Mid and South Essex NHS Foundation Trust

H.M Area Coroner
Ms Sonia Hayes
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

Our Ref: [redacted]

[redacted]

13 August 2024

Dear Ms Hayes

Regulation 28 Report to Prevent Future Deaths- Aaron Deeley

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) dated 19th June 2024, relating to the Inquest of Mr Aaron James Deeley

Thank you for this opportunity to share the improvements we have made since the tragic death of Mr Deeley. We know that sadly, increasing numbers of our acutely unwell patients also face mental health challenges, and this is an important area of focus for us.

We have carefully considered the specific areas of concern arising from Mr Deeley's Inquest and I have set out below our response to each matter raised.

Matters of Concern

While a patient is admitted to an acute Trust ward for treatment for physical health treatment and is being held under section 5 (2) Mental Health Act for a Mental Health Act assessment due to concerns the patient presents a risk to themselves or others with a mental disorder, it permits the patient to be held for a maximum period of 72 hours.

a) **Patients admitted into the Accident & Emergency department detained under various sections of the Mental Health Act have a Responsible Clinician allocated. Patients who are not under section have access to the Mental Health Liaison Team.**

If a clinician is concerned about a patient's mental health whilst in the Emergency Department (ED), the Mental Health Liaison Team (MHLT) is available 24 hours a day and 7 days a week to provide support. The MHLT are responsible for prioritising referrals as they receive them, and there are escalation routes in place for the ED team if required.

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We have recently reviewed our policy *'MSEPO-21231 Admission & Treatment of Patients with a Mental Health Disorder in an Acute Hospital Setting'* which reinforces the mental health support available to patients whilst in ED and inpatient wards.

The policy includes clear and practical guidance for staff setting out how to access the MHLT and when to escalate concerns.

b) **Patients admitted onto a ward at the acute Trust detained under various sections of the Mental Health Act have an allocated Responsible Clinician. As section 5 (2) is a holding power only, there is no Responsible Clinician allocated for a vulnerable patient being held pending assessment for consideration for detention under the Mental Health Act.**

&

c) **During the waiting period of up to 72 hours, Mental Health Liaison will not attend the acute ward or make assessment of the presenting risks of self-harm.**

We recognise the legislation does not require a patient to have a 'responsible clinician' allocated whilst they await assessment. During this time, it is the ward's responsibility to risk assess the patient and maintain their safety. We know this can be challenging, especially when both acuity and patient flow is high.

The wards are advised to refer to the MHLT when they have concerns about a patient's mental health and associated risk(s). We are encouraging staff to have early conversations with the MHLT, and where possible, a discussion with a psychiatrist before the application of a Section 5(2), working towards holistic and collaborative risk assessments. I am advised that the MHLT are routinely advising ward staff on how best to support patients.

A key management tool for staff caring for acute patients with mental health needs is our *'MSEPO-21228 Policy for Enhanced Supervision and Engagement'*. We have therefore made several improvements to this policy to provide more practical guidance and support for staff during this important time while patents await assessment. We have also delivered training to nursing colleagues in relation to the updated policy and refreshers on record keeping standards so that staff are appropriately skilled in how to complete the supervision paperwork correctly.

All ward managers are empowered to escalate to senior managers if a patient requires additional mental health support. We are accessing Registered Mental Health Nurses where needed to maintain patient safety, and we are confident that managers are escalating these patients appropriately.

We acknowledge that our pathway documentation for patients detained under Section 5(2) needed reform. We have therefore added a new flowchart to our '*Admission & Treatment of Patients with a Mental Health Disorder in an Acute Hospital Setting'* Policy. A copy of the flowchart is attached for reference.

Our new training sessions cover the practical application of this flowchart with worked examples for staff to understand the correct route to treatment for patients. We are confident that staff attending the training are clear on the steps they should take to maintain patient wellbeing and safety, whilst awaiting formal assessment.

We share your concerns that the MHLT may not attend the acute ward or make assessments of the presenting risks of self-harm. There may of course be instances where it would be inappropriate to attend upon an acutely unwell patient and conduct such formal mental health assessments. For example, when a patient is unconscious or intoxicated. However, there are instances when our team feel MHLT support would benefit the patient prior to them being 'medically fit.'

We have listened to this concern, and we feel this is a key topic for us to take forward with EPUT in our future working arrangements. As you will be aware, the MHLT service is commissioned by our local Integrated Care Board (ICB), and there exists a contractual arrangement between the ICB and Essex Partnership University Trust (EPUT).

We have taken the lead with organising a joint working group with the ICB, EPUT and ourselves to discuss this issue as well as the mental health services provided to us, as a whole, to make sure we are getting this service right for our patients.

The joint working group will meet for the first time on 23 September 2024, and senior colleagues will set out terms of reference including the sequencing of assessments for patients with both a mental and physical health need; a written service level agreement so that staff are clear on when to ask for support, and when to expect it; a document setting our clear roles and responsibilities for staff at both trusts.

We are confident we have the right colleagues attending this meeting to make important decisions about improving the standard of mental health care for patients in our hospitals.

d) The acute care healthcare professionals do not have specialist mental health training to conduct a mental health assessment and the consequential presenting harm.

As an acute trust we cannot expect all staff to be able to conduct comprehensive mental health assessments and associated risk assessments, this is a service that EPUT are contracted to provide. However, staff must be trained to identify when mental health assessments are required, and all staff should know when a patient is at risk of harm, to themselves or others.

We have therefore employed a Mental Health Lead Nurse tasked to review our current policies, processes, and training needs. They are already working closely with partner agencies to strengthen current practice and increase staff knowledge.

Training has been delivered to Heath Care Assistants by the Mental Health Lead Nurse targeted on enhanced supervision skills, how to gain greater awareness of mental health issues, and how to engage meaningfully with patients and offer support.

We have also recently developed a rolling training programme with EPUT so that our staff can learn from the experts, and develop their skills and confidence delivering de-escalation techniques, therapeutic engagement, risk assessment, awareness of warning signs, triggers and environmental hazards and risk management.

The training is delivered by EPUT on a three-weekly basis to cohorts of MSE staff and this will continue indefinitely.

In addition to staff training, improvements have already been made to policies as discussed above, and we are keeping our training needs under review.

e) **There was confusion at the acute Trust as to what regime was required to ensure that a patient awaiting Mental Health Act assessment could be put under 1:1 observation. The Trust policy was confusing and did not cover patients like Aaron Deeley.**

Section 5 of our Policy for Enhanced Supervision and Engagement has been re-written in collaboration with the Mental Health Lead Nurse to clearly set out the criteria that should be met for a patient to trigger for enhanced supervision.

Appendix 4 of our *'Admission & Treatment of Patients with a Mental Health Disorder in an Acute Hospital Setting'* provides further guidance on assessing individuals with a decision-making flowchart included (attached).

f) **There is no joint protocol to cover the working between the two Trusts on this issue as the referral for Mental Health Act assessment goes outside of both organisations.**

It is a key priority for us to develop a robust joint protocol with EPUT, and this will be the first order of business at our meeting in September 2024.

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Our vision is that patients in our hospital should have access to appropriate and timely mental health care in parallel with their acute treatment; many patients may not be medically fit, but they are well enough to receive mental health support, and we know the sooner they have this, the better. We are committed to working with EPUT to develop a collaborative patient centered approach.

There is a lacuna for patients awaiting Mental Health Act assessment and requiring simultaneous physical healthcare when a significant risk has been identified such that a patient may require detention for their own safety.

We have delivered training so that staff are able to identify patients such as this, and we have improved our policies and guidance to make sure patients are carefully supervised when needed. We would be happy to supply full copies of the new policies if this would provide further assurance.

We now have clear escalation routes to senior colleagues who can access external support, for example Registered Mental Health Nurses, when the ward team are unable to meet the patient's needs, or the risks mean that extra help is needed. I am aware these practices are happening, and we are appropriately managing and mitigating risks.

Further, we have important work to do with our colleagues at EPUT to develop a clear joint working protocol. We have a plan, and the right colleagues involved in this project to make this happen.

We hope that the action we have taken, and the plans we have in place have provided assurance that your concerns are being addressed. However, if you have any further concerns or you would like to discuss this case further, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
on behalf of [redacted]
Chief Executive
Mid and South Essex NHS Foundation Trust

Enc

Section 5(2) process

On admission staff should:
-Record a detailed description of the patient and maintain a record of their clothing.
-Utilise the MSE Enhanced Supervision Policy to assist in decision-making regarding necessary supervision level.
-Record past risk history and current concerns e.g., patient is voicing suicidal ideas.
-Refer to Mental Health Liaison Team at earliest opportunity. Request support and review if risk increases; this may reduce further escalation and the need for Sec 5(2)

For Section 5(2)
Patient (Adults and Children) must be considered to:

1. Have a mental disorder.
2. Be at risk of harming self or others.
3. Patient must be unwilling to stay informally.
4. Does not apply to A&E or Outpatients

If patient is identified as needing to be detained on a Section 5(2) and agreed by the Clinical team. The form H1 must be fully completed.

The Doctor must complete Part 1 and Nursing staff must complete Part 2 of form H1. The specific date and time must be recorded within the clinical notes when this detention started.

Matron/ward manager/Nurse in charge to develop appropriate care plan and arrange enhanced supervision.

Within the first 2 hours of detention, the Mental Health Liaison Team must be notified:
Broomfield: [redacted]
Basildon: [redacted]
Southend: [redacted]

Ward staff/Doctor are responsible to send H1 form to the Mental Health Act Office: [redacted]

This must be sent within 3 hours.
A copy of the form must be retained in patients' record.

Ward staff must make every effort to ensure the patient is aware of their rights and provide the 'rights leaflet' and document in patients' notes.

The leaflet can be found here:
RIGHTS AND RESPONSIBLITIES OF NEAREST RELATIVE UNDER THE MENTAL HEALTH ACT 1983 (nationalarchives.gov.uk)

The Mental Health Liaison Team (within 72 hours of detention):

- To review and decide if a full Mental Health Act assessment is required.
- The Liaison Team Psychiatrist may review the patient and decide to discharge from Section 5(2). The patient is then "informal" (voluntary patient) again.

During the detention of Section 5(2) a patient requires physical health treatment:

- Adult patients - seek consent.
- Children - seek consent from patient/parent/ appointed keyworker.

If there is any doubt of patients' capacity (16 and over) complete a Mental Capacity Assessment.

If under 16 arrange an urgent MDT.

If lacks capacity, follow Trust's MCA Policy MSEPO-21103/ seek advice from the Safeguarding Team/
Legal Team if necessary:

[redacted]

In an urgent situation, to save a life or prevent serious harm to a patient if it is reasonably believed that a patient lacks capacity, treatment/ care must be provided.