IN THE MATTER OF THE INQUEST IN TO THE DEATH OF VINCENZO JOSEPH MICHAEL LIPPOLIS

RESPONSE OF NAVIGO TO THE PFD DATED 26/10/2022

FROM MR PAUL COOPER, HM ASSISTANT CORONER FOR LINCOLNSHIRE

Introduction

1 This is the response of NAViGO to the Regulation 28: Report to Prevent Future Deaths (the Report) raised by Mr Paul Cooper, HM Assistant Coroner for Lincolnshire, dated 26 October 2022, following the conclusion of an inquest on 26 October 2022 into the death of Vincenzo Joseph Michael Lippolis, who died on 1 November 2021 when he was found hanging in a woodland by his shoelaces.

2 NAViGO Health and Social Care CIC (Community Interest Company) provides NHS commissioned adult mental health services in North East Lincolnshire.

Organisations named in the Report

3 Two organisations are named in the Report and it will be helpful in reading this response to understand the involvement of each:

3.1 NAViGO provides psychiatric liaison services at the Diana Princess of Wales Hospital, Grimsby (the Hospital). On 16 October 2021 Vincenzo Joseph Michael Lippolis attended the Emergency Department at the Hospital after .an attempt at hanging himself. When medically fit he was referred by the Emergency Department for assessment by the Hospital Liaison Psychiatric Team. This was NAViGO's only involvement with Vincenzo Joseph Michael Lippolis.

3.2 Lincolnshire Partnership NHS Foundation Trust (LPFT) is an NHS Foundation Trust providing adult mental health services in Lincolnshire but outside the area of North East Lincolnshire covered by NAViGO. Vincenzo Joseph Michael Lippolis lived in Mablethorpe, Lincolnshire, which is part of the area covered by LPFT services. NAViGO is not aware of the full extent to which LPFT has previous, or subsequent, involvement with Vincenzo Joseph Michael Lippolis.

Issues raised by the Coroner

4 The Report raises two matters of concern, in summary:

4.1 That Vincenzo Joseph Michael Lippolis was not sectioned under the Mental Health Act 1983 following assessment by the Hospital Liaison Psychiatric Team on 16 October 2021; and

4.2 That LPFT had telephone contact with Vincenzo Joseph Michael Lippolis on 17 October 2021 rather than face to face contact and more effective analysis.

5 This response only responds to the first concern relating to NAViGO's involvement.

6 The only observation made on the second concern is that NAViGO's Hospital Liaison Psychiatric Team contacted the relevant LPFT services after the assessment at the Hospital and requested a face to face follow-up with Vincenzo Joseph Michael Lippolis by his local services (as detailed in the written report of [redacted], NAViGO Liaison Practitioner, dated 22 October 2022, provided to the Coroner).

The Concern in relation to NAViGO

7 The concern as set out in the Report is:

"In the NAVIGO report of 22nd October 2022 in response to the mother's request as to "why Vincenzo wasn't sectioned under the Mental Health Act after his detrimental (suicide) attempt on 16th October if only for observation" the SW replies "An admission to a mental health unit would not provide a therapeutic benefit as Vinny's social stressors would still be present in the future". The response does not seem to consider/reflect the admission criteria under s.2 or s.3 of the MHA.

Please clarify the rational as the family believe an opportunity has been lost and a death could have been averted."

Response to the Concern

8 The response falls in two parts:

9 *First, the appropriateness of raising the concern in the report:*

9.1 It is suggested that it would have been more appropriate for these matters to have been dealt with in the inquest.

9.2 It is noted from the timeline in section 4 of the Report that comments from [redacted] were only requested on 14 October 2022. Her comments were provided on 22 October 2022. [redacted] was not asked to attend the inquest and it is noted in the timeline on 24 October 2022 that "Comms with Mum - discussed the clinical notes from [redacted] - content that this answers her question". That may well be the reason [redacted]

9.3 However, it is clear from the report that questions did remain at the inquest itself. In fact, the Report appears to be seeking additional evidence, or clarification of evidence, on the circumstances around the Deceased's death, specifically the assessment on 16 October 2021, rather than raising concerns about potentially on-going issues.

9.4 It would, it is suggested, have been more appropriate to have adjourned the inquest at that point to hear evidence directly from [redacted] with NAViGO as an Interested Person under s47(f) Coroners and Justice Act 2009.

10 *Secondly, observations in relation to the concern raised:*

10.1 The provision of a Hospital Liaison Psychiatric Team for initial assessment of people attending an Emergency Department, where a mental disorder is suspected, is entirely consistent with nationally recognised practice.

10.2 Following assessment there may be further actions from arranging further support in the community to arranging additional assessment for possible admission to a mental health hospital, either informally with the patient's agreement or compulsorily under the Mental health Act 1983 (the MHA).

10.3 Mr Lippolis was assessed by two experienced practitioners, one a Social Worker and one a registered Mental Health Nurse. This, again, is consistent with good practice.

10.4 Those practitioners could not, themselves have made an application for detention under the MHA. That would require assessment by two doctors and an Approved Mental Health Practitioner. Of the two doctors at least one must be approved under s12 MHA, as having special experience in the diagnosis or treatment of mental disorder, and at least one should, if practicable, have previous acquaintance with the patient.

10.5 However, the Liaison Team practitioners, were experienced in assessing for signs of mental disorder and would have had the criteria of the MHA in mind during the assessment.

10.6 Relevant elements of the MHA in this case are:

10.6.1 Section 1(3) specifically excludes dependence on alcohol or drugs as a disorder or disability of the mind for the purposes of the MHA.

10.6.2 Section 2 allows for the compulsory admission of a person for assessment (and treatment) if he is suffering from a mental disorder of a nature or degree which warrants detention for at least a limited period AND he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

10.6.3 Section 3 would normally only be considered after use of section 2 unless the person was already well known to services and had a diagnosis of mental disorder. It allows compulsory admission to hospital for treatment and has stricter criteria for admission including that it is necessary that the patient receive treatment and it cannot be provided unless the patient is detained.

10.7 It is also relevant to consider the Code of Practice to the MHA, which gives statutory guidance to practitioners. Practitioners must have regard to the Code of Practice and follow it unless they have good reasons not to (see the Introduction to the Code of Practice paragraphs I to V).

10.8 Chapter 1 of the Code of Practice sets out a number of principles to be followed. The first is "Least restrictive option and maximising independence". Paragraph 1.2 states "Where it is possible to treat a patient safely and lawfully without detaining them under the (MHA), the patient should not be detained".

10.9 As set out in the written comments of [redacted] dated 22 October 2021 the assessment found:

10.9.1 The risk of suicide was significantly increased whilst Mr Lippolis was under the influence of cocaine and alcohol.

10.9.2 At the time of assessment he was not under the influence of drugs or alcohol and he denied any suicidal thoughts, plans or intent to end his life.

10.9.3 There was no evidence of acute mental illness.

10.9.4 The suicide attempt resulting in the Emergency Department admission appeared to be directly linked to a relationship breakdown and alcohol and cocaine misuse.

10.9.5 Mr Lippolis regretted his actions and was keen to engage with the local LPFT crisis team and his local drug and alcohol services.

10.9.6 He spoke fondly of his work and family being protective factors.

10.9.7 Mr Lippolis appeared to understand that substance misuse increased his impulsivity and therefore was happy to work with services to address this and decrease the risk of a further suicide attempt.

10.10 The rationale for referral back to local LPFT services and not further assessment for admission was therefore that:

10.10.1 Admission under the MHA cannot be justified on safety grounds alone. There must be an element of mental disorder at least warranting assessment.

10.10.2 Mr Lippolis did not appear to be suffering from a mental disorder at the time of assessment.

10.10.3 His primary triggers for self-harming behaviours were drug and alcohol misuse, which are not issues that can be used to justify compulsory admission under the MHA in the absence of a mental disorder.

10.10.4 He was willing to engage with local services so support and treatment could be provided outside hospital, and were more appropriate for provision outside hospital. [redacted] comment that "an admission to a mental health unit would not provide a therapeutic benefit as Vinny's social stressors would still be present in the future", reflects the fact that an admission would not have made the destabilising factors disappear. It was more appropriate for Mr Lippolis to engage with the issues in the community.

10.10.5 There was no indication that he would further self-harm at that time and he did not, in fact, do so. There is a period of 15 clear days between the assessment on 16 October 2021 and his tragic death on 1 November 2021.

10.10.6 The decision not to admit Mr Lippolis but to refer him to local services for follow-up was agreed by him and entirely consistent with the principle of least restriction and maximising independence.

10.10.7 Given his presentation at assessment and immediately afterwards it would be entirely speculative to suggest that a very short admission, with no symptoms of acute mental disorder, would have prevented whatever triggered his actions on 1 November 2021.

10.10.8 The referral to local, LPFT, services was made with a recommendation for face to face follow-up, consistent with good practice.

Action proposed by NAViGO in response to the concern

11 NAViGO does not propose to take any action in relation to its systems or processes in response to the concern raised. The response above sets out the rationale for the decision. It followed an assessment of Mr Lippolis in line with nationally recognised practice by two experienced practitioners. The decision was based on Mr Lippolis' responses and presentation at the time and the professional judgement of the practitioners. For the reasons given above there is, in NAViGO's judgement, no change to systems or processes that need be made in order to avoid deaths in future. Decisions will always depend on the particular circumstances of each individual assessment.

12 It is hoped the response assists the family in understanding the process and rationale for the decision on 16 October 2021.

13 NAViGO regrets that it did not have the opportunity to provide that information, through its staff, at the inquest.

14 If the family have any further questions NAViGO would be happy to receive them from the family and will respond directly to the family. Any further questions can be raised by contacting:

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NAViGO House

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Grimsby

North East Lincolnshire

DN32 0QE

[redacted]

[redacted]

Signed [redacted]

Position Chief Executive

Dated 4.1.2023

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