Safeguarding Adults Review F: Laura

Produced by Warrington Safeguarding Adults Board

Acknowledgements

The Warrington Safeguarding Adults Board would like to thank all the panel members who have supported this Safeguarding Adults Review (SAR). In order for a multi-agency SAR to be able to identify and embed multi-agency learning, agencies have to be committed to an open reflective practice process. Without the commitment of agencies to such a process, the WSAB would not be able to meet its statutory responsibilities.

We also thank Laura's family. Laura's family shared their experiences and perspectives with staff and Chair of the Safeguarding Board to impart a greater understanding of Laura and the life she lived. Laura's family also provided relevant research information to help inform this report.

We worked closely with partners from other areas that were involved in the care and support of Laura. We would like to thank them for their participation.

1 Introduction

1.1 This report records the findings of a Safeguarding Adults Review (SAR) undertaken by Warrington Safeguarding Adults Board (SAB) following the death of Laura, who was an adult with care and support needs. A SAR is required under Section 44 of the Care Act 2014 when:

> *"…an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."*

1.2 The purpose of a SAR is to identify what partner agencies might have done differently to prevent serious harm or death, so that lessons can be learned and systems and practice improved to prevent similar harm happening to others.

1.3 The completion of a SAR is not intended for the purpose of holding individuals or agencies to account, as other processes exist for that purpose. Instead, a SAR sets out to encourage reflection on how agencies could work together more effectively in order to safeguard adults with care and support needs.

1.4 A SAR is not completed to investigate the circumstances of a death for regulatory action. These are the responsibilities of other bodies. However, the findings and recommendations of a SAR are shared with these bodies to help them in carrying out their responsibilities. For instance, in the case of this review, terms of reference have been shared with the Coroner, and there are arrangements in place to ensure relevant information can inform coronial processes.

1.5 This SAR has been carried out subsequent to some, and parallel with other, enquiry processes. Amongst these processes are a serious incident process under the NHS Serious Incident Framework, and a police investigation, which determined that no criminal enquiry would be taken forward.

1.6 Laura's family have been consulted at various stages in order to inform the SAR about Laura's and her family's experiences of services, as well as to explore their main areas of concern, and ambition to see improvements for the benefit of others.

1.7 The SAR has been undertaken in co-operation with agencies from Gloucestershire, who commissioned the placement at Arbury Court from Gloucestershire where Laura had lived for most of her life. Gloucestershire agencies had provided or commissioned a range of services for her since 2009, when she was 15, and participated in the SAR to provide information in relation to care received prior to commissioning Laura's placement in Warrington.

2 Laura

2.1 Laura was born in 1994 as one of twin girls. Laura had no contact with her biological father for the majority of her life. She was one of a number of siblings, half-siblings, and step-siblings. Some of her family currently reside abroad and some within Gloucestershire.

2.2 At the beginning of this review process, Laura's mother, step-father, and twin sister met in Gloucester with the Chair and the Board Manager of Warrington SAB. A second meeting was held with her step-father in Warrington (her mother was unable to attend due to Laura's twin sister being unwell). There have been a number of telephone conversations between the Board manager and Laura's step-father and an exchange of emails and research information.

2.3 Laura's family described her as intuitively intelligent and creative. They talked of someone who, as a child, picked up new skills and knowledge quickly and, as a young adult, was quick to identify and defend those she saw as needing support. It is recorded that this view was echoed by other people who used services, who described Laura as 'supportive'. Laura was small in stature but was noted often to take on the mantle of 'protector'.

2.4 It is possible Laura had started to self-harm at the age of 9, but a pattern of self-harm did not emerge until around the age of 13 years, in 2007. This was after Laura alleged that she had been molested by a family friend who had stayed at the family home for a short time. At 16 years, in 2010, Laura left home. During this time she slept rough or stayed with one of the members of her group of friends. This led to concerns and to a period of foster care, prior to Laura moving into supported accommodation. It is recorded that there was a breakdown in the relationships with members of her family. Despite these difficulties, Laura later worked with support agencies as a volunteer and participated in drama workshops that were aimed at helping to educate young people about mental health, substance misuse and homelessness. Laura wrote a play based on her own experiences and worked with other volunteers to perform it across schools over the next few years.

2.5 In 2011, at 17 years, Laura is reported by her family to have experienced a further sexual assault, by a member of her wider step-family. It is reported that her alleged attacker later overdosed and was left paralysed and in a coma. Laura did not report the alleged assault.

2.6 Laura's self-harming behaviour was noted to worsen around the time of the alleged sexual assault. Just before Laura's 18th birthday in 2012, she was admitted to a mental health hospital ward as a result of significant self-harm by cutting. Laura later began to access Cognitive Behavioural Therapy (CBT) but her family noted that she seemed to struggle to access additional support beyond the CBT sessions, and they felt she still had unmet needs. Specifically, they expressed a view that Laura needed inpatient-based treatment so that outside of sessions there was support available to understand and motivate her to address her self-harming behaviour.

2.7 In 2015, at 21 years, Laura was residing in supported accommodation for women with mental health support needs in the Gloucester area. Whilst accessing a local women's support group, Laura was arrested by police for possession of a bladed article. At the time, she had been discharged from hospital making threats to kill her alleged sexual attacker. Laura was prosecuted and received a suspended sentence.

2.8 Also in 2015, Laura moved into a newly renovated flat and began a relationship. She and her partner developed an innovative approach to photography using drones, with a plan to build a business. Alongside this, Laura commenced her psychology degree. A significant

achievement for Laura, noted by her mother and sister, was her purchase of a car due to the personal progress it represented for her. In October 2015, Laura became pregnant.

2.9 In January 2016, Laura miscarried. Her relationship broke down due to her partner's ongoing relationship with his ex-girlfriend. Her family reported that substance misuse was occurring and may have been a feature of her relationship with her partner. Laura was also experiencing problems with her neighbour, who had allegedly threatened her and vandalised her new car. In June 2016 Laura had a significant self-harm cutting episode and was hospitalised leading to an admission to Wotton Lawn Mental Health Hospital, operated by 2Gether NHS Foundation Trust (2GNHSFT). Whilst Laura was an inpatient there, her family discovered that her neighbour had continued a campaign of intimidation and threats despite a restorative justice intervention with the Police. This had led to Laura being afraid to make any noise in her flat to the extent that she would sleep in her car whenever she would return home after 9pm.

2.10 Upon admission to Wotton Lawn, Laura was assessed and diagnosed with borderline (emotionally unstable) personality disorder with antisocial and schizotypy[1] aspects in addition. Laura was described in 2Gether NHS Foundation Trust reports as using self-harming behaviour as a maladaptive coping strategy to deal with feelings of distress or anger. Laura was also known to purposefully restrict her dietary intake and self-medicate with alcohol and cannabis. Laura's use of substances was seen to increase her vulnerability to self-harm due to reducing her inhibitions as well as increasing her vulnerability to harm from others.

2.11 At the time of her death in February 2017, Laura was 22 years old and residing in a Psychiatric Intensive Care Unit (PICU) in Warrington. She was awaiting the availability of a low-secure placement to enable her to access therapeutic interventions to address her maladaptive coping strategies.

2.12 Although some of the information above is outside of the period of Laura's life being reviewed for the SAR, it is considered important to note the positive moments and the difficulties Laura faced during her earlier life, as well as her experience of support and services. The detailed review period is described in section 4 of this report.

[1] For description of symptoms associated with diagnosis and debate about validity of such diagnoses www.mentalhealth.org.uk/a-to-z/p/personality-disorders

3 Methodology

3.1 A safeguarding adult review (SAR) referral was received by Warrington Safeguarding Adults Board in December 2017, subsequent to the completion of a section 42 safeguarding enquiry. Laura's family had also requested that a SAR be considered. As a result, in February 2017, a formal screening of Laura's case was taken forward to identify whether or not the statutory criteria for a SAR were met. A recommendation was made to the WSAB Independent Chair that the case be taken forward as a SAR. The SAR screening panel identified the following issues:

- It appeared likely that there had been a lack of clarity in care coordination for Laura, which might have added to problems with communication and case oversight by partner agencies
- It appeared likely that there had existed a lack of robust risk management planning to respond to the fluid nature of Laura's risk-taking behaviour stemming from her mental illness along with a lack of assurance processes around established risk management plans
- There appeared to be a lack of understanding in relation to thresholds for safeguarding concerns that would require multi-agency ownership to ensure independent scrutiny and oversight was in place
- There appeared to be a lack of understanding about which agency held the responsibility as lead commissioner of the placement in Warrington and where the responsibility lay with respect to contract compliance monitoring

3.2 The WSAB Independent Chair confirmed the decision to undertake a SAR. It was acknowledged that a significant review had already commenced in relation to practice within the Gloucestershire area, where Laura had lived and where for the majority of time had received her care and support. As a result, it was determined that this safeguarding adult review would focus on engaging relevant agencies, local and Gloucestershire-based, to participate in identifying lessons to be learnt for multi-agency practice and systems. The WSAB Chair also highlighted that some of the issues that were pertinent to Laura's care, treatment, and changes in placement were of concern at a national level. It was therefore proposed that any learning should be informed by and inform national developments, particularly in relation to the shortage of specialist therapeutic mental health service provision (including hospital bed availability) and research on best practice that could be used to prevent further tragedies.

3.3 In May 2018, a panel was established to oversee the SAR. The make-up of the panel reflected the fact that Laura had been placed in a private hospital in Warrington, but that the placement had been commissioned by agencies in Gloucestershire.

Contributors to this SAR were:

- Detective Constable, Serious Case Review Officer, Cheshire Constabulary (CC)
- Safeguarding Practitioner, North West Ambulance Service NHS Trust (NWAS)
- Named Professional Safeguarding Adults - North West Boroughs Healthcare NHS Foundation Trust (NWB)
- Head of Adult Safeguarding and Quality Assurance Division, Warrington Borough Council (WBC)
- Designated Nurse Safeguarding Adults, Warrington Clinical Commissioning Group (WCCG)

- Warrington WSAB Third Sector Representative
- Senior Nurse Quality and Safeguarding, NHS England (NHSE)
- Safeguarding Lead, Gloucestershire Clinical Commissioning Group (GCCG)
- Safeguarding Lead, 2Gether NHS Foundation Trust (2GNHSFT)
- Members of Laura's family
- Chair, Gloucestershire Safeguarding Adult Board (GSAB) SAR Subgroup
- Hospital Director, Arbury Court Psychiatric Intensive Care Unit, Elysium Healthcare

3.4 The agreed methodology included the use of Individual Management Reviews (IMRs) and the construction of a multi-agency chronology that would clarify individual agency contact and involvement during the timeframe under review. The SAR Panel then planned and carried out two separate learning events. The first was to explore the commissioning of services with respect to Laura. The second was to consider best practice in relation to working with people diagnosed with personality disorders and self-harming behaviours. The Panel also determined that understanding the experience of service users, particularly with a view to inform challenges for practice in this area, would be beneficial. Therefore, agencies were also asked to share currently available feedback from service users that could be compared to and add to the learning from nationally-available service user surveys.

3.5 In order to ensure that independent scrutiny and challenge to the SAR took place an independent expert's[2] perspective on the Panel's recommendations and findings was recruited to review the report.

3.6 The scope of this SAR was set out in terms of reference (ToR) that were shaped by the Panel and which reflected discussions with the family. Three core areas for focus were agreed as:

1. The decision to place Laura in Arbury Court - to explore the decision-making, information sharing and monitoring of the placement, with the purpose of identifying lessons that can be learnt by all Warrington, Gloucestershire and National Health and Social Care commissioners.

2. The response to self-harming behaviours and particularly to those service users diagnosed with personality disorders residing within mental health facilities, with the purpose of identifying good practice methodologies that could be implemented in relation to de-escalation and also identifying thresholds for reporting of safeguarding concerns.

3. The lived experience of young adults with complex mental health needs through the perspectives of service users, with the purpose of identifying improvements that can be made in practice.

3.7 The timeline for the SAR was agreed as June 2016 to the end of February 2017, covering Laura's initial admission into inpatient mental health services in Gloucestershire and to include her transfer and later her death in the Warrington area.

3.8 The SAR also accessed the following information and reports and identified learning for insight into care and support received from:

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[2] He is a professor of clinical psychology/consultant clinical psychologist with particular expertise in personality disorder. His details and report can be found in Appendix 1.

- 2gether NHS Foundation Trust Review of Care
- A low secure facility assessment report by Wotton Lawn Hospital
- 2gether NHS Foundation Trust Complex Care Policy & Complex Care arrangements overview document
- Timelines for agency involvement from Arbury Court & Wotton Lawn Hospital
- Timelines for NHS England involvement and correspondence
- A research paper into deaths by suicide in Gloucestershire by Suicide Crisis
- A range of nationally available research and guidance documents that will be referenced in the body of the report

3.9 The SAR Panel also liaised with the Coroner to share progress updates and information as available and appropriate. On this occasion coronial processes were at an information-gathering stage, so an inquest hadn't yet taken place. If the inquest identifies further learning, then this will be reflected upon by the WSAB Safeguarding Adult Review and Learning (SARL) Group at a later time so that necessary additional recommendations can be proposed to the SAB as required.

3.10 Similarly, Gloucestershire CCG is commissioning an externally-led independent investigation into the care and treatment received by Laura in Gloucestershire with clearly defined terms of reference. This commenced in April 2019. Once again, should a review of this work result in any aspect of learning that may be applicable to the Warrington area, these will be reflected on for action via the WSAB SARL subgroup.

4 Case Summary: key events and interventions

4.1 Chronology

4.2 June 2016 – November 2016 (whilst residing and receiving care in Gloucester)

4.2.1 June 2016

In June 2016, Laura had a number of admissions to Cheltenham Hospital Emergency Department and the assessment of the risk posed to Laura through her self-harming behaviours was judged to be high. This led to a referral to mental health services, which Laura declined to engage with. Instead, Laura contacted 2Gether Trust's Crisis Resolution and Home Treatment team to report that she had self-harmed. She was taken to hospital and agreed to an informal admission to Abbey Ward at Wotton Lawn Hospital, an 88 bed hospital provided by 2Gether Trust. The purpose of the informal admission was to review her medication and assess her mental state over the period of a week. Although the admission was considered informal, it was noted that if Laura attempted to leave, a detention under section 5(2) of the Mental Health Act (MHA) was to be considered to enable a full assessment to take place.

4.2.2 Laura did leave the ward on 25th June. A staff search located Laura to the front of the hospital. Laura self-harmed later that day necessitating an admission to the local acute general hospital because the wounds required sutures in theatre. She returned to Wotton Lawn two days later. Within 10 hours of returning, Laura self-harmed again, and for the first time used a ligature. Laura's family visited later the same day and during the visit a ward round including multi-agency professionals took place. Laura explained she had been 'hearing voices'. A change in medication to include anti-psychotics was proposed to address this, but Laura was concerned about weight gain resulting from taking it. It was considered whether or not to use MHA powers as Laura was refusing to allow staff to remove items that she could use to create a ligature, and shortly after this Laura did in fact self-harm by means of a ligature made from a shoelace. Laura also had problems that day with her vision; she was taken to the acute general hospital again, because it was suggested that this was due to self-harming by punching herself to the eye some days earlier.

4.2.3 Laura went missing from the ward again on 28th June, and asked to discharge herself the next day. She was held under section 5 MHA to enable a full assessment to be made.

4.2.4 July 2016

By 1st July a mental health assessment was completed and Laura was detained under section 2 of MHA. After self-harming, Laura declined to attend a general acute hospital for treatment. She changed her mind and wanted to attend hospital with her sister, but this wasn't possible due to her not being allowed to take MHA section 17 leave during this period. It is reported that Laura became aggressive, the first of 22 recorded incidents of aggression before she moved to Warrington; seven of which resulted in the use of physical restraint. On 3rd July, Laura requested to appeal against her

detention, but she withdrew the request on 22nd July. The section 2 period was due to end on 28th July, and was reviewed. It was agreed that Laura would stay on voluntarily. Her self-harming behaviours continued through her time under assessment, and she also continued to abscond.

4.2.5 On 21st July, Laura's mother spoke to the named nurse[3] to share concerns that she felt Laura's condition was worsening since her admission, and felt that Laura's needs might be better served on a specialist unit.

4.2.6 <u>August 2016</u>

In the first week of August, Laura was on Abbey Ward as an informal patient. She self-harmed 4 times that week, requiring 2 acute general hospital admissions. The injuries were serious enough that tissue and tendon damage required surgical repair. Laura was self-harming after absenting herself from the ward, which she was entitled to do as an informal patient. Staff tried to control Laura's access to items that could be used to self-harm and revoked her leave so that a consultant could undertake a review. It was decided to allow leave as long as staff were told where Laura intended to go. Following this Laura left the ward without notifying staff and did not return as she had agreed. Her bag was searched on return and staff found razor blades inside it. A one to one session with a nurse took place and it was agreed that escorted leave would be put in place. Laura later tried to leave unescorted, and it became necessary to use physical restraint to prevent her from leaving. At this time, Laura expressed her hopelessness and intent to kill herself if she left the premises. A MHA section 5(2) was put in place for a second time. On 8th August, Laura was detained under section 3 of the MHA and was permitted only escorted section 17 leave.

4.2.7 During the rest of August, Laura expressed her frustration with her detention, citing issues with staff members, one to one observations, refusal for leave, absence of the consultant so that her observation levels could be reviewed, and her discomfort with being under the care of a consultant who was also overseeing the care of her twin sister. Laura made a complaint during this period after a staff member allegedly grabbed her legs to prevent her climbing over a gate. In response the staff member explained that they used physical contact because their radio failed and they felt unable to leave Laura to seek additional colleagues to help for fear she would abscond when they stepped away.

4.2.8 It was during the early part of August that Laura first alleged that she had been previously sexually assaulted by a member of her family, her step-brother. This was first mentioned to a healthcare assistant, and not recorded, and then later during a one to one discussion with a nurse. After this second discussion, on 12th August, Laura absconded from the ward and was located, through Facebook contact with another patient, in a local graveyard. She was taken to the local Accident and Emergency department with wounds to her arms. Wotton Lawn ward staff were informed on 13th August that Laura's mother was concerned that she had been found without any

[3] The **Named Nurse** is a registered **nurse** who is responsible for assessing, planning, implementing, evaluating and coordinating patient care on an individual basis with a patient

underwear and with vaginal bleeding. Laura's mother had sought advice from staff on noticing blood and raised a concern that Laura may have been sexually assaulted during the period that she had been absent. It was not possible to uncover from the information searches carried out to inform this SAR what, if any, examinations, were offered or declined by Laura as it was not documented about whether or not a direct allegation of sexual assault was made by Laura. However, Laura did later say to staff that she felt the lack of a police enquiry or sexual assault referral centre (SARC) involvement or follow up meant that she was unworthy of attention or help. It appears in the records that on 19th August Laura agreed for a referral to a sexual assault referral centre to be made, but it remained unclear from information provided to the SAR Panel whether or not this had been followed up.

4.2.9 On 12th August, the day that Laura absconded, she was referred for assessment to the Psychiatric Intensive Care Unit (PICU) at Wotton Lawn. The PICU assessment noted that NICE guidelines would not recommend managing a person with borderline personality disorder in a PICU, as this is not a 'least restrictive' environment. PICU staff offered Abbey Ward colleagues advice on harm minimisation strategies instead of having Laura admitted to PICU.

4.2.10 Laura returned to Abbey Ward on 16th August. Her risk for absenting herself and self-harming, with risk of accidental death, were reassessed as 'high'. Laura was placed on one to one observations, requiring line of sight observations in communal areas and randomised observations every 5 minutes whilst in her bedroom.

4.2.11 It was at this time that Laura was referred to the Complex Care Team (CCT) in Gloucestershire, which is part of 2Gether NHS Foundation Trust, but is commissioned by Gloucestershire CCG to undertake the work and manage the budget for specialist placement processes. The CCT noted that Laura had been assessed by Cassel Hospital in May 2015. Cassel Hospital is a national specialist assessment and treatment centre for those with intractable personality and family issues. Cassel determined Laura had not been ready for treatment at the time of their assessment. The CCT proposed that Laura be seen by in-house psychology services to explore what care and support within the local services might be appropriate. It was recorded that, until clear determinations had been made about what Laura needed and what outcomes were expected, her Care Coordinator was unable to re-refer to Cassel. A psychologist was appointed to assess Laura on 16th August.

4.2.12 Laura went missing from the ward in the early hours of 21st August. Day notes made by staff show that it was unclear to those on duty how she had managed to leave. However, earlier records show that Laura's mother contacted the ward previously to say that Laura had been leaving by climbing the drainpipes in a walled area. This absence ended with Laura being returned to the ward after having to be physically restrained by police officers for over 30 minutes, and having an injection of Lorazepam. Following this incident, a further referral was made to PICU, and declined. An additional referral was made on 26th August, and was again declined. Again, PICU staff cited that the referral would mean that the least restrictive approach was not in

use, and proposed that 'distress tolerance', sensory assessment and mindfulness sessions were implemented as part of a behaviour management plan.

4.2.13 September 2016

By 8th September, there had been a series of further self-harming incidents. Laura spoke to the Mental Health Act Administrator[4] to share her intention to appeal her detention. Laura's pattern of self-harming continued, and now her behaviour also included some aggressive incidents with other patients, including a letter Laura sent to another patient's relative that staff had perceived as threatening. A professional's meeting took place on 12th September. Updated information from assessment by the psychologist identified "mixed personality disorder of predominant emotionally unstable personality disorder with schizotypal and antisocial traits with schizotypal as the dominant factor". The outcome of the meeting was a recommendation for a community-based management programme, which was discussed with Laura's mother on 13th September. It was agreed at the meeting that Laura would undergo a further psychological assessment, and work towards a community discharge. Concerns were raised by Laura's family in relation to accommodation services that could support Laura after discharge. Although Laura had recently appealed against her detention, her stated preference was to continue with an inpatient stay.

4.2.14 The new psychology assessment was completed on 19th September. There followed a referral to Complex Care Services for an inpatient dialectical behaviour therapy (DBT)[5] intervention. Laura cancelled a MHA manager's hearing and expressed an interest in cancelling her MHA tribunal too.

4.2.15 On 27th September, Laura met with the Recovery Care Coordinator to complete her tribunal report. She also met with staff from Cygnet Hospital Kewstoke for assessment for a placement, but Cygnet's assessors cited concerns around Laura's level of self-harming behaviour and observations, and agreed that a possible transfer could be revisited 6 weeks later. This would give Laura a chance to see if the number of incidents could be reduced, in turn reducing the number of observations. Laura received this news at around the time that a patient on her ward completed suicide. It was reported that Laura was struggling to respond to this event, and three days later a further patient sadly also completed suicide.

4.2.16 October 2016

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[4] The MHA administrator works in the hospital and deals with collecting and keeping the section and CTO papers safe. They make sure that procedures are followed – like making sure you are given the right information and arranging hearings. https://www.mind.org.uk/

[5] Dialectical behaviour therapy (DBT) is a type of talking treatment. It's based on cognitive behavioural therapy (CBT), but has been adapted to help people who experience emotions very intensely.

It's mainly used to treat problems associated with borderline personality disorder (BPD)

www.mind.org.uk

On 12th October, Laura made her third ligature attempt, using a carrier bag on this occasion. Staff felt that this may have been an imitation of one of the other recent patient deaths on the ward. Staff recorded it as an attempted suicide. There had been a change in the observation schedule on the ward, and staff felt that Laura wouldn't have expected to be found. When staff discussed this suicide attempt with her, she said that she wanted to experience what her fellow patient had. Laura's mum contacted the ward to share her concerns about section 17 leave arrangements, communication issues between staff about Laura's care and about the fact Laura was still able to make a suicide attempt while under observation. The letter was received, but not responded to. Laura also wrote a letter to ask for a copy of her care plan and this was not recorded or responded to. Laura's family highlighted during this review their concerns that to their knowledge a serious incident report was not completed after this suicide attempt to their knowledge. They felt that this was particularly important because there had been two other patient deaths that weekend. Laura's family also brought to the attention of the review that Laura had informed staff that, if she ever wanted to end her life, this would be the method she would use. We did not see this in evidence submitted to the SAR separately, but Laura's family explained that is was included in a log entry made by Dr Taylor on 12th October at 13:02pm. It was also not possible to identify a serious incident report connected with this suicide attempt from information submitted in support of this review. Laura continued to self-harm (7 incidences) and absent herself (5 incidences) during October. There were 5 aggression incidents, including against other patients, leading to a need for staff to physically restrain Laura on 3 occasions. Staff made another two referrals to PICU, and each was declined, with advice that behaviours prior to absconds should be tracked, noting that Laura's inability to attend a funeral for one patient and the discharge of another may have been triggers for certain behaviours.

4.2.17 <u>November 2016</u>

On 4th November Laura was re-assessed. Later that day she absconded from the ward and self-harmed. Police officers located her and took her to an acute general hospital due to her self-harm injuries. In the following days a further referral was made to PICU.

4.2.18 On 7th November, a meeting took place between Laura, her family and staff on the ward to discuss her care and a lack of response to communications sent by Laura's family. The matters raised at this meeting are considered a single agency issue and are therefore not a specific focus of this review; the issues having been subject of the 2GNHSFT Complaints process. The information is included to provide context in understanding Laura's journey of care and observing how communication issues can arise and how they affect professionals, families and service users. In this instance, it was identified that part of the root cause of the communication difficulties may have been due to the fact that Laura and her Care Coordinator were not situated on the same ward. Following the Complaint investigation, 2GNHSFT made changes to ensure a patient's care management arrangements were handled by staff located on their ward to avoid delays in review processes and to make key staff more readily available to patients and family members.

4.2.19 During the period of time that followed, Laura appeared to be particularly dissatisfied about the circumstances surrounding two incidents that took place on the ward. The first was her attempt to bring cannabis onto the ward. When the cannabis was found during a room search, it was confiscated. It was alleged that Laura damaged the door in her room (though Laura's family say that the door was already in a damaged state when Laura arrived), and this preceded several more incidences of aggression. Laura also told her family about her intent to harm herself during this period. The second incident was an allegation that she may have been involved in a fire-setting incident on the ward. It was suspected that Laura's role was to distract staff whilst a fire was set by another patient by asking to be taken to her room to collect snacks. Once the fire was found, the other patient was transferred to PICU. Laura reportedly became agitated. It was reported that four attempts at physical restraint were necessary by police and ward staff alongside the use of intra-muscular injection for rapid tranquillisation. This incident subsequently led to a further PICU referral. Laura's behaviour appeared to have changed, and it was agreed that a PICU placement would be the most suitable way to manage aggression and risks associated with the most recent incidents.

4.2.20 During the weeks leading to this, an assessment had been sought by Heatherwood Court to see if it would be possible to refer Laura to them. On the 10th November, Heatherwood Court[6] confirmed that they would not accept a referral. There was also no local availability of a PICU bed. An out-of-area placement was sought. Arbury Court was identified as a suitable placement and had a PICU bed available. Laura was transferred there on 11th November. It was recorded by staff at Wotton Lawn that Laura was tearful and worried about a transfer to an out-of-area placement.

4.3 Warrington area Health and Care Provision – 11 November 2016 until 20 February 2017

4.3.1 <u>November 2016</u>

Laura was admitted to Primrose Ward at Arbury Court. It is documented that Laura's case history was not shared at point of transfer, though the review was not able to establish why it was not shared. The case history included key information, such as Laura's use of bags in self-harming attempts. Gloucestershire PICU (Greyfriars) and Primrose Ward at Arbury Court attempted to share information on the 14th November. Laura's injuries caused by self-harming were assessed on 15th November by a visiting GP.

4.3.2 Laura was taken to Warrington Hospital (an acute general hospital managed by Warrington and Halton Hospitals Foundation Trust (WHHFT)) as she needed treatment for self-harming injuries on 17th and again on 20th November. A&E staff reviewed Laura's previous injuries whilst they were addressing the wounds that caused the acute admission. They arranged for follow-up appointments in case Laura remained in Warrington for a longer period of time, though at this time the expectation was that

[6] Heatherwood Court is a private hospital located in Pontypridd Wales

the stay in Warrington would be brief and that Laura would return to her home area soon.

4.3.3 On the 23rd November, Laura appeared to be engaging well and taking part in activities on the ward. There was a record of superficial self-harming, but it was reported that Laura no longer required a PICU bed. Staff at Arbury court tried to speak to the care coordinator in Gloucestershire to discuss transfer to a placement there. In response, on 28th November, Arbury Court staff were asked to liaise with a forensic psychiatrist in 2GNHSFT's Complex Care Team, who was responsible for carrying out assessments for secure placements. Arbury Court were also informed at this point that a decision had been taken to minimise the number of transfers for Laura, and that the overall plan was for Laura to be discharged, following assessment, to a low secure specialist unit placement instead of returning to Gloucestershire.

4.3.4 <u>December 2016</u>

2GNHSFT records show that a professionals' meeting took place on 6th December. It was concluded at the meeting that Laura would not move until the outcome of the referral to the low secure unit assessment was known because it had been agreed that multiple moves should be avoided, and that the PICU in Gloucestershire should remain the point of contact for Laura's family.

4.3.5 Laura and her family reported an alleged theft of money from Laura's room during December. A formal complaint was raised and investigated, which included checking CCTV footage on the ward, but no perpetrator could be identified. Laura was later (January 2017) reimbursed of the money she reported as lost by Arbury Court after chasing for a response to her complaint. Laura's family also raised concerns about poor and conflicting communication with respect to visiting rules, for example, Laura's brother, aged 11 at the time, was not allowed to walk around the site, and when Laura's family brought along the family dog, Laura wasn't allowed to see it, but Laura and her family said that this had been agreed prior to the visit. Laura's family also expressed concerns about not receiving weekly updates about how Laura was getting on after the transfer.

4.3.6 A safeguarding referral was made on 6th December after Laura reported that she witnessed a member of staff assaulting another patient. Laura also self-harmed on the same day using a ligature with her mobile phone and a bandage.

4.3.7 Laura's concern around her reports of the alleged assault she witnessed led to the opening of a safeguarding enquiry under section 42 of the Care Act. A social worker from Warrington Borough Council attended the PICU to speak to Laura on 7th December. The social worker made contact with Laura's mother, who explained that they were concerned with respect to Laura's wellbeing and safety in hospital and was concerned too that Laura was likely to find further ways to self-harm. The social worker returned to the PICU on 9th December to review records and speak to staff.

4.3.8 On 8th December, Laura's assessment by 2GNHSFT for a low secure placement showed that Laura was now suitable for this environment. NHS England, whose role it was to

find a low secure bed for Laura, became involved at this point. NHS England contacted Cygnet Hospital in Kewstoke on 19th December to request an assessment for a low secure bed. Laura found the period of the search for a low secure bed extremely distressing. A message Laura sent to her mum, at around this time read as follows:

> *"If you love me then you'd understand that it can either go two ways from here, I end up staying and doing everything I can to end everything because I simply cannot cope in the system anymore. They are no longer doing anything for me anymore. Or I can get out and do what [my relative][7] did, find responsibility and spend time with my family and get better. There is no way out of this place. They haven't even chased up my surgery. They do nothing they say they do because they are private and can get away with it. It's not going to be a story about being miles away from home, it's going to be a story like [my friend's], about a young girl who could no longer cope being locked up. No one will understand how much of a failing this place is until it happens. This isn't feeling low, this is feeling no way out. I'll get treated quicker in the community than I ever will in here, the treatment that I need. I can do DBT in the community and live with you."*

4.3.9 For the remainder of December, Laura continued to self-harm intermittently, and on the 28th December a wound severe enough to bring about tendon damage and an infection required hospital attendance. Laura was also involved in several aggressive incidents, in the main related to a specific patient on the ward and an allegation of assault related to a nursing home resident in the surrounding area. This assault allegation did not lead to formal charges against Laura being brought. Each incident was addressed using verbal de-escalation techniques, support and medication. One incident did require the use of physical restraint to separate a group of three patients.

4.3.10 <u>January 2017</u>

On 5th January, Cygnet Hospital Kewstoke indicated their decision not to accept Laura to a low secure unit. It was proposed that Laura might be suitable for a different Cygnet service in Derby, which included the availability of a specialised female personality disorder service. It was agreed an assessment for this would take place on 18th January. Laura continued to self-harm during January, and there were further aggressive incidents, which appear sometimes to have been triggered by room searches and removal of items that Laura used to self-harm. One aggressive incident during this period involved Laura allegedly damaging a wardrobe door in her room, which led to an accidental injury to a member of staff. As a result of this incident, she was placed in seclusion.

4.3.11 On 24th January, Arbury Court requested an update on the Cygnet Hospitals assessment to see if Laura was to be accepted to the specialist low secure placement in Derby. On 26th January, Cygnet indicated that the outcome of their assessment was

[7] Name removed for confidentiality reasons

that Laura would not be accepted to a bed in Derby. NHS England continued the search for a low secure placement. The language used in assessments changed at this point so that previous suspicions around fire-setting and manipulation of other patients was now represented as fact.

4.3.12 On 29th January, Laura's family submitted a formal complaint to 2GNHSFT relating their concerns about Laura's care arrangements. Arbury Court also contacted 2GNHSFT to query ongoing referral arrangements for Laura. It was agreed that a care planning teleconference would help clarify the current situation for all involved, particularly given that it seemed Laura had become aware that an assessment had been requested before her care providers at Arbury Court had.

4.3.13 <u>February 2017</u>

During this period, there were a number of changes made to Laura's care plan and observation levels. After a self-harm incident on 12th February, requiring sutures to Laura's leg, there had been an increase in observations to level 2. At a ward round on 14th February, prior to the assessment from Heatherwood Court, her medication was reduced (reduction in diazepam, oramorph stopped) and the observations regraded to general. The explanation was that there was an ongoing plan to reduce and stop Laura's diazepam usage. The SI report references that Laura was staying in her bedroom and sleeping more than usual.

4.3.14 From the 15th to 20th February, there were further aggressive incidents and Laura's self-harming behaviour continued with the use of personal property, such as CDs. Laura was considered to be expressing distress and frustration due to the delay in her discharge to a low secure placement during this time. It was recorded at a psychology session on 16 February, "she did not have much to bring to the session. Her presentation was different in that her body language suggested she was frustrated, she avoided eye contact and she appeared low in mood." This was put to Laura but she did not expand as to what was the matter. We spoke about moving on and she stated she was "frustrated as I was meant to leave today". Later that day, following an incident of self-harm and an attempt to leave the ward, when Laura was restrained, it is reflected in observation sheets that she was moved to level 3 observations (eyesight). The SI report cited later in this report notes some discrepancies in the records of observation levels around this time. Subsequently, on 17th February, observation levels were reduced to level 2 in isolated areas and general in communal areas. On 19th February, Laura was recorded as having a family visit with no concerns noted by staff. However later that day, night staff noted that she had become upset following another patient having a seizure, saying this had reminded her of a friend who had died from a seizure.

4.3.15 On February 20th 2017, Laura was able to access plastic bags and tragically they were used in a fatal incident of self-harm. The cause of death was subsequently confirmed as asphyxia.

4.4 <u>Events of the 20th February, 2017 leading to the fatal incident</u>

Whilst this report, commissioned by Warrington SAB is focused primarily on considering through examination of Laura's situation how agencies might work better together in the future, a Serious Incident Investigation conducted by Elysium Healthcare, a police investigation conducted by Cheshire Constabulary and processes under the guidance of HM Coroner, each consider for their specific purposes further analysis of events that occurred on 20th February, 2017.

4.4.2 The information provided to the SAR panel describes a series of events that occurred on the day of 20th February leading up to the fatal incident. The panel is aware of some discrepancies between records and personal accounts in relation to timing and the factual accuracy of the events that were recorded and reported. This is also highlighted in the SI report.

4.4.3 Laura was described by a student nurse in a record to have been quiet in manner and interactions in the morning, eating a continental breakfast and the records show that after breakfast she spent the remainder of the morning in her bed space. She is recorded as having spent time in the lounge over the lunch period and participated in some baking.

4.4.4 In the morning an MDT ward round took place and Laura's observations were reduced to 'general' in all areas. The MDT was not minuted and Laura did not attend, reportedly on the basis that she was imminently about to be transferred and appeared to be positive about the move. The SI report described a sequence of events that started with Laura having thrown her mobile phone down the corridor and moving to her bed space at 16:25. A minute later, a nurse checked on Laura and discovered her appearing to be attempting to create a ligature over her bathroom door. This incident was described retrospectively in a report by a student nurse (recorded at 16:56). The record notes that Laura was found engaged with a potential ligature in the bathroom, which she denied and attempted to remove from the door. The entry also refers to Laura having superficial cuts to her arm, which she stated had been done with her finger nails. This was later queried by the police in their investigation as it was not felt by attending officers that the injury was consistent with that explanation. The reports of a ligature and the discovery of a razor blade in Laura's clothing after her death received significant attention in the Serious Incident investigation and highlighted significant discrepancy in staff accounts around how this was responded to.

4.4.5 Laura left her room at 16:39, and went on to approach staff to request laundry bags. Her bed linen had been soiled following the self-harm incident earlier in the day. Two red plastic bags were given to Laura and she took them to her room at 16:43. It is unclear what, if anything, had been discussed or recorded with the ward team before Laura was given the plastic bags, though the serious incident report provided by Arbury Court states that there had been a review following the earlier incidents as to whether a higher level of observations was indicated but ultimately that it was felt to be unnecessary. Laura declined a meal at about 17:15. Just before 18:00 a staff member carrying out a check found Laura on her bed, having used the plastic bags to suffocate herself with a ligature around her neck. Staff removed the bags and ligature

and called an ambulance. Staff attempted to resuscitate Laura, and paramedics directed and continued the resuscitation attempt once they arrived at approximately 18:20. Laura was pronounced dead shortly after 19:00.

5 Findings and Analysis

5.1 SI Findings

A serious incident investigation commissioned by Elysium Healthcare was undertaken by Dr Amit Chatterjee, Consultant in Forensic Psychiatry, Thornford Park Hospital, Elysium Healthcare. This investigation included consultation with staff that were involved in Laura's care at Arbury Court and was subject to oversight and review from representatives from NHSE (defined as a stakeholder) and Warrington Safeguarding team. An addendum to the original report was completed in respect of outstanding matters that were raised by the family, NHSE and Warrington Council.

5.1.1 The serious incident report focusses on the presence of the potential ligature as well as the issuing of plastic laundry bags. The report refers to the discrepancies in staff accounts about the identification of the ligature and a general agreement that, if properly understood, this would have resulted in a higher level of observations. It also highlights a lack of policy guidance around the use of plastic bags and different interpretations of staff regarding their use. The report identifies the missed opportunity to correctly assess the risk of the earlier potential ligature incident combined with subsequent unsupervised access to the plastic laundry bags.

5.1.2 The SI report also points to a number of care and service problems which include the use of the risk assessment tool and associated planning, such as the specific risk of ligature and medication overdose; an apparent lack of a transition plan in accordance with NICE guidance for managing endings and supporting transitions for patients with personality disorders; and short comings with recording, including contact with the family and minutes of meetings.

5.1.3 Together these informed a number of key lessons learned:

SI Lessons learned

i. There has been an overhaul of the way in which plastic bags are used within clinical areas. Black and red plastic bags have been added to the security checklist in order to monitor the number and whereabouts of these bags. Black bags are stored in a locked cupboard in the kitchen and red bags locked in the laundry room (only accessible by the Security Nurse). Housekeeping and the Security Nurse monitor the number of bags twice a day and in total 15 red bags and 8 black bags are kept on the ward at any one time. Hessian bags were also supplied to patients and staff so as to stop their use of any other plastic bags and staff were made aware of the above review for security and search purposes. The security changes have also been added to the annual Security Awareness Training and there is consultation regarding the high risk items data base.

ii. START and other risk tools should be completed with clear MDT input that drives forward care plans and management decisions, with families and patients being involved in the process if appropriate. This is being reviewed by the MDT.

iii. Care plans for known problems are to have clearer management guidelines, for example for a patient with a known risk of tying ligatures, a care plan specifying this risk and times when the team need to review ligature related items needs to be in place (this may be at a time when the patient is observed to have tied a potential ligature or a time where there is clear evidence of an increase in self-harming behaviours). This should include risk items to be removed, a review as to what the appropriate level of observations should be and other nursing or treatment interventions that would be appropriate.

iv. Poor record keeping and information has gone some way to increasing the concerns of the family in this case. It is imperative that there is ongoing improvement in the way in which teams not only interact, but record their interactions within clinical notes. Arbury Court has acknowledged that the errors in Next of Kin address were down to "administrative errors", but this information is now to be checked on admission through the team social worker and Mental Health Act Office. [Laura's step-father] has suggested that he would like to see families be able to directly "confirm" clinical notes relevant to any interactions they have with staff, however this is likely to prove difficult to implement due to issues around information governance and security.

5.1.4 The SI report went on to make a number of specific recommendations to address these issues.

SI Recommendations:

i. Review of :

- The hospital framework and policy around the management of plastic bags within clinical areas
- Appropriate risk assessment tools to be completed within a multi-disciplinary framework, with training provided for staff tasked to complete such tools and for them to be regularly updated. Patients and carers should feel empowered to engage in this process.

- Care plans to provide clear action plans for management of known risks, linked to any risk assessment tools implemented.

ii. Other recommendations

- To ensure that there is an identified individual within each clinical team (likely team social worker) with the responsibility to ensure that the Nearest Relative's contact details are correct and up to date at the point of admission

To ensure that clinical teams are aware that interactions with family (written or verbal) should be accurately recorded within care notes and so that they make up part of the clinical record.

5.2 SAR Findings

5.2 Expectation of Safety

5.2.1 It was difficult for the SAR Panel to understand how an adult who was known to be at risk and admitted to an inpatient PICU facility could go on to experience 56 incidents resulting in physical and emotional harm and then, ultimately, resulting in her death.

5.2.2 Laura was a known risk with respect to her use of ligatures; she used ligatures to self-harm on 6 occasions in the 9 months prior to her death. Agencies also knew that, after a fellow patient had taken their own life using this method, Laura had expressed a fascination with it (October 2016). The SI report cited in the previous section also highlights the absence of a specific management plan in relation to the risk of self-harm through the use of ligatures. In reviewing Laura's care arrangements, the SAR panel identified that the potential ligature on the day of her death was significant and, as the SI Report highlights, there was a missed opportunity to review observations or other preventive measures. In reviewing Laura's care arrangements, the SAR panel identified that, even on the day before her death, some staff reported that she may have attempted to self-harm with a ligature. This underlines how serious an error of judgement it was to have supplied Laura with plastic bags without supervising the use of the bags given what was known about Laura's history and wellbeing at the time. The expectation of rigorous attention to safe care, upon which Laura should have been able to depend, was not met.

5.2.3 Evidence[8] shows that self-harm is the single biggest predictor of suicide attempts. Those diagnosed with a personality disorder who also use hanging or strangulation in their self-harming behaviour are a particularly high-risk group for suicide completion. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) includes managing risks by using nursing observations to monitor access to implements and materials that could be used for the purpose of hanging and

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

strangulation, and also that potential ligature points in accommodation should be identified and removed. Cheshire Constabulary, who investigated Laura's sudden death, raised concerns that they had identified a number of potential ligature items including electrical leads and bags with straps when conducting a room search. It was noted that Elysium have subsequently taken the step of withholding plastic bags from unsupervised inpatients as part of implementing learning from the Safeguarding Enquiry and Serious Incident Review in relation to Laura. Appleby, in the most recent edition of the NCISH report[9], noted that self-strangulation through the use of ligatures remains the commonest method of suicide for all patients in the UK, indicating access to opportunities remained an area of concern that needed attention. In recent years there has been an average of 114 suicides by in-patients in the UK per year, including 89 in England. There were on average 18 suicides by in-patients under observation per year in the UK over a 7 year study period. Ninety-one percent of deaths under observation occurred under level 2 (intermittent) observation. Compared to in-patient suicides generally, patient suicides under observation were associated with personality disorder, alcohol and drug misuse, detention under mental health legislation and death in the first 7 days following admission.

5.2.4 The SAR Panel asked for information from Gloucestershire 2Gether NHS Foundation Trust (2GNHSFT) and Elysium (Arbury Court) about routine expected practice on Psychiatric Intensive Care Units (PICU) to understand practice in the lead up to Laura's death. The focus was on how materials and environments could be managed differently given Laura had been able to use a gap in observations and access to plastic bags to self-harm. However, it was understood that the risk of access to materials such as these cannot be entirely removed. As the National Inquiry noted, the goal must be to strike a balance between patient safety and supporting patient choice and self-determination where ever possible. Where freedoms and rights are restricted, the wider purpose of nurturing self-esteem and building the resilience that can be gained through taking responsibility cannot necessarily be met. It follows, then, that creating a sterile environment beyond a single patient's room for an extended period could potentially create more issues than it resolves. It was also noted by professionals at the SAR Panel that, in treating those diagnosed with personality disorder and self-harming behaviours, it is important that there should exist the opportunity to learn how to develop alternative coping strategies for use in community living settings.

5.2.5 A contributory factor to the poor decision making on the day of Laura's death was the lack of clear sharing and escalation of information about the attempted self-harming incident and apparent attempt to use a ligature earlier. There was a lack of clear recording and information sharing about this incident, which contributed to staff decisions being based on poor evidence of risk intelligence. The impact of this was an absence of suicide reduction measures, based on research and utilised on previous occasions with Laura during her stay, were not implemented. This was a missed opportunity to use evidence that could have prevented a patient's death. A key learning point for staff in practice, and for those in supervisory/management roles, is

[9] https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-69-Mental-Health-CORP-annual-report-v0.4.pdf

that it is imperative that information and concerns associated with risk and care plans are shared and recorded in a timely manner.

5.2.6 In relation to the frequency of incidents, the Panel heard from the provider and two service commissioners that admissions for those with a diagnosis of personality disorder and self-harming behaviours retain risk of an incident taking place. Research and professional experience identifies that people diagnosed with personality disorders are at an increased risk of self-harm[10]. Best practice identifies that support to develop coping strategies is most effective where patients are cared for in settings similar to community environments. This is supported by research that found admission to inpatient units for personality disorder is, for many individuals, ineffective and counter-productive[11]. 2GNHSFT reported that Laura's placement at the Arbury Court PICU was not intended to prevent self-harm but was in response to the risks Laura's behaviours posed to others, for instance in the assaults against staff and the necessity for physical restraint to be applied over extended periods. Nevertheless, the prevalence of self-harm incidents from the multi-agency chronology create a stark picture, which raised questions about the role safeguarding processes might have played in terms of offering independent scrutiny with respect to Laura's situation.

5.2.7 During her time at Wotton Lawn Hospital in Gloucestershire, Laura was reported to have been absent without leave on 31 occasions. During four of these episodes, Laura self-harmed. This led to four attendances for treatment at the local Gloucestershire general hospital. After one of the absences, it was alleged that Laura had been the victim of a sexual assault. For the 6 months' period that Laura was resident at Wotton Lawn, there were some 46 incidents of deliberate self-harm reported, the majority of which related to cutting. For the period 11th November 2016 to her death on 20th February 2017 when Laura was resident at Arbury Court, it was reported that 56 self-harm incidents took place, involving ligatures, cutting, burning and punching/head banging behaviours. Across two different organisations in two different geographical areas there were over 100 incidents of self-harm in a 9 month period, with a steady and substantial increase across the period. The panel reflected that admission for safety seemed to be at odds with the reality of the safety that inpatient settings could achieve. Laura's family similarly asked the question as to whether this reflected good care. Her family's view was that Laura's absences should not have been possible. They informed 2GNHSFT of Laura's means of absconding from the placement, but saw no evidence of this being tackled until after Laura's transfer out of the Gloucester area.

5.2.8 Professionals involved at the learning events carried out as part of the SAR felt that as incidents of self-harm were an established feature of Laura's behaviour it would be

[10] Researchers Runeson and Appleby have explored the links between suicide, self-harm and those with mental health disorders, further information can be found with the following article - https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/shortterm-management-of-repeated-selfharm-in-secure-institutions/4FE315BC1E941DD2812014CE16196CE5/core-reader#

[11] This is identified within Safer Care for Patients with Personality Disorder 2018 by the National Confidential Inquiry into suicide and homicide by people with mental illness which sites research from the Journal of Personality Disorder.

unrealistic to expect to eliminate them in these settings. This view is supported by NICE to the extent that their guidance[12] is clear that plans and interventions may likely be focused on seeking to reduce the behaviours with an ultimate goal of stopping, once alternative coping mechanisms can be implemented. The Mental Health Act principle of applying the least restrictive practice also creates the mandate to balance an individual's need for self-determination with the need to keep patients safe by seeking to reduce self-harming behaviours. This raises the question, how can agencies measure the effectiveness of the efforts made to prevent self-harm? This is an issue similarly identified in the NCISH - an acceptance of inevitability can lead to the lack of recognition of risk.

5.2.9 2GNHSFT completed a local review following Laura's death[13]. As a part of their review they considered whether any of Laura's absences and self-harming behaviours had met the criteria for a serious incident review or referral into safeguarding processes during Laura's stay at Wotton Lawn Hospital. The behaviours are seen as features commonly and frequently observed in the management of in-patients with EUPD. It wasn't felt in the review that the criteria would have been met, despite the frequency and severity of Laura's self-harming behaviours. In the context of her EUPD, Laura's behaviours were not considered unusual. An area for improvement was noted in the review where it was suggested that the Duty of Candour and further discussion with the patient might have been considered. The Duty of Candour is a statutory (legal) duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. Warrington SAR panel discussed the findings of the review and expressed concern about how thresholds around repeated self-harm are viewed, particularly in relation to diagnosis of EUPD. The panel agreed that the Duty of Candour was likely to support communication and transparency in relation to repeated self-harm in patients for whom it was a feature of their presentation, however would be concerned if the severity of individual self-harm incidents and the manner of their occurrence did not themselves trigger consideration of the serious incident process for those patients.

5.2.10 For Laura's time in Warrington at Arbury Court Hospital, the SAR Panel considered whether or not the frequency of Laura's need for attention at the A&E department of the general hospital could have been an opportunity for independent scrutiny. The panel identified that there had been missed opportunities to seek some independent scrutiny of Laura's care. NWAS and WHHFT acknowledged that admissions to hospital on 17th and 20th November 2016 had presented missed opportunities to make a safeguarding referral. WHHFT reflected that, given the number of attendances and the longer-term damage being done to tissue from cutting behaviour, a referral into safeguarding scrutiny processes should have been made. This could have ensured that any concerns were managed via appropriate risk and care planning at Arbury Court. A

[12]NICE guidance on self-harm in over 8s: long term management identifies planning with the client to reduce, reduce associated harm and or stop alongside reiterating these messages for service users and their families - https://www.nice.org.uk/guidance/cg133/ifp/chapter/What-can-I-expect-during-an-assessment

[13] Report on the pathway and care and treatment of LD, Dr Sally Morgan and Steve Ireland, 2018

referral made at that time could also have meant that day to day risk management became subject to external multi-agency scrutiny.

5.2.11 There can be negative consequences with bringing a heightened level of attention to self-harm carried out by those diagnosed with personality disorders. Personality disorder professionals linked to Laura's case noted the danger of an over-attentive approach that could lead to dependency on services and professionals rather than making progress through increasing levels of self-management.

5.2.12 As touched on earlier, NCISH finds that it falls to health and social care professionals to strike the balance that ensures the response to the risk of self-harm applies the least restrictive approaches whilst still holding patient safety paramount. On Laura's final day, the balance was not reached. Laura's risks were not taken into account when the decision to provide her with plastic bags was made. In relation to her preceding days, it is less clear for her family as to whether actions were part of a planned and risk-assessed approach, or whether the self-harm incidents demonstrated that there were issues in care quality, and the internal SI report identified a number of areas in which improvements were required. Clearer thresholds for safeguarding referrals in this area might have supported some reassurance for individuals and/or carers, and could have brought more effective challenge to providers through independent scrutiny of approaches towards reducing and managing Laura's self-harming behaviour.

5.3 <u>Responses to Sexual Assault Allegations</u>

5.3.1 Laura's mother said that she believed Laura had been sexually assaulted on three occasions, once as a child, once at home by her step-brother, and once when absent without leave from Wotton Lawn Hospital. Laura also discussed the latter two sexual assaults with staff during her stay at Wotton Lawn. For the alleged assault as a child, Laura's mother explained that she understood that it hadn't been possible to take a criminal prosecution forward because the initial intervention by school staff had involved the use of leading questions. In the case of the second assault, Laura's step-brother had gone on to self-harm severely, resulting in a coma; Laura's mother said that Laura felt unable to report the incident as a result. It isn't documented about whether or not Laura made a direct allegation of sexual assault, but when the third sexual assault did not result in the possibility of a prosecution being taken forward, Laura reported that she felt the lack of a police enquiry or sexual assault referral centre (SARC) involvement or follow up meant that she was unworthy of attention or help.

5.3.2 The third incident alone falls within the scope of this SAR timeframe, but it is important to consider it in the context of the other sexual abuse reports described above.

5.3.3 The alleged sexual assault on 12th August 2016 first came to the notice of agencies when Laura's mother had sought advice from staff at Wotton Lawn Hospital upon noticing Laura had been bleeding. This concern was discussed with Gloucestershire Police with a plan for medical examination by the specialist sexual assault referral centre (SARC). As part of this review, Gloucestershire Constabulary (GC) were asked

how this incident had been logged. GC explained that Laura had not made a disclosure of assault and that Wotton Lawn staff and Laura's mother had been given an officer's contact details in case Laura wanted to make a disclosure at a later date that might change the standing decision, which was to take no further action.

5.3.4 Staff at Wotton Lawn noted that they had queried that Laura had declined vaginal swabs. Laura indicated that the lack of support she received and the decision to not pursue the case as perhaps being a reflection on her own value, linking the lack of intervention to previous allegations of sexual assault. The staff member receiving this information suggested counselling and noted the need for sexually transmitted infection screening at the local Hope House facility. It is not clear from information received by the panel whether or not this was actioned, though 2GNHSFT noted that it would have been good practice if this had been followed up by hospital staff with Gloucestershire Constabulary and Sexual Assault Referral Centre agencies.

5.3.5 This may represent a missed opportunity for Police and Hospital staff to engage with Laura to revisit her disclosure about the alleged sexual assault of 12th August. The hospital staff records do not indicate an awareness of the need to revisit Laura's wishes to make a disclosure about the assault. There is also no reported follow up contact with GC to clarify the status of their enquiry. This might not have changed the outcome in terms of whether or not a prosecution was possible, but it could have supported a Making Safeguarding Personal (MSP) approach in practice that in turn could have created the opportunity to positively challenge Laura's sense of agencies' attitudes towards her and then explore other restorative options, such as seeking the support of an independent sexual violence advocate.

5.3.6 When viewed in isolation, the actions taken in relation to the alleged sexual assault on 12th August 2016, could be considered as proportionate and in line with Laura's wishes. For instance, practitioners at Wotton Lawn Hospital proposed counselling and a referral for sexual health screening. Gloucestershire Constabulary logged the concerns raised and requested follow-on contact if a disclosure was made. However, given her known history, in the context of a third sexual assault allegation in which it had been decided that no further action would be taken with respect to the investigation of the alleged offence, the cumulative impact meant that Laura may well have needed additional support. A MSP approach would be responsive to Laura's capacity to engage at a given time and acknowledge her distress. At a later date, with informed support, she might have been able to make a formal disclosure.

5.4 <u>Commissioning, Communication and Sharing Information</u>

5.4.1 **Use of language in assessment reports**

The choice and use of language in reports can have a lasting impact on patients/service users,. Practitioners should take care to ensure that statements are supported by observations and evidence and that opinions are clearly identified. The SAR identified that there did appear to be occasions where information shared between agencies was not clear and/or sufficiently supported by evidence leading to potentially

damaging recording. One example of this was Laura's initial low secure access assessment on 8th of December, which identified that she was suitable for a low secure placement and noted her complex challenging behaviours as including:

> "probable fire setting and possible psychological influence on a vulnerable in-patient …the view of nursing staff who were involved at that time was that she had developed an unhealthy relationship with this patient and staff were concerned that Laura might have interacted with the other patient in a way that influenced the patient's decision to take their own life."
>
> "In addition, whilst on the ward, there was a fire. The exact circumstances of this remain somewhat unclear. It was reported that she handed in a lighter and when the fire alarms went off, misdirected staff…"
>
> "…the main concerns are absconding and general vulnerability, and also – to a lesser degree – risks to others through her history of violence and fire setting."

This assessment presented Laura as posing the most risk to herself through her own self-harming behaviours but acknowledged concerns from staff in relation to her potential role in another patient's self-harm and fire setting.

When this information was received by Cygnet for their Kewstoke hospital (see 4.38) their assessment in January 2017 took a different view of Laura's presenting risks:

> "presents with a complex and enduring pattern of challenging behaviours in the form of physical violence, verbal hostility, fire-setting, deliberate self-harm, suicide attempts, absconsions, drug and alcohol misuse, and psychologically targeting vulnerable service users."
>
> "She also presents a considerable risk to the safety of others due to patterns of verbal hostility and physical violence, incidents of fire-setting whilst in Arbury Court PICU ward, psychologically targeting vulnerable service users."

A suspicion of possible involvement in one incident, whilst potentially a serious concern had been subsequently presented as a behaviour of 'fire-setting'. The event described also happened at a different setting in a different part of the country, and there was no evidence that there had been multiple incidences of Laura having become involved in fire-setting. This changed and critical language had the potential to influence ongoing assessment and placement decisions. In both reports, it was alleged that Laura had possibly influenced a vulnerable in-patient, who had gone on to take her own life. This was speculative and Laura had not been considered as a person of interest in the inquiry into this person's death. Laura's family reported that the suggestion that she had taken a role in influencing her friend to complete suicide caused her a great deal of additional distress. This underlines the importance that

ought to be placed on the careful use of language in reports and highlights the cognisance assessors should have with respect to the long-reaching effects of their words in reports, particularly where they are not working with facts.

5.4.2 Laura's family had been concerned that inaccurate information was recorded at various times in Laura's case history. When they met with the SAB Chair and Manager they cited specific concerns in relation to inaccurate recording, including reference to Laura's sister's care within Laura's notes. Whilst this was a matter for 2GNHSFT, and was in fact part of the family's separate complaint, this is referenced here by the SAR to give context to concerns that the family raised about information sharing and its impact on Laura's, and their confidence in services.

5.4.3 Although there was evidence that the NHS England Mental Health Case Manager gave some of the original context to the information shared by Cygnet, there was evidence that recording had changed and that these changes provided a different narrative about Laura for providers that might have had a place available for her to move to. The assessment by Cygnet led to a period of time (25/1/17 to 8/2/17) during which Laura was identified as requiring a medium secure placement. It was not until another provider assessed Laura that her need and risk profile returned to low secure. Laura was later accepted for a low secure placement so this example did not lead to a change in her treatment plan permanently, but appears to have influenced how providers perceived Laura's needs and risks. This highlights the importance of accurate record-keeping and care taken in the representation of service users where multiple organisations are recording information about the same individual.

5.4.4 **Communication between agencies and across local areas during commissioning activity**

The 5 Year Forward View for Mental Health published in 2016[14] recognised pressures and problems in all areas of provision of services, and attitudes towards people with mental health difficulties. It made a number of recommendations with Recommendation 22 and 23 being most pertinent for this SAR and quoted in part below:

5.4.5 Recommendation 22: In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Recommendation 23: NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least

[14] A report from the independent Mental Health Taskforce to the NHS in England February 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

5.4.6 There have been a number of reports and research since 2016 identifying potential and actual negative impacts for people needing high intensive support, but little progress in adequate funding or evidence based service models to resolve the well identified increased risks inherent in out of area placements.

5.4.7 The 10 Year NHS Plan confirms the ambitions of the 2016 Report and in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, and sets some targets for change required to deliver fewer out of area placements and provide evidence based therapeutic experiences/treatment in hospital environments[15].

5.4.8 In relation to Laura, there was some evidence of communication between NHS England, 2GNHSFT and Arbury Court to share updates on Laura's presentation and agencies' progress on sourcing a placement transfer, including potentially trying to get her nearer to home area. However there were differences in views of the effectiveness of communication at the time of Laura's placement at, and proposed discharge from, Arbury Court.

5.4.9 In their IMR, 2GNHSFT found that communication between Gloucestershire PICU (Greyfriars) and Arbury Court was in line with expected policy and there was evidence of proactive telephone contact between the PICUs to enquire about Laura and the placement. However, Arbury Court records indicate that there remained communication gaps despite this contact. Arbury Court records indicate that there were difficulties in making contact with the care coordinator in the initial weeks of placement, and that on 28th November they remained unaware that a decision had been made by Gloucestershire commissioning teams for Laura to remain at Arbury Court and for commissioners to seek a discharge directly to a low secure placement rather than to return to the Gloucestershire area PICU once a placement became available. An email between 2GNHSFT and Arbury Court on 13th January indicated that the main point of contact for updates was still unclear from Arbury Court's perspective, as was the bed search status.

5.4.10 On 30th January, a teleconference was requested to address communication issues because it had become clear to Arbury Court staff that Laura had been referred for a placement assessment that they were not aware of. The issue identified linked to the role of NHS England in sourcing a placement and communicating directly with Laura's family, whilst not always sharing information at the same time with Arbury Court. There were times when the Gloucestershire commissioners were first aware of decisions and progress in placement searches, and others when the family and Laura had become aware of situations before the Gloucestershire commissioners or Arbury Court. This lack of consistency and the informal communications that followed made

[15] https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

it difficult for Arbury Court to respond to Laura's understandable queries about discharge from PICU and into low secure accommodation, and also difficult for Gloucestershire services to be able to provide similar progress updates. We know from Laura's messages home that she found this distressing, and that she felt it reflected the low value given to her in the eyes of the providers responsible for supporting and caring for her.

5.4.11 NICE guidance recognises that out of area placements can introduce challenge and delay. Their quality standards set out the expectation that:

> "a named practitioner from the home area and the inpatient ward should work together to review the placement and ensure it lasts no longer than required."

The SAR panel, recognising this key message around the additional challenges and delays that out of area placements can introduce felt that there were a number of shortfalls in terms of communication in this critical period. A care coordinator had been allocated in the home area, however it was evident that there had not been clarity from Arbury court's perspective regarding a named practitioner to whom they should address their communications and work with and the role of NHS England had further complicated this. The consequence was that all parties were not always aware of the same information, or of the progress made in discharge planning at the right time. Laura's experience serves to underline the need for careful clarification of roles and responsibilities including that of NHSE in complex cases such as this. Professionals should regularly review how effective communication is from their own and the adult's perspectives, checking whether or not involved parties have a clear understanding of what and where decisions are being made.

5.4.12 There were also communication issues identified between services based in Warrington. Both Warrington safeguarding services and the acute general hospital identified within their Individual Management Reviews (IMRs) that there had been practice that could have been improved. These were also linked to the fact that Laura's was an out-of-area placement and included the clarity of communication and the use of a single point of contact in each agency.

5.4.13 Laura first came to the notice of safeguarding services in Warrington on 6th December 2016. An independent advocacy organisation, Pathway Associates, highlighted her situation to the local authority and commissioners having been alerted to concerns raised by Laura to her mother. Her mother had contacted Pathway Associates requesting support on Laura's behalf. The concerns alleged poor quality of care, theft of money and allegations of an assault on another patient that Laura said she had witnessed. The response by Warrington Borough Council (WBC) was to commence a Section 42 enquiry and a social worker met with Laura to discuss her perspective on these concerns. 2GNHSFT records indicated an awareness by the Complex Care Team of Laura's concerns and it was noted that they wanted to liaise with WBC. However, there is little recorded information regarding specific interaction between the two agencies about the safeguarding concerns. On review, WBC could not locate a record

of direct communication with the commissioner, 2GNHSFT, during the enquiry. This identified a potential missed opportunity to ensure that 2GNHSFT, as commissioner of Laura's care, had a full understanding of the concerns and the local safeguarding response. As the commissioner, 2GNHSFT retained an ongoing role to monitor the quality and effectiveness of the placement as well as Laura's wellbeing. Ensuring effective communication regarding safeguarding situations is a key part of this role.

5.4.14 Warrington and Halton Hospital NHS Foundation Trust (WHHFT) also identified potential missed opportunities to facilitate a shared monitoring of care and concerns. They noted two specific considerations: The first was that hospital attendance information letters were sent only to Laura's GP in Gloucestershire up until February 2017, so her GP in Warrington may not have been informed of all of the incidents or concerns that they ought to have been aware of. This includes the period from the end of December 2016, when it was understood by Arbury Court that Laura would not immediately return to Gloucestershire. The continued reporting of information back to a Gloucestershire GP following the firm decision for Laura to remain at Arbury Court suggests that there had been an information sharing gap. Secondly, the acute general hospital, WHHFT, identified a missed opportunity to raise safeguarding concerns with WBC. WHHFT reflected that the frequency of attendances with deliberate self-harm injuries should have triggered professional curiosity about a potential safeguarding issue and/or a need for external assurances. This was a missed opportunity to seek independent assurance that Arbury Court's internal reviews of ongoing self-harm were sufficiently robust. Although the section 42 enquiry had identified no evidence of links between care and risk, the WHHFT attendance information might have informed decision making around safeguarding. NICE guidelines say that discharge from secondary care following an act of self-harm should be passed onto a GP and any relevant medical health services, but do not specify responsibilities for frequent attendances from a patient under the care of mental health services. During the course of this SAR WHHFT proposed and implemented a frequent attendee process as a result of this learning to ensure that pathways included prompts to reflect on unmet needs and/or identify care quality issues. These processes create the potential for greater independent scrutiny.

5.4.15 **Communication with Laura and her family**

In working with adults, professionals need to find the agreed and legitimate balance in terms of helping families to take part in 'the team of care' whilst respecting the rights and wishes of the individual they are supporting. NICE guidelines acknowledge that data belonging to capacitated adults must only be shared with their permission. This can be difficult for families of those receiving care and support for mental ill-health. As in Laura's case, consent to share might be withdrawn periodically, which can result in families being uninformed about their loved one's condition and excluded from care planning. Laura's family explained that they believed Laura would often withdraw consent to share when her mental health was deteriorating. A focus of the SAR was to identify whether or not there were specific opportunities for learning in relation to communications by all of the agencies involved with Laura and her family.

5.4.16 Laura's family were actively involved with Laura even when she was in hospital. Laura would often send messages to her mother or step-father, who in turn would contact the ward; this is evident within both Wotton Lawn and Arbury Court records. Communications from her parents related to concerns regarding her continued self-harm, ability to abscond in spite of reportedly high observation levels and the planning around treatment of her mental health condition. There are records that suggest that the family did not always receive a response to concerns raised. For example, on 19th August 2016, Laura's mother reported that Laura had told her the route by which she was absconding from the ward and how she had been able to travel the route, and Laura's mother relayed this to the ward. Laura's mother does not feel that this resulted in any improvement with respect to managing Laura's ability to abscond. 2GNHSFT acknowledged that there were no records of letters sent by Laura's parents to the ward manager in October and November 2016 requesting copies of her care plans and expressing concerns about Laura's continued self-harming. 2GNHSFT held a meeting with Laura and her family in November 2016 to discuss their concerns and that a key factor was that Laura was not placed on the ward that was intended to serve her locality, which meant her medical team were not as available to her. 2GNHSFT noted that their failure to document these discussions had not been helpful to maintaining a holistic understanding. When Laura was transferred to Arbury Court, there were similar problems with communication an issue identified and addressed in the Safeguarding Enquiry. Ward staff at Arbury Court proposed to implement a once weekly phone call to her parents and occasional invites to weekly ward rounds. This was recorded as being adequately managed from the Arbury Court social work team's perspective. But miscommunications appeared to continue, for instance when the family visited with a dog they believed they had permission to bring onto site and were subsequently unable to. The family say that the planned regular weekly calls did not go ahead. Laura's family remained concerned that she was not safe and on 2nd February 2017 raised a formal complaint with 2GNHSFT and expressed concerns to NHS England that their daughter's out of area placement planned for one week had become a placement lasting months.

5.4.17 Both professionals and Laura's family found communication a challenge in this case, with neither party feeling satisfied it was meeting Laura's needs. Records seen by the SAR Panel highlight a number of instances when communication was not effective. Professionals involved in Laura's care have already identified changes in practice, which may have helped to build better relationships with her family.

5.4.18 Good communication requires that agencies actively listen, with parties agreeing and recording what has been said and checking out what has been understood. This, in turn, might have prevented a growing sense of dissatisfaction for Laura's family.

5.4.19 **Communication around discharge planning**

NICE guidance recommends the careful management of endings and transitions between services, in the knowledge that transitions can evoke strong emotions and reactions, including increasing the risk of self-harm. This requires services to

collaborate effectively together on a plan to support the individual during the transitional period. For Laura, coordination of communication was not always well planned. Records demonstrate that Laura was sometimes aware of an assessment before ward staff were made aware, which would have made it practically impossible for the same staff to prepare and support her during that assessment. An example of this was when Laura informed the Arbury Court staff she was awaiting an assessment from St Andrews Healthcare on 30th January; the ward staff hadn't been made aware of this. NHS England appeared to have discussed this request with Laura's mother but had not informed Arbury Court. This led to a request by Arbury Court for a teleconference to clarify care planning. The outcome of this was a recognition of the need for single points of contact for the family and professionals to ensure information was shared in the correct order.

5.4.20 This highlights a significant missed opportunity earlier in the placement to support Laura through clear and consistent communication about her discharge. It cannot be known what impact this may have had on her emotional state, but research evidence and professionals' experience confirms that a patient transfer is a time of heightened emotion that may result in anxiety driven risky behaviour.

5.4.21 To avoid uncertainty for service users, professionals must ensure that they develop and share communication pathways for use during the key moments of transfer and discharge. This becomes a greater imperative when a person is to be moved to a facility in another locality, particularly if this is some distance from family/community support networks.

5.5 <u>Laura's Patient Experience</u>

5.5.1 Research cited later in this section suggests that those diagnosed with personality disorders and exhibiting self-harming behaviours often describe their care experiences as poor, and that treatment to address the underlying causes of their disorder is, at best, inconsistent. Laura's family expressed concerns that Laura's care and treatment may have been affected by the negative attitudes of some staff to her behaviours and personality disorder diagnosis.

5.5.2 Research carried out by the Royal College of Psychiatrists found that unhelpful staff attitudes towards patients who self-harm can be an issue. They developed a position statement in 2010 in relation to suicide and self-harm, which identified that staff can experience a sense of frustration with self-harming behaviours that ultimately impacts on their day-to-day response to patients. They described that instead of providing the care and understanding that the patient needs, this can be overtaken by hostility and disengagement. Other research has gone so far as to propose the diagnosis of personality disorder is abandoned due to the potential negative impact it has on attitudes towards a patient. Further research in 2017 indicated that these negative attitudes were still prevalent. NICE guidance notes that service users often do not re-engage or enter health services due to difficulties over how they receive care. They also noted that users report negative attitude, ignorance and sometimes punitive behaviour. This evidence was collated from focus groups with service users,

interviews and literature reviews. It is conceivable that, during her journey of care, Laura might have encountered some negative attitudes from staff, particularly if they had little up to date training in evidence based practice in working with people who displayed behaviours that have triggered a PD diagnosis.

5.5.3 As a part of conducting the safeguarding adult review, two learning events were convened, the first a session on understanding self-harm, and the second a session providing an overview on Borderline Personality disorder (also known as Emotionally Unstable Personality Disorder (EUPD)). In both of these sessions, perceptions and experiences of care were discussed. Mental health service providers and the Personality Disorder Team in Warrington described their approach to supporting people diagnosed with personality disorder as balancing clinical intervention against the dangers of over-involvement leading to greater dependency and self-harming behaviours. This approach has been described by service users as 'intentionally limited' where care is offered on a short-term basis in order to promote self-care through alternative coping strategies. This also reflects the views in the Gloucestershire suicide research findings[16], where professionals place some responsibility on the service user to manage their behaviour. Experienced professionals' views are that patient self-determination and independence should be fostered whenever possible. They described working with risk due to the potential positive benefits, such as avoiding hospital admissions beyond 24 to 48 hours to prevent individuals becoming stuck in overly controlling environments, which ultimately exacerbated behaviours of self-harm. Similar approaches were described by 2GNHSFT in the first learning event. By contrast, staff not specially trained in working with people diagnosed with personality disorder and who self-harm reflected views that patients should be safeguarded. This latter view appeared to reflect the perspectives of Laura's family.

5.5.4 Records of Laura's care provide some evidence of interactions in line with service user focus group proposals. For example, in the NICE guidance the focus groups made recommendations for improvements that involved providing safe environments, offering an opportunity to reflect, and being listened to. On occasion Laura was given 1-1 sessions with a staff member subsequent to aggression or self-harm episodes to reflect on what had happened and explore her feelings. 2GNHSFT refer to Laura's treatment as including admission to an open ward to balance the need for a safe environment with the need to avoid high levels of restriction that can lead to increases in self-harm. There are also records that suggest she may have experienced care impacted by the issues (poor environment, not being listened to, no space and support for reflection) noted above. For example, at Arbury Court in December 2016 there are several records of aggressive interactions between some patients, including Laura, on several occasions:

> "… Patient 39 proceeded to try and swill patient 97 with a cup of water, patient 97 retaliated and threw a cup of water back at

[16] Research into deaths by suicide in Gloucestershire, Suicide Crisis, 2018

> patient 39 and Laura was sitting in the vicinity and water went onto her Laptop and IPod. Laura became irate and made attempts to physically assault patient 97 and patient 39 made attempts to also access patient 97 threatening to "kill her". Patient 97 was relocated [to] quiet lounge for support and de-escalation. Laura and patient 39 repeatedly stated that they would "seriously harm", "kill her" if she returned to ward area. …On call RC contacted due to safeguarding risk to patient 97 as continued threats of physical assault directed towards her"

This example is an entry on 29th of December 2016. Prior to this date, patient 97 had started a verbal altercation with Laura. Over the preceding days there was a pattern of interaction between these patients that was negative and instigated by each of the three patients at different times. Laura's threats and aggression are appropriately not tolerated, but there is no record of consideration being given to the fact that these three patients pose risks to each other in terms of emotional distress, which was a specific area Laura was struggling to manage. This aspect of Laura's experience does not seem to be recorded, instead the focus is on recording the aggression she demonstrated and the restraint required to keep Laura and others safe. There was also no explanation available to the panel in terms of considering Laura's behaviour in light of her having found it so difficult to live within the environment of the PICU and the issues she experienced and described around communication and being listened to.

5.5.5 Laura raised complaints about staff during her time at both Wotton Lawn and Arbury Court. These related to staff use of physical restraint (grabbing her legs whilst she was trying to abscond over a garden wall), inappropriate comments (staff allegedly talking about patients to each other in front of them) and her frustrations around delayed responses to requests (requests for leave from the ward). Laura also appeared to have positive interactions with staff at times where she would share her current concerns and seek support, for example in relation to her past sexual assaults.

5.5.6 To try to understand better how Laura may have felt about her experience of receiving care, the SAR panel sought to explore evidence that had been collected about the experiences of current service users with a diagnosis of personality disorder. Local agencies were not able to provide specific feedback by patient type, so it was not possible to see how local experience reflects national findings. Anecdotally, it seemed to be the case that outside of specialist services there were challenges in ensuring staff are sufficiently aware and trained to confidently respond to the support needs of individuals with a personality disorder. Training staff in line with the Royal College of Psychiatrists and NICE guidance prepares staff to understand and care for those with behaviours indicative of personality disorder and who self-harm.

5.6 <u>Treatment</u>

5.6.1 A key part of Laura's treatment plan was to gain access for her to Dialectic Behavioural Therapy (DBT). Both the Panel and Laura's family queried her access to treatment for

her self-harm in the interim whilst awaiting her placement for DBT. Laura's family had also expressed concerns about the medication Laura was prescribed and the absence of any treatment beyond medication whilst at Wotton Lawn and Arbury Court. Laura's assessments indicated that DBT would be an appropriate treatment option and placements offering this intervention were being sought from September 2016. This was after the completion of her psychology assessment at Wotton Lawn. The transfer to a PICU in November raised challenges because the proposed DBT intervention could not be implemented in that environment. However, it was noted that this left a period of time (September 2016 – February 2017) when Laura was continuing to self-harm without active treatment aside from medication.

5.6.2 Laura's low secure assessment by Gloucestershire in December 2016 stated:

> "It is not entirely clear what her current medication is but she was on quite a variety of psychotropic drugs when discharged from Wotton Lawn…in personality disorders it's not currently recommended by NICE and a medication review is indicated"

It was proposed that a comprehensive risk assessment was undertaken at Arbury Court. Reference was made to psychological treatment; in-patient DBT was proposed but there was no reference to treatment that was already on-going. On arrival at Arbury Court issues around discrepancies in records of medication prescribed are noted between the discharge summary on 21st November 2016 and the low secure assessment report overview in December 2016. The SAR Panel requested that Arbury Court and Wotton Lawn submitted a concise overview of treatment undertaken whilst Laura was resident within their facilities.

5.6.3 Arbury Court's treatment Overview Report stated that Laura was prescribed medication for anxiety and agitation, specifically, Pregabalin, Diazepam and Lorazepam. She was also given Oramorph for pain. This medication was reported as "reviewed regularly and optimized as appropriate". It was noted that Laura was also offered iron supplements for anaemia, but would often refuse this, which was assessed by staff as an additional example of self-harm. Laura was also offered nursing talking therapies which included 1-1 sessions with a primary nurse. Alongside this were occupational therapy sessions each week on the ward and in the therapy department. Arbury Court noted that Laura engaged with these and by January 2017, due to improvements in her engagement with staff, was seen to participate in occupational therapy activities twice a week. It was also noted that a Positive Behavioural Support Plan was developed on 12th November 2016 and updated 4 times during her stay. This Plan aimed to identify with Laura what may trigger distress or certain behaviours and what interventions could be used to manage or minimise this. Laura also met with a psychologist in weekly 1-1 therapy sessions. Laura attended 9 of the 11 sessions offered. The psychologist reported working on low level emotion regulation/distress tolerance skills to support Laura to cope within the PICU setting. These sessions were based on Cognitive Behavioural Therapy (CBT) and Laura

was noted to understand these and could provide examples of her application, but at times of distress Laura needed prompting to remember to try and use these skills.

5.6.4 Wotton Lawn's Treatment Overview Report stated that Laura was prescribed medication between June and November 2016. The Low Secure Report indicates at the point of discharge this included Aripiprazole, Oramorph, Pregabalin, Diazepam, Chlorphrenamine, Zopiclone and Ferrous Sulfate. In relation to broader treatment, it was noted that Laura had ten named nurse care plans put in place to coordinate responses to certain circumstances, such as leave from the hospital, Prevention and Management of Violence and Aggression (PMVA) and any packages delivered to her on the ward. Laura was reported to have had access to assessment and input from Occupational Therapy, Physiotherapy and exercise and health practitioners. The hospital psychology team also completed an assessment to inform proposals for future treatment.

5.6.5 Within the period under review, Laura did experience a delay in accessing the DBT intervention she and her care team had identified as suitable for her needs. This was in part due to her continued self-harming behaviours and subsequent high observation levels, which led providers to decide in their assessments that Laura was not at the right stage for this treatment to be effective. It was also partly due though to difficulties in identifying and securing a placement once it was agreed that this would be right for Laura. During her time in the PICU she continued to self-harm, and from her family's perspective this appeared to be a period with no meaningful intervention and a reliance on medication. NICE guidance indicates an expectation that when working with a patient who self-harms psychological interventions should be offered that include cognitive-behavioural, psychodynamic or problem-solving elements. It specifies that drug treatment is not considered to be an intervention that reduces self-harm. It also says that harm reduction as a short term intervention may be required and proposes reinforcing coping strategies, and alternative methods of self-harm that are less destructive. The submissions from Laura's care providers suggest that drugs were utilised to manage symptoms of anxiety and aggression. They also suggest that psychological interventions were being utilised to explore alternative CBT-based coping strategies with Arbury Court indicating this was being undertaken on a weekly basis with a psychologist.

5.6.6 It was recognised that Laura had also experienced a wait for treatment before the period under review by this SAR. This is outside of the WSAB's remit for review but provides some insight into Laura's and her family's frustration at delayed access to DBT or readily available psychological ward-based interventions. Laura's family noted that they had expressed concerns about unmet support needs in previous years when Laura was accessing treatment in the community. We had access to a Gloucestershire suicide charity research paper from 2018[17] that identified areas of focus for Gloucestershire services through the coronial process, based on details from 25 cases reviewed by the coroner. The paper suggests that there is a lack of availability of DBT

[17] Research into deaths by suicide in Gloucestershire, Suicide Crisis, January 2018.

for patients with Emotionally Unstable Personality Disorder (EUPD) and that patients were asked to manage their own safety. Alongside research reports by the BMA citing CQC findings of delays of 6 months for talking therapies at 2GNHSFT services in Gloucestershire, this brokers a broader understanding of the family's anxiety about Laura's delayed treatment and lack of access to DBT. According to the BMA research, this appears to be a national problem.

5.6.7 As part of the SAR process, as described earlier, a learning event was conducted with providers and the Personality Disorder Link Worker for WBC to explore existing practice and challenges. It was identified that there was delayed access to DBT-based therapies for those with Emotionally Unstable Personality Disorder (EUPD). It was noted that, as in Laura's case, short term work can be done with individuals in the form of CBT by the Personality Disorder Link Worker whilst they await access to the specified treatment. Nevertheless, it was noted that there is limited provision for individuals with EUPD and the wider services (non-specialist) staff subsequently responding to their needs are not sufficiently trained to manage these effectively. For example, accident and emergency departments responding to self-harm incidents are not trained in EUPD and appropriate responses. This reflects the findings of Safer Care for Patients with Personality Disorder[18], which canvassed the views of staff and patients. It found experiences of lack of access to DBT, use of drug treatments and staff expressing their concerns about little training to support patients with EUPD. Both WSAB and GSAB should give consideration to seeking some assurance about their local service provision for service users diagnosed with personality disorder.

5.7 <u>Mental Health Act Processes</u>

5.7.1 Laura was detained at both Arbury Court and Wotton Lawn under section 3 of the Mental Health Act. Once this process was triggered, Laura's rights included access to an independent mental health advocate (IMHA), the right to challenge the decision via a tribunal, and an expectation for her case to be kept under review. Records from Laura's time on both wards indicated that she exercised her right to challenge her detention, in July and September 2016. On both occasions she withdrew her appeal and this seemed to correspond to discussions regarding onward referral to in-patient DBT treatment centres. There were also records in December 2016 indicating that an IMHA had been assigned to Laura in line with guidance.

5.7.2 However, Laura's family noted that her section 3 detention renewal, particularly towards the latter part of her stay at Arbury Court, was not transparent. Specifically, they commented on the renewal of Laura's section 3 detention without their involvement as nearest relative. Whilst a timeline of Laura's detention is included in the information given to the SAR, there is no recording in relation to the renewal of Laura's detention on 7th February 2017. A review of the records identified that Laura was detained under section 2 in July 2016 and immediately appealed this. The Mental Health Act Administrator engaged with Laura, but she chose later in that month to

[18] This is a national research document that reviewed patient deaths and conducted a survey with patients and staff to understand the experience and antecedents to deaths - http://documents.manchester.ac.uk/display.aspx?DocID=37564

withdraw her appeal. When this MHA section expired, a decision was taken jointly with Laura to continue the stay on the ward on a voluntary basis. This changed to a section 3 detention in August after Laura had attempted to leave the ward. Laura initially chose to appeal this detention in September, again withdrawing her challenge a few weeks later.

5.7.3 Paperwork relating to Laura's detention was passed from Wotton Lawn to Arbury Court, but there is little reference to these processes when it comes to renewal of the Section 3 in February 2017. The SAR Panel cannot identify how the family as nearest relative were involved in this process. There were records of the family attending ward round meetings and Care Programme Approach meetings (27th June 2016, 22nd August 2016, 30th August 2016, 13th September 2016, 13th December 2016, and 8th February 2017). The Mental Health Act identifies that it is the duty of the responsible clinician to advise hospital managers that the patient continues to meet the conditions required for a Section 3 detention before it can be renewed for a further 6 months. It does not state that the nearest relative must be involved in this process; instead the expectation is that the nearest relatives are informed by the hospital managers as soon as is practicable following the review of the detention. Although the review of Laura's detention appears to have taken place, this appears to be a missed opportunity to support access to The Triangle of Care[19], the approach that proposes that the role family members play in a person's care and support is acknowledged, that their expert knowledge is included as part of the assessment and that their input supports recovery and discharge.

5.7.4 Laura's family were invited to meetings about Laura's care, but there appear to be possible gaps in support offered to them. They were not directly involved in caring for Laura, but they were advocating for her and she demonstrated reliance on their support. Given that Laura had been an inpatient at Arbury Court since November 2016 and at Wotton Lawn since June 2016, it isn't clear why this would have taken place at this stage rather than earlier on. Within the timelines of significant events there are also comments regarding Laura's reliability as a witness to her care. She is described as presenting her family with information that was not a factual account of what had happened. Professionals recorded that this would lead to family member concerns as they would receive Laura's account as a factual representation. This clearly created challenges within the relationships between professionals and Laura's family. This was acknowledged by NHS England in February 2017 and appears to have been exacerbated by the communication challenges noted earlier. It was proposed that Laura's family should be engaged early on in treatment plans when Laura was discharged to a low secure setting.

5.7.5 Overall, through the information received for this Review in the time line under review, there does appear to have been efforts made by agencies to engage Laura's family in care and treatment processes. There is evidence too that these were largely offered in line with National guidance. There were missed opportunities to deliver a

[19] https://carers.org/article/triangle-care

consistent approach to involvement at Arbury Court, which exacerbated a growing distrust and dissatisfaction with agencies approach to care provision. The renewal of Laura's detention under section 3, whilst within legal expectations, might have reinforced the family's sense of exclusion and poor care. Some of these gaps are likely to be result of the out of area placement and the communication challenges explored elsewhere in this Review. We know though, for instance through the Carers' Trust's Triangle of Care standards, that promoting early engagement and clear communication with family members can aid both the person and their family. On the basis of what we found in this Review, it is considered that it would benefit practice if agencies could reflect on whether or not they are meeting the six standards of the Triangle of Care, to assure themselves that carers are appropriately involved and supported throughout mental health service delivery. The SAB may also wish to explore adoption of these standards within the local area.

5.8 Delayed Transfer

5.8.1 Laura was temporarily placed 'out-of-area' in Warrington at Arbury Court because she was assessed as requiring a PICU placement, and there wasn't a PICU placement immediately available in Gloucestershire. Within a short period of time, approximately 4 weeks, Laura was reassessed as requiring a low secure rehabilitation placement, but a transfer to a low secure environment was delayed. There were three key barriers to a discharge from a PICU environment:

- The first was that a decision was taken that Laura would be best served by not moving her to another short term placement, whilst waiting for a longer-term rehabilitation placement that provided for Laura's assessed treatment needs.
- The second was that there was an apparent scarcity of low secure placements that could meet Laura's needs.
- The third was that, whenever Laura came to be assessed by a representative of a provider to check that she would be suitable for their provision, the provider's view did not concur with that of Laura's Care Coordinator, and the provider did not feel that Laura was suitable for their provision.

5.8.2 Laura spent just over three months on a PICU out of her home area awaiting a low secure placement. As explained in the chronology in section 4, Laura was transferred to Arbury Court on the 11th November. It was determined by a professionals' meeting of Gloucestershire leads on the 6th of December that multiple moves were not in her best interest and she should move from the Warrington area to her rehabilitation placement. Her low secure assessment report was provided on the 8th of December and NHS England sought an assessment for a placement on 19th of December 2016. Laura was not offered a low secure placement until the 15th February 2017, with a planned move date of 23rd February.

5.8.3 CQC[20] have reported on the issues within the mental health system nationally. In a snapshot survey carried out by CQC in May 2017, 857 patients were in out of area

[20] https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

placements and 96% of the placements had been deemed to be inappropriate. CQC noted that this snapshot was likely to underestimate the actual level of use of out of area placements. Compared to previous datasets, the snapshot showed an increase of up to 40% on this practice. A problem often associated with the increased use of out of area placements includes the limited ability of care coordinators to make visits out of area, to the detriment of effective discharge planning. This issue was also pointed out in a recent research paper by Agenda, which focused on the female experience of mental health care.[21] Agenda identified 3,975 female patients that had been placed out of area in 2018, purportedly due to a lack of beds near where they lived. They also found that women were more likely to experience being held in an inappropriate setting for longer than is necessary. Laura's placement was out of area due to the lack of local bed availability, and as can be seen in earlier sections of this report, there is evidence that care coordination was hampered by problems with communication across the services involved, leading to Laura waiting over two months for a discharge placement to be secured. Whilst some of these issues already discussed relate to practice, others are issues within the system that commissioners and service providers have little control over: there is an acknowledged underfunding of mental health services, including hospital provision nationally. Alongside the case specific learning for practice noted above, the pressures within the mental health system, whilst acknowledged, in 5 and 10 Year Health Plans, are not funded to deal with current increasing pressures. Lack of access to appropriate treatments and care can create safeguarding risks for people already vulnerable because of their mental health issues, and SABs have a responsibility to assure themselves that local providers are able to meet local needs.

[21] 45 Women in Crisis: How Women and girls are being failed by the Mental health Act 2018 - https://www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-september-2018/women-in-crisis-how-women-and-girls-are-being-failed-by-the-mental-health-act-1983/

6 Conclusions and Recommendations

6.1 Timely recording & sharing of risks

6.1.1 Laura's means to self-harm through ligature and self-strangulation were facilitated on the day of her death through poor information sharing between staff on the ward. After Laura's death, Elysium (Arbury Court) instigated training around recognition of risk factors, recording in care plans and no unsupervised use of plastic bags. This involved policy and practice changes for this organisation. As the SAR has a multi-agency focus this learning and practice needs to be shared to ensure that this missed opportunity is highlighted across services within Warrington and beyond.

6.1.2 **Recommendation 1**

WSAB should promote learning around inpatient suicide, timely information sharing between agencies, and the risks associated with unmanaged observation levels with all inpatient services in Warrington. WSAB will need to be assured that this has made an impact on practice.

6.2 Independent Scrutiny through Safeguarding

6.2.1 Working with patients diagnosed with personality disorders and self-harming behaviours is very challenging. Research informs us that staff can be desensitised by the level of harmful behaviours leading to unintentional neglect on their part.

6.2.2 **Recommendation 2**

WSAB should be assured that local providers have an agreed protocol in place to identify high risk behaviour incidents and/or patterns of self-harming behaviours, to include thresholds for reporting of safeguarding concerns.

6.3 Making Safeguarding Personal

6.3.1 When service users have a history of trauma, it is important that this is taken into account when responding to current presentations and needs. In Laura's case, the history of trauma related to allegations of sexual assaults without supported access to justice through the criminal justice system and ongoing therapeutic support. Although standard legal processes appear to have been followed, the impact on her self-worth was not recognised.

6.3.2 **Recommendation 3**

WSAB should promote learning in relation to trauma informed practice. This is to encourage staff to take account of an individual's history of trauma to inform response decisions.

6.4 Information Sharing

There were difficulties evident in this case in relation to the sharing and recording of information. These difficulties existed across agencies, localities and with Laura and her family. The risk of delayed discharge was exacerbated by the inaccurate interpretation of information and disagreement over the accuracy of records. There

was a missed opportunity to communicate safeguarding actions robustly between geographical areas to lead commissioners. There was also evidence that, due to the range of agencies involved, the communication pathways that were in place were not sufficient to ensure all parties were informed and updated in relation decisions around assessment and discharge. As a result of this, there was a lack of clarity for Laura and her family in relation to her discharge, which undermined their confidence in the care being given.

6.4.1 **Recommendation 4**

The WSAB, in collaboration with NHS England leads, should consider how communication should be improved for cases with out of area placements where NHS England Commissioning Services are involved. This should include designated points for contact, frequency of contacts, expectations for minimum information sharing in relation to safeguarding concerns and nearest relative details.

6.4.2 **Recommendation 5**

WSAB should be assured by all agencies that practitioners understand the importance of factual and accurate record-keeping. All information recorded should be clear, sufficiently supported by observations and evidence, and opinions should be clearly identified.

6.5 National Shortage of Safe, and Treatment-Evidenced, Support for People with Complex Mental Health Support Needs

Laura's placement within Warrington was an emergency response to increased aggression and risk to others. Laura and her family understood this to be a short-term out-of-area placement, due to the lack of suitable beds in the area she was ordinarily resident within. A decision was taken to reduce the number of required discharges to a long-term treatment placement by discharging directly from Arbury Court. As a result, Laura stayed within the Warrington area for over three months. Efforts were made to transfer her to placements that could offer more appropriate treatment options, but a lack of bed availability impacted on the time taken.

6.5.1 **Recommendation 6**

The WSAB should promote Laura's report within the SAR library, with NHS England and with other SABs with a view to escalating concerns about pressures within the mental health system and the potential risks that exist if they remain unresolved.

6.6 Availability of Treatment Services for people diagnosed with Personality Disorder

NICE guidance makes recommendations about appropriate treatment options for individuals diagnosed with personality disorders. The review found that these treatment options are not widely available and often have long waiting periods before they can be accessed. The delay in access creates risks for those service users most in need of treatment.

6.6.1 **Recommendation 7**

WSAB and GSAB should seek assurance within their areas that local service provision for service users diagnosed with personality disorders should meet NICE guidelines and be available to all those in need of such services without waiting times that put individuals at risk.

6.7 Developing a team approach

Although the application of the Mental Health Act followed set guidance, it was noted that there were missed opportunities to engage her family in Laura's care planning. This was not as a result of Laura's withholding consent to share information or professionals being unaware that her family were significant to her and regarded themselves as part of her care team. Instead, it appears that there were occasions when professionals did not engage with her family in as timely and inclusive a manner as they might have done. There is a great deal of value in carer engagement when it comes to the recovery of those with mental ill health. Providers of mental health services must ensure that they are working inclusively with carers within the bounds of patient choice and confidentiality.

6.7.1 **Recommendation 8**

The WSAB should assure itself that providers are aware of the Carers' Trust's standards, which are set out in the 'Triangle of Care' approach, and have adopted those standards or have plans in place to do so.

Appendix A Independent Review of Report

Professor Peter Kinderman undertook a review of the SAR report prior to the finalisation of the recommendations of the report. During the process of finalising the recommendations his review informed the revisions that were made. Please note therefore that some of the recommendations that are quoted within this report may be slightly different from the final recommendations in Section 6.

We would like to take this opportunity to thank Professor Kinderman for his time and careful consideration of the report.

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Professor of Clinical Psychology

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External independent report on the Safeguarding Adults Review F: Laura

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1) I am Professor of Clinical Psychology at the University of Liverpool, and Consultant Clinical Psychologist with Mersey Care NHS Foundation Trust, registered with the Health and Care Professions Council (HCPC); PYL16885.

2) I have been provided with a copy of 'Safeguarding Adults Review F: Laura' produced by, and provided to me by, Warrington Safeguarding Adults Board, and dated 5th February 2020.

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3) My first observation is that this is a thorough, comprehensive and professional review. In my professional judgment, the review of the circumstances and background to Laura's death was professional and appropriate, meeting the requirements for such a review as set out in Section 44 of the Care Act 2014. The review was detailed and thorough, and, in my professional opinion, addressed all the aspects of Laura's care that I would have expected. The information was presented clearly and, in my judgment, the conclusions drawn followed from the evidence presented.

   3.1 I also believe that the recommendations made in the review are proportionate. I have a few minor and relatively technical comments:

   3.2 (Paragraph 6.1.2) Recommendation 1. The review includes a recommendation that "*WSAB* [Warrington Safeguarding Adults Board] *should commission a training event from this SAR* [Safeguarding Adults Review*] to promote learning."* That is an appropriate recommendation that addresses an identified need (given that there were clearly lapses in policies and procedures that led to Laura obtaining the means of harming herself), and it is clear that such an event should involve "*all inpatient services in Warrington*". However, it also recommends that "*subsequently each agency should assure the SAB that organisations*

have implemented any necessary procedural changes". It is unclear to me whether this refers to 'procedural changes' outlined in this review, or, alternatively, to any learning occurring at that training event. This could be clarified.

3.3 (Paragraph 6.2.2) Recommendation 2. The review includes a recommendation that "*WSAB should review local procedures to amend current process guidance ... and take steps to monitor implementation*". This again follows from the evidence provided, but does not offer specific recommendations in terms of implementation. I entirely appreciate that reviews of process guidance take time, and that events (such as that recommended above) are necessary parts of this, but a general commitment to review processes and implement changes does appear a little non-specific.

4) **Trauma-informed care:** The review rightly recommends a focus on trauma-informed care (paragraph 6.3.2 and recommendation 3). I completely endorse the recommendation that "*staff are encouraged to take account of an individual's history of trauma to inform response decisions and to consider the effects of a failure to consider person centred practice as happened in Laura's case*". However, the review might be strengthened with some suggestions as to what that might mean in practice. For me, this reflects a need to implement practices that are primarily psychological in nature, where care follows from a co-produced formulation (an approach seen as core to the clinical practice of both clinical psychologists and psychiatrists), and recognises the impact of events on our mental health (such as the British Psychological Society's 'Power Threat Meaning Framework).

5) **System-wide inadequacies and failures:** In my professional judgment, this review powerfully illustrates how the care that Laura received, across the board, by almost every agency, and for many years was complex (even confused), underfunded, poorly conceptualised and inadequate.

5.1 It is fair – because we rely on mental health services to address the human consequences of adverse circumstances – for this review to focus on the provision of services for people who pose a risk of self-harm or suicide, but in truth there are wider failings identified here.

5.2 This review is not designed to explore the causes and development of Laura's mental health problems, but it is widely recognised that most mental health difficulties, and especially those similar to Laura's, have their origins in childhood. It is wholly typical to see this pattern in Laura's case.

5.3 The review notes (paragraph 2.4) that Laura had harmed herself certainly by the age of 13, and probably by the age of 9. The review notes the involvement of social services (with a reference to foster care), and it must be assumed that NHS mental health services, GP services, social services and the education services were aware of the risks to Laura.

5.4 The review also notes (paragraph 2.4) that Laura alleged that she had been molested by a family friend. This brings into focus the role of police and criminal justice agencies.

5.5 It is, of course, true to say that Laura's interactions with the police were complex. The review notes (paragraph 2.5) that Laura is alleged to have suffered a further sexual assault, which she did not report, and that (as well harming herself, paragraph 2.6), Laura at that time was arrested and prosecuted for being in possession of a knife (paragraph 2.7).

5.6 The review recognises that Laura's behaviour would have been highly challenging, but is important – in the wake of tragedies such as Laura's death – to reflect not only on the

immediate causes and issues to be learned about acute care, but also on the fact that such tragedies have long trajectories.

5.7 It is vital that we invest in services – in social services, education and the criminal justice system – that are able to recognise and respond to signs of distress in young people, and to protect them from those adverse events which so often have led to those problems. It is, therefore, appropriate to note this need in this context.

6) **Similar considerations apply to NHS mental health care services in Laura's case:** I agree with the thrust of the SAR review that important lessons can be learned from Laura's experiences, and that significant failings were observed in Laura's care, but I appreciate that it is the responsibility of the Coroner's Court and other legal processes to determine whether any identified individuals and services were negligent. I did not, of course, conduct this review myself, and therefore must rely on the enquiry and review process of Warrington Borough Council's Warrington Safeguarding Partnerships. However, in my professional opinion, this was a thorough and professional review.

6.1 The review notes (paragraphs 5.4.1. and 5.4.2) that negative attitudes and behaviours persist in respect to people who have experiences such as Laura's and who have received the diagnosis of 'personality disorder'.

6.2 As noted above, a powerful recommendation in this review is that staff should be trained and supported in delivering trauma-informed care. I concur, but more is also needed.

6.3 As this review notes, care for people who harm themselves is often poor and inconsistent (paragraph 5.4.1) and staff often hold unhelpful attitudes (paragraph 5.4.2). In my professional opinion, this is often a consequence of a conceptualisation of such problems as 'illnesses' or symptoms of underlying illness. This results in a range of attitudes consequent upon pathologisation – locating the problem in the person rather than in the circumstances she has endured, assuming that there is a fault or flaw or dysfunction in her thinking style or even her brain, assuming that she is different or lacking in resilience (as compared with other people), assuming that (because she is suffering from a 'mental illness') she requires 'treatment', and, unless she receives such treatment, she will remain at risk.

6.4 In my professional opinion, while, in Laura's case, staff appeared to be adhering to relevant clinical guidelines and codes of practice, such attitudes are widespread in health and social care (and, indeed, in wider society) and can be harmful.

6.5 The review (paragraph 5.4.2) mentions calls for "the diagnosis of personality disorder [to be] abandoned due to the potential negative impact it has on attitudes towards a patient". I entirely agree (and have made such calls myself). These recommendations should not be interpreted as meaning that individual members of staff have failed in their responsibilities, but it does mean that significant changes are required if tragedies such as Laura's are not to be repeated.

7) **A pattern of non-responding to reports of sexual assault:** There are several references to times when reports of sexual assault were not followed up.

7.1 The review rightly highlights how, from an early age, Laura's reports of sexual assaults were responded to in a manner that could adversely have affected her mental health. Paragraph 5.2 points out how it had not been possible to pursue a criminal investigation in childhood, and that; "When the third sexual assault did not result in the possibility of a prosecution being taken forward, Laura reported that she felt the lack of a police enquiry or

sexual assault referral centre (SARC) involvement or follow up meant that she was unworthy of attention or help".

7.2 As noted in paragraph 5.2.6, these actions could (in isolation) be seen as appropriate, but they do form part of a pattern of an institutional failure to respond to her needs – ultimately reinforcing a pathologisation of her distress.

7.3 In paragraph 6.3.1 of the review, it is reported (in respect to Laura's reports of sexual assaults) that: "*Although standard legal processes appear to have been followed, the impact on her self-worth was not recognised*". That is an important failing. Although it may well have been impossible to proceed with prosecution, a 'trauma-informed' approach to care (rather than an ethos based on the concept of 'personality disorder') may well have led to staff (both in the criminal justice and health care services) responding differently.

8) **Chaotic and inadequate services:**

8.1 In paragraph 2.9 the events surrounding Laura's miscarriage, relationship ending, substance misuse and problems with her neighbour were responded to with an admission to hospital and a restorative justice intervention with the Police. Given that Laura ended up sleeping in her car whenever she would return home after 9pm, this seems to me to have missed the opportunity to provide fully for Laura's needs. In paragraph 2.10, Laura's admission to hospital was characterised with her assessment and diagnosis of 'borderline (emotionally unstable) personality disorder with antisocial and schizotypy aspects'. In paragraph 4.2.4, Laura is reported to been formally detained under section 2 of Mental Health Act and many recorded incidents of aggression resulted in the use of physical restraint. In paragraph 4.2.6, the review notes bag searches (appropriate, because Laura had harmed herself and staff found razor blades inside the bag), further use of physical restraint and only escorted leave. Paragraph 4.2.10 of the review records how Laura was placed on one-to-one observations, requiring line of sight observations in communal areas and randomised observations every 5 minutes whilst in her bedroom.

8.2 All of this strikes me as very conventional treatment for people presenting with the needs and challenges of someone like Laura. However, it is also clear that there will have been very substantial negative impact on Laura's self-worth. Again, I cannot criticise individuals or services, but I do not think Laura, like many people in her position, was well cared for.

8.3 The important point here is not to criticise the staff for (for instance) searching Laura's possessions or having policies for restricting access to ligature points, but to emphasise the need for training in, and implementation of, trauma-informed care.

8.4 The review also (paragraph 5.5.4) notes substantial use of medication. At the point of Laura's discharge in 2016, this included Aripiprazole, Oramorph, Pregabalin, Diazepam, Chlorphrenamine, Zopiclone and Ferrous Sulfate.

8.5 This level and nature of medication use is inappropriate in cases such as this. NICE guidelines are explicit in stating that; "There are no drugs that are established as effective in treating or managing borderline or antisocial personality disorder". The use of medication in Laura's care reflects both a chaotic approach to care and the pathologizing of psychological problems.

8.6 The review also (paragraph 5.5.4) that Laura had ten named nurse care plans, as well as a number of therapy 'packages'. I am concerned about the complexity of this and the possibility for confusion.

8.7 The review repeatedly (and appropriately) comments on lack of consistency and shortfalls in communication (paragraphs 5.3.9 and 5.3.10). Recommendation 4 (paragraph 6.4.1) is, therefore, welcome.

8.8 I should note, however, that the pattern of chaotic communication noted (and addressed in recommendation 4) is a system-wide problem, and indicative of poorly-funded public services, with too few, under-paid, under-trained and over-worked staff with little time for reflection.

8.9 The recommendation for training in, and implementation of, trauma informed care, is therefore important.

9) **Provision of appropriate, well-funded, services:**

9.1 Recommendations 6 and 7 of the review (paragraphs 6.5.1 and 6.6.1) make the important point that appropriate services for people with needs such as Laura's must be available. This is, in my opinion, central to this review.

9.2 As I have said, however, this is a problem that is not limited to Laura's death, nor to the services that cared for Laura, but is a problem for the entire UK health and social care system.

9.3 The recommendation for training in, and implementation of, trauma informed care, is, again, therefore important.

10) **The immediate circumstances of Laura's death appropriate:**

10.1 The review (paragraphs 4.3, 4.4 and in the recommendations) details the immediate circumstances of Laura's death. In my professional judgment, the review is thorough and proportionate. It is self-evident that there were lapses in vigilance that permitted Laura to take her own life. The recommendations made in this review are, in my judgment, appropriate and proportionate, and I can see no evidence of mistakes or lapses that have not been addressed.

10.2 My most important concern in respect to the review of the immediate circumstances surrounding Laura's death is that she was, at the time of her death, waiting for appropriate services.

10.3 The review states (paragraph 2.11) that: "*At the time of her death in February 2017, Laura was 22 years old and residing in a Psychiatric Intensive Care Unit (PICU) in Warrington. She was awaiting the availability of a low-secure placement...".*

10.4 The review details (see, for instance, paragraph 4.2.20) the complexity of finding appropriate accommodation and care for, but also reports that; "*Laura was tearful and worried about a transfer to an out-of-area placement*". This pattern of complexity, delay, and distress was characteristic of Laura's care. In paragraph 4.3.8, the review reports that; "*Laura found the period of the search for a low secure bed extremely distressing*", and includes a distressing personal message.

10.5 The review itself contains evidence that this issue was closely related to Laura's distress and subsequent death. In paragraph 4.3.14, it is reported that, on 16th February 2017, Laura was considered to be expressing distress and frustration due to the delay in her discharge, and reportedly stated that she was; "*frustrated as I was meant to leave today*".

10.6 This is, in my professional judgment, serious. At best, it means that Laura was distressed at an unreasonable wait for services – unreasonable because she had a right to expect such services (proportionate to her needs and commensurate with NICE guidelines) to be available. At worst, this wait contributed to her wish to die.

11) **Summary:**

11.1 In my judgment, the review of the circumstances surrounding Laura's death has been thorough, appropriate and proportionate. The review correctly highlights a variety of issues where learning (and in some cases investigation) is needed, and I concur with these recommendations.

11.2 I would add that our collective failure to provide Laura with appropriate care is shameful. This should not be interpreted as extending beyond the findings of this review, but I do believe that the care that Laura received fell – as it does for so many people – short of what she should have expected.

11.3 The review into the circumstances of Laura's death was, in my judgment, appropriate and proportionate. It is not for this review (or me) to conclude whether any individuals or services were negligent. Nevertheless, it is worth reflecting on the fact that both individual lapses in judgment and system-wide failures may well have contributed to Laura's death, and that these are failures that could, with political commitment, be addressed.

11.4 In my professional judgment, we – as a community – failed to address Laura's distress as a child, and to explore the possible reasons for her distress. We failed to treat her humanely and to protect her from harm. As a young person and an adult, we pathologized and medicalised her distress and processed her through the mental health care system. Although I agree with the review's conclusions that lessons can be learned and I understand that it is for appropriate legal processes to determine whether any individual or service fell short of the standards one would normally expect, those standards are themselves routinely woefully low, inappropriate for a civilised country, and our mental health and social care systems are scandalously underfunded.

11.5 At the time of her death, it seems likely that there were no appropriate services immediately available for Laura. It would be unfair to criticise staff or managers of those services for this lack of provision. But the chain of circumstances that led to the inadequacy of services available for Laura involved political decisions; decisions as to the funding and management of health and social care. The individual 'bed manager', or social worker, searching for an appropriate placement for Laura cannot be held responsible for the fact that she was *"awaiting the availability of a low-secure placement..."*. But human, political, decisions have resulted in that state of affairs, the situation is not inevitable, and, if we are to avoid more tragedies such as Laura's, we need to make better decisions.