SANDWELL AND WEST BIRMINGHAM NHS TRUST

Trust Board: Wednesday 12th July 2023

Patient/Family Story

Summary of the Story: -

Mr Peter Atkins telephoned his daughter on 15th March 2021 having experienced suicidal thoughts which were becoming worse. The crisis team were contacted advising they closed in 15 minutes and could not help. Peter's GP was called; Covid prevented an appointment being provided. Family arranged a talking therapies appointment for 6th April via 111.

Family called 999 on 20th March 2021. Paramedics arrived and spent 40 minutes with Peter, reassuring him and family that they would take him to Emergency Department (ED) where he would be safe. A Next of Kin (NoK) contact number was taken by paramedics and family were advised they would receive a call once Peter was assessed. Mr Atkins was taken to Sandwell Hospital ED via ambulance with suicidal intentions early that evening. He was categorized as a priority 3 and referred to the Oak Unit.

Peter was placed on the corridor and assessed further with observations completed. He was placed into a high visibility cubicle and reviewed the by Oak Unit team (RMN) at 22:30hrs (MH Nurse). He maintained rapport and good eye contact during the assessment. He remained calm, interacting well and communicated openly and clearly with no aggression with normal speed and tone in speech.

Peter stated that he currently took Venlafaxine 75mg, however his GP had reviewed this, increasing the dose to 150mg. Following this assessment, it was noted that psychiatric assessment may be appropriate regarding the repeated "ask for help," poor mental health, history of psychosis and previous sectioning.

Peter was deemed to have capacity and safe to be discharged by the Oak Unit. He was discharged at 22:38hrs. A nurse statement reflects Peter was asked whether he needed help getting home to which he replied he would contact his wife via his own mobile phone, showing the nurse his wife's phone number stored in his phone. Also, that staff offered to contact Peter's wife on his behalf, and he declined this.

Peter left the department alone in his slippers. His wife found Peter asleep in his porch the following morning at 05.00 where he had been since 23.30 the previous evening. Peter was taken in and warmed up with a hot drink and put to bed.

Later that evening on 21st March 2021, after watching a TV programme with his wife Peter went to put the bins out and never returned. His wife found him in the garage where he had taken his own life.

HMC recorded a conclusion of suicide at inquest on 11th May 2021. Following inquest HMC raised concerns with the Trust about the communication at the time of Peter's discharge from the ED.

Family members subsequently explained that information (about Peter showing staff his wife's number on his mobile phone) could not be true as Peter never owned a mobile phone. They had passed contact telephone numbers to paramedics believing a family member would be contacted to collect Peter on discharge. Having received no call, they believed he had been kept in hospital for his safety. Paramedics included a home telephone number and a 'pick up' number on their EPR.

Peter possessing a mobile phone is contrary to what family explained. He was allowed to leave ED without further action as he was assessed as having mental capacity to make decisions about his discharge and his method of transportation home (both by the mental health liaison nurse SWB staff).

What are the key lessons / themes to emerge from this story?

There were concerns regarding the Oak Unit assessment (RMN) and whether psychiatric assessment should have been sought given Peter repeatedly asked for help with history of psychosis and a previous sectioning. Oak unit stated their EPR has much more detail than Unity; therefore, their assessment was also based on previous encounters was much more detailed than documented on Unity.

However, Peter's family have been unable to understand the discharge arrangements from Sandwell ED given the time of the evening Peter left the department and that he had presented with suicidal thoughts. Although Peter had mental capacity, he was vulnerable, and no contact was made to next of kin on discharge.

Whilst rationale for decision making at discharge has been provided, this conflicts with the family's own knowledge and accounts. Family are keen to work with the organisation through the Mental Health Assurance Group, citing their experiences to prevent this happening in future.

Following an Incident form, a discussion was held in Ed with the following recommendations.

- Patients presenting in this way are promptly assessed by a senior nurse and Dr at triage to assess for potential medical issues and MH risk state. New assessment form being developed by the Mental Health Lead
- Even when the patient is medically for a Dr assigns themself as point of contact between patient and the MH team.
- Patients medically fit and referred to MH team should be assessed by the MH team promptly to minimise risk from delays in assessment.

- MH team to ensure they speak with the Dr or nurse in charge of the patient, informing of their assessment, the on-going care plan and discharge plan. MH team should also strive to input notes onto the EPR ASAP, so ED clinical staff are aware of the plan once the MH team leave the ED.
- Either the MH team or ED staff should speak with the patient before they leave to check if they would like us to contact family / NoK / friends or relatives. If the patients consent to this, every effort should be made to make that contact and inform of the plan for the patient.

Next Steps in agreement with the family

1. Implement the recommendations above and monitor within the clinical group.
2. Record the story to show at Trust Board but also share across the Trust for learning,
3. Arrange for her to meet with Group Director of Nursing for MECC in the coming few weeks.
4. invite the daughter to the Mental Health Assurance Group for September to go through what further can be / has been done.