

Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

**Lincolnshire Safeguarding Adults Board
SAR report in respect of
Simon**

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1. Simon¹

- 1.1. Simon was a white British male, who was 45 years old when he died. He lived alone in local authority housing. Simon liked peace and quiet, enjoyed lots of different types of music, and had a sweet tooth. He loved learning about history and liked to watch original Tom and Jerry cartoons. Simon said that he struggled to ask for help, or to start conversations, and had relied upon his mum for support, however she had died in 2016. Simon said that he struggled to make friends.
- 1.2. Simon had been known to mental health services in Lincolnshire for many years, including the Crisis Resolution and Home Treatment Team (CRHT) and the Community Mental Health Team (CMHT), he had also been an inpatient on mental health wards, and was a Transforming Care² Service User. Simon had been abused in the past by those who should have cared for him. Simon also spent time in prison, leading to the loss of contact with his own children. Simon described his time in prison as a violent experience and said that before his prison sentence he had felt brave and confident.
- 1.3. Simon had mental health diagnoses of frontal lobe damage due to a brain injury in childhood. Agencies have this recorded as being acquired at the age of eleven, and Post-Traumatic Stress Disorder (PTSD) because of childhood sexual and physical abuse. He was also diagnosed with organic³ delusional disorder⁴ with symptoms of hypervigilance⁵ and persecutory delusions.⁶ He was known to use amphetamines in place of prescribed medication.
- 1.4. Simon's GP practice had a diagnosis of autism recorded, however, this is understood to have been a "working diagnosis". In 2014 he had a psychological assessment completed by a highly specialised clinical psychologist. This clearly described key indicators for autism, namely little flexibility of thought, literal interpretation, and difficulties in reading the actions and body language of others, along with communication difficulties. However, the assessment did not mention autism specifically. This is because – in line with diagnostic criteria for autism spectrum disorder⁷ - it was not possible to give Simon an official autism diagnosis as he was also experiencing psychosis.

¹ All names, identifying features and locations have been anonymised to protect Simon's privacy.

² A national programme led by NHS England which is all about improving health and care services so more people with learning disabilities and/or autism can live in the community with the right support, close to home and have the same opportunities as anyone else

³ A decrease in mental functioning that is not a result of a psychiatric condition.

⁴ A mental health condition that causes unshakable beliefs in something that is untrue.

⁵ Increased alertness where the individual is constantly assessing potential threats. This is not always related to an underlying condition but can be caused by necessity, such as when a person has experienced abuse

⁶ A type of paranoid thought pattern where individuals believe they are being targeted, harassed, or conspired against by others, often without concrete evidence supporting such beliefs.

⁷ ICD-11 – World Health Organisation 2019

- 1.5. Following Simon's death, a LeDeR review was completed.⁸ Information from the LeDeR review has been included in this report. The LeDeR review confirmed that Simon's care package met his needs, and reviews of the care package were up to date. The review also identified a lack of daily crisis team visits, following escalation of Simon's self-harming, and that the Christmas period affected his care. There was also recognition that different Community Psychiatric Nurses (CPNs) responded to Simon, which did not enable the building of a therapeutic relationship. The review did find that Simon received good care, that he had access to services from various teams and appeared to engage with staff. He was offered assessment in hospital and was provided with follow up in the community. The LeDeR review concluded that following the completion of the Safeguarding Adult Review (SAR), a decision would be made whether further action was required.
- 1.6. Lincolnshire Partnership NHS Foundation Trust (LPFT) professionals who were involved with Simon described him as lonely and isolated, kind and a "gentleman". Simon was described as not confident, and someone who would be unlikely to initiate conversation but would engage in a conversation if spoken to. LPFT professionals also reflected that Simon always seemed to be holding something back, and it was not always obvious when he was struggling to understand what he was being told. It was felt by the CMHT that Simon put other people's feelings ahead of his own. LPFT professionals reflected that they were "very aware of how lonely Simon seemed" and that Simon did not seem to have any hopes for the future.
- 1.7. The CMHT practitioner who worked with Simon during the period prior to his death, reflected on an occasion where they accompanied Simon along to a local community hub to assist with increasing his social networks. Simon and the practitioner looked at a rack of used clothes for sale and Simon indicated he would like to purchase a scarf, which would cover his self-harm scars. However, he did not have any money, and so a staff member of the community hub purchased it for him. As they left the hub, Simon became tearful, which the CMHT practitioner recognised as overwhelm from a stranger's act of generosity. The practitioner felt that this emotional reaction spoke to the sense of loneliness and isolation Simon was experiencing within his life.
- 1.8. It is unclear to what extent Simon was isolated from his family. He had asked for his family's contact details to be taken from his records; however, he did also tell professionals that he spoke to his brother each week. There appears to have been some trauma in Simon's life. Information contained in a 2014 psychology report on the LPFT clinical system, indicates that Simon had experienced physical, sexual and emotional abuse from his stepfather between the ages of 5 and 35. Simon shared that he had grown up in a controlling environment. However, Simon felt shame about his experiences and said that he did not want to go into

⁸ This is a review of key episodes of health and social care that a person received that may have been relevant to their overall health outcomes. The aim of the review is to learn from deaths of people with disabilities and/or autistic people, so that future avoidable deaths may be prevented. The reviewers look for areas that need improvement and areas of good practice, which can be shared.
<https://www.dpt.nhs.uk/download/uDHNwC7j8d>

detail about this.

- 1.9. Simon's CMHT Worker felt that as well as being estranged from his family, Simon was also isolated because his communication difficulties made it hard to build new relationships. This was compounded by experiences of abuse from people he had befriended in the past. Incidents were documented in LPFT records about damage that had been done to Simon's home by people he considered to be friends. He had also been stolen from and assaulted by an individual, who was acting as his carer, and he had been financially exploited by another individual. LPFT considered that Simon continued to be vulnerable to exploitation throughout the scoping period for this review.
- 1.10 Simon had a history of self-harm and suicide attempts, which had been escalating in seriousness and frequency since October 2023, leading up to his death. On 22nd December 2023, three days before Simon was found deceased in his flat, Simon had been taken into the local Emergency Department by ambulance. A safeguarding referral was made by the ambulance crew, however, Simon died before this was followed up by Adult Social Care. Simon discharged himself from the Surgical Emergency Assessment Unit (SEAU), against medical advice, at around 8pm. The CRHT were immediately informed and at 10pm that evening they went to his home. Apart from speaking to Simon at his front door that evening, the LPFT CRHT were not able to gain access to him again, until police entered his flat on the evening of 25th December 2023 and found him deceased.
- 1.11 The coroner's inquest found the medical cause of Simon's death to be haemorrhage and stab wound to the chest following amphetamine kick. The coroner reached a verdict of suicide on 25th June 2024.

2. Methodology

- 2.1 Following Simon's death, a SAR referral was submitted by LPFT, due to concerns about agency responses on the day of Simon's death. The purpose of a SAR is to:

"Promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring."
- 2.2 On 13th February 2024, the Significant Incident Review Group – Adults (SIRGA) met to discuss the referral. It was decided that a full information trawl should be conducted to inform the decision making. The case was subsequently discussed at the SIRGA meeting on 19th March 2024, when a recommendation was made to commission a statutory, discretionary SAR, under section 44 (4) of the Care Act (2014). The Independent Chair of the Lincolnshire Safeguarding Adult Board (LSAB) agreed with the SIRG recommendation and approved the commissioning of a SAR.
- 2.3 The scoping period for the SAR was agreed by SIRGA as 1st October 2023 through to the date of Simon's death. The start date for this scoping period was significant because Simon self-

harmed during October 2023, and from this point his mental health appeared to deteriorate, leading up to his death.

2.4 The key lines of enquiry for this SAR were agreed by SIRGA as follows:

- How well did practitioners engage with Simon, enabling them to understand him as an individual?
- How effective was practice both within agencies and between agencies in safeguarding Simon?
- How well did the wider system support multiagency practice when working with Simon?
- What evidence was there of good practice when working with Simon
- What learning can be identified and how can the learning from Simon be applied to the wider system

2.5 The Key Lines of Enquiry reports were written by the agencies involved with Simon. These were written by staff who had no contact with Simon, and who were independent from the line management of staff who had contact with Simon. The Key Lines of Enquiry reports were then shared with the Independent Chair of the SAR.

2.6 In order to ensure that the learning from this review came predominantly from the practitioners' experiences of engaging with Simon and responding to his presenting needs, it was agreed that in order to supplement the key lines of enquiry, a practitioner event be held, where those directly involved with Simon – along with line managers and those responsible for safeguarding – would discuss specific periods of the two months prior to Simon's death, with a view to dynamically identifying systems learning within a shared space.

2.7 At this event in December 2024, the early themes identified from the Key Lines of Enquiry Reports were discussed with attendees, along with a collaborative analysis of the chronology of contacts with Simon.

2.8 Agencies involved

Lincolnshire Community Health Services (LCHS)	<u>Clinical Assessment Service (CAS)</u> – as part of the urgent care offer, patients are referred to the CAS by health professionals or by NHS 111.
Lincolnshire Police	<u>Police control room</u> – contact management operators and contact control operators taking calls
Lincolnshire Partnership NHS Foundation Trust (LPFT)	<u>Community Mental Health Team</u> – provide care for people recovering from ongoing mental health problems <u>Crisis Resolution and Home Treatment Team</u>

	<u>(CRHT)</u> – supporting people experiencing a mental health crisis – part of the acute inpatient and urgent care services. <u>Transforming Care Service</u> – A national programme all about making health and care services better for people with learning disabilities and autism <u>Liaison Psychiatry Service</u> – specialists psychiatry assessment, support and treatment for adults in acute hospital care.
Lincolnshire Integrated Care Board (ICB)	<u>Primary Care – GP Practice</u>
United Lincolnshire Hospital NHS Trust (ULHT)	<u>Emergency Department</u> – a medical treatment facility specializing in emergency medicine
Lincolnshire Fire and Rescue	<u>Home Fire Safety Visit</u> – personalized fire safety action plan, to keep occupants safe from fire
East Midlands Ambulance Service (EMAS)	<u>Paramedic Service</u> – involves highly skilled pre-hospital clinicians who respond to medical emergencies
City of Lincoln Council	<u>Housing</u> – local authority landlord services

2.9 Panel members

Agency	Nature of contribution	Role of panel member
Lincolnshire Safeguarding Adults Board (LSAB)	Panel member	SIRGA Independent Chair
ViMar Solutions Ltd	Independent Chair and Author	Independent Reviewer
LSAB	Panel member	Interim Business Manager
LSAB	Panel member	Audit and Policy Officer
Lincolnshire County Council – Adult Social Care and Community Wellbeing (ACCW)	Panel member Chronology	Area Manager – Safeguarding
Lincolnshire Community Health Services (LCHS)	Report Chronology Panel member	Deputy Named Nurse for Safeguarding
Lincolnshire Police	Report Chronology Panel member	Review Officer
Lincolnshire Partnership NHS Foundation Trust (LPFT)	Report Chronology Panel member	Head of Safeguarding, Public Protection and Mental Capacity
Lincolnshire Integrated Care Board (ICB)	Report Chronology Panel member	Deputy Designated Nurse for Safeguarding Adults, Children and Looked After Children

United Lincolnshire Hospital NHS Trust (ULHT)	Report Chronology Panel member	Named Professional Adult Safeguarding
Lincolnshire Fire and Rescue	Report Chronology Panel member	Community Fire Safety Manager
East Midlands Ambulance Service (EMAS)	Report Chronology Panel member	Safeguarding Specialist Practitioner
City of Lincoln Council	Panel Member	Assistant Director with responsibility for safeguarding

Advisory Role

Legal Services Lincolnshire	Legal Advisor
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Independent Reviewer

- 2.10 Dr Liza Thompson chaired and authored this review and was selected by LSAB as suitably qualified and experienced. Dr Thompson holds a PhD in Law and has worked within a multi-agency environment responding to the needs of vulnerable people for over twenty years. She is also independent from all agencies involved in this review.

Family involvement

- 2.11 Following the decision to hold a SAR, the Safeguarding Adult Board (SAB) contacted two of Simon's brothers and a sister via letter. There had been no responses from family at the point when the Independent Reviewer was appointed. There were a series of discussions about family members, with the SAR panel, at the practitioner event, and between the Independent Reviewer and a representative from Children's Social Care. It transpired that Simon had many family members, with extended family and several of his own children. However, following a discussion with practitioners at the practitioner event, and a discussion with Children's Social Care, there were no further immediate family members identified for the SAB to contact regarding involvement in the SAR. A follow-up letter was sent to his three siblings but at the time of authoring the report there had been no contact with the SAB from any members of Simon's family.

Equality and Diversity

- 2.12 In order to attempt an understanding of the world through Simon's eyes, the panel first considered Simon's protected characteristics, as set out in the Equalities Act 2010. It was considered that Simon's diagnoses of organic delusional disorder with symptoms of hypervigilance and persecutory delusions, along with PTSD and the working diagnosis of autism were significant in their complexities and would have undoubtedly shaped how Simon perceived the world, but also how Simon was perceived by the world.

- 2.13 Organic delusional syndrome is a rare and little-known mental disorder that is characterised by persistent false beliefs that are not based in reality. Patients with organic delusional syndrome are thought to experience different types of false beliefs.⁹ Simon experienced persecutory delusions, which are a type of delusional condition where an individual believes they are being targeted or harmed by a person or group, despite a lack of evidence to support this belief. People experiencing persecutory delusions may feel constantly threatened and may exhibit signs of anxiety or distress because of their beliefs.
- 2.14 Simon was also identified as being hypervigilant, which is a symptom of both organic delusional syndrome and PTSD. Hypervigilance is a state of heightened alertness, which involves fixation on potential threats, overestimation of threats and dangers, trouble breathing, dizziness, muscle tension, poor sleep – amongst many other effects.
- 2.15 Simon was prescribed medication to address this condition, however it is thought that he did not fully comply with his medication plan and had been using amphetamines instead as he stated this reduced his symptoms. Research shows the use of amphetamines being associated with higher odds of psychosis, suicidality and depression.¹⁰
- 2.16 In order to understand Simon’s experiences of the world, it was also important that the panel looked beyond the Equality’s Act and acknowledged Simon’s social and environmental circumstances. Simon was isolated from his family due to incidents which had happened throughout Simon’s life, possibly from childhood through to adulthood. Simon appears to have been the victim of abuse from family, friends and other people who he should have been able to trust.
- 2.17 Research has found that individuals exposed to childhood trauma¹¹ are more likely to report delusional-like experiences, and that exposure to more types of traumas increased the likelihood of delusional like experiences.¹²
- 2.18 Simon’s isolation from family, and his lack of friends or support networks may have led to experiences of loneliness, which in and of itself can significantly increase risks for depression and anxiety. In turn, people with chronic illnesses, and disabilities are at higher risk of chronic loneliness.¹³
- 2.19 Simon’s mental health conditions gave him delusional thoughts, he perceived the world as a threat, and this would have impacted on his ability to trust people. The trauma he experienced would have also impacted on his ability to trust people, particularly considering the abuse he

⁹ Cummings, J “Organic Delusions: Phenomenology, Anatomical Correlations, and Review” *British Journal of Psychology* (2018)

¹⁰ McKetin, R et al “Mental Health Outcomes Associated with the use of Amphetamines: A Systematic review and Meta-Analysis” *The Lancet* (16) (November 2019) pp.81-97

¹¹ Wright, A et al “The Impact of Childhood Trauma, Hallucinations, and emotional Reactivity on Delusional Ideation” *Schizophrenia Bulletin Open* (2020)

¹² Saha, S et al “The Association Between Trauma and Delusional-Like Experiences” *Psychiatry Research* (189) (September 2011) pp.259-264

¹³ [New Government research identifies clear links between loneliness and mental health distress - GOV.UK](#)

had suffered was perpetrated by family and other people he should have been able to trust. The lack of trust in the outside world would have led Simon to isolate himself; whilst being alone in his home or in the community, he would have continued to have delusional persecutory thoughts, and some of the symptoms described; of hypervigilance and sleep issues.

- 2.20 In addition to Simon's mental ill health, he also had some complex physical health issues, which included transmural myocardial infarction,¹⁴ atherosclerotic heart disease,¹⁵ left ventricular failure¹⁶ and asthma.
- 2.21 Each of Simon's characteristics and circumstances placed him at risk of suicide.¹⁷ From his gender and age; as males aged 45-59 made up the largest group of people dying by suicide in 2023,¹⁸ to his unemployed status, substance use and low income.¹⁹ Simon's physical and mental health problems further raised his risk of suicide, as did his experiences of childhood trauma.²⁰ In addition, people with autism are at greater risk of suicide,²¹ and suicide rates in Lincolnshire are above the national average. Cumulatively, Simon was at a very high risk of suicide.
- 2.22 Through the research for this review, LPFT practitioners recollected that Simon was someone who seemed to struggle with identity and had recorded on his communication passport²² that *"I want a new identity and to become a new person"* and also *"I would like a change a different life"*. A strong sense of identity is critical to a person's emotional and psychological wellbeing.²³ Adverse childhood experiences, such as those which Simon had, occurring during formative years, can disrupt the formation of a coherent identity. Individuals without a strong sense of identity may feel isolated from others, and it is known that Simon led a very isolated life. It is considered that a lack of belonging can also be an exacerbating factor for suicide risk.²⁴

3 Significant Incidents and Review Findings

- 3.1 On 12th October 2023, Simon presented at his GP practice with self-harm injuries to his neck and tongue. An ambulance was called, which arrived quickly, and he was taken to the local Emergency Department (ED) at ULHT. At the practitioners' event it was discussed how Simon would have found ED very difficult, as it is a busy and chaotic department. It was discussed

¹⁴ An acute shortage of the blood supply to the heart, leading to the development of end to end necrosis of the heart muscles.

¹⁵ A build-up of plaque, damaging the inner lining of the artery

¹⁶ Heart losing its ability to pump

¹⁷ [Lincolnshire-Suicide-Audit-2022.pdf](#)

¹⁸ [Suicides in England and Wales - Office for National Statistics](#)

¹⁹ [NCISH | Annual report 2025: UK patient and general population data, 2012-2022](#)

²⁰ Tarrier, A and Gregg, N "Suicide Risk in Civilian PTSD Patients – Predictors of Suicidal Ideation, Planning and Attempts" *Social Psychiatry and Psychiatric Epidemiology* (2004)

²¹ [Suicidality in autism: risk and prevention](#)

²² This provides a practical and person centred approach to passing on key information about people with complex communication difficulties, who cannot easily speak for themselves.

²³ [activesocialcare.com/handbook/work-in-a-person-centred-way/supporting-identity-self-esteem-and-wellbeing/](#)

²⁴ Van Orden, et al "The Interpersonal Theory of Suicide" *Psychology Review* (2010) pp.575-600

how for someone who was quiet, and struggling with confidence, it is a difficult environment, could have meant up to twelve hours' wait. ED staff were not aware of Simon's possible autism; there was nothing referring to this within his notes. Although there was a communication passport available between Transforming Care and LPFT, this was not accessible to ULHT departments.

- 3.2 In Lincolnshire there is a relatively new department Mental Health Urgent Assessment Centre (MHUAC) run by LPFT. This is situated in a separate building to the ED, which does mean that patients walking into ED must first be assessed then transferred to MHUAC. This was in place at the time; however, Simon was presenting with acute physical injuries which required immediate treatment. Simon initially refused treatment for his injuries but had been assessed by the treating physician as lacking capacity in this regard. A referral was made to the Psychiatry Liaison service, for mental health support and advice regarding the legal frameworks. The Approved Mental Health Professional (AMHP) service was also involved in these discussions. Hospital staff were advised that Simon could be treated for his facial injuries under the Mental Capacity Act.
- 3.3 After Simon was treated for his injuries, he was taken to the s.136 suite²⁵ where he underwent a Mental Health Act assessment and was deemed not to be detainable. He was in agreement with admission and was then transferred to the Psychiatric Clinical Decision Unit (PCDU)²⁶ until an acute bed was identified. On 18th October 2023, Simon was transferred to Ellis Ward, which is an LPFT ward, where he remained on informal admission until 3rd November 2023.
- 3.4 The day after he was admitted to Ellis Ward, Transforming Care came in to see Simon, so that a communication passport could be completed and shared with the ward staff. It was identified that Simon used gestures alongside words, and engaged well with visual tools, alongside spoken words. Simon is recorded as struggling with reading and writing, and he needed support with making appointments, paying bills and remembering to take his medication. Speech and Language,²⁷ and Occupational Therapy²⁸ screenings were also completed with Simon. When Simon was discharged from Ellis Ward, he was provided with a calendar of community appointments, which appeared to be effective as Simon attended seven of the eight appointments recorded on the calendar.
- 3.5 Simon identified his religious beliefs as the Christian denomination of Methodist. During the time he was on the ward he spoke to practitioners about his religion, and the guilt he felt due to the suicide attempts, which he felt went against his religion. Exploration of this may have provided an opportunity to better understand Simon's circumstances. It was discussed at the practitioner event that practitioners may not have felt equipped to discuss this with Simon,

²⁵ This is a place of safety for people who have been detained under section 136 of the Mental health Act.

²⁶ This is available if a mental health presentation is of a level of concern that cannot automatically be managed in the community. It allows a 24-48 hour longer period of assessment to decide whether they would benefit from an admission

²⁷ SALT provides treatment support and care for adults and children who have difficulties with communication, or with eating, drinking and swallowing.

²⁸ Help with everyday tasks for people who have difficulties due to disability, illness, injury or mental health problems.

however LPFT do have a chaplaincy service which could have been utilised to assist Simon at this time.

- 3.6 Upon discharge from the LPFT ward, Simon was supported by the CRHT whilst in the community who visited his home. He was then referred into the Community Mental Health Team (CMHT). At the practitioner event it was shared that Simon had a lovely home, although it was very sparsely furnished. Simon was offered support with finances following some discussions about possible debts.
- 3.7 During this time, it became clear to CMHT that Simon was isolated within the community, and so they took him along to a local community group. This was a positive step and during this time Simon appeared to be getting on well with the support he was receiving. He was asked at this point if he would like to explore the questions about religion which he had raised whilst in the LPFT ward, he declined this but stated he would like to save this for discussion in the future. The CMHT worker reflected at the practitioner event that it was going to take time to build trust with Simon, but they felt this was building up slowly.
- 3.8 Throughout this period, and also historically, Simon's GP struggled to engage him in a primary care mental health review. This was discussed at the practitioner event, and it was felt that as Simon was fully engaged with LPFT, a primary care mental health review was not considered to be a priority. This was a missed opportunity for a joined-up approach to Simon's care, particularly considering the number of medications which had been prescribed from primary care and mental health. A medication review would have also been of benefit to possible support a reduction in the number of Simon's daily medication.
- 3.9 After Simon had been home from the LPFT ward a few weeks, he reported some repairs which were needed at his home, to the Council – who are the landlords of Simon's home. Council contractors came to complete the repairs; however, the repairs left some gaps in the walls which appeared to cause Simon distress, he contacted the Council on 28th November 2023 with concerns that pests could come through the gaps. He also requested support from pest control.
- 3.10 The day after this contact with the Council, Simon drank bleach, a neighbour was alerted, and they called for an ambulance. Simon was conveyed to hospital and admitted to Dixon Ward (ULHT) for treatment of his physical issues, linked to the ingestion of bleach. Ward staff referred to Psychiatry Liaison Service for support. Simon was stating that he was disappointed that his suicide attempt had not been successful and was descriptive about his intention to attempt suicide again once he was discharged. Dixon ward staff agreed to contact Psychiatry Liaison when Simon was medically fit for discharge, and a contingency plan was formulated if Simon attempted to leave the hospital. This plan involved Dixon Ward doctors utilising the short-term holding power of s.5(2) of the Mental Health Act, and during this time Psychiatry Liaison explored admission for Simon to the Psychiatric Clinical Decision Unit, and a review of Simon's medication in light of his inability to swallow since ingesting bleach.
- 3.11 Once in hospital, Simon told practitioners that he had been "putting on a front" whilst in the

community, and practitioners at the practitioner event reflected that he may have been telling professionals what they wanted to hear. LPFT staff at the practitioner event reflected that whilst Simon was in the community - and was asked about suicidal ideation or intention to self-harm - he denied any plans. It was felt that his self-harming actions may have been impulsive – making it difficult to assess Simon’s risk of harm from himself.

- 3.12 Simon was admitted back to Ellis Ward (LPFT) informally, and during this time he presented to hospital staff as fixed on the idea of ending his life. He told staff about his plans for suicide and stated that this time he would not get it wrong.
- 3.13 Simon was escorted home on a few occasions during this informal admittance, he was able to collect items from home. Also, during this admission, LPFT staff observed Simon giving another patient his phone number and was later overheard on the phone with this peer who was asking Simon to buy him vapes from the shop. Simon was spoken to, advised not to buy items for other patients, and reassured that if he felt unsafe, he could seek support from the ward staff.
- 3.14 Simon was discharged from the ward on 15th December 2023 and was supported by the Community Psychiatric Nurse. It was reflected at the practitioner event that the 20-week period after hospital discharge is a period of risk, therefore the CRHT intervene during this period before handing over to the CMHT. Whilst Simon was supported by the CRHT, he had interactions with thirteen different staff members, some face to face and some via telephone. This is not unusual as the Crisis Team staff do not carry a case load, and so whoever is on shift will be allocated visits and calls on a daily basis. During the period following discharge from hospital, there would be multiple agencies working alongside one another, and this would gradually reduce overtime. Since Simon was originally admitted to hospital in October 2023, there had only been short spells where he was living in the community before he was back in hospital.
- 3.15 Also on 15th December, Simon’s GP Practice sent him an invite for a blood test, in relation to a review of his cholesterol medication. This was booked for 10th January 2024.
- 3.16 The following day, Simon was visited at home by the CRHT. He said he has been keeping himself busy since discharge from Ellis Ward. He expressed a desire to re-engage with CMHT and to establish a routine. He spoke about volunteering, and said he planned to return to the community centre which the CMHT had introduced him to. He spoke about the high number of medications he needed to take and the CRHT staff suggested using a Dossett box. Simon agreed to contact the pharmacist to request this. At this point he denied any thoughts or plans to harm himself.
- 3.17 Following the practitioner event, the Independent Chair met with the local authority housing providers, who highlighted the benefits of including social housing landlords in safety planning discussions, particularly when a patient is discharged with ongoing care and support needs. This is an area of learning within this review and will form a recommendation.

- 3.18 On 19th December 2023, a medication request was sent to the community pharmacy by the GP Practice – this was following receipt of the LPFT discharge letter for Simon, which detailed his medication.
- 3.19 Also on 19th December 2023, the Transforming Care Team visited Simon to continue the assessment they had started with him while he was in the LPFT ward. Simon told the practitioner that he had not slept well as he had stomach cramps, and he had been sick that morning. He agreed to them coming into his flat for a short visit. Simon said he was taking one day at a time and was decorating his flat for Christmas. The Transforming Care practitioner asked Simon if he would attend church, but Simon declined this. Simon was supported to contact the pharmacy, where his medication was being delivered. He was initially encouraged to make these calls himself but then became anxious and the Transforming Care worker took over the calls. Simon denied using any more amphetamine. He presented as being highly anxious, he was struggling to identify a reason to be living, but he did not disclose active plans for suicide. The reason for the cramps and vomiting was not explored by the practitioner. This is an area of learning, where Simon’s physical health appeared to be overshadowed by his mental health.
- 3.20 Later that day, the LPFT CPN also visited Simon. He told this practitioner about the stomach cramps and nausea. This was explored with Simon, who thought it might be food poisoning from something he ate the night before. He was given advice that if the cramps persisted for more the 48 hours, he should contact his GP. The flat was noted to be clean and tidy, with no signs of neglect. Simon spoke to the CPN about structure and daily routines, and denied any suicidal ideation, or thoughts of self-harm.
- 3.21 The following day, a CRHT practitioner visited, as part of the two weeks “staying well” plan following inpatient discharge. Simon was noted to be anxious and stated that he was finding all the support in the community to be overwhelming – this was the third professional to visit within the last 24 hours. He said he was hoping the CPN would support him to build structure into his day, which he was hoping would improve his mood. He expressed regret at his recent suicide attempt, and also stated he felt embarrassed by his actions. The practitioner asked about support networks, and Simon stated he only kept in touch with his brother, and sometimes spoke to the neighbour, but said he had no other social network.
- 3.22 The cramps and stomach pain were still an issue, so the CPN practitioner completed National Early Warning Score (NEWS)²⁹ – which led to the practitioner calling 111 who advised transporting Simon to ED. Once at the hospital, Simon was checked in and the CRHT practitioner advised Simon to contact them for a lift home. It was good practice for this practitioner to complete NEWS for the physical concerns.
- 3.23 Whilst in hospital, Simon’s physical issues were managed, and he returned home at 3am, with a lift from the CRHT practitioner. When asked, he could not recall what had been said to him while in the ED but recalled he had been given an intravenous drip and had a prescription to

²⁹ A standardised warning system tool developed by the Royal College of Physicians to identify acute deterioration

collect medication from the hospital pharmacy. This was shut as it was 3am, and the CRHT practitioner agreed to arrange this to be picked up and dropped back to Simon by the CRHT team later in the day. This was good practice from CRHT in supporting Simon in getting to and from hospital and also helping by picking up his prescription.

- 3.24 When dropping off the prescription to Simon, the CRHT practitioner also reminded Simon of the next appointment with them, which was booked for 23rd December 2023.
- 3.25 This additional prescription took the daily amount of medication to 17 different tablets per day. The GP Practice was dispensing Simon's medication on a weekly basis to reduce the risk of overdose.
- 3.26 The next day, 22nd December 2023, around 7.30pm Simon called the CRHT and said he had "messed himself up". He told them he wanted to speak about his mental health but was advised that his physical health needed to be seen to as an emergency. An ambulance was called by the LPFT team – citing a risk to life - and Simon was taken into ED, with stab wounds to his chest, wrists and arms.
- 3.27 Ambulance crew completed an ASC safeguarding referral and updated the GP.
- 3.28 Once in hospital, Simon was given urgent care to stabilise, he was transferred to the surgical unit the following morning around 4am and was seen that morning as part of the ward round. CRHT had been in touch with ED to advise that they were actively involved with Simon. At the point of being transferred to the Surgical Unit, Simon was therefore referred to CRHT. Also, at the point of Simon's transfer to the Surgical Unit, MHLT had not yet come onto shift. It is recorded that later in the day, Simon began to get agitated, at 1.30pm he declined a wound assessment by the nurse and started to pull out his canular. Later that evening, at 7pm on 23rd December 2023, when the nurses handed over, Simon went outside for a cigarette but did not return.
- 3.29 Upon realising that Simon had not returned, the Surgical Unit staff followed the missing patient procedure, however the paperwork was not completed to detail the steps which were taken. The missing patient process involves attempts to contact the patient directly, and then contacting other agencies involved with the patient. The Surgical Unit staff therefore contacted CRHT - as CRHT had indicated they were actively involved with Simon - to advise that Simon had taken his own discharge from the unit. CRHT said they would go around to Simon's flat to check on his welfare as he was a high risk of suicide and self-harm. The call had been made by the Surgical Unit staff to CRHT at 8pm, and a visit was completed to Simon by 10pm that night.
- 3.30 Upon CRHT's arrival at Simon's property, he answered the intercom and came to the entrance of the building's lobby – although he did not allow the CRHT practitioner access to his flat. He said he was tired and just wanted to go to bed. It was agreed that the CRHT would visit him in the morning of 25th December 2023. The rationale for this appointment being two days later was that Simon had always called when he needed support, and when he had self-harmed –

and he was not presenting with suicidal ideation at this point.

- 3.31 The CRHT went to Simon's property as planned in the morning of 25th December 2023. He did not answer and there were no signs of movement. They returned to the property around 5pm that day, and when they did not get an answer, they called non-emergency number 101. The CRHT told the call handler that this was the second cold call to Simon's property that day, and they were concerned because he posed *"significant risk to himself at the moment, he has recently just come out of hospital, probably a week or two ago. He was an inpatient for drinking bleach and slitting his throat. We came out this morning, but he didn't answer (for) the planned appointment."* The CRHT explained they had been to visit Simon that morning, and could not get an answer, so came back later, but he was not answering the door. When asked if whether Simon required medical assistance, the CRHT replied *"we don't know – we've not been able to see him but there is a possibility that he's either done something more serious, but he has got a history of massive overdoses and drinking bleach."* The CRHT confirmed that Simon had been told they were visiting that day and explained that *"We've gone round the back and the bathroom window is open and we can see into the flat and there is no one in the kitchen or the living room, the TVs not on or anything. There are some bleach bottles, like window cleaner, kitchen surface cleaner, there's quite a lot of them out in the kitchen. We can't see if he's drank any or if there's any contents missing unfortunately."* The call handler went through some questions with the CRHT practitioner and also called the local hospital to check Simon had not been admitted there. The call handler then stated that *"we have got a new policy for welfare calls...we have reviewed the incident and (the supervisor) had suggested that it would be an ambulance you need to contact..."* The CRHT practitioner asked, *"how is the ambulance going to get into his flat?"* and was told *"if the ambulance arrived, they would then contact (police) or whoever they need to, or they might have the ability to force entry themselves if they have got the tools with them to do so."* The CRHT practitioner asked, *"ambulance can't force entry can they though?"* and was told *"yes, fire, police and ambulance all have the rights to force entry if there's grounds for concerns."*
- 3.32 The CRHT practitioner then called EMAS, at 17:33. They explained to the call handler that they had been out to see Simon twice that day, but with no answer. The CRHT explained they had escalated this to the police, as the patient had just got out of hospital following slitting his throat and drinking bleach, and that police said they needed to ring an ambulance first. The call handler confirmed with the CRHT that they had not been able to gain access to the property, and the CRHT confirmed again that they had tried to ask police to support with a welfare check but that police had said to escalate this to EMAS first. The call handler asked CRHT to hold whilst they checked what the protocol was for this type of attendance. They returned and stated this would be a "health care admission pathway" and went through questions including whether clinical help was needed for immediate lifesaving intervention – and the CRHT said there was a strong possibility of this. The CRHT explained that Simon had front lobe damage from childhood trauma and will present with learning disabilities and/or autism traits but is high functioning – they also confirmed that Simon was not aggressive.
- 3.33 The call handler asked if Simon was definitely inside the property, and the CRHT said they did not know this for sure, which was the issue. The doors were locked, and they could not see

any signs of life, other than numerous cleaning products on the kitchen table and a bathroom window open. The CRHT again said that Simon was known to drink bleach which had led to hospital admission. The CRHT was put onto hold again, and when the call resumed the call handler asked why the CRHT had gone out today and were told that an appointment had been made with Simon for that morning, which he was not home for. CRHT stated that police had asked for two cold calls before they could do a welfare check. There is no record of this advice having been given by police, and this is not internal LPFT policy. The call handler then explained that because they did not know if Simon was inside, if the crew attended all they could do was knock on the door, and therefore it would be advised to call for police and advise Simon is a vulnerable missing person. The call handler told the CRHT to advise police EMAS cannot attend as they cannot confirm that Simon is inside, and therefore police would have to gain entry and call EMAS back if an ambulance is required.

- 3.34 At 18:04 the CRHT practitioner contacted their LFPT colleague, who was based in the force control room (FCR) and asked for help. CRHT told the FCR LPFT practitioner that EMAS had advised calling police and report Simon as a missing person. The FCR LPFT practitioner spoke to the FCR Inspector and advised that they believed this was now a missing person enquiry and not a medical concern.
- 3.35 A Missing Person Proforma was completed with the CRHT practitioner, although they held limited information as they had not worked directly with Simon before. Simon was graded as a medium risk missing person which was logged as a priority incident, meaning the next available officer would be allocated. At 18:40 the case was allocated to a Sargeant due to no resources being available. At 20:57 the Area Inspector reviewed the case and asked for the next available resource to be allocated. A resource finally became available at 22:11, who attended the scene and conducted enquiries with Simon's neighbours, identifying a neighbour with a spare key. Once they tried the key in the door, it was clear that there was a key in situ on the inside of the door, indicating that Simon was in the property. Police were able to gain entry due to this new information and found Simon deceased.
- 3.36 Simon had died from a substantial pleural haemorrhage, from a puncture wound to the heart, the appearance of the wound was consistent with self-infliction.
- 3.37 An analysis of the contact between LPFT staff, the Force Control Room and EMAS, on Christmas Day, along with detailed discussions at the practitioners' event, indicates that all agencies were correctly following their policies and processes which were in place at the time. However, the review raises learning around due process when a person is thought to be at risk of harm, due to a mental health emergency in a private place. The CRHT practitioner followed their agency's due process by calling police to assist with a welfare check, however police had recently changed their policy – according to the call handler – which left the CRHT at the property with concerns for Simon and no way of accessing him.

Right Care, Right Person

- 3.38 Since this incident, the Right Care, Right Person model has been formally introduced

nationally. This approach was designed to ensure people who have health and/or social care needs, are responded to by the right person, with the right skills, training and experience to best meet their needs.³⁰ It is an operational model that changes the way emergency services respond to calls involving concerns about mental health, and it is aimed at making sure that the right agency dealt with health-related calls instead of the police.³¹

- 3.39 At the centre of the Right Care, Right Person approach is a threshold to assist police and health services in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. The threshold for a police response to a mental health-related incident is; to investigate a crime that has occurred or is occurring, or to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.³²
- 3.40 The Right Care, Right Person approach was not introduced in Lincolnshire until March 2024, therefore it was not directly linked to the response which the CRHT received from the Force Control Room. However, following discussions at the practitioners' event, and subsequent discussions with police, EMAS, and Lincolnshire Fire and Rescue Service, it is apparent that the "new way of working" mentioned by the call handler who the CRHT spoke to, would have referred to a shift in police responses to calls linked to mental health crisis, which may have been introduced ahead of the Right Care, Right Person approach being introduced formally across statutory services in Lincolnshire.
- 3.41 The Right Care, Right Person approach had been scheduled for introduction in Lincolnshire during November 2023, however this introduction was pushed back until March 2024 when it was introduced across all services in Lincolnshire. It is logical to assume that leading up to the introduction of a countywide, multiagency approach - which by its nature is centred around police responses - call handlers would be briefed regarding the new approach. In fact, local press had reported on the introduction of Right Care, Right Person, in October 2023.³³ Therefore regardless of the official launch of the Right Care, Right Person approach actually being three months after the CRHT called the Force Control Room for assistance with Simon's mental health crisis, the response which the CRHT received would have been impacted by the plans to launch the Right Care, Right Person approach later in the year.
- 3.42 Since the launch of the Right Care, Right Person approach in Lincolnshire, a working group, made up of emergency services, the Lincolnshire Integrated Care Board and local authority statutory services, have been meeting regularly to discuss barriers and challenges which have emerged during the launch period. One of the issues which had been identified, is the perception of agencies and professionals that the new approach is a police force led approach.
- 3.43 This review also highlights the fact that during December 2023, the CRHT continued to assume that calling the Force Control Room would afford them a response during a mental health

³⁰ [National Partnership Agreement: Right Care, Right Person \(RCRP\) - GOV.UK](#)

³¹ [NHS-right-care-right-person.pdf](#)

³² [Right Care Right Person toolkit | College of Policing](#)

³³ [New scheme introduced after Lincolnshire Police attend 12,000 concerns for safety - Lincolnshire Live](#)

crisis, within a private dwelling. This assumption, which is based on the long-established practice of calling police for welfare checks and for gaining entry to properties when there are welfare concerns, is incorrect; although a long-established practice within community-based services. During the practitioners' event it was shared that since the introduction of The Police and Criminal Evidence Act 1984 (PACE)³⁴ it has been unlawful for police to force entry unless a crime was being committed, or unless there was an immediate risk to life and limbs. The introduction of the Right Care, Right Person approach will eventually embed into practitioners that police should not necessarily be their first call, when there is a mental health crisis, in a private property.

- 3.44 The Right Care, Right Person approach continues to be an evolving situation, which will be led by the Integrated Care Board, on behalf of NHS England. In the meantime, Simon's story will be shared with practitioners to highlight these changes in approach.
- 3.45 In cases of medical, or mental health, emergencies police are not permitted to gain entry to a property – unless there is a clear risk to life or limb. Since the introduction of Right Care, Right Person a "Gaining Entry, Cause for Concern Protocol" has been developed, between Lincolnshire Fire and rescue (LFS), EMAS and Lincolnshire Police.

Current Process for Gaining Entry Following Concerns for Welfare

- 3.46 If there is a call for a medical emergency to 111 or 999 EMAS, depending on the risk identified this will be triaged and if EMAS attend and cannot gain entry when on the scene, they will alert LFS who will attend and gain entry. If LFS are unable to attend they will advise EMAS, and EMAS will call police.
- 3.47 If there is a call for a mental health emergency to 111 or 999 EMAS, depending on the risk identified this will be triaged and as above, if EMAS attend and cannot gain entry when on the scene, they will alert LFS who will attend and gain entry. If LFS are unable to attend they will advise EMAS, and EMAS will call police.
- 3.48 If there is a call to 111 or 999 for a missing person, the police will review the circumstances of the call and will decide on whether it is for attendance and will define the grading of response which is linked to the grading of the risk for the missing person.
- 3.49 Practitioners are also advised to contact NHS 111, option 2 when responding to mental health crisis situations, and to dial 999 and request an ambulance if there is a mental health emergency.
- 3.50 In Simon's situation, the practitioner followed a course of action which was widely accepted practice, to call police if there was a concern for a person within a property. However, the practitioner could not be sure that Simon was in a medical emergency and could not provide assurance that Simon was in the property, therefore eventually police followed the missing person pathway.

³⁴ [Police and Criminal Evidence Act 1984 \(PACE\) codes of practice - GOV.UK](https://www.gov.uk/government/legislation/the-police-and-criminal-evidence-act-1984)

- 3.51 Upon assessment of the risk, there was no immediate risk to life identified, a medium risk assessment was made, and the next available resource was allocated. The next resource became available just after 10pm, which was five hours after the initial call made by the CRHT team. The CRHT Practitioner had stated they could see bleach bottles on the side and had also indicated that Simon had recently been hospitalised for drinking bleach, this was not deemed to constitute a clear risk to life. This was because the practitioner could not indicate that any of the bleach was missing from the bottles, and it was considered that the bleach could have still been on the table from the last time Simon ingested bleach and was hospitalised. The call handler did not deem there to be enough information given to evidence immediate risk to life, and to constitute s.17 powers of entry.³⁵
- 3.52 The Second National Analysis of Safeguarding Adult Reviews, published in April 2024³⁶ identified an improvement priority around adult safeguarding powers of entry, along the lines of the provision currently available in Wales and Scotland. The panel support such a recommendation which, at the time of writing Simon's review, was being escalated to the Department of Health and Social Care.
- 3.53 Considering the tightening of processes in responding to mental health crisis and other non-crime situations, practitioners are advised to enhance their safety planning with patients and service users who present as a high risk of harm from themselves within their homes. See [Appendix One](#) for an example of prevention advice for practitioners.
- 3.54 Examples of safety planning can include sharing information across agencies regarding access arrangements for properties, key safe details, sympathetic neighbours who can be called upon, of family members who may be able to help to access a property during a crisis.
- 3.55 Simon was living in local authority owned property, who have an out of hours team. In cases such as Simon's, practitioners are reminded that they can include housing providers in safety planning, for example informing the landlord when a person has recently been discharged from hospital, particularly if they remain unwell or vulnerable to further illness or harm. Although landlords also do not have the right of access, they are able to hold intelligence regarding the whereabouts of a spare key, which neighbours may be helpful when trying to contact the tenant, or other information which may assist practitioners faced with a crisis situation.

4. Key Lines of Enquiry

4.1 How well did practitioners engage with Simon, enabling them to understand him as an individual?

- 4.1.1 LPFT were the only agency during this scoping period who had an ongoing relationship

³⁵ Police and Criminal Evidence Act 1983 – entry for the purpose of saving life or limb (and other purposes such as arrest or preventing serious damage to property)

³⁶ www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023-executive

with Simon. He did not attend GP appointments and had not seen his GP during the scoping period apart from presenting to the surgery with self-harm injuries in October 2023.

- 4.1.2 From reviewing the GP practice information provided for this review, there appears to be a lack of follow up with Simon, following missed appointments. LSAB have produced guidance for missed appointments, which GP Practice A may benefit from introducing within their practice (see Appendix Three).³⁷
- 4.1.3 As introduced in the Equality and Diversity section above, Simon's conditions would have made it difficult for him to trust and be open with other people. Practitioners reflected that he always seemed to be holding something back, and there is no sense of any one agency or practitioner knowing full details of Simon's history, for example the nature of the trauma he experienced or the details of his family composition.
- 4.1.4 From October 2023 to his death there had only been short spells where he was living in the community before he was back into the inpatient ward. The longest period of Simon being in the community, during the scoping period, was 3rd to 28th November 2023. During this time, he was initially supported by the CRHT. He was then referred into the Community Mental Health Team (CMHT). The practitioner who supported him consistently throughout this period attended the practitioner event and spoke about Simon.
- 4.1.5 The communication passport completed with Simon by Transforming Care when he was first admitted to Ellis Ward in October 2023 identified some things that he liked and were important to him. For example, he stated he had a sweet tooth, enjoyed different types of music and liked peace and quiet.
- 4.1.6 The matter of religion was raised by Simon during this period on Ellis Ward, and although this was not fully discussed with him by ward staff, the CMHT practitioner did follow this up with him in the community. This indicates good engagement with Simon as an individual.
- 4.1.7 Unfortunately, each time Simon returned to the ward, he was discharged to CRHT and this meant different practitioners – making it impossible to build a relationship with him each time.
- 4.1.8 During the period that CMHT supported Simon, it became clear that he was isolated within the community, and so they took him along to a local community group. This was

³⁷ <https://www.lincolnsb.org.uk/resources/not-attend-not-supported-attend-guidance>

a positive step and during this time Simon appeared to be getting on well with the support he was receiving. He was asked at this point if he would like to explore the questions about religion which he had raised whilst in the LPFT ward, he declined this but stated he would like to save this for discussion in the future. The CMHT worker reflected at the practitioner event that it was going to take time to build trust with Simon, but they felt this was building up slowly.

- 4.1.9 Simon was also supported with his finances during this period. Simon appeared to be getting on well during this time, however when he was readmitted to Ellis Ward on 28th November following ingestion of bleach – he told hospital staff that he was been putting on a front and had felt overwhelmed by the support in the community.
- 4.1.10 Taking into consideration Simon's loneliness, and his apparent improvement when in the structured and supported environment of the hospital, supported housing could have been considered for Simon. He may have benefited from a self-contained flat within a supported accommodation scheme. This would have offered him the independence and privacy from others, whilst providing support, for example reminders to take his medication, and support with attending appointments.
- 4.4.11 Throughout this period, and also historically, Simon's GP struggled to engage him in a mental health review. This was considered at the practitioner event, and it was felt that as Simon was fully engaged with LPFT, a primary care mental health review was not considered to be a priority. This was a missed opportunity for a joined-up approach to Simon's care, particularly considering the number of medications which had been prescribed from primary care and mental health. A medication review would have also been of benefit to possible support a reduction in the number of Simon's daily medication, however it is important to note that LPFT were responsible for decisions about Simon's prescribing in relation to mental health.

4.2 How effective was practice both within agencies and between agencies in safeguarding Simon?

- 4.2.1 The GP did not appear to be aware of the need to safeguard Simon during the scoping period. Simon had not attended his mental health review appointment, which was not identified as a concern. This lack of engagement with his primary care mental health could have led to a conversation between the GP Practice and LPFT, who were the main agency involved with Simon.
- 4.2.2 If LPFT had been made aware of Simon's lack of engagement with the primary care mental health review, they could have brought him along to an appointment. This would have provided an opportunity to review the many medications which Simon was expected to take each day.
- 4.2.3 Whilst Simon's care and treatment from LPFT was in line with their Clinical Care Policy, there remains an unresolved concern regarding the extent to which his prescribed medication regime may have included some contraindications or side effects relevant to

his suicide.

- 4.2.4 Managing the level of medication prescribed may have made it easier for Simon to comply with his medication regime, which in turn would have stabilised his mood, and maybe reduced his suicidal ideation.
- 4.2.5 During the scoping period, Simon's clinical risk assessment was updated ten times, using the LPFT dynamic document to reflect and manage the risks as they were currently presented. Simon told practitioners on 14th October 2023, that he had not been taking his prescribed medication for some time, and he felt that amphetamines helped him to manage his intrusive thoughts and gave him focus. He was prescribed Aripiprazole³⁸ instead.
- 4.2.6 NICE guidelines³⁹ indicate that if a person with depression is assessed to be at risk of suicide, treatment for depression should not be withheld on the basis of their suicide risk, however toxicity in overdose should be taken into account, particularly if the person is taking other medication, and if necessary the amount of medication available to the person should be limited and there should be consideration of increasing their level of support and making a referral into specialist mental health services.⁴⁰
- 4.2.7 In addition, NICE guidelines state that when prescribing medication for people with depression who are thought to be at increased risk of suicide, their mental state and mood should be assessed before starting the prescription, along with an awareness of possible increased prevalence of suicidal thoughts and a risk management strategy should be in place.⁴¹ The person should be reviewed after one week of starting the antidepressant medication, and subsequent reviews should be completed as often as needed, and no later than four weeks after the medication commenced. The frequency of ongoing reviews should be based on their circumstances and changes in suicidal ideation or risk of suicide.⁴²
- 4.2.8 Learning from this review, around reviews of prescribed medication upon discharge from hospital, and the review of medication by hospital based mental health services; has been shared at LPFT's Trust Divisional Medical Meeting by the Trust's Clinical Director.

4.3 How well did the wider system support multiagency practice when working with Simon?

- 4.3.1 Simon received input from Transforming Care throughout the scoping period. This is a multi-disciplinary team of psychiatrists, speech and language therapists (SALT), occupational therapists (OT) and psychologists, providing liaison to mainstream mental health services, including in-reach into acute and rehabilitation mental health inpatient services, to enable timely discharge. The day after Simon was admitted to Ellis Ward in October 2023, Transforming Care visited him to complete the communication passport

³⁸ A prescription medication to treat various mental health conditions, it works by altering the effects of certain chemicals in the brain, particularly dopamine and serotonin.

³⁹ Paragraph 1.2.12

⁴⁰ [Recommendations | Depression in adults: treatment and management | Guidance | NICE](#)

⁴¹ [Recommendations | Depression in adults: treatment and management | Guidance | NICE](#)

⁴² Paragraph 1.4.22

which went on to support interactions between Simon and professionals for the remainder of the scoping period.

- 4.3.2 Although Simon was not formally diagnosed with autism, LPFT held a Dynamic Support Register (DSR)⁴³ system wide meeting on 17th October 2023, in recognition of Simon being at risk of hospital admission. The DSR is a tool used in a local area to identify children or adults with autism or a learning disability who are at risk or may become at risk of admission to a mental health inpatient setting without specific and timely dynamic support.⁴⁴ Plans were being made for a referral to the s.75 Social Worker⁴⁵ to look at a wider assessment of Simon's needs. These plans were not followed through, as shortly after this Simon was back in hospital, and responses to his need became reactive rather than proactive.
- 4.3.3 During the scoping period of this review, the GP Practice did not have a clear escalation policy in place for patients who did not attend appointments related to mental health. This created gaps in communication with LPFT. However, following learning from Simon's review, the Practice has introduced processes to support patients who have not attended and who have mental health concerns, and where necessary this includes escalation pathways between the Practice and LPFT.

4.4 What evidence was there of good practice when working with Simon?

- 4.4.1 The CMHT practitioner working with Simon during the scoping period, built rapport with him over a series of sessions. The practitioner spent time getting to know Simon and consider in their assessment what would benefit him. They were able to encourage Simon to agree to a referral to Social Prescribing⁴⁶ which would have been a positive step towards reducing his social isolation. The CMHT practitioner's documentation was very thorough, and included behavioural observations of Simon, as well as his social environment.
- 4.4.2 Simon's GP Practice requested his preferred mode of communication, which was text messaging and therefore sent communications in this manner. He was also only seen by two named GP Practitioners and was only prescribed medication by one GP throughout his registration at the practice.
- 4.4.3 There was evidence of persistence and tenacity from Lincoln CRHT throughout various interactions with Simon during the scoping period. From proactivity in completing the NEWS assessment with Simon when he complained of stomach pains, through to

⁴³ The DSR is a tool used in a local area to identify children or adults with autism or a learning disability who are at risk or may become at risk of admission to a mental health inpatient setting without specific and timely dynamic support.

⁴⁴ www.england.nhs.uk/wp-content/uploads/2023/01/Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf

⁴⁵ s.75 NHS Act 2006 – partnership agreements to enable greater integration between health and social care – the s.75 Social Worker would be located within LPFT and would have delegated duties to undertake assessments and fulfil duties within the Care Act

⁴⁶ This is an approach of the NHS Universal Personalised Care, it connects people to activities, groups and services in their community to meet their practical, social and emotional needs that affect their health and wellbeing.

ensuring he was collected from hospital on that occasion and taking him home due to his vulnerabilities.

4.4.4 Following Simon self-discharging from ULHT on 23rd December 2023, staff promptly alerted the CRHT, who agreed to follow up with Simon immediately. This happened within 90 minutes of him leaving the ward.

4.4.5 On Christmas Day, the CRHT staff were persistent in their attempts to seek support from emergency services to get help to Simon. This would have been an upsetting and frustrating event for the CRHT practitioners; however, they followed the advice given at the time and continued to escalate the best they were able to in the circumstances, via the LPFT Force Control Room practitioner. The CRHT practitioners continued to advocate for Simon for many hours, and challenged the services, which demonstrated compassionate care and concern for Simon throughout.

4.5 What learning can be identified and how can the learning from Simon be applied to the wider system

4.5.1 This review highlighted the need for practitioners across all services to understand the limitations of police in gaining entry to a property. All agencies should ensure their front-line staff are aware of processes to follow if their patient/service user is experiencing a mental health crisis, or there is a medical emergency.

4.5.2 The review identified the need for full and clear explanations given when contacting emergency services to request entry to a property following concerns for welfare. This should always include contextual information, and clear rationale for the practitioners' concerns.

4.5.3 The review also highlighted the need for proactive and robust safety planning, which should be completed and updated regularly to ensure the information, which is stored, is correct. This can include details of means to access a property, alongside prior consent from the person to gain access in an emergency. An example of this would be installation of a key safe, with the number being held by the relevant agencies, or a key being kept by a neighbour, with the details of this being stored on the agency records.

5 Recommendations

Area of Learning:

Practitioners are encouraged to undertake preventative steps ahead of crisis situations, for example installations of key safes, consent to contact neighbours or landlords, and information sharing across agencies involved with adults at risk – to enable access to properties without the assistance of emergency services, during a crisis.

Recommendation:

LSAB will seek assurance from agencies involved in this review, that the instructions at Appendix

One have been shared across services, along with the details of Simon's case, to reiterate the need for preventative steps prior to crisis.

Area of Learning:

Information gathered for this review indicated that Simon instigated a conversation with LPFT staff regarding his faith. The panel identified a lack of proactive response to queries which Simon raised.

Recommendation:

LSAB will develop a communications strategy regarding faith and suicide to improve professionals' confidence in supporting people, by providing appropriate responses and signposting.

Area of Learning:

The review highlighted gaps in knowledge and understanding of current practice regarding powers of entry. The panel also considered that following the introduction of Right Care, Right Person, agencies and professionals should be equipped with resources to support people who appeared to be at risk.

Recommendation:

A resource pack will be created and made available to practitioners to support with requesting assistance for a people who appear to be at risk.

Area of Learning:

The National Network for SAB Chairs have been working closely with ADASS and others, to build the case for an adult safeguarding power of entry.

Recommendation:

LSAB to escalate to the National SAB Network, the finding in relation to the lack of access to the adults property, to support their recommendation and ongoing work around Safeguarding Power of Entry

Appendix One

Prevention advice

If you know someone who is vulnerable, including by age, mental illness and physical health, here are some of the things you can consider in preparation for emergencies:

- Has someone got access to the property and are their details known? This may be a landlord, carers, a family/friend keyholder or the details for the key safe at the property. If possible, the key should be kept with a trusted person closer to the address and contactable on evenings and weekends to enable quick access when concerned.
- Who are the emergency contacts? If you haven't seen the person for a few days or if there is a concern for them, it is recommended to obtain details of the family, friends or professionals who are involved with the person for ease of contact. Details include a full name and relevant phone numbers as a minimum. The emergency contact may be the same person as the key holder in some situations.
- If you become concerned for someone because you cannot make contact with them, before reporting them as a missing person you should (where applicable):
 - Try contacting the person on different platforms (social media, phone, text etc.). Do this at different times of the day to allow time to respond.
 - Ring round friends and family.
 - Ask neighbours if the person has been seen or anything has been heard from the property, noting the last sighting.
 - Ring any professionals who the person has been contact with such as support workers and mental health teams.
 - Attend the home address or other relevant address they occasionally stay at, where accessible, search the area, remembering to look in sheds, garages and outbuildings. Check all doors and windows as one may be unlocked or open. If you are unable to attend for any reason, ask someone to go on your behalf such as a friend or neighbour.
 - Look for any notes or clues in the person's home or on their belongings.
 - Contact local healthcare providers including local hospitals.
 - Check the person's social media, have they been active online and is there any content that may assist in locating them.
 - If the person is in work or education, contact the place to identify if they have been there or any contact has been had.
 - Consider whether it is possible the person is somewhere else such as holiday, working away or visiting friends.

If a person is in immediate danger, call 999. If you believe they are experiencing a medical emergency, you should request Ambulance.

If you do not believe they are in immediate danger, and you have done what you can to locate them yourselves and are still concerned, contact police on 101 where they will assess whether the person is to be considered as a missing person.

Hearing or speech impairments

If you have a hearing or speech impairment and you've pre-registered with the [emergencySMS service](#), you can use our textphone service 18000 or text us on **999**.

If you're a British Sign Language (BSL) user, you can call [999 BSL](#) to use a remote BSL interpreter.

Silent 999 calls

If you're in danger but you can't talk on the phone, you should still call **999**, then [follow these instructions](#).

Appendix Two

Concern for Welfare advice and information

It is advised when first engaging with a patient or a service user that the following information be considered in case of the event of a concern for their welfare.

This information would assist in managing concern which may arise from a patient/service user not attending appointments as expected or not answering their door when professionals arrive for an appointment or unarranged visit.

In any event, unless information is available to suggest there is a real and immediate risk to the person's life, reasonable amount of time should be allowed for lateness.

Patients/Service users should be advised from the outset about how calls may be received, such as the form of contact and whether withheld numbers by be used.

It may be preferred for this information to be on a form for new and existing patients and service users. This information should be reviewed on a regular basis to ensure it is current and accurate.

The below may be considered when gathering information at the first contact so that professionals are equipped to deal with concerns for a patient's/service user's welfare.

- Name, Date of Birth, Address
- Key information about home address, such as; key safe details, neighbours or others who have a key to access property, Landlord details, Animals at the address, Vehicles (and whether used by the patient), Site Wardens details and carers that visit the address.
- Who else lives at the address? Details for those people, contact, relationship.
- Other places/addresses the patient/service user regularly visits or stays at. This may be for just one night or longer stays. May include family addresses, friends, or work/business for example.
Details for these locations and when the patient/service user typically visits.
- Contact Details for Patient/Service User
Phone (more than one if relevant such as Home/Mobile)
Email Address
- What is the preferred method of contact?
- Associates who can be contacted – In the event professionals cannot get hold of the service user, is there anyone else that can be contacted that is likely to know where they are/have regularly contact. Name and contact details.
- Work/Education – Any relevant work or education details, such as contact numbers or address.
- Holidays – Any time away planned in the coming 6 months/1 year. Does the patient/service user tend to take spontaneous trips?
- In the event of not attending an appointment or being able to make contact, what action would you expect services to take?

Missed Appointment Considerations

What was said by them when they arranged the meeting?

Is there a reason they may have missed the meeting?

What is the history of the person, re missing appointments?

Is there any information that suggests this person is at a real and immediate risk of harm?

Have enquiries been made based on the above information known about the person to locate them and check welfare?

Information regarding Police Powers of Entry for a Concern for a person

The conditions under which a Police Officer may enter and search a property without a warrant are set out in Section 17(1e) of the Police and Criminal Evidence Act 1984. The legislation states 'a constable may enter and search any premises for the purpose of saving life or limb or preventing serious damage to property'.

Section 17(1e) is a high threshold. *Syed v DPP 2010* is a stated case where the Court held that a concern for 'welfare' was not sufficient to justify an entry within the terms of Section 17(1e). The Judge stated that Parliament set the threshold at the height indicated because it is a serious matter for a citizen to have his house entered against his will and by force by Police officers.

Article 8 ECHR sets out the right to respect for your private and family life, including the right to respect for your home, meaning that public authorities should not enter your home without permission. This can only be breached where it is lawful, necessary, and proportionate to do so.

Police will triage calls for service from partners to assess whether it is likely this threshold has been met and therefore Police have powers to act if they attend. If there is reason to believe a person is inside a property and they or their property are in immediate need of protection, then Police may attend to utilise powers under S17(1e) PACE. Where EMAS are attending due to there being a medical concern, EMAS will contact Lincolnshire Fire and Rescue from the address if they are unable to gain entry themselves.

If the risk is unknown or the person is not thought to be at immediate risk, the following actions may be taken (where applicable) to try locating and safeguard the person before reporting to Police:

- Try contacting the person on different platforms (social media, phone, text etc.), do this at different times of the day to allow time to respond.
- Ring round friends and family.
- Ask neighbours if the person has been seen or anything has been heard from the property, noting the last sighting.
- Ring any professionals who the person has been in contact with such as support workers and mental health teams.
- Attend the home address or other relevant address they occasionally stay at, where accessible, search the area, remembering to look in sheds, garages and outbuildings. Check all doors and windows as one may be unlocked or open. If you are unable to attend for any reason, ask someone to go on your behalf such as a friend or neighbour.
- Look for any notes or clues in the person's home or on their belongings.
- Contact local healthcare providers including local hospitals.
- Check the person's social media, have they been active online and is there any content that may assist in locating them.

- If the person is in work or education, contact the place to identify if they have been there or any contact has been had.
- Consider whether it is possible the person is somewhere else such as holiday, working away or visiting friends.

Where the above have been completed and the person's welfare can still not be established and there is a concern, Police may be contacted and advised of all relevant information to assess whether the person will be considered a missing person.

All non-emergency reports of concern for welfare by services should be reported via 101 to enable effective information sharing and discussions about risk.

Appendix Three

