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7 December 2015

By email to Leicester.coroner@leicester.gov.uk
Mrs L Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Brown

Re: William Abel

Further to your report dated 20 October 2015, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of Mr William Abel. Please be assured that Leicestershire Partnership NHS Trust has taken these matters very seriously and undertaken a review of the circumstances of the case in response to concerns raised. I trust that you will be satisfied that we have taken the appropriate measures to reduce the risk of a similar incident occurring.

The Serious Incident investigation was conducted in the immediate period after William's death. It was signed off by our commissioners in June 2015 and we met with Williams' father on the 24 June 2015 to share with him the results of our investigation.

In the intervening period leading up to the Coroner's inquest, the Triage Car service manager and team manager reviewed the appropriateness of the decisions made on the night in question in terms of completing a Mental Health Act assessment, the clarity defining the responsibility of the police in deciding whether to detain William, the quality of the documentation detailing these decisions and the level of involvement of William's father in the decision making process and his role in William's care.

We offer specific detail as to the recommended protocol change in the responses to the Coroner's concerns below.

The matters of concern raised are as follows. –

1. Mr Abel had a diagnosis of paranoid schizophrenia and he was still under the care of the Mental Health services at the time he was found in the vicinity of the railway lines, expressing suicidal intention. He had missed appointments and there was a history of non-compliance with medication. Staff were available to have conducted a Mental Health Act assessment, on the night he was safely escorted from the railway lines, but this was not done.

The Mental Health nurse considered William's clinical history, his presenting symptoms and situation. This included William contacting his father himself whilst at the Police Station to ask for help and support. The nurse decided that, based on her clinical experience and the information she had about William that a Mental Health Act assessment would not be supported by the Social Care team and so it was not completed. We agree with the inquest findings that this was not the correct decision.

Actions:

The nurse concerned is undergoing a detailed programme of reflective practice led by the service's Senior Matron. This will be fully completed by December 2015.

The protocol for Mental Health Practitioners working with the Triage Car is being revised so that where there are clear indicators which prompt a discussion with a patient about the possibility of an admission to an Acute Hospital and a patient refuses to consider an informal admission, a Mental Health Act Assessment will be considered. If the assessment is not undertaken, the reasons for this decision taken within the context of the patient's presentation and the circumstances of the contact with the services, will be clearly documented. The changes to the protocol have been communicated via email to the Triage Car and Crisis Team via the service and team managers and the final revised protocol will be discussed in both team meetings. The communication exercise was completed during November 2015.

We will undertake an audit to monitor compliance of the revised protocol in December 2015 and report the audit and further actions to be taken in January 2016.

2. Mr Abel was discharged into the care of his father, and inadequate communications were made with the family, as the father was not made aware of the professional concerns regarding a relapse in his mental health, that hospitalisation had been considered and the family was expected to be responsible for his safe keeping. No attempt was made to obtain any family information that could have impacted on the decision to take no further action that night.

We agree with the inquest findings that William's father was not fully aware of our concerns for William's health and documentation detailing this discussion was unsatisfactory. It is vital that if further relevant information is available from patient's families, that this is sought, documented and made part of each individual's assessment and care planning.

Actions:

Family members' presence during an assessment will be documented and we will ensure they are offered the opportunity to give their views, observations and understanding in relation to the crisis and the support required of them by the individual. This information will be documented on the assessment form by the assessing professional and form part of the outcome of assessment.

The Triage Car and Crisis Team have both been reminded of this protocol via their team manager and their team meetings during November 2015.

3. NICE guidelines (Clinical guidance 136) state that health care professionals should discuss whether the patient would like the family to be involved in their care, and to provide them with information to understand the mental health problem and its treatments. This guideline does not appear to have been met in this case.

William telephoned his father himself from the Police Station and asked him to come and support him. However, we note the importance of patient choice in the involvement of their family and have communicated a reminder to our Crisis and Triage Car teams via email and team meetings during November 2015.

Actions:

The service is introducing an outcome of assessment and plan record form to support the routine work of the Triage Car and Crisis Teams, ensuring that all patients come into contact with the Triage Car Mental Health Practitioner team are given key written information clarifying the immediate advice given, and where and how to access help should they need it. This will also be given to a carer, friend or family member if they are present at the assessment and the patient has consented to their involvement. We will implement this change for the Triage Car team by the end of December 2015 and the wider Crisis Team by the end of January 2015.

All the actions described will be monitored through the service's clinical governance arrangements.

We hope this reassures you that we have taken appropriate action in response to the Coroner's findings in respect of individual staff concerned and the systems and processes supporting the Triage Car and Crisis services to provide safe and effective care in order to reduce the risk to our future patients.

Yours sincerely

Dr Peter Miller
Chief Executive