

Worcestershire Safeguarding Adults Board

Serious Case Review into the death of "04"

Executive Summary

November 2011

Subject of the Review anonymised as "04"

Date of Birth of 25.02.1969

Date of Death 24.09.2010

## **Contents**

	Page
Background information	3
The Serious Case Review Process	4
Key Issues	6
Conclusions	9
Recommendations	10
Next Steps	11

## **1. Background**

Following the Worcestershire Serious Case Review Policy and Guidelines (updated April 2010), the Worcestershire Safeguarding Adults Board established a Serious Case Review in respect of O4 in November 2010. This followed O4's death on the 24<sup>th</sup> September, 2010, when she was found hanging by the neck in a toilet cubicle at a railway station in Worcestershire.

O4, was a female Lithuanian national, who had been living and working in the area since May 2010. Prior to September 2010, little is known about her history, previous health or life style, apart from one incident on the 21<sup>st</sup> September when the Police were called to attend to O4 at a supermarket car park by a member of the public who had been concerned about 'a foreign lady leaning against a safety bar ... with blood on her hands and a bump on her head'. The police had spoken to O4, but she had declined medical help and had stated that the injuries were sustained as a result of a fall when she was hung over.

At around 10.00 am on Thursday, 23<sup>rd</sup> September O4 was found asleep in the gardens of a public house in Worcestershire. Staff from the public house observed her for several hours but when roused it was evident that she was drunk, and about 2.00pm they called an ambulance. She refused to be medically examined and talked about jumping in the river. The police were then called to the scene as O4 appeared to be still suffering from the effects of alcohol. She told the officer that she wanted to kill herself. She had facial injuries, which she then attributed to a road traffic accident a few days previously.

The Police decided to detain O4 under Section 136 of the Mental Health Act 1983, (amended 2007), at 14.45 and she was taken to the Police Station, as a place of safety, as is the local practice in cases where the individual is intoxicated. She was seen by the Force Medical Examiner at 17.05, who contacted the on-call Approved Mental Health Practitioner. It was agreed later that evening that an assessment was not required and that the Police should discharge her if they had no further concerns when she was sober the next day.

O4 was discharged from Custody at about 9.00am on the morning of the 24<sup>th</sup> September when she was deemed sober and rational. She was released and directed to the railway station as she stated that she wished to visit friends in London.

Later that afternoon she was seen on CCTV recordings wandering around the railway station, drinking from a bottle, for about 2 ½ hours. She was asked to leave the station and was escorted from the premises, as she was intoxicated. Shortly afterwards she was seen on the CCTV images entering the Ladies Toilets at the Station and 15 minutes later at 18.05 was found hanging by the neck inside a toilet cubicle. Despite attempts to resuscitate her she was pronounced dead at the scene.

## **2. The Serious Case Review Process**

The purpose of a case review is not to apportion blame or investigate it is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard Vulnerable Adults.
- To review the effectiveness of the procedures.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning (developing best practice).
- To prepare or commission an overview report which brings together and analyses the finding of the various reports from agencies in order to make recommendations for future practice.

This review covered the period May 2010 to September 2010 when 04 was known to be living and working in Worcestershire.

Key Issues to be addressed by the Review

- Was 04 dealt with appropriately by the relevant agencies with whom she had contact in the last 2 days of her life? To include consideration of the role of the Police Force Medical Examiner.
- Individual Management Reviews to include a brief appendix giving an agency view on whether the 136 suite arrangements are working satisfactorily within Worcestershire.
- Did 04's life experience, including the nature of her employment and living arrangements in England have an impact on the manner in which she was dealt with by the agencies involved in her care during her last 2 days of life. To include contact with 04's family if possible to gain their views on these matters.
- What lessons can be learnt about the way Worcestershire agencies involved in 04's case carried out their duties to prevent a similar event occurring in future.

The Police and the Worcestershire Mental Health Partnership NHS Trust, (*note: this organisation became part of the new Worcestershire Health and Care Trust in July 2011*), were asked to provide full Individual Management Review (IMR) reports covering the identified key issues, in addition to detailed chronologies of their involvement with 04 during the period covered by the

review. It was the responsibility of all agencies in their management reports to ensure a clear analysis and challenge of their agency involvement.

The family were made aware of the Serious Case Review and will be notified of the outcomes.

The Serious Case Review Panel was established in January 2010. All Panel members were Senior Managers from the key agencies. The managers on the Panel had had no direct contact or management involvement with 04. They contributed and provided extra information throughout the process.

### Panel Members

Alex Quinn	Independent Chair and report writer
David Hemming	Community Safety Manager, Wychavon District Council
Nicky Barry	Adult Protection Team Manager Worcestershire County Council
Phil Shakesheff	West Mercia Police
Karen Rees	Worcestershire Mental Health Partnership NHS Trust

The Chair of the Panel and report author is a recently retired former Acting Head of Adult Services in Walsall. Her social care experience over the last 30 years has involved working with Children and Families, both for the NSPCC and local authorities, before concentrating latterly on Adult work. The Chair had responsibility for reporting to the Serious Case Review Sub-Group of the Worcestershire Safeguarding Adults Board.

The Panel referred as part of the Serious Case Review to the Worcestershire Section 136 Mental Health Act 1983 Protocol which is signed up to by all agencies. The Protocol states that: *'inevitably the Police will also come into contact with individuals for whom it is unclear as to whether their behaviour is a direct result of intoxication or due to mental health problems. It is not normally possible to assess an individual's mental state whilst they are significantly impaired by alcohol and/or other substances and therefore caution should be used in making decisions to conduct assessments under the Mental Health Act (MHA). A full mental health assessment may only take place when the detained individual is no longer under the influence of alcohol and/or other toxic substance.'*

To aid the Panel's understanding further requests for information were made from the local Community Safety Officer, the staff from the Public House where 04 was found, and her employer. The Panel was briefed by Health colleagues and the Police on the operational working and application of the Local Section 136 Protocol.

The Panel had access to transcripts of 2 telephone conversations between staff involved in the operation of the Section 136 on the evening of 23<sup>rd</sup> September.

Further information and clarification was gathered by the Chair from the Coroner, the Police Professional Standards file and the pathologist involved in 04's post mortem examination.

### **3. Key Issues**

The issues arising from the Serious Case Review of 04 fall into several distinct areas:

- 1 The Place of Safety.
- 2 The Roles and Responsibilities of the staff involved.
- 3 The Cultural Issues.
- 4 The Communication issues.

#### **3.1 The Place of Safety**

The designated Place of Safety is determined by the Police and was in this case the Custody Suite at the local Police Station. It has become usual practice, when an individual is intoxicated, that the police station is used, as opposed to a specialist unit, and this procedure is supported by the Worcestershire protocol. However, the protocol also states 'It should always be borne in mind that the use of a Police Station can give the impression that the person detained is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with and therefore the effectiveness of the assessment process.'

The Worcestershire Section 136 Protocol quotes from the Mental Health Act 1983 Code of Practice and states that 'A police station should not be assumed to be the automatic second choice'. However this was the current practice in Worcestershire at the time of the Review. The Mental Health Act 1983 Code of Practice is clear that what it calls 'routine' use of police custody will only happen on an 'exceptional' basis.'

Professional bodies, such as the Royal College of Psychiatrists, also state that the use of police stations as a place of safety is inappropriate even for those with 'disturbed behaviour' and acknowledge that this is a wide spread view held by users, carers police and social workers.

These points raised in the various documents of staff guidance on Place of Safety for Section 136 individuals could have had an effect on 04, her response to her detention and her treatment by the professionals involved.

At the time of contact between the Force Medical Examiner and the Approved Mental Health Practitioner, it does not seem that any consideration was given to an alternative place of safety for 04 while she regained 'capacity' and sobered up, although there would have been ample time to move her during the 72 hours of the Section 136.

### 3.2 The Roles and Responsibilities of staff involved in the Section 136

The Police initial response to the Section 136 was appropriate as per the Worcestershire Section 136 Mental Health Act 1983 Protocol.

The Police informed the Force Medical Examiner, who attended promptly, however the police did not contact the Approved Mental Health Practitioner. The reason for this decision is not recorded. The Protocol states that they will do contact the Approved Mental Health Practitioner.

The Force Medical Examiner did carry out a brief physical examination on 04 as per the protocol, which goes on to state 'a full mental health assessment may only take place when the detained individual is no longer under the influence of alcohol and/or other intoxicating substances'. The Force Medical Examiner advised the Custody Officer on rousing 04 and stated that a further medical review was required when she was sober.

It is not clear from this initial assessment of 04 as to whether or not she was 'mentally disordered.' There is no evidence of a Mental Capacity assessment being carried out.

As 04 was detained under a Section 136 she should have received a full mental health assessment, this was her right, when she was no longer intoxicated. There is no clear evidence for the clinical decision not to assess being taken, particularly considering that the small amount of clinical and verbal information available, all of which indicated risk and vulnerability, this could have been explored further with 04 when she had the capacity to be interviewed. There was time left within the 72 hours of the Section 136 to complete a full assessment.

Where possible the Approved Mental Health Practitioner should assess jointly with the Force Medical Examiner and the Mental Health Act 1983 Code of Practice also states that 'the same care should be taken in examining and interviewing people in places of safety as in any other assessment.' In this case the Approved Mental Health Practitioner did not see 04, as it was agreed with the Force Medical Examiner in a telephone conversation on the evening of the 23<sup>rd</sup> September 2010 that this was not necessary.

The Approved Mental Health Practitioner role in the Worcestershire Section 136 Protocol is to:

'To endeavour to ensure that assessment begins as soon as possible after the arrival of the individual at the Place of Safety'

'To co-ordinate the process of assessment once they have assessed the individual'.

'To establish whether patients have particular communication needs or difficulties, and take steps to meet them.....'

None of this happened in this case as the Approved Mental Health Practitioner agreed, during a conversation with the Force Medical Examiner, that he would just check with the Police and that they, could decide the next morning whether 04 was fit for discharge. The lack of clarity about mental disorder was not challenged. All of these decisions were taken whilst 04 was still intoxicated.

The lack of any previous knowledge of 04, her history, or indication of the level of risk in this situation would suggest that a further face to face assessment was required when she was fit for interview.

### 3.3 The Cultural Issues

Throughout the process no account is taken of the fact that English was 04's second language. The Panel had no written evidence of whether or not she was fully aware of the circumstances surrounding her detention and the nature of the Section 136.

The situation may have been particularly difficult for her being detained in a police station at this time as she understood that she was under suspicion of theft.

No consideration of the impact upon the individual and her ability to co-operate with the assessment process was apparent. The choice of the Police Station as a Place of Safety may have been practical in this case, however, it took no account of the effect such a detention might have had on someone from a different culture and may well have increased her anxiety.

### 3.4 The Communication Issues

Police communication systems did not link the incident on the 21<sup>st</sup> September involving 04, (described in paragraph 2, page 1), with the further incident on the 23<sup>rd</sup> September 2010.

It still remains unclear, from the information received by the Panel, whether or not the Approved Mental Health Practitioner was aware that 04 had old scarring to her wrists where she had attempted self-harm in the past.

The Approved Mental Health Practitioner did not clarify whether or not the Force Medical Examiner considered 04 to have a mental disorder.

## **4. Conclusions**

04 did not receive a Mental Health assessment, as she was still intoxicated at the time she was seen by the Force Medical Examiner.

It is impossible to say whether or not 04's suicide could have been prevented had she received a Mental Health assessment. However, for reasons which still remain unclear, 04 was not offered a full assessment as required by the Mental Health Act, Section 136.

04 was not seen by the Force Medical Examiner or the AMHP as required by the Worcestershire 136 Protocol when she had sobered up, as per the original plan suggested to the Police and documented at 18.08pm 23<sup>rd</sup> September, 2010.

04 was not given any information re further help or details of community services on her release from custody on the morning of the 24<sup>th</sup> September, 2010.

The use of police cells as a place of safety, when individuals are intoxicated, under a Section 136, is not recommended or considered good practice. The Worcestershire Protocol quotes the Mental Health Act Code of Practice and states that a 'police station should only be used on an exceptional basis'.

The choice of the custody suite as a place of safety was not reconsidered in the discussions between the Force Medical Examiner and the Approved Mental Health Practitioner at any stage during 04's detention. In view of 04's background and concerns about her job re the theft allegations, this choice may have had a detrimental effect on 04.

Worcestershire's Protocol for the operation of Section 136 was not followed.

The Panel consider that they were not able to complete the Terms of Reference in this Serious Case Review as they were unable to gain clarification, either from the IMRs or other enquiries, on why and how key decisions were made around 04's mental health, despite several attempts to gain this information.

Neither Independent Management Reviews included an appendix giving an agency view on whether the Section 136 suite arrangements are working satisfactorily within Worcestershire. The Panel did receive a report on the Section 136 working and the AMHP role from Worcestershire Mental Health Partnership NHS Trust, but not from other agencies.

## 5. Recommendations

These are the combined recommendations of the Independent Overview Report Author, and the Panel, incorporating those of the individual IMRs, on the Serious Case Review of 04.

1. The Mental Health Act Multi-Agency Group should review the Worcestershire S136 Mental Health Act Protocol. The group should ensure that all relevant professionals are aware of their duty to undertake a Mental Health Assessment of all persons detained under the Section 136 of the Mental Health Act 1983, (amended 2007), in line with the Mental Health Act Code of Practice. Individual professional responsibilities following the discharge of the Section 136 should be clarified and actions recorded. Following the review of the Protocol inter-agency training should be considered on the reviewed Protocol for all relevant staff, with particular reference to the communication between **all** the professionals involved through the process.
2. West Mercia Police Authority to ensure their internal process is always followed for commissioning Independent Management Reviews of deaths of detained persons following their discharge from custody where they have had medical services from the Police Authority.
3. West Mercia Police Authority should undertake an examination, in conjunction with the General Medical Council, of the role of the Force Medical Examiner in this case. West Mercia Police Authority should also review the mechanism for clinical supervision of Force Medical Examiners and identify who should be responsible for this.
4. In light of previous Serious Case Review recommendations, both for Children and Adults, agencies and individual workers should be encouraged to clarify and challenge the professional rationale for decisions made by colleagues throughout the section 136 process.
5. The use of the Section 136 Elgar Suite should be reviewed with a possibility of the implementation of a more flexible staffing arrangement between key agencies therefore making the facility available when particularly vulnerable adults, who are intoxicated, are concerned.
6. All agencies should review their recording policies and procedures in relation to the section 136 process to ensure that documentation is comprehensive and evidences decision making. This review should include the recording of the decision making processes. In the case of 04, many actions were recorded, however the reasoning behind the decision making was not; this made it difficult to ascertain why policies and procedures and earlier decisions were not followed through. The resulting training issues should be addressed via inter-agency training and should include case file audits to ensure the practice is implemented.

7. The Worcestershire Safeguarding Adults Board should pass the Coroner a copy of this report to highlight the concern of the Panel that full consideration occurs in future of whether the mental health and social care needs of the individual were properly assessed and responded to, following their death, if it occurs within a few days of discharge of the individual from a Mental Health Act section 136 detention.
8. West Mercia Police current custody procedures should be updated in line with any new procedures evolving from the current review underway of the Section 136 Protocol. This should include a quick guide and flow chart outlining the roles and responsibilities of West Mercia custody staff, the Force Medical Examiner and all other partners involved in Section 136 Mental Health Act detentions and subsequent Mental Health assessments. Guidance should also be given to custody staff should they wish to make appropriate challenges to any decisions taken by the Force Medical Examiner, the Approved Mental Health Practitioner or any other colleagues involved in the process.
9. The Worcestershire County Council Drug and Alcohol Advisory Team should work with the Police to ensure that information on substance misuse advisory services is available in the Custody Suite to hand to individuals on their release from custody, giving details of services available to them in the community.
10. The South Worcestershire Community Safety should work with partners and various employers, to look at the feasibility of producing an information pack or booklet initially for transient workers in local employment in one locality. Such a pack would be given to them on commencement of their employment and would include details such as how to register with a GP and other local services and information. If successful this can then look at the feasibility of extending such an information pack across Worcestershire.
11. The Worcestershire Safeguarding Adults Board should amend the Policy and Guidelines for Serious Case Reviews. This should include guidance to the effect that the Panel must review the standard template for the Independent Management Reviews at its first meeting and make any adaptations that are necessary to fit the particular circumstances of the case.

### **Next steps**

The key agencies cited above will be asked to update the Worcestershire Safeguarding Adults Board with details of how they are putting the recommendations into practice and the Board will closely monitor their progress.