted at discharge, and what had been altered to mitigate the recurrence.

Community

3.1.89 On 08.01.24, Richard was assigned a CCO. They participated in the ward rounds and discharge CPA. Upon discharge, the CCO monitored the community recovery-based

[59] https://www.nice.org.uk/guidance/cg178/chapter/Recommendations#subsequent-acute-episodes-of-psychosis-or-schizophrenia-and-referral-in-crisis
[60] Suicide risk mitigation - Symptoms, diagnosis, and treatment | BMJ Best Practice

care plan objectives. Despite escalating to request that they be shared with the panel, they were not.

3.1.90 Richard was discharged from the ward with support from the crisis team; the family stated they were told two weeks of support would be given.

3.1.91 The crisis team indicated they had one telephone conversation and one visit with Richard before discharging him to the community recovery team.

3.1.92 Richard was discharged to his CCO as he did not wish to work with the crisis team.

KL0E 7: What protocols are in place at AWP to facilitate the discharge of patients from the ward and compliance with the MHA? Is the Mental Capacity Act considered part of the discharge process, and were the procedures implemented?

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3.1.93 On 18.01.24, Richard's section 2 was revoked, and he agreed to remain on the ward voluntarily.

3.1.94 Richard would require consent to continue care and treatment as a voluntary patient on the ward. The Code of Practice states: *"Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it."*

3.1.95 The Mental Capacity Act (2005) outlines five statutory principles. AWP determined that Richard had the capacity to make the decision to receive care and treatment and to remain a voluntary patient. This aligns with the first principle: *"A person must be assumed to have capacity unless it is established that he lacks capacity."*

3.1.96 Six days before Richard's discharge from the ward, the ward consultant recorded their impression:

"*Psychosis significantly improved. As a result, the risks present at admission have been reduced considerably. Ongoing features of depression are now likely exacerbated by the ward environment and distance from family/support at home. Unlikely to improve further in this environment. Willing and able to accept community-based support around mood, psychosis and general support. Has the capacity to agree to this.*"

3.1.97 Elaine attended the ward round five days before Richard's discharge and informed the OT that Richard would need a discharge support crisis plan and key contact information. Elaine perceived Richard's mental health to have deteriorated because of his job loss and routine disruption. In addition, she believed Richard would need an increase in his community support program. The OT clarified that this would necessitate approval and funding from BCC.

3.1.98 Richard's potential discharge for the following week was discussed. Elaine expressed anxiety about the discharge. Additionally, Elaine was not made aware that Richard was a voluntary patient. KLOE 9 explores this further.

3.1.99 Section 74: Care Act 2014 states that where a relevant trust is responsible for an adult hospital patient and considers that the patient is likely to require care and support following discharge from the hospital, the trust must, as soon as is feasible after it begins making any plans relating to the discharge, take any steps that it considers appropriate to involve the patient and the patient's carer. BCC was not informed of the family's request for increased support.

3.1.100 The AWP *'Inpatient Services Admission and Discharge Procedure'* establishes discharge standards, as listed below:

"A Care Programme Approach (CPA) meeting will be convened to handover care from the ward to the appropriate service. This meeting will include the service user and their carer."

3.1.101 Richard, the CCO, and the crisis team were present at the meeting, and Elaine and Pete joined virtually.

3.1.102 Milestones Trust was absent; AWP indicated they emailed the Milestones Trust head office, inviting them to the discharge CPA the day before discharge, which Richard's Milestones Trust support workers did not receive.

3.1.103 Milestones Trust should have been informed of Richard's progress and permitted to participate in the CPA. The panel agreed that notifying them one day before his discharge was unreasonable.

3.1.104 Richard was discharged to receive care and support from the crisis team and his CCO in the community.

3.1.105 The records did not indicate that Richard received the discharge letter AWP sent to his GP.

3.1.106 The transition from hospital to community care is a high-risk period, particularly during the first two weeks after discharge. Deaths were associated with admissions lasting less than seven days, the absence of a discharge care plan, and adverse life events, suggesting that some patients return to the stresses that necessitate hospitalisation.[61]

3.1.107 AWP recognises this and highlights it in the discharge procedure: "All patients must be followed up by a community team within 72 hours *of discharge."*

[61] https://documents.manchester.ac.uk/display.aspx?DocID=37580

3.1.108 Richard received a home visit from his CCO on the day after discharge. The conversation focused on medication, accommodation, family support, Milestones Trust support, previous employment, and benefits.

3.1.109 The CCO also discussed the role of the Recovery Team, the plan for review with the team doctor, the future frequency of visits, and that Richard could call the duty number for extra support.

Bristol City Council Adult Social Care

3.1.110 Richard's discharge from the ward was the subject of Section 42(2) enquiry; please refer to Appendix II.

KL0E 8: Did ASC receive a request to conduct a carer assessment? If so, was this conducted in adherence to the legislation, and what was the result? If not, what measures would ASC anticipate to ensure compliance with the carer's assessment?

3.1.111 Section 10 of the Care Act (2014) states that anyone over eighteen caring for a disabled, ill, or elderly adult has the right to a carer's assessment. These assessments should assess the carers' mental and physical health, capacity, willingness to provide care, and interpersonal relationships.

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3.1.112 The CPA did not specify whether Elaine, Pete, or Jackie were Richard's carers. The consultant's *'impression'* perceived that family support was essential to facilitate Richard's recovery in the community. Consequently, it was necessary to consider whether they would require support and to offer a carer assessment.

Bristol City Council Adult Social Care

3.1.113 A carer's assessment was not conducted. The support plan identified Richard's mum as a key source of support in addressing his decisions and concerns. As a result, the chair would expect ASC to consider whether she would benefit from a carer assessment.

KL0E 9: What support was provided by AWP to Richard's family after they expressed opposition to the discharge, and how did AWP collaborate with them? How is the 'Triangle of Care' implemented in AWP?

3.1.114 The Triangle of Care is a therapeutic alliance between health professionals, service users, and carers. It is designed to foster safety and recovery and maintain mental health by helping and supporting carers[62]. The following are the six primary standards:

[62] https://carers.org/triangle-of-care/the-triangle-of-care

1. Carers and their essential role are identified at first contact or as soon as possible.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available.

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.115 AWP have maintained the Carer's Trust Triangle of Care two-star accreditation.

3.1.116 The accreditations are:[63]

1. **Stage one** is complete. All inpatient and crisis teams have been assessed, and the provider is committed to improving.
2. **Stage two** is complete. All community services have been assessed, and the provider remains committed to improvement.
3. **Stage three**, for integrated providers, is complete. All physical health services have been assessed, and the provider remains committed to improving.

How did AWP collaborate with the family?

3.1.117 The ward staff contacted Jackie on 06.01.24 to inquire about Richard's typical presentation. She informed the staff that Richard was not a good talker, did not initiate conversations, and could only concentrate if engaged. She stated that he drifted off if he was not feeling well and responded with either a yes or no. She stated that he did not have confidence in individuals outside his family.

3.1.118 As discussed in KLOE 2 and reinforced by Jackie, AWP's awareness of Richard's interests may have facilitated discussions with Richard to establish engagement.

3.1.119 Elaine and Jackie contacted the ward on 16.01.24, expressing concern that Richard had declined to share information with Elaine. Jackie also requested that Richard be transferred to Bristol Inpatients so that he could be closer to his family.

3.1.120 The panel were unable to confirm whether AWP had explored the request.

3.1.121 Elaine attended the ward round five days before Richard's discharge (per KLOE 7). She was provided with a ward-round update of Richard's current presentation. Richard was no longer suicidal; the voice was subdued, and the voice

[63] https://carers.org/downloads/triangle-of-care-an-overview---web.pdf

was no longer being 'nasty' or directing him to do things. Richard had expressed his wish to secure employment.

3.1.122 Elaine acknowledged the challenges of Richard being in an acute ward environment and away from his support network. Following the discussion, Elaine stated that Richard might benefit from support from Bristol Community Rehabilitation.

3.1.123 Nevertheless, AWP stated that they did not believe that rehabilitation was necessary due to the support they received from Milestones Trust and their residence in supported accommodation.

3.1.124 The panel could not establish why Elaine's request for a discharge support plan and increased community support was not discussed with Richard or explored with ASC or Milestones Trust.

3.1.32 Families play a crucial role in mental illness treatment. Families may be expected to provide care for patients with mental illness. Family involvement in patients with mental illness may result in better patient outcomes, including fewer relapses, longer intervals between relapses, fewer hospital admissions, shorter inpatient stays, and increased medication and treatment plan compliance.[64]

3.1.125 It is imperative to ensure that families are heard and their perspectives and viewpoints are acknowledged. Additionally, they should receive copies of the crisis and contingency plans and information on supporting themselves and their loved ones in the community.

3.1.126 Elaine and Pete participated in the discharge CPA; however, AWP did not document their contributions.

3.1.127 Elaine and Jackie composed a letter requesting clarification on the extent of support Richard would receive following discharge. This CPA meeting partially addressed this but could have been more comprehensive. The ward staff received the letter following the meeting, but the ward manager could not locate it.

3.1.128 AWP report staff implement the Triangle of Care' by:

Valuing a family's experience and knowledge about their relative to support services in providing the best care possible.	1. The family participated in the CPA meeting. 2. AWP did not record the family's input at the CPA meeting. 3. AWP was unable to locate the family's letter. 4. AWP did not record a discussion with Richard or contact BCC to discuss the increased community support. 5. No discharge letter was recorded and sent to Richard.

[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8801858/

Contacting the family involved and promoting them as integral partners in their relative's care.	○	Jackie was contacted soon after Richard's admission to allow AWP to understand his typical presentation.
Advising the family on what to do in a crisis.	○	There is no record suggesting this occurred, and AWP confirmed there was no up-to-date risk assessment or crisis contingency plan.
Advising the family to seek the support they need through carer's assessments.	○	Not completed.

Bristol City Council Section 42(2) Enquiry

3.1.129 Elaine discussed her experiences with AWP's care and treatment for Richard.

1. In Elaine's previous experiences, the family was informed of what happened when Richard was detained under the MHA. This contrasted with the admission in December 2023. Elaine reported there was little contact with the ward, and when the family called the ward, there was either no answer or they were advised someone would call them back, which did not occur.
2. On the morning Richard was discharged, the OT called Elaine to tell her he would be coming home. Elaine felt it was too soon. A meeting was held via teams, but it was felt that Richard should return home as he was "not doing well" in the hospital environment. He was spending all his time in his room and only coming out for food left out in the evening—he stated this was because this was the food he preferred.

KL0E 10: In what manner did the AWP and Milestones Trust assess Richard's capacity to consent to treatment/visits and discharge from the AWP mental health unit? Were the assessments shared? How did this impact the care Richard received?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.130 AWP determined that Richard could consent to treatment and voluntary admission to the ward (KLOE 7).

3.1.131 A discharge letter was sent exclusively to Richard's GP.

Milestones Trust

3.1.132 Milestones received an email from the CCO one day before the discharge; however, it was not addressed to the appropriate team. The email indicated that the CCO wished to discuss Richard, who had been admitted to the ward. The email stated that he was nearly ready for discharge, and the CCO wanted to discuss post-discharge care. The email confirmed that a discharge meeting was scheduled for the following day.

Risk

3.1.133 In December 2023, Richard was detained under the MHA due to concerns regarding self-neglect, low mood, and command hallucinations that instructed him to kill himself.

KL0E 11: Were agency assessments and decisions conducted appropriately and promptly? Were factors such as mental health risk to self and loss of employment assessed, and if so, what were the care plans to address these?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.134 The ward team documented the circumstances surrounding Richard's need for detention. However, such circumstances remained at discharge; Richard lost his job and routine. The ward OT unsuccessfully engaged Richard in discussions concerning employment.

3.1.135 Documents from AWP disclosed that most of Richard's time in the ward was spent in his room. Jackie disclosed that Richard was not particularly talkative and only engaged with individuals already acquainted with him.

3.1.136 Therefore, it would be difficult for the ward staff to assess Richard's mental health and risk comprehensively. This intensifies the necessity of involving family and Milestones support workers in risk assessments.

3.1.137 AWP's last contact with Richard was his CCO's request for a re-referral to the crisis team. The CCO was instructed to review Richard the following day and re-refer him if necessary.

3.1.138 The panel was unable to understand the necessity of a reassessment. The AWP panellist was asked to follow up on this. However, an update was not received.

Milestones Trust

3.1.139 Richard was well-known to his Milestones support workers. They indicated that Richard maintained a consistent routine for an extended period. His weeks were meticulously organised: three days at work, two weekday visits from Milestones, a Saturday shopping trip with his mum, with Sunday being his day off.

3.1.140 Richard's support workers observed the impact of his job loss on him. Additionally, he encountered complications with his car during that period, so he could not accompany his mum shopping.

KL0E 12: What tools are available to practitioners to identify and support those at risk of self-harm and experiencing command hallucinations?

3.1.141 Risk assessment and management are essential components of clinical practice in mental health services. Consequently, mental health professionals are expected to possess risk assessment, formulation, and management expertise. Nevertheless, the tools employed to assess risk may differ among mental health services; as a result, staff members must receive training on the specific tools used in their clinical area.

3.1.142 The NICE Guidance for Self-Harm: Assessment, Management, and Prevention of Recurrence[65] emphasises fifteen recommendations, one of which stresses involving family members and carers.

"Be aware that even if the person has not consented to involve their family or carers in their care, family members or carers can still provide information about the person."

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.143 AWP uses a "safety assessment" developed in collaboration with staff, stakeholders, and individuals who have had such experiences.[66] This assessment was made after Richard's death.

3.1.144 AWP uses a patient electronic record to record risk. However, this was last updated in May 2018.

Milestones Trust

3.1.145 In situations where Milestones Trust provides minimal support to individuals, it identifies potential risks and communicates them to external agencies to assist them in managing them.

3.1.146 Richard had a support plan. Staff members are expected to address any concerns, as they have received training in Mental Health approaches.

3.1.147 Post-discharge, the team contacted AWP to express concerns and escalate to Richard's care team.

3.1.148 The support worker contacted AWP four days before Richard died. AWP reported that they had visited Richard and that he was "still alive". The support worker expressed concern regarding Richard's behaviour, as he was not communicating with them, ignoring texts and cutting off communications. They expressed concern regarding his discharge from the ward and clarified that this was not his typical behaviour.

[65] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations
[66] https://www.awp.nhs.uk/about-us/news/stories/celebration-good-work-safety-assessment-project-team

3.1.149 The support worker was told the CCO had arranged a visit with Richard the day before Richard died.

KL0E 13: Did practitioners consider multi-agency decisions and take these into account?

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.150 AWP OT contacted Milestones Trust by phone and discussed the support Richard would receive after discharge, which was confirmed to be four hours weekly.

Milestones Trust

3.1.151 Richard was well-known to the Milestones support workers and had worked with the staff for twelve years. However, the Milestones support workers were not consulted during Richard's hospital admission, discharge, or return home. Elaine notified them of his discharge.

3.1.152 At his discharge, Milestones Trust were uncertain about the appropriate method and location to address their concerns as they were not provided with these details.

4.1 Conclusions

4.1.1 The purpose of the review is to understand *What insights agencies can learn regarding support for individuals experiencing an acute mental health crisis*.

4.1.2 Between 2018 and 2023, Richard maintained his mental health with the support of his family, Milestones Trust, and his routine.

4.1.3 In December 2023, one week before his admission to AWP, he lost his employment and was unable to drive due to issues with his car, which disrupted his routine and prevented him from taking his medication.

4.1.4 The auditory hallucinations were becoming increasingly intense, which directed him to end his life and exacerbated his depression. Additionally, he was observed to exhibit inadequate self-care. He was detained under the MHA and admitted to AWP.

4.1.5 His admission was approximately thirty miles from his home and family, which made it challenging for them to visit him regularly.

4.1.6 Richard had identified the causes of his mental health decline and voiced concerns about a recurrence should he be discharged. Richard was noted to be a private individual and did not engage with others; the focus of his admission was medication, which had been increased, although, at discharge, the medication did not reflect the change.

4.1.7 Richard had worked with Milestones' support workers for twelve years. Nevertheless, they were not notified in advance to participate in the discharge meeting nor asked to provide any information to aid in Richard's recovery at home during his admission.

4.1.8 Richard did not receive a risk assessment from AWP, and there was no crisis or contingency plan. His family was not provided with a carer's assessment, and BCC was not informed of the family's request to increase the community support package.

4.1.9 It was evident that Richard's situation on discharge had not changed, and the routine that had kept him well was absent. Despite the knowledge of additional professionals, the review revealed single agency working by AWP.

4.1.10 To support further understanding of safeguarding, the six principles of safeguarding adults[67] were considered

Empowerment:	Richard had voiced his concerns about his discharge, worried he might return to his pre-admission state.
Prevention:	The learning gained will be applied to prevent future harm to others.
Proportionality:	Richard was discharged from AWP to the least restrictive environment with the support of the crisis team.
Protection:	The learning gained will be used to keep others safe.
Partnership:	Agencies had not worked together to support collaborative work.
Accountability:	Transparency and accountability are crucial for safeguarding procedures. The review has proposed recommendations to improve safeguarding responses.

5.1 Recommendations for the Safeguarding Adult Board

Recommendation One: Strengthening Discharge Planning

Avon and Wiltshire Mental Health Trust Partnership NHS Trust

1.1 Develop a structured multi-agency discharge plan incorporating input from relevant agencies, family, and friends (where appropriate) and include a crisis and contingency plan. The plan should specifically address the needs of individuals at risk of deterioration.

1.2 Develop and implement a post-discharge monitoring system that clearly outlines the roles and responsibilities of involved agencies to prevent relapse.

Recommendation Two: Enhancing Multi-Agency Collaboration

Avon and Wiltshire Mental Health Trust Partnership NHS Trust, Bristol City Council, and Milestones Trust

[67] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

2.1 Establish explicit protocols for collaborative work among ASC, AWP, and Milestones Trust.
2.2 During scheduled reviews, all key stakeholders should be invited to enhance decision-making and facilitate the exchange of information.

Recommendation Three: Enhancing Knowledge and Understanding of Mental Health Crisis Support

Milestones Trust

3.1 To provide staff members training on the duties and responsibilities of Mental Health and Adult Social Care, safeguarding, and mental health crisis intervention.

Avon and Wiltshire Mental Health Trust Partnership NHS Trust and Milestones Trust

3.2 Establish a unified protocol or handbook outlining AWP's mental health crisis support referral pathways, limitations, and responsibilities.

Recommendation Four: Embedding Learning from the Review

Avon and Wiltshire Mental Health Trust Partnership NHS Trust, Bristol City Council, GP Practice and Milestones Trust

4.1 To ensure that the lessons acquired from the review are incorporated into policy and practice through ongoing training and supervision to reflect on cases and discuss best practices in safeguarding.
4.2 Establish a feedback cycle to ensure that recommendations result in measurable improvements.

Appendix I

Action Plan

Recommendation One: Strengthening Discharge Planning				
1.1	**Develop a structured multi-agency discharge plan incorporating input from relevant agencies, family, and friends (where appropriate) and include a crisis and contingency plan. The plan should specifically address the needs of individuals at risk of deterioration.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	AWP is in the process of moving away from CPA and embedding a new framework to ensure that patients receive the support and safety they need. Your Team—Your Conversation—Your Plan is the simple, flexible framework that has been co-designed and implemented across BNSSG. It aims to ensure that care and support are co-produced and collaborative and that system-wide service delivery is seamless and centred on assisting people to achieve the outcomes that are important to them. Safety planning is key in ensuring that contingencies are in place for the most vulnerable individuals. There are weekly Clinically Ready for Discharge meetings, which are multi-professional and agency-led, including BCC, to ensure all individuals' needs are highlighted and actioned prior to discharge. Monthly assurance meetings monitor compliance with quality and safety KPI's including records management which reviews the inclusion of safety planning.	Monthly records, audit data review.	March 2025	North Somerset and South Glos have embedded Your Team, Your Conversation, Your Plan into practice. Bristol localities have introduced them across all services and are monitoring compliance through local governance structures. Completed 31st March 2025.
1.2	**Develop and implement a post-discharge monitoring system that clearly outlines the roles and responsibilities of involved agencies to prevent relapse.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	There are systems in place to support post-discharge monitoring.	Review current systems in place to	March 2025	Bristol locality has introduced Your Team, Your Care, Your Plan across all

	The Crisis team first follows up on all individuals discharged from the hospital to ensure initial support. The support required and duration of support are a collaborative process between the individual and the allocated teams involved, which may include housing, social care, and third-sector support if the individual is involved in care. All individuals discharged from the hospital are allocated a Keyworker under Your Team, Your Care, Your Plan. The Keyworker will ensure that safety planning and a Personal Wellbeing Plan are in place to ensure appropriate support and monitoring of mental wellbeing and potential relapse is in place. The Transfer of Care hub leads daily monitoring of clinical need and demand. This multi-agency meeting identifies priorities for support and assessment of patient flow within inpatient and community settings.	monitor post-discharge care.		services and is monitoring compliance through local governance structures. Completed 31st March 2025.

Recommendation Two: Enhancing Multi-Agency Collaboration				
2.1	**Establish explicit protocols for collaborative work among ASC, AWP, and Milestones Trust.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	The Clinically Ready for Discharge meeting identifies all required agencies involved in an individual's care to support discharge. Actions and responsibilities are recorded to ensure progress is made in a safe and therapeutic manner, with the individual at the heart of the plan. Discharge planning meetings are in place to ensure that all agencies, families, and individuals have the opportunity to collaborate.	CPA policy updated Your Team, Your Care, Your Plan Policy introduced	March 2025	The Trust CPA policy has been updated to reflect changes in practice to support Your Team, Your Care, Your Plan Policy. Bristol locality has introduced Your Team, Your Care, Your Plan across all services and monitoring compliance through local

				governance structures. Completed 31st March 2025.
BCC/	BCC ASC will ensure that collaborative partnership expectations are made clear through the development of the Multi-agency Safeguarding Hub (MASH) Standard Operating Procedure, with clear escalation routes identified in support of this. This will be guidance for all partners, including AWP and voluntary sector agencies.	MASH SOP is already in draft version.	31.05.2025	
Milestones Trust/	Milestones has established an internal Protocol for teams to follow if a person we support is admitted to the hospital. This has been shared with teams. (Protocol attached to plan) Key point from this protocol is that Milestones must be involved in discharge planning, and managers are responsible for contacting wards to ensure this happens. Milestones information sharing officer Sophie Reed will engage with the appropriate person in AWP to develop a Protocol regarding information sharing. (currently awaiting named person to move this forward)	That an AWP contact name is given for us to liaise with	Ongoing	Update 4.8.25 Milestones have not yet received details of a name and continue to have issues in relation to appropriate information sharing We want to request that an AWP point of contact is identified .
2.2	**During scheduled reviews, all key stakeholders should be invited to enhance decision-making and facilitate the exchange of information.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	The central principle underpinning the new approach of Your Team, Your Care, Your Plan is that people and their social networks should have the loudest voice in planning their care and support. AWP will adopt a "nothing about you without you" approach, with all care plans being co-produced based on discussions about what matters to a person, what has	Policy updated and shared	March 2025	Your Team, Your Care, Your Plan Policy is in place and shared with all teams through local governance and on-going training opportunities.

	happened, their concerns, desired outcomes and strengths, and the resources that might help them achieve these outcomes. AWP will use a "team around the person" approach, working collaboratively with friends, family, carers, and partner agencies. We will understand people in their social context, focus on building relationships, and include others in support conversations where appropriate, proportionate, and helpful.			Bristol locality has introduced Your Team, Your Care, Your Plan across all services and is monitoring compliance through local governance structures. Completed 31st March 2025.
BCC/	As part of the BCC ASC Target Operating Model re-design, clear expectations regarding reviews and partnership working will be included in refreshed review guidance, supported by Key Performance Indicators.	Will form part of the upcoming service re-design.	31.03.2026	
Milestones Trust/	Milestones uses electronic Care planning and support planning processes, which will identify when a review is due / required. Milestones will communicate with external agencies to flag reviews needed and will commit to participating in these.		Ongoing	4.8.25 This is an ongoing task and our electronic system supports us to communicate with external agencies as required.

Recommendation Three: Enhancing Knowledge and Understanding of Mental Health Crisis Support				
3.1	**To provide staff members with training on the duties and responsibilities of mental health and adult social care, as well as safeguarding and mental health crisis intervention.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
Milestones Trust/	Milestones has introduced a compulsory induction day for all our staff working in Mental Health services, this day includes: • looking for soft signs of MH deterioration and escalating this to the correct place	That all new starters and existing staff where appropriate are offered this day.	Ongoing	4.8.25 These induction days now happen monthly and are mandatory for all new starters.

	• Working in a preventative way • What to do in a crisis (how to plan, protocols to follow, how to talk to the police, mental health teams, inc. the crisis team) • Lone working • False Allegations • Self-care (for staff) • Mental capacity and working, with specific reference to Mental Health			
3.2	**To establish a unified protocol or handbook that outlines AWP's mental health crisis support referral pathways, limitations, and responsibilities.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	Crisis Teams work according to a standard operating procedure, which is in place and available to be shared if required.	Action in place	March 2025	Team SOP in place. Completed 31st March 2025
Milestones Trust/	Milestones has implemented an emergency information sheet for people supported by us (attached). This has been discussed with everyone living in the community in their own homes, so people are clear about raising concerns out of hours. Milestones still require definitive information concerning AWP's out-of-hours crisis numbers.	This is to be shared with people at sign-up and reviewed yearly.	Ongoing	Completed (update provided on 19/08) - This action has been completed, all people living in their own homes have this information sheet.

Recommendation Four: Embedding Learning from the Review				
4.1	**To ensure that the lessons acquired from the review are incorporated into policy and practice through ongoing training and supervision, and to reflect on cases and discuss best practices in safeguarding.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	Local governance structures are in place to share learning with all Bristol mental health teams - Event Management Reviews - Patient Safety Reviews - Safety, Effective Oversight Group	Action in place	March 2025	See action details Completed 31st March 2025

	There are divisional and Trust governance structures to support the escalation and cascade of learning and training opportunities. A monthly meeting with AWP safeguarding colleagues to discuss local and Trust issues, learning and information sharing. The Trust Learning Response Group and Patient Safety Review Panel are multi-professional governance frameworks to ensure learning is shared and, where identified, introduced into policy. Safeguarding bulletins are shared where indicated. Monthly training reports are reviewed for all teams through local Assurance monitoring meetings. Team/Ward managers are responsible and accountable for ensuring their team's training is current and escalating where challenges are identified.			
BCC/	A practice tool to support the new quality Assurance Process has already been designed, linked to learning from Safeguarding Adult Reviews. The ASC Quality Assurance framework is under review, and upon re-launch, the supervision tool will be part of the new process.	Will support work already underway in this area, linked to learning from previous statutory reviews.	31.06.2025	
GP Practice/	Learning from reviews is incorporated within Level 3 Safeguarding training that is offered to Primary Care in BNSSG			Already provided and ongoing
Milestones Trust/	Now that the SAR has been completed, Milestones will hold a lessons-learned meeting. This will include key stakeholders within the organisation.	Senior Operations Manager to prepare content to share at the Lessons	By June	In progress - Lessons learned meeting held on 19.6.25 and key points from

	Our information governance officer has shared information related to the SAR review. Proposal to share learning at the annual Caldicott Guardian conference	learned meeting At the end of the conference in May, Sophie will provide feedback.		SAR shared. (Minutes available if required.)
4.2	**To establish a feedback cycle to ensure that recommendations result in measurable improvements.**			
Agency /Lead	**Action**	**Key milestones**	**Target date**	**Completion Date and Outcome**
AWP/	Trust governance structures are in place to ensure sustainability for learning. The Evidence of Improvement Panel is a multi-professional meeting attended by all AWP localities. Trust governance structures are in place to ensure a feedback and escalation cycle at all organisational levels.	Action in place	March 2025	See action details Completed 31st March 2025
BCC/	The ASC Quality Assurance framework for safeguarding includes a new audit process with a clear feedback loop. A learning and development lead is currently being recruited to apply the SAR learning and impact practice.		30.06.2025	
GP Practice/	Learning from this SAR will be shared for review with Primary care in BNSSG.			Once report published
Milestones Trust/	Actions to be reviewed organisationally at 3 months (July and Sept) to review actions above	July 25 review Sept 25 review		Actions reviewed 4.8.25

Appendix II

Section 42(2) Safeguarding Adult Enquiry

Bristol City Council

Safeguarding Adults

Tel: 0117 90 38132
Fax:

Closure of Safeguarding Adults Process

Printed Record Details	
Printed By	TAMMY RICHARDS, Senior Practitioner
Print Date	10-Jan-2025 15:32
Service User	Mr Richard Arkwell, 17-Dec-1970 ■ (Ref: 2005231)
Lead Assessor	TAMMY RICHARDS, Senior Practitioner
Status	Completed
Dates	
Date Requested	15-Jul-2024
Date Started	15-Jul-2024 16:58
Details	
Title	Mr
Surname	Arkwell
Forename	Richard
Preferred Name	
Gender	Male
Marital Status	
Dates	
Actual DOB	17-Dec-1970
Age	53 years ■
Actual DOD	06-Feb-2024
NHS Number	4903176371
NI Number	NW587726C
Key Identifiers	
Person ID	2005231
NHS Number	
NHS Number	490 317 6371
Ni Number	NW587726C
Address	

Primary Address *from* 23-Nov-2016	453 Fishponds Road Fishponds Bristol BS16 3AP
Contact Methods	
Mobile	07506387022
Home	0117 9657164
Accommodation Details	
Type	Detached House Or Bungalow
Other	
Floor	
Tenure	
Lives Alone	
Household Composition	

GP Details	
General Practitioner	GP AT PRACTICE
Contact Methods	
Main telephone	**0117 2354220**
Contact Methods	
Main telephone	**0117 2354220**
Address	FISHPONDS HEALTH CENTRE, BEECHWOOD ROAD, FISHPONDS, BRISTOL, BS16 3TD
Legal	
Legal Representation	
Legal Status	Informal In Patient (18-Jan-2024)
CPA	
Advocacy	
Advocacy Support	
Service User Groups	
Long-Term Support Reason	Not recorded
Short-Term Support Reason	Not recorded
Eligibility	
Learning Disability	
Mental Capacity	
Consideration of mental capacity **not specified**	
Identity	
Religion	

Ethnicity	White British
Nationality	
Language	English *(**Preferred**)*
Current Employment	
Employment Status:	Voluntary (Unpaid)
Position:	Volunteer
Start Date:	12-Apr-2016
Employment Status:	Employed (Paid)
Position:	Gardener
Start Date:	12-Apr-2016
Factors & Risks	
Special Factors	
None	
Risks to the Service User	
None	
Risks from the Service User	
None	
Other Risks	
None	
Allergies	
None	
Date of original Safeguarding Referral:	06-Feb-2024 18:26
Enquiry Start Date:	23-Feb-2024
Enquiry End Date:	07-Oct-2024
Safeguarding/Safety Plan	

Please update the progress of any actions identified during the Enquiry and add any on-going actions:

What are the risks?	What outcomes does the adult want to achieve?	Best Interest Decision (If the person lacks the mental capacity to make the decision)	How can safety be increased? Measures/actions to reduce the risk	Who will do it? Person/Agency responsible and contact details	Timescales	Progress
Inadequate assessment of risks to people's wellbeing on discharge/by community teams may put people at increased risk of harm.	Richard is sadly deceased so cannot tell us		Safeguarding Enquiry	Tammy Richards requested information from AWP and gave terms of reference to them	1st March 2024	Completed but factual evidence only provided- not possible to know if policies and processes followed or learning identified.

There are concerns other patients may be at risk from practices on the ward			Organisational Safeguarding Review	North Somerset LA- Michael French Michael.French@n-somerset.gov.uk	25th June 2024	Completed- wider concerns not substantiated and no further action taken.
AWP may not identify the risks through their own processes and risks to others may continue.			Patient Safety Review	AWP	Provided in May 2024	Completed - no lesson learnt identified either for the ward or the crisis team or care coordinator.
That as the people who knew Richard the best his family might identify additional risks that professionals may not be able to recognise.			Opportunity for them to feed back their views	Tammy Richards	Contact made with Pete Franklyn -brother-in-law in May 2024 and July 2024	Family provided with opportunity to meet to discuss with me, or to choose not to discuss with me as they preferred. No contact received by October. Family will have opportunity to be involved in the SAR that has now been started.
Multiple-agencies were involved in supporting Richard and failure in these agencies working together may place others at risk.			SAR being completed	Commissioned by KBSP Claudine Mignott - Head of Service Panel Member		Feedback on lack of learning identified by AWP provided to Claudine Mignott

Outcomes and Closure	
Safeguarding Concern outcome:	Parts of the Concern were Substantiated
Was this a hate crime?	No
Was this a mate crime?	No
Were there any actions taken to support the management of risk?	Yes
Impact of Safeguarding/Safety Plan:	Risk remains

Closure Checklist	
The Lead Worker should ensure that all of the following actions have been taken before closure, if applicable:	
Has the adult been advised on how and who to contact if there are any further concerns?	No
Referral for assessment and support?	No
All organisations involved in the Enquiry updated and informed?	No
Feedback provided to the referrer?	No

If person alleged to have caused harm is aware of referral, have they been informed of the outcome?	No
Action taken to support other service users?	Yes
Referral to Children's Services?	No
Consideration for a Safeguarding Adults Review?	Yes
Closure Summary	

This could include: your views; views of other professionals; rationale for decision; lessons learnt; did the plan work?; if any providers involved, has anything changed in their processes as a result?	Concerns were raised by Richard's family about the discharge process and subsequent community support provided to him by AWP following him requiring inpatient treatment under the Mental Health Act in December 2023. It is acknowledged this admission was contributed to by his loss of supported employment after the provider decided to make changes that impacted all those who were employed in these roles resulting in redundancies. The loss of part of his support which had helped and maintained his recovery from previous mental ill-health was not considered thoroughly within the discharge planning that took place. Whilst it was discussed with Richard on the ward, it is not clear from information provided by AWP that these conversations were effective. There was no consultation with the commissioners of this care Bristol City Council. Reliance was placed on liaison with the provider of the rest of his support Milestones, but when they flagged the family wanted a referral to the local authority this was not actioned. Richard left the ward having made a partial recovery after a decision was made that the inpatient setting was not of benefit to him. Therefore we can assume that the risks to him were still present on some level; it was hoped he would continue his recovery in the community. The patient safety review by AWP acknowledges that Richard was unlikely to tell people about possible relapse indicators and there was a need to rely on other evidence. His family raised concerns about possible relapse indicators following their interactions to him and his care coordinator was unable to make a full assessment at their last visit. The family were not contacted following this visit which they have expressed may have been a missed opportunity for them to visit him and ensure his safety. Richard sadly died following this visit through self-harm. AWP completed a patient safety review but did not identify lessons learnt. It is my professional opinion that there are lessons to be learnt and this has been fed back to senior managers at BCC to allow a strategic response. It will contribute to the SAR process now underway which will allow actions of all agencies involved to be explored and in a greater depth than this safeguarding enquiry. Recommendations for changes that could lessen risks to others are as follows. (Full response attached as separate document on main page of Safeguarding Enquiry) • Where hospital wards are aware of a changes in a persons care package that has led to admission under the MHA- they need to notify the LA involved at the point of admission and request a review of their support. • Wards to liaise with the commissioners of a person's care to assess if it is sufficient and not the providers of that care. • AWP to devise a process to record communications from families raising concerns such as letters, that allows them to be recorded as part of a person's record and gives families a record that this has been recorded and what actions have been taken. • An assessment of capacity should be completed in cases where the loss of care or support has led to admission and the person has 'declined' any replacement of that support to • ensure they understand the risks of not having that care when discharged from hospital. If the person makes a capacitated decision to leave with less care this should be risk assessed by professionals prior to any hospital discharge. • All capacity assessments must consider executive dysfunction. Past evidence of patterns of harm that have developed must be included in current capacity assessments in terms of understanding, retaining, using and weighing in decision making. • Where a person is taking daily medication and not taking it is a relapse indicator, if the commissioned care/support by AWP is not daily it should be risk assessed how compliance will be monitored. • Review of risk assessments and Crisis plans is necessarily when a person is being discharged having only partially recovered on a ward based environment. • Involving family and notifying them of concerns on community visits should be included as part of a crisis plan / risk assessment and any safety planning (subject to consent or consideration of capacity and best interests if applicable) • The safety plan must consider how "objective evidence" will be sought for people where it is known they will likely not tell people about possible relapse indicators as part of assessments

Form Version (for IT use): 4.9

Making Safeguarding Personal Outcomes

Has consent been given for the closure of the Safeguarding Enquiry?	No

Please give details:	Richard is sadly deceased
Has consent been given to share information with the parties involved?	No
Please give details:	Richard is sadly deceased
Feedback Questions	
Was the adult able to answer the feedback questions?	No
Why was the adult not able to answer the feedback questions?	Deceased
Please record any additional comments from the adult at risk or their representative:	Richard's family were approached following the completion and receipt of the patient safety review and offered the opportunity to discuss. They were unsure if they wished to do this, feeling they may reply directly to AWP and copy me in. I have not been copied in to a reply and respect they did not feel able to meet with me at what has been a distressing time for them. I hope if they can/wish to be involved in the SAR more of their views will be captured through this review.

Attachments (2)

Attachments

Creation Date	Document Date	Category	Type	Status	Editor	Notes	Batch Status
15-Jul-2024 17:00	08-May-2024	Form Attachment	Form Attachment	Completed	TAMMY RICHARDS Safeguarding Adults	Patient Safety review	
15-Jul-2024 17:02	15-May-2024	Form Attachment	Form Attachment	Completed	TAMMY RICHARDS Safeguarding Adults	Letter from AWP to Family	

Acronyms

AMHP	Approved Mental Health Professional
ASC	Adult Social Care
AWP	Avon and Wiltshire Partnership NHS Trust
BCC	Bristol City Council
BRI	Bristol Royal Infirmary
CCO	Care-Coordinator
CPA	Care programme Approach
ICB	Integrated Care Board
IPS	Individual Placement and Support
KBSP	Keeping Bristol Safe Partnership
KLOE	Key Lines of Enquiry
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NBT	North Bristol NHS Trust
OT	Occupational Therapy
PALS	Patient Advice and Liaison Service
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SMART	Specific, Measurable, Achievable, Relevant, and Time-Bound
SWAST	South Western Ambulance Service NHS Foundation Trust
TTA	To Take Away
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust