Our Ref: KD

16th June 2016

Miss Emma Brown
Area Coroner Birmingham and Solihull
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

Headquarters
Delta House
Delta Point
Greets Green Road
West Bromwich
B70 9PL

Web: www.smhft.nhs.uk

Dear Miss Brown

Re: Regulation 28 report to Prevent Future Deaths – Mr. Richard Paul Martin Grant.

Following a review of information held by the Trust in relation to Mr. Richard Grant I am in a position to provide a detailed breakdown of all actions taken by the Trust for your consideration.

Your concerns were identified as:

(1) The Mental Health Nurse Catherine Collins of the Oak Unit mental Health Liaison Team gave evidence that a referral to the Black Country Partnership Single Point of Referral (SPOR) team was faxed on the 7th December 2015. Only when Mr. Grant chased with the Oak Unit why he had not received an appointment or further contact from Mental Health Services on 4th January 2016 was it identified that his referral ought to have been sent to the Birmingham and Solihull Mental Health NHS Foundation Trust Single Point of Access team. [redacted] and the Black Country Partnership have provided no explanation for what happened to Mr. Grant's referral between it being sent on 7th December 2015 and the 4th January 2016. A clear risk to life arises from patients who have been referred because of suicide attempt not being referred to the right team within a reasonable time.

(2) A letter detailing [redacted] assessment and the outcome of it was not sent to Mr. Grant's GP until at least 22nd December 2015, [redacted] did not know why there was such a delay nor whether it was typical. There is a clear risk to life from GPs not being aware of the circumstances and outcome of assessments of patients who have attempted suicide for such an extended period.

Background:

The patient self-harmed at around 00:00hours on 05.12.15 and self-presented at Accident and Emergency at 07:47hours seeking medical attention stating he had felt suicidal and made deep lacerations to his arms. Following treatment the patient was referred to the

Mental Health Liaison Service (MHLS) at 09:30hours with MHLS attending approximately 10 minutes later. The MHLS Nursing Assessment documents the patient disclosing self-harm with a Stanley knife in his garage with intent to commit suicide. The Assessment also documents the patient's reported motivation for self-harming and that he was regretful of this action and had no further suicidal intent. The Clinical Risk Tool was completed which returned a score of 4 thereby indicating low risk. The tool employed is the Threshold Assessment Grid (TAG) which is standardised assessment tool that has been developed to identify the severity of mental illness and suitability for further psychological treatment by assessing perceived risk, safety concerns and clinical factors.

The patient rejected the idea of support through Crisis Home Treatment Team (CHTT) as being too intrusive and agreed to a discharge plan comprising:

1. Referral to Single Point of Referral (SPOR) in respect of counselling
2. Provision of self-help telephone numbers for specific agencies.
3. Sharing of information with the patient's GP regarding the assessment and outcome.
4. Undertake follow up within 7 days.
5. Provision of CHTT 24/7 helpline and MHLS phone numbers.

A follow up phone call was made to the patient on 06.12.15 who reported feeling a lot better after confiding in his sister and that he was not experiencing any further suicidal thoughts at that time.

On 22.12.15 information was shared with the patient's GP.

The agreed referral was faxed to SPOR on 07.12.15. On 04.01.16 MHLS received a phone call from the patient enquiring on the progress of this referral. It was at this point that MHLS contacted SPOR and were advised the patient was out of area. A further referral was faxed to Single Point of Access in Birmingham the same day with an appointment subsequently being arranged for 22.02.16.

On 22.12.15 information was shared with the patient's GP.

Mr. Grant was found deceased on 07.01.16.

Care and Service Delivery Problems:

A referral was faxed from the MHLS to SPOR on 07.12.15 and confirmation of receipt received. The referral was reviewed by SPOR and a response faxed back to MHLS as the patient was an out of area patient and should therefore be treated by his relevant mental health services provider.

A review of the relevant postcode list by MHLS would have identified the patient as being out of area and would therefore have indicated the correct referral route, i.e. Birmingham and Solihull Mental Health Trust.

While SPOR responded to the referral as being an out of area patient and recorded this in the duty book there is no recorded fax trail and confirmation receipt was not obtained. SPOR local procedures include returning invalid referrals to the referrer.

SPOR do not provide counselling services but act as a gatekeeper and signpost patients to the relevant service following assessment. At present MHLS do not use the Common Assessment Tool and do not allocate a cluster to patients (clustering rates patients into groups based on assessed complexity and severity of need to ensure they are directed to the appropriate service). This has resulted in the need to refer to SPOR, who would complete the requisite assessment and clustering tools, rather than referring directly to the required service.

The patient's GP was not informed of the patient's self-harm, his presentation at A&E or his MHLS assessment until 22.12.15.

Action Being Taken:

1. A MHLS checklist is being developed and shared through team meetings which include prompts to review postcodes of patients to avoid incorrect referral route – Timescale for completion May 2016. (Completed)

2. Review of SPOR duty system is underway and will include ceasing practice of sending inappropriate referrals back to referrer. Clinician will continue to review all referrals and will forward / signpost referrals directly onwards. System will also include confirmation of receipt by telephone call. Timescale for completion May 2016. (Completed)

3. MHLS protocol being reviewed to encompass use of Common Assessment Tool and Clustering Tool to enable direct referrals from MHLS. Timescale for completion August 2016.

4. MHLS standard developed requiring all letters are drafted within the same or following shift and are dispatched within 3 working days. (Completed)

The Trust recognises there were deficiencies in the practices employed in the care of Mr. Grant and wishes to apologise for the enormous distress experienced by Mr. Grant as a result of these deficiencies and indeed to Mr. Grant's family for their loss. I would be happy to meet with Mr. Grant's family to explain.

I am confident that the actions taken in response to this tragic incident are appropriate and proportionate to ensure there will not be a recurrence of these events. The report has been shared within the Trust and across the Mental Health Division to highlight the lessons learned. [redacted] Mental Health Director will continue to monitor the implementation of the actions identified.

I look forward to your response and hope you are reassured by the Trust's actions in this matter.

Yours sincerely

Karen Dowman
Chief Executive