Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

Teo

Overview Report

Independent Author: Sylvia Manson

Date agreed by NSAB: 5th September 2023

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1. Introduction

1.1 This review considers the sad circumstances of the death of Teo who died in October 2020 having been fatally injured on a train line. The coroner concluded that Teo had died by suicide.

1.2 Teo had mental health needs and had been discharged from psychiatric inpatient care two weeks earlier.

1.3 This Safeguarding Adult Review (SAR) considers the circumstances surrounding his death. The SAR will examine the systems and multi-agency support that surrounded Teo to identify any learning that could improve services to others.

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014, section 44, requires Safeguarding Adults Boards (SABs) to arrange a 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.

2.2 Northamptonshire Safeguarding Adults Board (NSAB) commissioned an independent author to carry out this review. The independent author is Sylvia Manson who is wholly independent of NSAB and its partner agencies.

2.3 The purpose of SARs is '[to] *promote effective learning and improvement action to prevent future deaths or serious harm occurring again.'*[1]

2.4 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[2]. The principles apply to this review as follows:

Empowerment:	Understanding how services worked to involve Teo in his care and treatment; involving those close to Teo in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used in responses to Teo.
Protection:	Considering whether decisions made, and care provided by agencies, was reasonable response to the information and risks known at that time.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Examining adherence to law, policy and practice guidance in delivering services to Teo; accountability and transparency within the learning process.

3. Terms of Reference and Methodology

3.1 Terms of Reference

3.1.1 The SAR will focus on the events surrounding Teo's last episode of care: this is from September 2020 when Teo's relapse in his mental health necessitated a period of inpatient care; through to October 2020 when tragically, Teo died by suicide.

3.1.2 The review's focus is on factors that are directly relevant to the circumstances of Teo's death. The review will examine the responses by services and practitioners to Teo and his Mum, as primary carer, during this period and specifically:

1. Consider how effective assessment of needs and risk were and the quality of care to meet those needs.
2. Evaluate whether responses met the relevant practice guidance, policy and legal framework.

[1] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014 and updated from time to time.*

[2] Ibid

3. Review how effectively agencies communicated and worked together in the care and treatment of Teo.
4. Understand the factors that influenced those responses, including the impact of Covid 19 pandemic and wider systems that aided or presented barriers to care.
5. Highlight good practice.
6. Identify areas of learning and make recommendation to the NSAB to support and improve multi-agency working, systems and practice.

3.2 Methodology

3.2.1 An Independent Author was commissioned by the NSAB in 2021 to compile the review report. Unfortunately, the review could not be finalised and a new Independent Author was appointed in March 2023. This report utilised all the information that had previously been made available throughout the review period.

3.2.2 The methodology applied for this SAR drew together questionnaires from agencies involved relating to their involvement, supplemented by viewing additional relevant documents relating to Teo's care during the scope period. The review also benefitted from the record of the outcome of the Coroner's Inquest and a Serious Incident report completed by Northamptonshire Healthcare NHS Foundation Trust (NHFT) in April 2021.

3.2.3 A learning event with practitioners involved, along with one-to-one interviews, allowed further examination of the emerging issues. A panel was appointed to support the review, comprising of representatives from the agencies involved. These panel members brought additional expertise, scrutiny and challenge to the review.

3.2.4 Understanding the experiences of those receiving support from agencies is central to learning. The independent author is grateful to Teo's mother for her contribution to this SAR. Her views and perspectives are integrated throughout the report.

3.2.5 Teo's mum has requested that his name be used within this review, rather than adopting a pseudonym. NSAB has respected this request. Details of individual practitioners have been anonymised and some information generalised to protect those practitioners' rights to confidentiality.

3.3 Agencies Providing Reports to the Review and Context of Involvement

Agency	Context of Involvement
British Transport Police (BTP)	Assisted Teo in October 2020, when he was found next to a train line and conveyed him to Kettering General Hospital for an assessment.
East Midlands Ambulance Service (EMAS)	Attended Teo in September 2020, following Teo's mum raising concerns about his mental health.
Kettering General Hospital (KGH)	KGH Emergency Department responded to Teo when he was brought in by British Transport Police.
Northamptonshire Healthcare NHS Foundation Trust (NHFT)	Provided mental health services to Teo since 2016: Early Intervention in Psychosis services; Community mental health recovery services and urgent care and assessment. NHFT also commissioned inpatient care from St Matthews Healthcare.
Northamptonshire Integrated Care Board (ICB): General Practice 1 (GP1)	ICB facilitated information and involvement from Teo's GP Practice. GP1 had provided primary care to Teo since 2014, other than short period during his inpatient admission in 2020.
North Northamptonshire Council (NNC) on behalf of Northamptonshire County Council (NCC)	NCC was the Council responsible for Teo's Adult Social Care support at the relevant time. Interactions with Teo were through their Approved Mental Health Professional Service (AMHP) – assessing Teo under the Mental Health Act 1983 in September 2020, and through their Customer Service Centre, who processed the notification about Teo from police. NNC is now responsible for the area in which Teo was living and hosts the AMHP service across the County which also covered West Northamptonshire Council's area.

Agency	Context of Involvement
Northamptonshire Police	Received a Public Protection Notification from British Transport Police and forwarded the information to Adult Social Care, October 2020.
St Matthews Healthcare (St Matthews)	Provided mental health inpatient care to Teo in September – October 2020.

3.4 Structure of the report

3.4.1 The report is structured as follows:

- Section 4: Teo's Background and Key Events
- Section 5: Context: Suicide and People with Schizophrenia
- Section 6: Analysis and Learning:
  - Teo's Risk Factors and Warning Signs for Suicide
  - Pre-Admission
  - Teo's Inpatient Admission and Preparing for Discharge
  - Responses to Teo Following Discharge
- Section 6: Conclusion
- Section 7: Recommendations

4. Teo's Background and Key Events

4.1 Background

4.1.1 Teo was a man in his early 20's at the time of his death. Teo's mum described him as a friendly and caring person who had achieved good grades at school. She recalled how he liked to dance with her and that he would hug her and tell her she was the best mum.

4.1.2 Teo was of White/European heritage. He and his mother and sister had moved to the UK from their home country in **2010**, when Teo was in his early teens. His sister returned to their home country soon after. English was not the family's first language. Teo was fluent in English. Teo's mum spoke English, but communication could be more challenging where more complex content was required. She has expressed that at times she felt she was not listened to because English was not her first language.

4.1.3 Their move to the UK followed the divorce of Teo's parents. Teo's father remained in their home country. Teo's mum reports that Teo struggled to cope with his parents' divorce. He began using cannabis at that time.

4.1.4 Teo began to have mental health problems when he was 16 years old, experiencing paranoia, auditory and visual hallucinations. Teo's GP Practice (GP1) referred him to mental health services. Teo received support through the Early Intervention in Psychosis Team (known as NStep).[3] He engaged well with the service.

4.1.5 Teo was managing to work at that time and was employed in various retail warehouses. His last employment was in 2019 and he was then in receipt of Universal Credit.

4.1.6 Teo and his family were tenants within a House of Multiple Occupation. Teo's mum reported it could be difficult living with others, particularly due to Teo's mental health difficulties. Teo often expressed that he preferred to be outside. He was known to enjoy exploring his local area and tended to disappear for periods of time by going for long walks, sometimes barefoot.

4.1.7 Very sadly, in 2019, Teo's father died by suicide. Teo's father had had a diagnosis of schizophrenia and would talk to Teo about his illness. Teo's own mental health deteriorated following his father's death. His mum described a deterioration in his self-care, such as not showering for months on end.

[3] NStep is a multi-disciplinary team providing a range of mental health interventions for people and their families, experiencing a first episode of psychosis.

4.1.8 Teo was admitted to psychiatric hospital later in **2019.** This was his first admission. Teo remained in hospital on an informal (voluntary) basis for seven weeks. On discharge, Teo continued with support from NStep, with his care being delivered under the Care Programme Approach (CPA).[4] In early **2020**, NStep began the process of transferring Teo's care over to the longer-term, Planned Care and Recovery Team (PCART), where he was assigned a new Care Coordinator. This transfer period lasted approximately four months.

4.1.9 In **2020,** Teo's mum secured their own tenancy. She and Teo planned to move in to the property during October 2020. His mum recalls Teo was looking forward to this move.

4.2 Key Events Within Scope Period: September – October 2020

4.2.1 Unfortunately, in **September 2020**, prior to this house move, Teo's mental health was deteriorating again.

4.2.2 Teo's mum phoned PCART on **8th September 2020** as she was worried about him. She reported that Teo was not showering or caring for himself and was laughing inappropriately. Teo's PCART Care Coordinator was self-isolating due to the Covid Pandemic, so their duty worker spoke with Teo's mum and arranged for the Care Coordinator to visit 2 days later.

4.2.3 When the Care Coordinator visited on **10th September 2020**, they noted signs of deterioration in Teo's mental health. Following discussion with the multi-disciplinary team, the Care Coordinator increased their contacts to weekly visits.

4.2.4 The Care Coordinator carried out a joint visit with Teo's previous Care Coordinator from NStep on **15th September 2020.** They were concerned about Teo's presentation. The Care Coordinator made a referral to the Approved Mental Health Professionals (AMHP) service[5] as they felt he needed urgent assessment under the Mental Health Act 1983 for a hospital admission.

4.2.5 The AMHP began the process of coordinating the assessment. The referral had been received at the end of the day and the Psychiatrists who knew Teo were not available but could be available the following day. The AMHP spoke with Teo's mum that evening and discussed the plan to assess him the next day.

4.2.6 The AMHP explored the potential for an assessment that evening, however Teo was not at home and the on-call Psychiatrist who had not known Teo was not available. The AMHP service alerted the police to the concerns about Teo and obtained an incident reference number. The AMHP service then spoke again with Teo's mum, advising her to contact the police if she was concerned and providing her with the incident reference number.

4.2.7 Teo's mum rang for an ambulance early on the morning of **16th September 2020.** Teo had been up all night and she was worried about this mental health. East Midlands Ambulance Service (EMAS) attended and offered to take Teo to hospital, but he declined. Teo's mum informed them that Teo was due to be seen by the mental health team later that day. The crew left, advising her to call 999 again if she had any further concerns. EMAS notified the AMHP service of their call out.

[4] The Care Programme Approach (CPA) is a package of coordinated care for people with mental health problems. This was in place during the scope period but has now been superseded by the Community Mental Health Framework.
[5] An assessment under the Mental Health Act 1983 requires an AMHP and two Doctors, one of whom must have special experience in the assessment and treatment of mental disorder. The Code of Practice: Mental Health Act 1983 (14.73) requires that where practicable, at least one of the medical recommendations must be provided by a doctor with previous acquaintance with the patient.

4.2.8 The AMHP service and Psychiatrists assessed Teo later that day. Teo was detained under section 2 of the Mental Health Act on **16th September 2020**.[6] Teo was admitted to an acute mental health inpatient bed in a local private provider, St Matthews Healthcare (St Matthews), based within Northamptonshire. This care was commissioned by the local NHS mental health service Northamptonshire Healthcare Foundation Trust (NHFT), due to lack of bed availability within their own acute care wards.

4.2.9 On admission, Teo was assessed by the Associate Specialist Psychiatrist.[7] Teo was also screened for illicit substances and this gave a negative reading. The inpatient team initially used 15-minute level of observation and offered Teo escorted leave from the ward. Teo was also registered with a different GP [GP2], who was linked to St Matthews.

4.2.10 Teo's medications for his mental health were reviewed and increased. He appeared to settle well.

4.2.11 On **1st October 2020**, two weeks after his admission, as Teo remained settled he was offered unescorted leave. Teo used this leave without any incidents occurring. His inpatient Consultant Psychiatrist felt that if his progress could be sustained, Teo could be discharged the following week. St Matthews liaised with the NHFT Bed Management and Liaison Manager to inform them of Teo's progress and to prepare community services for his discharge.

4.2.12 Teo's mum contacted the ward on **5th October 2020** to check how Teo was doing. Staff discussed his progress and the plan to discharge Teo in three days' time. Teo's mum requested that he be given a letter to help him access his benefits. She also raised concerns that Teo was still not attending to his personal care.

4.2.13 Teo's inpatient Consultant Psychiatrist ended his detention under the Mental Health Act 1983 on **6th October 2020**. Teo remained in hospital as an informal (voluntary) patient for a further two days when there was a further multi-disciplinary team (MDT) meeting at St Matthews, to finalise his discharge plan. St Matthews was unable to invite Teo's mum to attend the MDT due to restrictions imposed for the Covid pandemic. Teo's mum's views were fed into the MDT meeting by nursing staff.

4.2.14 The NHFT Bed Management and Liaison Manager was present at this MDT. The outcome from the MDT meeting was that Teo could be discharged home but would need intensive support to consolidate his recovery.

The discharge plan was:

a) Refer Teo to the Urgent Care and Assessment Team (UCAT) for a follow up post-discharge assessment within 48 hours.
b) Teo to be discharged with three weeks of medication for his mental health.
c) Continued involvement of Teo's Care Coordinator from PCART.
d) Community team to refer Teo for Occupational Therapy.
e) Teo to re-register with his GP.
f) St Matthews to prepare a discharge summary for Teo's GP and PCART.

4.2.15 Teo was discharged from hospital on the same day as the MDT (**8th October 2020**), three weeks after his admission. Teo's mum has reported that she had expected to be contacted after the MDT but did not receive a call from St Matthews and was unaware of when Teo was due to be discharged.

4.2.16 When Teo arrived home, he immediately left the house and did not return that night. Teo's mum rang St Matthews the next morning **(9th October 2020)** to say that Teo had not returned home. St Matthews told her that Teo was no longer in their care and advised her to phone the police. St Matthews then contacted the Bed Management and Liaison manager to pass on Teo's mum's concerns and to request they let UCAT and Teo's Care Coordinator know he was missing.

[6] Section 2 of the Mental Health Act 1983 has the purpose of assessment followed by treatment, and can last up to 28 days.

[7] An Associate Specialist Psychiatrist is a senior grade Doctor with at least four years of postgraduate training.

4.2.17 Teo's mum also rang the Care Coordinator. The Care Coordinator was not working for PCART that day but advised her to ring the police. They also offered to speak with UCAT and the duty worker at PCART. This call was on a Friday (**9th October 2020**) and the Care Coordinator informed Teo's mum that they were due to be on annual leave all the following week. The Care Coordinator then rang UCAT to pass on Teo's mum's concerns and to let the team know they were going to be on annual leave the next week. UCAT did not contact the PCART duty worker.

4.2.18 Teo's mum also phoned NCC's Adult Social Care Customer Service Centre (CSC), passing on concerns that Teo had recently been discharged from mental health inpatient care but had left their home and not returned. Teo's mum was advised to contact the police if there concerns that he was missing.

4.2.19 Teo returned home having been away for seventeen hours. Teo's mum recalls he did not appear to understand her when she spoke to him. Although she advised Teo to rest, he left the house once more, coming and going during the day and again did not return home that night.

4.2.20 UCAT phoned Teo's mum the following morning (Saturday **10th October 2020**). Teo's mum confirmed he had returned home that morning, but she remained concerned about him as he would not speak to her. UCAT arranged a visit for that afternoon.

4.2.21 When UCAT attended, they asked to speak to Teo and his mum outside due to the presence of the other people living in the property. Teo said he was ok and was going out to meet friends. He added that he did not need to let anyone know where he was going, including his mum. Teo's mum said she was worried about him, thought he was taking drugs and that other people would hurt him. Teo responded that no one was going to hurt him. When UCAT asked, Teo confirmed that he was not going to hurt himself. UCAT told Teo that his Care Coordinator would be in contact the following day. Teo walked away.

4.2.22 The following day (**11th October 2020**), Teo's mum recalls phoning St Matthews again and that she was advised not to let Teo go out and to stay with him. St Matthews have no record of this conversation as his electronic clinical records were no longer open to them.

4.2.23 The next day (Monday **12th October 2020**) Teo's mum sent two text messages to Teo's Care Coordinator. The Care Coordinator was on the first day of their leave so the text messages were not read nor responded to (see 4.2.17).

4.2.24 Teo's Community Psychiatrist wrote to the GP Practice that he was registered at during his admission [GP2], outlining the plans for Teo's follow up appointment. The same day this letter was sent to GP2, Teo re-registered with his previous GP Practice [GP1].

4.2.25 Two days later, on **14th October 2020**, Teo was seen by a train driver on the side of the train line, just outside the train station. The train driver took Teo to the train station where they were met by British Transport Police (BTP). The BTP officers were concerned about Teo's mental health. They phoned Teo's mum who confirmed that Teo had schizophrenia and had been discharged from inpatient care six days earlier. BTP tried to contact the Northamptonshire Police Street Triage car[8] (staffed by police and a mental health worker) for support, but this was not available as it was engaged in another incident. The officers called for an ambulance but having waited with Teo for two hours, the officers took him to Kettering General Hospital (KGH) Emergency Department (ED).[9]

[8] The Police Street Triage car is staffed by a police officer and a mental health professional to provide specialist mental health skill at initial point of contact for mental health crisis.

[9] The accounts of the communication and transfer process between BTP and KGH differs. This is explored within section 6.3 analysis.

4.2.26 Teo informed KGH that he had been out for a walk in the woods and had got lost and wanted to go home. The KGH ED staff asked Teo if he had any suicidal thoughts which he denied. Teo also declined the offer of referral to the mental health liaison team. KGH advised the BTP officers that they felt Teo was fit and well and could be returned home.

4.2.27 The officers returned Teo back to his home. Teo's mum recalls that she asked the officers to take him to hospital but BTP responded they were unable to do so as he had been seen there already. Teo's mum said she would call his GP that morning to make an appointment for him. The BTP officers then completed a notification form to the Northamptonshire Police Public Protection and Vulnerability Unit which was reviewed and sent on to NCC's Adult Social Care.

4.2.28 Teo's mum phoned GP1 the next day (**15th October 2020**) and told them about what had happened since Teo's discharge (GP1 does not recall Teo's mum mentioning he had been found next to a train line). When GP1 spoke with Teo, he said that he was ok. When GP1 said that his mum was worried about him, Teo responded that *'she is always worried about me*.' GP1 advised Teo's mum that Teo was an adult and not to worry. Teo's mum recalls voicing that Teo did not know what he was doing and was a danger to himself. When the phone call ended, Teo's mum asked Teo why he didn't tell GP1 he was unwell. Teo apologised and said he did not want to go back into hospital.

4.2.29 GP1 sent an urgent email to Teo's Community Psychiatrist the following day (Friday **16th October 2020**), noting that the GP Practice was aware Teo had recently been discharged and requesting a plan of monitoring. This was also uploaded onto Teo's electronic records that NHFT shared. Later that day, GP1's Practice received a communication from BTP. The communication detailed finding Teo on the railway lines two days earlier and that he said he had been going for a walk and lost his bearings. The communication outlined BTP speaking with Teo's mum and that he had been seen by staff at KGH ED who felt he was fit to return home. BTP were referring Teo back to his GP for possible further appointments regarding his mental illness. GP1 added this information into Teo's electronic patient records.

4.2.30 On the same day, CSC received the notification from Northamptonshire Police. The notification contained the same information from the BTP that had been sent to GP1. CSC forwarded the information to GP1 noting that CSC would be taking no further action. This information was not received by GP1 until six days later.

4.2.31 On Monday **19th October 2020**, Teo's Care Coordinator returned from their week of annual leave. 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 with Teo's mum, the Care Coordinator arranged an appointment for a week's time.

4.2.32 On **21st October 2020**, GP1 received the notification from BTP via CSC, that detailed the episode involving Teo being found next to the train line. The Safeguarding lead at GP1's Practice sent a 'task' (electronic communication on the patient record system) to Teo's Care Coordinator asking if the Care Coordinator was intending to follow up with Teo, referencing the BTP notification that was attached.

4.2.33 Teo's mum recalls that on the day of his death **(22nd October 2020),** he appeared to be different – it was still difficult for her to have a conversation with him but Teo was very warm toward her, thanking her for always caring for him. She recalled that Teo was happy that they were due to move house and that he would not have to live anymore in a shared tenancy.

4.2.34 Teo's mum remained concerned that he was hearing voices and looked like he was elsewhere. She phoned PCART late that afternoon and spoke to administrative staff. They arranged for her to have a call back within 24 – 48 hours as part of the team's standard duty response. The administrator later informed Teo's Care Coordinator of Teo's mum's call.

4.2.35 Teo came home later that afternoon (**22nd October 2020**), hugged his mum and told her he loved her before leaving the house again, reportedly to go and meet friends. Teo's mum phoned him during the evening. He seemed to be alone and his mum thought that the friends he had referred to may be voices in his head. Teo's mum got no further responses to her calls to Teo. That night (**22nd October 2020**), BTP phoned Teo's mum to say Teo had been hit by a train, just outside the train station and that sadly, Teo had died.

5. Context: Suicide and People with Schizophrenia

5.1 Every suicide is a tragedy. National analysis of people who die by suicide identifies that, on average, there are over 6,000 such deaths per year.[10] Approximately 27% of those people who died had been in contact with mental health services within 12 months of their suicide.

5.2 Suicide is a major cause of death among people with a diagnosis of schizophrenia, with between 5 - 13% of those people dying by suicide.[11] Research found that factors that are associated with increased risk of suicide include being young, male and with a high level of education and good functioning before their illness. Relationships were also relevant, particularly where the person had experienced recent loss or rejection, family stress or instability, there being a family history of suicide, social isolation and being unmarried.[12] Illness-related risk factors were also important predictors: previous deliberate self-harm, suicide attempts, depressive symptoms, active hallucinations and delusions, as well as the person having insight into their illness, fear of further deterioration and loss of faith in treatment. One nationwide follow-up of individuals discharged from hospital after a first episode of schizophrenia, found that not taking any regular antipsychotic medication was associated with a 37-fold increase in death by suicide.[13]

5.3 Use of alcohol and illicit substances was also a key feature.[14] The National Confidential Inquiry into Suicide and Safety (NCISH) found that over half of people who die by suicide (who are in recent contact with mental health services), have a history of alcohol or drug misuse. However, this is not a straightforward picture with the use of illicit substances potentially leading to the person losing inhibitions against ending life and increase their impulsive actions. The reasons for the person using alcohol and/or illicit substances may be to self-medicate. It may also be due to psychological and social factors such as housing/financial pressures /loss/bereavements which also contribute to suicide risk.

5.4 Specific periods may present higher risks. The NCISH report highlighted that in-patient admission and recent discharge from hospital is a period of high risk – over 25% of people in receipt of mental health services who had died by suicide had been in contact with acute care settings (i.e. inpatient care), post-discharge care or crisis/urgent care. Loss of contact with services was common before a suicide. The highest number of deaths by suicide after discharge from psychiatric in-patient care occurred on day three post-discharge.[15] Places were also noted to be risk factors. The NCISH report in 2019, noted that suicides by methods resulting in multiple injuries (jumping from a height or in front of a train) accounted for over 200 patient deaths per year. Specific locations often become known locally because they are frequently used.

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[10] National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report 2023 University of Manchester [Accessed March 2023].

[11] 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. [Accessed March 2023].

[12] Ibid.

[13] Tiihonen J, Wahlbeck K, Lonnqvist J, et al. (2006) Effectiveness of antipsychotic treatments in a nationwide cohort of 2230 patients in community care after first hospitalisation due to schizophrenia and schizoaffective disorder: Observational follow up study. *Br Med J* 333: 224. Cited in [Accessed March 2023].

[14] Hor K, Taylor M. Suicide and schizophrenia: a systematic review of rates and risk factors. J Psychopharmacol. 2010 Nov;24(4 Suppl):81-90. doi: 10.1177/1359786810385490. PMID: 20923923; PMCID: PMC2951591. [Accessed March 2023].

[15] National Confidential Inquiry into Suicide and Safety in Mental Health; Annual Report 2023 University of Manchester [Accessed March 2023].

5.5 Whilst research highlights these risk factors, prediction of suicide by people with schizophrenia is known to be complex. Clinicians cannot accurately predict patients who will die by suicide.[16] Many patients may have multiple risk factors but do not go on to die by suicide. Nonetheless, clinical guidance recognises the importance of identifying risk factors within care plans and guides on practice that is likely to have greatest success in reducing risk of suicide.

5.6 The National Institute for Health and Social Care Excellence (NICE) sets out clinical guidance including guidance in suicide prevention, managing conditions such as schizophrenia and transitions of care from inpatient services to community services.[17] Public Health England (PHE), provided guidance aimed at reducing access to the means of suicide, specifically in relation to preventing public places being used for suicide and to increase opportunity for last-minute interventions.[18]

5.7 The NCISH has developed a list of key elements for safer care in mental health services, based on their evidence from studies of mental health services, primary care and accident and emergency departments over the last 20 years.[19] The key elements are summarised below:

NCISH: Elements for Safer Services	Descriptor
1. Safer Ward	Remove ligature points; prevent patients leaving the ward without staff agreement; skilled observation, noting increased risk in first week of admission.
2. Early Follow Up on Discharge	Patients discharged from psychiatric in-patient care should be followed-up by the service within 72 hours of discharge. A comprehensive care plan should be in place at the time of discharge and during pre-discharge leave.
3. No Out of Area Admissions	Being admitted locally means that patients stay close to home and have the support of their friends and family as well as being less likely to feel isolated or to experience delayed recovery.
4. 24-hour Crisis Resolution and Home Treatment team	Community services include 24-hour response for crisis and treatment by skilled staff
5. Family Involvement in 'Learning Lessons'	Services should consult with families from first contact with the individual receiving care, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.
6. Guidance on Depression	Services that implemented NICE guidance for depression and self-harm guidelines had significant reductions in suicide rates.
7. Personalised Risk Management	1. 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. 2. Specific training for staff in how to assess, formulate and manage risk, including training staff in being comfortable asking about suicidal thoughts.

[16] 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. [Accessed March 2023].

[17] 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];. [Accessed March 2023].

[18] Public Health England Preventing suicides in public places A practice resource, 2015.

[19] The National Confidential Inquiry into Suicide and Safety in Mental Health Safer services: A toolkit for specialist mental health services and primary care, University of Manchester, Updated 2022.

NCISH: Elements for Safer Services	Descriptor
	3. Effective communication of personalised risk management between different agencies, services and professions involved with the patient, including their family and carers and with primary care.
8. Outreach Teams	An outreach service that provides intensive support to patients who are difficult to engage or who may lose contact with traditional services including patients who don't regularly take their prescribed medication or who are missing their appointments.
9. Low Staff Turnover	Organisations with low turnover of non-medical staff had lower suicide rates.
10. Reducing Alcohol and Drug Misuse	Specialist alcohol and drug services are available within mental health services. Frontline staff have alcohol and drug misuse assessment skills/training in this.
11. Managing Self Harm	Mental health liaison service available offering 24-hour specialist assessment for all self-harm patients. Protocols highlight short-term risk of suicide.

5.8 This NCISH guidance will be used in considering how effectively services responded to Teo.

6. Analysis and Learning

6.1 Teo's Risk Factors and Warning Signs for Suicide

6.1.1 When a tragic event occurs there is a tendency to look back at events and evaluate them based on the knowledge of what the sad outcome was. However, reviews must be cautious to avoid this hindsight bias.

6.1.2 Reviews must seek to understand what information was known at the time and whether reasonable actions were taken in relation to this information. Reviews also need to consider what opportunities there were to draw information together to improve risk assessment and management.

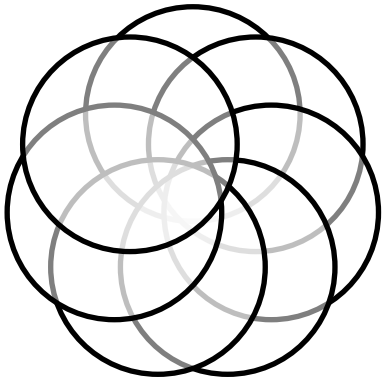
6.1.3 Teo had no known history of depression. His NHFT records from 2017 noted Teo had a long-standing history of self-harm/suicidal thoughts but with no intent noted or evidence that Teo had acted on these thoughts**.** While history is a primary risk factor, as outlined in section 5 above, other risk factors are also relevant.

6.1.4 Figure 1 below depicts the risk factors for suicide that are now known to have been relevant to Teo during the scope period:

a) Some information about risks was known to all the services and practitioners involved.
b) Some information about risks was known only to some services or practitioners.
c) Some information was known to Teo's mum.
d) Some information was known only to Teo - his thoughts, feelings, experiences, and intentions.

6.1.5 Understanding risks required a dynamic process that sought to open up and bring together information that was known by those different parties. While some factors were 'static' i.e. fixed and historical, other risk factors and warning signs only emerged after Teo had been discharged.

Figure 1:



6.1.6 As noted in section 5, the fact that these factors were present does not pre-determine the outcome of suicide – many people may have similar clusters of risk factors but thankfully only a minority of people go on to die by suicide. However, risk factors and warning signs do need to be identified and considered as part of the wider care and treatment plan if risk of suicide is to be reduced.

6.1.7 The following sections consider how effectively services sought to open up, and draw together these factors during the pre-admission, admission and post-discharge episodes of care. The analysis considers how effective the responses were that followed and explores the systems that aided or presented barriers to care.

6.2 Pre-admission

6.2.1 In the period leading up to Teo's admission his care was being transferred from NStep to PCART. Teo and his mum had had a good relationship with NStep. It was good practice that this was a gradual transition period to help Teo and his mum build a therapeutic relationship with his new Care Coordinator.

6.2.2 Those services had carried out regular reviews in line with the CPA and updated Teo's risk assessments and risk management plans. It was positive (albeit expected) practice that Teo had been part of these assessments. The records noted he had agreed with the assessments. The assessment pre-admission identified that Teo had historic thoughts of harm to himself but that he denied any current self-harm/suicidal thoughts.

6.2.3 Whilst historic and current thoughts/intent are primary factors, suicide risk assessments should also endeavour to draw together other risk factors and warning signs, as described within section 5 above.

6.2.4 Teo's wider records did contain information regarding Teo's father's history of schizophrenia and that he would talk to Teo about his illness. We do not know to what extent, if any, Teo's father's experience of schizophrenia influenced Teo's beliefs about the likely course of his own illness. Teo's father had died the previous year and Teo understandably struggled with this. There are no documented records of his Care Coordinators exploring the impact of this loss with him. It is also not clear whether Teo's father's death by suicide was known to them – there was no reference within his risk assessment of heightened risk through recent loss or family death by suicide. Nor was there any specific information about the date of Teo's father's death or of his birthday.

6.2.5 Information about losses, bereavements and known suicide of family/friends, needs to be explored and highlighted within risk assessments, including information about anniversaries that may be a higher risk period for self-harm or suicide.[20]

6.2.6 NHFT's clinical lead for their suicide prevention strategy has been seeking to develop the NHFT risk assessment and safety planning frameworks as well as their standards for suicide prevention, using learning from research such as NCISH reports. Learning from this review should feed into this development work.

Learning Point - Recommendation 1

6.2.7 When Teo's mum raised concerns about his deteriorating mental health in September 2020, there is evidence of mental health services listening to her concerns and being responsive through increased frequency of home visits. Although NStep had formally ended their involvement by this time, it was positive practice that the PCART Care Coordinator arranged a joint visit. This gave the added benefit of a practitioner who knew Teo well, had experience of his relapse and risks, and could advise on the most effective care and treatment.

6.2.8 There was some delay in carrying out the assessment under the Mental Health Act 1983. The Care Coordinator referred Teo to the AMHP Service for an urgent assessment but the assessment was not carried out until the following day. There remains a national challenge in the timeliness of carrying out Mental Health Act assessments, commonly related to the availability of beds, of assessing Doctors and transport if the patient is admitted to hospital.[21]

6.2.9 In Teo's circumstance, the referral to the AMHP service was received late afternoon. The AMHP service gathered information to assess risk, including contacting Teo's mum for more background, as well as ascertaining the current situation. There was nothing in the available information from Teo's mum or from his clinical team to suggest Teo was at imminent risk to himself or others.

6.2.10 The AMHP service explored the potential for carrying out an assessment that evening. However, as Teo was not at home and the Psychiatrist who knew him was not available, it was reasonable to coordinate the assessment for the following day. It was also good practice to alert the police that Teo may come to their attention overnight and to provide Teo's mum with advice and an incident number should she need to ring the police.

6.2.11 The EMAS was also responsive to Teo's mum's concerns about him, offering to take Teo to hospital and assessing his mental capacity for this decision when he declined and liaising with the AMHP service to inform of their involvement.

6.2.12 All of this was good, albeit, expected practice.

6.2.13 When the AMHP made an application for Teo to be detained, NHFT had to source an inpatient bed from St Matthews due to lack of availability for acute care beds within NHFT. Pressures on acute inpatient beds is a national concern and was exacerbated by the Covid 19 Pandemic.[22] NCISH research (reference 5.7. above) has highlighted that avoiding out of area admissions is an important factor in patients' recovery. NHFT had tried to minimise the disruption to patient care by commissioning additional bed capacity from St Matthews, within Northamptonshire.

6.2.14 NHFT had arranged for a clinical Bed Management and Liaison Manager to oversee the coordination of bed availability and progress of patients placed at St Matthews. This single point of contact was an effective means of overseeing care that was being commissioned and managing bed availability. However, this role also extended to being the single point of contact for patient's care planning and liaising with community services. The following section considers the implications of this.

[20] NCISH Elements for Safer Services standard 7 and see 5.7. above.

[21] Community Care February 2023: Unavailability of beds, doctors and transport increasing risks for those in crisis, warn AMHP heads [Accessed March 2023].

[22] British Medical Association Mental health pressures in England [Accessed March 2023].

6.3 Teo's Admission and Planning for his Discharge

6.3.1 On admission, St Matthews received information about Teo from the Mental Health Act assessment. The AMHP report described the concerns about his deteriorating mental health, including his mum's views and that Teo was very guarded in what he disclosed. The report referenced his lack of engagement with his community team and his non-concordance with medication. The report also gave some background about his diagnosis and previous admission including that he had previously misused cannabis. The report outlined Teo's social circumstances, including that his father had had schizophrenia and that he had died the previous year - there was no reference to this death being by suicide. The report noted that Teo's risks were associated with deteriorating mental health, self-neglect, irritability, and hostile behaviours and vulnerability to exploitation by others. The reference to risk of suicide noted that Teo had denied any thoughts of self-harm or suicide. His risk of self-harm or suicide was recorded as 'unknown'. There was no reference to his past thoughts of suicide.

6.3.2 The admitting inpatient Psychiatrist used this information within their assessment of Teo. The Psychiatrist explored Teo's use of cannabis. There had been no concerns raised by community services or Teo's mum that he had been using cannabis prior to admission. Nonetheless, it was good practice to carry out a drug test which showed up as negative.

6.3.3 Teo's inpatient Psychiatrist explored risks of self-harm and suicide, noting Teo had no history of depressive episodes. They had no information about his history of suicidal thoughts. Teo denied any current thoughts of self-harm or suicide. He talked to the admitting inpatient Psychiatrist about his father having died by suicide but appeared to be very dismissive and showed no emotion when talking about this. When the psychiatrist enquired about him appearing aloof, Teo had described his mental state as "*I could sometime feel like smashing my head on the wall but next minute I am OK.*" Due to this distress, the admitting inpatient Psychiatrist concluded that there was risk of self-harm and suicidal behaviour.

6.3.4 Teo's inpatient care appeared to meet requirements in being least restrictive of his rights and freedoms whilst being purposeful, in relation to assessment and treatment.[23] Teo's care reflected expected treatment for his acute illness through review of medication, use of observation and leave, nursing care, alongside offers of psycho-social interventions such as Occupational Therapy and Psychology.[24]

6.3.5 Teo had remained guarded and minimised all his symptoms throughout his admission. As Teo's mental health improved, his risks were reviewed. His risk assessment was updated two days prior to discharge. The relevant section referenced his risks on admission and under '*Risk to Self*' *it noted* '*Yes: History of smoking Cannabis. Currently none identified during his admission*.'

6.3.6 Although Teo's behaviours during the admission had not caused any concerns of suicide, there was no further formulation of suicide risk within his risk assessment. As noted in section 6.2., risk assessments for suicide need to recognise factors over and above history or current suicide thoughts/behaviours.

6.3.7 There was a missed opportunity to draw together other relevant risk factors and warning signs for suicide within his risk assessment. This analysis was also not present within Teo's discharge summary. The discharge summary did reference salient factors, including the circumstances of his admission, and risks at that time, including self-harm and suicide. The discharge summary outlined Teo's social circumstances, family background (including his father dying by suicide), and his history of illicit substance misuse. The report concluded by summarising Teo's progress during the admission and the discharge plan. Whilst this narrative contained useful information, the discharge summary would have benefitted from inclusion of a formulated risk assessment that referenced how risks identified on admission had been addressed, what risks remained, protective factors and how remaining risks should be managed within the discharge plan.

Learning Point - Recommendation 1

[23] Mental Health Act 1983 Code of Practice Guiding Principles [Accessed March 2023].

[24] National Institute for Health and Care Excellence [Accessed March 2023].

6.3.8 There was a delay in St Matthews sending out this discharge summary to Teo's community services and to his GP1. Three weeks after he was discharged (which was after Teo's death) PCART had still not received the discharge summary. PCART had access to Teo's inpatient electronic records and it is unlikely that the lack of this discharge summary would have made a substantive difference in preventing Teo from dying. St Matthews' view was that the pressures of Covid 19 were impacting on their capacity at that time but nonetheless the delay did not meet their required standards. St Matthews has implemented internal measures to improve timeliness of discharge summaries.

Learning Point

6.3.9 St Matthews was also challenged due to Covid, in involving Teo's mum in his care, including in his risk management plan and discharge plan (in line with NCISH standard 5 and 8 referenced in section 5.7. above and NICE guidance.[25]) Teo's mum was a huge part of his life and a main protective factor for him. From her perspective she felt excluded from his inpatient care. The review noted that she had not received information about her rights as Nearest Relative under the Mental Health Act 1983 when Teo was admitted under section 2 of the Mental Health Act 1983.[26] This was an omission and St Matthews as a detaining authority need to ensure it has robust arrangements in place to provide this information.

Learning Point

6.3.10 Due to the restrictions imposed by the Covid 19 pandemic St Matthews was unable to invite Teo's mum to attend the inpatient MDT meetings. Teo's mum spoke English but St Matthews acknowledged that she may have benefitted from support to elaborate on her views. St Matthews was able and willing to access an interpreter for Teo's mum had she wished. However, Teo's mum's working pattern and availability made it difficult for her to commit to times for contact to enable this to happen, often calling the ward late at night. St Matthews reported that staff made many attempts to contact her. On the occasions staff were able to speak with Teo's mum, her views were shared at the MDT and contributed to the discharge planning. For example, referring Teo for community Occupational Therapy was in response to Teo's mum's concerns about his continued poor self-care.

6.3.11 Whilst acknowledging Teo's mum's experience, the evidence is that St Matthews took reasonable steps, available to them at that time, to involve her in Teo's care. St Matthews confirmed that post-Covid, they have been able to return to their usual practice of promoting involvement through attendance at MDTs and the unrestricted visiting for family and friends.

6.3.12 Teo's mum had been a main carer for Teo and would continue to be on his discharge. There is limited information about how her 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 and in fact, there is no evidence throughout Teo's involvement with NHFT mental health services of this. A publication by the Centre for Mental Health reported on the poor implementation of duties under the Care Act 2014 for local authorities to provide carers with assessments, and to support identified needs.[27] 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

6.3.13 There were other challenges in the communication between St Matthews and external services, as relevant to NCISH Elements for Safer Services Personalised Risk Management, '*Effective communication of personalised risk management between different agencies, services and professions involved with the patient, including their family and carers and with primary care'* (section 5.8. above).

[25] National Institute for Health and Care Excellence Transition between inpatient mental health settings and community or care home settings; Quality standard [QS159] 2017 [Accessed March 2023].

[26] Nearest Relative is a specific role providing rights and responsibilities under the Mental Health Act 1983. There is a duty under sec 133, to provide Nearest Relative information about their rights when their relative is detained.

[27] Centre for Mental Health Mental health carers' assessments in policy and practice; Kirsty Matthews, 2017. [Accessed March 2023].

6.3.14 The NHFT Bed Management and Liaison Manager was the single point of contact for St Matthews. This was to oversee bed availability, service users' progress and to communicate with the service user's Community Mental Health Services. There was daily communication between St Matthews and the Bed Manager; the St Matthews' electronic patient records were available to NHFT staff and the Bed Manager kept the Care Coordinator and UCAT informed of Teo's progress and plans for discharge. However, this single point of contact detracted from direct two-way communication between St Matthews and Teo's Care Coordinator. Teo's Care Coordinator did not input to his inpatient risks assessments or discharge plans. NHFT has confirmed that although not explicitly within NHFT policy, it is considered good practice for the Care Co-ordinator to engage with the inpatient team during a patient's stay both at the point of admission and prior to discharge. Covid may have prevented in person visits but direct phone/video platform was available. Involvement by the Care Coordinator may have improved communication and facilitated improved support for Teo's mum.

Learning Point - Recommendation 3

6.3.15 Primary Care are also key players in a patient's discharge plan. St Matthews had a standardised policy to register all patients with the hospital's GP [GP2]. The rationale for this was that St Matthews had an enhanced contract with a GP Practice [GP2] to provide in-reach to the hospital to improve patients' physical health care. People with severe mental illness face greater health inequalities and are less likely to have their physical health needs met.[28] St Matthews' contract for an enhanced GP service [GP2] was an important measure to redress this. However, for Teo his admission was planned to be short term and he was already registered with a GP Practice [GP1] within the County. The process of de-registering from this practice meant that there was a break in continuity of care. As will be raised in the following section, this impacted on the communication in the important days post-discharge.

Learning Point

6.3.16 St Matthews has now revised their GP registration criteria so that for patients on an acute admission, they are registered only on a temporary basis with St Matthews GP [GP2]. For longer term admissions, patients are registered on a permanent basis but re-registered with their local GP prior to the discharge date.

6.3.17 Teo's mum's view was that he had been discharged from hospital too quickly in October 2020. Whilst respecting her viewpoint and having noted the learning points above, the decision to discharge Teo did appear to be well founded. Teo's mental state was markedly improved with no overt psychotic symptoms and he was displaying insight into his mental health care needs. Teo had a high level of support from his mum and when well, a good history of engagement with mental health services. It was reasonable to view that his care could be met within the community. On the day of discharge Teo's risks were explored as part of the MDT review, including exploring any thoughts of self-harm or symptoms for depression and anxiety – Teo disclosed none.

6.3.18 The discharge plan did seek to provide effective follow up care and was in line with clinical guidance:

a) Arrangement for 48 hour follow up by UCAT, rather than standard 72 hour follow up. This was an additional safety measure as St Matthews had not been able to test Teo on overnight leave due to Covid restrictions.
b) Ongoing recovery orientated care and support through PCART.
c) Recommendation for PCART Occupational Therapy to support Teo with his activities of daily living.
d) Teo to re-register with a GP.
e) Teo was discharged with an extra week of medication in case of difficulty in getting registered with the GP.

[28] NHS England Physical Health in Severe Mental Illness (SMI) [Accessed March 2023].

6.4 Responses to Teo Following Discharge

6.4.1 Early on in Teo's discharge warning signs began to emerge:

a) He began spending long periods away from home.
b) His mum was concerned about his mental health - he appeared distracted, pre-occupied and confused.
c) His mum worried that he was using cannabis once more.
d) Teo was showing signs of dis-engaging from community services.

6.4.2 The question is how well those signs were recognised and responded to. In exploring this, the context of Teo's presentation needs to be acknowledged. Teo was known to spend long periods of time away from home. He enjoyed walking in the countryside, possibly due to the pressures of living in a House of Multiple Occupation.

6.4.3 Teo's mum had been very worried about him prior to his admission and understandably wanted to protect him by being with him. However, Teo was a young man in his twenties. It may be expected that he would want independence, particularly after being confined to hospital.

6.4.4 The experience of being detained can impact on an adult's relationship with mental health services. There is no evidence that, at this stage, there were grounds to enforce engagement either under the Mental Health Act 1983 or Mental Capacity Act 2005: Teo had the right to make choices about his care and treatment. Clinicians were reliant on the therapeutic relationship to engage Teo in care and this can take time to rebuild.

6.4.5 The responses by different clinicians in those early days post discharge needs to be considered within this context.

6.4.6 Teo's mum was a main stay of his support and she was worried about him from the day of his discharge. The chronology tracks her contacting multiple services in those first 48 hours after discharge. Teo's Care Coordinator was responsive to Teo's mum, responding to her call although they were not working for PCART that day. It is unfortunate timing that the Care Coordinator was then on leave during the first week after Teo's discharge. The Care Coordinator had informed Teo's mum that they were due to be on leave and previously advised her not to text their work phone.

6.4.7 Teo's mum did have contact points for his Care Coordinator, PCART duty and UCAT as well as for the NHFT Mental Health Hub.[29] However, understanding the role and remit of different services can be difficult for service users and their families. This is made even more challenging when there is a crisis and where English is not their first language. 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 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.[30]

Learning Point - Recommendation 2 & 3

6.4.8 This detail of Teo's discharge plan was also needed by all services involved. NHFT has identified learning about the effectiveness of communication between their community mental health services.

6.4.9 Teo's Care Coordinator had informed UCAT that they were due to be on leave for the following week. It is positive that UCAT were providing a 48-hour post discharge follow up that covered the weekend period. This went beyond the expected standards for transitions of 72 hour follow up.[31] It is less clear what the plan was beyond that visit in the absence of the Care Coordinator. The Care Coordinator had

[29] This is a 24/7 hour phone line with trained staff helping people access the right mental health support.
[30] 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.
[31] National Institute for Health and Care Excellence Transition between inpatient mental health settings and community or care home settings; Quality standard [QS159] 2017 [Accessed March 2023].

omitted to tell their PCART duty system that they were on leave or a personalised contingency plan for when they were away. Given Teo's mum's concerns this was not a sufficiently robust approach.

Learning Point - Recommendation 3

6.4.10 The substance of the UCAT 48-hour follow-up visit was limited. The UCAT practitioners had to speak to Teo and his mum outside the property. UCAT did listen to Teo's mum's concerns about his mental health and that he was using cannabis again. Teo was resistant to their involvement, which made it difficult for UCAT to assess his mental health or explore his current use of alcohol/illicit substances. UCAT did enquire whether Teo had any thoughts of harming himself which he denied. We do not know whether Teo did have any suicidal thoughts at that time. It is important to ask this question to give an individual the opportunity to talk about thoughts of suicide, although a negative response cannot be relied upon. However, Teo had no therapeutic relationship with UCAT, he had recently been detained against his will and did not want to go back into hospital and he had been guarded about his experiences, thoughts and feelings.

6.4.11 The UCAT Countywide Operational Policy sets out requirements for the follow up visit, to review the service user's transition from inpatient care to the community:

a) Within required timeframe.
b) Review mental health and associated risks.
c) Complete safety plan.
d) The person being aware of their care, treatment, and support.
e) If concerns are noted, UCAT will consider further assessment if required.
f) Handover any concerns to the person's team.
g) Liaise closely with family and carers.

6.4.12 Some, but not all these measures were met. Teo was difficult to engage in assessment and UCAT had no authority to prevent Teo walking away. It is likely that had UCAT been more persistent, Teo would have found this overly intrusive and this may have alienated him from any further contact. However, an arrangement for further assessment was needed as was an effective handover to PCART, which did not happen.

6.4.13 UCAT did not arrange a further visit. A miscommunication meant that the UCAT Practitioner was not aware that Teo's Care Coordinator was on leave. Their presumption, and communication to Teo's mum, was that the Care Coordinator would be in contact the following day. Under these circumstances, it is understandable that Teo's mum tried to contact his Care Coordinator (albeit that she had been advised not to leave text messages), but her text messages were left unread.

6.4.14 NHFT recognise this learning and have highlighted the importance of thorough handovers between PCART and UCAT. Learning from this review also indicates a need to ensure there are resilient plans in place when a Care Coordinator is on annual leave.

Learning Point - Recommendation 3

6.4.15 Two days later Teo was found by the train driver at the side of the train lines near to the train station. This was a pivotal event as it was a significant additional layer in Teo's warning signs.

6.4.16 Teo's explanation of getting lost in the woods was plausible but needed to be evaluated using professional scrutiny. Train lines are known locations for suicide. 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. Use of alcohol and/or illicit substances may be used to desensitise and overcome inhibitions. Finding Teo in those circumstances, alongside his other risk factors, needed to be identified as a red flag.

6.4.17 It was good practice by that train driver and then by the BTP to question the significance of finding someone next to a train line, particularly as Teo appeared to them to be experiencing symptoms of mental illness. BTP appropriately sought to gather more information from Teo's mum. They then took the steps available to them to try and get Teo's mental health assessed.

6.4.18 BTP sought to get advice through the Northamptonshire Police Street Triage car. 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). The potential implications of Teo being found next to a train line, alongside his other risk indicators, should have triggered further assessment by mental health clinicians. The NHFT Mental Health Hub could also have provided BTP with access to Teo's electronic records (subject to email request and necessity test), however, this option was not known to BTP. BTP then conveyed Teo to KGH ED.

6.4.19 BTP and KGH have different views about what information was exchanged. The BTP record was that they had informed KGH that Teo had been found next to a train line. The KGH member of staff did not recall BTP informing them of this fact and there was no record of Teo's attendance to refer to. It is not possible to reconcile these different perceptions other than to note that what was said, and what is heard, do not always correlate. The Coroner highlighted the fact that KGH had not referred Teo to the in-house mental health liaison team as a missed opportunity.

6.4.20 It is not possible to say whether assessment by mental health specialists would have identified concerns about Teo's mental health and potential suicidal thinking. Teo had been very guarded and he may not have revealed any more information. However, having knowledge of this additional warning sign, may have triggered increased vigilance, support and review by Teo's mental health services.

6.4.21 Learning surrounding this incident highlights the important role that services such as police and NHS Emergency Departments play for people in mental health distress. Those services are often the first point of contact and play a key role in the gateway to access more specialist care. Those practitioners need to be highly attuned to risk factors and warning signs for suicide. Professionals need to demonstrate professional curiosity where a person's account of their situation doesn't add up, where explanations and behaviours raise professional antennae. Asking the person whether they are planning to harm themselves or end their lives is an important step but is not enough. Professionals need to ask the next question and know when to seek additional expertise.

6.4.22 Demonstrating professional curiosity can be more difficult when practitioners are under pressure. These events occurred during the first year of Covid when public services, including the police and NHS, were still under immense day-to-day pressures, and EDs were trying to triage people at the front entrance to prevent the spread of Covid. Staff need time, support and training to be able to critically evaluate and know when to refer on.

6.4.23 KGH did provide training for staff on mental health, including suicide. KGH also had a mental health triage tool to help staff in their decision making. KGH has already identified learning from Teo's death. They have provided further training in mental health and mental capacity, with plans for additional training. KGH has also developed new Operational Guidance for ED including revising their triage tool and guidelines where patients decline onward referral.

Learning Point - Recommendation 4

6.4.24 The BTP officers demonstrated good practice in their response to Teo. Professionals need to feel confident about constructively challenging the assessment of others, where they remain unconvinced about another practitioner's assessment and/or their planned course of action. Services also need be aware of the right of Nearest Relatives to request a Mental Health Act assessment, so that they can inform families of their rights when a family member appears to be in mental health crisis.

Learning Point - Recommendation 2

6.4.25 There was also learning about the quality of communication within and between agencies that followed this incident. BTP sent a 'Public Protection Notification' through to Northamptonshire Police detailing the events that had occurred. This was reviewed by the Police Public Protection team and forwarded to Adult Social Care CSC and to Teo's GP [GP1]. This was good practice. According to records, the PPN referral was dated 14.10.2020, and was recorded on Northamptonshire County

Council's Carefirst recording system as received on 16.10.2020. The referral was overseen by a principal care manager (PCM) and then shared by the CSC with the GP on 21.10.20.

Learning Point

6.4.26 Up until that point there had been no communication between community mental health services and Teo's GP [GP1]. Teo had only just re-registered with GP1. The letter that Teo's Community Psychiatrist had written to his GP had gone to GP2, where Teo was registered while at St Matthews.

6.4.27 When Teo's mum rang GP1 the day after the train line incident, GP1 had very limited information. Although Teo's mum talked about his behaviours since he had been discharged, GP1 had no recall that she mentioned Teo had been found next to a train line. In these circumstances, it was reasonable that GP1 tried to offer Teo's mum reassurance but then followed this up with an urgent email to Teo's Community Psychiatrist to ask about his care plan. GP1 also uploaded this request onto Teo's electronic record that was shared with NHFT.

6.4.28 GP1 then received the notification from BTP that detailed finding Teo on the train line and that he had not been assessed by mental health services following this. GP1 assumed that PCART would also have also received this notification so did not alert PCART, although did upload the information onto his electronic record. NHFT shared this record but Teo's Care Coordinator was still on annual leave with no-one from PCART was accessing his records and so this information remained unknown. GP1 has recognised learning from this episode around the importance of not assuming other services have received information about patients.

Learning Point

6.4.29 GP1's Practice has also increased the role that their lead GP for Safeguarding takes, including providing additional support to the other GPs in their practice for patients that are open to mental health services.

6.4.30 The final unfortunate incident relating to quality of communication, related to the Care Coordinator's return from leave. The Care Coordinator picked up the texts that Teo's mum had sent a week earlier. Although they were on a training day, the Care Coordinator rang Teo's mum. In this, they were being responsive to Teo's mum. However, as the Care Coordinator had no access at that time to Teo's clinical records, they were unaware of the incidents of the previous week. They were unaware that UCAT had had limited engagement Teo's mum's concerns about his mental health and possible use of cannabis and that he had been found on a train line but not been assessed by mental health services.

6.4.31 The Care Coordinator spoke with Teo's mum but does not recall her raising any significant concerns. They agreed to a home visit the following week.

6.4.32 Two days later GP1 received the notification report from CSC that detailed the concerns from BTP about Teo being found next to the train line, next to the train station. GP1 sent this as a 'task' to Teo's Care Coordinator on their shared electronic record, asking the Care Coordinator to follow up. Very sadly, this was not seen in time for the Care Coordinator to respond.

6.4.33 The following day was the day that Teo died. Teo's mum contacted PCART to raise concerns that Teo was experiencing symptoms of psychosis. Although PCART was organising a response through their duty system, very sadly Teo died that night before he could be seen.

7. Conclusion

7.1 Teo's suicide was a tragedy for him, for his family and for the services that had tried to support him.

7.2 The review has examined how services worked together to support Teo in the last two months of his life. Reducing risks of suicide for people with schizophrenia is complex. Teo's death occurred in the first year of the Covid Pandemic. This added further challenges to the care and treatment provided to Teo during the period the review explored.

7.3 The review has benefitted from understanding Teo's mum's experience of his care. Teo's mum was in a key position to understand his mental health and played an essential role in his care. Teo's mum believes Teo was let down by services in the last months of his life. Learning from her perspective has highlighted the importance of listening to and involving families as well as the need to provide support to carers.

7.4 The review has also considered how well and the extent to which research and guidance was used to guide Teo's care. Despite the sad outcome, there were many aspects of Teo's care that did follow clinical guidance and many examples of good practice. However, the review has also highlighted areas of learning.

7.5 Risk assessment needs to be a structured and dynamic process, that is recorded and accessible to others providing care to the person. In respect of Teo, there was a need to improve the formulation of risk factors associated with suicide. There were missed opportunities to be professionally curious about concerning behaviours, to identify warning signs for suicide and to trigger further assessment.

7.6 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.

7.7 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.

7.8 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.

8. Recommendations

8.1 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.

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 NCISH 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.*

Recommendation

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

3.1. 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.

3.2. 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 NCISH 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.

9. 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 report prior to publication. After reviewing the document she commented on a number of points (see below). The Independent Author has reviewed the information provided, and noted the following:

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.

Sylvia Manson

Date: September 2023

Sylman Consulting

10. Glossary

Abbreviation	Meaning
A & E	Accident and Emergency Department
AMHP	Approved Mental Health Practitioner
BTP	British Transport Police
CSC	Adult Social Care's Customer Service Centre
EMAS	East Midlands Ambulance Service
GP	General Practitioner
KGH	Kettering General Hospital
MDT	Multi-Disciplinary Team
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NHFT	Northamptonshire Healthcare NHS Foundation Trust
NSAB	Northamptonshire Safeguarding Adults Board
N-Step	Psychosis Early Intervention Team
PCART	Planned Care and Recovery Team
UCAT	Urgent Care and Assessment Team

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12. About the Reviewer

The review report was written by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years of experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act 2014 statutory guidance.

Sylvia now works for the Mental Health Tribunal as a Specialist Member, along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.