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Our Ref: ASC/SF/SM/5102/21161
Date: 16 December 2015

Leicester City Council

Ms L C Brown
Assistant Coroner, Leicester City and South Leicestershire
Town Hall
Town Hall Square
Leicester, LE1 9BG

Dear Ms Brown,

Re: Barry Thraves

Thank you for your report made 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.

Following receipt of your letter, the Head of Service for Adult Mental Health has met with colleagues within Adult Social Care here at Leicester City Council and has discussed the case and concerns with the Service Manager in Leicestershire Partnership Trust. I am aware that Leicestershire Partnership Trust will be responding separately to you and providing their own feedback to the concerns. Officers within Adult Social Care have considered very carefully the concerns and what lessons there are to be learnt from this case. Please be assured that we have taken this matter very seriously and please find below our responses and action plan in relation to each of your matters of concern.

i) **Psychiatric follow up was planned for 2 months but an appointment was not offered for 4 months; on Barry not attending no action was taken and there was no evidence before the court that any clinical consideration of his risks was undertaken at the time.**

This concern relates to Leicestershire Partnership Trust's involvement with Mr Thraves and I am aware that The Trust will be responding to you on this point.

ii) **Community support did not take place as planned, and the family were not even made aware that this was awaited and Barry was on the list. It was not clear what, if any, information Barry had received apart from a very brief letter of discharge that specifically did not mention the community support.**

Case records show that ward staff Beaumont Ward at the Bradgate Unit referred Mr Thraves to Adult Social Care on 11 November 2014 on his discharge from hospital. This referral was made to Adult Social Care's Single Point of Contact and a duty worker within this team contacted Barry and his sister between 11 and 13 November 2014 as part of the process of gathering information about Mr Thraves's needs. Both Mr Thraves and his sister identified that he needed support to access

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the community and social inclusion options and so it was explained to him that he would be transferred to a Mental Health Team for a full assessment. The case was transferred to the AMH (West) Team on 14 November.

It is most unfortunate that from the date of transfer to a Mental Health Team Mr Thraves had to wait for an assessment, which subsequently resulted in his sister contacting his Social Work Team.

In order to ensure an individual, and any relevant persons, are aware of the process following a referral to Adult Social Care a new process has been developed which will be effective from 1 January 2016. The process shall be triggered where Adult Mental Health identifies that someone will need to wait more than 14 days for an assessment from the point that the case is transferred to the team. Adult Mental Health Teams will write to them explaining that they have been referred for an assessment, that they will be seen as soon as possible but that they should contact the team if anything changes. Any appropriate leaflets about other support services available will be sent out at this point.

The Team Leaders will be responsible for this process and the fact that this letter has been sent out will be recorded within the system. This will ensure that individuals have the contact details for the team who will be dealing with their assessment and so on and understand the process that will be taken.

Having the details in writing will also make it easier for people to share this information with family and carers. Where there is an identified carer whom the person wants involved with their care the team leader will send a copy of that letter to the carer.

In order to ensure all staff are aware and adopt this process and email was sent to the relevant teams, by the Head of Service on 15 December and Team Leaders will discuss this in team meetings so that all workers are aware of the process.

iii) **The expectation of the Local Authority is that appointments should take place within 28 days, but the unit is significantly under-resourced and delays are common and appear to be tolerated, and have been for some time. Earlier timely appointments could assist in identifying and intervening with relapsing patients. This opportunity was lost.**

The Local Authority aims to assess people as soon as possible. There is no longer a national indicator to assess people within 28 days of referral but Adult Social Care works towards these timescales.

Unfortunately at this time the team was under particular pressure due to long term sickness and vacancies, subsequently resulting in individuals waiting a long period of time for assessments. It is most unfortunate that this consequently impacted upon Mr Thraves and also other people awaiting assessment at that time. Fortunately, the staffing situation has now improved, vacancies are filled, and waiting times for assessment have reduced.

At times when Team Leaders are unable to allocate cases to workers immediately, Team Leaders are responsible for prioritising and reprioritising cases awaiting allocation.

This is done on a weekly basis, checking the cases requiring allocation and the caseloads of workers within the team to identify people who can pick up new cases. When a Team Leader is off work this responsibility is picked up by the covering manager, and there will always be a covering manager.

In accordance with new processes, from 1 January 2016, anyone awaiting allocation will be contacted fortnightly by phone to check whether anything has changed and if the case needs re-prioritising. Team Support Workers within each team will undertake this task and report back to the Team Leader, who can then reprioritise cases as required. This process has been implemented via email from the Head of Service to Team Leaders on 15 December 2015 and will be followed up by conversations in team meetings.

Adult Social Care is currently restructuring and establishing an Enablement Service to work alongside the Adult Mental Health Social Work Teams. This service is designed to be in place for 1 April 2016 and will offer adults with mental health problems practical support from the point of referral so that no one should have to wait for an assessment.

iv) **Communication between the community mental health team and other stakeholders was poor, with important information that had been identified (that Barry was depressed and not compliant with his medication) not being shared with the GP, nor were the GP or psychiatric team aware that Barry was not receiving any community support.**

It is noted that the AMHP's report to the Coroner identifies that the psychiatrists and AMHP assessing Mr Thraves were aware that he was not compliant with his medication. It is acknowledged that it should be standard practice for information to be shared with relevant professionals, such as the GP. In order to ensure this takes place in practice the Head of Service has e-mailed all AMHPs on 15 December 2015 to remind them of the importance of feeding back to GPs following an assessment under the Mental Health Act, where the GP was not part of that assessment. In order to reinforce this practice a specific process to be followed has been implemented which requires the AMHP to provide information by telephone no later than the following working day after the assessment, and for such feedback to be subsequently provided in writing, via letter, outlining any relevant information within two days.

Social workers across Adult Mental Health have been reminded of the importance of feeding back to the whole multi-disciplinary team and to carers, not solely the Registered Medical Officer.

v) **Information was not made readily available for either Barry, or the family who were trying to support him, of who was involved in his care, the extent of their role and who to contact to discuss this further or in the case of any deterioration or change in presentation. This made the task of the supportive sister considerably more onerous and difficult and introduced unnecessary further delays in obtaining support for Barry at a time when his mental health was deteriorating and he was in need of urgent review.**

The process identified at point ii above, specifically the letters that will be sent to anyone who has to wait for an assessment from an Adult Mental Health Team, will explain Adult Social Care's role and how to contact the team should the situation change. As detailed above, having this information in writing will enable individuals to share this with family and carers.

Officers working within Leicester City Council's Adult Mental Health Services were saddened to hear of Mr Thraves's death and as a result of his death and the circumstances surrounding it have considered extremely carefully the support provided to him. This was done through conversations between the Head of Service, Locality General Manager, Team Leaders and the AMHP. The processes identified and implemented, to be effective from 1st January 2016 are processes which aim to improve that service for people requiring their support.

I do hope that the above answers your concerns and identifies the ways in which Adult Social Care will be working to take action to prevent future deaths. However, if you have any queries regarding this please do not hesitate to contact Sarah Morris, Head of Service for Adult Mental Health on 0116 454 5417.

Yours sincerely

[redacted]
Strategic Director, Adult Social Care