Leeds and York Partnership NHS
NHS Foundation Trust

Date: 06th January 2022

[redacted]

Leeds and York Partnership NHS Foundation Trust
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB

Mr Kevin McLoughlin
Senior Coroner, Western Yorkshire (Eastern District)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

Dear Mr McLoughlin

RE: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: Neil Peter BASTOCK, (deceased)

Thank you for the correspondence regarding the outcome of the inquest, which was concluded on 01 November 2021, touching upon the death of Mr Neil Peter Bastock. I would firstly like to take this opportunity to express my sincere condolences to Neil's family and friends at the tragic death of Neil.

Following the Regulation 28 Report to Prevent Future Deaths issued on the 1 November 2021 to Leeds and York Partnership NHS Foundation Trust (LYPFT), please find below the details of our response to address the concerns raised.

The Matters of Concern within the report have been broken into the points below in bold text with the Trust's response following:

1. **The decision to rescind the section on 17.09.2020 was made:**

   a. **By a Responsible Clinician who had been in this role for only two weeks.**

      The core professional standards require that any new Responsible Clinician has sufficient familiarity with a patient's past and current history to support robust decision making. To ensure the Trust learns from the sad death of Mr Bastock, the Professional Medical Lead will formalise the support and supervision arrangements that are in place for locum medics by reviewing the current induction package to ensure support and supervision arrangements are explicit and proportionate.

      The Trust will also review their clinical handover process to ensure it supports robust clinical decision making when locum medics commence in post.

   b. **His family were not involved in the decision at all and only became aware of it after it had been made.**

Improving involvement of families and carers is a priority for the Trust and we have participated in the Triangle of Care improvement programme. Triangle of Care is recognised as a clear framework to support LYPFT's commitment to listening to carers and it provides a set of standards to monitor, evaluate and review carer support and involvement. Subsequently carers were included as a priority in LYPFT's 3-year Patient and Carer Experience and Involvement strategy, launched in April 2020. Progress of the Triangle of Care in LYPFT is overseen by a 'Carer's subgroup', comprising staff members and carers. This group reports into LYPFT's overarching 'Patient Experience and Involvement Strategic Steering Group' chaired by our Director of Nursing, Professions and Quality.

We acknowledge there was a missed opportunity to involve Mr Bastock's sister in the decision-making process and the team have subsequently reviewed and shared the principles set out in the Triangle of Care Programme. The ward manager will ensure these principles are enacted to make sure a consistent offer is given to service users and family members in line with the principles. The service has also identified a Carer Champion who will attend the monthly Triangle of Care Steering group to ensure progress against this work is shared and monitored. The Patient and Carer Experience Team also have a dedicated Carer Coordinator who supports carer champions and team/service leaders with their work relating to Triangle of Care.

c. No formalised assessment of his mental capacity was made prior to the decision.

To support an improvement in relation to this area, the Trust's Head of Mental Health Legislation, in conjunction with the Medical Director, will carry out a review of the current training provision for medical staff in relation to mental capacity assessments.

In January 2022, a Trust-wide audit relating to mental capacity assessments and best interest decisions will be undertaken. The Mental Health Legislation Team will review the audit tool to explore if the decision to rescind a detention can be incorporated within this audit.

A discussion will be held through the Trust's Mental Health Legislation Operational Steering Group to amend the form completed by the Responsible Clinician when a decision to rescind the section is made, this will include a prompt for the Responsible Clinician to ensure that a mental capacity assessment is documented.

d. His care plan had not been updated.

The wards local system procedure outlines that care plans should be reviewed and updated weekly or if there are changes to a patient's presentation. Mr Bastock's care plan was updated to reflect his informal status however, no further updates were made. At the time of Mr Bastock's admission, the Trust had transitioned to a new electronic care record system which is now robustly embedded across the organisation. From January 2022, an audit of care plans will be undertaken monthly and the findings including areas for development and good practice will be shared with the team via the local Clinical Improvement Forums. The ward has also embedded regular care planning

meetings to support a consistent team approach to care plans ensuring that care plans are reviewed and updated appropriately.

Trust-wide, work is underway to simplify the existing care planning document on the electronic patient record. This will include a specifically designed in-patient care plan with a link to the FACE risk assessment. An initial draft of the care planning document will be shared through the Trust governance processes in January 2022. A guide is being developed to support staff in recording information consistently and this will include the level of engagement and agreement the service user had with each element of the care plan. Additional support will be given to staff to implement this new care plan effectively.

e. The pressure on bed availability in the Newsam Centre may have influenced the decision.

The decision made by the clinical team to discharge Mr Bastock was in relation to detention under the Mental Health Act as opposed to discharge from hospital, which would have had no impact upon bed availability.

There are ongoing pressures nationally on availability of inpatient beds, and it is something we pay particularly attention to at LYPFT as we strive to ensure the people of Leeds can receive inpatient care locally. I would like to reassure you that decisions to discharge our service users from inpatient wards are clinically based and only when it is safe to do so rather than in response to resource issues.

2. Mr Bastock's treatment in the Newsam Centre lacked continuity. The responsible clinician was a locum who had recently taken over from another locum psychiatrist. There was no ward manager on the ward to provide leadership for the care being provided. There was no psychologist on the ward to contribute to care planning. The nursing records were incomplete, possibly due to teething problems associated with the recently introduced electronic recording system.

Work is underway across the organisation to address the challenges relating to medical recruitment including a number of recruitment initiatives. The risk associated with medical staff vacancies is reflected on the Trust's risk register. The use of locum staff is an action taken by the Trust to mitigate some of the risk relating to medical staffing vacancies. Mr Bastock was known to one of the covering Consultants which offered him some continuity and familiarity but one Consultant Psychiatrist throughout a period of care is undoubtedly preferred, and we acknowledge the potential impact of this as Mr Bastock found it difficult to build up trusting relationships.

Although the Ward Manager changed during Mr Bastock's admission there was no period where the ward was without a Ward Manager. The incoming Ward Manager was already working within the Trust and was familiar with the service. A comprehensive handover took place and as the Ward Manager leaving was taking up a role within the Trust as Matron of the Acute Inpatient Services; he was able to provide support and leadership to Ward 4 after leaving his post. We recognise that changes in leadership

can create an element of instability for both patients and staff, therefore, to ensure we learn from the death of Mr Bastock, the senior leadership team has met with teams to provide additional support to any areas that are undergoing a transitional period.

During the period Mr Bastock was a patient of Ward 4 there was a Consultant Psychologist aligned to the ward who was available to support the team in their decision making and care planning.

As previously responded to at question 1d, the wards local system procedure outlines that care plans should be reviewed and updated weekly or if there are changes to a patient's presentation. Mr Bastock's care plan was updated to reflect his informal status however, no further updates were made. At the time of Mr Bastock's admission, the Trust had transitioned to a new electronic care record system which is now more embedded across the organisation. From January 2022, an audit of care plans will be undertaken monthly and the findings including areas for development and good practice will be shared with the team via the local Clinical Improvement Forums. The ward has also embedded regular care planning meetings to support a consistent team approach to care plans ensuring that care plans are reviewed and updated appropriately.

3. **When the section was rescinded, Mr Bastock became a voluntary patient on the ward. In the three days following 17 September 2020, various factors should have triggered a need to reconsider the decision, including:**

   a. **Mr Bastock left the ward on occasions and once did not return until 5:00am.**
   b. **On his return, recorded evaluation of his situation and what action was required from the team treating him.**

   Mr Bastock spent three periods of unplanned leave off the ward prior to his death. The Trust's Missing Service User Procedure outlines the actions staff should take in the event a service user does not return to the ward and what should happen on their return. A return interview must be undertaken to explore what the service user did; where they went and what actions need to be taken to prevent reoccurrence.

   On reflection, there was insufficient focus on the final aspect of this process for Mr Bastock's previous unplanned leave. This area will be reiterated to staff to ensure that if a patient will not engage in a discussion regarding their vulnerabilities when off the ward, this information is to be shared with the wider MDT team to inform an agreement about how and if to support ongoing leave requests made.

   In addition to this, to ensure the Trust has learnt lessons from Mr Bastock's death the Acute Inpatient Service have developed a template to support good practice around the planning and reviewing of leave and takes into consideration:
   - Involvement of families and carers in the decision to grant leave
   - Feedback from service users, families, and carers
   - Evaluation of previous leave
   - Changes to mental state and presentation
   - Any risks associated with ongoing leave
   - Ability of service user to engage with their personal care plan

The template will be implemented across the service following approval at the Service Clinical Improvement Forum in January 2022. The information gathered in the template will be used as part of the MDT meeting to inform decision making regarding ongoing care. It will also enable the team to review reoccurring concerns following periods of leave and consider if a patient is engaging with their current care plan. We will audit the impact of this change in practice in July 2022.

c. A family member voiced concern that he was unwell and was not ready to be discharged, yet this warning was not heeded.

As responded to within question 1b, the Trust is committed to improving how we hear and act upon the voice of the carer/family/friend through the Triangle of Care. The essence of Triangle of Care is six key elements (standards) required to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services. The six key standards state that:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information, are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available

We acknowledge that there was a missed opportunity to ensure that the information shared by a family member was included with the discussions taking place regarding Mr Bastocks care.

We are confident the work the Trust is engaged in with Triangle of Care will improve this occurrence in the future. We would like to apologise this was not the case for the family of Mr Bastock.

d. Another family member reported that he had gone to his former partner (whom he had not seen for several years) to give her 250 pounds he had withdrawn from a cash machine for his children. The possibility that this act amounted to a farewell gesture was noted in the nursing record, but its significance was not sufficiently considered.

This incident was raised with Doctor [redacted] and his view at the time was that of a positive gesture and an attempt from him to re-engage with other family members. Doctor [redacted] attempted to discuss this with Mr Bastock who at the time, did not want to engage in the conversation. With the benefit of hindsight, we acknowledge that this information could have been interpreted differently.

As referred to in question 3, if a patient will not engage in a discussion regarding their vulnerabilities when off the ward, this information is to be shared with the wider MDT

team and an agreement about how and if to support ongoing leave made. To ensure the Trust has learnt lessons from Mr Bastock's death the Acute Inpatient Service have developed a template to support good practice around the planning and reviewing of leave and takes into consideration:

- Involvement of families and carers in the decision to grant leave
- Feedback from service users, families, and carers
- Evaluation of previous leave
- Changes to mental state and presentation
- Any risks associated with ongoing leave
- Ability of service user to engage with care plan

The template will be implemented across the service following approval at the Service Clinical Improvement Forum in January 2022. The information gathered in the template will be used as part of the MDT meeting to inform decision making regarding ongoing care. It will also enable to team to review reoccurring concerns following periods of leave and consider if a patient is engaging with their current care plan. We will audit the impact of this change in practice in July 2022.

e. Mr Bostock had indicated he felt unable to live alone. Although a social work assessment had taken place, no plan in relation to alternative accommodation had materialised. In the absence of such transition infrastructure, it was premature to consider him for discharge from the section.

Prior to the deterioration of Mr Bastock's mental heath in 2020 he had made progress over a number of years and worked hard with the Community Mental Health Team in the development of coping strategies which enabled him to live independently and utilise his support networks when appropriate.

Mr Bastock had indicated he was fearful about returning home which is a frequently expressed feeling for people when working towards discharge. Mr Bastock's section was rescinded because he agreed to remain in hospital as an informal patient and not because his imminent discharge was planned.

Mr Bastock was assessed by an Occupational Therapist as having the functional ability to return home and appropriate input was sought to help with this, including a referral to a social worker, allocation to a CPA care co-ordinator and ongoing contact with Caring for Life. Early input from the Intensive Support Service was arranged to help facilitate successful discharge. Unfortunately, these interventions to support Mr Bastock transition back home were not documented within his care plan or risk assessment. The learning from Mr Bastock's case will be shared with the team through the Trust's clinical governance structure and staff will be reminded of the importance of ensuring all interventions are documented. An audit of care plans will be undertaken monthly by the ward manager and the findings will be shared with the team via the local Clinical Improvement Forums.

f. When Mr Bostock left the ward, there was a failure to notify the police of him as a missing person, given his suicide risk (irrespective of whether this complied with the prevailing missing person's policy stipulated timescales).

The Trust Missing Service User Procedure outlines the actions staff should take in the event a service user does not return to the ward. The Missing Service User Procedure, although led by the Trust is jointly agreed with West Yorkshire Police. Both organisations have taken a further review of the procedure to ensure it contains the learning from this incident. The draft procedure has been circulated to stakeholders for comment and will then be ratified and circulated by January 2022. The updated procedure will be disseminated to all staff via Trust wide email, and any required adjustments will also be made to any associated training.

The revised procedure will direct staff to ensure that a discussion or return interview will be held with service users upon their return to the ward following a period of unauthorised leave. This information should then inform the service user's care plan with regards to directing staff what action to take in the event that a service user does not return from leave and future decision making with regards to agreeing leave. The Trust will audit our compliance against this aspect of the procedure in July 2022.

To support the further learning that will take place, the Trust will be developing an action plan which will include all the recommendations provided within this response, we will of course share this with you. We would be pleased to provide any further information or clarification required. If you feel that a meeting with staff to discuss any of the above would be helpful, please do not hesitate to contact us.

I hope this response provides assurance of improvement, consistent with the concerns highlighted in the Regulation 28 and we thank you for the opportunity to further reflect on the learning following the sad death of Mr Bastock.

Yours Sincerely

[redacted]

Dr [redacted]
Chief Executive