Northamptonshire
Safeguarding Adults Board

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Safeguarding Adults Review

Teo

Executive Summary

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1. Introduction

1.1 The Care Act 2014, section 44, requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adult Review (SAR) if, in summary, an adult (with needs for care and support) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The purpose of SARs is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

1.2 This review considers the sad circumstances of the death of Teo who died by suicide in October 2020 having been fatally injured on a train line. Teo had mental health needs and had been discharged from psychiatric inpatient care two weeks earlier. The terms of reference for the review, focused on the last two months of Teo's life.

2. Teo and the background to this review

2.1 Teo was a man in his early 20's at the time of his death. Teo lived with his mum in a House of Multiple Occupancy. They had moved to the UK from their home country in 2010, following his Mother and Father's separation.

2.2 Teo had struggled with his parents' separation and began to use cannabis. His mental health problems began when he was 16 years old, and he received support through the Early Intervention in Psychosis Team. Teo was subsequently diagnosed with schizophrenia.

2.3 Teo's father had also had a diagnosis of schizophrenia. Very sadly, in 2019, Teo's father died by suicide. Teo's mental health deteriorated following his father's death and he was admitted to psychiatric hospital. Following his discharge, Teo's care was transferred to the Planned Care and Recovery Team (PCART).

2.4 In September 2020, Teo's mum alerted services that Teo's mental health was deteriorating again. Teo was subsequently detained under the Mental Health Act 1983.[1] As Northamptonshire Healthcare NHS Foundation Trust (NHFT) did not have any acute inpatient beds available, Teo was admitted to an acute bed commissioned by NHFT from St Matthews Healthcare (St Matthews) which was within Northamptonshire.

2.5 Teo made a good response to his inpatient care. NHFT maintained an oversight of Teo's progress through their Bed Management and Liaison Manager, attending the multi-disciplinary meetings and liaising with Teo's PCART Care Coordinator.

2.6 Teo's recovery continued, and he was discharged after three weeks with the following discharge plan:

- Follow up within 48 hours by the NHFT Urgent Cate and Assessment Team (UCAT)
- Continued involvement by PCART Care Coordinator
- Referral for PCART Occupational Therapy
- Discharge with 3 weeks of medication.

[1] Section 2 Mental Health Act 1983. This lasts for up to 28 days for assessment followed by treatment if necessary.

2.7 During his admission, St Matthews had registered Teo with a St Matthews GP, so Teo was also to be re-registered back with his own GP. St Matthews were due to prepare a discharge summary for Teo's GP and PCART.

2.8 The day after his discharge (a Friday), Teo's mum became concerned as Teo had stayed out overnight. She contacted Adult Social Care Customer Contact Centre, St Matthews and PCART. Teo's Care Coordinator responded and advised her they were due to be on annual leave for the following week. The Care Coordinator liaised with UCAT to pass on Teo's mum's concerns, notifying them of their planned leave.

2.9 UCAT visited that weekend as planned for Teo's 48 hour follow up visit. Teo had returned home but his mum remained concerned about his mental health and thought he may be using drugs. Teo did not wish to engage with UCAT. UCAT gave advice to Teo's mum and ended the visit, advising her (incorrectly) that his Care Coordinator would be in touch the following day.

2.10 Over the next few days, Teo's mum remained concerned about his mental health and texted his Care Coordinator. As the Care Coordinator was on leave, the messages were unread.

2.11 Two days later, Teo was seen by a train driver on the side of the train line, just outside the train station. The British Transport Police (BTP) who met with Teo, were concerned about his mental health. They were aware through Teo's mum, that he had schizophrenia and had just been discharged from inpatient care. BTP tried to contact the Northamptonshire Police Street Triage car (staffed by police and a mental health worker) for support, but this was not available as it was engaged in another incident. They took Teo to Kettering General Hospital (KGH).

2.12 BTP handed over information to KGH staff. Teo minimised concerns, saying he had been lost and wanted to return home. He denied feeling suicidal and declined the offer of referral to the mental health liaison team. Teo returned home without further assessment. BTP, completed a notification form to Adult Social Care and Teo's GP, summarising events.

2.13 The next day, Teo's mum phoned his GP to discuss her concerns. Teo assured the GP that he was ok. At this stage, the GP was unaware of the incident the previous night at the train line – the GP did not recall Teo's mum referring to this and they had not yet received the notification from BTP. Teo's GP also had no update about Teo's inpatient stay or the discharge plan. A letter written by Teo's community Consultant giving details of his discharge plan had gone to the St Matthews GP as Teo was still registered there at that time. The following day was a Friday. The GP emailed Teo's Community Psychiatrist to request information about his discharge plan. Later that day, the GP Practice received the notification from BTP about finding Teo on the railway line. The GP Practice added this information into Teo's electronic patient records. This record was also available to PCART.

2.14 Teo's Care Coordinator returned from annual leave the following Monday. They were on a training day but saw the text message that Teo's mum had left on their work phone one week earlier. The Care Coordinator phoned Teo's mum but had not read Teo's clinical records so had no knowledge of what had happened since his discharge. After a brief discussion, they arranged an appointment for a week's time.

2.15 Two days later, Teo's GP Practice received the notification from Adult Social Care regarding BTP finding Teo next to the train line. This was received six days after it had been received by Adult Social Care. The GP Practice Safeguarding Lead reviewed it and sent an electronic 'task' to Teo's Care Coordinator, attaching the notification and asking if the Care Coordinator was intending to follow Teo up. Sadly, this was not viewed by the Care Coordinator before Teo died.

2.16 The next day, Teo's mum was concerned that Teo was hearing voices and appeared to be distracted. He also seemed different – thanking her for always caring for him. Teo's mum phoned PCART later that afternoon. As his Care Coordinator was not available, the team arranged for a call back within 24 – 48 hours and informed Teo's Care Coordinator of the call. Tragically, Teo died that night having been hit by a train, just outside the train station.

3. Summary of analysis and learning points

3.1 Suicide is a major cause of death among people with a diagnosis of schizophrenia.[2] Research has identified factors for increased risk of suicide and made recommendations for safer care.[3]

3.2 Many of those risk factors were relevant to Teo's circumstances. These included:

- Mental Health: diagnosis of schizophrenia; active symptoms; family history of suicide; recent loss; history substance misuse/concern of current substance misuse; history of suicidal thoughts (though no intent)
- Engagement and treatment: recent acute mental health episode; recent discharge from hospital; partial engagement with services; insight into illness; guarded behaviour - potential fear of further deterioration and loss of faith in treatment; non-concordance with medication
- Socio-Economic: isolation; single; limited relationships; unemployment; unstable housing
- Demographics: age; gender
- Risk Behaviours: frequenting location of high suicide risk (train line); missing/absence.

3.3 Whilst research highlights these risk factors, prediction of suicide by people with schizophrenia is known to be complex. Although many people may have multiple risk factors, thankfully most do not go on to die by suicide.[4] Reviews must be cautious to avoid hindsight bias. These risk factors that can now be seen, were not all known, or recognised, by the practitioners who were responding to Teo at that time. Teo also had no known history of depression and when asked, denied any suicidal thoughts.

3.4 The review explored how well practitioners drew together these risks factors and coordinated care to Teo and his mum. The areas of good practice, and areas of learning are summarised in three episodes of pre-admission: inpatient care and discharge.

Pre-admission

3.5 It was good practice that there had been a gradual transition between NSTEP and PCART and that these teams worked together when Teo's mental health began to deteriorate.

3.6 There were regular reviews and updated risk assessments. These identified some risk factors such as past suicidal thoughts, however, the review highlighted the importance of drawing together other risk factors that were known at that time. These included areas such as the recent death of his father by suicide. Research indicates the importance of identifying anniversaries where risks may be heightened.[5]

3.7 NHFT are planning to develop their risk assessment and safety planning frameworks for suicide prevention. Learning from this review should feed into this development work.

Learning Point - Recommendation 1

3.8 Practitioners were constrained by resources, and this was exacerbated by the Covid Pandemic. Teo's assessment under the Mental Health Act 1983 could not be carried out on the day due to a lack of availability of Psychiatrists. Nonetheless, there was evidence of NHFT, the Adult Social Care Approved Mental Health Professionals Service and East Midlands Ambulance Service being responsive to Teo's mum and managing risks effectively at that time.

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[2] Pompili et al: Suicide risk in schizophrenia: learning from the past to change the future. Ann Gen Psychiatry. 2007 Mar 16;6:10. doi: 10.1186/1744-859X-6-10. PMID: 17367524; PMCID: PMC1845151. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1845151/ [Accessed March 2023].

[3] National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report 2023 University of Manchester https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/ [Accessed March 2023].

[4] Simon RI. Imminent suicide: The illusion of short-term prediction. *Suicide Life Threat Behav.* 2006;36:296–301. Cited in Welton RS. The management of suicidality: assessment and intervention. Psychiatry (Edgmont). 2007 May;4(5):24-34. PMID: 20806027; PMCID: PMC2921310. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921310/ [Accessed March 2023].

[5] National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report 2023 University of Manchester https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/ [Accessed March 2023].

3.9 The national shortage of acute mental health beds worsened during the Covid Pandemic.[6] Avoiding out of area admissions is a key element for safer care and NHFT had achieved this through commissioning local beds from St Matthews.[7]

Teo's admission and planning for his discharge

3.10 Teo's admission assessment recognised risk factors for self-harm and suicide, although he denied being at risk. Teo's inpatient care reflected expected treatment for his acute illness, and he responded well.

3.11 Teo's risk assessment was reviewed two days prior to his discharge but this had limited information. Teo's discharge summary did contain important information about his admission, social circumstances including his history of substance misuse and father recently dying by suicide. However, it would have benefitted from a well formulated risk assessment that made explicit the risks on admission, risks on discharge and how these would be addressed within the discharge plan.

Learning Point - Recommendation 1

3.12 There was a delay in St Matthews sending out this discharge summary to PCART and to Teo's GP – PCART had still not received the discharge summary when Teo died. It is unlikely this delay made a substantive difference to Teo's care, but St Matthews acknowledged the delay did not meet required standards due to the pressures of Covid.

3.13 Restrictions due to Covid, also meant that Teo's mum was not permitted to visit him in hospital. Teo's mum felt excluded. St Matthews endeavoured to involve her through phone contact and feed her views into the multi-disciplinary team meetings. They took reasonable steps within the constraints. However, the review noted Teo's mum had not received information about her rights. St Matthews as a detaining authority need to ensure it has robust arrangements in place to provide this information.

Learning Point

3.14 There is limited information about how Teo's mum's needs as a carer were considered within the discharge plan. There is no reference to considering a referral under the Care Act 2014 for a Carer's Assessment by St Matthews, or historically, by NHFT. Considering the needs of carers must be central to care planning and offering a referral for a Carer's Assessment is an important component of this.

Learning Point - Recommendation 2

3.15 St Matthews and NHFT had used the NHFT Bed Management and Liaison Manager as the single point of contact. There was daily communication about Teo's progress, however, direct involvement by the Care Coordinator may have improved communication and facilitated improved support for Teo's mum.

Learning Point - Recommendation 3

3.16 St Matthews' policy of registering with the hospital GP aimed to improve patients' physical health care. However, for Teo, his was a short-term admission and he was already registered with a local GP. The process of de-registering detracted from continuity of care and impacted on the communication in the important days post-discharge. St Matthews has now revised their GP registration criteria.

Learning Point

3.17 Teo's mum's view was that he had been discharged from hospital too quickly in October 2020. However, from the information available, Teo was making a good recovery, his discharge plan did seek to provide effective follow up care and was in line with clinical guidance.[8]

Responses to Teo following discharge

3.18 Practitioners endeavoured to be responsive to Teo's mum's concerns in those early days post discharge. She had been provided with information and contact points for services. However, Teo's mum may have benefited from having a copy of Teo's discharge plan in a user-friendly format, including the plans for support in the Care Coordinator's absence and a contingency and crisis plan. Carers who

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[6] British Medical Association Mental health pressures in England https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis [Accessed March 2023].

[7] National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report 2023 University of Manchester https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/ [Accessed March 2023].

[8] National Institute for Health and Care Excellence; Suicide prevention, Quality standard [QS189]; Psychosis and schizophrenia in adults, Quality standard [QS80]; Transition between inpatient mental health settings and community or care home settings; Quality standard [QS159];. https://www.nice.org.uk/ [Accessed March 2023].

are also Nearest Relatives should also be aware of their rights under the Mental Health Act 1983, to request their relative be assessed under that Act.[9]

Learning Point - Recommendation 2 & 3

3.19 The detail of Teo's discharge plan was also needed by all services involved. It is positive that UCAT were providing a 48-hour post discharge follow up that covered the weekend period. However, the substance of the UCAT 48-hour follow-up visit was limited and the handover of concerns to PCART was not robust. There needed to be greater resilience to cover during the Care Coordinator's leave.

Learning Point - Recommendation 3

3.20 The incident of Teo being found next to the train line was a pivotal event. Visiting a train line can be part of a person's preparation and/or rehearsing the plan, building up courage for a suicide by means of high lethality. It was good practice that the train driver and BTP identified these risks and sought assistance.

3.21 Had the Police Street Triage car been accessible, the mental health practitioner would have had access to Teo's mental health records. This *should* have enabled them to access a well formulated risk assessment from his recent admission and discharge (recommendation 1). When BTP took Teo to KGH, the member of staff did question him about suicidal thoughts which he denied. However, the enquiry needed to extend beyond this, being attuned to other risk factors, demonstrating professional curiosity, and knowing when to involve more specialist services.

Learning Point - Recommendation 4

3.22 There was also learning about the quality of communication within and between agencies that followed this incident. It was good practice for BTP to send notifications to Teo's GP and to Adult Social Care about the train line incident. The response to that notification by Adult Social Care was not timely. Teo's GP Practice also acknowledge they should not have assumed PCART had seen the entry in his records.

Learning Point

3.23 There was also learning for NHFT about the need for resilience to cover a Care Coordinator's leave, and ensuring the Care Coordinator is appraised of any changes in risk on their return.

Learning Point - Recommendation 3

4. Conclusion

4.1 Teo's suicide was a tragedy for him, for his family and for the services that had tried to support him. Teo's mum believes Teo was let down by services in the last months of his life. Learning from her perspective highlights the importance of listening to families and supporting carers. However, reducing risks of suicide for people with schizophrenia is complex, made more challenging during the Covid Pandemic.

4.2 Despite the sad outcome, there were many aspects of Teo's care that did follow clinical guidance and many examples of good practice. The review has also highlighted areas of learning. There was a need to improve the formulation of risk factors associated with suicide. There were missed opportunities to be professionally curious and identify warning signs for suicide.

4.3 The review highlighted the importance of communication between all parties, to ensure effective coordination of care. This is particularly important in the higher risk period following discharge.

4.4 It is not possible to say whether improved risk assessment and communication between services could have averted Teo's suicide. Sadly, there remain unanswered questions. We do not know whether Teo had pre-planned his death or whether his suicide was an impulsive action. We do not know whether he was experiencing psychotic symptoms on the day he died or whether he had been using cannabis. We also do not know whether Teo would have disclosed this information had he been assessed by mental health specialists in the days leading up to his death.

4.5 Risks of suicide cannot be eliminated but they can often be reduced. Learning from Teo's death needs to be used to reduce the risk of suicide for others. This is the aim of the recommendations from this review.

[9] Section 13(4) of the Mental Health Act 1983, puts a duty on the Local Authority if requested by the Nearest Relative, for the AMHP to consider the patient's case with a view to making an application for his admission to hospital.

5. Recommendations

5.1 Since Teo's death agencies involved in his care have already taken steps to address many of the learning points highlighted within this review. The recommendations have taken account of this work.

Recommendations
Recommendation 1: Risk Assessments ***Learning:*** *The review highlighted a need to strengthen the formulation of risk assessments by acknowledging the importance of exploring current and historic suicidal thoughts or behaviours but also identifying other risk factors and warning signs.* **Recommendation** NHFT and St Matthews should use learning from this review in developing their risk assessment and safety planning frameworks (including risk assessments within discharge summaries). The risk assessment should apply clinical guidance including the NCISS Elements for Safer Services Personalised Risk Management, i.e.: Comprehensive management plan based on an assessment of (changing) personal and individualised risks. Conducting risk assessment should emphasise building relationships and gathering good quality information on: (i) The current situation (ii) Past history (iii) Social and economic factors (iv) Significant dates and anniversaries (v) Online experience
Recommendation 2: Carers and family members ***Learning****: The review highlighted the need to identify, involve and support Carers of adults with mental health needs. This included making referrals under the Care Act 2014, for a Carer's Assessment and ensuring carers or other family members are aware of their rights where they are also Nearest Relative.* **Recommendations** 2.1. NHFT and St Matthews should provide assurance to NSAB of the systems and processes in place to identify, involve and support Carers, including referrals for Care Act 2014 Carers' assessments. 2.2. Agencies contributing to this review should provide assurance to NSAB that staff who may be providing frontline response to carers in crisis, are aware of Nearest Relatives' rights under section 13(4) of the Mental Health Act 1983 so to inform Nearest Relatives of their right to request an assessment under those provisions.
Recommendation 3: Communication and Coordination of Care ***Learning****: The review highlighted the importance of effective communication between the different services, the person and their family. There was a need for improved coordination of the discharge plan and risk management plan, including resilient contingency plans during the Care Coordinator's absence. Lack of communication between services, resulted in practitioners being unaware of emerging concerns and warning signs.* **Recommendations** 1.1. NHFT should provide operational guidance for the expected standards of engagement by the service user's Care Coordinator/Keyworker during inpatient admissions. This guidance should define the distinct role of the Care Coordinator/Keyworker, to that of the Bed Management Liaison manager where the admission is to another provider's inpatient service. 1.2. NHFT should ensure Adult Mental Health Community Services has resilient arrangements in place to meet the Care Coordinator's/Keyworker responsibilities during periods of their absence. This should include person-centred contingency plans.
Recommendation 4: Supporting the Workforce in Suicide Prevention ***Learning****: The review identified a need to support practitioners in how they assess, formulate and manage risk in respect of potential suicide.* **Recommendation** NHFT, St Matthews and KGH should use learning from this review in their training and development for staff, specifically recognising the range of risk factors and warning signs for suicide. Training should meet NCISS Elements for Safer Services guidance, i.e. training staff in how to assess, formulate, and manage risk, including training staff in being comfortable asking about suicidal thoughts.

6. Teo's mum wished to make some further contributions to the report

In line with the Local Safeguarding Adult Review (SAR) Protocol, Teo's mum was offered the opportunity to review a paper copy of the overview report prior to publication. Some changes were made to the overview report, noted as an addendum which is included below. Please note that not all information below is included in the executive summary and paragraph numbers match those in the overview report, not this summary.

4.2.28 This paragraph relates to Teo's mum phoning his GP, the day after Teo had been found next to the train line. The GP had spoken to Teo and he had said he was ok. Following the call, Teo's mum had asked Teo why he had not told the GP he was unwell. The report stated that '*Teo apologised and said he did not want to go back into hospital*'. Teo's mum said this is incorrect. The entry should read '*Teo said he wanted to go to hospital. No further contact was made with the GP.'*

6.1.3 Teo's mum questioned the reference in the report to Teo's self-harm as she was not aware of this. The records do note that Teo had no known past incidents of self-harm or attempted suicide. However, Teo had had thoughts of self-harm and suicide. It is important to distinguish between thoughts of self-harm and suicide, and acting on those thoughts. This was described within the report as follows: 6.1.3. '*NHFT records from 2017 noted Teo had a long-standing history of self-harm/suicidal thoughts but with no intent noted or evidence that Teo had acted on these thoughts*.'

6.2.4 Teo's mum's belief was that Teo's father had died from a heart attack, following taking strong medication for a severe headache. It has not been possible to determine whether his death was from suicide or natural causes. However, in relation to learning, the fact that Teo informed St Matthew's that he had died from suicide, would increase his risk factors from suicide and should inform the risk assessments for his care. The recommendations arising from this remain unchanged.

Teo's mum also questioned the reference to how Teo had coped following his father's death. 6.2.4. '*....Teo's father had died the previous year and Teo understandably struggled with this.*' The author acknowledges that although Teo's mental health deteriorated following his father's death, it is not clear whether this was directly attributable to his father's loss. Teo's mother states Teo did not have a relationship with his father.

6.3.10 Teo's mum also has a different view regarding the communication between herself and St Matthew's. The reference in 6.3.10 to her working shifts is incorrect, she recalls always trying to contact St Matthews every day. She spoke with Teo on the phone. Teo's mum also spoke with the ward nurses and wished to speak with the Doctor but believes her messages to the Doctor were not passed on.

The review recognises the importance of involving and supporting carers. St Matthews acknowledged that their ability to involve Teo's mum at that time, was inhibited due to the Covid restrictions and are committed to involving carers in patients' care.

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Sylman Consulting