Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

Claire

Overview Report

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Date: 18th September 2016

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Executive Summary

1 Introduction

This Safeguarding Adults Review relates to the sad circumstances surrounding the death of Claire a 57 year old woman. Claire was a very intelligent woman with a broad range of interests, a wide circle of friends and a loving family.

Claire had a long history of mental illness. In February 2014, Claire and her family were informed that Claire would have to move from her current care provider, The Dallingtons to an alternative support service. Claire moved to her new support service, Lindsay House in July 2014 with a plan to be supported by Community Mental Health Services.

On the 6th September 2014, Claire was admitted to Harbour Ward, a mental health in-patient ward of Northamptonshire Healthcare Foundation Trust. Claire was in mental health crisis and had been significantly self-harming.

During her admission, Claire required three attendances to Northampton General Hospital due to dehydration and injuries from further self-harm.

On the 25th September and whilst being supported to stand up from the side of her bed on Harbour Ward, she suffered a respiratory arrest. Claire was admitted to Northampton General Hospital where she remained until she died on 16th October 2014.

A Safeguarding Adults notification was made to Northamptonshire County Council by Northampton General Hospital on 3rd October 2014 relating to care Claire had received at Northamptonshire Healthcare Foundation Trust. Following investigation, it was found there had been neglect and omissions of care to Claire by Northamptonshire Healthcare Foundation Trust on Harbour Ward.

At the inquest on the 19th January 2016, the Coroner found that between the 22nd and 25th September 2014, Claire had sustained a fracture to her vertebrae. Imaging done on 22nd September was not adequate enough to identify a possible fracture. The Coroner judged that the communication between Northamptonshire Healthcare Foundation Trust and Northampton General Hospital was inadequate and that the fracture was a major contributory factor in Claire's death.

2 Summary of the Learning Points from the Review

The following themes and learning were identified from the review. These are detailed more fully in the main body of the report (section 6).

2.1 Components for Effective Transitions Between Placements

2.1.1 A high level of care and attention was given to planning the transition for Claire from The Dallingtons to Lindsay House. There was good evidence of involving Claire and her family in the transition planning and sensitivity to working to Claire's pace.

2.1.2 The Dallingtons provided a detailed psychiatric history about Claire's risk factors; relapse indicators and intervention strategies. This was not adequately utilised and incorporated into Claire's Care Programme Approach, Care Plan and Crisis Plan by the Care Coordinator.

2.1.3 Claire's Care Programme Approach, Care Plan, Risk Assessment and Crisis Plan were out of date and were wholly inadequate for the new environment that Claire was moving to. Lindsay House had not received detailed information regarding Claire's risk history and signs of relapse until the day of admission.

2.1.4 There was limited choice of placements available to meet Claire's needs. The availability of resources to help identify a suitable placement i.e. the brokerage role offered by the Northamptonshire Healthcare Foundation Trust Individual Packages of Care Team, was not provided to Claire as she was funded from out of area.

2.1.5 Initially there were different views about the suitability of a placement at Lindsay House – differing views between Claire and her family and between the Care Coordinator and Haringey services. However, the decisions to use Lindsay House appears to have been reasonably based upon Claire's needs, matched to availability of resources and least restrictive environment necessary to manage her risks. This judgement of suitability was based upon support being available from Community Mental Health Services. Claire had the mental capacity to make this decision.

2.1.6 There was lack of clarity of roles and responsibilities between the Haringey workers and the Care Programme Approach Care Coordinator. However, Haringey as commissioning body was well engaged in Claire's care.

2.1.7 The agreed support plan by the Care Programme Approach Care Coordinator was not put into effect within the first month of the placement. It is not possible to say whether the agreed support from community services would have averted Claire's first mental health crisis but it is likely this had a detrimental effect on confidence in the Care Plan by Claire and the staff at Lindsay House who were dependent upon this external support.

2.1.8 The value of the care and attention given to the initial stages of the transition were lost as the plans were not followed through.

2.2 Components for Effective Transitions Between Placements – Key Learning Points

i	The value that detailed transition planning plays in prevention. Time and attention given at this stage is well invested.
ii	Involving the service user and those important to them is a pre-requisite to effective Care Planning. Transitioning at the service user's pace is a key element of this.
iii	Views of the service user need to be heard as distinct to the views of their family/carer – advocacy provides an important function in this.
iv	The choice of placement needs to be properly risk assessed based on appraisal of the combined skills of the provider and the realistic support package that can be provided by community services. The commissioning of services and community support should be the same standard for people placed out of area as for those placed within their home area.
v	A critical success factor are Care Plans and Crisis Plans that adequately reflect current and historic risks and detail the management of those risks. This information needs to be available in advance of the placement.
vi	The early weeks of transition are a high risk period – failure to deliver on the agreed Care Plan can seriously jeopardise successful transitions.
vii	There needs to be clear roles and accountability for decision making between commissioning bodies and the Care Programme Approach Care Coordinator. This includes accountabilities for risk assessment when making placement decisions. Good communication and recording is particularly important where the commissioners are from out of area.

2.3 Behavioural Support and Responses to Claire's Mental Health Crisis

2.3.1 Supporting people in mental health crisis requires detailed Care Plans and Crisis Plans developed with the person and those who support them. There needs to be a shared understanding of the person's history and risk factors – using this to develop preventative strategies, de-escalation techniques and robust guidance on responding to crisis.

2.3.2 Claire's Care Plan and Crisis Plan were not fit for purpose. The Crisis Plan did not provide meaningful information to help others respond to her relapse. More detailed information about risk factors was not readily accessible. This was because the risk documentation was not completed and the Northamptonshire Healthcare Foundation Trust electronic record system was difficult for staff to navigate.

2.3.3 When Claire was experiencing mental health crisis at Lindsay House, Community Mental Health Services as the specialists in mental health, should have been able to act as a collective body to ensure she received a response from them.

2.3.4 This did not happen for Claire because each Northamptonshire Healthcare Foundation Trust service rigidly applied criteria about why their service should not respond. The outcome was Claire, with her long history of severe mental illness and significant self-harm, was left to be supported by her GP, Police and Ambulance Crew who didn't know her. These services provided good responses.

2.3.5 Once admitted to Northamptonshire Healthcare Foundation Trust, there were serious omissions by Harbour Ward in managing Claire's mental health care.

- Claire's strengths and insights into what helped her were not used – the staff did not work in partnership with her.
- The extensive knowledge and support available through her family were not sought and when offered, were not utilised.
- Opportunities to use information about what had worked in other settings were not taken.
- Analysis of behaviours was not used to understand the reasons for behaviours, reduce risk of self-harm and de-escalate behaviours.

2.3.6 Harbour Ward had:

- Access to a psychologist.
- An evidenced based model of care was in place.
- Northamptonshire Healthcare Foundation Trust supervision requirements were being met.
- Training in areas such as managing challenging behaviours and dignity in care.
- Full staff complement with higher ratio of qualified nurses to unqualified staff.

2.3.7 The need for a Psychiatric Intensive Care Unit bed had been identified but none was available. However, failures in providing effective responses to Claire's behaviours were not necessarily about competence or resources but were based around culture of care and attitudes to Claire.

2.4 Behavioural Support and Responses to Claire's Mental Health Crisis – Key Learning Points

i	Crisis Plans must derive from robust risk assessment of historic and current factors. The Crisis Plan needs to provide detailed, person-centred information about preventative strategies, de-escalation techniques and guidance on effective responses to behaviours when in crisis.
ii	Those involved in responding to crisis need ready access to the necessary information for clinical decision making. Electronic record systems must be fit for this purpose.
iii	Mental Health Services need to be flexible enough to revolve around the person rather than around each services' criteria. Individual Mental Health Services must own the collective responsibility to meet the needs of service users in their care.
iv	GP's and providers of community services, need to have clear escalation routes where they have concerns about service provision and be clear about when and how to refer for a Mental Health Act assessment.

v	When the ambulance service is requesting Police assistance, where information is known about a person's mental health needs, this should be conveyed to assist Police in making appropriate responses.
vi	The fact that there is a model of care in place and staff have the technical knowledge and training to know how to implement it is not in itself enough. Working with service users in crisis is testing, particularly when the person has behaviours that are challenging. This requires staff to hold professional and personal values of working in partnership with the person and seek out the meaning behind their behaviours. Managers need to assure Care Plans are being acted upon and in a way that reflects this ethos.

2.5 Physical Health Needs for People with Severe Mental Illness

2.5.1 Poor physical health for people with severe mental illness is a nationally recognised area of health inequality. A NHS England contractual financial incentive scheme (Commissioning for Quality and Innovation) to improve responses to physical health needs in mental health services was not sufficient to ensure adequate care was provided to Claire within Harbour Ward.

2.5.2 The reasons behind poor mental health have been highlighted in national user-led research[1]. This includes:

- Physical health concerns not being taken seriously because of a mental health diagnosis.
- Delays in treatment as people are caught between mental health and physical health services, which can exacerbate physical health problems.
- Lack of communication, both between Primary and Secondary care and between Mental Health and Physical Health Services.

These were all evident in the physical health care that Claire received.

2.5.3 There was a lack of focus on Claire's physical health needs during her in-patient stay at Northamptonshire Healthcare Foundation Trust. Staff appear not to have recognised the importance of physical health checks as part of holistic care. The lack of any robust systems within Harbour Ward meant that observations were not routinely carried out and findings were inaccurate. Poor communication and recording practices meant tasks were not followed up. This had significant impact on Claire's physical care. The fact that Claire lost 15kg in weight in a 15 day period is only one example of this.

2.5.4 There was also a lack by Northamptonshire Healthcare Foundation Trust of revisiting and questioning assessments carried out by Northampton General Hospital– reinforcing Claire's presentation as being psychosomatic or 'behavioural.' This suggests diagnostic overshadowing and contributed to the effectiveness of care Claire received and the speed to which medical attention was sought.

[1] Rethink, (2012) *20 Years Too Soon*, Available from: https://www.rethink.org/media/511826/20_Years_Too_Soon_FINAL.pdf [Accessed: 12/07/16]

2.5.5 The inquest into Claire's death examined evidence about the care she received within Northampton General Hospital. The findings were that scans carried out by Northampton General Hospital were not sufficient to identify spinal fractures. This review did not find evidence, that the care and treatment provided (or omitted), or decisions made about Claire's care, were adversely influenced by her mental health needs. However, there are concerns about the efficacy of the referral process for specialist spinal treatment that was in place at that time. There were issues raised about the timeliness of referrals and clarity about the appropriate referral pathways for acute and rehabilitative care.

2.5.6 There was debate between Northampton General Hospital and Northamptonshire Healthcare Foundation Trust about which service was best able to meet Claire's needs. The reality was that Claire had extensive physical and mental health needs. Both services needed to work closely together to combine their specialist knowledge. Poor communications between these services limited effective holistic responses to Claire.

2.6. Physical Health Needs – Key Learning Points

i.	There are significant health inequalities for people with severe mental illness. Financial incentives are not sufficient to change mental health practice. Redressing this requires a shift in culture for Mental Health staff to a more holistic approach to care, supported by robust systems.
ii.	Organisations need to ensure professional challenge and objective assessment is in place regarding physical health care for people with mental health needs to reduce the risk of diagnostic over shadowing.
iii	Secondary services such as Mental Health Trusts and Acute Trusts need to be able to develop a shared care ethos, collaborating and combining their specialist knowledge to deliver effective holistic care.
iv	Pathways of care to specialist services need to be clearly mapped out to enable timely referral to the most appropriate specialist services. This is relevant to all patients but particularly important where there is a complex presentation such as mental health and physical health comorbidity.

2.7 Culture of Care

2.7.1 The review highlighted some examples within the community where the culture was one of collaboration and flexibility, 'going the extra mile' to meet Claire's needs. The planning for Claire's transition was a good example of this. Claire's sister also highlighted Lindsay House showing kindness, compassion and considering dignity in care.

2.7.2 There was also learning about the negative affect of silo working within Community Mental Health Services and a culture by some of guarding boundaries to their service rather than taking collective responsibility to meet a person's need.

2.7.3 There were serious concerns about a pervasive negative culture that operated within Harbour Ward. There was a rigid and discriminatory view regarding Claire's behaviours that led to oppressive and at times abusive responses to her. There was a disregard for Northamptonshire Healthcare Foundation Trust's procedures and apparent indifference to responding to physical health needs.

2.7.4 The combination of these factors contravened basic standards of dignity and decency as well as failing to provide Claire with adequate mental or physical health care. Care provided breached professional standards and Codes of Practice.

2.7.5 This culture was maintained and unchallenged because of unhealthy and counterproductive working patterns amongst key senior staff members.

2.7.6 There is a need to look further at the reasons this culture developed – examining factors such as effective clinical leadership from medics and other disciplines and the use of professional supervision.

2.7.7 There was evidence within Northampton General Hospital, of involving Claire and her family in care – enabling decision making, respecting wishes and religious beliefs and working in line with the Mental Capacity Act 2005. Northampton General Hospital appears to have applied learning from a previous Serious Case Review in this regard.

2.7.8 There was limited evidence of joint working between Northamptonshire Healthcare Foundation Trust and Northampton General Hospital and a need to further develop a culture of shared care and collaboration between these services.

2.8 Culture of Care – Key Learning Points

i	The culture of care is intrinsic to the success or failure of any Care Plan. This has more to do with the values and attitudes of staff than the professional qualification they may hold.
ii	Services need robust systems and processes and defined models of care. However, these are ineffectual without core values that respect the individual, work in partnership with others and keep focused on the person and their needs.
iii	Organisational assurance needs to go beyond reviewing data and auditing processes. Quality of care is tested by listening to the lived experience of service users and their carers and observing practice on the ground.
iv	Clinical leadership is essential to modelling acceptable practice and establishing a culture that puts the person's needs at the centre.
v	Working with people in mental health crisis can be challenging and professional supervision is necessary to help staff step back, question their values and beliefs and how this may affect their practice.

2.9 Systems and Service Provision in Mental Health

2.9.1 A Government Independent Task Force[2] has highlighted widespread and chronic underfunding in Mental Health leading to very stretched provision. This has affected the care for people in a mental health crisis.

2.9.2 This does not excuse unprofessional practice and dysfunctional cultures but this context does need to be acknowledged as part of the learning.

2.9.3 Lack of resources within the community, such as appropriate placements, reduced the availability of providers to meet Claire's needs. In order to encourage The Independent and Voluntary Sector to provide mental health services, there is a need to support those services and skill up their workforce.

2.9.4 The Government has pledged new funding for mental health. The local allocation of this should take into account learning from this review. The Northamptonshire Safeguarding Adults Board in its strategic assurance role, may wish to seek assurance of this and be sighted on whether the Northamptonshire Crisis Care Concordat is leading to improved outcomes for service users in mental health crisis.

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[2] Mental Health Taskforce, (2016) *Five Year Forward View for Mental Health: A Report From The Independent Mental Health Taskforce to the NHS in England*

2.10 Systems and Service Provision in Mental Health – Key Learning Points

i	The Government has acknowledged that mental health services need to be adequately resourced and to have 'parity of esteem' with physical health provision. This aspiration needs to be delivered to services on the ground.
ii	Strategic plans focused on supporting people's recovery in the community and out of hospital have to be matched by comprehensive services and accommodation to meet their needs. Attracting providers to deliver services for mental health is likely to need adequate funding, support by specialist services and the development of a workforce with skills required.

2.11 Safeguarding Responses

2.11.1 Opportunities were missed to raise a safeguarding referral regarding Claire's treatment whilst at Harbour Ward. This was by staff on the ward who did not interpret the responses to Claire as abusive or neglectful.

2.11.2 There may also have been missed opportunities for other services interacting with Northamptonshire Healthcare Foundation Trust to raise a safeguarding referral.

2.11.3 Northampton General Hospital did raise a safeguarding referral on Claire's last admission to hospital. It was positive this was raised subsequently but it could reasonably have been raised at an earlier stage and provided more information about the nature and degree of the concerns.

2.11.4 Responses by Northamptonshire County Council as the lead for safeguarding adults, lacked rigour in gathering a fuller picture of the concern before deciding that Northamptonshire Healthcare Foundation Trust should follow up on the referral. This meant the seriousness of the concerns were not fully appreciated. Northamptonshire County Council did not therefore consider the wider implication for other patients on Harbour Ward and seek assurance about the care they were receiving.

2.11.5 There was insufficient communication between Northamptonshire Healthcare Foundation Trust and Northamptonshire County Council about how the safeguarding referral would be investigated as part of their serious incident investigation process. As Police had very limited information, they were not given an opportunity to consider any potential role they may have in the process.

2.11.6 The safeguarding referral was signed off as 'closed' 10 months after the referral was made – this was without scrutiny of the outcome or reviewing the detail contained within the serious incident report. This delayed recognition of the seriousness of the concerns and that the criteria for a Safeguarding Adults Review were met.

2.12 Safeguarding Responses – Key Learning Points

i	The importance of professional curiosity in practice - the ability to consider alternative interpretations for how a person is presenting including being open to the possibility of abuse or neglect.
ii	Safeguarding referrals need to provide sufficient information for the Local Authority to be able to judge the best means of responding. (A safeguarding referral is now managed as a Section 42 Care Act enquiry). Decisions about causing others to follow up the enquiry, need to be based upon sufficient information and clear rationale. This includes the Police having sufficient information to judge whether they have a role to play.
iii	Where a Local Authority is requesting another service to respond to the safeguarding concern, the Local Authority must maintain oversight and provide scrutiny for how that task is carried out, assuring the adequacy of the protection plan and the outcomes achieved for the person(s).
iv	Where a concern is being managed as a serious incident and a safeguarding enquiry, there is a need to determine how these two processes work together. Where the two processes are integrated, the Local Authority maintains accountability for assuring the enquiry is carried out satisfactorily and wellbeing secured for the person(s) involved.
v	The importance of reviewing all safeguarding concerns before closure, to determine in a timely way, whether the criteria for a Safeguarding Adults Review may be met.

3 Context of Safeguarding Adults Reviews

3.1 Under Section 44 of the 2014 Care Act 2014, Safeguarding Adults Boards are responsible for Safeguarding Adults Reviews in circumstances where an adult dies as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

3.2 The decision to undertake this Safeguarding Adults Review was made by the Chair of the Northampton Safeguarding Adults Board based on a recommendation from the Safeguarding Adults Review Sub Group.

3.3 The Northamptonshire Safeguarding Adults Board commissioned an Independent Author, to provide the Safeguarding Adults Review report. The author is an experienced chair and author of reviews and holds a professional background in mental health services and safeguarding adults. The author is independent of Northamptonshire Safeguarding Adults Board and its partner agencies.

3.4 The purpose of Safeguarding Adults Reviews is described in the statutory guidance [s.14.164]: '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to reduce the likelihood of similar harm re-occurring.

3.5 The purpose of a Safeguarding Adults Review is not to hold any individual or organisation to account. Other processes exist for that purpose. A Safeguarding Adults Review enables all of the information known to agencies to be seen in one place. This is beneficial to learning but the Safeguarding Adults Review also recognises that this benefit of hindsight was not available to individual practitioners at the time.

3.6 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity. The principles apply to the review as follows:

- Empowerment: Understanding how Claire and her family were involved in her care; involving Claire's family in the Learning Review.
- Prevention: The learning will be used to consider prevention of future harm to others.
- Proportionality: Understanding whether least restrictive practice was used and being proportionate in carrying out our review.
- Protection: The learning will be used to protect others from harm.
- Partnership: Partners will work together to understand circumstances of Claire's death and how they can improve future partnership working.
- Accountability: Accountability and transparency within the learning process.

4 Terms of Reference and Methodology

4.1 Terms of Reference

4.1.1 The Safeguarding Adults Review will consider the care and support from agencies to Claire from February 2014 to 16th October 2014. This period covers the transition for Claire from her placement at The Dallingtons to an alternative placement at Lindsay House through to when Claire died.

4.1.2 The Safeguarding Adults Review will consider the circumstances surrounding Claire's care and treatment, whether agencies made effective responses to her and how well agencies worked together to meet her needs and to safeguard her. The specifics are as follows:

Terms of Reference
1. To establish whether there are lessons learned from the circumstances of Claire's care and the way in which local professionals and agencies worked together to safeguard adults at risk.
2. To review the commissioning arrangements of providing a placement within Northamptonshire for Claire's complex mental health needs specifically considering i) Whether the care package was appropriate to manage behaviours that challenge. ii) Whether there was robust transfer of care between placements. iii) Whether there was sufficient oversight of the placement and assurance that the commissioned services were effectively meeting her ongoing needs
3. To understand the extent to which the wishes of Claire and her family were taken into account about her care and treatment including compliance with the Mental Capacity Act 2005 and the accessibility and involvement of advocacy
4. To review the quality of assessments, risk assessments and Care Plans relating to: i) Claire's mental health to keep her safe from harm ii) Claire's physical health to keep her safe from harm iii) The interface between physical and mental health needs
5. To consider the quality of information sharing and multi-agency working between partner agencies and whether this had an impact on the care she received
6. To examine any issues of diversity and discrimination, specifically in relation to disability and mental health e.g. whether there was an assumption that Claire's mental health problems were responsible for her physical health – diagnostic overshadowing
7. To identify any organisational factors such as capacity or culture which may have impacted on Claire's care.
8. To review the effectiveness of procedures, both multi-agency and those of individual organisations.
9. To review if previous learning from Serious Case Review (AP) in Northamptonshire had been embedded into practice.

4.2 Involvement of Claire's Family

4.2.1 Claire was part of a loving and highly supportive family who took a very active and lifelong role in her care. The involvement of Claire's family in this review is critical to understanding the experience of Claire and the perspective of those closest to her.

4.2.2 The Independent Author and Safeguarding Adults Review Chair are grateful to Claire's sister and brother in law for their contribution to this Safeguarding Adults Review. Claire's family had already contributed to a Serious Incident review by Northamptonshire Health Foundation Trust and to the Coroner's Inquest. Repeated review of the painful circumstances of Claire's death was not an easy task for them. Despite this, they wished to contribute in order that services may learn and improve and, crucially, make a difference to others.

4.2.3 The Independent Author and Independent Liaison Officer met with Claire's family at the beginning of the review. The family was able to contribute their perspective against the Terms of Reference. These views have been included within this report. The review also drew information from emails the family had been sent during the scoping period.

4.2.4 The draft of the Safeguarding Adults Review report was shared with Claire's family who approved the references made in the report to their views.

4.3 Methodology

4.3.1 The methodology applied for this Safeguarding Adults Review combined formal individual management reports and a chronology from each agency with discussion and a learning event.

4.3.2 The reports were reviewed and discussed in detail at a meeting between the panel and authors. The learning event brought together agencies and practitioners in further drawing out the learning and contributing to the recommendations.

4.3.3 The Independent Author and Chair met with agency authors at the beginning of the review to discuss the terms of reference. Participating agencies were encouraged to apply a systems approach[3] to their reports i.e. explore all contributory factors in order to identify changes needed at an organisational level as well as at individual practice level.

4.3.4 The Independent Author and Chair were supported in the review by a panel. The panel members were from the Northamptonshire Safeguarding Adults Board's partner agencies and brought a further level of expertise and scrutiny of the individual agencies' reports. The panel membership was:

- SAR Panel Chair, Assistant Director for Safeguarding NHS Nene & Corby Clinical Commissioning Groups.
- Independent Author.
- Expert by Experience and Independent Liaison Officer.
- Service Manager Safeguarding Adults and Quality Assurance Northamptonshire County Council.
- Director of Nursing and Quality, Kettering General Hospital NHS Foundation Trust.

[3] SCIE, *Learning Together*, Available from: http://www.scie.org.uk/children/learningtogether/about.asp [Accessed: 12/07/16]

- Designated Nurse for Adult Safeguarding NHS Nene and Corby Clinical Commissioning Groups.

- Detective Chief Inspector Adult Safeguarding Protection Vulnerable People Northamptonshire Police.

4.3.5 **Participating Agencies**

AGENCIES CONTRIBUTING REPORTS TO THIS SAR	
Barnet, Enfield & Haringey Mental Health NHS Trust	Provided the role of placement review on behalf of Haringey Local Authority and Clinical Commissioning Group
The Dallingtons, St Matthews Healthcare	Provided nursing care to Claire from 2013 to 7th July 2014
East Midlands Ambulance Service NHS Trust	Transported Claire to Northampton General Hospital on six occasions during the scope period.
GP Practice	Provided Primary Care to Claire from July 2014
Lindsay House	Provided residential care and support to Claire from 7th July 2014 until her admission to hospital on 6th September 2014
NHS Haringey Clinical Commissioning Group	The Funding Authority for Claire's care from April 2013.
Northants Police	Attended Claire at request of East Midlands Ambulance Service on 5th September; received incident report relating to injury to a member of Northamptonshire Healthcare Foundation Trust staff; notified of safeguarding adults referral 6th October.
Northampton Healthcare Foundation Trust	Provider of community and inpatient mental health services to Claire throughout the scope period including the Care Programme Approach Care Coordinator role.
Northampton General Hospital	Provided acute hospital care to Claire during September and October 2014
Northamptonshire County Council Adult Social Care	Provided assessment under the Mental Health Act 1983 on 10th September 2014 and managed the safeguarding adults referrals 3rd October 2014 and 10th Nov 2014[4].

[4] It is unfortunate that the Northamptonshire County Council report did not make any reference to the Mental Health Act assessment of 10th Sept 2014 – Northamptonshire County Council reported solely on the safeguarding service. Northamptonshire County Council could not locate their report relating to this Mental Health Act assessment. This Mental Health Act report was subsequently located by Northamptonshire Healthcare Foundation Trust and reviewed by the Safeguarding Adults Review author. This omission should be noted by Northamptonshire County Council in assuring documentation of Approve Mental Health P records and for coordinating future responses to Safeguarding Adult Reviews.

AGENCIES CONTACTED FOR INFORMATION BUT NO REPORT REQUIRED	
Leicester Royal Infirmary	Received a referral from Northampton General Hospital for surgery in September 2014 but did not provide treatment. No records held. No information provided to the Safeguarding Adults Review
NHS Nene Clinical Commissioning Group	No direct responsibility for Claire but chaired the Safeguarding Adults Review and provided information regarding Northants Mental Health Crisis Care Concordat.
Total Voice - Advocacy	Minimal involvement in May 2014 – a referral was made to advocacy but Claire declined involvement. No reports provided for the Safeguarding Adults Review

5 Context of Health and Social Care Provision

5.1 This section provides an outline of roles and responsibilities of services involved with Claire.

5.2 **Mental Health Provision**

Claire had a history of being detained under section 3 of the Mental Health Act 1983 (amended 2007). The Mental Health Act places a duty on Health and Social Care to meet mental health aftercare needs of anyone who has been detained under certain sections, including section 3.

5.3 The bodies responsible were Haringey Clinical Commissioning Group and Local Authority, as this was where Claire originated when she was detained. Even though Claire chose to remain in the Northampton area, Haringey remained responsible for commissioning and funding her care. They delivered these duties through the following:

1. Commissioning and funding the placements in Northampton. Within the scope period this was The Dallingtons (part of the St Matthews Group) and then Lindsay House. From February 2014 to 7th July 2014, the **St Matthews' Consultant Psychiatrist** took over medical responsibility.

2. Haringey Clinical Commissioning Group provided oversight of commissioned care through three agencies:
   i. A **Community Psychiatric Nurse** working for Haringey Clinical Commissioning Group as part of a Placement Efficiency Project – clinical review focused on sourcing better value placements, stepping patients down their care pathway.
   ii. A **Mental Health Nurse** who was part of the Haringey Clinical Commissioning Group Continuing Healthcare Team.
   iii. Haringey Mental Health Trust - Barnet, Enfield & Haringey Mental Health NHS Trust retained responsibilities on behalf of the Clinical Commissioning Group for Section 117 aftercare (Mental Health Act 1983) to act as **Case Manage**r, to review Claire's placements and ensure they met her needs – from May 2014, this was a Support Worker.

3. Northampton Healthcare Foundation Trust provided Claire with Community Mental Health Support including a **Community Psychiatric Nurse** based in the Community Mental Health Team. Northamptonshire Healthcare Foundation Trust also provided **Consultant Psychiatrists** from 2011 to February 2014 and then from July 2014 until Claire's death.

5.4 The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with complex mental health needs. Claire's care was being delivered under the Care Programme Approach. The Care Programme is led by a nominated Care Coordinator. The Care Coordinator holds a key role within the Care Programme Approach. This is the person within secondary services who is responsible for coordinating the person's overall care, drawing up the Care Plan, coordinating involvement of others and reviewing whether care (and risks) are being addressed. In 2011 the role of Care Coordinator was transferred from Haringey to Northamptonshire Healthcare Foundation Trust Community Psychiatric Nurse, referred to throughout this report as the **Care Coordinator**.

5.5 Northamptonshire Healthcare Foundation Trust, as most Mental Health Trusts, have a specific team to support people who are in mental health crisis. **The Crisis Resolution Home Treatment Team** provides additional short-term intensive community support. The service is designed to offer flexible home-based care 24 hours a day, seven days a week as an alternative to hospital admission, supplementing other community health services. The Crisis Resolution Home Treatment Team is made up of a variety of professionals including Nurses, Medical Staff, Occupational Therapists, Social Workers and Healthcare Support Workers. Where a person is known to services and has Community Mental Health Trust involvement, the expectation is this that service will be first point of response, calling in the Crisis Resolution Home Treatment Team where necessary.

5.6 A Mental Health Act assessment may be necessary in circumstances where a person's mental health needs and their risks arising, are so extensive that it is necessary for them to receive in-patient care but they are refusing admission (or are unable to give free and informed consent to the admission). In such circumstances, an assessment is carried out by two Doctors (usually a GP and Consultant Psychiatrist) and an **Approved Mental Health Professional** – a role provided by the Local Authority.

5.7 **Specialist Services – Physical Care**

NHS Acute Hospital Trusts provide a range of physical healthcare treatments. However, not all NHS Trusts provide all treatments. For some specialist conditions, such as spinal surgery and rehabilitation, specialist treatment centres are accessed across a geographical patch.

5.8 **Safeguarding Adults**

5.8.1 Safeguarding adult's means protecting an adult's right to live in safety, free from abuse and neglect. Under the Care Act 2014, the Local Authority has a duty to make enquiries (or cause others to do so) when a person with care and support needs (such as mental health needs) is at risk of or is experiencing abuse or neglect. The Local Authority works with partner agencies such as Health and Police, and with the person, to agree a Protection Plan.

5.8.2 Northamptonshire County Council has lead responsibility within Northamptonshire for overseeing these enquiries and Protection Plans, working under multi-agency procedures.

5.8.3 The Northamptonshire Safeguarding Adults Board is responsible for assuring how local safeguarding arrangements are working and that partner agencies are working together to protect adults in Northamptonshire.

Main Body of the Report

6 Claire and her Background

6.1 Claire's sister Michèle provided the Safeguarding Adults Review with a picture of Claire.

6.2 Claire was a very intelligent woman with a wide range of interests. She was a talented flautist and had a keen interest in classical music.

6.3 Claire was considered for Cambridge and the Royal Ballet but sadly the development of her mental illness prevented her being able to take this forward. Claire had periods of being very mentally unwell. At times of mental distress, she had significantly harmed herself, leading to permanent injuries including the loss of an eye.

6.4 Claire's Mother died when Claire was in her teens. Her sister Michèle remained in very close contact with Claire and was the main source of advocacy and support relating to her care and treatment.

6.5 Though Claire had periods of being very ill, it is an indication of her personality that Claire retained a wide circle of friends from her childhood and throughout her life. She also became a Jehovah's Witness and had friends from this faith. Over 80 people attended her funeral.

6.6 Claire had many years of care in hospital and residential care facilities. From 1994, Claire was a patient at St Andrews Hospital in Northampton. This is an independent mental health hospital. Claire's sister, Michèle retained regular contact with Claire and visited her regularly. Michèle was also Claire's financial appointee.

6.7 Claire's care was funded by Haringey Primary Care Trust and from 2013, Haringey Clinical Commissioning Group as the newly formed responsible NHS body. Claire had no remaining links with the Haringey area but had developed strong links in the Northampton area. Consequently, in 2010, when Claire was deemed ready for a move to the community she wanted to remain locally. Michèle advocated for this on Claire's behalf.

6.8 Claire moved to Westwood Lodge in Northampton which subsequently became The Dallingtons, an independent hospital. Claire had been receiving consultant support from Northamptonshire Healthcare Foundation Trust. During 2013 Michèle sought additional funding to enable Claire's consultant care to be transferred from Northamptonshire Healthcare Foundation Trust Community Services across to the Consultant (referred to in this review as St Matthews Consultant Psychiatrist) based at The Dallingtons. This Consultant Psychiatrist took over Claire's care in February 2014.

6.9 Unfortunately, The Dallingtons decided to change their service to male only. On 6th February 2014, residents were informed of this and that Claire would have to move to a different placement. Michèle recalls this was devastating for Claire as she had been making good progress at The Dallingtons and Claire felt like she was being evicted.

6.10 Michèle reported a high standard of care provided at The Dallingtons. There was confidence in the St Matthews Consultant Psychiatrist's assessment and treatment plans for Claire, including how he had tried to coordinate input from the community team and his respectful attitude toward Claire. Michèle's view was this care and attention carried through to the planning for Claire's transition.

The planning for this transition is the start point for this review.

7 Key Episodes within the Scope Period

The review has identified three key episodes that are seen to have significance in understanding Claire's experience of care and the circumstances leading up to her death.

7.1 Key Episode 1: Supporting Claire in her Transition to Lindsay House.

7.1.1 This key episode sets out particular incidents that occurred during the transition phase. This episode is important to understanding the circumstances surrounding the choice of placement and the Care Planning that was designed to reduce risk of relapse at a point of great vulnerability for Claire.

7.1.2 During **February 2014,** planning began for the transition to an alternative placement to meet Claire's needs. Claire had been informed by The Dallingtons that there was no notice period and that the service would work to a timeline that best suited her needs.

7.1.3 Planning meetings were held involving The Dallingtons, Claire, Claire's sister, Claire's Care Coordinator and Haringey Placement Efficiency Project Community Psychiatric Nurse.

7.1.4 At this time, it was agreed St Matthews Group Consultant Psychiatrist would take over her care to manage the transition. The St Matthews Consultant Psychiatrist reviewed Claire's history and compiled a 32-page report of Claire's history. He stressed the importance of a structured 24hr supported placement.

7.1.5 In **March 2014** the Care Coordinator requested the Northamptonshire Healthcare Foundation Trust, Individual Packages of Care team to provide information about potential alternative placements. This team identified Phoenix House as similar provision to The Dallingtons.

7.1.6 Lindsay House was also considered. Lindsay House, run by Rethink, offered care for people with mental health needs. Lindsay House did not have registered Mental Health Nurses or Psychiatrists employed but accessed these services through Northamptonshire Healthcare Foundation Trust.

7.1.7 The two potential placements were considered by the agencies involved. Neither placement was ideal but the reality was there were no other suitable resources locally. At an accommodation meeting on **17th March,** attended by the Care Coordinator, St Matthews Consultant Psychiatrist, Placement Efficiency Project Community Psychiatric Nurse, Claire, Claire's sister and brother-in law and Lindsay House, all agreed Lindsay House to be suitable with the exception of Claire[5]. Recommendation was made by St Matthews Consultant Psychiatrist for the Northamptonshire Healthcare Foundation Trust Consultant to see Claire monthly and the Care Coordinator to see her fortnightly – this plan was agreed.

7.1.8 From **March through to June 2014**, attention was given to planning the move to Lindsay House. This included meeting between Claire and her Care Coordinator to discuss concerns about the placement and responses to some of Claire's behaviours when unwell.

7.1.9 Following an overnight stay in **26th April,** Claire expressed some concerns about the move, due to the mixed sex environment but was informed no alternatives were available. A referral to the advocacy service Total Voice followed and on **21st May,** an advocate visited Claire. Claire declined the advocacy support.

7.1.10 A multi-agency planning meeting was held on the **4th June**. The meeting was attended by Care Coordinator; Lindsay House; St Matthews' Consultant Psychiatrist and a Staff Nurse and Occupational Therapist from The Dallingtons; Placement Efficiency Project Community Psychiatric Nurse; Claire; Claire's sister and brother-in law. At this meeting, St Matthews' Consultant Psychiatrist, reiterated the need for careful monitoring due to risk of Claire relapsing. Consideration was given to a gradual discharge but Claire stated a preference for a complete move – reassurance was given by the Care Coordinator of 2 weekly visits and the backup from a duty worker[6].

7.1.11 **During June 2014** there was further planning between the Care Coordinator and Lindsay House – setting up a post discharge meeting date; outpatient appointments and appointment to meet Keyworker.

7.1.12 Claire expressed concerns about the move following her visits but following a further visit on **3rd July** Claire was stating she was happy to move.

7.1.13 On the **7th July,** Claire moved from The Dallingtons to Lindsay House with St Matthews' Consultant Psychiatrist providing a discharge summary. From the point of agreeing the move to Lindsay House, the move took 3.5 months.

7.2 Key Episode 2: Responses to Claire's Mental Health Crisis at Lindsay House

7.2.1 This is a key episode because it describes the build up to Claire's mental health crisis that resulted in admission to hospital. This episode helps to understand the events that led to Claire's crisis and the actions taken or omitted by those involved.

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[5] Northamptonshire Healthcare Foundation Trust, Chronology and email 13th March 2014 from Haringey CPN recording meeting

[6] The Dallingtons IMR

7.2.2 On the **7th July**, Lindsay House are provided with the report compiled by the St Matthews' Consultant Psychiatrist, detailing the nature and degree of Claire's mental health history.

7.2.3 On the **9th July,** Claire's Care Coordinator visited her at Lindsay House. She completed a capacity assessment relating to self-management of medications. An appointment was made to meet with the Lindsay House key worker to review Care Plans and risk assessments.

7.2.4 The Care Programme Approach Care Plan and Crisis Management Plan that was in place on the Northamptonshire Healthcare Foundation Trust electronic record, was one that had been developed by the Care Coordinator at the last recorded Care Programme Approach review in October 2013. The historical section of the Northamptonshire Healthcare Foundation Trust risk documentation 'Working with Risk 2' was not completed.

7.2.5 The following day, the Lindsay House keyworker completed a Safety Management plan – to manage self-harm and reduce risks. It is not clear whether this was developed independently or following the Care Coordinator's advice. Claire's sister's recollection was that it was drawn up with Claire and without the Care Coordinator's involvement. This Care Plan and Risk Assessment was not shared with any of those involved from Haringey as would be expected practice.

7.2.6 On the **12th July,** records indicate that Claire was disorientated. She was de-robing throughout the day – this behaviour was a known indicator of Claire's mental distress.

7.2.7 On the **17th July,** Claire was registered with a new GP practice due to moving to a new geographical area. At this time the GP did not have any detailed information about Claire or her extensive mental health needs. Claire attended an appointment a few days later for a 'new patient interview.'

7.2.8 Lindsay House record further de-robing incidents on the **19th July**.

7.2.9 On the **23rd July,** Lindsay House records note a meeting was planned with Claire's Care Coordinator. The Care Coordinator did not attend. As the Care Coordinator had last visited Claire on the 9th July, a visit had been due in order to fit within the 2 weekly frequency that had been agreed.

7.2.10 From **29th July,** Claire began to leave her room undressed. On the **3rd/4th August** Claire's behaviours that were indicative of relapse/mental distress emerged. Claire began to throw herself on floor, express suicidal ideas, was clammy and sweating. Lindsay House called an ambulance and Claire was conveyed to A&E in the early hours.

7.2.11 Claire's GP called the Crisis Resolution Home Treatment Team. The Crisis Resolution Home Treatment Team informed they would not be able to attend for several hours but that Lindsay House could contact them the following day[7]. Claire was physically examined at A&E and a general assessment of her mental health was carried out by the A&E Triage Nurse. Claire was returned to Lindsay House at **7.24am on the 4th August** having been referred to the Crisis Resolution Home Treatment Team by A&E[8].

7.2.12 On her return to Lindsay House, Claire again became highly distressed and was described by Lindsay House as 'actively self-harming.' Lindsay House phoned the Crisis Resolution Home Treatment Team at **8am on the 4th August** and requested an urgent assessment, informing them Claire was running at walls head first. The Crisis Resolution Home Treatment Team advised Lindsay House to contact the police and to contact Claire's Care Coordinator[9].

7.2.13 The Crisis Resolution Home Treatment Team contacted A&E and discussed Claire's attendance. The Crisis Resolution Home Treatment Team were informed that Claire had just been discharged with a plan for her to be seen at home by The Crisis Resolution Home Treatment Team. The Crisis Resolution Home Treatment Team informed A&E that their team were unable to complete the assessment at Claire's home and that Claire should have been kept in at A&E to ensure review.

7.2.14 At 9am on that morning, Lindsay House tried to contact Claire's Care Coordinator at the Community Mental Health Team. The Care Coordinator was on leave. The Northamptonshire Healthcare Foundation Trust chronology records that Lindsay House informed them the GP was going to carry out a Mental Health Act assessment (this did not occur and the GP record makes no reference to this). The Community Mental Health Team advised Lindsay House that the Care Coordinator would be contacted on her return from leave. The GP was reassured about the availability of the team duty worker.

7.2.15 The GP record of this period, notes a contact from Lindsay House on the **4th August**, following Claire's discharge from A&E earlier that morning. Lindsay House informed the GP that Police would not attend as Claire was not in a public place.[10] Lindsay House had contacted Mental Health Services who said they would assess if referred to by a GP. The GP made a referral to the Community Mental Health Services.

7.2.16 The following day, **5th August**, the GP was contacted again by Lindsay House. The Crisis Resolution Home Treatment Team had called to see Claire but were unable to assess as she was sleeping. Claire was still highly distressed – removing her clothes and throwing herself to the ground. The GP reviewed medication but advised further contact with The Crisis Resolution Home Treatment Team to carry out a mental health assessment.

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[7] Lindsay House Chronology

[8] Northampton General Hospital Chronology

[9] Northamptonshire Healthcare Foundation Trust Chronology

[10] Police have powers to detain a person they believe to be mentally disordered and is in a public place. The power allows removal to a place of safety for assessment under the Mental Health Act.

7.2.17 On **6th August** Claire's Care Coordinator received a fax from the GP requesting urgent assessment as the Crisis Resolution Home Treatment Team were unable to assess Claire. The reason given was that Claire should be reviewed by her Care Coordinator. The Care Coordinator phoned Lindsay House and was told that Claire was more settled. An appointment was made for following day. The Care Coordinator provided the GP with Claire's Care Plans and history.

7.2.18 On **7th August** the Care Coordinator visited Lindsay House and met with Claire, Claire's sister and Lindsay House keyworker. The Care Coordinator provided Lindsay House with emergency contact numbers which included 111, the Community Mental Health Team and the Crisis Resolution Home Treatment Team.

7.2.19 Claire then had a slightly more settled period. On the **27th August** a multi-agency discharge meeting was held. This was attended by the Care Coordinator; Northamptonshire Healthcare Foundation Trust's Consultant Psychiatrist; Lindsay House, Claire and Claire's sister. Barnet, Enfield & Haringey Mental Health NHS Trust acting for Haringey, had recently allocated a new Case Manager to review the placement. This person was a Mental Health Support Worker. This Barnet, Enfield & Haringey Mental Health NHS Trust Support Worker also attended the multi-agency planning meeting but had no background history for Claire.

7.2.20 The Barnet, Enfield & Haringey Mental Health NHS Trust report notes that they, and the Care Coordinator expressed concerns about the placement but at the time, Lindsay House and Claire's family were in support of it. The Northamptonshire Healthcare Foundation Trust's Consultant Psychiatrist confirmed regular review was required. Claire's sister recalls Claire's medication was also revised and reduced at this time and that this caused Claire some anxiety.

7.2.21 From **31st August to 2nd September,** Claire's behaviours began to escalate again. Lindsay House contacted Out of Hours GP service and Care Coordinator who provided advice about medication.

7.2.22 On the **4th September,** Lindsay House again sought support from the Care Coordinator as Claire was persistently self-harming by falling on her head. The Care Coordinator was not available so Lindsay House spoke with the Care Coordinator's 'buddy' who gave medication advice. Later that day, Lindsay House requested the GP call - Claire was refusing to go to A&E. They also phoned back the 'buddy' worker who was not available. Lindsay House sought support through the team duty worker but were told the duty worker would not go out as the GP was attending.

7.2.23 Meanwhile, the GP called The Crisis Resolution Home Treatment Team prior to attending Lindsay House. The Crisis Resolution Home Treatment Team informed the GP they would not accept a referral unless Claire was first seen by the GP. The GP duly saw Claire at Lindsay House and re-contacted The Crisis Resolution Home Treatment Team as requested. The GP was then informed that Claire's Care Coordinator would be visiting the next day and it was not necessary for the Crisis Resolution Home Treatment Team to visit. The GP was advised to complete a Mental Health Act assessment if necessary. The GP then liaised with Northamptonshire Healthcare Foundation Trust Consultant Psychiatrist for advice on management – the ambulance that had been called was then cancelled.

7.2.24 In the early hours of the **5th September,** Claire sustained a self-inflicted head injury. Police and ambulance service attended. Claire was taken to A&E and then admitted to the orthopaedic ward. Following examinations, Northampton General Hospital contacted The Crisis Resolution Home Treatment Team to advise that Claire was ready for discharge.

7.2.25 The Crisis Resolution Home Treatment Team liaised with the Lindsay House Manager. The Manager expressed concern about the level of support provided to Claire and that the support Claire needed could not be met by Lindsay House. Claire also did not want to return to Lindsay House.

7.2.26 The Crisis Resolution Home Treatment Team completed a mental health assessment of Claire and on the **6th September**, Claire was admitted to Harbour Ward, an acute in-patient ward of Northamptonshire Healthcare Foundation Trust.

7.2.27 On the **9th September**, Claire's sister Michèle wrote a letter of complaint to Northamptonshire Healthcare Foundation Trust's Chief Executive regarding the care Claire had received by the Community Mental Health Team.

7.3 Key Episode 3: Care and Treatment Provided to Claire as an In-Patient

7.3.1 This key episode highlights events surrounding Claire's period of in-patient care at Harbour Ward and admissions and treatment at Northampton General Hospital prior to when Claire died.

7.3.2 When Claire was admitted to Harbour Ward on the **6th September,** she was an informal patient i.e. not detained under the Mental Health Act. Claire was placed on enhanced observations due to her poor physical health and self-harm. Claire complained of temporary blindness. She had extensive bruising to her eyes, face and head. Claire's weight on admission to Harbour Ward was 98 kgs.

7.3.3 On the **7th September,** Claire's clinical condition deteriorated. She was dehydrated and following consultation with Northampton General Hospital, Claire was admitted to Northampton General Hospital where she was examined and treated. Northampton General Hospital noted in their record that Claire was a Jehovah's Witness and held an Advance Decision regarding treatment with blood products.

7.3.4 While Claire was in Northampton General Hospital, her Care Coordinator liaised with Claire's sister Michèle who raised concerns about Lindsay House's ability to meet Claire's needs. Claire was discharged from Northampton General Hospital on the **8th September** and returned to Harbour Ward. A Northamptonshire Healthcare Foundation Trust medic examined her and requested that nursing staff maintain food and fluid charts.

7.3.5 On the **8th September**, Claire's care coordinator raised concerns within her Community Mental Health Team meeting about the ability of Lindsay House to meet Claire's needs. There was also consideration from Harbour Ward of a safeguarding referral regarding the care Claire received at Lindsay House though no referral was completed.

7.3.6 Over the period **9th September – 12th September,** Claire's levels of distress and self-harming behaviours escalated. Records report she was banging her head and gouging her eye. Claire was reported to be climbing on a chair and jumping off head first and kicking out at staff. She was nursed throughout on enhanced observations and the de-escalation room was used. Throughout this period, Claire made repeated complaints about back pain, pain to her face and ribs – believing she had a broken back and neck.

7.3.7 On the **10th September.** Claire was assessed under the Mental Health Act 1983. The Approved Mental Health Professional's assessment report described Claire as being very low in mood and that she was '*planning to break her neck by falling onto her head*'[11]. The medical recommendation referenced Claire was aiming to fracture her neck, that she would need restraint for her safety and would probably need psychiatric intensive care. Claire was detained under Section 3 of the Act. The following day Claire was **r**eviewed by the ward Doctor and a second medical opinion.

7.3.8 On the **12th September** Claire complained of pain when coughing. She was short of breath and clammy. Claire was reviewed again by the Northamptonshire Healthcare Foundation Trust medic who sought advice from Northampton General Hospital. Claire was transferred to A&E.

7.3.9 Claire was examined by the Northampton General Hospital consultant. She was complaining of chest pain radiating to her back. Northampton General Hospital took X-rays and CT scans to Claire's head, neck and back. Northampton General Hospital found no evidence of fractures. Records indicate Claire had bibasal consolidation of her lungs on the CT scan and raised white blood cells (a marker of infection). The A&E Consultant and Doctor discussed the results – it is unclear whether Claire's whole presentation was discussed.

7.3.10 Claire was discharged back to Harbour Ward on the **13th September** with advice about pain killers. A discharge summary letter was sent to the GP but not to Harbour Ward, Northamptonshire Healthcare Foundation Trust. No information was given regarding use of antibiotics. She was reviewed the following day by the Harbour Ward Doctor - the Northamptonshire Healthcare Foundation Trust medical notes did not include any comments regarding her physical observations. Claire's weight at this time was 88kg – 10 kg loss in 7 days.

7.3.11 From the **15th – 18th September** Claire remained on enhanced observations but was slightly more settled. There were no records of her complaining of back or chest pain.

7.3.12 From **18th September** Claire again became more acutely distressed with resultant self-harming behaviour. Despite this her observations were downgraded to 15 minute observations during the day and enhanced at night.

7.3.13 During this period Claire's sister Michèle and husband were on holiday and their daughter, Claire's niece visited. Michèle recalls her daughter was left for hours on her own with Claire at a time when Claire was throwing herself on floor.

[11] AMHPs Mental Health Act Assessment Form ; 10th Sept 2014

7.3.14 Claire's sister Michèle had also requested Claire's St Matthews Consultant Psychiatrist to visit her on Harbour Ward. St Matthews Consultant Psychiatrist did visit Claire, the week of **15th September**. He spoke with the Deputy Ward Manager and discussed Claire and interventions that The Dallingtons had successfully used. He checked that Harbour Ward had access to the extensive report he had written – this was confirmed.[12]

7.3.15 Claire was reviewed by the Harbour Ward Doctor on the **19th September** as Claire was complaining of chest and back pain. Claire had abnormal blood results and was requiring oxygen therapy. She was commenced on antibiotics.

7.3.16 On the **21st September** Northamptonshire Healthcare Foundation Trust reported to the Police an assault to staff from Claire. Northamptonshire Healthcare Foundation Trust report that Claire was meant to be sitting up to relieve fluid on her lungs but kicked out at her keyworker when asked to sit up. At this time Claire was doubly incontinent and reported to be '*putting self on floor'*.

7.3.17 Claire weighed 83kgs on the **21st September.** This was a loss of 15kgs in a 15 day period.

7.3.18 On the **22nd September** Claire told ward staff she was unable to walk. Claire was found lying on the bathroom floor with bruising to her eye, back and arms. Claire was admitted to Northampton General Hospital for assessment of a head injury.

7.3.19 Claire had a CT scan of her head – no intracranial bleed or evidence of fracture was found. An X-Ray identified lower respiratory infection for which Northamptonshire Healthcare Foundation Trust were already providing antibiotics. Northamptonshire Healthcare Foundation Trust reports that a full body map, doctor's referral letter, drug chart and NEWs chart were all given to Northampton General Hospital by escorting staff upon Claire's arrival at Northampton General Hospital (and were produced by Northampton General Hospital for the inquest). Claire informed Northampton General Hospital staff that she was struggling to keep her head lifted and was informed this was due to swelling.

7.3.20 Claire was discharged back to Harbour Ward Northamptonshire Healthcare Foundation Trust the same day. A discharge letter was sent from Northampton General Hospital to the GP but not to Northamptonshire Healthcare Foundation Trust.

7.3.21 **Between the 22nd and 25th September** when Claire returned to Harbour Ward, Claire had further disturbed behaviours. Claire continually stated she was in too much pain to get up from bed and resisted requests from staff to get out of bed. On the **23rd September**, Claire requested a bed pan. She was informed none were available and that she would have to hold on for 2 hours. Over this period, there were no records of continence care or providing a bed pan. Bed sheets were changed. It appears Claire was left to be incontinent in her bed during this three day period[13].

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[12] Dallingtons' information to Safeguarding Adults Review Panel 2nd June 2016 and email sent 30/7/16

[13] Northamptonshire Healthcare Foundation Trust Individual Management Report

7.3.22 On the **25th September,** while still on enhanced observations, Claire put herself on the floor. She stated she had a broken back and was unable to move. A hoist was used to transfer Claire back into bed. Claire continued to complain of pain and being unable to sit up. Claire had laboured breathing. Doctors took urgent bloods and requested increased frequency of observations.

7.3.23 Later on the **25th September**, Claire went into sudden collapse. The Northamptonshire Healthcare Foundation Trust chronology notes this occurred when staff were '*helping to toilet'* though the Northamptonshire Healthcare Foundation Trust report states it was when staff were attempting to sit Claire up at the side of her bed. Harbour Ward staff believed Claire to have gone into cardiac arrest and an ambulance was called. The ambulance staff were not informed of recent self-inflicted head injuries to Claire. The ambulance and Northamptonshire Healthcare Foundation Trust used a hoist to transfer Claire and transported her to Northampton General Hospital without spinal collar and block. The ambulance staff recorded that Claire was smelling strongly of urine.

7.3.24 **Claire's Final Admission to Northampton General Hospital**

Claire had her final admission to Northampton General Hospital on **25th September.** She was transferred to the Emergency Assessment Unit and a range of tests were carried out. History obtained was that Claire had been unable to move her legs for the last 2 days.[14]

7.3.25 On the **26th September** Claire was diagnosed with a severe spinal injury - spinal cord compression, fractures to mid spine and neck, severe damage to mid spine and burst fracture with displaced disc. She was transferred to Northampton General Hospital Cedar ward. Claire's Northampton General Hospital Consultant discussed her injuries with the Leicester Royal Infirmary Spinal Consultant. Leicester declined a referral for surgery as Claire's symptoms were post 48hrs. Their advice was to refer Claire to Stoke Mandeville for rehabilitation.

7.3.26 A range of further tests were carried out on **27th September** and the Intensive Care Unit (ITU) Critical Care Outreach reviewed her and advised on her care. Claire's anti-psychotic medication was discussed with the Pharmacist due to the side effects Clozapine may have on Claire's treatment. The pharmacist advised to withhold the Clozapine as it would affect her consciousness.

7.3.27 The Northampton General Hospital records indicate Claire was unable to consent to her treatment and it was provided under a Mental Capacity Act 'Best Interests' decision. Claire was transferred to Northampton General Hospital High Dependency Unit.

7.3.28 On the **28th September,** Northampton General Hospital discussed Claire's condition with Claire and her nieces. Referral to Stoke Mandeville was made but advised this transfer was not feasible due to Claire's poor physical condition and surgical intervention was required prior to rehabilitation. Northampton General Hospital discussed with Claire her treatment options and risks arising from her Advance Decision regarding not using blood products. Claire was given advice to help her weigh the risks.

7.3.29 On the **30th September** Claire was transferred to ITU and her Consultant discussed her condition with Claire's sister.

[14] Northampton General Hospital IMR report.

7.3.30 On the **1st October** a further referral was made to Stoke Mandeville. Claire was seen by Stoke Mandeville for advice 2 days later and Northampton General Hospital were advised Claire would need to be ventilator free before they could provide a service.

7.3.31 Coventry and Warwick NHS Trust were contacted on the **2nd October** for a specialist opinion as Leicester had declined to intervene. The following day Coventry and Warwick advised they could not consider the referral as their Trust was not commissioned to provide services to Northampton. Claire's family were updated.

7.3.32 On the **3rd October** Claire was seen by the Northampton General Hospital Safeguarding Adults Lead following contact by ITU. ITU had raised a 'Safeguarding Alert.'

7.3.33 The safeguarding notification was reviewed by Northamptonshire County Council on the **6th October** (next working day) and following an internal strategy discussion, request was made to the Northamptonshire Healthcare Foundation Trust Safeguarding lead to investigate within 21 days. Police viewed the referral but had no further involvement.

7.3.34 On the **6th October** Northampton General Hospital made a re-referral to Leicester Royal Infirmary for possible fixation and stabilisation of Claire's spine. The next day Leicester accepted the referral but needed to await availability of a ventilated ITU bed. The plan was to move Claire the next day subject to her respiratory functions improving. Northampton General Hospital consulted with Claire's family.

7.3.35 During **8th – 9th October** further attempts were made to stabilise Claire and on the **10th October** (Friday), Claire was improved enough for transfer to Leicester. However, the Leicester surgeon was not available so the plan was to transfer Claire after the weekend.

7.3.36 Throughout **11th–14th October,** interventions continued aimed at improving Claire's respiration. The Specialist Registrar Cardiologist consulted with Claire's family regarding her treatment and views about a pacemaker. The family did not feel fitting a pacemaker was appropriate. On the **15th October** the Consultant Cardiologist made a best interest decision to insert a pacemaker. Claire's Advance Decision regarding use of blood products was respected.

7.3.37 On **16th October,** Claire's condition deteriorated. Her family were contacted. Claire died on this day.

7.4 Subsequent Actions Outside of Scope Period

7.4.1 This section notes key events that though outside the scope period, fit within the terms of reference in relation to how safeguarding adults' procedures were applied.

7.4.2 On the **10th November** a referral was received by Northamptonshire County Council from Claire's GP regarding failure by the Crisis Resolution Home Treatment Team to attend to Claire on the 4th September Northamptonshire County Council shared the referral with the Police. A decision was made to manage this jointly with the safeguarding referral raised by Northampton General Hospital on the 3rd October and that Northamptonshire Healthcare Foundation Trust should also put into place protection plans.

7.4.3 Northamptonshire County Council sent a follow up letter to Northamptonshire Healthcare Foundation Trust in **March 2015** regarding the safeguarding investigation - Northamptonshire County Council had expected Northamptonshire Healthcare Foundation Trust to complete the investigation by the end October 2014.

7.4.4 In **July 2015** Northamptonshire Healthcare Foundation Trust advised Northamptonshire County Council that their serious incident report was completed and awaiting sign off. Northamptonshire Healthcare Foundation Trust sent an outcome form to Northamptonshire County Council following their investigation advising that allegations of neglect and omissions of care were substantiated.

7.4.5 **In August 2015** Northamptonshire County Council acknowledged receipt to Northamptonshire Healthcare Foundation Trust and requested evidence of how their outcome had been reached. The referral relating to Claire was then closed by Northamptonshire County Council – no further evidence was received.

7.4.6 In **December 2015**, Northamptonshire Healthcare Foundation Trust made a referral to the Northamptonshire Safeguarding Adults Board for a Safeguarding Adults Review.

8 Analysis of Themes and Learning

The review drew information from agency reports; chronologies; meeting with family; meetings with the agency report authors and a learning event. A number of themes and learning emerged:

8.1 Components for Effective Transitions Between Placements

8.1.1 In recent years, Claire had had a period of relative stability in her mental health enabling discharge from St Andrews in 2010 to Westwood Lodge (subsequently The Dallingtons). The Dallingtons informed the review that Claire did have periods of mental health distress but this had never led to self-harming behaviour requiring external medical attention.

8.1.2 Nonetheless, Claire had an extensive history of high risk behaviour resulting in significant and permanent harm. The nature and degree of her mental illness had required care within a very structured psychiatric environment for over 20 years. What was abundantly clear was that the transition needed to be handled with extreme care in order to avoid relapse.

8.1.3 A successful transition required a number of components including:

- **Understanding Claire's care needs:** A shared recognition of Claire's needs – her psychiatric history; abilities; strengths; risks; relapse indicators.

- **Involvement:** Full involvement of Claire and her family, and working at a pace that Claire could cope with.

- **Support Services:** Securing appropriate accommodation and mental health resources to meet Claire's needs.

- **Care Planning:** A detailed Care Plan to meet Claire's needs including robust Risk Assessment and Crisis Plans that were known by all parties.

- **Review:** evaluation at an early stage to assess whether the planning had addressed needs.

These components are considered below:

8.1.4 **Understanding Claire's Care Needs:**
The review highlighted the care and attention The Dallingtons gave in supporting Claire through this transition. The St Matthews' Consultant Psychiatrist compiled a detailed thirty-two page psychiatric history report. This provided the opportunity to share with all services Claire's risks and strengths; her relapse indicators and the successful therapeutic strategies.

8.1.5 The Dallingtons also provided a discharge Care Plan and met with Lindsay House staff as part of the hand-over of care. Claire's sister recalls the St Matthews' Consultant Psychiatrist highlighted the need for everyone at Northamptonshire Healthcare Foundation Trust Community services to be made aware of Claire's very complex needs. The level of planning carried out by The Dallingtons was valued by Claire's sister Michèle.

8.1.6 At this time, there were other professionals involved who had also known Claire for many years and understood her risks well. The Care Coordinator had worked with Claire since 2011 and was well placed to understand Claire's background and the local resources to meet her needs. Claire's sister expressed some frustration that Claire's Care Coordinator did not attend an early planning meeting held in February 2014 as it left the Haringey Placement Efficiency Project Community Psychiatric Nurse with very limited information about local resources.

8.1.7 At the learning event for this review, it was identified that Northamptonshire Healthcare Foundation Trust has an Individual Packages of Care team, who have a specialist role to provide a 'brokerage' function for placing people with complex needs i.e. assessing the person's needs and matching this with local appropriate resources. As Claire was funded from out of area, this service was not fully involved in sourcing placements appropriate to Claire's needs (as this responsibility would sit with the funding body). The Care Coordinator contacted the Individual Packages of Care Team by phone for advice but this was the limit of the input.

8.1.8 From Haringey, the Placement Efficiency Project Community Psychiatric Nurse in particular, was very active in supporting Claire's transition planning and had supported her following her move from St Andrews. However, understandably their knowledge of local resources was limited.

8.1.9 The agency reports from Haringey Clinical Commissioning Group and Barnet, Enfield & Haringey Mental Health NHS Trust identified that coordination and communication between their three workers (the Placement Efficiency Project Community Psychiatric Nurse; Barnet, Enfield & Haringey Mental Health NHS Trust Support Worker and the Haringey Clinical Commissioning Group Continuing Health Care Nurse) left room for improvement.

8.1.10 At the Safeguarding Adults Review panel meeting it became evident that the roles and lines of accountability were not always clear between the Haringey workers and the local

Northamptonshire Healthcare Foundation Trust Care Coordinator. The Northamptonshire Healthcare Foundation Trust report author felt that Haringey as the funding body, took the leading role in deciding on the placement – Haringey's view was that the Care Coordinator was the lead for Care Planning, including advising on accommodation needs and risk assessing prospective placements.

8.1.11 Haringey Clinical Commissioning Group and Barnet, Enfield & Haringey Mental Health NHS Trust have made recommendations regarding the coordination of workers, recording practices and risk assessment documentation. ***(Appendix 1 Barnet, Enfield & Haringey Mental Health NHS Trust 1,2,3; Haringey Clinical Commissioning Group 1,2,3,4,5,6,7).***

8.1.12 Though there was a confusion of roles, the review also highlighted that Haringey services were well engaged in reviewing Claire's care needs both historically and during this transition phase.

8.1.13 As the funding body, this is the expected practice. However national inquiries[15] demonstrate that people with complex needs placed out of area, do not always have the level of oversight and scrutiny of care commissioned. This was not the case with Haringey and the ongoing involvement of the Placement Efficiency Project Community Psychiatric Nurse in particular was valued by Claire's family.

8.1.14 **Involvement:**
There was good evidence that all agencies had involved Claire and her family in planning for the transition and were working at a pace sensitive to Claire's needs.

8.1.15 The Dallingtons could have served notice for Claire to move but they chose not to so that the move could happen at Claire's pace. Both the Dallingtons and Lindsay House (who were holding a bed for Claire) showed great sensitivity in this regard.

8.1.16 Considerable time and attention was given to laying the ground for the move. An example was the attention taken in allocating a room at Lindsay House and working with Claire's family to make it homely for Claire. There had been concern over Claire and her sister's first choice of room at it was on the first floor – this presented risk to sexual safety and dignity if Claire became disinhibited. Lindsay House advised a room for Claire next to their office. This was good practice and an example of collaborative working, using professional skills to advise and guide service users and families in decisions.

8.1.17 The move took three and a half months from point of agreeing the placement at Lindsay House to the final transfer date. At this stage, reports indicate Claire was happy to move to Lindsay House.

8.1.18 **Support Services**
Though Claire and her family were involved in decisions, the reality was that their choice and wishes were curtailed by the limited placements available to meet Claire's needs.

[15] South Gloucester Safeguarding Adults Board, (2012) *Serious Case Review Winterbourne View*

8.1.19 The Northamptonshire Healthcare Foundation Trust report questions why Phoenix House was not pursued, particularly as Claire expressed her concerns on at least 3 occasions about moving to Lindsay House due to the mixed sex environment. Northamptonshire Healthcare Foundation Trust also note that the move was triggered by Dallington's change of service provision rather than Claire's changing needs and therefore similar provision should have been sourced. However, there were also concerns about Phoenix – it was also mixed sex, generally provided short term provision and had residents under Ministry of Justice restrictions[16].

8.1.20 At the time Claire's sister Michèle felt the level of restriction at Phoenix would be a retrograde step for Claire. As Claire's sister recalled, it was thought that Lindsay House offered a home for life and this stability was important for Claire's mental health.

8.1.21 The Northamptonshire Healthcare Foundation Trust author indicated that the Care Coordinator was not happy about the placement at Lindsay House and had informed Haringey of this but felt Haringey and the family were driving the decision. However, the records from the planning meetings and follow up emails did not evidence these views. As the Northamptonshire Healthcare Foundation Trust author observed, the Care Coordinator needed to be proactive in escalating any concerns she may have had.

8.1.22 It was important that Claire's views were heard as distinct from her family's views. A referral was made to advocacy to aide this process but Claire declined to accept an advocate. Claire had mental capacity to make decisions about her care needs and was not under any community based section of the Mental Health Act. She was therefore able to make judgements about her placement and to be supported by those working with her to consider her options.

8.1.23 Ultimately judgements that were made about the placement at Lindsay House appeared to have been reasonable based upon the information held at that time and the level of support that Mental Health Community Services had agreed to provide. Claire had mental capacity to make decisions about her care needs and was not under any community based section of the Mental Health Act. She was therefore able to make judgements about her placement and to be supported by those working with her to consider her options.

8.1.24 **Care Planning**

There was ample opportunity to develop detailed Care Plans and Crisis Plans, given the slow pace of transition and breadth of information available about Claire. However, this was an area of significant omission.

8.1.25 The last documented Care Plan held in the Northamptonshire Healthcare Foundation Trust Care Coordinator's records was generated at a Care Programme Approach review held in October 2013. This was written at a point when Claire was in a settled, structured placement staffed by qualified mental health professionals. The statement within Claire's Crisis Plan was she enjoys reading/knitting.

[16] Email Barnet, Enfield & Haringey Mental Health NHS Trust CPN 19th March 2014, provided to the review by Claire's Sister

8.1.26 The thirty-two page background report written by St Matthews' Consultant Psychiatrist was held within the Northamptonshire Healthcare Foundation Trust electronic record but was not readily accessible. No summary had been made. The depth of information available about Claire's relapse indicators and intervention strategies was not linked through into her Care Programme Approach Care Plan or transferred onto the Northamptonshire Healthcare Foundation Trust Risk Assessment 'Working with Risk 2.'

8.1.27 Consequently, the Care Programme Approach Care Plan; risk management and Crisis Plan was of very limited value to staff at Lindsay House and to those from Community Mental Health services who may be called in to support Claire.

8.1.28 The absence of an up-to-date Care Programme Approach Care Plan; risk management and Crisis Plan was a significant omission that will be reviewed further in Section 8.3. Northamptonshire Healthcare Foundation Trust has made recommendations regarding the quality of Care Plans, risk assessments and Crisis Plans. ***(Appendix 1 Northamptonshire Healthcare Foundation Trust 2,3,4, 21)***

8.1.29 Lindsay House also reported that their service had not been provided with the background report from The Dallingtons until the day Claire was admitted. This meant their service did not have the full depth of risk history or the detail of rapid relapse that could affect Claire. However Claire's sister, recalled staff had received the report prior to Claire's move and that staff had also attended pre-placement planning meetings where Claire's history was discussed.

8.1.30 Lindsay House felt that as Claire had had a long period of settled behaviours, she would still have been appropriate for their service. Nonetheless Lindsay House identified insufficient attention by their service to assessing risk. Their report has highlighted lessons learned for them. This includes:

- The need for needs and risks to be discussed with the whole team prior to accepting a referral.

- The assessment for admission should document a clear rationale behind the decision.

- The need for clear requirements around contingency planning and management of risk – being 'fully satisfied that there are water tight contingencies in place for times of crisis.'

Lindsay House had strengthened their processes in this regard and did not make any specific recommendations for action.

8.1.31 Haringey Clinical Commissioning Group observed that when Claire's proposed change of placement was presented to their Funding Panel, they also had no Care Plan or Risk Assessment. Haringey identified this as an omission as the Funding Panel should have sought assurance from the responsible Haringey workers of the suitability of the placement at Lindsay House.

8.1.32 Lindsay House drew up a Care Plan shortly after Claire was admitted. Given the slow stream admission, this should have been prepared in advance of the move. It is not clear whether this was prepared under guidance of the Care Coordinator – Claire's sister recalled the keyworker devised the Care Plan only with Claire. Haringey, as funding bodies, never received a copy of this Care Plan as would be expected practice.

8.1.33 **Review**
The Care Coordinator did pre-plan a post-discharge meeting date; outpatient appointments and appointment to meet the Lindsay House keyworker. She also visited Claire within 2 days of her move to Lindsay House – all this was good practice.

8.1.34 However, the keyworker from Lindsay House, recorded a planned meeting with the Care Coordinator on 23rd July 2014, 2 weeks after the Care Coordinator's first visit. The Care Coordinator didn't attend and Northamptonshire Healthcare Foundation Trust have no record that she was aware of this meeting – the next visit was on 7th August.

8.1.35 Whether this meeting on the 23rd July was scheduled or not, within the first month of Claire's placement, the agreed frequency of fortnightly visits by the Care Coordinator had fallen through. Within this period, Claire had had her first crisis episode.

8.1.36 At the review meeting on the 27th August, the Haringey Barnet, Enfield & Haringey Mental Health NHS Trust Support Worker attended, along with Claire's Care Coordinator; Northamptonshire Healthcare Foundation Trust's Consultant Psychiatrist; Lindsay House, Claire and Claire's sister. This Support Worker was newly allocated and did not have any background history regarding Claire.

8.1.37 At the Safeguarding Adults Review panel meeting the Barnet, Enfield & Haringey Mental Health NHS Trust author confirmed that at this time, there was no process for allocating review work within the team according to the levels of complexity the service user may have – any member of their team, qualified or unqualified, could be allocated review work. Given the lack of background information, coupled with the Barnet, Enfield & Haringey Mental Health NHS Trust worker being unqualified, there is question about the ability of this worker to properly risk assess the placement and formulate options.

8.1.38 Barnet, Enfield & Haringey Mental Health NHS Trust support worker recorded their overall conclusion that the placement was inappropriate due to:

- No staff with mental health training.[17]
- Staff unable to cope when Claire relapses and respond by containing the other residents until Claire feels better.
- High number of male residents.
- Two incidents of severe head banging in seven weeks since the start of the placement.
- No out of hour's service.

[17] Though not referenced in the record it is presumed this means professional mental health qualification.

These conclusions were not recorded within the Barnet, Enfield & Haringey Mental Health NHS Trust main record, it was not escalated to the Line Manager or Haringey as the funding body and there was no follow up action[18].

8.1.39 Claire's sister reports that at this time Claire was anxious about being moved due to concerns being raised about the suitability of the placement. Claire's views are recorded in the assessment as *"I'm happy here and I would like reassurance that I will not have to leave".*

8.1.40 This was early stages of the placement. The suitability of the placement could not really be tested until Claire had settled into some degree of routine, staff developed relationships with her and understood the best way to respond to her complex needs. The dilemma was that to achieve this, Claire needed some sense of security in the placement, security that those reviewing could not provide.

8.1.41 Claire's sister Michèle highlighted the importance of getting these early stages right.

> **Claire's sister Michèle**
> ***'If Claire had been properly supported by Campbell House [Northamptonshire Healthcare Foundation Trust Community Mental Health] when she first moved to Lindsay House and perhaps hospitalised after her first blip in August … the outcome would have been different.'***

8.1.42 It is not possible to be conclusive about whether provision of the planned support at this stage, would have prevented Claire going into crisis. What is clear is that the care and attention given to the initial stages of the transition and the planning put in place was not followed through. A period of complete instability for Claire followed.

8.1.43 Northamptonshire Healthcare Foundation Trust has made recommendations regarding community services. ***(Appendix 1 Northamptonshire Healthcare Foundation Trust 22, 23, 24).*** The author makes a further recommendation regarding supervision and oversight of the Community Mental Health Team cases at crucial points such as transitional phases for service users with complex needs. [***Recommendation 6***]

8.2 Components for Effective Transfer of Care – Key Learning Points

i	The value that detailed transition planning plays in prevention. Time and attention given at this stage is well invested.
ii	Involving the service user and those important to them is a prerequisite to effective Care Planning. Transitioning at the service user's pace is a key element of this.
iii	Views of the service user need to be heard as distinct to the views of their family/carer – advocacy provides an important function in this.

[18] Barnet, Enfield & Haringey Mental Health NHS Trust individual management report and panel meeting.

iv	The choice of placement needs to be properly risk assessed based on appraisal of the combined skills of the provider and the realistic support package that can be provided by community services. The commissioning of services and community support should be the same standard for people placed out of area as for those placed within their home area.
v	A critical success factor are Care Plans and Crisis Plans that adequately reflect current and historic risks and detail the management of those risks. This information needs to be available in advance of the placement.
vi	The early weeks of transition are a high risk period – failure to deliver on the agreed Care Plan can seriously jeopardise successful transitions.
vii	There need to be clear roles and accountability for decision making between commissioning bodies and the Care Programme Approach Care Coordinator. This includes accountabilities for risk assessment when making placement decisions. Good communication and recording is particularly important where the commissioners are from out of area.

8.3 Behavioural Support and Responses to Crisis

8.3.1 Within this theme, the author will consider how agencies worked with Claire to reduce her high levels of distress and risky behaviours. This section will also consider responses by agencies to Claire when in mental health crisis. This will review responses to Claire while at Lindsay House and when admitted to Northamptonshire Healthcare Foundation Trust Harbour Ward.

8.3.2 **Behavioural Support and Crisis Responses while at Lindsay House**
There has been significant focus in recent years on developing appropriate responses to people in mental health crisis including where individuals may have behaviours that are challenging.[19]

8.3.3 The Department of Health published guidance on positive and proactive approaches to addressing behaviours that may be problematic, leading to restrictive care.[20] This focuses on person centred Care Planning - involving the person and their carer to help understand behaviours and using this to design preventative strategies. A Care Plan should detail de-escalation techniques and set out responses when the person goes into crisis including at what point support is sought. Importantly, the plan should also examine and learn from the wider context of the episode to reduce risk of recurrence.

8.3.4 The importance to Claire of a robust Behavioural Support Plan and Crisis Plan cannot be overstated. Claire was at a crucial point in her recovery and extremely vulnerable to relapsing with severe risks of harm when unwell.

[19] MIND, (2013) *Mental Health Crisis Care: Physical Restraint in Crisis;* Department of Health, (2012) *Transforming Care: A National Response to Winterbourne View Hospital*
[20] Department of Health, (2014) *Positive and Proactive Care: reducing the need for restrictive interventions*

8.3.5 **Northamptonshire Healthcare Foundation Trust Individual Management Report**
[Historic admissions] '…Claire had presented with symptoms of thought disorder, persecutory delusions, auditory hallucinations and ideas of reference.

She had a history of significant self-harm including jumping from a first floor fire escape whilst in hospital sustained fractures to her heels, pelvis and vertebrae and also in response to a feeling that a contact lens was stuck behind her eyeball she scratched the eye making it bloodshot and causing two sub-conjunctival haemorrhages. Later the same day she gouged her left eye out, pushing her finger through the muscle. The eye was subsequently enucleated and a prosthetic eye administered.'

8.3.6 It was the Care Coordinator's role to develop this Care Plan, Risk Assessment and Crisis Plan. As outlined in section 8.1 above, the Care Plan was very outdated (October 2013) and the risk assessment documentation was incomplete. A Crisis Plan that consisted mainly of a list of contact numbers, one being 111, and statement that '*Claire enjoys reading/knitting*' was wholly inadequate to Lindsay House or others in guiding how to de-escalate and respond to Claire's extreme self-harming behaviours.

8.3.7 Any Crisis Plan can only be effective if it is communicated to all those expected to respond in crisis i.e. Lindsay House; GP; The Crisis Resolution Home Treatment Team; buddy worker; Community Mental Health Team duty worker.

8.3.8 Northamptonshire Healthcare Foundation Trust also highlighted the challenges in easily accessing information from the electronic patient record that was used at this time. Though services such as The Crisis Resolution Home Treatment Team could view Claire's electronic records, accessing the wealth of background information was cumbersome.

8.3.9 As the information about risk and risk management had not been summarised into Claire's Care Plan and Crisis Plan, this meant that Northamptonshire Healthcare Foundation Trust community health workers (The Crisis Resolution Home Treatment Team; the team duty worker and buddy), were unlikely to access the necessary information to assess and manage risk.

8.3.10 During Claire's short stay at Lindsay House, Claire had significant episodes of mental health crisis and self-harming behaviour (3rd – 6th August, and 4th September 2014). At no point during the peak of Claire's distressed and self-harming behaviours, was she assessed by The Crisis Resolution Home Treatment Team, her Care Coordinator, by the Northamptonshire Healthcare Foundation Trust Community team 'buddy' or duty worker. Attempts by Lindsay House and Claire's GP to mobilise support resulted in being signposted to other services that then also failed to respond.

8.3.11 It is not clear whether this lack of response was a direct result of the limited information available i.e. whether those services were not aware of Claire's vulnerability and risks.

8.3.12 The Northamptonshire Healthcare Foundation Trust report suggests it was more than this. The Northamptonshire Healthcare Foundation Trust author described some individuals in these services as rigid in interpreting their criteria rather than seeing the person and their needs. The Northamptonshire Healthcare Foundation Trust Individual Management Report highlights this well.

> **Northamptonshire Healthcare Foundation Trust Individual Management Report**
> ***'It is clear both the Crisis Resolution Home Treatment Team and the CMHT staff that were contacted by the GP and Lindsay House staff at the beginning of August and September 2014 for support with Claire's escalating behaviour, had become completely rigid in their adherence to their respective operational policies and both teams refused to undertake a face to face visit. The crisis (escalation) plan that was emailed by the CPN to Lindsay House after the episode in August consisted of little more than a list of telephone numbers. This was inadequate and of limited use to the Lindsay House staff, who followed the instruction to telephone the Community Mental Health Team if Claire's behaviour escalated, only to be told to call the Crisis Resolution Home Treatment Team instead. The GP and Lindsay House staff were then caught in a loop; being told by one team to contact the other with no one in either team taking responsibility to visit to assess the situation.***
>
> ***Strictly speaking the teams were operating to policy but between the two teams they had lost sight that there was a person in the community with escalating behaviour that needed urgent Mental Health intervention.'***

8.3.13 What this meant for Claire was that her crisis care was left to be managed by unqualified staff at Lindsay House, by a GP who did not know Claire, and by police and ambulance staff.

On two occasions, Claire required admission to A&E. On the second occasion she didn't return to Lindsay House.

> **GP Individual Management Report**
> ***'When speaking with the [GP Practice], this level of concern is described as 'desperate', with a feeling that Claire was unsafe to remain at Lindsay House, but mental health services not taking responsibility that Claire is under their care. Therefore, clinical care pathways appear to get blurred with which service (Crisis Team or Community Mental Health Team) is responding or expected to respond.'***

8.3.14 The review highlighted that the GP was very responsive. The GP attended, supported Claire and Lindsay House staff in caring for her and made great efforts to get Northamptonshire Healthcare Foundation Trust Community Mental Health Services to respond. The GP also contacted Claire's sister. The GP's contact with the Northamptonshire Healthcare Foundation Trust's Consultant Psychiatrist on the 4th September was reasonably seeking specialist secondary care opinion on management. The GP showed tenacity in pursuing support from Community Mental Health Services and carried out their role sensitively albeit with limited knowledge of Claire.

8.3.15 An area of learning was for the GP to consider other routes of escalation if they were not happy with the response from Northamptonshire Healthcare Foundation Trust. This could either be through Northamptonshire Healthcare Foundation Trust senior management and/or commissioners (Section 8.11 considers the safeguarding responses). It may also have been appropriate for the GP to make a direct referral to the Approved Mental Health Professionals Service (managed by Northamptonshire County Council) to request an assessment under the Mental Health Act, given Claire's mental health needs and resistance to care.
The GP report author makes recommendations in relation to this. ***(Appendix 1 GP Practice 1)***

8.3.16 The ambulance service attended in a timely way, requested support appropriately and conveyed Claire to hospital. However, the East Midlands Ambulance Service report identified that the consent to treatment record was not fully completed in relation to the assessment and conveyance.

8.3.17 During the Safeguarding Adults Review panel meeting, it was noted that the Police record of the request from the ambulance service referred to '*an aggressive 57 year old woman*'.

8.3.18 Police receive guidance and training on responding to people with mental health needs. Making the Police aware of a person's mental health needs enables the Police to consider in advance of attendance, responses that are sensitive to the person's mental health needs. East Midlands Ambulance Service reported that they had provided more information – requesting support for a lady who was head banging, that she was injuring herself and that the care home staff had stated could be aggressive. They did not feel it necessary to make explicit her mental health needs.

8.3.19 In the event, Police did respond and there were no concerns identified about their role. However, this incidental learning point about communicating mental health needs is important for future communications between Police and ambulance services. Northamptonshire Police recently introduced a mental Health Nurse within their Control Room to provide advice on mental health issues at peak times. This Mental Health Nurse has access to Northamptonshire Healthcare Foundation Trust records and can assist Police in understanding needs and providing sensitive and safe responses. It would maximise the value of this initiative if East Midlands Ambulance Service and Northamptonshire Police worked together to strengthen the process for communicating a person's known mental health needs when requesting assistance.

8.3.20 Claire's sister Michèle, informed the Independent Author that from looking at Claire's injuries she could not fathom how mental health services could have refused to come out to see her.

> **Claire's sister Michèle**
> ***'She was experiencing psychosis, self-harming and in extreme pain…. the irony is when she was admitted, (to Harbour Ward) we thought, thank goodness, she's been sectioned and they will get her back on track.'***

8.3.21 It is of note that when Claire demonstrated these same behaviours within a mental health in-patient environment, she received 2:1 nursing care and sadly, even this did not safely manage her behaviours.

8.3.22 Northamptonshire Healthcare Foundation Trust has made recommendations regarding the working practices between the Community teams and referral processes to the Crisis Resolution Home Treatment Team. ***(Appendix 1 Northamptonshire Healthcare Foundation Trust 22, 23, 24)*** The author also makes a recommendation regarding strategic commissioning of community mental health services so that providers such as Lindsay House are supported by specialist mental health services. [***Recommendation 3***]

8.3.23 **Behavioural Support and Crisis Responses while at Northamptonshire Healthcare Foundation Trust Harbour Ward**

8.3.24 Northamptonshire Healthcare Foundation Trust informed the review that the Safeward[21] model is used within the acute in-patient wards. This model provides analysis of interaction between patient conflict (behaviours that can result in harm) and containment (methods staff use to control difficulties on the ward).

8.3.25 Northamptonshire Healthcare Foundation Trust have psychologists that work with in-patient staff. Northamptonshire Healthcare Foundation Trust informed the review that there was a case formulation carried out with the team in relation to Claire and her behaviours. However, the Northamptonshire Healthcare Foundation Trust investigating team could not see from the records that this had been acted upon.

8.3.26 Findings from the review indicated concerns about the fundamental requirements for working with Claire toward her recovery.

8.3.27 The Northamptonshire Healthcare Foundation Trust report identified that staff did not form a therapeutic relationship with her. The fact of the fragmented nature of her care episode (three admissions to Northampton General Hospital during the Northamptonshire Healthcare Foundation Trust in-patient period) may have contributed. However it also appears that Claire was seen as a problem and her presentation 'behavioural' rather than looking behind the behaviour to understand the reasons. Responses to behaviours appeared to be confrontational and controlling rather than engaging and working with Claire in partnership.

8.3.28 We know that over her years at St Andrews and The Dallingtons, Claire had developed good insight into what helped her stay calm. At the Safeguarding Adults Review learning event, we heard that the Care Plan that was in place on Harbour Ward did record Claire's views on the things that helped her stay calm. An example was that Claire should be able to eat food in her room. There was however, rigid application of 'rules' and the activities that she knew helped calm her were not facilitated.

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[21] Journal of Psychiatric and Mental Health: Safewards: a new model of conflict and containment on psychiatric wards, L Bowers Feb 2014
Safewards, (2016) *Technical*, Available from: http://www.safewards.net/model/technical [Accessed: 12/07/16]

Northamptonshire Healthcare Foundation Trust Individual Management Report
'During her time on Harbour Ward Claire repeatedly asked the nursing staff to spend regular time resting on her bed as this was one of the main ways she calmed herself. The staff were generally unwilling to support these requests, however on one occasion it was agreed between Claire and her key worker that she would be allowed regular periods to rest in her room. The key worker documented this in Claire's Care Plan but did not verbally handover this agreement. When the key worker went off duty and Claire tried to put the plan into effect the Nursing staff on duty would not let her go to her room, which resulted in an escalation in her behaviour. … Care was not sufficiently individualized or recovery orientated'

8.3.29 The report from Northamptonshire Healthcare Foundation Trust indicates that the responses not only missed opportunities to work collaboratively with Claire. At times the responses breached basic standards of dignity and respect. This is reviewed further in Section 8.7, the theme relating to culture of care.

8.3.30 We know that Claire's family had made a massive contribution to her Care Planning in the past and as part of this were able to advise on strategies helpful to Claire. Their level of contact during this admission remained high, however there was very limited evidence of Northamptonshire Healthcare Foundation Trust seeking to involve them as partners in Claire's care.

8.3.31 Claire's sister Michèle attempted to get staff to see Claire as a person. When Claire was admitted her face and body were badly bruised and swollen and her eyes almost closed so Michèle brought in a recent photo of her looking happy to give staff a view of Claire the person. This was never circulated.

8.3.32 Claire's sister spoke to her key worker after Claire had been violent towards the staff and requested that Claire should be allowed to regularly rest in her room as this calmed her. This request was not implemented.

Northamptonshire Healthcare Foundation Trust Individual Management Report
'Claire had a supportive family and network of friends however the views of both Claire and her support network were often neither sought or when offered not implemented'

8.3.33 Claire was under enhanced observation for the majority of her in-patient stay. Northamptonshire Healthcare Foundation Trust staff considered that Claire should be nursed in their Psychiatric Intensive Care Unit (PICU) and this had been identified in the Mental Health Act medical recommendation on 10th September. However, there was no bed available. This unmet need was discussed within the bed meeting, held twice weekly and consisting of senior managers and the Inpatient Consultant Psychiatrists. A PICU bed was not accessed during her stay.

8.3.34 Despite Claire continuing to present with very disturbed behaviours, on the 15th September her level of observation was reduced. The Northamptonshire Healthcare Foundation Trust report author felt this was not reflective of Claire's need, but rather an attempt by Harbour Ward staff to signal Claire was ready for transfer from their short term assessment ward to a Mental Health recovery ward. This is also presented as a contributing factor in not increasing the level of observation when Claire started self- harming and was aggressive toward ward staff on the 21st September.

8.3.35 The use of enhanced observation offered the opportunity to build a therapeutic relationship with Claire. At this time, the composition of qualified staff to unqualified was higher than the normal ratio. This should have afforded more skilled intervention and guidance to the unqualified staff as part of the enhanced observations – there is no evidence of this happening.

8.3.36 There was also poor Risk Assessment documentation. The 'Working with Risk 1' document was not updated to reflect changes and incidents. This meant there was poor communication between the multi-disciplinary team in assessing Claire's changing needs. It also meant there was no opportunity to step back and analyse Claire's presentation over time, using Safewards model[22] to consider factors such as staff and environment and how this may be perpetuating her disturbed behaviour.

8.3.37 It is difficult to see the reasons behind these basic omissions in applying preventative strategies, reducing conflict and carrying out post incident analysis:

- Staff had had access to a psychologist and Safewards - an evidenced based model of care was in place.

- Staff had received training in areas such as managing challenging behaviours and dignity in care.

- The ward was running at full staff complement with higher ratio of nurses to unqualified staff.

- Other psychiatric units such as St Andrews and The Dallingtons appear to have been able to engage with Claire in her recovery.

8.3.38 At the Safeguarding Adults Review panel, The Dallingtons were asked whether they would have been willing to be contacted by Northamptonshire Healthcare Foundation Trust Harbour Ward for advice on successful interventions they had used with Claire. This was confirmed - indeed the Safeguarding Adults Review panel were informed that the St Matthews' Consultant Psychiatrist visited Claire on Harbour Ward at the request of Claire's sister. Northamptonshire Healthcare Foundation Trust had no record of this visit or the discussion he had with the ward's Deputy Manager.

8.3.39 Northamptonshire Healthcare Foundation Trust highlight from their investigation that staff had strong views on Claire's presentation and the treatment she should receive.

[22]Safewards, (2016), *Safewards: An Introduction*, http://www.safewards.net/model-diagram

Northamptonshire Healthcare Foundation Trust Individual Management Report ***'Some staff were seemingly negative regarding the personality difficulties experienced by Claire. The investigating team believe there was a strong desire by the nursing team to move Claire on from H Ward to one of the Mental Health Recovery wards and this may potentially have impacted on decisions related to changing and downgrading Claire's enhanced observations. It may also have affected the decision not to increase the observations when Claire's started to self-harm and become aggressive towards the staff on the evening of 21st September. This omission provided Claire with the opportunity to cause herself sufficient injuries the following morning to require her to be sent to the A&E unit at Northampton General Hospital.*** ***In interviews, the team vocalised the consideration of risks as relating to themselves as individuals as opposed to the risks for the patient.***

8.3.40 What is apparent is that the management of Claire's crisis behaviour by Harbour Ward was a long way from expected professional practice. Staff may have had the competence and technical understanding of how they should respond and who they should involve. The fact that this was not applied appears to be due to personal and discriminatory judgements about Claire.

Section 8.7 considers the culture of the ward that allowed these attitudes to go unchallenged.

8.3.41 Northamptonshire Healthcare Foundation Trust has made a series of recommendations regarding person centred care involving the multi-disciplinary team. ***(Appendix 1 Northamptonshire Healthcare Foundation Trust 2, 3, 4, 5, 7, 9, 10, 11, 12, 20).***

8.4 Behavioural Support and Responses to Claire's Mental Health Crisis – Key Learning Points

i.	Crisis plans must derive from robust risk assessment of historic and current factors. The Crisis Plan needs to provide detailed, person centred information about preventative strategies, de-escalation techniques and guidance on effective responses to behaviours when in crisis.
ii.	Those involved in responding to crisis need ready access to the necessary information for clinical decision making. Electronic record systems must be fit for this purpose.
iii	Mental health services need to be flexible enough to revolve around the person rather than around each services' criteria. Individual mental health services must own the collective responsibility to meet the needs of service users in their care.
iv	GP's and providers of community services, need to have clear escalation routes where they have concerns about service provision and be clear about when and how to refer for a Mental Health Act assessment.

v	When the ambulance service is requesting police assistance, where information is known about a person's mental health needs, this should be conveyed to assist Police in making appropriate responses.
vi	The fact that there is a model of care in place and staff have the technical knowledge and training to know how to implement it is not in itself enough. Working with service users in crisis is testing, particularly when the person has behaviours that are challenging. This requires staff to hold professional and personal values of working in partnership with the person and seeking out the meaning behind their behaviours. Managers need to assure Care Plans are being acted upon and in a way that reflects this ethos.

8.5 Physical Health Care for People with Severe Mental Illness

8.5.1 There is substantial research that identifies that people with serious mental health conditions have significantly poorer physical health than the rest of the population.

Five Year Forward View for Mental Health[23]
Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.

8.5.2 NHS England introduced a financial incentive scheme in 2014/15 to address this Health inequality[24]

NHS England 2014/15
Commissioning for Quality and Innovation will promote a change in culture and practice on in-patient wards, for the first time incentivising providers to train staff to carry out physical health assessments and treatments and ensure resources for such care are available on all inpatient wards.

8.5.3 A report by Rethink[25] detailed some experiences from service users' and reasons they gave for poor physical health. These included:

- Physical health concerns not being taken seriously because of a mental health diagnosis.
- Delays in treatment as people are caught between mental health and physical health services, which can exacerbate physical health problems.

[23] Mental Health Taskforce, (2016) *Five year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England*
[24] NHS England, (2015) *NHSE Commissioning for Quality and Innovation (CQUIN)*, Available from: https://www.england.nhs.uk/wp-content/uploads/2014/06/cquin-add-mh-guid.pdf [Accessed: 12/07/16]
[25] Rethink, (2012) *20 Years Too Soon*, Available from: https://www.rethink.org/media/511826/20_Years_Too_Soon_FINAL.pdf [Accessed: 12/07/16]

- Lack of communication, both between primary and secondary care and between mental health and physical health services.

This theme will consider whether these experiences were also relevant in Claire's care.

8.5.4 **Rethink: 'Physical health care not being taken seriously because of a mental health diagnosis'** When Claire was admitted to Harbour Ward, she should have received a range of physical health care checks. Some of the checks were associated with targets for the NHS England Commissioning for Quality and Innovation financial incentive.

8.5.5 The NEWS (National Early Warning Signs) is a system for recording physical observations and recognition of deterioration. The Northamptonshire Healthcare Foundation Trust report identified that Claire's score was '*repeatedly incorrectly calculated with no escalation plan or frequency of observations defined*.'

8.5.6 Harbour Ward did not apply systems for allocating tasks, signing off that the task was completed or handing over tasks outstanding. This meant that where physical health checks had been completed and identified a need to act, the task was not allocated and no action was taken.

8.5.7 The ward's record keeping system perpetuated this poor communication. Harbour Ward did not record on the electronic patient record Care Plans as was expected practice. Records were kept on handover sheets – these were shredded the next day with the result that patient information was lost. The Northamptonshire Healthcare Foundation Trust report found that significant amounts of information were either missing from the records or written retrospectively, including some evidence of false entries.

8.5.8 The combination of lack of competence; poor allocation of tasks and absence of accurate recording had a significant impact on the management of Claire's physical health.

8.5.9 An example of this is highlighted in the Northamptonshire Healthcare Foundation Trust report.

> **Northamptonshire Healthcare Foundation Trust Individual Management Report**
> ***"Claire's oral intake had been highlighted as a concern on admission and was identified by the admitting Staff Nurse as being at risk with a Malnutrition Universal Screening Tool score of 2; however no actions were taken to address this. Claire's MUST score was repeated on three further occasions by a Charge Nurse and a Staff Nurse and appropriate actions were not taken as a result of the scores. Of even greater concern is that two of these recordings were completed whilst Claire was an in-patient at Northampton General Hospital and therefore no assessment on Harbour ward could have been possible at the same time. During staff interviews it was identified that the correct process for reviewing MUST assessments was not followed and staff considered this to be a "tick box" exercise. Certain staff also stated that fraudulent completion of the MUST assessments was a necessity for a 100% achievement rate in the trusts audits.'***

8.5.10 When Northamptonshire Healthcare Foundation Trust were initially reviewing information for their serious incident investigation, they could not find any information regarding physical health checks being carried out between the 6th to 13th Sept. However, it transpired that the record card of observations carried out over this period had appropriately been taken to Northampton General Hospital when Claire was admitted and the record had remained there – Northampton General Hospital produced this in evidence during the Inquest.

8.5.11 It remains unclear what observations were done or the quality of these observations. Observations should have been shared as daily NEWS with anything outside of normal having an escalation plan.

8.5.12 This did not happen. Claire lost 15 kilograms in 15 days. Some staff noticed her weight loss but no action was taken as a result. The ward staff had no access to a dietician but at no stage did nursing staff raise concerns to the medical team.

8.5.13 Records are that Claire first made a complaint of back pain on the 10th September 2014. In the short remaining period of her admission to Harbour Ward, there was a record of Claire complaining of back or chest pain every day other than on 2 -3 days.

8.5.14 Following Claire's admission on the 12th September, Northampton General Hospital informed Northamptonshire Healthcare Foundation Trust Harbour Ward staff, that there was no evidence of a spinal fracture. Harbour Ward staff therefore responded as if Claire's complaints were psychosomatic or 'behavioural'.

8.5.15 It is reasonable that Harbour Ward would be guided by the view of Northampton General Hospital as experts in physical care. The review also has to be cautious about using the benefit of hindsight and the knowledge we now have that Claire had undiagnosed spinal fractures for at least some of the time she was an inpatient on Harbour Ward.

8.5.16 However, there is also the fact of Claire's insistent and sustained complaints of pain, her inability to move easily coupled with the recent history of injuries to her head; face; neck and back. Given this, it would be reasonable to expect the Harbour Ward medical and nursing staff to question the diagnosis from Northampton General Hospital and re-refer Claire for further tests.

8.5.17 Northamptonshire Healthcare Foundation Trust medics did refer Claire back to Northampton General Hospital on the 12th September and 22nd September. The referral on the 22nd was triggered by further self-harm and concern of head injury.

8.5.18 When Claire was admitted to Northampton General Hospital on the 25th September, the history provided to the Northampton General Hospital Consultant was that Claire had not moved her legs for 2 days. This should have prompted immediate medical attention from Harbour Ward and Northamptonshire Healthcare Foundation Trust.

8.5.19 Had communication between the Harbour Ward nursing and medical team been more effective regarding her physical health, the re-referrals and consultation between Northamptonshire Healthcare Foundation Trust and Northampton General Hospital may have been made more promptly.

8.5.20 Lack of questioning of the Northampton General Hospital diagnosis could also be due to levels of competence. Northamptonshire Healthcare Foundation Trust report that the staff interviewed did not consider Claire's head banging as potentially sustaining a head injury and consequently did not initiate the Glasgow Coma Scale monitoring. This is concerning given that Claire had so recently been treated in hospital for a head injury arising from self-harm.

8.5.21 Reasons could also be due to an over willingness to discount physical symptoms as symptoms of mental illness – commonly referred to as diagnostic overshadowing. The attitudes surrounding this are discussed further in Section 8.7. below.

8.5.22 What is clear is the need for Northamptonshire Healthcare Foundation Trust to assure physical health needs are an integral part of mental health services Care Plans and that there are appropriate systems to support this. Northamptonshire Healthcare Foundation Trust has made a series of recommendations for their service to address this.
(***Appendix 1 Northamptonshire Healthcare Foundation Trust 8, 10, 12, 13, 14, 15, 17, 18, 19, 25, 26***).

8.5.23 NHS Nene Clinical Commissioning Group, as the commissioning body, also has a duty to assess the quality of care they commission. The author makes recommendations for the Northamptonshire Safeguarding Adults Board to receive assurance from NHS Nene Clinical Commissioning Group and Northamptonshire Healthcare Foundation Trust regarding the physical health care provision of patients in in-patient care and that the systems and processes are actually delivering effective outcomes to patients. *[**Recommendation 5**]*

8.5.24 The Safeguarding Adults Review panel also considered whether Claire's mental health presentation influenced assessment of her physical health needs by East Midlands Ambulance Service when conveying her to hospital on the 25th September – specifically, consideration of a spinal collar and block. The information presented to the review was that East Midlands Ambulance Service responded reasonably to the information provided to them (cardiac arrest) and to the observation made of Claire's presentation i.e. that Claire had experienced a respiratory arrest. There was no indication that the response was overshadowed by her mental health presentation.

8.5.25 The review also considered whether there were any omissions in Claire's physical care from Northampton General Hospital that may have been attributable or overshadowed by her mental health needs.

8.5.26 The panel considered the findings from the inquest:

> ***Coroner's Narrative verdict***
> ***'Imaging done on 22nd September 2014 was not adequate enough to pick up a C7 vertebrae and identify a possible fracture. This was a missed opportunity in her overall regime of care'.***

8.5.27 The Safeguarding Adults Review panel also debated the circumstances surrounding the referral to Leicester Royal Infirmary for specialist spinal services on Claire's admission on the 25th September. This related to the timeliness of responses and clarity of referral pathways.

8.5.28 Once Claire was in Northampton General Hospital, there was a 12 hour period from identification of lack of power in Claire's legs; reduced anal tone and possible spinal tenderness to obtaining any imaging.

8.5.29 It also took 24 hrs. from arrival to the emergency department to first referral to Leicester Royal Infirmary. This referral was not accepted by Leicester – the reason given was that the 48 hour window for acute intervention had passed. There was then a further day before there was discussion with Stoke Mandeville for rehabilitative care – again, the referral was not accepted as Stoke Mandeville advised rehabilitation was not appropriate at that time as surgical stabilisation may be required.

8.5.30 Following a further referral to Stoke Mandeville on the 1st October, the Stoke Mandeville Outreach Matron attended but could not assess Claire as she was under sedation. However the Matron provided guidance on bowel care. Stoke Mandeville could not offer admission as this was dependent upon Claire being ventilator free. Stoke Mandeville offered further outreach contact the following week.

8.5.31 Seven days later, Northampton General Hospital sought specialist opinion from University Hospital Coventry and Warwick. Though University Hospital Coventry and Warwick said they were not commissioned to provide services for Northamptonshire, it is understood that they would have been an available service for a traumatic injury because of the Trauma Network.

8.5.32 Ten days after the original referral to Leicester Royal Infirmary was turned down a re-referral was made and accepted. Claire was never able to be transferred because of her deteriorating condition and being too poorly to cope with the transfer.

8.5.33 It is not known whether there was a missed window of opportunity for Claire to be seen earlier by the specialist services. Claire had pneumonia at the time of the first referral and it is not clear whether spinal treatment at Leicester University Hospital at this earlier stage would have had any bearing on the outcome for her.

8.5.34 From the information available to the Safeguarding Adults Review, there was no evidence that these decisions or the care provided by Northampton General Hospital were compromised by Claire's mental health needs. The decisions taken were clinical decisions and the actions/inactions could have been taken for any patient with similar clinical presentation.

8.5.35 The circumstances surrounding the previous Serious Case Review of AP[26] i.e. care being compromised due to the person's disabilities (in this case learning disability), were not evident in the care provided at Northampton General Hospital.

8.5.36 Northampton General Hospital made a recommendation regarding a spinal pathway to facilitate referrals. (***Appendix 1 Northampton General Hospital 1***).

8.5.37 **Rethink: 'Caught between Mental Health and Physical Health Services'**
The review also highlighted some debate between Northampton General Hospital and Northamptonshire Healthcare Foundation Trust about Claire's physical and mental health care needs and which environment could best respond.

8.5.38 There was a question particularly surrounding Claire's admissions to Northampton General Hospital and Northamptonshire Healthcare Foundation Trust on the 12th and 22nd September – Northamptonshire Healthcare Foundation Trust questioned whether full investigations were carried out and whether Claire should have remained in Northampton General Hospital care for longer. Northampton General Hospital maintains that their investigations were thorough and continued admission was not clinically indicated. Northamptonshire Healthcare Foundation Trust presented to the review their Solicitor's notes that were taken at the inquest hearing[27]. This recorded evidence presented by the Northampton General Hospital A&E Consultant that prior to the inquest, he had requested their Radiologist review the CT scan taken on the 12th September. The Radiologist had found additional fractures, in particular, Claire had two rib fractures and a sternum fracture. The Solicitor's notes from the inquest record the Northampton General Hospital Consultant's view that it was much less likely that Claire would have been discharged on the 12th September if the T12 fracture had been discovered and in any event, felt an overnight admission was warranted.

8.5.39 All this evidence was reviewed within the inquest hearing and it is not the role of this Safeguarding Adults Review to review evidence that has already gone through a due legal process. What is apparent is that Claire had extensive physical and mental health needs. Both services had some expertise in mental health and physical health but neither was specialist in both fields. Northamptonshire Healthcare Foundation Trust and Northampton General Hospital collectively held the specialist skills to address Claire's needs. What she needed was effective communication and collaborative working between these services. A recommendation is made by the author in relation to this. [***Recommendation 7***]

8.5.40 **Rethink: 'Lack of communication, both between primary and secondary care and between mental health and physical health services'.**
There was no evidence that communication with Claire's GP adversely affected her physical health needs. There were a number of points of learning regarding communication between the Northampton General Hospital and Northamptonshire Healthcare Foundation Trust.

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[26] Ibid

[27] Northamptonshire Health Care NHS Foundation Trust: Hempson's note of Inquest 'Claire' 19th January – 26th January 2016

8.5.41 For Claire's four admissions during September 2014, Northampton General Hospital were provided with written referral information from Northamptonshire Healthcare Foundation Trust, outlining her presentation and requesting investigations. However direct contact was very limited.

8.5.42 Claire was accompanied by a member of staff from Northamptonshire Healthcare Foundation Trust, as per protocol for patients detained under the Mental Health Act.

8.5.43 This was an opportunity to communicate to Northampton General Hospital knowledge of Claire, her mental health needs and details about her physical health presentation while at Northamptonshire Healthcare Foundation Trust. There is limited information from the Northampton General Hospital or Northamptonshire Healthcare Foundation Trust reports to understand what contribution this person played.

8.5.44 Discharge summaries from Northampton General Hospital are routinely sent to the GP but not to the place of discharge, in this case Northamptonshire Healthcare Foundation Trust. This meant that detailed information regarding Claire's care was not provided directly to Northamptonshire Healthcare Foundation Trust. Northamptonshire Healthcare Foundation Trust maintain this was a reason for a delay in starting antibiotics for her chest infection when Claire was discharged back to them on the 13th September and antibiotics for chest infection were not started until the 19th September.
Northamptonshire Healthcare Foundation Trust has made a recommendation regarding this. (***Appendix 1 Northamptonshire Healthcare Foundation Trust 26***)

8.5.45 The Safeguarding Adults Review panel, discussed the levels of communication between the two services. Northampton General Hospital identified 4 episodes of communication.

- On the 7th September a referral letter from the Northamptonshire Healthcare Foundation Trust GP with special interest

- A letter sent with Claire from her Northamptonshire Healthcare Foundation Trust consultant to Northampton General Hospital on 12th September (standard transfer of care)

- 22nd September a Doctor from Northampton General Hospital rang a consultant at Northamptonshire Healthcare Foundation Trust

- 10th October. Phone call from Northamptonshire Healthcare Foundation Trust Consultant to enquire on Claire's progress and advice on her anti-psychotic medication.

At no time was Consultant to Consultant discussion initiated by the Northamptonshire Healthcare Foundation Trust and Northampton General Hospital Consultants. Claire's family recall the poor communication was exacerbated during this period due to the Northamptonshire Healthcare Foundation Trust Consultant being on annual leave.

8.5.46 Improved direct communication could have made a positive impact on Claire's care and potentially, outcomes for her. An example was seen in Harbour Ward discouraging Claire from lying down due to fluid on her lungs - following advice from Northampton General Hospital. The impact of this was significant in terms of the responses outlined in Section 8.3 (Behavioural Support and Response to Crisis) but also the factors leading up to her emergency admission on 25th September.

> ***Northamptonshire Healthcare Foundation Trust Chronology***
> ***'Advised that had attempted to sit Claire up at the side of the bed when she became unresponsive, floppy and stopped breathing.'***

8.5.47 Whilst avoiding lying down was necessary for Claire's physical health needs, the impact of this on Claire's mental health needs and the resultant conflict this gave (as described in section 8.3 above) was significant.

8.5.46 There appears to have been limited consultation between Northamptonshire Healthcare Foundation Trust and Northampton General Hospital about how to best manage her physical health needs, the implications any treatment plans could have on her mental health and developing joint plans to manage this.

8.5.47 As the Coroner's narrative verdict indicated:

> ***Coroner's Narrative verdict***
> ***'It is evident that the two way communication between Harbour Ward and Northampton General Hospital was inadequate, lacking consistency and specific related information regarding her back pain. This would have contributed to her suffering, care and treatment.'***

8.5.48 A recommendation is made by the author in relation to this, in addition to the recommendations made by Northampton General Hospital and Northamptonshire Healthcare Foundation Trust (***Appendix 1 Northampton General Hospital 2; Northamptonshire Healthcare Foundation Trust 17, 26***). [***Recommendation 7***]

8.6 Physical Health Needs – Key Learning Points

i.	There are significant health inequalities for people with severe mental illness. Financial incentives are not sufficient to change mental health practice. Redressing this requires a shift in culture for mental health staff to a more holistic approach to care, supported by robust systems.
ii.	Organisations need to ensure professional challenge and objective assessment is in place regarding physical health care for people with mental health needs to reduce the risk of diagnostic over-shadowing.
iii	Secondary services such as Mental Health Trusts and Acute Trusts need to be able to develop a shared care ethos, collaborating and combining their specialist knowledge to deliver effective holistic care.
iv	Pathways of care to specialist services need to be clearly mapped out to enable timely referral to the most appropriate specialist services. This is relevant to all patients but particularly important where there is a complex presentation such as mental health and physical health comorbidity.

8.7 Culture of Care

8.7.1 Examining the culture of care is important to understand behaviours and motivations behind staff actions and the service Claire received.

8.7.2 **Culture of Care in Community**
The review has highlighted some circumstances where the culture was one of collaboration and flexibility with a focus on meeting Claire's needs. The attitudes toward Claire's transition and efforts put into this outlined in Section 8.1 was a good example of this.

8.7.3 Claire's sister also highlighted the basic kindness and compassion shown by some individuals at Lindsay House. There was good evidence of considering her dignity and respect and trying to deliver person-centred care with Claire and her family.

8.7.4 However, the review found that within Community Mental Health Services, there was also a culture of silo working. Services failed to act as a collective and owning responsibility for ensuring an effective response to Claire was given when she was in crisis. For some workers, the culture of guarding boundaries to their service blinded them to seeing Claire's need.

8.7.5 **Culture of Care in Harbour Ward**
The Northamptonshire Healthcare Foundation Trust report discussed in some detail the relevance of culture within Harbour Ward.
It is worth emphasising at this point that Northamptonshire Healthcare Foundation Trust's contribution to the review has been one of promoting transparency and openness with a clear desire to acknowledge where things have gone wrong and identify learning.

8.7.6 As noted in Section 8.3 (Behavioural Support and Response to Crisis) there appeared to be a pervasive negative attitude by Harbour Ward staff toward Claire. This overrode professional interpretation of behaviours.

8.7.7 Claire's niece observed during a visit that staff talked to her like she was a naughty child. Claire's sister Michèle felt the team seemed to take an instant dislike to Claire.

Claire's sister Michèle
'there was a climate of disregard and cruelty.'

8.7.8 The Northamptonshire Healthcare Foundation Trust's own agency report made stark reading. Responses to her infringed basic standards of dignity and decency.

Northamptonshire Healthcare Foundation Trust Individual Management Report & Chronology

'Claire herself expressed to her family that she had lost her routine and could not access the things that helped her to stay calm when she got distressed. It became apparent that Claire did not have her glasses so could not see to read, and her taped music and reading materials were still at Lindsay House. When this was raised with the staff they suggested Claire read a magazine or watched the television, ignoring the fact Claire did not have her glasses and that she did not usually read magazines or watch television. Some of Claire's friends visited and they offered to collect her personal effects from Lindsay House, however, this was not facilitated.'

'Claire requested a bed pan and informed none available and that she would have to hold on for another 2 hours.'

'During their interviews staff confirmed that bed pans were available and the Ward Matron discussed how bed pans would be sourced if for any reason the unit did not have supplies at that time.

The investigating team feel that the refusal of bed pans was based on the staffs' collective insistence that Claire's requests were based on behavioural "demands" and not on the patients inability to get out of bed. One of the Charge Nurse's continued to state throughout the interview that the patient was deliberately incontinent and the general feeling of the investigators is that this was continually handed over by staff and therefore considered to be normal/ factual.

There is very little documented in the clinical record regarding Claire's continence care whilst she remained in bed over this 3 day period. There are some references to Claire being incontinent and the sheets being changed however there is no record of any continence pads or bed pans being used. On interview with the staff they confirmed changing sheets and refusing to supply bed pans and some said Claire had not asked to go to the toilet during their shift. The investigation team can only conclude that Claire was left with no alternative but to be incontinent in her bed during this three day period.'

8.7.9 There was a sense of a culture operating on the ward that was inward looking. Staff appeared fixed in their views about Claire's presentation and decisions were made without reference to the multi-disciplinary team. There was poor communication between the medics and the nursing team. Opportunities to ask advice from others such as family or The Dallingtons were not used.

8.7.10 Working within acute mental health in-patient units can be extremely challenging. The nature of mental disorders can present real difficulties for those involved in care and it is not always easy to form therapeutic relationships. The levels of assault to mental health staff are high.

8.7.11 In relation to Claire, her keyworker was pregnant and understandably, an assault by Claire was particularly concerning for her. However, there was a lack of professionals stepping back and seeking meaning behind Claire's behaviours and questioning why Claire was continually complaining of pain.

8.7.12 Harbour Ward's fixed ideas about Claire's behaviour meant staff did not pursue further checks. This was an example of diagnostic overshadowing i.e. misinterpreting physical symptoms as symptoms of her mental illness. Claire's reaction was merely seen as further evidence of her 'problematic' behaviour.

Northamptonshire Healthcare Foundation Trust Individual Management Report
"At the time we were told there was no fracture so we acted accordingly and believed her complaints were psychosomatic.'

8.7.13 The Northamptonshire Healthcare Foundation Trust report highlighted a general disregard for some physical health check procedures – this led to a tick-box response without addressing the need.

8.7.14 This culture also allowed other routine violations of policies; procedures and recording practices. As outlined in Section 8.5, this included disregard for recording practices; falsification of data and records; and ignoring systems for checking tasks were completed. We know this all had a significant impact on the care Claire received and was likely to also have affected the physical care of other patients on Harbour Ward.

8.7.15 Overall, the culture on Harbour Ward was dismissive of Northamptonshire Healthcare Foundation Trust's standards as well as Claire's rights. The observation of the Northamptonshire Healthcare Foundation Trust report author was that some staff were apathetic about non-compliance with standards and the repercussions of poor compliance with any protocols. The reported practices and behaviours of staff were also in breach of Professional Standards and Code of Practice[28].

8.7.16 Subsequent audits carried out by Northamptonshire Healthcare Foundation Trust identified that these poor practices were not endemic across the Trust but something of a sub-culture had developed on Harbour Ward.

[28] NMC The Code Professional Standards of Practice and Behaviour for Nurses and Midwives versions 2008 and 2015

8.7.17 The Northamptonshire Healthcare Foundation Trust investigating team found the poor culture within the ward was maintained because of unhealthy and counterproductive working patterns amongst key senior staff members. This allowed, and potentially perpetuated the lack of professional practice and permitted negative attitudes and, in the Safeguarding Adults Review author and panel's view, abusive practices to go unchallenged.

8.7.18 There remains the question of why this culture was able to develop on Harbour Ward. Detailed analysis of this is beyond the scope of this Safeguarding Adults Review. However, Northamptonshire Healthcare Foundation Trust will need to examine this further to understand the factors at the root of this and to be fully assured that this culture does not continue to exist. Their recommendations relate to this. (***Appendix 1 Northamptonshire Healthcare Foundation Trust 5, 6***)

8.7.19 The role of clinical leadership by medics and other professional disciplines will be important elements to explore.

8.7.20 Supervision also plays an essential role in helping staff to reflect on, and develop their practice. Northamptonshire Healthcare Foundation Trust reported that the minimum requirement for all staff within Northamptonshire Healthcare Foundation Trust is to have eight supervision sessions per year, two sessions in each quarter.

8.7.21 Northamptonshire Healthcare Foundation Trust confirmed that supervision requirements were met by the services involved and their investigation found no issues in relation to supervision. However, the effectiveness of supervision is dependent upon the quality as well as frequency. This will also be an important element for Northamptonshire Healthcare Foundation Trust to explore as part of redressing culture of care within their services.

8.7.22 **Culture of Care in Northampton General Hospital**
One of the Terms of Reference for this review relates to whether learning from a previous Northamptonshire Serious Case Review of Alice Porter[29] had been embedded into practice.

8.7.23 This Serious Case Review of AP, highlighted areas of Northampton General Hospital practice that required further development.

- Lack of communication between and within staff groups and between Northampton General Hospital staff and outside agencies.
- No assessment of AP's capacity.
- Poor documentation of diagnosis, care given and communication with AP's family and carers.
- Failure to identify AP's symptoms as an indication of possible spinal shock or cerebral involvement, despite being told she had hit her head and lost consciousness when she initially fell.

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[29] Northamptonshire Safeguarding Adults Board, (2014) *Serious Case Review AP*

8.7.24 The evidence from the Northampton General Hospital review indicates that there was good communication with Claire and her family throughout the period of her admission and inclusion in Claire's Care Planning.

8.7.25 There was appropriate consideration of Claire's mental capacity. The existence of an Advance Decision, which included strong views associated with Claire's faith was well documented. Care was taken to talk through with Claire the risks of not having blood products. Claire's wishes were respected while she was able to make the decision and her Advance Decision was upheld when she latterly lost capacity. When Claire was not able to make other decisions, the Consultant consulted with her family. Claire's family wished Claire to be made comfortable and had not wished her to have a pace-maker or have a head brace fitted. However, the Consultant made a Best Interest decision in line with the Mental Capacity Act 2005.

8.7.26 Though there are questions about the effective and timely referral to specialist spinal services, there was no evidence that Claire's mental disorder adversely affected these decisions or treatment. There was no evidence of diagnostic over-shadowing or Claire's mental disorder adversely affecting the services she received or attitudes from staff. Reasonable measures were put in place to respond to her mental health needs.

8.7.27 However, as outlined in Section 8.5, (Physical Health Care for People with Mental Illness) there was some indication of an inward looking practice – whilst communications within Northampton General Hospital were effective, communications between Northampton General Hospital and Northamptonshire Healthcare Foundation Trust could have been improved to offer a more holistic response to her physical and mental health needs. There was not a sense of shared care between these two agencies, exemplified by the fact that no communication took place between the Northamptonshire Healthcare Foundation Trust and Northampton General Hospital Consultants during the period of her admissions.

8.7.28 As noted in Section 8.6 both Northampton General Hospital and Northamptonshire Healthcare Foundation Trust have made recommendations about improving the knowledge of mental health/physical health respectively. Northamptonshire Healthcare Foundation Trust has recommended reviewing discharge protocols. However, both services need to go further and consider joint actions to develop collaborative working practices where a person has complex comorbidity. The author makes a recommendation relating to this. [***Recommendation 7***]

8.8 Culture of Care – Key Learning Points

i.	The culture of care is intrinsic to the success or failure of any Care Plan. This has more to do with the values and attitudes of staff than the professional qualification they may hold.
ii.	Services need robust systems and processes and defined models of care. However, these are ineffectual without core values that respect the individual, work in partnership with others and keep focused on the person and their needs.
iii	Organisational assurance needs to go beyond reviewing data and auditing processes. Quality of care is tested by listening to the lived experience of service users and their carers and observing practice on the ground.
iv	Clinical leadership is essential to modelling acceptable practice and establishing a culture that puts the person's needs at the centre.
v	Working with people in mental health crisis can be challenging and professional supervision is necessary to help staff step back, question their values and beliefs and how this may affect their practice.

8.9 Systems and Service Provision in Mental Health

8.9.1 This theme will briefly look at some wider systemic issues that may have been contributory factors to Claire's care and the tragic outcome for her.

8.9.2 Recognising wider systems' issues is in no way meant to detract from the issues raised in earlier sections of this report relating to professional practice and culture. However, the review must also take account of the wider system in which these services were operating in order to identify learning.

8.9.3 The pressures within mental health services and years of underfunding is well established. The extract below highlights well the impact of this for front line practitioners, service users and families.

> **Five year Forward View for Mental Health**[30]
> ***Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.***
>
> ***Almost one-fifth of people with care coordinated through the Care Programme Approach have not had a formal meeting to review their care in the previous 12 months…***

[30] Mental Health Taskforce, (2016) *Five year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England*

> ***In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital A&E departments have 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police.***
>
> ***... Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.'***

8.9.4 This context, helps to understand the pressures staff may have been under. It does not excuse practice but does make more noteworthy the good practice that was in evidence, such as the early work that went into the transitions phase. It may also give some understanding of issues such as demoralised and disaffected staff.

8.9.5 This climate and lack of resources in mental health services also has substantial effect on the availability of community resources. Support packages commissioned by Health and Social Care services are dependent upon market forces i.e. whether independent businesses and voluntary sector organisations are able or willing to provide care and support services to people with mental health needs.

8.9.6 Section 8.1 of this review, (transition planning) identified that Claire had very limited choice when it came to placements to meet her needs and this then impacted on the management of her risks.

8.9.7 As in Claire's situation, supporting people's mental health recovery will often need combined packages between residential/supported living providers and specialist mental health services provided by Mental Health Trusts and Social Care.

8.9.8 Strategic planning needs to encourage Independent and Voluntary Sector providers to provide mental health services. There is a need to support those services and skill-up the workforce to manage the spectrum of needs and effectively manage crisis. This shift will increase the ability for people to recover within their communities. It will also reduce pressure on acute in-patient mental health wards and intensive care units. As well as national policy, this is directed by statutory guidance.

> **Mental Health Act Code of Practice 1.4**
> **Commissioners, providers and other relevant agencies should work together to prevent mental health crisis and, where possible, reduce the use of detention through prevention and early intervention by commissioning a range of services that are accessible, responsive and as high quality as other health emergency services**

8.9.9 The Government has pledged to invest more funding in mental health[31] responding to the findings of an independent taskforce. This is badged as part of the biggest transformation of NHS Mental Health Services in England for a generation and amongst other things, people facing mental health crises will be able to get community care 24 hours a day, seven days a week.

8.9.10 The Government published a Mental Health Crisis Care Concordat in 2014[32]. The concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects commitment from local services to deliver these aspirations and Northamptonshire has developed an action plan to address these aims.[33]

8.9.11 As part of its wider strategic assurance role, the Northampton Safeguarding Adults Board should seek assurance that the local investment of these funds takes into account the learning from this Safeguarding Adults Review. The Northamptonshire Safeguarding Adults Board may also wish to be sighted on the implementation of the Northamptonshire Crisis Care Concordat and whether the action plan is delivering improved experiences for service users. The author makes recommendations relating to this. ***[Recommendations 3 and 4]***

8.10 Systems and Service Provision in Mental Health – Key Learning Points

i.	The Government has acknowledged that mental health services need to be adequately resourced and to have 'parity of esteem' with physical health provision. This aspiration needs to be delivered to services on the ground.
ii.	Strategic plans focused on supporting people's recovery in the community and out of hospital have to be matched by comprehensive services and accommodation to meet their needs. Attracting providers to deliver services for mental health is likely to need adequate funding, support by specialist services and development of a workforce with skills required.

[31] The Guardian, (2016) *NHS vows to transform mental health services with extra £1bn a year,* Available from: https://www.theguardian.com/society/2016/feb/15/nhs-vows-to-transform-mental-health-services-with-extra-1bn-a-year [Accessed: 12/07/16]

[32] HM Government, (2014) *Mental Health Crisis Concordat*, Available from: http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf [Accessed: 12/07/16]

[33] Northamptonshire Mental Health Crisis Care Concordat Action Plan, (Updated January 2016)

8.11 Safeguarding Responses

8.11.1 At the time covered by this review, policy guidance for Safeguarding Adults was contained in No Secrets[34]. Northamptonshire had local safeguarding adults procedures setting out how agencies, led by Northamptonshire County Council, should work together to respond to abuse and neglect of vulnerable adults and protect the person from harm.

8.11.2 From reviewing the reports submitted to this review, it was evident that these procedures were not carried out effectively by all agencies. There were missed opportunities to raise safeguarding referrals regarding Claire.

8.11.3 Northamptonshire Healthcare Foundation Trust note that on the 8th September, Harbour Ward considered making a safeguarding referral regarding the care Claire received at Lindsay House. It is not clear what the reasons were for considering this though the Northamptonshire Healthcare Foundation Trust report notes risks associated with care in an establishment inappropriate to meet needs. This in itself would not be grounds for safeguarding unless it was associated with risk of abuse or neglectful care. In the event no safeguarding referral was completed.

8.11.4 The description of the treatment Claire received while an in-patient on Harbour Ward certainly would be categorised as abuse and neglect, given the affront to her dignity in relation to lack of continence care, lack of attention to essential food and hydration and the repeated omissions and commissions of physical care, that Claire was totally dependent on them to provide. In the view of Claire's sister, the treatment of Claire by some staff was cruel.

8.11.5 Northamptonshire Healthcare Foundation Trust had relevant whistleblowing policies in place – no member of staff used these procedures or raised a safeguarding adults' referral. From the Northamptonshire Healthcare Foundation Trust investigation, it appears the culture on the ward blunted staff from viewing the treatment of Claire as neglectful or abusive.

8.11.6 At the Safeguarding Adults Review learning event, attendees also considered whether the agencies interacting with Northamptonshire Healthcare Foundation Trust (Northampton General Hospital and East Midlands Ambulance Service) may also have missed opportunities to raise a safeguarding alert. Objectively, Claire was presenting with significant distress, extensive bruising, she had repeat admissions to Northampton General Hospital; weight loss and smelling strongly of urine. These are all indicators of potential abuse. However, the context was Claire had a well-documented history of self-harming behaviour and was receiving treatment within a specialist mental health service. It was reasonable therefore for services to make the assumption that Claire's presentation was arising from Claire's mental health needs for which she was receiving the appropriate treatment.

8.11.7 At the Safeguarding Adults Review learning event the group recognised the need for all staff within services to hold a degree of professional curiosity and remain open to the potential of safeguarding concerns, challenging the care a person is receiving and making safeguarding referrals where indicated.

[34] Department of Health, (2000) *No Secrets*: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

8.11.8 Northampton General Hospital did raise a safeguarding referral to Northamptonshire County Council on 3rd October 2014. It was positive that Northampton General Hospital raised a safeguarding referral but this was eight days after Claire had been admitted to hospital. On admission Claire had not been able to use her legs for two days before admission, she had significant weight loss, was smelling of urine and had extensive bruising due to falls and self-harm. This coupled with five separate admissions to Emergency Department in two months, as a result of injury or dehydration should reasonably have triggered an earlier safeguarding referral.

8.11.9 The description written on the safeguarding referral to Northamptonshire County Council did not sufficiently capture the nature of concern. It recorded – '*fractured neck following a fall'…*citing Northamptonshire Healthcare Foundation Trust and under any immediate action *'unwitnessed fall, fracture to cervical spine - admitted to ITU'* This gave little context as to why this was being identified as potential abuse or neglect. Had the additional information been linked, this would have built a profile of the degree of concern.

8.11.10 What should have followed was a strategy discussion/meeting led by Northamptonshire County Council to agree the next steps, how best to investigate the matter and, importantly, what protection plan was needed for Claire and any other people potentially at risk on Harbour Ward.

8.11.11 It is not clear from the Northamptonshire County Council records what level of strategy discussion was held, who this involved or the rationale that an internal investigation by Northamptonshire Healthcare Foundation Trust would suffice. What did happen, was that Northamptonshire County Council emailed the Northamptonshire Healthcare Foundation Trust Safeguarding Lead asking them to investigate and to put a protection plan in place.

8.11.12 The Police are key partners in safeguarding. They work closely with Adult Social Care in their public protection role and will take the lead role where abuse or neglect may constitute criminal activity. Police were informed of the referral, but given the sparse information it contained, they concluded there was no role for them.

8.11.13 There appears to have been minimal liaison between the Northamptonshire County Council and Northamptonshire Healthcare Foundation Trust. Northamptonshire Healthcare Foundation Trust had identified early on that a Serious Incident Investigation was warranted (this was automatic on the death of a detained patient).

8.11.14 The Northamptonshire County Council report indicated that their service was not aware that the matter was being managed by Northamptonshire Healthcare Foundation Trust as a Serious Incident. However, a standard letter from Northamptonshire County Council to Northamptonshire Healthcare Foundation Trust that followed the request stated '*We assume this will follow the Safeguarding / SI Process'* and requested the Northamptonshire Healthcare Foundation Trust notify Care Quality Commission; NHS Nene Clinical Commissioning Group and the Northamptonshire Healthcare Foundation Trust Safeguarding Lead of the outcome

8.11.15 The Northamptonshire Healthcare Foundation Trust Safeguarding Lead's recollection is that they had confirmed with Northamptonshire County Council that the matter would be dealt with under the Serious Incident Process and that the original Terms of Reference for their review had been shared with Northamptonshire County Council. There is disparity about this between Northamptonshire County Council and Northamptonshire Healthcare Foundation Trust and lack of records.

8.11.16 What is apparent it that there was missed communication and documentation of this process between the services. It also did not appear to be recorded by Northamptonshire County Council that the investigation would extend well beyond the 21 days requested.

8.11.17 The need for improved integration between the serious incident and safeguarding process had already been raised in a previous Serious Case Review[35] and has been guided in policy since 2011[36] The Northamptonshire Safeguarding Adults Board had a policy for this but it was not effectively applied.

8.11.18 Northamptonshire County Council's role was to oversee the safeguarding investigation and ensure an effective protection plan was put in place. The Northamptonshire Healthcare Foundation Trust Safeguarding Lead stated that immediate protection planning was carried out by their service as *'a HR investigation had commenced and the staff involved were not on duty, I visited the ward and discussed with the Ward Manager the incident and the safety of other patients and the was assured that the ward had safe staffing levels[37]'*

8.11.19 Northamptonshire County Council did not maintain oversight of this protection planning in any robust way. Significantly, because the nature and circumstances of the concerns were not fully understood by Northamptonshire County Council, they lost the opportunity to assess risks to other service users within Harbour Ward and ensure they were being adequately protected – the prime function of safeguarding.

8.11.20 During this process, in November 2014, Northamptonshire County Council received a second referral about Claire and Northamptonshire Healthcare Foundation Trust. This was from Claire's GP, raising concerns about the lack of care provided to Claire by Community Mental Health Services during September 2014. It is not clear why this referral was so delayed and is a learning point for the GP Practice.

8.11.21 The records indicate significant delay by Northamptonshire Healthcare Foundation Trust in concluding the investigation and then an absence of rigour by Northamptonshire County Council in reviewing the outcome from their investigation. Notably, this meant that Northamptonshire County Council signed off the safeguarding incident as closed in August 2015, before viewing the Serious Incident Investigation report. The seriousness of the circumstances of Claire's death were not therefore known to Northamptonshire County Council at this time. There was no assurance that adequate Protection Plans were in place for any others potentially at risk.

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[35] Northamptonshire Safeguarding Adults Board, (2014) *Serious Case Review Alice Porter*

[36] Department of Health, (2011) *Safeguarding Adults The Role of Health Services*

[37] Email from Northamptonshire Healthcare Foundation Trust Safeguarding Adult Lead 14th July 2016

8.11.22 It is of note that the request for a Safeguarding Adults Review was raised by Northamptonshire Healthcare Foundation Trust in December 2015, fourteen months after Claire's death. Had there been the expected level of oversight by Northamptonshire County Council, the criteria for a Safeguarding Adults Review would have been identified by them at a much earlier stage.

8.11.23 Northamptonshire County Council identified these areas for improvement and where not already acted upon, made recommendations for actions. (***Appendix 1 Northamptonshire County Council 1,2,3,4,5,6,7,8***) The author makes an additional recommendation to examine further how safeguarding referrals work alongside serious incidents. ***[Recommendation 8]***

8.12 Safeguarding Responses – Key Learning Points

i.	The importance of professional curiosity in practice - the ability to consider alternative interpretations for how a person is presenting including being open to the possibility of abuse or neglect.
ii.	Safeguarding referrals need to provide sufficient information for the Local Authority to be able to judge the best means of responding. (A safeguarding referral is now managed as a Section 42 Care Act enquiry). Decisions about causing others to follow up the enquiry, need to be based upon sufficient information and clear rationale. This includes Police having sufficient information to judge whether they have a role to play.
iii)	Where a Local Authority is requesting another service to respond to the safeguarding concern, the Local Authority must maintain oversight and provide scrutiny for how that task is carried out, assuring the adequacy of the protection plan and the outcomes achieved for the person(s).
iv)	Where a concern is being managed as a serious incident and a safeguarding enquiry, there is a need to determine how these two processes work together. Where the two processes are integrated, the Local Authority maintains accountability for assuring the enquiry is carried out satisfactorily and wellbeing secured for the person(s) involved.
v)	The importance of reviewing all safeguarding concerns before closure, to determine in a timely way, whether the criteria for a Safeguarding Adults Review are met.

9 Good Practice

9.1 This review has identified many areas where sadly, practice fell below the standard of care Claire should have received. However, there were also areas of good practice to draw out and build upon.

9.2 **Good Practice within the Community**

- The care and attention provided by The Dallingtons, Haringey and Lindsay House in planning Claire's move to Lindsay House.
- The involvement during the transition phase of Claire and her family.
- Agencies working to Claire's pace in planning her move to Lindsay House.
- The quality of risk assessment carried out by The Dallingtons as part of discharge planning.
- The commitment by Haringey services to maintaining 'hands on' involvement for a service user placed some distance out of their area.
- The human responses provided by Lindsay House – kindness and compassion shown to Claire and the care and attention given to her dignity.
- The responsiveness of Claire's GP in the face of significant challenges and the support he provided to Claire and Lindsay House.
- The tenacity shown by the GP in trying to secure specialist mental health services attendance to Claire when in crisis.
- Responsiveness by ambulance and Police.

9.3 **Good Practice in In-Patient Care**

- The attendance by St Matthews' (The Dallingtons) Consultant Psychiatrist to Claire while she was an in-patient on Harbour Ward.
- The recognition by Northampton General Hospital of Claire's advance decision and their application of the Mental Capacity Act in assisting her decision making or making best interest decisions when she was not able to do this for herself.

9.4 **Good Practice in the Northamptonshire Safeguarding Adults Board Learning Process**

- The contribution and commitment by all agencies to this SAR, to learn from this tragic situation.
- Candour shown by agencies – in particular, the frank, detailed and critical self-appraisal by Northamptonshire Healthcare Foundation Trust of their involvement and follow up actions taken.

10 Conclusions

10.1 This review has considered the events surrounding Claire’s last few months.

10.2 The learning has highlighted a whole train of events, any one of which could have changed the direction of Claire’s path and the painful circumstances that preceded her death.

10.3 The review has identified critical factors:

- The value of investing in preventative work – adequate provision of community support; collaboration between services to deliver robust care and Crisis Plans focused on the person and their needs.

- Mental health care and physical health care have to work hand-in-hand – specialist services working together to provide a holistic response to the person’s needs.

- A culture for effective care is a combination of professional knowledge and a personal value base that respects the person, seeks to understand their behaviours, uses professional skill to respond to need in a compassionate and purposeful way.

- Communication – between services and service users and their families; communication within agencies and between agencies. As identified in most Safeguarding Adults Review, communication is a pre-requisite to any care and a core factor when things go wrong. This review is no exception.

10.4 Claire’s family has contributed to the review despite the distress it has caused them. They did this in order to make sure lessons were learned and applied to the care of others.

10.4 The Northamptonshire Safeguarding Adults Board, and its constituent agencies, have a responsibility to ensure the learning from this review is used to truly inform change in the care experienced by service users and their families.

11 Acting on Learning

11.1 Since October 2014, agencies have made a number of changes that are relevant to the circumstances of this review, some as a direct consequence of the learning. These changes include (but not limited to) the following:

11.2 **Northamptonshire Healthcare Foundation Trust**

Northamptonshire Healthcare Foundation Trust informed the review ‘*of the extensive work that has been undertaken immediately and the changes in practice as a consequence of the incident as described in the Serious Incident Report. Northamptonshire Healthcare Foundation Trust have recognised the failures in care and actions required. The learning and changes that have occurred has been reported to our regulators.*

Northamptonshire Healthcare Foundation Trust have embarked on organisational change through support of an independent agency (Implementing Recovery Through Organisation Change) to develop co-production of services through Northamptonshire Healthcare Foundation Trust staff, service users and carers working together. As part of this work the Care Programme Approach documentation is being reviewed ensuring focus on the voice of the service user and the carer. These developments will be underpinned with Trust wide training by the project group of staff, service users and carers to embed personalised Care Planning into the culture of Northamptonshire Healthcare Foundation Trust.'

Additional actions are:

- Northamptonshire Healthcare Foundation Trust report they have implemented all twenty-eight actions on their improvement plan.

- Northamptonshire Healthcare Foundation Trust has transformation plans that include the structure of Community Services. As part of this, Northamptonshire Healthcare Foundation Trust are reviewing the referral routes into crisis support services to make a more flexible service. The Care Coordinator will take responsibility for crisis care, bringing in additional services such as the Crisis Resolution Home Treatment Team to support. Service procedures and protocols have also been revised to emphasise the need for collaboration and shared responsibility in responding to people in crisis.

- Northamptonshire Healthcare Foundation Trust has carried out audits of quality of care on in-patient areas to assure that the culture and working practices on Harbour Ward were not apparent in other areas of the Trust.

- Northamptonshire Healthcare Foundation Trust has been working to improve the standards of care on Harbour Ward – both for mental and physical health care. This includes provision of regular supervision.

- Northamptonshire Healthcare Foundation Trust has implemented a new electronic patient record system that should improve communication across the in-patient/community system, ease the generation of Care Plans, risk assessments and Crisis Plans and make navigation across the record easier.

- Northamptonshire Healthcare Foundation Trust has appointed five physical health nurses to work across their inpatient units.

11.3 **Northampton General Hospital**

- Northampton General Hospital has implemented a spinal pathway to facilitate referrals to specialist services and has a service level agreement with Leicester University Hospital.

- A new Service Level Agreement is in place with Northamptonshire Healthcare Foundation Trust for mental health liaison services, based at the hospital and covering adult and older adult wards.

- Nursing staff have received training in mental health.

11.4 **Lindsay House**

- Lindsay House has revised their Local Operating Procedure and referral procedures to strengthen team discussion on a person's risk and requirements for contingency planning.

- Lindsay House has also amended their referral assessment form to record rationale behind decision making to accept/decline a referral.

11.5 **Northamptonshire Police**

- The Police, as part of the response to the Mental Health Crisis Care Concordat, have appointed a Mental Health Nurse within their control room at peak times. This nurse is able to advise on mental health presentations that the police may be called to. The Mental Health Nurse is able to access Northamptonshire Healthcare Foundation Trust records to determine whether a person is known to mental health services and what care and Crisis Plans are in place.

- The Police also have dedicated Police officers at Northamptonshire Healthcare Foundation Trust Berrywood Hospital (mental health inpatient) and St Andrews Healthcare (independent mental health hospital).

11.6 **Barnet, Enfield & Haringey Mental Health NHS Trust**

- Barnet, Enfield & Haringey Mental Health NHS Trust now have a system for allocating care review cases so that more complex cases are allocated to qualified members of staff to do the review.

- The team will now not accept cases without full history.

11.7 **Northamptonshire Safeguarding Adults Board**

- The Northamptonshire Safeguarding Adults Board has revised procedures following the implementation of the Care Act 2014.

- All safeguarding concerns related to providers of Care and Support, such as Northamptonshire Healthcare Foundation Trust, are now case managed by a nominated worker from the Northamptonshire County Council Safeguarding Team to oversee.

- In May 2015, Board members reviewed procedures for managing Serious Incidents alongside safeguarding referrals. (Subsequent to this there were national changes in the serous incident reporting process so further revisions will need to be made.)

11.8 **Northamptonshire County Council**

- Northamptonshire County Council has incorporated consideration of whether criteria for a Safeguarding Adults Review are met, as part of the closure sign off process for all safeguarding adults enquiries.

11.9 **Haringey CCG**

- The Funding Panel (ratification) procedure has been strengthened with a checklist of paperwork required prior to authorisation. This scrutiny is also applied by the Local Authority where they are the funding body.

- A commissioning review has taken place looking at Continuing Healthcare policy and delegating authority of a particular Continuing Healthcare function. There is a framework for the Section 75 agreement (National Health Services Act 2006. A flow chart is in place outlining accountability and the governance structure to make explicit the delegated functions.

12 Recommendations

12.1 Each agency has made recommendations for their agency. These are detailed in Appendix 1. The author accepts these recommendations and has made some additional recommendations for some agencies that have been identified in the course of this review.

12.2 Claire's family, stressed the importance that the learning from this review leads to changes – not just changes to procedures and process and a 'tick box' of targets, but changes to the actual experience of people receiving services. This view is shared by the author, panel and Northamptonshire Safeguarding Adults Board.

Recommendations	
1	The Northamptonshire Safeguarding Adults Board to seek assurance from each of the agencies contributing to this Safeguarding Adults Review that their recommended actions have been acted upon. The assurance should focus on outcomes, rather than process, with the Northamptonshire Safeguarding Adults Board receiving qualitative information about how the changes have improved the well-being of service users, their families and carers.
2	The Northamptonshire Safeguarding Adults Board should ensure the learning from this review is shared with the Northamptonshire Safeguarding Adults Board members, agencies contributing to this Safeguarding Adults Review and other agencies, such as Leicester Royal Infirmary, that were involved In Claire's care. The Northamptonshire Safeguarding Adults Board should seek information from these agencies about how the learning has been disseminated and acted upon.

3	As part of its wider strategic assurance role, the Northamptonshire Safeguarding Adults Board should seek assurance from NHS Commissioners (NHS Nene and NHS Corby Clinical Commissioning Groups) and Northamptonshire Adult Social Care that the strategic plans for investment of additional Government funding for mental health takes into account the learning from this Safeguarding Adults Review. This includes reporting on plans to develop the range of providers offering Community support services such as residential, domiciliary care, shared care and supported living accommodation. NHS Commissioners and Northamptonshire Adult Social Care should identify what plans there are to develop the workforce to meet the needs of people within community settings and how these services will be supported by specialist mental health services such as those commissioned through Northamptonshire Healthcare Foundation Trust.
4	The Northamptonshire Safeguarding Adults Board, through the Health and Wellbeing Board, should be sighted on the implementation of the Northamptonshire Crisis Care Concordat and whether the action plan is delivering improved experiences for service users.
5	Northamptonshire Safeguarding Adults Board to receive assurance from NHS Nene Clinical Commissioning Groups and Northamptonshire Healthcare Foundation Trust regarding the physical health care provision of patients in inpatient care. i) NHS Nene Clinical Commissioning Groups as the commissioning body should provide information to Northamptonshire Safeguarding Adults Board about how they exercise their duty to assure the quality of care commissioned in this regard, specifically, that targets set are achieving the expected outcomes for patients. ii) Northamptonshire Healthcare Foundation Trust should provide evidence to the Northamptonshire Safeguarding Adults Board that the systems and processes in place are delivering effective outcomes to patients' physical health care across all services within their Trust.
6	Northamptonshire Healthcare Foundation Trust: In addition to the recommendations that Northamptonshire Healthcare Foundation Trust has already made, it is recommended that: i) Northamptonshire Healthcare Foundation Trust review and assure the supervision and guidance provided at critical points in a service users care pathway and management of risks arising e.g. transitional phases, stepping down to less structured environments. ii) As part of their transformation plans, Northamptonshire Healthcare Foundation Trust should determine how access to Crisis Services can be more responsive and flexible according to the service users need and the services that are supporting them. Evaluation of any changes already in place must be focused on the lived experience of service users.

7	Northampton General Hospital and Northamptonshire Healthcare Foundation Trust must develop a working protocol based around shared care and collaboration where a patient is presenting with complex presentation and mental and physical health comorbidity. The protocol should include joint responsibilities for services and responsible Consultants and set out clear expected standards of communication.
8	Northamptonshire Safeguarding Adults Board should review and update the current guidance relating to responding to safeguarding enquiries alongside serious incident investigations. This should take into account the latest NHS England serious incident reporting guidance and the Care Act 2014 statutory guidance to consider how these processes can be managed in a robust and proportionate way. This review should include perspectives of Northamptonshire County Council, NHS Clinical Commissioning Groups and the Police.

Sylvia Manson

Date: 18th September 2016

Sylman Consulting

Appendix 1: Recommendations Made by Agencies Contributing to the Review

Barnet, Enfield & Haringey Mental Health NHS Trust	
1	The Team Managers must ensure sufficient case oversight particularly if the patient is placed out of borough.
2	All staff should be reminded of the necessity to upload risk assessment form on to the electronic recording system RiO.
3	All staff should be reminded of the importance of accurate and contemporaneous record keeping.
The Dallingtons, St Matthews Healthcare	
1	For The Dallingtons to request funding authority for an overlap period of double funding to ensure follow up post discharge can be carried out for any future discharges.
GP Practice	
1	GP's should be made aware of how to escalate concerns about mental health services when they are unhappy with the response or level of intervention provided.
Lindsay House	
	(No specific recommendations made)
East Midlands Ambulance Service NHS Trust	
1	The Author will inform the locality Quality Manager of the outcome of the review and request that the attending crew members have up to date training on clinical record keeping.
2	On conclusion of the IMR the author will complete a patient story and lessons learnt article to be disseminated throughout the organisation.
NHS Haringey Clinical Commissioning Group	
1	The quality of prospective service provider's documentation must be carefully scrutinised before and after a placement i.e. the needs assessment, initial Care Plan and Risk Assessment and subsequent progress updates, comprehensive Care Plan and Risk Assessment.
2	Clinical staff within the Clinical Commissioning Groups should ensure that as the joint funding and placing agency, the Clinical Commissioning Groups receive regular updates and needs to be kept informed of any serious incidents that occur in placements. These clinical reports are to be actively requested from providers and put on the information system in a timely way.

3	It is recommended that the Continuing Healthcare Team (Mental Health Nurse) writes brief guidelines to support future Haringey Clinical Commissioning Group good practice in relation to roles and responsibilities when a client is being stepped down from hospital or moved from one care setting to another. This should incorporate the role and remit of the Placement Efficiency Project Nurse so as to clarify the interface between the Continuing Healthcare team and the seconded role with the Haringey Clinical Commissioning Group.
4	The role of the Placement Efficiency Project Nurse was to support the current clinical team in relation to placement care pathways. It is suggested that the terms of reference for such projects should include clear guidelines outlining the role and remit of Placement Efficiency Project staff and who they are accountable to day to day. *(abridged)*
5	It is suggested that good information recording should be on the agenda at team meetings and covered during individual one to one supervision. *(abridged)*
6	All documents presented to the funding panel should be listed and dated on the Eligibility Panel Cover sheet and uploaded to the Caretrack information systems … Part of the role of the Chair of the panel is to ensure the terms of reference of the panel are adhered to and that standards of presentation are maintained. *(abridged)*
7	The working relationship with the Mental Health Trust can be enhanced by utilising team meetings, individual supervision, collaboratively continuing to attend Complex Care Joint Panels and Trust move on meetings with Haringey Community rehabilitation Team and other Trust services. …….In addition to this, joint liaison meetings between Haringey Clinical Commissioning Group commissioners and senior Trust clinical staff could include an agenda item around clinical interface…how this could be maintained and improved. (abridged)
Northants Police	
1.	Northamptonshire Police advise officers to use body worn video to capture any significant injuries seen on a child or vulnerable person irrespective as to the injuries having been a result of any criminal activity. A full Police Notebook entry should be made as to the circumstances causing the use of the body worn video in such instances.
Northampton Healthcare Foundation Trust	
1	To ensure the learning from this investigation is shared with all of the mental health wards, Community Mental Health Teams and the Crisis Resolution Home Treatment Team within Northamptonshire Healthcare Foundation Trust.
2	All Patient related care to be person-centred and this must be evidenced in all Patient related documentation including Care Plans and Working With Risk documents.
3	All Patients to have an agreed detailed emergency/relapse Care Plan.
4	Evidence of listening to families/carers needs to be documented including gathering detail of any existing coping strategies that work for the Patient.

5	Assurance is required that the poor practice identified in this investigation is not prevalent across the other mental health wards.
6	The Harbour Ward Team require an independent/external team review to examine their leadership, behaviours and culture.
7	The role of the Key Worker and Allocated nurse are to be included in the Adult Mental Health In-patient Operational Policy.
8	All Harbour Ward Registered Nurses are to undertake medication competency assessments.
9	A review of the behavioural "rules" on Harbour Ward needs to be undertaken to ensure all 'blanket' rules have been removed and that all restrictions are individually and appropriately Care Planned.
10	Harbour Ward must adopt the same system of handover as the other mental health wards.
11	All in-patient staff to receive appropriate handover that includes multi-disciplinary components and challenges preconceived ideas/beliefs relating to Claire's behaviour.
12	Ward rounds must generate an action list that is recorded within the contacts screen. The action list must be checked at the next ward round (or sooner if agreed in the task), completed actions evidenced, incomplete actions reviewed and the results referenced in the contact.
13	Regular internal audits are to be carried out to ensure that Physical Observation Monitoring is completed in an accurate and timely manner.
14	A weekly audit of the Malnutrition Universal Screening Tool assessments undertaken on the wards to ensure that the audits have been completed and the relevant action taken.
15	Raise awareness on all the mental health wards that "Head Banging" should be classed as a head injury and the appropriate action that should be taken should this occur.
16	The staff off duty rota is to be planned within the expected parameters.
17	BWH staff must document the name and designation of any person from Acute Hospital who contacts the ward to update them with test results and/or the progress of a Patient.
18	Consider the appointment of general nurses to lead on physical health care within the mental health wards.
19	Ensure mental health inpatient nursing staff have appropriate physical health skills, including NEWS, Glasgow Coma Scale, APOV and escalation.

20	The introduction of Situation Background Assessment Recommendation tool for handover between staff and organisations.
21	A sample of Community Mental Health Team open cases should be audited for their compliance of completing the Working With Risk 2 documentation and the quality of their crisis (escalation) plans.
22	The Buddy/Duty Worker roles and responsibilities in the Community Mental Health Team's operational policy need to be clearly described so they are not open to interpretation by individual staff members.
23	The expectation that the Crisis Resolution Home Treatment Team and the Community Mental Health Teams must work cohesively to support people in the community with a mental health crisis must be made explicit in their respective operational policies.
24	The Crisis Resolution Home Treatment Team Operational Policy to be reviewed and consideration of including "trusted assessor" referrals from GPs.
25	Ensure all relevant Bank staff have appropriate medication competencies.
26	Review discharge protocols with the two District General Hospitals when discharging between District General Hospitals and psychiatric hospital to ensure both physical and mental health needs understood and appropriately managed.
27	Ensure Trust Serious Incident reports are person-centred.
28	Discuss, and agree, with Claire's family how to evidence and assure that the action plan has been implemented.
Northampton General Hospital	
1	The actions that became evident recommended a Spinal Pathway to facilitate referrals which was completed and is now embedded to inform best practice at Northampton General Hospital, attached herewith.
2	The education of generic staff through liaison with the Psychiatry Team to facilitate training within the Emergency Department and Acute Medical teams as to the management of patients with psychiatric and physical health comorbidity as part of their formal teaching programme.
Northamptonshire County Council Adult Social Care	
1	Northamptonshire County Council safeguarding referral documentation to be amended to reflect the way professionals are should record evidence of how decisions are made and expectations of other partners.
2	Develop and deliver training to Northamptonshire County Council staff to increase knowledge and understanding of the criteria of the Serious Incident process and supporting staff to question and challenge the decision making process.

3	Referring agencies to inform Northamptonshire County Council when an incident is to be investigated under the Serious Incident Framework, giving realistic expectations of completion dates.
4	Northamptonshire County Council in collaboration with Northamptonshire Healthcare Foundation Trust to consider actions to be taken towards the original healthcare provider, Berrywood in this case, to gain assurance of the safety of other patients during the time of the investigation. Documentation of decisions made / visits undertaken to be kept on Northamptonshire County Council electronic notes system.
5	Northamptonshire County Council to be invited to join the investigation team when there is omission of care under consideration that meets the criteria for safeguarding.
6	Northamptonshire County Council to consider the management of Serious Incident investigations separately from other non Serious Incident safeguarding investigations.
7	A clear escalation process be developed across all Board partner agencies to manage the investigation process when time frames for report submission are exceeded.
8	Develop a quality assurance process where serious incident reports are reviewed by Northamptonshire County Council and 'next steps' documented and actioned.

Glossary

Advance Decision provision under the Mental Capacity Act to refuse treatment for specific medical treatments at a future point when the person may lack capacity to be able to consent to or refuse the treatment.

CCG – Clinical Commissioning Group commissioners of local health care

CPN Community Psychiatric Nurse

The Crisis Resolution Home Treatment Team -Crisis Resolution Home Treatment Team

CQUIN stands for commissioning for quality and innovation. The system makes a proportion of healthcare providers' income conditional on demonstrating improvements in specified areas.

CPA The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

Datix - patient safety incidents healthcare software and risk management software systems for incident reporting and adverse events.

GCS – Glasgow Coma Scale is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person

Making Safeguarding Personal - is a personalised approach that enables safeguarding to be done with, not to, people.

Mental Capacity refers to whether someone has the mental capacity to make a specific decision or not at a specific time

Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis.

MUST Malnutrition Universal Screening Tool

NEWS National Early Warning Signs is a system for recording physical observations and recognition of deterioration.

Northamptonshire Healthcare Foundation Trust WWR – Northamptonshire Healthcare Foundation Trust risk documentation 'Working With Risk'

Northamptonshire Safeguarding Adults Board –Northampton Safeguarding Adults Board, statutory requirements under the Care Act 2014 – objective is assurance that local safeguarding arrangements and partners act to help and protect adults in its areas for whom safeguarding duties apply.

Police PNB pocket note book

Safeguarding Referral – when a safeguarding concern is passed on to a Safeguarding Adults referral point and accepted as a Safeguarding Adults referral.

Safeguarding Adults is used to describe all work to help adults at risk stay safe from significant harm. Safeguarding duties apply to an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse and neglect.

SBAR Situation Background Assessment Recommendation a structured method for communicating critical information that requires immediate attention and action.

SI (Serious Incident) events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

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About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care front line services and management.

Sylvia was the Department of Health NHS lead for safeguarding adults during 2010-11, developing Health guidance published by the DH in 2011 and the Safeguarding Adults principles now contained in the Care Act statutory guidance. Past roles have also included Department of Health regional implementation lead for Mental Capacity Act 2005; Deprivation of Liberty Safeguards and Mental Health Act 2007.

In addition to independent work, Sylvia Manson is Head of Safeguarding in a CCG and a specialist lay member of the Mental Health Review Tribunal

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