

Birmingham & Solihull Mental Health NHS Foundation Trust

Mental Health Legislation Group to be held

Report: April – June 2024
Strategic or Regulatory Requirement to which the paper reports – mental health legal updates
Action: This report is for discussion
Claims/PFDs: We have received 2 PFD's since 1 st April 2024 XXXX Section Redacted as it does not relate to PFD XXXX MHA/MCA queries of note/trends: XXXX Section Redacted as it does not relate to PFD XXXX Legislation: XXXX Section Redacted as it does not relate to PFD XXXX Caselaw: <i>XXXX Section Redacted as it does not relate to PFD XXXX</i>
Board Director: XXXX Medical Director

Previously discussed:



PFDs:

The Trust has received two PFD Regulation 28 Reports since 1st April 2024

XXXX

XXXX died by hanging from a tree on 26 September 2023 after absconding from XXXX and climbing over two fences to escape the day before.

When absconding XXXX kicked in two fire doors after becoming agitated on the ward. XXXX had been admitted a few days before from PLT following MHA assessment due to XXXX psychotic depression and increased risk of suicide and was being observed at the time. XXXX had not previously shown any agitation on the ward and XXXX was known to have previously been a kick boxer and consequently was physically very strong. An RCA was carried out which did not identify any care and service delivery problems initially. Following questions from the Coroner relating to information which was shared with the police at the time of absconsion, it became apparent that the police stepped down the missing person report, after attending the ward to gather information, despite the ward repeating to them that XXXX was high risk. Further investigations revealed that the missing person form filled in by the ward was from an out of date policy and staff were not aware of the current policy.

Following a multi day inquest the Coroner issued a PFD stating XXXX concerns as follows;

- (1) XXXX was not reassured BSMHFT staff are handing attending police officers 'appendix C – risk rating' as required by their missing person policy. XXXX was not reassured WMP officers are aware they should be provided with 'appendix C – risk rating'.
- (2) A 'monitoring tool' in the BSMHFT Missing Patient Policy requires routine monitoring to ensure nurses are completing 'appendix A' and 'appendix B', but not 'appendix C – risk rating'. XXXX was told this was under review, however XXXX remained concerned that this is still outstanding 9 months following the death.

- (3) The Coroner was not reassured BSMHFT Clinical Service Managers ('CSMs') are (a) coordinating the attempts to locate high-risk missing patients, and (b) inviting a representative from WMP to attend 'daily appraisal' meetings to discuss the high-risk missing patient's absence as required by their missing patient policy. XXXX was not reassured WMP officers are aware this is the CSM's role and of the expectation of being invited to a 'daily appraisal'.
- (4) The Coroner was not reassured the RCRP 'challenge' process has been effectively communicated to BSMHFT.
- (5) The BSMHFT Missing Person Policy purports to append WMP's missing person process but makes no mention of RCRP. The Coroner was therefore not reassured the BSMHFT Missing Person Policy is therefore accurate and up-to-date.
- (6) RCRP does not require WMP to formally indicate to BSMHFT (i.e. via a form) when the police have taken a different view about the risk category. BSMHFT will often be unaware of the different view taken by the police rendering the 'challenge' process redundant and reducing the chances of the police identifying they have overlooked key information.
- (7) The BSMHFT Missing Patient Policy and RCRP do not require BSMHFT to hand attending constables a copy of the risk assessment, or require attending constables, or later the Locate team, to request a copy of the risk assessment. In the event of a conflict about risk category, requiring attending constables to take early possession of the written risk assessment may lead to the police identifying they have overlooked key information and revisit their own risk category.
- (8) RCRP and APP do not require attending constables to have particular regard to the expertise of mental health clinicians and hesitate or be extra vigilant before rejecting their opinion on risk category. RCRP and APP appear to regard reports from mental health clinicians no differently to those from members of the public, and family and friends of the missing person.

XXXX XXXX

XXXX died due to sodium nitrate/nitrite poisoning. XXXX had not been seen for a few weeks when XXXX was found at home. XXXX had been under the care of the CMHT and had been regularly reviewed up until recently. XXXX had been receiving a depot regularly but did not attend for XXX last depot and attempts were made to contact XXXX. Sadly XXXX was most likely deceased at this time. The police had previously been made aware of suicide kits that XXXX had bought and we heard evidence from them to the actions they took. XXXX had assured them XXXX was using the sodium nitrate for cooking. The Police also had a second contact with XXXX but it was most likely after XXXX had died when they tried to contact. The police did not inform the trust of either contact with XXXX so they were unaware of XXXX history with sodium nitrate. XXXX gave short evidence on the SJR and the findings. He confirmed they were administrative issues.

Initially the Coroner decided to write to the Trust to obtain confirmation around staffing and also that the meeting on Early Warning scores has taken place. However in the interim he changed XXX mind and issued a PFD Regulation 28 Report. The following concerns were raised;

1. XXXX heard evidence that there was a 6-day delay in the Community Mental Health Team making a referral to the Home Treatment Team which was put down "clinical pressures". Upon discussion, these "clinical pressures" related to staffing levels and the evidence was that at the time the team was meant to have 7 clinical members of staff but only had 3. The Coroner was told that matters have improved somewhat and that now there is sufficient staffing levels.
 2. However, it was confirmed that gaps in staffing levels do occur which can have a knock-on effect of causing issues with service delivery and care for patients.
 3. It is not difficult to foresee that inadequate staffing levels will give rise to missed opportunities for patients to be assessed; for interventions to take place; and for treatments to be given - particularly where patients may choose to disengage with services but who do not demonstrate any "red flags" or early warnings, as was the case with XXXX.
 4. As such, the Coroner was concerned about the risk of future deaths occurring if staffing issues arise in the future.
- 2.1The Coroner heard evidence from the Structured Judgment Review that a learning point was identified that early warning signs were not completed to the required expectation or standard.
2. As such, an Action Plan was prepared and a task was agreed that this would be discussed at the Trust Risk and Task Finishing Group to establish clear clinical standards, with the same then being disseminated within the Trust. This was allocated to the Clinical Service Manager for ICCR and was due to be completed by May 2024.
 3. In evidence, it was confirmed that target had been missed due to a meeting being cancelled, but assurance was offered that it would take place in July - after the inquest has concluded.
 4. The Coroner was concerned that if this target is pushed back and/or is not met, for whatever reason, there is a risk that future deaths will occur.

Clinical negligence:

XXXX Section Redacted as it does not relate to PFD XXXX

XXXX Section Redacted as it does not relate to PFD XXXX

Settled matters- April – June

**XXXX Section Redacted as it does not relate to PFD XXXX
Legislation:**

XXXX Section Redacted as it does not relate to PFD XXXX

Caselaw:

**XXXX Section Redacted as it does not relate to PFD XXXX Points
of interest:**

XXXX Section Redacted as it does not relate to PFD XXXX