South West
Yorkshire Partnership
NHS Foundation Trust

22nd February 2023

Trust Headquarters
Fieldhead Hospital
Ouchthorpe Lane
Wakefield
WF1 3SP

Mr Eccleston
HM Assistant Coroner, South Yorkshire (West)
Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

Dear Sir,

Regulation 28 Response – Daniel Lee

We write in response to the Regulation 28 report following the inquest touching the death of Mr Daniel Lee. We would like to start with offering the family of Mr Daniel Lee our sincere condolences for their sad loss.

We hope the information supplied in this response provides assurance that the concerns raised are taken seriously by the Trust. We will respond to each of your concerns in turn below and adopt the same summary headings detailed in the Regulation 28 report.

As you will be aware, the Trust submitted an Intensive Home-based Treatment Team (IHBTT) overview statement and Serious Incident Investigation report into the inquest proceedings to assist with your inquiry. This response will therefore build upon information previously available to you as part of the inquest proceedings.

Superficiality of risk assessments

At the outset of this response, we considered it would be helpful to provide you with information in respect of how community mental health services, specifically IHBTT services, operate. The model of IHBTT is a national approach, to which the Trust adheres.

The role of the IHBTT can be summarised as follows:

- To provide an alternative to hospital admission
- To offer the patient the Least Restrictive option (working on the Principle of Least restrictive option and maximising independence as set out in the Mental Health Act Code of Practice [2015]).
- To gatekeep all admissions to ensure that individuals are not unduly detained under the Mental Health Act or admitted to hospital inappropriately.

[redacted]

The IHBTT provides rapid and intensive interventions for people with acute mental health problems in the least restrictive environment as close to their home as clinically possible. The IHBTT has flexibility to respond to differing service user needs as it operates on a 24 hour, 7 day a week basis. Service users in receipt of IHBTT intervention and support are often identified as being in an acute period with their mental health and once the service user's acute period has resolved, they will be referred or sign-posted to appropriate follow up services, which may include referral into longer-term secondary mental health support services (e.g. Core or Enhanced community mental health teams), discharge to their GP or sign-posted to other appropriate support services (e.g. Andy's Man Club or similar). Care and interventions by the IHBTT are often provided in the short term, by nature of the service users being in an acute phase of their mental health.

The IHBTT is a multi-disciplinary team (MDT), consisting of Psychiatrists, Registered Mental Health Nurses, Social Workers and other allied health professionals, not dissimilar to a ward MDT. Therefore, the approach to an individual's care is multi-disciplinary from the initial referral to the discharge. For example, assessment for acceptance onto the IHBTT caseload is completed by an IHBTT practitioner and an IHBTT psychiatrist (or two practitioners if a psychiatrist is unavailable) and all service users on the IHBTT caseload are discussed at the daily and weekly MDT meeting, with the attendance of the various professionals, as a means to ensure appropriate and on-going oversight of risk assessment, risk management and care planning.

Those professionals employed in the IHBTT, in the most part, work 12 hour shifts three times per week (not including optional overtime hours). Given that the IHBTT is a 24 hour and 7 day a week service, maintaining continuity of care and contacts is a key consideration of all care provided. Continuity of visiting practitioners was always attempted with Mr Lee, to ensure consistency of risk assessment, risk management and care planning (as evidenced below). An additional complexity in the allocation of staff for visits for Mr Lee was that he reported a preference to have face-to-face contacts with male practitioners, and so all efforts were made to accommodate this request where possible.

Having reviewed the IHBTT contacts, we noted that Mr Lee received 40 contacts (home visits, telephone contacts and psychiatric reviews) whilst receiving care by the IHBTT.

- of these 40 contacts, 26 were planned face-to-face home visits with IHBTT practitioners.
- of these 26 home visits, 14 were undertaken by three different practitioners (six, five, and three contacts per practitioner)
- four home visits were undertaken by two different practitioners (two contacts per practitioner)
- the remaining 8 were one-off contacts where the practitioner only visited once.

[redacted]

This demonstrates that 18 of the 26 IHBTT face-to-face home visits with Mr Lee were made by 5 practitioners, with each practitioner seeing him on two or more occasions.

As indicated above, the IHBTT operates an MDT approach to risk assessment, risk management and care planning. Mr Lee was discussed during daily MDT meetings to ensure a consistent approach between both new and recurring visiting staff, and to ensure that all staff were aware of the on-going care arrangements and risks. Mr Lee was also discussed on a weekly basis at the IHBTT Case Management Review, which included an appraisal of risk and assignment of risk rating. The Case Management Review is again an MDT meeting that involved the various professionals from the service with knowledge of Mr Lee. The MDT and Case Management Review meetings are undertaken to further ensure consistency of risk assessment, risk management and care planning.

We can confirm that Mr Lee was allocated a 'Key Worker' within the IHBTT on 21st July 2021, and this information was recorded on page 21 of the Serious Incident Investigation. The allocation of a Key Worker was undertaken during the IHBTT Multi-Disciplinary Team Meeting on 21st July 2021 at 13:30hours and was allocated based on the caseload numbers of practitioners at the time.

The Key Worker's responsibilities include:

- The ongoing assessment and management of risk, inclusive of updating the FIRM (formulation informed risk management) risk assessment when a change in risk is identified;
- The continual assessment of individual patient need;
- Monitoring the efficacy of prescribed medication, observing for any notable side effects or adverse reaction;
- Care planning and ensuring a collaborative care planning process;
- Initiating and maintaining carer and family contact and involvement;
- Providing accurate and timely feedback to inform the weekly case management review and where possible participate in the Case Management Review (weekly discussion to appraise risk); and
- Ensuring that all entries made in relation to a home visit follow the progress note template.

The key worker provided the oversight role as per the responsibilities detailed above and was involved in the discharge pathway for Mr Lee. However, they did not have direct face-to-face contact with Mr Lee because of personal circumstances that changed their shift availability (during this period the practitioner predominantly worked nights).

As a result of the learning from Mr Lee's death, how the team allocates a Key Worker has changed to include the following:

- All service users will be allocated three Key Workers, with shared responsibilities;

[redacted]

- Allocation of Key Workers is undertaken by the Clinical Lead for IHBTT, taking into account the following:
    - Presenting clinical risks: does the patient require a male or female practitioner.
    - Immediate staff availability- taking into account planned shift patterns, annual leave, absence and training.

At the time of Mr Lee's care with IHBTT, the allocation of visits was undertaken based on availability of staff. Current practice is that in the first instance the service will now make every effort to allocate one of the three Key Workers to undertake the visit. This is a further introduced means of ensuring consistency of risk assessment, risk management and care planning. The IHBTT Clinical Lead undertakes a regular caseload audit to ensure that Key Workers have been allocated to every service user's care.

We note your concern that the *"risk assessment on 16.07.21 was flawed"*. This assessment was completed by an experienced Psychiatrist and Mental Health Nurse, both of which agreed with the assessment of self-harm and suicide risk following the assessment. A risk assessment considers a wide and diverse range of information, as evidenced by the clinical entries for this contact, the IHBTT inquest statement and the Serious Incident Investigation report. There was a recent history of attempted ligature, the circumstances around that were explored, factors including Mr Lee's engagement, insight into his problems, future planning and presentation post self-harming event were all considered as part of the global assessment of risk. These factors when combined informed the grading of the risk. The assessment and level of risk in a person is a combination of static (historic) and dynamic (current) factors. In Mr Lee's case, there were no further attempts of self-harm or suicide after 16th July 2021 (static) until his death on 16th September 2021, and he remained engaged with services throughout.

We hope the above information assists your understanding of the Trust's IHBTT service and the changes made as a result of the learning from Mr Lee's death. The Trust wishes to assure you that all efforts will continue to be made to ensure appropriate allocation of Key Workers, consistency of contacts with practitioners whilst an individual remains on the IHBTT caseload, and risk assessment, risk management and care planning will continually be reviewed as part of the MDT approach to care within the IHBTT.

Lack of key worker approach

Please see response above regarding the allocation of a Key Worker and MDT approach to care for service users on the IHBTT caseload.

Lack of communication with the armed forces

[redacted]

At the outset of an individual's care, and as part of the initial IHBTT assessment, practitioners are required to identify and record any other agencies involved in the service user's care. The IHBTT Clinical Lead undertakes a weekly caseload audit to ensure practitioners are appropriately identifying agencies involved in the care, and any deficits identified as part of the audit are addressed through the supervision of the practitioners involved.

In December 2022, the IHBTT introduced a practitioner role with a specific focus on ensuring liaison with the armed forces or veteran services where the person has been identified as being involved with these agencies.

The practitioner currently working in this role is a veteran themselves, and the service offer for any person who is either engaged in the armed forces or who is a veteran, will be offered a visit by this practitioner. This practitioner is also able to act as a Key Worker to these service users as necessary.

Superficiality of communication with the family

The Trust considers that families and carers provide a significant and important role in the care of a service user. This is reflected in the Trust's values - *"We know that families and carers matter".*

The Trust identified through the Serious Incident investigation report that Mr. Lee's family did not feel, nor was it evidenced fully, that they were substantially engaged with in respect of his care. As a result, the recommendation was made at Page 35 of the Serious Incident Investigation report *"For the service to provide assurance that the involvement of service users, their families and Supporters, is being actively sought both at the initial assessment stage and also as care plans are reviewed and changed, in line with Trust policy".*

Assurance is currently gained in respect of communication with, and involvement of, families and carers as follows:

- The IHBTT use a progress note template for every home visit. Included within this template is a heading titled "Family Feedback". This acts as a prompt for staff to liaise with families or carers on every visit.
- The IHBTT Clinical Lead's regular caseload audit identifies whether staff have sought recent and regular feedback from service users, their family and any carers.
- The IHBTT Clinical Lead's regular caseload audit identifies whether a carer has been offered a carer's assessment, as required at the outset of a services user's acceptance onto the IHBTT caseload, and monitored through the weekly Case Management Review meetings; and
- Allocation of three Key Workers to ensure continuity of contacts with the service user, their families and carers

[redacted]

Anxiety about appropriate risk sharing

We understand this concern relates to the contact with Mr Lee's partner on 15th September 2021. We would like to take this opportunity to clarify the contact as per the information detailed in the IHBTT statement and Serious Incident investigation report.

Mr Lee's partner contacted the IHBTT service on 15th September 2021 to report her on-going concerns regarding Mr Lee. The clinical entry records that Mr Lee's partner had not informed or agreed with Mr Lee that she would be contacting the service, nor did she wish for him to be made aware of the contact. Family contacts of this nature are helpful to practitioners when considering the practitioners assessment of risk and the person's presentation. However, and as you will appreciate, it places practitioners in the situation where they may not be able to refer to the family concerns directly with the service user because of the possible consequences of doing so (e.g. break-down of relationships, anger or agitation etc). This is the 'difficulty' referred to by the practitioner in their clinical entry on this occasion.

As indicated in your Regulation 28 report, Mr Lee had a pre-arranged appointment with an IHBTT practitioner following this telephone contact from his partner. As per the IHBTT statement and Serious Incident investigation report records, the visiting IHBTT practitioner discussed the contact from Mr Lee's partner with the practitioner that took the telephone call. The contact from Mr Lee's Partner was therefore appropriately considered as part of the visiting practitioner's assessment, without any barriers as to understanding around information sharing.

I do hope the above information is of assistance and answers the concerns raised within your Regulation 28 report following the sad death of Mr Daniel Lee.

Yours faithfully,

[redacted]

[redacted]
Chief Medical Officer

[redacted]