North Somerset Safeguarding Adults Board Executive Summary

Safeguarding Adults Review: Learning from the circumstances of the deaths of Abi and Kim

Introduction

This review was commissioned by the North Somerset Safeguarding Adults Board (SAB) and the reviewer was appointed in July 2021. This was over a year after Abi's death by suicide on Knightstone ward. Between the SAB's first contact and the time of the appointment of the author Kim died by suicide on the same hospital ward.

The purpose of having a SAR is *not to reinvestigate or to apportion blame, but to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults; review the effectiveness of procedures; inform and improve local inter-agency practice; improve practice by acting on learning and highlight good practice.*

North Somerset SAB state that *"the council and our partner organisations will apply the following principles to any SAR: We will apply a culture of continuous learning and improvement across all safeguarding organisations; We will pursue a drive to identify opportunities to improve and promote good practice; We will create a review approach proportionate in scale and complexity to the issues in question; We will appoint individuals independent to the organisation or individual under review to manage the investigation; We will encourage professionals to contribute their opinions to any review without fear of retribution for actions taken in good faith; We will encourage families to contribute to the review. We will keep them adequately and sensitively informed at every step of the process"*[1].

Abi and Kim - a pen picture

Abi

Abi grew up in Devon with her mum, dad and sister. Her parents separated when she was 13. She attended a grammar school. She worked at a ski resort in Austria as a qualified ski instructor and later began a social work degree back in the UK but did not complete this. She was outdoorsy and active, enjoying skiing, snowboarding, scuba diving, and travelling abroad. She worked in an outdoor shop and also at an ultrasound clinic. She is described by those who knew her well as clever, funny, kind and a good friend, who often supported and advised others experiencing mental health crises. She lived most of her life in Devon and wanted to go back there. She is much missed by her family and friends.

Kim

Kim grew up in South Africa. She worked as a paramedic after leaving school, then moved to the Netherlands in her early twenties with her husband, where she worked on a flower farm, before they moved again to the UK together. They had three children, the youngest of whom was born in 2014. She spoke Dutch Afrikaans and English. Kim's Christian faith was important to her and the church in the village where she lived still provides significant support to Kim's husband and their children. Kim's parents also live in the UK. Kim is much missed as a mother, daughter, wife and friend.

[1] North Somerset Safeguarding Adults Board website

Circumstances leading to the review.

Abi died by suicide on the night of 25th April, 2020, on Knightstone ward, Cygnet hospital, Kewstoke. She had ligatured using an item of her clothing in her bedroom. She was a 27 year old White British woman. She had been placed there from Devon, her home area and had been there for just under 6 months. She was detained under Section 3 of the MHA at the time.

Kim died by suicide on the night of 20th May, 2021, on Knightstone ward. She had ligatured using an electrical cable in the communal laundry room. She was a 39 year old South African woman. She had been placed there from Wiltshire, her home area and had been there for less than a month. She was also detained under Section 3 of the MHA at the time of her death.

Knightstone ward is a 15 bed women's ward, a tier 4[2] specialist personality disorder unit. It only admits women who are detained under the MHA, almost all of whom are placed out of area i.e not ordinarily resident in North Somerset. It forms part of a much larger, 70 bed, hospital site at Kewstoke, which comprises several different types of wards, and is one of many hospitals run by the independent health provider Cygnet across the UK. It is exclusively commissioned by the NHS and has no private patients. It sits in the Weston Super Mare area of North Somerset.

As both women died while resident in North Somerset the North Somerset SAB have commissioning responsibility for both SARs and S42 enquiries[3] under the Care Act.

Specific areas of focus and scope of the SAR

At micro and meso levels it would aim to understand the events leading up to the deaths of both Abi and Kim, with a specific focus at the time of the review around the culture, management and relationships on Knightstone ward, Cygnet hospital, Kewstoke. At a more macro level it would aim to consider the practice of out of area placements, particularly for women with a psychiatric diagnosis of Emotionally Unstable Personality Disorder (EUPD). The involvement of commissioning and management staff as well as national bodies would support this.

Questions that were asked in relation to **out of area placements** included: *How are decisions made about initiating and reviewing specialist and/or out of area placements and how collaborative are these decision-making processes? How are the risks of such placement moves weighed against their potential benefits? How are disagreements about aims, expectations and progress of placements managed? How are family, friends, relevant professionals and service users involved in decision-making and are they able to visit placements beforehand? Are all relevant legislative frameworks, including the MHA, MCA and HRA adhered to and are organisation and area roles and responsibilities for these clearly understood? At commissioning and management levels how are out of area placements agreed to, reviewed and overseen? What is the relationship between the local authorities, mental health trusts and independent health providers where multiple agencies are involved and how well understood and navigable are these relationships? How do these relationships relate to the national governance of Cygnet, the CQC and NHS England? How do commissioning and funding arrangements impact on working practices within Cygnet Kewstoke?*

[2] Mental health services (non-forensic) are divided into four tiers, with tier 1 being primary or universal care services and tier 4 being highly specialist

Questions in relation to seeking to understand the **ward culture and environment in relation to relationships** included: *How does psychiatric diagnosis, and in particular a diagnosis of 'Emotionally Unstable Personality Disorder' influence the way in which decisions about risk are made? How do staff and service users understand this diagnosis? How do they feel that this diagnostic context influences the culture of the ward? How does it impact on the involvement of service users, families and friends in decision-making? How are service user interests and plans supported? How are healthy relationships supported amongst staff, service users and between staff and service users? How has this been managed during the Covid crisis where staffing has been impacted? What are the effects of the use of agency, temporary and bank staff on the ward? How safe and supported do staff feel? How safe and supported do service users feel? Are individual, peer, reflective and external models of supervision supported? How do staff understand and use professional curiosity and defensible decision-making processes?*

Questions asked in relation to **responsibilities on the ward, its culture and environment** included: *How is staff training and development supported? How do staff understand safeguarding principles and processes and their responsibilities in relation to safeguarding? How do staff conceptualise, understand, work with and record their work on the ward, particularly in relation to risk and recovery? How do staff understand their responsibilities in relation to legislation including the MHA, MCA and HRA? How embedded is a rights-based approach and how well used are advocates? How able do staff feel to raise any concerns that they have? What processes support both ad hoc and formal service user feedback? How are staff and service users supported following serious incidents and deaths and how is the impact of trauma recognised and understood?*

Questions relating to **ward staffing, governance and oversight** included: *How is staff training and development supported? How do staff understand safeguarding principles and processes and their responsibilities in relation to safeguarding? How do staff conceptualise, understand, work with and record their work on the ward, particularly in relation to risk and recovery? How do staff understand their responsibilities in relation to legislation including the MHA, MCA and HRA? How embedded is a rights-based approach and how well used are advocates? How able do staff feel to raise any concerns that they have? What processes support both ad hoc and formal service user feedback? How are staff and service users supported following serious incidents and deaths and how is the impact of trauma recognised and understood?*

It was agreed that the scope of the review would include **placement decisions for Abi and Kim as well as their preceding contact with community mental health services as well as their time on Knightstone ward and their deaths there.**

Who was involved in the SAR?

Chronologies and reports were received from the following agencies:

Cygnet hospital, Kewstoke

North Somerset SAB

University Hospitals Bristol and Weston Foundation NHS Trust

Giffords GP surgery, Wiltshire

Avon and Wiltshire Mental Health Partnership NHS Trust

Avon and Somerset Police

South Western Ambulance NHS Foundation Trust

Approved Mental Health Professional Services

Devon County Council

Devon Partnership NHS Trust

NHS Devon Integrated Care Board (previously Clinical Commissioning Group)

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (previously Clinical Commissioning Group)

Care Quality Commission

Involvement of staff and women on Knightstone Ward:

The author wrote two different letters for staff working on Knightstone ward and for women detained on Knightstone at the time of the SAR being undertaken. In May 2022 the author visited Knightstone ward on two separate occasions. Letters to service users were distributed with the support of the safeguarding lead, who also brokered introductions to women on the ward and facilitated the support of a nursing staff member who the women knew well. The author met privately with four women, two of whom were on the ward at the time of Kim's death. One woman had been on the ward at the time of Abi's death, she had left and been readmitted but didn't feel able to talk to the author.

Involvement of family and friends

The involvement of family and friends is central to this SAR and its learning and the author has tried to centre their voices within this report.

Abi's parents are separated. Both have been involved in this SAR. They discussed other family members but did not identify anyone else they thought that the reviewer should be speaking to. Abi's father was her Nearest Relative (NR) under Section 26 of the MHA, a role which confers specific legal rights, including the right to oppose detention under the MHA and the right to discharge the patient from their Section. Abi's father was an involved NR had previously exercised these rights.

Kim had a husband and three young children. Her husband was her Nearest Relative under the MHA but in this SAR and other processes he has deferred to Kim's friend, who also acted as her advocate when she was alive. The author met with Kim's friend who provided a full account of her views.

When the author spoke with Abi's parents and Kim's friend neither of them were aware that another death had taken place on the ward.

The circumstances of Abi's mental health care and placement

Abi had begun to exhibit mental health difficulties at school by 11 and was working with a psychologist. She began working with CAMHS aged 13. At 17 she had a 4 month admission to a CAMHS inpatient unit for an eating disorder and another 4 month inpatient admission under the MHA a few months later. She was diagnosed with depression and worked with Icebreak young people's service in Plymouth. She had periods of time as an adult with little contact with mental health services. She began a social work degree and returned to Devon after this, then had contact with mental health services again.

She had diagnoses of Emotionally Unstable Personality Disorder (sometimes called Borderline Personality Disorder), alcohol misuse and a historic eating disorder. She had attempted suicide over 80 times.

From January 2018 onwards she had significant contact with mental health services in the community and multiple inpatient admissions. Safeguarding concerns were raised by family about some of this care prior to Abi's admission to Knightstone ward on 29th November 2019.

The admission to Knightstone and circumstances of Abi death

Abi's care plan was written on 6th December 2019. It was reviewed 6 times, the last time being 25th March 2020. She also had nursing management plans written on 23rd January 2020 and 18th April 2020, following incidents that resulted in an increase in observation levels.

Her care plan primarily involved Dialectical Behaviour Therapy (DBT) groups on the ward and 1:1 DBT sessions with a psychologist. She stated on 19th December that she didn't want to work with a male psychologist and a stated preference for working with women was long-standing. She was accompanied by a female chaperone to an appointment on 30th January but she stopped her sessions on 26th February. A clinical decision was made on 3rd March that she should continue to work with a male psychologist to establish a relationship with him and reduce 'therapy interfering behaviours'. She was offered a female psychologist on 15th April.

On 17th April following a ligature attempt resulting in attendance at the Bristol Royal Infirmary ED Abi was moved to the 'Bluebell' area of the ward, a 'sterile' area and her observations increased to 1:1.

There were two further incidents of head banging, where Abi was given rapid tranquilisation, before observations were reduced to 'high level intermittent' at her ward round/MDT meeting on 23rd April.

On 22nd April she attended her only session with a female psychologist.

On 23rd April at the MDT meeting Abi's mother raised concerns about her previous ligature attempt, head banging and hiding medication.

On 24th April there was another incident requiring rapid tranquilisation.

On 25th April she attended Olanzapine' after jumping and hurting her foot. On returning with staff she went to the quiet lounge, self-soothe room, her bedroom and then the TV lounge. She was observed writing on a piece of paper at 9.43pm. She went to her room and switched the lights off at 9.46pm. At 10pm a male staff member knocked and called and stayed outside her door for 23 seconds, before asking a female staff member to enter her room.

On 25th April 2020 at 10pm Abi was found unresponsive on her bed with an item of clothing tied around her neck. Emergency responders were called and the clothing was removed. Paramedics arrived at 10.19pm and took over CPR from staff. She was confirmed dead at 10.55pm.

The circumstances of Kim's mental health care and placement

As a child Kim was sexually abused by a close family member. She self-harmed by punching herself in the abdomen and took an overdose aged 10 but did not appear to have any contact with mental health services until 2016. In 2014 during her third pregnancy she developed Graves disease and then multiple resultant serious physical health difficulties following the birth of her child. In October 2016 her GP referred her to secondary mental health services stating that she was self-harming with suicidal intent. From then onwards Kim had significant involvement with community and inpatient mental health services. On 17th March 2021 while detained under S3 of the MHA. Kim's community CC emailed documentation for the April funding panel for a specialist Tier 4 placement but it was asked that a decision be made sooner due to bed pressures. Two placement options were presented. Between 12th and 14th April the panel engaged in asking questions. They were told that Kim's preference and that of her family was for Knightstone because it was geographically closer to home, they were impressed by its CQC report and because of its treatment options which she was under the impression could involve animals. The panel agreed to Knightstone and funding confirmation was given on 20th April. On 23rd April Kim was transferred to Knightstone ward.

The admission to Knightstone and circumstances of Kim's death

Kim had started to attend an OT group on Knightstone, had spoken with staff and watched tv with other women on the ward. She said that she found 1:1 observations intrusive and her observations were reduced to 15 minutes in communal areas on 7th May.

On 10th May she was moved to a bedroom near the nursing office so that she could be observed with the door open. On 16th May she cut herself superficially with a piece of cable tie. On 17th May she completed an OT assessment. At some point between 16th and 19th May she tampered with her door, removing a small piece of door furniture and hiding it in a tea bag box. On 19th May she broke the glass on her ipad screen with a USB charger and also punched herself in the face.

On 20th May at ward round she said she had continued thoughts of self-harm and wanting to die. She had enjoyed a family visit, wanted escorted leave, requested that her cardiology appointment be rescheduled, agreed to see the psychologist regularly and was reviewing having EMDR. Her observations were reduced to 30 minutes, it was agreed that she could have 30 minutes escorted leave and her Olanzapine (an anti-psychotic medication) was increased. She used her leave that day and had an Occupational Therapy (OT) session.

Staff statements report that Kim was last seen by staff in her room at 10.20pm on 20th May. At 11pm staff were unable to locate her. It was escalated to the nurse in charge for the team to search the ward. At 11.10pm she was found behind the door of the unlit laundry room, on the floor, with an electrical cable tied around her neck. The cable had been suspended by hanging the plug over the top of the closed door. The alarm was activated, emergency responders arrived, the cable removed and CPR commenced. SWAST paramedics arrived at 11.25pm and took over CPR. She was confirmed dead at 11.55pm.

Completed and Outstanding External Processes

Police involvement led to no criminal proceedings into either death.

The CQC are the regulator for Cygnet Kewstoke. There have been inspections of Cygnet, Kewstoke (all wards) which were as follows: 2016 routine, 2017 3 x follow ups, Feb 2019 routine and August 2019 focussed. Following Abi's death, the hospital were on 'enhanced engagement' and remained on the CQC risk register for monitoring. Following Kim's death, the CQC visited the hospital under their Specific Incident Framework and found '*no further potential for any areas of provider failure identified*'. The most recent CQC contact was an unannounced focused inspection around two other wards at Kewstoke hospital, Nash, and Sandford. These took place on 31st August 2022 and 3rd October 2022 following concerns and deaths about various patient safety issues and feedback from stakeholders. The hospital remained on 'enhanced engagement' and was on the local CQC risk register throughout 2022. All inspection details and ratings are publicly available.

A Root Cause Analysis (RCA) into Abi's death was undertaken by Cygnet and completed on 17th July 2020. No Root Cause was identified, however. The report stated that it found quality issues and made recommendations for service improvements but did not find any *"blatant failings"* or *"a direct causality that is attributed to the care delivery problems identified."* It concluded that there were *"elements of the incident that were preventable, given the clinical history, presentation and risk"* but that the clinical team were *"justified in their approach to managing Abi's risk whilst balancing least restrictive practices to aid her treatment. It is therefore ascertained that the event could not have been entirely preventable".*

A Root Cause Analysis into Kim's death was undertaken by Cygnet and completed in November 2021. The Root Cause was given as being *"that the ward environment and staffing issues facilitated Kim's plan to harm herself. She had a clear plan and utilised the opportunity to fulfil it due to her view of the ward arrangements".* The report's conclusions noted that the observation chart did not include a record of 30 minute observations from 6pm on 20th May and she was stated to have been observed missing during hourly observations. Kim had previously stated that 15 minutes was not long enough to kill herself and that she would wait for a *'weak link'* on the ward to carry out her plan to die. The 2 minute lapse in supervision while in the laundry room was deemed as *"crucial",* even though it is considered possible that she may still have been able to place an item in the lock as this was deft and quick. She was being supervised by a male agency member of staff who had never worked on Knightstone before.

A S42 enquiry[4] into Abi's death was undertaken by North Somerset safeguarding team in May 2020, with a resulting whole service enquiry concluding in November 2020.

A S42 enquiry into Kim's death was undertaken by North Somerset safeguarding team in April 2022.

A coroner's inquest into Abi's death concluded in May 2022, with the jury in the coroner's area of Avon concluding that Abi died by suicide.

A coroner's inquest into Kim's death concluded in April 2023, with the jury in the coroner's area of Avon concluding that Kim died by suicide contributed to by neglect.

[4] A Section 42 enquiry is any action that is taken (or instigated) by the local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

Following Kim's death staff at her GP surgery also discussed her death at a Significant Learning Opportunity meeting.

Learning and Recommendations

There were elements of good practice in the care of Abi and Kim and multiple changes have already been made by many agencies involved, including Cygnet and specifically Knightstone ward, but their deaths were tragic events that should not have happened. Both were detained under the MHA as a result of the chronic suicide risks they posed to themselves in the community. They both died in a specialist personality disorder placement after years of presenting with similar risks at home and in non-specialist adult acute and PICU inpatient environments. Both took their own lives at night, having made considered and sadly accurate assessments of the staffing context and physical environment of the ward so as to maximise the likelihood of being able to complete their suicide attempts.

Independent health providers commissioned by the NHS are the sole providers of such specialist tier 4 personality disorder placements in the UK. The learning and recommendations focus on these contexts of specialist and out of area care are complex and the systemic issues that need to be given ongoing consideration.

It is suggested that these recommendations are reviewed by the North Somerset SAB in a year's time and that they are also considered at a national level alongside learning from similar concerns being raised elsewhere[5].

Additionally, the NHS Long Term Plan[6] is likely to have major implications for the provision of all mental health services. This comes alongside the signalling of a culture shift in the provision of care for people with an EUPD diagnosis by the Royal College of Psychiatrists[7], which builds on evidence highlighting that significant change is needed across these services.

Good practice identified across agencies

All agencies involved have been subject to national recruitment and retention challenges for years and the Covid-19 pandemic created new and exceptional difficulties for services, particularly those providing inpatient care and it is important that this context is acknowledged.

Kim's placement at Knightstone was agreed to by the funding panel swiftly, outside of the monthly panel meetings. Although Knightstone was a more expensive placement option than the other placement option presented it was agreed to because it was closer to her home and the preferred option for her and her family and friends, showing good consideration for their views.

Some staff within Devon Partnership Trust were able to establish good relationships with Abi, demonstrating compassion and hope and involving her in decision-making around risks even when her risks to herself were very high. There was evidence of good communication between all teams

[5] https://www.bbc.co.uk/news/uk-59964353
[6] https://www.longtermplan.nhs.uk/
[7] Services for people diagnosable with personality disorder, Position Statement, PS01/20, January 2020https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2

within DPT. There was also evidence of real engagement with the complexities of issues around information sharing and consent when Abi changed her views about what information could be shared with who. Abi's father was particularly well engaged with as her NR and Abi was also clearly made aware of her rights under the MHA. DPT undertook and implemented learning from both RCA processes undertaken while Abi was in inpatient care on Delderfield ward.

The response by Avon and Somerset police to the death of Kim demonstrated some learning since the death of Abi. They also highlighted a sensitive, professional and compassionate response by attending officers at both deaths that was mindful of the emotional impact on hospital staff, as evidenced on body worn video. They also identified that the process for identifying potential cases for statutory review was also robust. Their response to the SAR was particularly considered and critically engaged.

SWAST paramedics fought hard to save Abi and Kim and raised concerns about delays in the response from Knightstone staff on both occasions.

One woman spoken to on Knightstone said that they had felt involved in the care planning process and another stated that there were more therapy options than on an adult acute ward, specifically mentioning bereavement counselling. Some staff were experienced by women as good and supportive and the OT timetable during the week was described as good.

1. Involvement with community mental health services and inpatient admissions prior to specialist placements

Learning

a) There were periods of time at the beginning of Kim's contact with mental health services was presenting in distress but was not taken on by her local CMHT, including after the ending of DBT sessions with IST and the sexual abuse counselling provided by the voluntary sector that she had found helpful. It is possible that this decision was informed by certain views about EUPD. She was also discharged from hospital at one point on the basis of her EUPD diagnosis, in a misinterpretation of the NICE guideline on BPD/EUPD. It is difficult for service users, families, friends and GPs to know where to access support in these instances. The existing NICE guidance[8] is that CMHTs should be responsible for the routine assessment, treatment and management of people with a personality disorder. The latest position statement from the Royal College of Psychiatrists talks about relational continuity and how this is often lost where services focus on risk management.

b) Frequent hospital transfers including to out of area beds had a particularly traumatic impact on Abi and her family. As the Devon AMHP team stated there were also implications for the care that she was being provided and for local services to know the detail of her current circumstances. It also impacted on the ability of her family to visit her. DPT are clearly prioritising reducing their numbers of out of area placements and stated in their submission to the SAR that there are ongoing discussions with NHS England/Improvement and the ICB. They stated that specific initiatives include a new adult mental health ward in Torbay; recruiting to home treatment teams; launching a First Response Service; opening a crisis house in Exeter and opening crisis cafes in Torbay, North Devon and Exeter. They reported that out of area placements from Devon have significantly reduced. Being far from

[8] https://www.nice.org.uk/guidance/cg78/resources/borderline-personality-disorder-recognition-and-management-pdf-975635141317 p 37

home on Knightstone also clearly impacted on Abi and Kim and the distance from friends, family and known care teams presented specific risks for them both.

c) Kim's difficulties were rooted in childhood sexual abuse but her physical health complications in pregnancy seemed to be the trigger for her self-harm, suicide attempts and contact with mental health services. It may be that this could have been better understood and responded to by services.

d) There were gaps in the provision of services to support families. These services may be provided in multiple ways but the provision of systemic family therapy is needed in all community mental health services. These may have been able to support Abi's family and reduce tension and conflict, much of which appeared to have been caused by a long-term involvement with services, and could also have supported Kim's family, including her children, providing a space to make sense of what was happening to Kim. Service users under mental health teams may or may not choose to attend sessions and family therapy teams may work with anyone in the service user's network.

e) There was no evidence that anyone in Abi's or Kim's social networks had been offered Carer's assessments. Local Authorities have a duty under S10 of the Care Act 2014 to consider the needs of carers. It is important that these assessments are routinely offered and that there is provision and support for carers, including access to information about their rights and explicit funds being made available for visiting relatives placed out of area.

f) There was contextual information that was missed for both Abi and Kim. There were potentially missed opportunities to link in with other services such as the sexual abuse counselling support that Kim had used and found helpful. This broadening out may also have helped to further understandings of Abi's difficulties and reduce the impact of her 'push-pull' relationships with family members.

g) It is considered that care planning could have involved families and friends and the service user view more regularly and with a long-term lens. Both Abi and Kim experienced significant trauma in the community before a specialist placement was considered and Abi and her family had asked for a placement on Knightstone years before it was considered as an option by her care team. There are both ethical and cost implications to this way of working and the service user view must be centred better. Everyone's views about the risks and benefits of a placement must be equally considered. The AWP SAR action plan regarding Kim's death states that "specialist placement decision making must be clearly recorded on RIO and audited for assurance".

h) Iatrogenic harm was a relevant factor in the care of both Abi and Kim, particularly for Abi and her family, who had been in contact with services for a longer period of time. For Abi's father these experiences exacerbated family fractures and difficulties in the family caring for Abi and working productively with mental health services. There is a need to understand people's historic relationships with services and how this may be impacting on attempts to provide current and future care.

i) A diagnosis of EUPD may be understood as a risk factor due to the stigma it carries, including attitudes from staff, and it remains contested with psychiatry. Recent research has found that healthcare workers have more negative attitudes towards people with a diagnosis of BPD/EUPD than those with other diagnoses.[9] Some services are moving away from its use to describe services for people with 'Complex Emotional Needs' or 'Emotional Intensity' for example. There remain risks associated both with the use of inpatient services and MHA detentions and exclusion from services

[9] McKenzie, K, Gregory, J and Hogg, L (2022), Mental Health Workers' Attitudes Towards Individuals With A Diagnosis of Borderline Personality Disorder: A Systematic Literature Review, *Journal of Personality Disorders,* 36 (1), 70-98

despite distress and high suicide risks and these were both evident for Abi and Kim. It is associated with a significant reduction in life expectancy and 9-10% of those with a personality disorder diagnosis will die by suicide.[10] EUPD is a diagnosis overwhelmingly given to women and is often, though not exclusively, associated with trauma and male sexual violence and its gendered aspects are significant, arguably often recreating patterns of abuse and structural power imbalances. There were ongoing questions about Abi's diagnosis, which she and her mother also requested be reviewed on Knightstone ward but this was refused. Kim was also given a diagnosis of C-PTSD by a private psychiatrist. The Royal College of Psychiatrists state that "there is a general agreement that diagnosis alone is insufficient and good care should be guided by a co-constructed biopsychosocial formulation which gives patients an experience of being understood. A diagnosis should only be made after appropriately skilled and thorough assessment, although this should not cause a delay in receiving suitable interventions and care".[11]

j) The family of Abi and Kim's friend have expressed regret at not knowing more accurate information about Knightstone prior to their placements. Kim's family and her friend in particular sought out information about Cygnet Kewstoke and were concerned on learning of the suicide of a man there detained on a different ward in 2019[12], raising this prior to the placement.

1. Recommendations

a) It is recommended that people with a diagnosis of EUPD are not excluded from CMHTs and that they are supported to build ongoing trusting relationships with a CC at an early stage in their presentation to services. Devon Partnership Trust and Avon and Wiltshire NHS Partnership Trust are recommended to ensure that their services are actively inclusive.

b) It is recommended that there is a multi-agency focus on reducing the use of out of area adult acute beds for those detained under the MHA and that SABs are involved in this work, considering the placement of people outside of their home area as a risk. NHS Devon ICB, BANES, Swindon and Wiltshire ICB and BNSSG ICB are recommended to continue to lead on working to reduce out of area placements, in line with national recommendations to do so.

c) It is recommended that there is a multi-agency focus on developing local specialist services including trauma and abuse support and women's specific services. The most recent guidance from the Royal College of Psychiatrists should be followed stating that community tier 2 and tier 3 services should be significantly developed and each NHS Trust should have a Personality Disorder Lead responsible for ensuring a coherent clinical pathway across all tiers. SABs should also be involved in this work. There should be a clear focus and strategy on reducing the need for specialist out of area placements. NHS

[10] Evans S, Sethi F, Dale O, Stanton C, Sedgwick R, Doran M et al (2017) Personality disorder service provision: a review of the recent literature, *Mental Health Review Journal* 22(2):65–82 and Paris J (2002) Chronic suicidality among patients with borderline personality disorder. Psychiatric Services, 53(6):738–42

[11] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2 p 10

[12] Failures in care for man who took his life at a private mental health unit, June 2020, https://thebristolcable.org/2020/06/revealed-failures-in-care-man-took-his-life-private-mental bristol/#:~:text=A%20Bristol%20Cable%20investigation%20by%20Matty%20Edwards%20Dominic,the%20story%20of%20how%20he%20was%20let%20down, The Bristol Cable

Devon, Swindon and Wiltshire ICB and BSSSG ICB are recommended to continue to commission and develop specialist trauma, personality disorder and gender specific services.

d) It is recommended that consideration is given to perinatal teams being able to take on women to care co-ordinate, or to support CMHT CCs, where their mental health difficulties are triggered by pregnancy, birth or complications arising from pregnancy or birth. It is more likely that these teams will be able to provide more appropriate care and have a greater understanding of the relationship between these issues and someone's mental state. AWP and DPT are recommended to consider broadening the use of perinatal mental health teams.

e) It is recommended that family therapy is accessible to all those who are under the care of community mental health services. It should still be available to families where someone is in hospital, including an out of area placement. AWP and DPT are recommended to ensure that family therapy services are available to all community mental health service users and their families.

f) It is recommended that community mental health services ensure that staff understand their duties under the Care Act. Where carer's assessments and services are not provided within integrated mental health services staff must be referring to the Local Authority. Devon County Council, Wiltshire County Council, DPT and AWP are recommended to consider how Carer's assessments are provided within community mental health services and ensure that they are provided in accordance with the Care Act.

g) It is recommended that as part of their assessment and care planning processes community mental health services do more mapping to identify key people and services involved in someone's wider support network. The service user should be at the centre of this in a process of identifying the 'team around the person'. AWP and DPT are recommended to evaluate how effectively they currently do this and to identify areas for improvement.

h) It is recommended that regular reviews are held with the 'team around the person' to reduce duplication in work and promote a more containing and consistent way of working. If someone is wanting specialist input this should be given thorough consideration in a responsive way, rather than as a reactive last resort. AWP, DPT, NHS Devon ICB and BANES, Swindon and Wiltshire ICB are recommended to review any current policies around specialist services requested by service users and families and how they relate to service user choice.

i) A consideration of iatrogenic harm should form part of all community risk assessments, including consideration of what has been harmful and ways of mitigating future harm. AWP and DPT are recommended to consider how to implement this into existing risk assessment practices.

j) It is recommended that a diagnosis of EUPD should be acknowledged as a risk factor in itself. The impact of diagnosis on an individual and their relationship to a diagnosis should be considered as part of care planning and risk assessment. Diagnosis should only form a part of the picture of someone's care and requests for diagnostic review should be considered. DPT and AWP are recommended to consider how to implement this into existing risk and care planning practices.

k) It is recommended that the North Somerset SAB and BNSSG ICB publish links to relevant information from the CQC and other sources, including SARs, about NHS providers and commissioned services within their area. This would support the choices being made by service users, families and care teams and increase transparency and better meet the requirement of the host ICB to notify placing ICBs of any safeguarding concerns about providers.

2. Specialist placement inpatient care – ward culture and environment: relationships; responsibilities; staffing; relationships with patients, their families and friends; governance and oversight

Learning

Psychiatric inpatient wards such as Knightstone need to be able to function as therapeutic environments, providing physical and psychological safety for both patients and staff. It is the view of the author that staffing issues and the high use of agency and bank ward staff present barriers to this. Women spoken to raised specific safeguarding concerns about the behaviour of some agency staff on shifts.

The Royal College of Psychiatrists state the essential workforce requirements for all disciplines working in personality disorder services as being 1. Selection of suitable staff able and willing to work at the required emotional level. 2. Good training, to understand the nature of the disorder and develop the necessary approaches and skills for it. 3. Supervision and reflective practice with adequate time to reflect on the personal impact of the work. 4. Formal and informal support (usually through healthy team functioning). 5. Personal therapy may also be required, depending on the individual circumstances. 6. Experts by experience (and carers) should be involved in training. 7. Exposure to and experience of working in or with the different elements and tiers of the whole pathway. They emphasise that tier 4 services require a way of training and working for all staff that is different to mainstream psychiatric provision and the need for tier 4 services to be embedded and functioning within wider systems of tier 2 and tier 3 treatment.

Although DBT is the primary psychological model used on Knightstone, with women having access to a range of other groups and therapies, both the NICE guideline and more recent research findings highlight relationships and the therapeutic environment to be the most significant factors for positive outcomes within personality disorder services. In the final stages of the National Personality Disorder Programme, the Department of Health commissioned a qualitative evaluation of the NIMHE pilot personality disorder service projects, called Innovation in Action (Regional Care Pathway for Personality Disorders in Northern Ireland, 2014). Its main findings were: Services designed specifically for personality disorder show: a) Human and economic cost savings, b) Prevention of continuing harm and deterioration of conditions, c) Improved level of employment and work-related activities, d) Repeat crisis presentations halted, e) Improved quality of life, f) Establishment of recovery communities and building of social capital

Required therapeutic characteristics: a) Therapeutic environment, b) Service culture and therapeutic philosophy, c) Reciprocal investment by staff and service users with shared experience

Intermediate qualitative findings: a) Improved quality of relationships and effective sense of personal agency, b) Use of social resources, c) Experience of psychological safety

Service characteristics: a) Organisational and recruitment characteristics are important for service success, b) No specific model amongst those reviewed emerged as superior, c) Services demonstrating greatest provision of, and commitment to, the fundamental assumptions and general therapeutic conditions appeared to demonstrate the most significant outcomes.

a) There was evidence during the process of the SAR of a disconnect in communication between the management of Cygnet nationally and Cygnet Kewstoke/Knightstone ward. There is ongoing significant staff turnover. At the time staff likely felt under scrutiny and the effects of this need to be

understood. Effective leadership within personality disorder services needs to be supportive and relational. Focussing on retention, particularly at management levels, would likely help to improve stability.

b) There are some concerns expressed about adherence to the MHA and MHA Code of Practice, suggesting a need for a more proactive rights-based approach. The guiding principles of the MHA do not appear to have been always upheld. Kim's MHA S3 was due to expire or be renewed at the time of her death but there is no mention of discussions about her Section with her or record of Hospital Manager's meetings. Kim's husband should have been involved as her NR and doesn't appear to have been. Abi's father also expressed concerns about his lack of involvement as NR and Abi's MHA status and he should have been involved as NR. Abi also does not appear to have been spoken to about her MHA detention being renewed.

c) There are some concerns regarding the correct use of the MCA and MCA Code of Practice. It is stated in Abi's RCA report that she had a capacity assessment regarding her finances some time before a Best Interests meeting was held but it is not clear what the decision to be made was. There is a concern that capacity being 'time and decision specific' was not fully understood by staff. There is also a lack of clarity about the Best Interests meeting and its adherence to the MCA CoP.

d) The Knightstone ward environment proved not to be safe for Abi or Kim and the women interviewed at the time of the review on the ward voiced they did not always feel safe, particularly at night. Relationships with staff that should function as protective factors were reported to have not been present often enough. It is significant that Abi and Kim both died at night and both women clearly planned their deaths and made calculated and accurate assessments of the ward environment, its staff and what would be possible. On the night that Kim died there were 3 agency staff members who were new to the ward. For Kim supportive relationships on a ward and not wanting to be found by people she cared for were important considerations in her suicide attempts. There are inherent risks in staff not knowing patients well, both in terms of understanding their behaviour and how they might best be supported and in responses to incidents when staff are unfamiliar with patients and the ward environment and these factors were present in the deaths of both Abi and Kim.

e) Observations and observation levels have been a major focus in relation to the deaths of Abi and Kim. Abi's S42 enquiry found that the therapeutic engagement within her observations fell short, in addition to the findings about poor observation records and incorrect paperwork. Kim's death also highlighted concerns about the undertaking of observations as well as decision-making around reductions in observations. The most recent systematic review of practice nationally around continuous observations on psychiatric wards shows significant variation in practice (Reen et al, 2020).

f) Women on Knightstone spoken to as part of the SAR process did not always feel that their general wellbeing was supported. There should be a focus on ensuring that Knightstone ward is a comfortable environment for women that promotes a holistic approach to health. Women should be able to sleep at night without being disturbed by alarms going off constantly and they should have access to more outdoor space as part of the ward. Different ways of thinking about promoting the ward environment as a therapeutic space should be considered.

g) There was a disconnect for Abi and Kim and their families in their experience of Knightstone and their expectations of the placement.[13] A range of therapeutic options should be part of care planning

[13] Cygnet Kewstoke brochure, https://www.cygnethealth.co.uk/locations/cygnet-hospital-kewstoke/

and clarity given about what could possibly be available (including the make-up of current staff members), when the joint care planning process is begun before the placement starts.

h) There was a lack of clarity about where to raise safeguarding concerns about the ward to other agencies, as evidenced by Abi and concerns raised about Knightstone by her mother, including on the day before Abi's tragic death. These issues were also raised in the S42 enquiry relating to Abi's death.

i) There are issues around the involvement of family and friends in someone's care. These were particularly complex for Abi in terms of her frequently changing her mind about what information she wanted shared with her mother but there was little evidence of engaging with these issues and seeking ways of fostering involvement (MHA CoP Section 10 deals with issues of confidentiality and consent and 4.31-4.44 provides guidance on the involvement of friends and relatives). There is a clear indication that services engaging poorly and inconsistently with Abi's family over the years exacerbated their difficulties. Abi's father should have been involved as NR and informed of the renewal of Abi's detention (MHA CoP 4.34). Information can always be received from family and friends without breaching confidentiality. There is a need to proactively involve family and friends to mitigate some of the risks of being placed out of area and to support the care team to better manage risks as their knowledge is as significant, if not more so, than professional expertise and a greater culture of openness is urged. There is evidence that Abi's family were either not involved or their views not taken on board sufficiently. Kim's advocate and friend wasn't sent the virtual link for her ward round on the day of her death and she did not feel included in decision making in a way that she had been when Kim was an inpatient in Wiltshire. Kim had historically let her know that she was at risk and this knowledge could have been used by her care team to support decision making and care planning as it had been previously.

j) Concerns were expressed by Abi's mother about a deterioration in her presentation on Knightstone. Questions were asked about medication and she and Abi requested that her diagnosis be reviewed. There was evidence of 'diagnostic overshadowing' in Abi's request for a female psychologist being rejected and viewed as a 'therapy interfering behaviour' likely related to her EUPD diagnosis, whereby she was effectively denied a service.

2. Recommendations

a) Cygnet are recommended that all staff receive exit interviews and that learning from these is implemented. Consideration should be given to ways of improving communication within Cygnet and developing safe and supportive relationships within teams.

b) Cygnet are recommended to ensure that all Knightstone staff receive additional MHA and MCA training. It is suggested that linking in with North Somerset Council for this could be beneficial for ensuring that the SAB is able to provide more oversight of the training that staff receive and build relationships with Council and Cygnet staff. North Somerset SAB are recommended to consider ways of supporting this.

c) Cygnet are recommended to ensure that night staffing levels are increased on Knightstone; that reflective supervision, facilitated by someone external to the ward, is provided regularly for all Knightstone staff; that the use of bank and agency staff is reduced significantly, with a view to being

Cygnet Personality Disorder services brochure,
https://www.cygnethealth.co.uk/content/uploads/2022/12/CYG-743-PD-Brochure-Web-V38.pdf

stopped, so that a core permanent nursing and support staff team can be established on Knightstone and to plan to ensure that there is always at least one female staff member on shift on Knightstone.

d) It is recommended that Cygnet undertake a whole system review of observation practice to ensure clarity about how it fits within the service aims or model of Knightstone and attempts to support service users with 'positive risk taking'. This review should involve people with lived experience of being detained. It must be ensured that there is then a consistency of understanding amongst staff undertaking observations.

e) Cygnet are recommended that initiatives to increase physical safety and a sense of safety and wellbeing on Knightstone ward are considered, such as the Safewards model,[14] used internationally.

f) Cygnet are recommended to consider greater provision of OT activities on weekends on Knightstone.

g) It is recommended that there is greater transparency about care options available. Cygnet are recommended to support choice in their liaison with placing authorities and CCs by making available specific information that is requested by service users and families. DPT and AWP are recommended to encourage this dialogue to support people moving to placements.

h) It is recommended that information about processes to report concerns, with accompanying flow charts and contact details, should be clearly displayed on Knightstone ward and provided to service users, family and friends. Home area contacts will differ for women on Knightstone but they should all understand how to escalate concerns within Cygnet and to North Somerset. North Somerset SAB, Cygnet, AWP and DPT are recommended to work together to support this to happen.

i) Cygnet are recommended that it is confirmed weekly who someone would like attending their MDT meeting/ward round on Knightstone and that virtual links are sent out in time. Greater effort and consideration must be given to ensuring that someone's wider social network is involved in their care wherever this is possible.

k) Cygnet are recommended that all staff working on Knightstone undertake EUPD specific training, preferably delivered by people with lived experience of an EUPD diagnosis and inpatient care. The Knowledge and Understanding Framework (KUF) training is the national framework commissioned by the DoH and MoJ building on the flagship 2003 NIMHE guidance, 'Personality Disorder: No longer a diagnosis of exclusion'[15]. North Somerset SAB are recommended to consider how to support this.

3. Community team oversight of inpatient care and out of area placements

Learning

a) The SAR submission from BANES, Swindon and Wiltshire ICB questions whether the reduction in Kim's observations came about as a result of discussions between Knightstone and the AWP Forensic and Specialist Placement Service but there does not seem to be any evidence of this, suggesting that

[14] Safewards, https://www.safewards.net/model/model-diagram

[15] Personality Disorder: No Longer a Diagnosis of Exclusion: policy implementation guidance for the development of services for people with personality disorder, (2003), National Institute for Mental Health in England http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf

a breadth of professional opinion as well as contextual personal opinion from her friend was missed. The Forensic and Specialist Placement Service state that one of their functions is to "monitor the provider's compliance with care quality standards and agreed care plans" and arguably it is in this context that they should have been consulted. Furthermore, the funding panel requested that the (then) CCG ensured that Kim's CC was provided with regular updates about the 1:1 observation level and that it be reduced when "clinically safe to do so". They also considered that Kim's family had "raised that transfer to a different hospital setting will likely lead to increased risk in terms of opportunity for Kim to seriously harm or kill herself and that this is considered by the provider". It does not appear that this view and the evidence from Kim's actions on Beechlydene ward were sufficiently considered by Knightstone.

b) There were seemingly different models for community CC provision for Abi and Kim, though Abi did appear to also have an IPP CC. Women placed on Knightstone will likely have multiple models of community CC. There are clearly pros and cons to either model but good relationships with the home team should be prioritised so that this can act as a safeguard in itself and so consideration should be given to flexibility around process.

c) There are clearly difficulties presented to the North Somerset SAB by the presence of a large out of area provider such as Cygnet Kewstoke. The nature of Knightstone ward means that placing ICBs will often be far away but retain responsibility for assurance visits and this presents ongoing challenges. Greater scrutiny by the SAB as well as co-operation with Cygnet is required.

d) The complexity of oversight processes may often be impenetrable for service users, families and friends and even other agencies to understand. This was highlighted by Abi's mother attempting to raise concerns about Knightstone and contacting Devon County Council the day before Abi died. Although it was not Devon's responsibility to act on her concerns, they were aware of Abi's history and should have referred her on or supported her to do so herself. Complexity of process appears to creates inherent risks, where things get missed, as well as assumptions that someone else is doing something.

e) There is an apparent needed for greater clarity of care review processes for funding bodies, to ensure an appropriate level of scrutiny that the care sought by the home team from an independent health provider and funded by the home area is actually being provided. It is should be made clear who is to report to which team and what information is required to be gathered and these funding panel reviews should be booked in advance.

f) National oversight and the role of NHS England should be clarified by the SAB. Beds at Cygnet Kewstoke are currently commissioned in various different ways, creating an additional complexity in oversight and scrutiny and making it difficult to understand who has ultimate responsibility for placements.

3. Recommendations

a) It is recommended that decisions about reductions in observation levels on Knightstone do not take place outside of agreed forums such as MDT meetings wherever possible. No decisions should be implemented before the views of the service user, their named community CC and friends and family are sought and documented as far as possible. Cygnet are recommended to update process and documentation to support this.

b) It is recommended that the community CC attend weekly MDT meetings on Knightstone to enable more effective involvement in the detail of care, the nature of the care being provided, the continued need for the placement and the views of the service user, their inpatient care team, families and friends. This would also ensure that there are fewer delays around discharge planning and conflicts around home leave. Community teams (whether specialist as in the case of Wiltshire or generic as in the case of Devon) must be sufficiently resourced to enable this to happen. DPT and AWP are recommended to ensure that this happens where they have service users out of area. Whichever model of community CC is used there must be clarity of process. The service user and their family as well as the inpatient care team should have a good understanding of the role of the community CC and know how to contact them. DPT and AWP are recommended to consider how to strengthen community CC relationships where people are placed out of area.

c) It is recommended that North Somerset Adult Care be provided with regularly updated lists of people placed out of area and their key contacts, including funder details, NR under the MHA and community CC so that they can contact the relevant people quickly if needed. Being placed out of area, either in a long-term specialist placement such as Knightstone ward or in an 'inappropriate' out of area bed, should be considered as a risk even where a decision has been made that it is necessary. North Somerset SAB are recommended to consider this and how it might best be implemented.

d) It is recommended that all service users, relevant family and friends and their care team have flow charts with contact details and the roles and responsibilities of everyone involved in their care, so that everyone understands who to contact about what and how to escalate concerns. These should be written prior to someone going to an out of area placement. Cygnet are recommended to ensure that every service user has this information. AWP and DPT, supported by BANES, Swindon and Wiltshire and Devon ICBs are to consider how to create consistent documentation to support this.

e) It is recommended that all agencies are proactive in supporting people to raise concerns with the correct agencies and explaining processes should the 'wrong' agency be contacted with safeguarding concerns. This recommendation applies to all agencies, but is likely especially applicable to Devon ICB, Devon County Council, North Somerset Council, AWP, DPT, BANES, Swindon and Wiltshire ICB, GP surgeries and the CQC.

f) It is recommended that contingency planning and discharge planning take place before and throughout the duration of a specialist out of area placement and that all key people are aware of these plans. Cygnet are recommended to ensure that sufficient meetings are held prior to a placement starting to support this. AWP and DPT are recommended to ensure that this happens with their service users.

g) It is recommended that ICBs/IPP funders are proactive in supporting community CCs to provide oversight of out of area specialist placement care and make clear to CCs their expectations for regular updates. Devon ICB, BNSSSG ICB and BANES, Swindon and Wiltshire ICB are recommended to work more closely with CCs in mental health teams who have people on their caseloads placed out of area.

h) It is recommended that NHS England are engaged with to consider ways of streamlining commissioning processes to ensure that it is always clear who retains ultimate responsibility for someone's placement in an out of area mental health setting.

4. Interagency responses to deaths, serious incidences of harm and presentations to other services during inpatient admissions

Learning

a) No multi-agency strategy meeting was held following Abi's death and a strategy discussion was held 6 days after Kim's death. This is understood as a clear gap in process and had significant implications. It also meant that opportunities to consider the safeguarding of the other women on Knightstone, all of whom were detained under the MHA, were missed.

b) UHBW Hospital Trust recognised in their submission to the SAR that it was missed by staff that Abi had attended the general hospital from Knightstone twice in the same month because the use of multiple IT systems meant that staff at WGH and BRI were unable to see each other's notes. AWP and UHBW IT systems cannot be merged but information should be shared. UHBW have requested for AWP employed mental health liaison staff to have access to UHBW electronic patient records, which will allow AWP staff to update UHBW records with their mental health assessments, strengthening communication and information sharing.

c) Opportunities were potentially missed when Abi attended general hospitals three times in the month of her death, the last time hours before she died and on 17th November when conveyed by SWAST following a ligature attempt and mixed overdose. These were not reported as safeguarding concerns and though they prompted changes to risk plans on the ward there were potentially missed opportunities for broader questions to be asked about safety on the ward from agencies outside of Cygnet.

d) Kim's GP surgery highlighted in their learning event that they were reliant on her various inpatient units to contact the surgery for updated summaries of health information and medications. They were aware that she moved wards several times. They also state that they have a mental health lead nurse who was also proactive in contacting wards where possible.

e) Avon and Somerset police identified that their responses fell short of expected practice in some areas following the deaths of Abi and Kim. They question whether fuller evidence gathering at the scenes of Abi's and Kim's deaths would have taken place if Investigations had attended as per existing policy and that this may have enabled criminal investigations to be better considered. Police Investigations should always attend deaths in healthcare settings and lead on the full collection of evidence such that a criminal investigation can be better considered. They also did not report the deaths of Abi or Kim to the CQC, local CCG or North Somerset Adult Care, missing opportunities for wider safeguarding considerations. They note that it may have been assumed that ambulance staff had done this but it highlights potential learning around process and a need to ensure that it is always done by an agency.

f) Police also identified a systemic disparity in the treatment of those detained under the MHA compared with other vulnerable groups, in terms of their expected response to deaths and other serious incidents. Safeguarding vulnerable adults should be equitable with safeguarding children, a view supported by College of Policing guidance,[16] including where no harm has occurred but people are in vulnerable situations or circumstances as anyone detained under the MHA is.

[16] College of Policing Authorised Professional Practice on Safeguarding and Investigating the Abuse of Vulnerable Adults, 2012 (updated 2021), https://library.college.police.uk/docs/acpo/vulnerable-adults-2012.pdf, College of Policing

4. Recommendations

a) A multi-agency strategy discussion should take place as soon as possible within 24 hours of a death or any serious incident on an inpatient ward and should include consideration of the safety of others on the ward. It is likely that a full strategy meeting will not always be possible where events take place out of hours but the Emergency Duty Team in the LA in which the event occurred should be referred to immediately and discussions held with health and police about any immediate actions that need to be taken. Avon and Somerset police, relevant adult care teams and EDTs are recommended to be reminded of this existing process and its importance.

b) It is recommended that IT systems merged so that admissions to ED across the Trust can be seen by staff. This was already in progress and was due to be completed by April 2022. UBHWT have confirmed that this has taken place.

c) It is recommended that when someone presents at a general hospital when detained under the MHA at an inpatient unit that staff should be more proactive in asking the person and their support staff questions about incidents of self-harm and accidental injury, checking what they would like to happen and asking if there is anyone else they would like to be contacted. UBHWT are recommended to highlight this to ED staff. It is recommended that additionally, someone detained under the MHA should always be seen by Psychiatric Liaison before being discharged back to their inpatient provider. UBHWT and AWP are recommended to work together to ensure that this process is embedded and its rationale understood. Liaison should always consider whether a safeguarding referral may be needed.

d) It is recommended that someone's home area GP surgery is maintained as part of their wider care network when they are in an inpatient setting. The responsibility should sit with the inpatient provider to communicate with the GP. Cygnet are recommended to ensure this consistently happens.

e) It is recommended that the revised SUSD policy is rolled out across the police force with appropriate training and guidance and the Sudden Death Report template be revised to better direct the actions of attending officers and ensure higher scrutiny of their management of the cases. Avon and Somerset police are recommended to ensure that inpatient mental health settings are added to the list in the SUSD policy guidance where an on-call Detective Inspector should be immediately informed. Processes should also be established to ensure the Lighthouse Safeguarding Unit is automatically tagged on all suspected suicides and guidance for when Live Cell should be tagged.

f) It is recommended that Avon and Somerset police consider developing an appropriate tool to support attending officers to consider safeguarding implications for other patients or service users when attending significant incidents, including but not exclusively related to, deaths, in institutions such as psychiatric wards.

g) All agencies attending a death or serious incident should make onward referrals to ensure that nothing is missed.

Glossary

AMHP – Approved Mental Health Professional

CC – Care Co-ordinator

CCG/ICB – Clinical Commissioning Group/Integrated Care Board

CMHT – Community Mental Health Team (sometimes also called Recovery team)

CRHT/IST – Crisis Resolution and Home Treatment Team/Intensive Support Team

CQC – Care Quality Commission

DBT – Dialectical Behaviour Therapy

ED – Emergency Department

EUPD/BPD – Emotionally Unstable Personality Disorder/Borderline Personality Disorder

HRA – Human Rights Act

LA – Local Authority

MCA – Mental Capacity Act

MDT – Multi-disciplinary Team

MHA – Mental Health Act

NR – Nearest Relative

PICU - Psychiatric Intensive Care Unit

RC – Responsible Clinician

RCA – Root Cause Analysis

SAB – Safeguarding Adults Board

SAR – Safeguarding Adult Review

Reviewer Biography

Rosie Buckland has an undergraduate degree from the University of Oxford and a Masters in social work from Bristol. She worked for many years as an AMHP and social worker in mental health, generic out of hours and various adult teams. She now works as an independent social worker providing training, consultancy and SARs and also works as systemic practitioner in a family therapy team in adult mental health services. She is in the final stages of a PhD at the University of Bath exploring power and the Mental Health Act. She has published academic articles a range of aspects of mental health care. She has no personal or professional connections to either of the families or agencies involved in this SAR.