LSAB
Making safeguarding personal

Safeguarding Adults Review
Helen
Overview Report

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Reason for Safeguarding Adult Review

A Significant Incident Notification Form (SINF) was received by the Lincolnshire Safeguarding Adults Board (LSAB) expressing concern around an individual who had passed away as a result of an overdose of canine insulin. In the hours prior to the person's death a number of agencies had been involved. This included transporting the person to an Accident and Emergency department from where she absconded, trying to locate her in the hours after her absconding and finally locating her at her home address.

The joint working during these few hours prior to Helen's death gave the LSAB cause for concern and subsequently a Safeguarding Adults Review was commissioned under Section 44(2) of the Care Act 2014. The LSAB was also interested in the wider learning that could be derived from examination of the multi-agency response to Helen in the two years leading up to her death.

Purpose of the Safeguarding Adult Review (Care Act 2014)

Safeguarding Adult Boards must arrange for there to be a review (SAR) of any case involving an adult in its area with needs for care and support if:

> *There is reasonable cause for concern about how agencies, members of safeguarding adult boards or other persons with relevant responsibilities worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adult died [S44 (2)].*

The purpose of an SAR is to:

- Identify the lessons to be learnt from the adult's case, and
- Apply those lessons to future cases.

This review is commissioned under Care Act 2014 [S44 (2)].

Scope

The person who is the focus of this report will be known throughout as Helen. The timescale covered in significant detail is from 1st March 2014 to 20th February 2016 05.00hrs.

About Helen

Helen lived alone, in a village in Lincolnshire, approximately 9 miles from the Humberside county border, and the Diana Princess of Wales Hospital in Grimsby was the nearest hospital with an A&E facility.

Helen belonged to a family consisting of her parents and sister. Helen lived near her parents and sister. She is described by her family as a loving aunty who was part of a close family and a well-known member of her community. She lived with her pets, worked as a veterinary nurse, and was passionate about animals. Her life included horse riding, volunteering and visits to the local pub where she was well known.

Helen was an intelligent, independent woman who was able to make her own choices. Helen had experienced significant abuse within a relationship when she was seventeen. She was married in September 2008 and separated from her husband in June 2014, following emotional and physical abuse. This impacted upon her mental wellbeing and led to her seeking professional support. Helen's ability to access recommended therapeutic services was sometimes compromised by her use of alcohol.

Helen's employer was supportive of her mental health needs, and offered flexible work patterns, reduced demands and time off depending on her needs. Helen was particularly close to one work colleague who was very supportive towards her both in and out of work.

There were several domestic abuse incidents which were attended by Police officers during Helen's marriage. After this relationship broke down there were further incidents involving harassment and breaches of a restraining order. Helen shared her concerns with professionals about the harassment and stalking she experienced after the relationship had ended. In November 2014 her husband was sentenced for harassment and received a restraining order with a finalisation date of 8th June 2016.

Helen had a history of self-harming, which started after a traumatic and abusive relationship she experienced in her teens. Her struggle with self-harm continued throughout the rest of her life.

It was felt that Helen was able to self-assess, manage and seek help when self-harm incidents occurred. She accessed several health services both within and outside of the Lincolnshire County Council geographic area.

Helen was well liked by the services she chose to access, however services reported that Helen was a private person, whose engagement with them was variable. Tragically, Helen died aged 33 years old, on the 19th February 2016 as a result of an overdose of canine insulin.

Related reviews and processes

- Independent Police Complaints Commission (now called Independent Office for Police Conduct)
- Her Majesty's Coroner's Inquest
- A Police investigation by the Divisional Detective Inspector
- Lincolnshire Partnership NHS Foundation Trust conducted serious incident review into Helen's death
- East Midlands Ambulance Service completed a Serious Incident (SI) investigation

Lincolnshire Police

Prior to this review there were independent review processes undertaken by the Independent Police Complaints Commission (IPCC) and Her Majesty's Coroner.

At the time of Helen's death, it was mandatory when a death or serious injury occurred following Police contact to make a referral to the then Independent Police Complaints Commission (IPCC). This has now been re-named the Independent Office for Police Conduct (IOPC).

In addition to the enquiries below, a Lincolnshire Detective Inspector was allocated to investigate the circumstances of Helen's death to establish whether any criminal act or third party was involved in her death. The conclusion to this investigation was that no criminal act had been committed or any third person involved. Also 2 offences under the Veterinary Medicines Regulations Act 2013 which related to possession and supply of veterinary medicinal products by a third party were investigated with the support and advice of Department for Environment, Food and Rural Affairs (DEFRA) who would be the lead agency in any prosecution. The forces decision was to correctly record the crimes and resolve them as not in the public interest to pursue (medication given in good faith and a tragic outcome).

A referral was made by the Lincolnshire Police Force and the IPCC's assessment was that an independent investigation would be carried out by them. This investigation took place and resulted in 8 officers/staff from Lincolnshire being spoken to, 2 of whom were recommended back to the force that they should be dealt with how the force felt fit in relation to a performance issue and that there was no case to answer in relation to misconduct or gross misconduct.

A Coroner's inquest was opened on the 25th February 2016 and concluded with a jury hearing on the 19th June 2017. The inquest concluded that the actual time of Helen's death was 02:28hrs. It was also accepted by the Coroner and her family that the diversions of Lincolnshire officers to other incidents were justified. Due to the timing of Helen's death it was also accepted that the final attendance which was delayed by the joint decision of an officer and his supervisor would have made no difference to the outcome. The Coroner, following deliberations with her family and barristers, decided that they would make no reference to Lincolnshire Polices actions being linked to failing to prevent Helen's death when asking the questions of and giving direction to the jury as they were no longer relevant.

Humberside Police

Humberside Police IMR detailed the call handling and the circumstances surrounding the death of Helen. Their report described that an IPCC investigation had been undertaken. The force authorised the release of their report to inform the Safeguarding Adults Review processes. The IPCC agreed with the final outcomes of unsatisfactory performance for five staff members at Humberside Police.

At the conclusion of the Coroner's inquest Humberside Police were issued with a Regulation 28 notice from HM Assistant Coroner in accordance with legal powers under the Coroners and Justice Act 2009 and Coroners (Investigations) Regulations 2013. Humberside Police had until 25th September 2017 to respond to this Regulation 28. This was achieved and the authors saw a cross border incident policy and letter to the coroner assuring of its dissemination to all Control Hub staff dated 22nd September 2017.

Lincolnshire Partnership NHS Foundation Trust

During the period that Helen was using community mental health services, Lincolnshire Partnership NHS Foundation Trust had commissioned an external company to conduct a study of adult community and outpatient services. This 'transformation project' aimed to remodel the community mental health services in response to the financial pressure faced by NHS organisations. The unanticipated outcome of this work changed the staffing numbers and roles within the community services that Helen received.

A subsequent root cause analysis investigation into Helen's death identified that the changes to the integrated mental health teams had meant that they were unable to meet some standards expected to be provided by mental health Trusts. The Trust's executive team have since rectified these issues. Recent Care

Quality Commission inspections have validated this work and identified that the Trust is outstanding in 'well-led' and 'good' in community based mental health services for adults of working age (October – November CQC Report 2018).

East Midlands Ambulance Service

East Midlands Ambulance Service (EMAS) completed a Serious Incident (SI) investigation for the EMAS attendance on the 18th February 2016. Helen had absconded from EMAS care on arrival to hospital and was found deceased the next day. The report identified several areas of learning and made the following recommendations:

- Trust wide awareness of management of insulin overdose compared to standard hypoglycaemia presentation has been promoted.
- Anonymised case study 'management of a patient's blood sugar' in E-news.
- Staff members involved in the incident have received supervision from their manager and reflected on Safeguarding, untoward incident process and procedure.
- EMAS did not have a policy for staff to follow when a patient absconds. An EMAS policy is now in place.
- A Quality Everyday poster highlighted when to refer to the untoward incident process and how to refer.

EMAS have completed all the recommendations from the SI report.

Independent Authors

This Safeguarding Adult Review (SAR) is jointly authored by Gill Poole and Fiona McClelland.

Gill qualified as a registered nurse, health visitor and has worked in both adult and children's safeguarding for over 20 years. Gill was independent chair of a Safeguarding Adults Board for over 10 years and has authored a number of Serious Case Reviews and Safeguarding Adult Reviews.

Fiona qualified as a registered nurse and has worked in mental health for over 25 years. At the National Institute for Mental Health in England (NIMHE) Fiona was a project manager implementing the National Service Framework for Mental Health across Yorkshire and the North East. Her work included suicide prevention; co work with the Sainsbury Centre to review the role of Community Mental Health Teams; implementing the Care Programme Approach across Health and Social Care in the North East and leading on projects to involve people and their families in change. Fiona has also worked as a Divisional manager within a NHS Foundation Trust; she was operational and strategic lead for all adult mental health and learning disability services across the City of Hull. Fiona has extensive experience of service development within the voluntary sector and has held positions as CEO of Hull and East Yorkshire Mind and Deputy Director/ Quality lead of care and support services within a UK wide charity. Fiona was also Assistant City Manager within Local Authority Adult Social Care services with a lead for workforce development, quality and improvement.

Both authors have significant experience of advocating for people using services and are driven by the values of person-centred working.

Methodology

A Safeguarding Adult Review is a multi-agency process to identify learning that enables the Safeguarding Adult Board partners to improve services for the future.

This report has been prepared following agency reviews of the care, treatment and support provided to Helen. Independent Management Reviews (IMRs) were received from United Lincolnshire Hospital Trust, Humberside Police, Lincolnshire Partnership NHS Foundation Trust, Lincolnshire Community Health Services, Northern Lincolnshire and Goole NHS Foundation Trust, East Midlands Ambulance Service, Lincolnshire Police and Helen's attended General Practice Surgery, (part of East Lincolnshire Clinical Commissioning Group).

In preparation for the Safeguarding Adults Review (SAR); clinical records were sourced and analysed in order to ascertain the care and treatment delivered by different providers.

Terms of Reference were developed and agreed; all agencies who were involved with Helen were asked to prepare Individual management reviews (IMRs), to address the questions posed by the terms of reference.

There have been a series of panel meetings where IMRs have been presented by their authors and further discussed by professionals from the various agencies involved with Helen. The two independent SAR authors undertook detailed questioning of IMR authors within the panel meetings. The SAR authors and Independent Chair of LSAB SAR panel visited Helen's family early in the process and met with her sister and parents. The SAR authors also met with a friend and work colleague who provided regular support to Helen.

Initially the Safeguarding Adult Review focussed on the time immediately prior to Helen's death; this was then revised to include 1st March 2014 to 20th February 2016 05.00hrs

Agencies that took part in the review

The following agencies are those who were involved with Helen, and whose information is relevant to this report. They were requested to provide an Individual Management Review (IMR). These IMRs were scrutinised by the authors and informed questions and discussions within subsequent panel meetings.

Agency roles in relation to Helen:

Lincolnshire Police

Lincolnshire Police's IMR reviewed incidents from 30th June 2014 when Helen became known to them, up to the date 20th February 2016. During that period Lincolnshire Police attended Helen in response to 15 incidents. Eight of the incidents involved contact or communication between Helen and her husband; five of these required the completion of a DASH form. One incident resulted in her husband being charged with Section 2 Harassment Without Violence. Subsequently a restraining order relating to non-contact was made.

Five incidents involved Helen taking a quantity of tablets, being taken to hospital by ambulance, leaving of her own accord, then Lincolnshire Police being contacted to assist in locating Helen. On all these occasions Helen was located by Lincolnshire officers and four times she was returned to the hospital at Grimsby. On the remaining one occasion she was appropriately left in the care of her sister who lived nearby.

The remaining two incidents refer to Helen self-harming using a knife and razor blade.

There was significant involvement of Lincolnshire Police in the hours prior to Helen's death.

Humberside Police

Humberside Police force covers an area which extends to the outskirts of Grimsby, where they share a border with Lincolnshire Police.

Humberside Police's IMR cover 4 incident logs between 30th August 2014 and 10th July 2015; all of which relate to Helen absconding from Diana Princess of Wales's hospital.

There was significant involvement of Humberside Police in the hours prior to Helen's death.

NHS commissioners

The NHS commissioning in the area covering where Helen lived is complex.

Collectively the four Lincolnshire Clinical Commissioning Groups (CCGs) work together to commission health services not only for their own area, but for the whole of Lincolnshire. This is to make sure that residents across the county can use the same local hospital, mental health and community health services. Each CCG takes a lead commissioning role, which means that they are responsible for managing the contracts for certain health care services across the whole of Lincolnshire.

Helen's attended GP practice is commissioned by East Lincolnshire Clinical Commissioning Group.

Helen's friend and family have reported through this review process that the complexity of commissioning boundaries did not support her use of services.

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)

This NHS Trust is a combined hospital and community Trust which provides hospital care in Scunthorpe, Grimsby and Goole.

Helen was a regular attender at NLAG Emergency Services. Between 24th May 2004 and 12th February 2016, she attended the Emergency Department (ED) at Diana Princess of Wales Hospital sixty-four times. The majority of these (forty-two) were self-harm or self-induced poisoning.

Helen would often leave the hospital prior to care being completed, including on the night preceding her death.

East Midlands Ambulance Service

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region. This region, which covers approximately 6,425 square miles, includes the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire, Northamptonshire and Rutland.

EMAS had 42 attendances to Helen during this scoping period from 1st March 2014 to 20th September 2016. All the attendances related to self-harm or deterioration in her mental health.

There was significant involvement of East Midlands Ambulance Trust in the hours prior to Helen's death. Helen is reported within EMAS's IMR to have developed positive relationships with staff who responded to her calls.

Lincolnshire Partnership NHS Foundation Trust

The Trust provides a range of health and social care services for people of all ages. The Trust provides care and treatment for a local population of 735,000 people within Lincolnshire. It also provides some specialist services for people who live within North East Lincolnshire. Below is an overview of the services involved in Helen's care. Helen's support and treatment moved between these services during the timescale reviewed. There were 178 contacts with LPFT services during that period; including the Integrated Community Mental Health Team; Crisis Resolution and Home Treatment Service; Steps2Change Talking Therapies; and the Drug and Alcohol Recovery Team.

Helen's care was open with the Integrated Community Mental Health Team at the time of her death.

Integrated Community Mental Health Team (ICMHT) - This service provides interventions to adults who are recovering from on-going mental health problems. This service is designed to work with people experiencing severe or long-term mental illness. The teams are multi-disciplinary and are comprised of, or have access to, Community Psychiatric Nurses (CPNs) Occupational Therapists (OT) Psychiatrists, Psychologists, Social Workers and support workers.

Crisis Resolution and Home Treatment Service (CRHT) - The Trust has integrated Crisis Resolution and Home Treatment teams with inpatient resources. There are four CRHT teams across the county based in Boston, Grantham, Lincoln and Louth. The teams operate in the community and provide quick access to assessment for people experiencing a mental health crisis. Following assessment staff members stay involved until the crisis care needs of the individual have been resolved. CRHT can work with people in the community to avoid admission to hospital providing intensive home treatment and support in this way for up to six weeks.

'Steps2Change' Talking Therapies – [formerly known as Improving Access to Psychological Therapies (IAPT) Service] is a service for anyone in Lincolnshire over the age of 16, who is feeling stressed, anxious, low in mood or depressed. They provide a range of evidence based talking therapies for problems such as depression, anxiety, post-trauma reaction, panic, phobia and obsessive compulsive disorder (OCD); Steps2Change Talking Therapies consists of qualified cognitive behavioural therapists, counsellors, interpersonal therapists, psychological wellbeing practitioners and employment advisors; all employed by Lincolnshire Partnership NHS Foundation Trust to provide psychological treatment on behalf of the Lincolnshire Clinical Commissioning Groups.

Drug and Alcohol Recovery Team (DART) - Lincolnshire's Drug and Alcohol Recovery Team (DART) were a commissioned service, providing support to anyone over the age of 18, suffering from drug or alcohol problems. The range and intensity of the interventions offered was determined through the use of objective assessment tools and collaborative discussions with the individual. The DART service was decommissioned with Addaction's new recovery and treatment services taking on all of Lincolnshire drug and alcohol service from the 1st October 2016.

The chronology of Helen's contact with services identifies that she found the support of some key individuals particularly helpful.

Lincolnshire Community Health Trust (LCHS)

LCHS provides community health care for the population of Lincolnshire covering an area of 2,350 square miles and a population of 714,000.

The services provided include four community hospitals with inpatient beds, minor injury/illness units (MIU's) and urgent care services (UCC), GP out-of- hours, sexual health services, services for children and families therapies, community nursing and specialist nursing services for the population of Lincolnshire.

The primary purpose of MIU's and UCC's care is for help with injuries that need attention urgently but are not critical or life threatening, such as cuts, sprains and minor burns.

The care provided for Helen was undertaken by Louth Urgent Care Centre, which would have been the nearest UCC accessible in relation to her home address.

Louth Urgent Care Centre is situated within the County Hospital; it is open 24 hours, 365 days per year. No appointment is necessary, and services include; urgent assessment, diagnosis and treatment, provided by teams of emergency nurse practitioners and an associate specialist doctor during the day, and a GP at night. Patients who cannot be safely treated here would be referred or transferred elsewhere as necessary.

Within the period of the scope Helen was seen by health and medical professionals on 46 separate occasions: this is a significant number of attendances to MIU services.

16 of these attendances were self - reported episodes of self-harm: with one episode of self-harm resulting in a transfer to Lincoln County Hospital.

Some episodes of self - harm were within a few days of each other and other episodes of self-harm were further apart for example 20 days – one month apart.

Helen was seen by various nursing and medical staff who would take a history of the presenting complaint, undertake examination and investigation (if required) give a diagnosis, treatment and advice on how to care for her wounds, medication advice when medication was prescribed, when to return for follow up and review if required. Helen was also given advice regarding the involvement of the Mental Health Community Team.

On the occasions that Helen presented with self-harm injuries support/referral to the Mental Health Community Team was offered but often declined.

Following Helen's discharge nursing or medical practitioners sent an attendance letter to her GP detailing the reason for her attendance and details of follow up if required. For example, if a review/redressing of a wound was required information would be passed on to the practice nurse to ensure that this was arranged.

The IMR stated that between 26th June 2014 and 3rd January 2016 Helen's attendance at Louth Urgent Care Centre increased significantly with 9 attendances recorded between 26th June 2014 and 13th December 2014 with injuries caused by self - harm.

The attendance on 13th December 2014 related to Helen being brought by ambulance with a significant self - harm injury. Helen was transferred by ambulance to Lincoln County Hospital for additional care.

There was a five-month gap before Helen's next attendance at Louth Urgent Care Centre on 12th June 2015. She then attended with a further six incidences of self- harm injury between then and 13th August 2015.

Records indicate that there was another gap of four months between 13th August 2015 and 28th December 2015.

Helen again presented at Louth Urgent Care Centre on 28th & 29th December 2015 with a self - harm injury and another self-harm injury on 3rd January 2016 before notification was received of her death.

LCHS IMR and the chronology both identify good practice in gaining Helen's consent to liaise and appropriately share information.

United Lincolnshire Hospital Trust (ULHT)

United Lincolnshire Hospitals NHS Trust provides hospital services from 3 acute hospitals in Lincolnshire: Lincoln County Hospital; Pilgrim Hospital, Boston, and Grantham and District Hospital.

Helen initially presented at A&E on the 3rd November 2014 with a physical injury. Helen did not attend her last appointment on 26th November 2014 and was referred back to the care of her GP.

Helen then attended Louth Hospital (LCHS) on 14th December 2014 and due to the nature and severity of the injury she was transferred to Lincoln A&E. Helen had undertaken self- harm and had a 7cm deep laceration to her arm.

Helen absconded from A&E before being treated. She was returned to the department within an hour, by the Police, and received further treatment.

ULHT had very little contact with Helen and were not involved in the hours preceding her death.

General Practice

This is a rural GP practice based on two sites. It serves a population of 9700 people, providing general medical services. The Practice is rated 'good' by the Care Quality Commission (CQC) in their February 2016 report.

Helen registered with the practice in 2003.

Helen sought help from her GP in March 2013, when she was accompanied by her friend. She received treatment for depression and was referred to the LPFT community mental health team.

Helen was seen very regularly at the surgery from this point onwards, mostly by her own GP. This was on a monthly, and at times weekly, basis. In the period of the review, her GP saw Helen 58 times. She was seen by other GPs five times, and nurses 33 times.

Helen was almost always accompanied by her friend, who stated that Helen found this support helpful.

The Sanctuary

As it was no longer in operation this service did not take part in or contribute to the review. It is to be noted that the authors had no means of accessing information directly from the service.

This was an overnight support service open between 6pm to 1am, commissioned from Open Door by a Clinical Commissioning Group (CCG) in a different county, for people experiencing a range of mental health problems. The Sanctuary was set up to relieve other emergency services including A & E, and was for adults experiencing anxiety, panic attacks, depression, suicidal thoughts or who were in crisis. The service was delivered either face to face or on the telephone. The service closed 30th September 2015 when it was not recommissioned.

This service was highlighted as beneficial and helpful to Helen by her family. Her friend and colleague identified this service as being accessible during the hours when Helen struggled to stay safe.

Agencies involvement in the hours prior to Helen's death

- Lincolnshire Police
- Humberside Police
- Northern Lincolnshire and Goole NHS Foundation Trust
- East Midlands Ambulance Service

The following is a summary of the circumstances surrounding the hours immediately before Helen died. The information is gleaned from the IMRs received from Lincolnshire and Humberside Police, NLAG and EMAS.

On the evening of 18th Feb 2016 between 18:45 and 22:00 Helen contacted a friend, the Crisis Team and 111, which is an NHS telephone number used when there is a health concern which is not seen as an emergency. Helen had called 111 disclosing that she taken a canine insulin overdose and was reported to be taking more whilst she was on the telephone.

An EMAS ambulance crew attended Helen's home at 22:45, and she told them that she had taken canine insulin intramuscularly into her abdomen at approximately 22:00 that night. Helen showed the crew an empty vial of canine insulin. She presented as calm and alert and was breathing normally on the crew's arrival. Two sets of physical observations were taken and an electrocardiogram (ECG). Helen had lowered blood sugar, so the crew administered 1mg Glucagon intramuscularly. The crew had no concerns about Helen's capacity to consent for treatment. The crew conveyed Helen to Grimsby Diana Princess of Wales Hospital for further assessment.

The ambulance arrived at the hospital around 23:30. Prior to booking Helen in at the hospital Emergency Department, Helen went to the toilet and returned to the crew. At 23:42 Helen told a crew member that she was going outside for a cigarette. The hospital CCTV shows Helen walking down the corridor away from crew member and exiting the hospital. At 23:48 Helen made a call to a taxi company to take her home; a taxi arrived, and she was driven home. When Helen did not return the crew completed a search of the grounds; when they could not find her, the incident was reported to the EMAS Emergency Operation Centre (EOC). Whilst Helen was in the taxi going home, EMAS contacted Humberside Police to report Helen missing and the crew on scene liaised with hospital security.

19th Feb 2016; Humberside Police Command Hub created a ‘Concern for safety’ incident log and it was graded as prompt. Prompt grading means the next available resource for deployment.

The taxi dropped Helen off at her home address at 00:20 and this was the last time she was seen alive or spoken to.

Between 01:23 and 01:35 Humberside Police called EMAS for a physical description of Helen, which EMAS provided from notes on their system. Humberside Police told EMAS that they thought Helen might live at a Lincolnshire address and that they had on their system that Helen had ‘*done this a few times before and went back to her home address*’. The Police mentioned they had no contact from the hospital and that they would check with them that Helen had not been found and was still missing. At 01:46 Humberside Police contacted Lincolnshire Police regarding a concern for safety, at 01:57 the safety incident log was re-graded as urgent.

Lincolnshire Police officers were deployed to Helen's address on several occasions between 02:01 and 03:33 but re-deployed from the Force Control Room (FCR) to attend what were deemed as higher priority incidents. It was 04:03 when an officer attended Helen’s home and reported no response to knocking; at 04:27 the officer reported that they had entered and found Helen unresponsive; cardiopulmonary resuscitation (CPR) was commenced and an ambulance requested. At 04:48 paramedics arrived and pronounced Helen’s death at 04:53.

At Helen’s home address syringes and vials were found which contained canine insulin. Enquiries revealed that a friend had given Helen the canine insulin to donate to a local dog’s home where Helen was a volunteer.

This series of events formed the basis of the Police, coroner and EMAS investigations. The findings of these investigations are referred to throughout this report and the author’s support the recommendations made as a result of investigations.

At the time of writing this report most recommendations from the investigations into the time immediately before Helen’s death have been completed.

Key issues that form specific Terms of Reference for this report

This report has explored areas agreed with the Safeguarding Adults Review Panel. These areas are known as the Terms of Reference and are listed below:

- Where was oversight of Helen’s care cited and how was this managed? Were there any other options available within your agency to work with partners?
- How did legislation policy and guidance inform Helen’s care?
- Review information sharing; communication and coordination of multi-agency care, including referrals, assessments; discharges and transitions, engagement and relationships.
- Was risk appropriately identified, analysed and managed?
- Are IT systems configured within and across agencies to share and manage risk?
- What were the services commissioned to support Helen doing and is there anything that should have been commissioned additionally?
- Were services configured and integrated in a way which supported Helen’s care?
- Did agencies have a clear understanding of their role and the role of other agencies?
- Were there, should there be any significant changes to services received by Helen which may have had an impact on her vulnerability or the vulnerability of others in the future?
- Did agencies have the appropriate safeguarding policies and procedures in place, and did they ensure effective safeguarding activity formed part of their service delivery during the significant event?
- Were there cross-border issues and how were these managed?

Term of Reference 1

Where was oversight of Helen’s care sited? How was this managed? Were there other options in your agency to work with partners?

Summary

The authors conclude that the overall responsibility for oversight of Helen's care was shared between the GP practice and Lincolnshire Partnership NHS Foundation Trust, (LPFT).

The GP had significant oversight of Helen's general care and her use of services. This is well evidenced. In the management of Helen's care, it was identified that the GP provided the central point of care. This included making professional assessments of the treatment Helen required and referring to secondary mental health services. The GP did not have direct oversight of Helen's mental health care and interventions, details of these were communicated via letter and in discussion by telephone.

It is evidenced that there was oversight within the mental health services of Helen's care. During the timescale of this review Helen moved from initially receiving psychological services through Steps2Change into secondary mental health services. Secondary services included the Crisis Resolution Home Treatment service and Integrated Community Mental Health Team.

It is felt by the authors that a more extensive care coordination process, such as use of Care Programme Approach (CPA), could have facilitated closer working across agencies and disciplines.

The use of the CPA means that a person has:

- The support of a CPA coordinator.
- A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks, including social care needs.
- A formal written care plan: including risk and safety/contingency/ crisis plan.
- Ongoing review, formal multi agency, multidisciplinary review at least once a year but likely to be more regularly.

A benefit of CPA supported by a current clear care plan and risk assessment is that this could have provided appropriate need to know information to all agencies working with Helen as she accessed different services. Communication between teams and across agencies appears to have been primarily via running case notes or verbal handover.

It is clear that all agencies involved recorded details of contact with Helen and attempted to share this usefully. Where the CPA is used all attempts should be made to seek the person's consent to working across agencies as required.

The authors feel that there was potential for closer partnership working to facilitate a joint approach and establish a shared plan of care, including risk assessment, which could have involved Helen and been made available in total, or in part, to other services which she accessed.

Analysis of oversight

The wide range of IMRs provided to the Safeguarding Adult Review (as described above), are evidence that Helen accessed multiple services and teams during the period 2014 – 2016.

This multiple access to services is not an unusual presentation for someone who has experienced trauma and abuse and who therefore struggles to regulate their emotions and self-harming behaviours. In December 2014 Helen was referred for psychiatric assessment, this assessment concluded that there was no major mental disorder. It was felt that Helen struggled to regulate her emotions and harmed herself in ways which "were indicative of Emotionally Unstable Personality Disorder related to trauma" (EUPD). There was no Personality Disorder (PD) diagnosis, but this formulation was valuable to inform approaches and ways of working with Helen.

Best Practice Guidance[i] reinforces the need for a coordinated response with oversight to ensure a consistent and therapeutic response is adhered to by all supporting agencies.

Helen received intensive support from her GP which started in 2013 and continued until her death. During the period analysed by this review contact with the GP was at least monthly, often fortnightly or weekly. The GP support was considered by the authors to be exceptional in terms of frequency of contact, consistency of personal contact and the continued interest and support of Helen throughout the period of the review.

Helen attended GP appointments with the support of a friend and the GP relationship appears to be one of trust and stability. If the GP was to be absent from work support from the other GPs in the practice and Helen's friend was arranged. Helen's friend was interviewed by the authors. She stated that Helen highly valued the relationship with her GP.

The GP described how information about any incidents of overdose would be followed up by the practice contacting Helen.

Through the IMR presentation day meetings panel members representing organisations who had submitted reports of contact with Helen during an emergency discussed being unclear of where the overall oversight for Helen's care was or should have been cited. The GP and LPFT's representatives reported being clear about their roles and access to information shared by other agencies with them.

On the night of Helen's death EMAS correctly called the Police however, there was no process to support the sharing of information or to escalate should there be any concerns about Police response.

Agencies reported sharing information with the GP and Mental Health services without knowledge of follow up or how their information impacted on any care plan or risk assessment in place.

During the review period six referrals were made to Lincolnshire Partnership NHS Foundation Trust, (LPFT) by the GP. A range of mental health services were provided to Helen. The authors noted that while Helen only formally moved from Steps 2 Change to secondary services there was a perception that Helen had experienced multiple transitions between parts of the mental health service. This impression was voiced by Helen, her friend, family and the GP who described changes in access to mental health teams as internal referrals, discharges and handovers between the mental health teams involved.

The GP reported that letters were received from the Crisis team, Steps2Change and Community Mental Health Team (CMHT). These were appreciated and the GP spoke in a panel meeting of examples of positive communication with LPFT.

In the chronological records there are reports of the GP's frustration when Helen was discharged from the care of mental health teams and required referral, and when services including counselling, Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT), were either discontinued or not available. In the third IMR presentation meeting the GP confirmed frustration and explained that this related to unclear processes for communicating concerns or queries. Discussion within the panel identified a need to define a clear escalation route for GP concerns.

It was concluded in IMR panel discussions that the use in services of the terminology "discharge" and "referral" can be inappropriate at times. It was noted that there have been subsequent policy changes to alleviate the potential for misleading terminology to be inappropriately used. This creates a false perception of the situation, which leads the person using the services and associated professionals to believe services have been withdrawn/stopped when that is not the case.

In December 2014 the psychiatrist, diagnosed "deliberate self-harm in the context of very prominent emotionally unstable personality traits" which were related to previous trauma. This information was shared and discussed through direct contact from the Consultant psychiatrist to GP. This was positive practice.

There was good evidence of oversight within the LPFT at the July 2015 interface meeting where Helen was transferred to the CMHT. This contact remained open until Helen's death and 15 contacts were reported. At the time of Helen's death, she was in contact with the CMHT, however this coincided with the period during which the CMHT staff numbers were low and there was only one registered professional at work thus record keeping was not comprehensive. It was reported to the authors that no care plan which she could access was developed with Helen at this time.

The authors believe use of the Care Programme Approach including the associated care plan could have offered an opportunity to establish increased oversight of Helen's mental health care and promote integrated approaches to the wider management of Helen's treatment and support.

It was identified that LPFT had staff based in A&E Lincoln County Hospital who contributed to discharge planning. This is recognised by the authors as positive practice.

It is acknowledged that during the period of the review LPFT was experiencing significant structural change within the organisation and that the impact of this was described within the IMR submitted by LPFT. An explanation of how mental health services were depleted at this time and staff were off sick was given in the IMR. It was recognised that there were staff shortages and usual practices around record keeping were not adhered to. This included the lack of an up to date risk assessment and care plan.

In the IMR submitted by LPFT it was identified that on 6th January 2016 a Frequent service user group meeting was held at NLAG's Diana Princess of Wales Hospital in Grimsby. This was initiated by NLAG and attended by key agencies supporting Helen. The GP IMR reports that at this time Helen was the most frequent attender at Diana Princess of Wales. It was reported that at this meeting the psychiatrist shared a formulation to assist other services to understand Helen's self-harming behaviours. The GP was not invited to attend but was informed of the outcomes afterwards. The notes of this meeting were not available to the authors and we were advised by NLAG that the Frequent Attender initiative was discontinued.

Although it appears that consensus was reached on how to work to support Helen there was no plan developed to communicate what was agreed.

The GP practice received electronic updates on Helen's access to other health services. The reviewers felt that Helen's GP had a comprehensive knowledge of her situation, needs, use of health services and other agencies involved in her care. However, as a rule the authors felt that it is not the role of individual GPs to coordinate a joined-up response across all agencies. The new role of practice care coordinator within GP practices would be well placed to do this going forward.

It is identified in guidance, including Refocussing the Care Programme Approach (see, End Note i) that care coordination where there is a mental health need is a defined role with an associated skill set.

LPFT reported that professionals involved in supporting Helen judged that use of the Care Programme Approach was not required for Helen at that time.

This was supported by the GP.

Prior to the day of Helen's death, it was felt that oversight of Helen's care by Lincolnshire and Humberside Police forces appeared proportionate within their role and contact with Helen. However, in the hours preceding Helen's death internal investigations conducted by the Police identified unclear cross border working protocols and communication. This will be referred to in the analysis of Term of Reference 8.

Learning

The authors conclude that the lack of an identified care plan, which could be shared with the GP, between teams and on discharge from services, limited the scope for maximising shared oversight of Helen's mental health care. Sharing plans of care with Helen herself and where appropriate with other agencies may have increased the opportunity for a more consistent approach to interventions, approaches used, and messages given to Helen.

It is felt that there were opportunities to improve oversight of Helen's care through collaborative care planning which could have included GP and other agencies. For example:

- As a repetitive pattern of self-harm emerged.
- At the time of the psychiatric assessment in December 2014.
- Further to the Frequent Attender Meeting.
- When Helen was supported within secondary mental health services.

The authors feel that as a result of this SAR there should be work undertaken to ensure that oversight is clearly established where a person who uses multiple services struggles to regulate their emotions and extensively self-harms in ways indicative of EUPD traits relating to trauma.

The use of the Care Programme Approach (CPA) would facilitate a full assessment of needs and require key agencies to come together, preferably with the person's consent, to agree a plan of care including risk assessment and relapse planning. Roles and responsibilities could be clearly understood, and the identified Care Coordinator would have agreed oversight of care and treatment. As part of the CPA process there is also a requirement to review the plan, at least annually or where there is change, including significant improvement.

Where a Mental Health professional deems that CPA is not the appropriate approach and wishes to confirm this LPFT Care policies state that advice can be sought in supervision or with clinical leads.

To facilitate effective oversight ongoing care of a person within Mental Health services who is identified as not eligible for CPA would also require formulation of a care plan and assessment of risk which is regularly reviewed.

Within panel meetings there was extensive discussion about the use of the CPA in practice since its inception in 1999. It was identified that the national policy focus on the application of CPA has varied over time including a reissue of guidance in 2008 which softened its impact and application as an approach to care coordination. LPFT identified an appetite to revisit the CPA as it is applied within the Trust to ensure that a more inclusive and robust process is established. It was felt that expanding the CPA would support existing initiatives and planned development of LPFT services. The CPA policy guidance nationally was reported to be due to be refreshed, this is timely as service configurations and use of services by the public has changed significantly during the last 20 years.

The discussion within panel meetings identified that there was a lack of clarity for the GP about who to approach with queries or concerns within the mental health trust. Whilst Helen's GP was proactive in ap-

proaching trust-based managers and professionals it was noted that other GPs may not contact the Trust. Helen's GP practice has a care coordinator; this is being rolled out to other practices. Currently, there are also neighbourhood teams, which will address interface communication.

Recommendation 1- Coordination of care and CPA

It is recommended that Lincolnshire Partnership Foundation Trust review their application and use of the Care Programme Approach to ensure it is robust; fit for purpose and in line with national guidance.

Action – LPFT: To identify a lead for the review of the Care Programme Approach Lead; to feedback on review of the use of CPA and proposed actions to be shared with the LSAB within 6 months of the publication of this report.

Term of Reference 2

How did legislation, policy and guidance inform Helen's care?

Summary

The authors have concluded that relevant legislation informed Helen's care appropriately. However, we believe that closer adoption of some policy and guidance, which was recommended during the time frame covered by the review, may have enhanced Helen experience of the care and support she received.

Analysis of how legislation, policy and guidance informed Helen's care.

There appears to have been considerable good practice in relation to how legislation was used when considering how best to support Helen. This includes consideration of the Mental Health Act 1983 as amended 2007, and Mental Capacity Act 2005.

Consideration of the use of the Mental Health Act by LPFT was proportionate and least restrictive. Similarly, Police decisions to not use S136 or S135 were appropriate.

Northern Lincolnshire and Goole NHS Foundation Trust, (NLAG) evidenced use of a capacity assessment to establish decision making whilst under the influence of alcohol.

Regarding policy and guidance there are some positive examples of how this informed and shaped Helen's care.

For example, the Frequent Attender initiatives active within NLAG when Helen was accessing services appear to have resulted in the frequent user group meeting which focussed on Helen's multiple service use and attempted to implement a shared response and understanding of Helen's self-harming behaviour.

It is acknowledged by the authors that Helen did not have a diagnosis of personality disorder, but that Helen struggled to regulate her emotions and harmed herself in ways which "were indicative of emotionally unstable personality disorder (EUPD) related to trauma".

However, some of Helen's identified needs and behaviour did benefit from approaches recommended in national guidance. During the period covered by the review there was published NICE (2009) guidance for management of Borderline Personality Disorder which advises on approach, management and support of people experiencing this presentation. This appears to have positively informed Helen's care.

The NICE guidelines are referenced in the LPFT IMR as influencing consideration of where Helen's needs would be best met. It is reported the NICE approach contributed to the decision that a hospital admission was not appropriate for Helen to receive mental health care.

There is reference to the need for a plan of care post an incident of overdose in July 2015. This plan was to include measures to avoid Helen feeling abandoned as some services were moving towards discharging her. The recognition of the need for this approach is in line with NICE guidance.

There were however other occasions cited in the chronology where Helen expressed clear feelings of abandonment and rejection often linked to actual or perceived service withdrawal or non-availability. This perceived abandonment, often coincided with a transition to another service or the ending of a service, this was an area of concern identified by Helen's friend and family.

The authors did not see evidence of a clear plan of approach understood by those supporting Helen to manage her experience of abandonment.

NICE Guidance provides good practice principles for managing the end of treatments or services and transition to a different service. The guidance also identifies the need to develop a comprehensive multi-disciplinary care plan including risk assessment and risk relapse responses. The guidance recommends use of CPA, provision of dialectical behaviour therapy (DBT) and emphasises the need for supportive su-

pervision of staff. It is recognised that DBT was not commissioned by the CCG to be provided locally at the time Helen was using services. The authors are aware that proposed service developments for people with a diagnosed personality disorder will include DBT going forward. This 'Personality Disorder Pathway' will be a positive enhancement of services.

The authors felt that NICE guidance could have informed the approach to Helen's care more extensively[ii].

NICE Self-harm, Quality Standard (2013) states that, "*people receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition* "and that *"people receiving continuing support for self-harm have a collaboratively developed risk management plan*".

It was not possible to identify that risk management plans had been developed.

The authors feel that consideration could have been given to use of the Care Programme Approach to effectively manage and deliver care with the other agencies involved. The CPA expects that all people using services would have a plan of care and that risk assessment; contingency and crisis planning be included. Where CPA is deemed professionally as unnecessary, collaborative care planning and risk management with regular review, would be appropriate, and in line with best practice as identified in NICE guidance.

It is recognised that the LPFT service review project, underway during part of the review period for Helen, was reported by LPFT to have had an adverse impact on Helen's Community Mental Health Team. This may have impacted on the capacity and ability to incorporate all aspects of NICE guidance into Helen's overall care planning and delivery. This is difficult to determine as record keeping was reduced at this time. The issue of record keeping has since been addressed within LPFT.

Lincolnshire Safeguarding Multi-Agency Policy and Procedures use a definition of an 'adult at risk' in line with the Director of Social Services and the Improvement and Development Agency (IDEA) definition of safeguarding adults in May 2011:

> "*Adult Safeguarding incorporates the concept of prevention, empowerment and protection to enable adults who are in circumstances that make them vulnerable, to retain independence, well-being and choice and to access their right to a life free from abuse and neglect."*

Helen did not meet the criteria as an adult at risk of harm; but the Policy and Procedures suggest that for people who appear to be at high risk there are alternative sources of referral and support. In such cases support may be found in local care management procedures or other local processes.

Throughout the Review it was identified across agencies and within episodes of care and treatment that Helen was not identified as an adult at risk as defined in legislation, policy and guidance. The authors support this position.

The authors identified positive practice in the identification and reporting of incidents and concerns as per the lack of tolerance of Domestic Abuse in Lincolnshire.

Learning

The Frequent User Group initiative brought together several agencies to focus on Helen's care and support. Helen was identified by NLAG as their most frequent attender in the period prior to the Frequent User Group meeting.

The Frequent User Group meeting was the most multi-disciplinary intervention evident to the reviewers during the timescale of the review period and appears to have promoted a shared understanding and approach towards Helen.

It was reported that this initiative had now ended, and it was unclear how the learning and information had been shared or embedded in practice.

From April 2017 – 2019 a national NHS England initiative was launched in the form of a Standard for Commissioning for Quality and Innovation (CQUIN). An indicator was developed to improve services for people with mental health needs who present to Emergency Departments (ED).

The CQUIN pilot and Royal College of Emergency Medicine best practice guideline published in August 2017 recommend identifying frequent attenders locally and establishing ED care plans to include management of self-harm and risk of absconding. The guidance also promotes case management, multi-disciplinary team involvement and the inclusion of primary care colleagues.

The review was advised at the second IMR presentation day by United Lincolnshire Hospitals NHS Trust (ULHT) that a bid for monies to establish a response to frequent attenders was being developed by their

ED consultant. The authors support the ULHT initiative to bid for workers to identify and support the effective management of frequent attenders at ED departments. However, as this is not yet achieved as a project for funding there was discussion about how this role may be fulfilled within existing resources. The GP based Practice Care Coordinators, within the newly created Primary Care Networks, were proposed as potentially being able to identify high volume health service users across a range of services and plan for wrap around coordination of their care and support.

There was considerable discussion within the Panel meetings regarding Helen's perceived abandonment when moving between services, or when her alcohol use precluded access to certain therapies. Discussion identified that the terms, "discharge" and "re-referral" which were used in services and notes did not support the service model in place. It was confirmed by LPFT that there has been work on the terminology used in services and that the Clinical care policies do not use these terms inappropriately. It was acknowledged that continued vigilance around the use of terminology will be required as culturally familiar language used in staff teams is often slow to change.

The authors are pleased to note that NICE Guidance Borderline Personality Disorder; recognition and management, and NICE Self-harm Quality Standard are intended to fully inform the approach and practice of mental health staff supporting people who will use the planned new Personality Disorder Pathway.

These planned Personality Disorder Pathway services, (which will support people with similar needs to Helen who have experienced trauma and abuse as well as people with a diagnosis of personality) are a key part of the narrative for Term of Reference six later in this report and it is noted that there is an aspiration to increase understanding of the relevant NICE guidance for all mental health staff.

Recommendation 2 Care transitions and the Personality Disorder Pathway

The authors recommend that as part of developing the new Personality Disorder Pathway there is consideration of how practice can be improved in the areas of, managing endings and supporting transitions. This could minimise the risk of people using services perceiving that they are abandoned.

Use of language in relation to transitions (transfers, referrals, discharges) should be consistent. Learning from this review should be shared, within LPFT CHMT's and the Personality Disorder Pathway.

Action – LPFT to disseminate findings of this review to the Personality Disorder Pathway and existing CMHTs.

Term of Reference 3

Review information sharing; communication and co – ordination of multi-agency care including referrals, assessments, discharges and transitions, engagement and relationships.

Summary

There was significant information sharing across agencies and numerous positive examples of cross agency communication are evident within the IMRs. However, the authors conclude that information shared did not always translate into adjustments to Helen's planned care and support. As identified previously, at times Helen and her GP reported feeling frustration when she was, or perceived she was, discharged from services.

It is understood from the IMRs and discussion within the Safeguarding adult review IMR panel meetings, that other agencies routinely shared information about their contact with Helen with the GP practice. This included information about each contact made with Lincolnshire Community Health Services (LCHS) when Helen attended Minor Injury Illness Units (MIU); East Midlands Ambulance services (EMAS) after each contact; Northern Lincolnshire and Goole NHS Foundation Trust (NLAG).

This facilitated an overview of Helen contact with emergency health services.

Helen, her GP, family and friend all identified that transitions; waiting for services to start and endings of services were a source of anxiety.

Helen was recorded in IMRs as well liked and pleasant, someone who tried hard to comply with advice; rarely missed appointments and was polite in her dealings with staff and services. The GP reported that Helen's practice of always attending appointments with a friend enabled her to manage the personal information she shared and to keep the depth of discussion at a lighter level than if she had attended on her own. The depth of Helen's engagement with services appears to have been controlled carefully by her, supporting the reports that she was a very private person.

Helen effectively excluded herself from some areas of support as certain therapeutic approaches are not advised or appropriate if someone is using alcohol. It was identified that Helen found it difficult to comply

with the requirements of some services to avoid using alcohol which was known to exacerbate her self-harm.

Helen is reported to have especially valued continuity of support and out-of-hours responses and it appears these were protective factors for her.

Analysis

Analysis of information sharing; communication and co – ordination of multi-agency care including referrals, assessments, discharges and transitions, engagement and relationships.

As part of this review process the authors have spoken with Helen's friend and family and reviewed comments Helen made to her GP and other agencies. This has been useful in identifying Helen's voice and some of her perceptions of her experience during the timescale covered by the review.

Information sharing

Information sharing between mental health services and the GP was reported as good and, as identified in the response to Term of Reference number one, overall oversight of Helen's care appears to have been shared between the GP and LPFT.

LPFT identified that 12 letters were recorded as having been sent to the GP and there were multiple calls identified in the chronology of events during the timescale of the review. These detailed the nature of the services involvement and support offered.

The IMRs provide evidence that there was considerable correspondence and electronic notification of events between agencies especially when Helen accessed emergency services.

For example, there are multiple notifications to the GP from Lincolnshire Community Health Services (LCHS); East Midlands Ambulance Services (EMAS); Diana Princess of Wales Hospital (DPWH – NLAG); LPFT.

LCHS and Diana Princess of Wales Hospital - NLAG evidence frequent referral or contact with Mental Health Crisis services to establish follow up arrangements after incidences of self-harm.

The issue of non-compatibility of IT systems was identified during this review process and is referenced in Term of Reference 5.

Communication and coordination of services.

There are positive examples of communication between services and coordination of care; for example, the frequent attender meeting.

As stated previously, Helen's GP was a consistent contact during the review period and saw Helen 58 times. The GP made four separate referrals to LPFT one of which was made when Helen was still open to LPFT crisis services.

LPFT provided a high level of support services to Helen. The authors found that there were periods of frequent contact with Helen by teams within LPFT. At times this was daily contact.

However, Helen did at times perceive that she was being "discharged" from services. This issue has been discussed earlier in this report.

Helen's experience of changes to her support included Helen saying she had lost confidence in her support, and sometimes expressing feelings of abandonment. This expression of abandonment often coincided with episodes where Helen was using alcohol in the evenings and did not manage independently to keep herself safe. Use of alcohol also impacted on Helen's ability to maintain appropriate contact with some services, for example CBT. According to the records mental health teams attempted to support Helen to stop drinking. They explained that she needed to be stable, regarding her drinking and self-harming behaviour, to ensure appropriate access to cognitive behavioural therapy. Unfortunately, Helen was unable to achieve this and so closure of CBT occurred in December 2014. The authors were advised that there was follow up from secondary mental health services after CBT ceased.

Conversations with Helen were documented by EMAS ambulance crew and included Helen talking about the distress or anxiety she was experiencing. Helen spoke about being unable to talk to someone; unavailability of the crisis team; being wound up by contact with crisis services and being discharged from services. Helen also spoke about being lonely and feeling anxious about upcoming appointments. When Helen expressed feelings of abandonment to the EMAS crew these were recorded in the reports which were forwarded to the GP.

The authors identified that transition between services, especially if it involved a change of key staff was difficult for Helen. As Helen was identified as someone who struggled to regulate her emotions managing perceptions of abandonment or rejection would have been key areas for support planning.

Movement between the Crisis team and CMHT was perceived as a particularly difficult time for Helen by her GP.

Discharge from Crisis teams coincided on several occasions with important events for Helen.

For example, one discharge discussion coincided with a wedding anniversary, 7th August 2014, this was notified to GP and letter received 15th August 2014 stating discharge from Crisis team and referral to Steps2Change Talking Therapies. On this same day Helen self-harmed. On 18th August 2014 Helen reports frustration during her GP appointment at being discharged by the Crisis team. On 27th August when Helen has had no contact from Steps2Change she reported to the GP losing confidence in the Crisis team.

In July 2015 as Drug and Alcohol services were withdrawn and Crisis support was also ending Helen identifies during her contact the need to talk to someone as she feels isolated and that strategies are not working. Positively the team leader asks for a plan to be drawn up to support Helen. Helen then overdoses and absconds from hospital. The planned crisis discharge goes ahead a week later.

The GP identified that when Helen was discharged by the crisis team or counselling ended, Helen would say she felt unsupported and would become more impulsive drinking and cutting herself.

It is reported that there was not a care plan for Helen however there was a running record within Mental Health Services of the plans to support Helen.

Cross agency communication and coordination immediately prior to Helen's death is to be referred to in the response to Term of Reference 8. This relates to an initial dispute about whose responsibility it was to respond when Helen absconded from the Emergency Department and resulted in a 1 hour 28-minute delay. This was addressed through internal investigations and the resulting recommendations will be referred to later in this report.

Engagement and relationships

A core relationship for Helen was the friend who supported her to attend appointments. By telephone or in person this friend was in contact with Helen almost daily for most of the review timeframe. Helen shared thoughts about her contact with services with her friend.

Helen was consistently reported as pleasant, usually keeping appointments and willing to engage in therapeutic work however, it was felt by services and GP that Helen's level of engagement was at times "superficial". The chronology shows that Helen found it hard at times to refrain from alcohol and self-harming behaviour. This sometimes excluded Helen from accessing psychological therapies, IAPT guidance states that to be beneficial, a person is required not to be using alcohol to excess in a manner which impacts on their ability to be emotionally present and use the therapy effectively.

The comments recorded by EMAS crew and recollections from her friend say Helen did not always feel engaged with designated workers, exceptions included:

- When seeing a counsellor in 2014 there was a decrease in accessing other services. It is recorded that Helen missed the contact with the worker when they moved on.
- When seeing a counsellor Helen experienced 3 weeks with no self-harm incidents. These remerged when counsellor on holiday for 2 weeks.
- During November 2014 the relationship with the Cognitive Behavioural Therapy worker was identified as valued by Helen.

The LPFT IMR identified evidence that their approach followed NICE guidance for the management of Borderline Personality Disorder (2009). NICE guidelines and practice guidance for working with people presenting with Personality Disorder needs emphasises the importance of continuity, trust and avoidance of situations which could be construed as abandonment. As identified above Helen reports abandonment when services ended, or she was in transition to another service.

It appears that Helen reduced self-harming behaviour and use of multiple services when she had a key supportive relationship with someone in the services. Helen regularly used the out-of-hours Crisis team however when they were not available at times when Helen sought support, she would contact a service in North East Lincolnshire.

It is noted that when Helen was in contact with The Sanctuary, she had an 8-week period with no incidents of self-harm. This service was commissioned to relieve emergency services including A & E. It was located in Grimsby and for adults experiencing anxiety, panic attacks, depression, suicidal thoughts or who were in crisis. The service was delivered either face to face or on the telephone. The service closed 30th September 2015 when it was not recommissioned. There were no records to access which include evaluation or analysis of the effectiveness of the service delivered by the Sanctuary; therefore, the authors have not been able to objectively analyse its effectiveness.

The access to out-of-hours support was especially successful for Helen. This was identified by Helen friend, family and her GP. Helen used this service from mid July 2015 until it closed. The Sanctuary in Grimsby offered Helen support by telephone and she accessed the centre in person. On occasions the Sanctuary sent a taxi for her.

Helen, her friend, family, GP and partner services identified that the Sanctuary was a very positive and protective service for Helen.

Learning

The authors conclude that Helen's experience of care in the period under review may have been improved by more effective joint working and proactive use of the information about Helen's experience which was routinely shared after the use of emergency services.

It appears that the configuration of mental health teams and the criteria for being described as discharged, accessing or moving between teams and services was at times problematic for Helen.

Continuity of contact with key individuals was important to Helen and it is known that this is not uncommon for people who have experienced abuse and trauma, self-harm or present with uncontained distress.

There are examples of positive cross agency communication including the Frequent Attender meeting and GP to Psychiatrist discussions. There is much evidence of information sharing but it is not clear how much of the communication and information shared impacts on the plans for care and treatment.

It was identified that the GP practice would follow up with Helen after notification of admission for overdose and that this influenced prescribing practice.

Although there were out-of-hours support services commissioned beyond the Crisis team, excepting a 6-month period when Helen accessed the Sanctuary, the authors were unable to establish if Helen used any other helplines.

Helen her family and friend believe the impact of additional out-of- hours support facilitated by the Sanctuary assisted in enabling Helen to experience the longest period of no self-harm during the review period.

This review has highlighted the need for the new primary care coordinator role, particularly in relation to what the GP does with information, including letters routinely shared by a variety of services. For example, EMAS let GPs know when someone rings up to 12 times and always send a letter to advise when there has been a face to face contact. It was also recognised that notifications from other agencies to GPs need to be prioritised. It was agreed that these actions should be reviewed to determine if there is a gap in information shared and how it is collated. Questions raised within panel meetings included - How are issues escalated? How professionals are assured that something is being done with information shared? It was agreed that there should be a scoping exercise to assess how notifications from other agencies are managed.

Recommendation 3 Care co-ordination and GP practices

The authors recommend that the GP based Practice Care Coordinator role within the Primary Care Networks are developed to provide coordination which identifies people who are high volume health service users. This cohort of people could then benefit from agreed plans to coordinate and manage their care and support in a consistent way.

Actions:

CCG to complete an in-depth review of what Helen's GP practice has done as a result of this SAR.

Term of Reference 4

Was risk appropriately identified, analysed and managed?

Summary

There is significant evidence that services that were supporting Helen frequently considered risk and that a large part of the support provided by LPFT was to assist Helen to manage the risks that her self-harming behaviour presented.

Helen was able to anticipate and assess her own risk and seek help. She was supported by her friend to manage her environment including access to medication and sharp objects. Further to self-harm Helen did access Emergency Services although Helen latterly absconding from Emergency Services did suggest a lack of insight into the need for ongoing physical care.

The authors did not see evidence of a risk management plan in line with guidance[iii]. It was confirmed that the last risk assessment produced by Mental Health Services was undertaken eight months prior to Helen's death.

As previously described the authors are aware of organisational redesign and transition which had negatively impacted on record keeping and availability of staff in Community Mental Health Services.

Analysis

Analysis of whether risk was appropriately identified analysed and managed.

The authors felt that the GP positively identified risk situations with Helen. For example, they pursued delays in referral or access to services: the GP also communicated openly with Helen and her friend about fears for her self-harming behaviour: the GP adjusted medication prescribed.

The GP practice did not receive notes from the Frequent Attender meeting however they were contacted by the psychiatrist who shared an update.

It is reported in a letter from LPFT to Helen’s family that the last risk assessment for Helen was undertaken on the 8th of June 2015.

The authors did not see the LPFT risk assessment and found no evidence that the risk assessment had been shared with other agencies beyond verbal reports at meetings.

The authors would have expected a risk assessment and management plan to be developed upon referral to Louth Integrated Community Mental Health team in August 2015.

The authors identified other occasions which presented an opportunity for a formal review of the written risk assessment. For example; three of the five mentions of suicidal thoughts occurred after referral to CHMT in August 2015 and there was a period of self-harm escalation around Christmas 2015.

It is accepted that there were significant internal changes within LPFT community services and that having been identified restorative action has been taken.

It is reported that summaries of care planning and risk were included in letters from LPFT to the GP. This is positive practice. The GP reported that they felt all action was taken to manage risk both by LPFT and the GP practice. The GP informed the IMR meeting that the potential for Helen's self-harming behaviour resulting in unplanned death had been openly discussed with her.

The potential for Helen's self-harm to result in unintended consequences, including death, had also been identified to Helen by her friend.

It was identified that the ED department at ULHT appropriately managed risk and evidenced good practice by communicating in a timely manner with the Mental Health team based at the hospital. Mental Health staff, who knew of Helen, was then able to contribute to discharge planning.

Authors support the EMAS recommendation in the IMR to update their Absconding Policy to include making a call to the person’s mobile phone, if the number is available. EMAS confirmed that this has been completed further to the second IMR presentation to panel.

The risk rating of Helen by Lincolnshire Police was identified as appropriate and the issue of final call prioritisation has been dealt with internally. It is recognised that this last deployment decision would not have affected the outcome for Helen.

Learning

The last day of Helen's life has been looked at in detail by this review and has been scrutinised by other agencies internal processes and the Coroner's inquest. Recommendations for joint working protocols with Humberside & Lincolnshire Police forces and EMAS have now been developed and form part of a larger initiative for joined up Police working beyond these two forces. This is considered in Terms of Reference number 8.

Further to discussion at the IMR presentation Lincolnshire Police Missing Persons Policy was shared and reviewed by the authors. No further action is required.

NLAG identified within their IMR recommendations to undertake a crisis plan prior to the discharge of a person attending ED who has self-harmed and to work across departments to manage the challenges posed by someone who is a regular attender. The authors support this work in progress.

Authors reviewed all risk assessment policies submitted throughout the Review process.

The authors were informed by LPFT that in 2017/18 a comprehensive Trust wide audit showed that over 80% of records contained a fully completed Trust approved risk assessment. There is a national Continuous Quality Improvement Programme covering risk assessment in care planning. This initiative is planned to commence in December 2019 and will be overseen by the Director of Operations within LPFT.

Recommendations

There are no recommendations specific to this Term of Reference.

Term of Reference 5

Are IT systems configured within and across agencies to share and manage risk?

Summary

IT systems and processes within and across all agencies are not configured to identify, manage, share and address risk for someone who uses services like Helen.

Analysis

ULHT have paper records and the acute Trusts have no access to each other's systems. This means that patients can attend different hospitals and themes and patterns of the person's presentation and service use may not be recognised.

LPFT has 3 different clinical systems; their IMR suggests that staff and teams communicate effectively through the use of interface meetings and via verbal communication.

The IT system used by the GP practice was visible to the staff at Louth Urgent Care Centre. Diana Princess of Wales Hospital and NLAG Trust provided correspondence which was scanned onto the LCHS electronic system of Helen's attendances and outcomes and were visible to Louth Urgent Care Centre staff. The outcomes of attendances at Mental Health services were not visible on Helen's records. Louth Urgent Care Centre would not be aware of any interventions put in place to support Helen's Mental Health needs.

NLAG's IMR stated that at the time of Helen's attendances, their Emergency Department did not have access to NAViGO (Mental Health) electronic record system. This has now been resolved. There was also regular contact with Louth Crisis Team.

EMAS do not case-hold and other services do not have access to their records. Electronic patient records are always shared with the GP and paper records left with the patient to provide to the GP. Due to the way EMAS records work, and the organisations inability to access other records, each attendance is assessed by the way the patient is presenting at that time and any information the crew can gather from available resources. In relation to the absconsion, EMAS at the time in question did not have a policy to support staff on what to do when a patient absconds from their care therefore no system was in place to ensure timeliness of contact with other partners, address the risks and set appropriate actions in place. On the 19th of February 2016, EMAS correctly called the police however, there was no process to support the sharing of information or to escalate should there be any concerns about the police's response.

Lincolnshire Police's IMR states that their IT systems and processes were appropriately configured to address risk. The IMR author then goes on to suggest, that in this case any failings in managing risk were down to human decision making, e.g. timings of communications between organisations, initial overview of who was the most appropriate agency to progress the search, individual decisions on priority of attendance.

The GP practice was unable to access or view electronic community Mental Health or acute hospital records

This review has identified that IT compatibility presents challenges locally as well as nationally.

Learning

IT systems are not configured within and across agencies to facilitate collaborative risk planning or the sharing and management of risk. This is a complex issue, nationally as well as within Lincolnshire, which needs to be managed across agencies, organisations and geographical boundaries.

The lack of linked IT systems presents a problem in the effective sharing and management of risks, not only in the geographic area covered by the report, but is an issue identified nationally.

The IT platform SystmOne is used by a number of the agencies that were involved in supporting Helen.

Cross agency information sharing can be complicated by people withholding consent. Helen was reported to be a private person, and this may have impacted on her approval of extensive information sharing if it had been suggested.

Recommendation

There is no recommendation specific to this term of reference.

Term of Reference 6

What were the services commissioned to support Helen and is there anything that should be commissioned additionally?

Summary

The health services commissioned to support Helen appear to have been structured in line with expected models and pathways of care.

Emergency Services accessed by Helen ranged from large Accident and Emergency departments at Diana Princess of Wales Hospital through to Minor Injuries Unit services in Lincolnshire and EMAS.

The authors support the assertion of LPFT and Helen's GP that a diagnosis of personality disorder is not a helpful term, and that Helen was identified as having issues resulting from post-traumatic stress disorder and associated self-harm and use of alcohol.

There was no identified service specifically commissioned to support people with needs which may fall into a provision or pathway suitable for people with a diagnosis of personality disorder, or who, like Helen "struggled to regulate her emotions and harmed herself in ways which were indicative of emotionally unstable personality disorder related to trauma."

Helen particularly valued out-of-hours support provided by the Sanctuary in Grimsby. This was discontinued in September 2015 when funding was withdrawn.

Analysis

Analysis of what the services commissioned to support Helen were doing at the time and anything that should be commissioned additionally.

The mental health services provided by LPFT during the review timescale reflect the elements of service prescribed by the National Service Framework for Mental Health in 2000. This includes Integrated Community Mental Health Teams (CMHT) and Crisis Resolution Home Treatment services (CRHT). There was also access to Steps2Change (IAPT service).

A Drug and Alcohol Recovery Team (DART) was also commissioned during the review timeframe.

Multiple referrals were initiated by the GP to enable Helen to access a range of care and support. At times some preferred interventions were not available within Lincolnshire, for example DBT. There is evidence that the GP and Psychiatrist attempted to access DBT for Helen but discovered this was only available out of area.

During the review period there were no dedicated personality disorder services commissioned for the LPFT catchment area. As no dedicated services were commissioned the requirements on the commissioners of LPFT services were to ensure that care was delivered in line with the Department of Health position statement on personality disorder (see Personality Disorder: No longer a diagnosis of exclusion: policy implementation guidance for the development of services for people with personality disorder. 2003) and associated NICE guidance. The provision of services in line with NICE guidance is referenced in the LPFT IMR. This has been explored by the authors and is referred to in Term of reference 2 and the associated recommendation.

It has been estimated in research (cited in the NICE guidance) that 0.1 – 2% of the general population experience personality disorder and "In mental healthcare settings, the prevalence of all personality disorder subtypes is high, with many studies reporting a figure in excess of 50% of the sampled population."

This would suggest that if 1% of LPFT catchment area population experienced emotionally unstable personality disorder that would equate to almost 7,500 people.

In addition to people with a diagnosis of personality disorder there is a recognised cohort of people with needs similar to those of Helen. Her psychiatrist described these needs as, "affective dysregulation and deliberate self harm in the context of very prominent emotionally unstable personality traits – trauma related".

The authors have noted that through their contribution to the Frequent Attender user group the psychiatrist's assessment appears to have informed cross agency formulations of approach.

Helen received services, from LPFT crisis team, CMHT and IAPT as previously described, to assist her with managing the impact of trauma and abuse. It was identified in the LPFT IMR that if personality disorder services had been commissioned "she would have been considered for their support".

There is a recognised overlap of some therapeutic approaches identified as useful for people with a personality disorder but from which people who have experienced trauma and abuse can benefit.

Learning

The authors feel that there was a deficit of commissioned specialist personality disorder service/ pathway which could have provided specific resources from which Helen may have gained benefit.

It was reported at the first IMR presentation day that new personality disorder service/ pathway was being commissioned for people who experience personality disorder and that this was to be provided through LPFT. Throughout the period of the review more detail about this planned, and subsequently commissioned pathway was made available to the authors.

The aim of the newly commissioned Personality Disorder Pathway was confirmed to the authors by the CCG as follows:

> *"The proposal provides a framework able to flex around the individual needs to ensure access to appropriate specialist interventions, provide support after discharge rather than facing a 'cliff edge', prevent escalation to crisis, avoid admissions and upskill the wider workforce across primary care, community care and secondary care services to be able to provide high quality care for complex patients with Personality Disorder."*

The summary of this planned service that was provided to the authors describes plans for specialist clinicians working in an integrated way with the CMHTs and crisis services to reduce admission and enhance community-based support.

Evidence based interventions will be in line with NICE guidance. The specialist therapists will have a more in-depth training in Trauma therapies such as Eye Movement Desensitisation and Refocusing Therapy (EMDR) and Dialectical Behavioural Therapy (DBT). Cognitive Analytic Therapy (CAT) is delivered by psychologists in CMHTs and the specialist psychologist.

Through transformation money, *LPFT* have funded 12 places on DBT training, initially in the Lincoln and Gainsborough pilot area. LPFT have funded 60 places for structured clinical management training for the personality and complex trauma team, CMHT, neighbourhood and CRHT staff. A request has been made to HEE for additional structured clinical management places for all CMHT staff to undertake this training across the county.

Additionally,

"*Intensive support clinicians and therapists will provide training, supervision and support to all healthcare professionals who work with patients with personality disorder including other staff within the NTs[1], GPs, Social Care, Police, substance misuse and others working within the criminal justice system. This will be done across the pilot areas and will up skill front line professionals to provide better care for these patients."*

The service aims to be county wide following the 18 month pilot period.

The authors feel that this will be a positive development and promote shared approaches and an increased understanding of how to support people accessing a range of services.

The service described also appears to be planned to integrate well with existing teams and facilitate a wider understanding across services of how to support people with personality disorder and those experiencing complex trauma.

The description is as follows,

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[1] Neighbourhood Teams

The new service has carried out engagement events and the newly formed personality and complex trauma team will provide care coordination in Lincoln and Gainsborough to people with personality difficulties who also have complex and high risk behaviours. The team will hold small caseloads and have the ability to provide consistent, intensive support and psychological informed therapies on the premise of structured clinical management or alongside intensive DBT. Outside of this direct work the team will work closely with CMHTs, neighbourhood teams, Complex & Community Forensic Service and the new Criminal Justice Liaison & Diversion Service.

The authors noted that the CCG description explains that there will be peer support workers to provide support with aspects of everyday living like housing, education and work.

The authors feel that there is an opportunity, as part of integrating newly commissioned Personality Disorder Pathway service into LPFT Mental Health Services that the pathways of care through Mental Health Services are informed by what this Review has learned about Helen's experience of her care. The authors feel that this reflection would be of value as throughout the Review process agencies identified that Helen is not alone in her experience of trauma and abuse induced stress which results in self-harming behaviour including substance abuse.

It was confirmed to the authors that the new Personality Disorder Pathway is aligned to existing care pathways.

Helen accessed the out-of-hours community based Mental Health service in Grimsby, the Sanctuary, between July and September 2015.

The GP's IMR and recorded comments in the chronology of care cites the Sanctuary as a protective factor and highlights the 24-hour response, including phone line, was highly valued by Helen.

Additionally, her family believe that the Sanctuary was beneficial for Helen - it was described as "*a place where someone was always interested, they built good relationships. The phone was always answered*".

Helen's friend identified the Sanctuary as the service most valued by Helen and felt that there was currently no service which could replicate its approach. It appears that Helen accessing the Sanctuary not only reduced her use of other services but is reported to have been a positive experience for her.

The natural support that Helen received from her family, friend and colleague consisted of supportive phone calls almost every evening; and practical support for Helen which enabled her to maintain a safer environment within her own home. Helen was fortunate that this natural support was available to her. The authors believe that without this, Helen could have displayed a higher level of service use and level of risk.

Recommendation

There is no recommendation specific to this term of reference.

Term of Reference 7

Were services configured and integrated in a way which supported Helen's care?

Summary

Helen used a range of services delivered by the Police, ambulance service, NHS and voluntary services. Whilst there is some evidence of integrated working across services, the authors feel, that for Helen there was no formal overarching system to share information and collaboratively plan Helen's care.

Analysis

Analysis of whether services were configured and integrated in a way which supported Helen's care

Analysis of service integration suggests that within agencies, service teams may have been integrated, but across agencies integrated working was less apparent.

Mental health services based at the hospital in Louth, clearly supported coordinated care however the lack of information sharing across different acute Trusts, meant ULHT were unaware of the presentations at other Trusts and vice versa.

The LPFT services were configured locally and it is believed they were accessible to Helen. The integration of the Mental Health teams was facilitated by a shared site for Louth services. The Crisis team services were integrated with the Lincoln team picking up out-of- hours calls and sharing information with the Louth team to follow up on concerns. Louth Crisis and Steps2Change worked alongside each other.

The Consultant Psychiatrist led on an integrated multi-agency plan after he assessed Helen in December 2014. This involved a joint approach with DART and again at the multi-agency Frequent Service User

Group meeting on the 6th January 2015 where the psychiatrist promoted flexibility of response across the multiple-agencies in Helen's best interests. The authors identified this as good practice.

Generally, the ongoing discussion between NLAG and Mental Health services in Grimsby and Louth appeared to function well.

During the scoping period EMAS did not make any significant changes to their services that would have impacted on the service to Helen or other adults at risk.

Lincolnshire Police stated in their IMR that there had been significant change in relation to assessments with the creation of the Police Safeguarding Hub. This allows a wider and more holistic function to manage all referrals, including all partnerships interaction and escalation is assessed at the time of referral. A link is needed with the work relating to the team around the adult.

Learning

There is no one place or forum where information is shared about people who present with needs similar to those of Helen. The Frequent Service User Group was a pilot which offered a forum to share information about people who were identified as frequent users of a range of services, this is no longer in operation.

Such information sharing about agency roles, in relation to a person's care is further complicated, as it was identified within panel meetings, that Helen did not fit the criteria for most single agency's definition of a high-volume health service user.

The new GP Practice based care coordinator role may improve the sharing of information and the ability to collaboratively plan care.

Recommendation

There is no recommendation specific to this term of reference.

Term of Reference 8

Did agencies have a clear understanding of their role and the role of other agencies?

Summary

Agencies do seem to have a clear understanding of their role as single agencies.

The oversight of Helen's health care and support was with the GP. There was clarity about the roles of other agencies, but not in relation to where an overall and coordinating oversight lay. This has been referred to in Term of Reference 1.

Analysis

ULHT effectively liaised with the Police to return Helen to the hospital when she posed immediate risk of harm to herself. The level of risk was determined by ULHT from their information and the role of the Police was to return her to hospital.

The authors found evidence of liaison with mental health services following Helen's presentation with self-harm to ensure that her mental health needs were addressed once treatment had been delivered, and to support with risk assessments for discharge from ULHT.

The review undertaken by Humberside Police established that there was no clearly documented understanding agreed by all agencies as to ownership of responsibilities and actions during the initial call handling on the night of Helen's death. This is evident on the incident log following the initial call between Humberside Police and EMAS when the log was delayed awaiting a more detailed update from EMAS. When this update was not provided, and the Police made additional telephone enquiries, it became evident that there was not a common understanding regarding ownership and roles of each agency in responding to this incident.

When Humberside Police notified Lincolnshire Police to request an address check, the incident log, recorded in detail the request and action that was required of Lincolnshire Police.

In a panel meeting, it was reported, that Senior Superintendents from Humberside and Lincolnshire Police forces are working together to establish a protocol which improves their relationship and operational working.

Furthermore, regional project work by a number of police forces, called DEMAND was described within the same panel meeting. This multi-agency piece of work includes:

- Understanding demand, capacity and capability

- Exploring single or multiagency attendance
- Quick assessment
- Ensuring detailed questions are asked to establish whether Police must go, should go, or someone else should go to an incident or request for help.

As part of the review panel discussions, an action was identified for Police panel members to report on progress on the DEMAND work.

NLAG Emergency Care Centre describes Helen as struggling to regulate her emotions, and therefore appearing non-compliant. Due to this, Emergency Department at Diana Princess of Wales Hospital sometimes struggled to support Helen. Since 2016 NLAG and NAViGO have been in regular dialogue trying to improve the quality of their joint working.

Learning

Agencies do seem to have a clear understanding of their role as single agencies

During the course of the serious incident investigation conducted by EMAS, it was identified that an absconding policy was required to include a supportive flowchart for staff. This was then developed in conjunction with Police colleagues.

As part of the review panel discussions, an action was identified for Police panel members to report on progress with the broader piece of work known as DEMAND. The DEMAND work is regional and aims to address interagency understanding and working across Police forces and associated agencies.

Recommendation

There is no recommendation specific to this term of reference.

Term of Reference 9

Were there, should there be any significant changes to services received by Helen which may have had an impact on her vulnerability or the vulnerability of others in the future?

Summary

Helen did not meet the criteria of frequent attender for some agencies. However, her combined use of services was substantial. The review highlighted the complex geographical cross border and agency border issues experienced by Helen.

Analysis

Since 2016, all LCHS urgent care health records relating to both children and adults who use out-of-hours and Minor Injury Units services are included on a Chronology of Significant Events.

It was difficult for LCHS to ascertain the outcome of Helen's attendances with mental health services as this information is not visible on their system. Therefore, Louth Urgent Care Centre staff would not be aware of any strategies that were in place to support her mental health needs.

NLAG's IMR highlighted the difficulties for both NLAG and Mental Health Services (NAViGO & Louth) in managing a patient wishing to fully control their own interventions and treatments; whilst relying on those same services to support and maintain a risky lifestyle.

Learning

LCHS's IMR suggests that had a Chronology of Significant Events been in place at the time of Helen's frequent attendances; staff would have had a clear record of her multiple / regular attendances with self- harm injury.

The use of Chronology of Significant Events should continue, and the principle could be considered by other agencies as good practice.

Helen found the Sanctuary to be non-judgemental and her friend stated that Helen found it an effective listening service.

Signposting to services such as the Samaritans might also be useful.

The authors wish to state their support for the planned Personality Disorder Pathway, as described in Term of Reference 6.

Recommendations

The authors have no specific recommendations for this term of reference.

Term of Reference 10

Did your agency have the appropriate safeguarding policies and procedures in place, and did they ensure effective safeguarding activity formed part of their service delivery?

Summary

Analysis of the IMR reports from all agencies suggests that there were appropriate safeguarding policies and procedures in place. Agencies regarded Helen as an adult with capacity, who did not fit the adult at risk criteria. Generally, safeguarding was not considered in relation to service delivery to Helen.

Analysis

ULHT IMR states that their records show that effective safeguarding activity formed part of the service delivered to Helen in relation to contacting the Mental Health Crisis Team after all attendances involving her self- harm.

ULHT had a Safeguarding Adult's Policy in place. Helen presented with self-harm which would not meet the criteria for a Safeguarding Adult's referral. Helen made no disclosures that were a cause for concern.

LPFT's Safeguarding Policies and Procedures that were in place during the timeline were robust, up to date and included relevant legislation and good practice guidance.

NLAG did not identify any safeguarding issues within their IMR. It is recognised that staff in A&E at Diana Princess of Wales Hospital followed due process by contacting the Police to look for Helen on the night of her death, after she absconded from there.

EMAS have an up to date Safeguarding Adults Policy. Compliance with policy and procedure is demonstrated through audit and EMAS's increasing referral rates from 2010 through to 2019 provides evidence of continued engagement with the safeguarding agenda.

It was reported that safeguarding is firmly embedded in all Lincolnshire Police's relevant policies. Procedures were followed, and at relevant times during this incident safeguarding risk assessments were made.

Learning

Helen was an adult with mental capacity who struggled to regulate her emotions and did not meet the criteria of an adult at risk.

During panel discussions it was agreed that experience of abuse and trauma can lead a person to express emotional distress and self-harm. This requires a tailored service approach, the elements of which sit within the interventions described for the planned Personality Disorder Pathway.

Recommendations

There are no specific recommendations for this term of reference.

Term of Reference 11

Were there cross border issues and how were these managed?

Summary

Helen lived in a village on the border of the Lincolnshire and Humberside Police geographic areas. Cross border issues were raised by the Police and EMAS in their IMRs.

There is additional complexity due to the rurality of the village and its proximity to the boundaries of NHS CCGs.

Analysis

The review undertaken by Humberside Police identified that there is a need for a clear pathway and process regarding ownership and responsibilities that is communicated and understood by all involved agencies who work across different boundary areas.

EMAS reported that whilst Helen could be left unobserved whilst in their care, once she absconded, the risk to her health increased and this was not reflected accurately to the Police force. A new policy has been put in place following this incident; this ensures that EMAS staff clearly identifies risk to patients when they abscond to enable other organisations to carry out accurate risk assessments.

Lincolnshire Police identified there was a problem in relation to the timing of the sharing of the information relating to Helen, both from EMAS to Humberside Police and then onwards to Lincolnshire Police. In hind-sight it would have been prudent for Lincolnshire Police to ask if assistance could be given by Humberside officers when the re-deployment issues began. Helen's address is only approximately 9 miles over the county border.

Helen's needs, especially in emergency situations required her to cross borders however follow-up care was often provided by teams closer to her home.

Communication of service use was largely through IT systems reporting back to Helen's GP.

With regard to mental health care and crisis support, one of the services which Helen chose to use was out of area and was not aligned to local services.

Learning

The IPCC recommended:

Humberside and Lincolnshire Police should consider drafting a memorandum to set out the responsibility and expectations of each Force in respect of cross-border response and investigations.

The Independent Police Complaints Commission agreed with Humberside Police that the outcome of the investigation for the staff related to unsatisfactory performance. The management of this outcome will be overseen by the Professional Standards Branch and Senior Managers within the Command Hub.

Humberside Police were to provide information in relation to the implementation of the organisational learn-ing surrounding the findings for the force within the Independent Police Complaints Commission Investiga-tion following the death of Helen to Lincolnshire Safeguarding Adults Board.

HM Coroner issued Humberside Police with a Regulation 28 notice following the inquest of Helen's death. Humberside Police had until 25th September 2017 to respond to this notice, a cross border policy was de-veloped, and the Coroner informed appropriately.

Humberside Police were to provide information to the Lincolnshire Safeguarding Adults Board regarding their response to the Section 28 order issued by HM Coroner.

The authors were informed that all actions recommended by HM Coroner have been completed.

Recommendation

There are no specific recommendations for this term of reference,

Summary of recommendations

Recommendation 1- Coordination of care and CPA

It is recommended that Lincolnshire Partnership Foundation Trust review their application and use of the Care Programme Approach to ensure it is robust; fit for purpose and in line with national guidance.

Action – LPFT: To identify a lead for the review of the Care Programme Approach Lead; to feedback on review of the use of CPA and proposed actions to be shared with the LSAB within 6 months of the publica-tion of this report.

Recommendation 2 Care transitions and the Personality Disorder Pathway

The authors recommend that as part of developing the new Personality Disorder Pathway there is consid-eration of how practice can be improved in the areas of, managing endings and supporting transitions. This could minimise the risk of people using services perceiving that they are abandoned.

Use of language in relation to transitions (transfers, referrals, discharges) should be consistent. Learning from this review should be shared, within LPFT CHMT's and the Personality Disorder Pathway.

Action – LPFT to disseminate findings of this review to the Personality Disorder Pathway and existing CMHTs.

Recommendation 3 Care co-ordination and GP practices

The CCG to seek assurance from General Practices about the coordination of care and how GPs are man-aging contact from other agencies. Assurance to include who looks at correspondence and/or takes any action.

The authors recommend that the GP based Practice Care Coordinator role within the Primary Care Net-works are developed to provide coordination which identifies people who are high volume health service

users. This cohort of people could then benefit from agreed plans to coordinate and manage their care and support in a consistent way.

Actions:

CCG to complete an in-depth review of what Helen's GP practice has done as a result of this SAR; and then share the learning across all GP practices.

LSAB to gain assurance from all GP practices about how information received from other agencies is shared.

Conclusion

The record of the Coroner's Inquest into Helen's death concludes that she died of a canine insulin overdose which she administered herself. It was determined that there was insufficient evidence that she intended to take her own life.

Throughout the review the authors have identified evidence and actions which support the Coroners conclusions. The recommendations of this review have identified actions and alternative practices that the authors believe could have improved Helen's lived experience.

The authors would like to thank the family and friend for their thoughts reflections and time which has greatly assisted the understanding of Helen and her experience during the time covered by this review.

The authors are grateful to panel members for their comprehensive reports and engagement in the panel meetings.

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End notes

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[i] Refocusing the Care Programme Approach: Policy and Positive Practice Guidance: Department of Health March 2008.

[ii] Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. 2007

[iii] The British Psychological Society, Understanding Personality Disorder: 2006 39 NIMHE