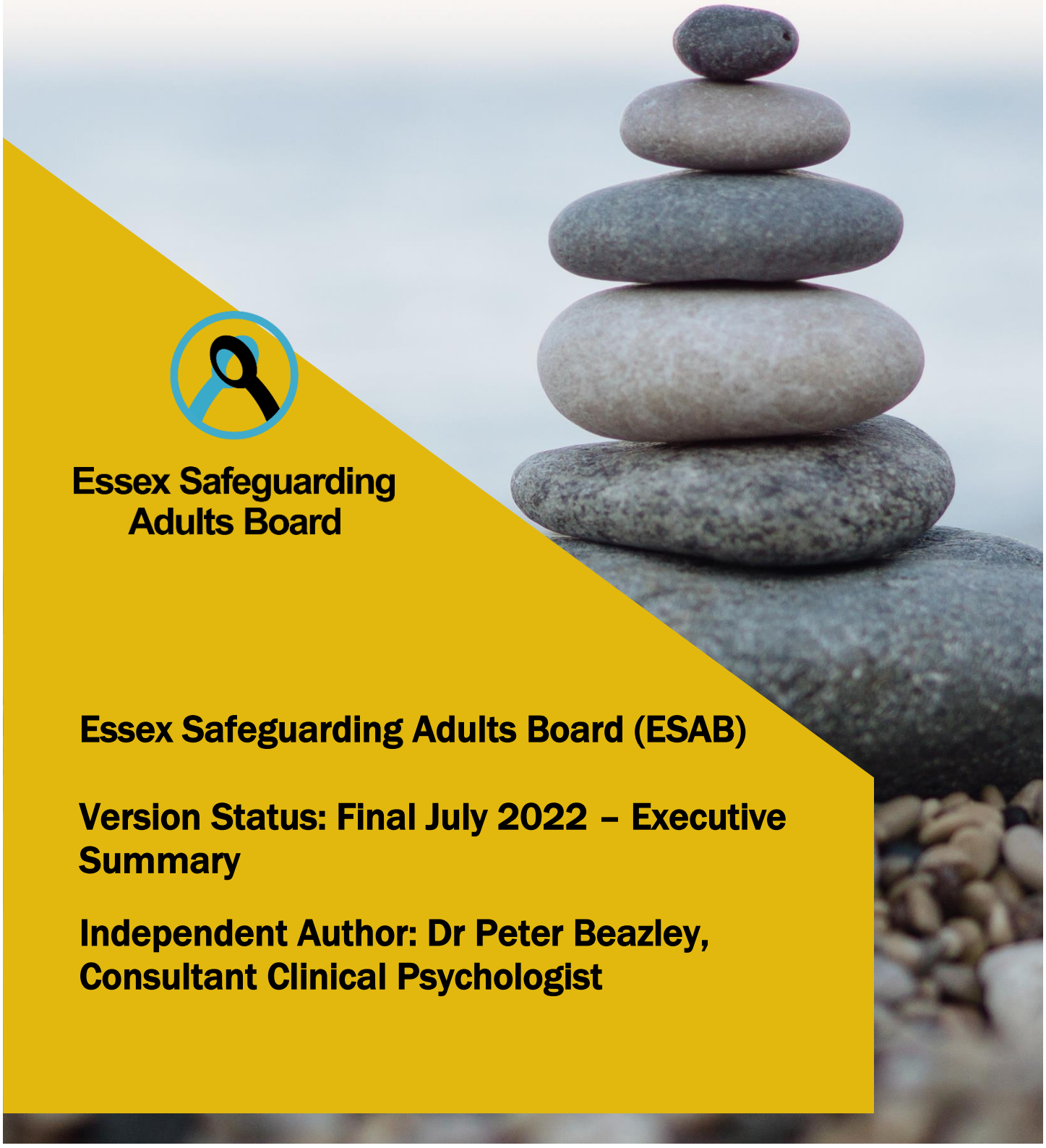
Safeguarding Adults Review (SAR)

“Miss J”



Essex Safeguarding Adults Board

Essex Safeguarding Adults Board (ESAB)

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Executive Summary

Miss J died, at the age of 20, on the 5th February 2020, at a Hospital in Essex. She had been admitted to the Hospital after tying a ligature whilst an inpatient at Private Mental Health Hospital 1, Essex. This is a secure psychiatric hospital for people who present a risk to themselves and/or other people.

The present Safeguarding Adults Review (SAR) considered the way in which professional agencies involved in Miss J's care worked to address her clinical needs and protect her from abuse and harm. The primary focus of the SAR is on events which occurred from October 2016 until her death in February 2020.

Miss J's family were from Africa, although she had grown up with her family in London. She had a number of siblings.

There is evidence that during her developmental years, Miss J was subject to a number of adverse childhood experiences, including abuse from her parents. She appeared to have had some involvement in gangs and had reported being the victim of sexual abuse. As an adolescent, Miss J was removed from the care of her parents and ultimately became subject to a Care Order under the Children's Act. She lived in a range of locations, but ultimately was detained, on the 6th April 2016, under the Mental Health Act (MHA; 1983) and admitted to Private Mental Health Hospital 2 (Norfolk). This unit has since closed, but at the time was a secure inpatient psychiatric hospital for adolescents.

It appears that this move was initially intended to be a short-term admission. However, ultimately, Miss J was to remain detained under the Mental Health Act continuously until her death. She therefore spent her whole late adolescence and her entire, short, adulthood in secure inpatient care. In total, during this period, she received care in four different secure inpatient units. Various clinical diagnoses were attributed to Miss J, but most consistently she was given a diagnosis of Borderline Personality Disorder. The core elements of her presentation which caused risk and required support appeared to be a difficulty in regulating her emotional responses (and a disproportionately acute emotional response to stressors), difficulties in forming and maintaining relationships, and behavioural challenges, which included both serious and repeated episodes of self-harm (commonly but by no means exclusively ligating), and interpersonal violence towards both other patients and staff. She sometimes reported hearing a voice which was given an identity 'Em' and reported sometimes finding this experience comforting and sometimes distressing.

During her initial admission to Private Mental Health Hospital 2, Miss J's presentation was characterised by periods of stability alternating with periods of challenging behaviour including episodes of severe self-harm and interpersonal violence. The clinical team working with Miss J appeared caught in a pattern of making plans for her discharge, and then subsequently making plans for responding to increased behavioural and clinical challenges. Whilst at Private Mental Hospital 2, she was assessed for a potential Learning Disability. The result of this assessment was that she received a diagnosis of Learning Disability, and plans were made to transfer her to a specialist secure unit for people with a Learning Disability. However, because she reached adulthood before such a bed became available, she was admitted temporarily to a mainstream Low Secure Unit (LSU) at Private Mental Health

Hospital 3 (Norfolk). She spent approximately four months here, before being transferred to Private Mental Health Hospital 4 (Essex), a Low Secure Unit providing care for people with a Learning Disability.

One of the points of learning from the SAR was in considering the process of assessment of Learning Disability, which was felt by the SAR Panel to represent, overall, a poor example of practice. The findings from this assessment appeared to be potentially unreliable. Indeed, the SAR Panel noted that after spending a little over a year at Private Mental Health Hospital 3, her clinical team then expressed the view that Learning Disability was not an aspect of her clinical presentation that required specialist care and treatment. She was subsequently transferred to Private Mental Health Hospital 1, a 'mainstream' secure unit, where she would spend approximately ten months before her death. The SAR Panel reflected on the potential risk that once a narrative about a diagnosis (such as Learning Disability) is 'set', it can be very hard to 'undo' that diagnosis, even if the assessment on which a diagnosis is based is unreliable or poorly executed.

Another point of learning that arose through the SAR related to the management of safeguarding concerns whilst Miss J was in secure care. In particular, within Private Mental Health Hospital 3 there was evidence of a significant potential safeguarding concern involving a staff member. This was responded to and investigated by the hospital. However, there is significant learning in relation to this incident generated through the police response to this concern. This includes issues in relation to both communication and resourcing.

More generally, the SAR considers the challenges in providing treatment and care for people who present with similar behavioural challenges as Miss J. It is noted, for instance, that there was very little evidence of Miss J receiving evidence-based recommended psychological treatments, specifically Dialectical Behaviour Therapy, at least until Miss J was admitted to Private Mental Health Hospital 1. However, even at Private Mental Health Hospital 1, where it was intended that Miss J would indeed receive such treatment as part of her care and treatment plan, there was evidence that insufficient resourcing impacted on the quality of delivery of this treatment. The potential reasons for this, and in particular the lack of a specific framework to ensure that NHS-commissioned units are appropriately resourced to provide such treatments, and do indeed deliver such treatments in a way that is in line with best practice, are considered as part of wider learning through the SAR.

Similarly, the SAR considered the fact that Miss J was prescribed antipsychotic medication for most of her period of detention. There was little evidence of systematic assessment of the benefits of this medication within the clinical records, which the panel considered surprising given the wider national recommendations suggesting that antipsychotic medication for people with Borderline Personality Disorder should be avoided. There is potentially learning here also for other units, including on a national scale, although better data as to the wider frequency of use of antipsychotic medication in people with Borderline Personality Disorder may be needed to identify the extent to which this is a broader concern.

The nursing and staff experience of working with self-harm was also a theme considered within the SAR. It is noted that the management and staffing response to repeated self-harm is likely to be incredibly stressful and emotive for staff members themselves. Over time, in the face of repeated incidents of self-harm, it is possible that staff members may become desensitised to such incidents, which carries a risk that they may become less effective in their response, recalibrate internal parameters of risk, or respond to further incidents of self-harm with a less robust

response than would be ideal. This is a problem that requires further research. However, these risks may be accentuated in environments where the clinical workforce is depleted or where clinical leadership is absent or invisible. There was evidence of both of these concerns considered by the SAR Panel. Therefore, the SAR also recommends consideration is given to the inclusion of minimum workforce standards, reflecting both leadership and the wider multidisciplinary team, being embedded within existing quality and commissioning standards.

In regard to the specific incident of self-harm which ultimately resulted in Miss J's death, the panel considered a detailed analysis of this event provided as part of an Independent Investigation commissioned by the provider. The panel also considered further information from the provider about the timing of the staffing response. The Independent Investigation provides within it a number of recommendations, and the SAR Panel is minded to lend its support to these recommendations. The SAR Panel considered that the context of this incident of self-harm was connected to a wider process of behavioural and emotional destabilisation that had commenced towards the end of 2019, and which, in turn, appeared to be connected to stress experienced in relation to three key potential issues (a relationship breakdown, her sister's illness, and a period of leave to visit her family which she ultimately felt was proceeding too quickly). The broad unavailability of Dialectical Behaviour Therapy treatment unfortunately coincided with the experience of these stressors, and the lack of leadership on the ward may have contributed to her experience of her leave to visit her family not being responded to. The view of the panel was that the primary learning here related to these broader contextual factors as opposed to the immediate staffing response towards the incident itself. The panel noted the difficult reflection that Miss J had tied ligatures on hundreds of occasions prior to the incident which led to her death. There was nothing fundamentally different about this incident. Furthermore, it was not clear whether her intent at this point had indeed been to end her life; the panel reflected on the possibility that Miss J had significant ambivalence about this, or, alternatively, the ligature had been an intended act of self-harm which had been miscalculated.

Finally, the panel considered issues of cultural competency and the involvement of Miss J's family in her care. On this latter point, the primary reflection is that Miss J's family were not involved because Miss J gave clear instructions that she did not wish them to know the details of her care or treatment. Nonetheless, there were potentially missed opportunities here, particularly in the decision-making around the granting of leave to the family home. Similarly, whilst there was some evidence of efforts to adjust or adapt to Miss J's cultural needs, it is not obvious that these were fully considered.

Despite the length of the report, the SAR has had to necessarily be selective about the areas that it prioritises for consideration, and it has focused on making recommendations which it believes are most likely to reduce the risk towards other clients who might similarly require admission or detention in a secure hospital setting, and which have the potential broadest scope. Whilst much of this learning may be somewhat specific to secure inpatient settings, it is also possible that other settings, particularly other institutional settings, might also benefit from aspects of this learning. In addition to the formal recommendations, the report also highlights some specific recommendations for future research, which may also, over a longer time frame, work to support future learning.

These include:

1. Research considering whether there is a risk that clinicians may have a tendency to under-estimate the likelihood of a length of admission for patients

with particular characteristics (e.g. younger age, personality disorder diagnosis).
2. A systematic literature review considering the evidence base for the effectiveness of 'close observations', in particular the use of 1:1 observations.
3. Development of 'minimum quality standards' for the assessment of Learning Disability and Personality Disorder, which should be clearly auditable to allow assurance of practice.

There is one final point. Contextually, it is important to note that Miss J's death occurred *before* the primary social impact of the global pandemic, and, in particular before the national lockdown which commenced in March 2020. Whilst the pandemic has undoubtedly been a contributory factor in the time taken to complete the SAR, the reader must place the learning and recommendations, and Miss J's experience, within this context. Whilst this context is not of any fundamental relevance to the learning derived in this report, it is emphasised that problems of resourcing and communication are, in a 'post-pandemic' context all the more relevant.

The Independent Author is grateful to the assistance of the SAR Panel and the time and commitment given by senior clinicians and professionals in ensuring the process of the SAR was meaningful and most likely to make an impact. Moreover, the author wishes to formally document his thanks to Miss J's family who provided helpful information in contextualising the SAR and helped the panel and the author better understand Miss J's personal circumstances. The hope of the panel and the author is that the learning derived in the present report will support learning that improves practice, and so consequently reduce the likelihood of another family experiencing such tragic loss in such difficult circumstances.

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Recommendations

1.1 Based on the above analysis, the SAR panel have agreed a number of recommendations to support future practice and learning. These recommendations are made to the Board to consider and subsequently oversee.

NB: please also refer to the document explaining the identified themes for the 6 x SARs published in November 2022.

Recommendation 1: Private Mental Health Hospital 1 in Essex

1.2 It is recommended that Essex Safeguarding Adults Board review and consider evidence that Private Mental Health Hospital 1, Essex has completed and responded to all recommendations made in its internally commissioned Independent Investigation. Of paramount importance is

assurance around clinical leadership and appropriate staffing, which is to include qualified psychology staff and appropriate Responsible Clinician cover. This should include both current staffing levels and strategic workforce plans. We make three further observations:

- The panel supports the recommendation in the independent Investigation that regular Reflective Practice groups are instigated at Private Mental Health Hospital 1, Essex and operated on a regular basis. The panel however does not view it as vital that reflective practice groups are provided by a particular type of psychotherapist (as suggested in the Independent Investigation). Such groups may be one way of buffering against the emotional adaptations that staff might experience in working with a difficult client group. The key considerations of delivery are that the person is sufficiently experienced (including in working in inpatient settings), and the format of reflective practice delivery is clear to all staff and embedded into routine ward practice. An external facilitator may be useful for avoiding 'blind-spots' and providing a counterbalance to dominant 'ward culture'. However, if an external staff member is used, clear lines of accountability must be drawn up such that any discussions about individual patients have the ability to impact care plans.

- The board should request specific further detail on the developments in policy, and application of the policy, regarding the use of intermittent observations.

- The board should additionally request evidence of sustainable workforce resourcing to enable delivery of DBT according to the operational plan, presuming that this is to remain part of the clinical offer. This must include appropriately trained staff, regular skills practice, and individual therapy. The recording of DBT based activity needs to be designed to allow later audit, and audit mechanisms should be built into unit policies such that any period where DBT activity does not occur (i.e. because of unplanned cancellations above a specific threshold) is appropriately identified and escalated.

1.3 The panel are grateful for Private Mental Health Hospital 1, Essex's decision to commission an Independent Investigation, which was clearly a comprehensive and extensive piece of work and made the task of the SAR panel much more straightforward. This is to be commended as an area of good practice.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)

Recommendation 2: Safer Staffing

1.4 The intention of this recommendation is to ensure that a formal mechanism exists to ensure that inpatient mental health providers are required to provide appropriate staffing to allow them to deliver the clinical services, therapies and treatments which form the principal basis by which the service aims to support the patient's recovery. There are three potential avenues suggested to the board, noted below:

1.5 The board should consider making representations to colleagues in the Department of Health or NHS Improvement, who are involved in developing the approach to safer staffing for Mental Health wards. The request should be that, following the learning from the present SAR, consideration is given to including both senior clinical leadership and wider elements of the MDT, including psychology staff, as well as Responsible Clinicians, in the minimum staffing numbers for a specific ward. Given the frequency of monitoring and reporting in the Safer Staffing framework, this would subsequently support commissioners in ensuring that providers had sufficient staff to ensure delivery of evidence-based therapies to detained patients.

1.6 An additional or alternative approach could be made to the Clinical Reference Groups (CRGs) who set the Low, Medium and High secure service specifications.[1] These service specifications are used to define the expectations of the commissioners for providers. Whilst these standards currently require units to have qualified psychology staff and other multidisciplinary professionals in place, as well as senior clinical leadership, they do not specify a minimum number, ratio or formula to assure adequate numbers of such staff. Such a formula could be developed for different wards based on bed numbers and expected clinical need, considering recommendations for treatments in NICE guidance, for instance.

1.7 Finally, a similar approach could additionally or alternatively be made to the Royal College of Psychiatrists Quality Network who set quality standards for Low and Medium secure units. These standards are used for the process of external 'peer review'. Whilst these standards also currently require units to have qualified psychology staff and other multidisciplinary professionals in place, as well as senior clinical leadership, they also do not specify a minimum number, ratio or formula of such staff.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems & Theme 5: Improving interagency communications between Health and Social Care)

Recommendation 3: Transfers of Care – Quality of Clinical Assessment

1.8 When a person detained under the Mental Health Act is transferred between units for any clinical rationale (e.g. because of apparent Learning Disability, or to obtain specialist psychological treatment), it is important to ensure that the problem or diagnosis has been assessed in line with both professional and national guidance.

1.9 Whilst the primary responsibility for ensuring that a given clinical assessment rests with the clinician who conducts the assessment, the present SAR highlights the potential adverse consequences if there is a failure in this process. In the present case, had commissioners, at the point of referral for transfer been required to check 'on what basis is the diagnosis of Learning Disability made?', it is quite possible that some of

[1] https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c02/

the deficits in this assessment would have been identified. In the present case, it is believed that Miss J's commissioners were NHS England.

1.10 A suggestion as to how to improve practice in this area would be for commissioners to utilise specific questions that must be answered in the process of allocating a bed, for instance:

- If a Learning Disability is a central component of the client's clinical presentation, does this diagnosis rest on a valid cognitive assessment including assessment of functional ability?
- If a Personality Disorder is a central component of the client's clinical presentation, has this diagnosis been reached following an assessment involving use of a structured and validated assessment tool (e.g. the IPDE[2])?
- If a specialist psychological treatment approach is a key rationale for the transfer, is there clear evidence that the provider has the appropriate resource, workforce and clinical expertise to deliver the treatment in line with the appropriate treatment model?

1.11 Alternatively, similar questions could be incorporated as mandatory questions to be answered, where appropriate, by a senior clinician who is asked to conduct a gatekeeping assessment.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems & Theme 5: Improving interagency communications between Health and Social Care)

Recommendation 3b: Transfers of Care – Ability of Receiving Unit to Provide Care and Treatment

1.12 Where an inpatient mental health unit is identified by commissioners to address a particular clinical need, it is important that there are clear audit mechanisms that allow rapid identification of any failure of a unit to actually meet that identified need. For instance, commissioners need to be able to identify if resource gaps in units that they commission mean, for instance, that DBT interventions are not being provided effectively or appropriately. This level of scrutiny needs to go above and beyond the 'appropriate treatment' test in the Mental Health Act, which has an inherently very 'low bar'[3] – i.e. the focus should be on whether the unit has the resources and is meeting the full range of treatments and therapies recommended within the care plan. This recommendation is likely to require further consideration and review in light of the existing mechanisms for quality control and audit conducted by NHS England and other bodies who might commission inpatient mental health care.

[2] This is the International Personality Disorder Examination which is a validated tool for conducting diagnostic assessments of Personality Disorder.

[3] Because the Appropriate Treatment Test includes such a vast range of treatment, it is quite possible to argue that somebody meets the test (and thus detention is warranted) when only a very limited portion of an overall effective treatment package is offered, for instance.

(Links to Theme 1: Challenges when working with those who experience Complex Needs)

Recommendation 3c: Transfers of Care – Information Sharing

1.13 Because there was evidence of slippage and variation in the amount of information about Miss J that was shared between her different admissions, it is recommended that a standard set of minimum documents are identified which are expected to be shared for all transfers of care. Hospitals should not accept referrals without these documents being provided prior to admission. These documents should include risk assessments, previous CPA minutes, relevant historical records, reports produced by the Responsible Clinician for official purposes (e.g. tribunals), psychiatric reports, psychology reports, social circumstance reports and safeguarding records. The CRG or the Quality Network (mentioned in Recommendation 2) could be approached to consider this as part of minimum standards.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems & Theme 5: Improving interagency communications between Health and Social Care)

Recommendation 4: Use of Antipsychotic Medication in Personality Disorder

1.14 There was evidence in the current case of antipsychotic medication being prescribed over a long period, which appeared to be at variance with the spirit of NICE guidance which suggests that such medication should not be used for treatment of personality disorder over the medium or long term.

1.15 There are potential parallels with this issue and the issue of the overuse of antipsychotic and other psychotropic medication in people with Learning Disability. This has been addressed on a national scale through an initiative known as STOMP (Stopping Over Medication of People with a Learning Disability, Autism or Both).[4] STOMP has involved a range of national partners developing guidance, resources and support for patients, families, and health providers to raise awareness of the overuse of medication.

1.16 Such an approach may also be beneficial in addressing potential overuse of antipsychotic medication in people with a personality disorder. However, at present it is unknown whether Miss J's case is representative of practice more widely. We therefore recommend that providers of inpatient mental health care are supported or encouraged to undertake an audit of the use of antipsychotic medication in people whose primary diagnosis is of personality disorder. One recent audit which was published by Dudley et al (2021)[5] and is potentially a good template for providers to follow. A larger

[4] https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/
[5] https://doi.org/10.1192/bjo.2021.841

scale audit (i.e. a national audit) would provide the most helpful data but consideration would need to be given to the best way of achieving this.

1.17 We would also suggest that a key component of any such audit would be to examine the extent to which the benefit and impact of such medication is assessed in an objective manner. In respect of psychotic symptoms, where these occur, for instance, this could include the use of psychometric scales assessing preoccupation or distress with symptoms. Where behavioural disturbance is part of the presentation, it should include quantitative measures of the frequency and severity of behavioural incidents over an appropriate time period. Such approaches are likely to be far less susceptible to bias than a clinician's 'impression' of improvement gained from, for example, a brief Mental State Examination.

(Links to Theme 1: Challenges when working with those who experience Complex Needs & Theme 5: Improving interagency communications between Health and Social Care)

Recommendation 5: Essex Police

1.18 It is recommended that the Board hold Essex Police to account for the recommendations made within the Essex Police IMR, in particular the joint review of safeguarding practice outlined.

1.19 In addition, the SAR panel recommend that specific attention is given to the staffing in the ASAIT, and that the Board request assurance on actions taken to ensure adequate staffing in this team. The IMR indicates that staffing levels in this service were impaired and contributed to the concerns raised in section 14.0 (in particular section 14.8 onwards).

1.20 In addition to reminding partners of the use of the A901 form, it is recommended that an audit in their use is conducted. This audit should consider whether there is variation in their use between local partners. The results of this audit should be considered by the Board. The Board should then require assurance from partners if evidence indicates the A901 form is not being used to report crimes as intended.

1.21 It is understood that one positive change which has already occurred in Essex Police is the establishment of embedded Police Constables within all Criminal Justice Mental Health Units (Low and Medium Secure Units) in the region. These officers are intended to act as a 'first point of contact' for criminal justice issues and may potentially mitigate against the risk of errors such as those which occurred in the present case.

1.22 The Independent Author notes that the IMR produced by Essex Police is itself an example of good practice. The IMR is clear, thorough and conducted by an independent author with significant expertise in the area. Essex Police are to be commended for the high quality of this report.

(Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)

Recommendation 6: Mental Health Act – Nearest Relative

1.23 Given the analysis in Section 15.0, it is recommended that the board consider responding to the expected second consultation of the proposed Mental Health Bill following the previous White Paper. A specific point about the determination of the Nearest Relative for care leavers could be a relatively specific but helpful point for patients such as Miss J.

(Links to Theme 1: Challenges when working with those who experience Complex Needs)