DORSET SAFEGUARDING ADULTS BOARD

SERIOUS CASE REVIEW OF A FEMALE ADULT LW

D.O.B.08/06/1984

D.O.D. 28/02/2011

Overview Report

Contents

1. Introduction and Terms of Reference

1.1 Summary

This Serious Case Review (SCR) was commissioned by Dorset Safeguarding Adults Board (DSAB) following the death of LW whilst an in-patient detained in a mental health facility under Section 2 of the Mental Health Act. The Board agreed that this death met the agreed criteria as follows 'an adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in his or her death'. It was known that LW had a lot of contacts with a number of statutory agencies over the period of time she lived in Dorset. She had a diagnosis of Borderline Personality Disorder (BDP) which is also known at times to challenge

those delivering services. Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide. (NICE Clinical Guideline 78, January 2009)

1.2 Terms of Reference and Methodology

1. Independent Management Reviews (IMRs) were commissioned from the following agencies which all had regular contact with LR in the six years preceding her death. These reports form the basis of this Serious Case Review:

- GP
- Dorset County Hospital (DCH) - Accident and Emergency responses including end of life care
- Dorset Community Health Services - Community Mental Health Team (CMHT) involvement, in-patient care and minor injuries treatment. Two reports including the internal investigation under the Serious Untoward Incident Review Procedure
- Dorset HealthCare University NHS Foundation Trust (DHUFT) - Community Mental Health Team involvement whilst LW was resident in Bournemouth
- Adult and Community Services- social care element of community mental health needs
- Dorset Police
- South Western Ambulance Service NHS Foundation Trust- addressing emergency ambulance services and the Urgent Care Service (GP Out of Hours service)

2. Briefings were held with DSAB Panel members and IMR authors to set out clear expectations and timescales within which the reports were to be completed

3. An independent author was appointed to draft an Overview Report

4. Two meetings were held with the Independent Chair, the DSAB Panel members and the IMR authors. The purpose of these meetings was to present the IMR reports and to consider the draft Overview Report

5. A meeting was also held with LW's family members and their views are reflected in the final report

6. The DSAB set out the purpose of the SCR as follows:

   To establish:

- A chronology of all of the involvements of the named agencies concerned with the care and treatment of LW from 01.01.2005 to 28.02.2011, to include where appropriate a full clinical history;
- The management of her care in the period immediately prior to her death;
- The prescribing history to include any liaison and consultation between the health care professionals holding responsibility for prescribing;
- The management of any presenting diversity issues;
- The effectiveness of procedures (both multi-agency and those of individual agencies), and the way in which professionals worked together in the months preceding LW's death;
- What account was taken of the Pan-Dorset Safeguarding Adults at Risk Policy and Procedures during her care and immediately after her death;
- What improvements to practice/inter-agency working can be identified from the learning, how any lessons learnt will be acted upon, and what is expected to change as a result.

7. Each agency producing an IMR was asked to identify and include recommendations for improved practice, and to produce an action plan for their organisation that follows the principles of SMART (specific, measurable, achievable, relevant and timely) working.

8. The SCR was required to take full account of the internal investigation carried out by Dorset Community Health Services (DCHS) in keeping with the NHS SW Serious Untoward Incident Review procedure.

1.3 <u>DSAB Panel members</u>

Jane Ashman – DSAB Independent Chair

Sara Glen – Detective Superintendent Dorset Police

Mary Smeaton – Safeguarding Manager South Western Ambulance Service

Adrian Dawson – Director of Public Health, NHS Dorset lead for Adult Safeguarding

Chris Kippax – Service Manager, Safeguarding Adults, Dorset County Council Adult and Community services

Independent Author - Cathy Morgan Social Care Consultant

2. The Facts

2.1 Background

2.1.1 LW was a twenty six year old woman who had a long and extensive psychiatric history. She had a diagnosis of Borderline Personality Disorder (BPD) although this diagnosis was under review towards the end of her life. She was under the care of both Dorset HealthCare University NHS Foundation Trust (DHUFT) from 2004 - 2008 and Dorset Community Health Services (DCHS) from 2008 -2011. During this period she also had regular contact with her GP and the Urgent Care Service (UCS), with Dorset Adult and Community services, with the police and ambulance services, and with Dorset County Hospital (DCH).

2.1.2 LW had a difficult early family life and was diagnosed with Attention Deficit Hyperactivity Disorder at the age of seven for which she was treated with medication between the ages of twelve and seventeen. She was reported to have been beaten by her mother and also became out of control and frequently went missing from home, subjecting herself to abuse including sexual abuse. She was in and out of care between the ages of eleven and sixteen. Her parents split up when she was 16 and her mother moved away and LW had no further contact with her, but she continued to have regular contact with her father.

2.1.3 LW was described as suffering from paranoia and anxiety along with feelings of unworthiness. She had a history of cutting herself and substance misuse (both drugs and alcohol). She had taken twenty nine overdoses between the ages of eleven and twenty, and had also made attempts to set fire to herself and to drown herself. The consequences of this history in terms of her treatment are highlighted in the conclusions to this report.

2.1.4 LW had carried out twenty three criminal offences between September 1999 and January 2004, including six violent offences. She served a nine month prison sentence for robbery and was released in June 2004. She had several admissions, both formal and informal, to psychiatric hospital between 2004 and her death in February 2011.

2.2 Chronology of Involvement by Agencies

2.2.1 The attached combined chronology (Appendix One) sets out the detail of LW's contacts with a range of services during the six years prior to her death. These records illustrate the distress that LW suffered and the efforts made to help her. They also illustrate the significant demands that LW made on these services and the difficulties involved in helping her to maintain equilibrium in her life.

2.2.2 LW's main focus of professional treatment and support throughout this period was from mental health services, both in hospital and in the community. When in the community LW also had frequent contact with her GP and with emergency services. These included the Urgent Care Service, the SW Ambulance Service, and Dorset Police. She also had several brief admissions to Dorset County Hospital.

2.2.3 LW was also supported in the community for the last few years of her life by her father and his partner and also for the last three years of her life by her partner and her partner's family.

2.3 Summary of Events

2.3.1 A summary of agency contact drawn from the combined chronology illustrates LW's struggle to manage her life and the impact of this on those around her, including the level of demand on the range of agencies involved:

- Fifteen admissions to hospital between February 2004 and February 2011, ranging in length from two days to ten months;
- Six Approved Mental Health Professional (AMHP) assessments between March 2009 and February 2011;
- Six admissions to Dorset County Hospital Accident and Emergency Unit between November 2008 and February 2011;
- Sixty eight calls to the SW ambulance service and Urgent Care Service (GP Out of Hours service) between May 2005 and February 2011 of which 76% were made to the Urgent Care Service;
- Nineteen attendances by the Police both in hospital and the community between March 2005 and February 2011

2.3.2 LW's condition was characterised by frequent episodes of self harm and substance misuse, and difficulties in engaging with the psychological interventions offered. Her diagnosis of Borderline Personality Disorder was not fully accepted by her, and she was also increasingly troubled by psychotic symptoms such as auditory and visual hallucinations which worsened towards the end of her life, leading to questions about her diagnosis. It was also accepted in January 2006 during LW's treatment at DHUFT that prolonged hospital admission and higher levels of security

were not helpful in controlling her symptoms and may in fact increase the risk of suicide. Her treatment was therefore based on agreeing a management plan in the community which included medication and access to short crisis admissions to hospital when needed. This was in the context of acknowledging that she continued to pose a significant risk of harm to herself and a potential high risk of harm to others (recorded in a summary by her Consultant following assessment 21/10/05). Multi – agency meetings were held to address issues of risk and prescribing protocols were agreed.

2.3.3 In 2008 LW's self harming behaviour was reported to be reduced and she had entered into a stable relationship with a female partner. LW moved from Bournemouth to Weymouth to be nearer to her partner with whom she subsequently lived until her death in February 2011. The two Mental Health Trusts held a handover meeting between the professional staff in January 2009. It was noted at this meeting that LW was more of a risk to herself when she was using alcohol and illegal drugs. It was also stated that 'a very boundaried approach with all clinicians operating a consistent and cohesive plan of treatment' worked best. It was noted that LW would usually follow through threats she made to harm herself but would do this in a way that resulted in her being 'rescued'. Nevertheless accidental suicide was acknowledged as a probable risk in the light of her history. The plan made was for the CMHT to support LW in the community with support out of hours from the Crisis Response Team, and it was agreed that if possible she should not be admitted to hospital. It should be noted that when LW moved to Weymouth she refused permission for transfer of her full psychiatric records as she wished to make a 'fresh start', and this wish was respected.

2.3.4 However LW's condition continued to be unstable. During 2009 she was twice made subject to a Section 136 after threats to harm herself, and was admitted informally to hospital for two days on both occasions. In October 2009 she was detained in hospital under section 5(2) of the Mental Health Act and again returned home after two days. There was concern about her reporting of psychotic symptoms in December 2009 and her medication was increased with a beneficial effect. During this period there were many occasions when she presented in a distressed state and would talk of her intention to kill herself.

2.3.5.LW was admitted to hospital briefly in January 2010, after having taken an overdose, when she described hearing voices. In May 2010 she had to be detained under section 5(2) of the Mental Health Act after stating she intended to jump off a bridge, and whilst in hospital she became very violent. In June 2010 there were episodes of slashing her wrists and lacerations on her arms but she was not admitted to hospital. In November 2010 it was proposed to review her diagnosis due to the complexity of her condition, and the fact that she was increasingly becoming distressed by psychotic symptoms typical of those that occur in schizophrenia. A letter to her from her psychiatrist stated 'I agree that you no longer show all the

features of emotionally unstable personality disorder and we are happy to review your diagnosis. Your condition is complex and it may not be possible to give a single diagnosis that explains all of your difficulties'. At the end of December 2010 LW took a serious overdose of antidepressants but was not admitted to psychiatric hospital and was followed up by the Home Treatment Team after being discharged from the general hospital. In January 2011 she was reported to be less depressed but to have been describing hearing voices and feeling things crawling over her. She took two further overdoses on 6 and 10 February 2011. On the first occasion she was admitted to the general hospital but subsequently discharged herself, and on the second occasion she refused hospital admission.

2.4 Circumstances and Management of Care prior to LW's Death

2.4.1 As set out above, in the months leading up to her death LW's condition continued to be unstable and she continued to be at risk of suicide. She was subject to a treatment plan that emphasised the importance of self management and taking personal responsibility for managing her symptoms and condition with support from her community care co-ordinator, her partner and the Crisis Service. The care plan looked at strategies to prevent hospital admission, recognising the importance of trying to avoid this. Her medication was collected on a weekly prescription. LW had frequent contact with the Crisis Response Service, who liaised with her care co-ordinator.

2.4.2 On 17 February LW was admitted informally to psychiatric hospital (Forston Clinic) during the night. She was saying she was low in mood and planning to kill herself. She reported hearing derogatory voices that told her to kill herself and said to staff 'I can't deal with psychosis; I will go home and do myself in'. She was recorded as being 'angry, agitated, irritable, anxious and unhappy'. Initially this was expected to be a short term admission, and a plan was made for her to stay in hospital over the weekend and be discharged on Monday 21 February. On 20 February LW gave staff a letter marked 'To Whom It May Concern' and asked them not to read it, saying that by the time anyone did 'it would be all over by then' and that staff could not stop her because she was an informal patient. She also called her partner and her grandparents. LW was not willing to stay in hospital informally and stated she would kill herself once she left hospital and her partner and grandparents stated that they thought she should not be discharged. She was then detained under Section 5 (2) of the Mental Health Act.

2.4.3 LW later required restraint after trying to leave the ward by climbing on a drainpipe. Her mood continued to fluctuate and she continued to assert her right to kill herself. Following a medical assessment on 22 February LW was detained under Section 2 of the Mental Health Act. The purpose of the detention was to review her diagnosis and make a further assessment and review of her medication, which required a planned reduction of her current medication. There were concerns about

the use of amitriptyline and the risks of overdose, and LW said in her interview with the doctor that she had sought prescription of amitriptyline as she knew it was dangerous in overdose. Reports suggest that this new plan made LW anxious but she understood the rationale for doing this and had a good relationship with staff who focussed on her sustained recovery rather than her negative behaviour. From 22 February staff were requested to observe for psychosis and other symptoms of mental illness. There were a number of incidents during her admission of disturbed behaviour and self harm, including LW reporting hearing voices. The incidents were short lived but unpredictable. For example on 23 February she was found in her bedroom with a ripped sheet tied around her throat, which she tightened when staff walked into the room. She also left the ward later that day and was brought back by the police 90 minutes later. LW was escorted when off the unit.

2.4.4 On 24 February LW was described as being more settled and there were no problems overnight. On the morning of 25 February there was an incident when she burnt her hand and said she was trying to 'rid herself of the devil' but this was done in a humorous manner. Later that morning it was recorded in the notes that she was 'polite and friendly, no distress, no obvious psychosis, relaxed in mood and attitude'. She was on level 3 observations which are general observations where members of staff are expected to be aware of the patient's whereabouts at all times but are not subject to specific timed observations.

2.4.5 At 12.10pm LW asked staff for towels and was given two. LW was later found by a nursing assistant in the bathroom, collapsed, with a ligature around her neck. Her face was purple in colour and she appeared to have sustained an injury to her head. The towel was removed using ligature cutters, cardiopulmonary resuscitation was commenced and an ambulance was called. LW was taken to Dorset County Hospital where she was intubated and ventilated and transferred to the Intensive Care Unit but she never regained consciousness. A brain scan indicated oedema and head injury. LW did not respond to treatment and her condition had worsened significantly by 27 February. In discussion with her partner and her father, life support was ceased and LW died on 28 February 2011.

2.5 Coroner's Verdict

2.5.1 Unusually, the Inquest in this case did not result in a single verdict. The Inquest took place over three days with evidence being presented to a jury by a number of witnesses. A Narrative Verdict was made and is attached at Appendix 2. The most significant points from the findings are as follows:

- The jury was not satisfied beyond reasonable doubt that LW intended to kill herself;
- The decisions regarding LW's detention in hospital on 20 February 2011 and 22/23 February 2011 were appropriate at that time;

- Professionals would have had a fuller understanding of LW's medical history if they had taken on board the details of her notes from Poole;
- The decision regarding the level of observation (level 3) in the period prior to LW's death was inappropriate. However the Jury did not feel she should have been on level 2 (a higher level of observation) all the time but that she should have been on level 2 observation on 23 February. The level of observation on 25 February was appropriate based on her behaviour but the level of supervision was inappropriate based on her needs;
- The decision on 25 February 2011 to supply LW with towels, a flannel and a bath plug and to permit her to bathe without supervision in a bathroom was inappropriate due to the circumstances on that day, and that this decision should have been made by more than one person;
- The cleaning of the bathroom prior to police arrival was a serious hindrance to the investigation;
- Whether alternatives could have been considered to placing LW on that particular ward at the time of admission;
- A full assessment and diagnosis of LW's condition had not been completed.

2.5.2 In addition the Coroner commented on the following wider issues:

- Professional complacency;
- The need for additional training for staff in how to care for patients with BPD;
- The adequacy of staffing levels on the ward at the time of LW's death and the need for an emergency alarm system for the safety of staff and patients;
- The need to review guidelines for levels of observation;
- The relevance of the 1983 Mental Health Act and the need for this to be updated to provide more options for clinicians to provide better decision making.

2.5.3 These points have been accepted by DCHS and their recommendations and action plan reflect this.

3. Analysis

There are a number of issues to consider in this analysis, many of which have been highlighted to a various extent by the agencies involved in this Review. This case is characterised by the complexity of a situation where an individual exhibits unpredictable, challenging and risky behaviours which involve multiple agency

responses over a period of several years. It is further complicated by LW's moving to live in a different area at the end of 2008 involving a transfer of responsibilities between agencies.

Key features to consider must therefore include the effectiveness of inter-agency communication and how information was shared; how risks were assessed and managed both in hospital settings and in the community; and how decisions were made and what actions were taken at significant points in the chronology.

3.1 Inter-agency Communication and Information Sharing

3.1.1 This is a crucial area to explore as LW's care was shared between specialist mental health providers (both in-patient and community services), and also included generalist services such as the out of hours emergency services, the police, the general hospital, and her GP. With so many different agencies and personnel involved, the opportunities for poor or missed communication were thus much greater.

3.1.2 There is some good evidence in the IMRs that this aspect of LWs care was taken seriously and systems were put in place to ensure that all parties were aware of the need to offer a consistent and coherent response to LW. Examples of this include the regular contact between the hospital and GP regarding the prescription of medication (which was set up by DHUFT after some concerns that the GP had prescribed medication without liaising with the CMHT), and the behaviour management plan that was regularly updated and shared with LW and all relevant parties including the GP, the ambulance services and the police, to try to ensure a continuity of response to incidents both in hospital and in the community. Risk management meetings were held in which LW was included, and she was involved in the decision made in December 2005 to manage her care in the community following her prolonged stay in St Ann's Hospital. LW had frequent contact with her GP and although she was registered with three different practices during the period of this Review, summaries of her mental health treatment were shared and her GPs talked regularly to mental health services regarding prescribing practices. In 2008 LW was seen twenty times by her GP and at one point was receiving daily prescriptions of medication.

3.1.3 However there is also some evidence that communication could have been improved. During the review process it became clear that LW had received prescriptions for medication from the UCS on twenty one occasions unbeknownst to the CMHT, although the GP would have been aware of this as all instances of prescription of medication from the UCS are routinely shared with the patient's own GP. It is not clear if the UCS had up to date information or feedback from the GP regarding prescribing to inform their practice. This increased LW's risk of suicide and may well have affected her mental state in terms of her psychotic symptoms, and it was noted that clusters of calls to the emergency services were often followed by an

overdose. The IMR which covers services provided by Dorset County Hospital also noted that there were some examples of poor communication on 7 November 08 when LW was discharged with an assessment of being at moderate-high risk of further self harm but this was not communicated to the CMHT Team, and the GP was also not informed of her discharge. There was also no evidence of the GP being informed of LW's (self) discharge on 08.02.11. However there was evidence of liaison with the CMHT and GP on all other occasions.

3.1.4 The combined chronology also illustrates the pattern of LW's frequent contact with emergency services and it is not clear if the mental health team was always fully aware of the extent and detail of this. For example the notes from LW's outpatient appointment with DHUFT on 26/06/08 record 'No symptoms of depression; no deliberate self harm for some time' whereas in the previous two weeks LW had made five contacts with the urgent care services complaining of hearing voices and feeling suicidal, and requesting medication. Two weeks after the outpatient appointment LW contacted the urgent care services again and was given an injection of Haloperidol at the Treatment Centre. Between the 26 June and her next outpatient appointment on 29 October LW made 13 contacts with the urgent care services, (including one 999 call), most often complaining of hearing voices, having hallucinations, self harming and feeling suicidal, which on three occasions resulted in medication being prescribed. However some of this information was picked up at the outpatient appointment in October: 'Seen in outpatients. Euthymic in mood. No signs of emotional disregulation. Still talks about voices and other psychotic symptoms and seems to be using a great deal of extra Haloperidol oral prn'.

3.1.5 The IMR from Dorset Community Health Services who were responsible for LW's mental health care from January 2009 – February 2011 also highlights some important issues around communication during LW's last admission to Forston Clinic in February 2011, when the admission criteria moved from a crisis admission to a risk management admission to a diagnostic and treatment assessment. The report concluded that some hospital staff responsible for her care did not fully understand the rationale for LW's detention, which led to confusion in the expectations and the boundaries of the admission to hospital and made the management plan difficult to formulate and disjointed from the original intention of her admission.

3.1.6 There was also an underlying communication issue which may have impacted on decision-making, regarding the agreement DCHS made with LW when she moved from Bournemouth not to transfer her hospital notes from DHUFT who had treated her from 2004-2009. Although the Data Protection Act does allow individuals the right to deny access to previous records this does not extend to patients who present with high risk behaviours, where the recommendation is that previous records should be sought in order to fully address risk. DCHS have stated in their own analysis of events that 'It is not clear whether the risk of not accessing LW's notes was fully assessed. The decision not to seek previous notes impacted on the

ability of staff to fully assess LW's risks particularly the risk of formal inpatient admissions'.

3.1.7 Although it had been made clear at the handover of LW's care from DHUFT in January 2009 that her treatment plan needed to focus on supporting her in the community with support out of hours from the Crisis Response Team and the avoidance of hospital admissions, in retrospect it is possible that the risks presented by detaining her in hospital in February 2011 were not fully assessed due to this gap in information. It is recorded by DCHS that 'different decisions may have been made regarding LW's detention under Section 2 of the Mental Health Act if those involved had realised the extent to which inpatient admissions in East Dorset, particularly those involving detention under the Mental Health Act, had seemed to increase greatly the frequency of attempted hanging and self-strangulation'. However the report goes on to say that 'at the time that LW was admitted, her level of suicidality was greater than usual, and if she had not been detained she would have returned home a few days before the funeral of her niece (and) she was very worried about having to meet her family there'. LW's partner and main source of support in the community was also under great strain, and was firmly of the opinion that LW should not be allowed to leave hospital. This view was also held by LW's father.

3.1.8 So although the decision to move away from the previous management plan of limiting inpatient admissions may have led to increased risks for LW, allowing her to leave hospital at that time would also have posed a high suicide risk. In addition the purpose of the admission was to assess LW's condition and review her medication regime and her diagnosis, which involved reducing her medication and carrying out a prolonged period of assessment, which necessitated a longer inpatient admission.

3.1.9 The inpatient care plan actively involved LW in the management of her own safety and this was in line with her community management plan. Based on previous knowledge it was felt that high levels of observation would increase the risk of dangerous self-harm and suicide, and the decision to give LW towels on 24 February was fully in line with the approach already being taken and which had been in place since before her transfer from DHUFT. The management plan allowed LW to wear her own clothes and laced shoes and have access to headphones and other electronic equipment, thus even if she had not been given the towels she would have had other means of asphyxiating herself.

3.2 <u>Risk Assessment and Risk Management</u>

3.2.1 Throughout the history of LW's care this aspect proved particularly challenging. The chronology from DHUFT illustrates the difficulties posed in caring for LW both as an in-patient and in the community. LW had ten admissions to psychiatric hospital between February 2004 and September 2007 spending approximately fifteen months in hospital including one long admission of ten months, and during this time was also supported between admissions by a Community Mental Health Nurse (CMHN) on a

weekly basis, by a Support Time Recovery worker for a period, and by the Crisis Team.

3.2.2 During admissions there were a total of one hundred and twenty seven reported incidents of which the most common were:

- Violent Incidents - Self Harm (65)
- Violent Incidents – Physical assault of staff (25)
- Violent Incidents - Violence not directed at an individual (17)
- Violent Incidents – other (16)
- The 65 'Violent Incidents-Self Harm' included:
- 36 'ligature round neck'
- 12 'Cutting'
- 4' head banging'
- 2 'overdose'
- 2 'ligature possession'
- During the periods between admissions when LW was in the community there were 428 recorded contacts with the CMHN and Crisis Team.

This context illustrates the complexity of implementing appropriate risk management protocols for LW both in hospital and in the community. However there are several examples of good risk management practice.

3.2.3 A risk management conference was held in December 2005 by DHUFT and a community management plan was drawn up. In attendance were the consultant psychiatrist from the Forensic Team, the ward manager, community staff, the consultant psychologist, the hospital manager, the risk advisor, the community team leader, and the consultant psychiatrist, and it was also attended by LW herself for part of the time. There was communication with the GP of the need to prescribe medication in limited amounts due to the risk of overdose. In January 2006 it was recorded that 'LW has acknowledged that she poses a significant risk of harm to herself in light of her past self harm behaviours and intention of committing suicide and continued (threats) to do further harm'. The records also state that 'It was felt that her current placement did not meet her longer term needs as an inpatient and provided little more than short term risk management for both herself and the services. Movement towards higher levels of security (was) only likely to exacerbate her sense of being trapped and at the same time dependant on services. She is

considered to be treatable either in a specific dedicated long term therapy centre on a voluntary basis or in the community'.

3.2.4 On 10 May 2006 LW's risk of suicide and harm to others continued to be assessed as significant both in the current to medium term. On 31 May 2006 following three overdoses in the previous week leading to a formal admission to psychiatric hospital, it is recorded that 'clear care planning issues for risk management and future plans were highlighted as a need if the plans to manage risks in the community are followed' and a full assessment of the risk history was completed on 1 June. A year later on 29 June 2007 a detailed risk management plan was drawn up that addressed the issues of who LW should contact when in crisis (including arrangement of a brief 72 hour psychiatric hospital admission if needed), how potential admissions to Accident and Emergency should be managed, and setting out that the Consultant Psychiatrist should be the lead prescriber of medication. Access to regular support in the community was also included. It was felt by the multi-disciplinary team that LW should take more responsibility for her own care and safety and that past experience of taking responsibility away from LW had been clinically counter- productive leading to an escalation of self harming behaviour. This underpinned the importance of the community management plan.

3.2.5 Different treatment options were considered for LW including Dialectic Behaviour Therapy (DBT) and admission to a long-term therapeutic setting. However LW did not engage with the psychological interventions offered and these options were therefore not able to be pursued. Instead her condition was managed by a combination of medication together with community support and avoidance of hospital admission from 2006. Regular risk meetings were held which LW attended and there is evidence of her engagement in the process. There continued to be regular attempts by LW to take her own life often leading to a short hospital admission of one or two days. Risk was reduced but it is important to recognise that it could not be eliminated and when in hospital LW was allowed access to materials such as shoe laces, headphones, sheets and towels which it was recognised could be used as ligatures, in line with the agreed management plan which encouraged her to take more responsibility for her own safety. LW's care was transferred to DCHS in January 2009 and this management plan continued, with the emphasis continuing to be on supporting LW in the community and avoiding hospital admission if possible.

3.2.6 Due to LW's instability, this management plan meant that significant demands were made on a wide range of community services, including the GP, the out of hours emergency services, the AMHP (Approved Mental Health Professional) service and the CMHT, and the numbers of contacts made with these services has already been summarised in Section 2 of this report. However this management plan in itself carried inherent risks, due not just to LW's unpredictable behaviour and continued frequent episodes of self-harm, but also due to the need for all of these

agencies to understand and consistently implement the agreed plan. Although considerable efforts were made to achieve this outcome, with regular inter-agency meetings and signed agreements, there were examples of poor or missed communication as set out in the previous section, the most important being the way in which LW managed to access additional medication on a regular basis from the urgent care service often without the knowledge of the CMHT. The review has also revealed a lack of full knowledge and understanding within mental health services about the role and powers of the police service, particularly in relation to the limits of their legal powers within a person's own home and within a hospital setting.

3.2.7 A comment made by one of the IMR authors highlighted the fact that decisions about risk and actions to be taken often fell on 'generalists' rather than staff with specialist knowledge and skills, which increased both the strain on services and the risks that decisions made may not always have been in LW's best interests (such as the prescribing issue identified above). This is not a criticism of the generalist services, who made great efforts to support LW and achieved positive outcomes, but it does illustrate the need to ensure that these services have the right information and support to carry out their roles effectively in situations such as this, and that they are kept properly informed and up to date with management plans.

3.3 Decision-Making and Actions Taken

3.3.1 The previous section of the report highlights not only the complexity of LW's case and the significant risks involved in caring for her, but also the real challenges in ensuring both that decisions made could be effectively communicated to all parties and followed through, and that these decisions were in line with the agreed management plan.

3.3.2 There is no doubt that the decision to manage LW in the community and reduce the frequency and length of hospital admissions placed additional pressures on her partner and her family and on the generalist services. Her frequent calls to the urgent care service illustrate this and it is perhaps not surprising that due to her high levels of anxiety and distress this resulted on a number of occasions in the prescription of medication, although this was counter-productive. The number of times she was taken to hospital following an overdose also served to emphasise the level of her distress.

3.3.3 The IMR provided by the SW Ambulance Service NHS Foundation Trust records that they 'had no information regarding any care plans, or adult protection processes for LW' and yet they were in the front line in providing emergency responses to LW on sixty eight occasions. Fifty two of these calls were made to the UCS and LW was given extra medication twenty one times. This illustrates how actions taken by one agency can inadvertently undermine the careful and detailed planning of another agency (in this case the mental health services) due to a lack of information. One might also expect that the GP would have ensured that the UCS

were fully informed about the importance of not prescribing additional medication to LW as this was in contradiction to the agreed management plan and increased the risk of LW taking an overdose.

3.3.4 The records from Dorset Police also show that at times this service felt unclear about how to respond to a particular situation or felt unable to help LW. One example is when on 24/10/07 LW contacted the police as she was 'hearing noises in her head telling her to stab her carer'. The police attended and found that LW was calm and waiting for the Crisis Team to contact her whilst her carer was in the bath. This resulted in some ongoing dialogue between the Crisis Team and the police by telephone, with the Crisis Team expecting the police to take action which they were lawfully unable to take within someone's own home. Meanwhile the Crisis Team felt they were unable to help, and LW left her house and walked along the road, still hearing voices and continued to make three further calls to the police during the evening.

3.3.5 The decisions made and actions taken to manage LW in the community are well documented and this plan did seem to work reasonably well for a period, although it could not fully eliminate the risks of self harm. The management of LW's care during her final admission prior to her death was in line with the agreed management plan, and the records clearly illustrate the level of her disturbance at this time and the demands she made on staff caring for her. The reasons for changing the agreed plan to enable a longer hospital admission are also properly recorded and were fully explained to LW.

3.4 Gender and Family Issues/Diversity

LW was a gay woman who was in a stable relationship with a female partner from the end of 2008. There is no evidence that this caused any issues in the treatment or management of LW and her partner was treated as her next of kin and eventually formally documented as this. There was a potential issue at the time immediately prior to LW's death when a decision had to be made regarding life support and the hospital staff were unclear about who was the next of kin, initially mistakenly assuming it was her father and brother. However this mistake was quickly rectified as the hospital notes had a record of LW's partner as the next of kin.

There were no concerns about diversity issues highlighted as a result of this Review.

3.5 Pan Dorset Safeguarding Adults at Risk Policy

3.5.1 This Review has revealed some variable understanding and use of this policy across the agencies involved:

- DHUFT have recorded that LW was not subject to a safeguarding plan while in their care but did have an intensive treatment plan and significant care planning around her needs. The Trust is signed up the Pan Dorset Adult

Protection Committee Policies and do provide local guidance for staff on Safeguarding Adults, as well as monitoring compliance with training. There was not an adult protection plan in place for LW as there was no indication that she was experiencing harm or abuse from others during her involvement with the team. The incidents of harm by LW to other vulnerable adults were reported to the police in line with safeguarding adults procedures.

- DCHS is signed up to Pan Dorset Adult Protection Policy and Procedures (2007) and all staff are trained and updated regularly on safeguarding adults at risk procedures. Procedural guidance enables staff to recognise, alert and take appropriate action when there is concern of harm to adults at risk. They reported that all the work, care management and planning in this case was compliant with interagency safeguarding adults policies and procedures and that all of the care given was consistent and compliant with all mental health professional standards and code of practice procedures and best practice procedures.

- DCH staff attend safeguarding adults training as part of Trust induction and as part of mandatory annual updates. This includes the procedure to be followed where there are concerns raised regarding vulnerable adult abuse. The Trust's Policy for the Protection of Vulnerable Adults (2009) reflects the Pan Dorset Adult Protection Procedures (2007). There was no adult protection plan in place in this case as there was no indication that LW was being abused as defined by the Policy and Procedures.

- DCC/DHUFT CMHT (AMHP Service) reported that Safeguarding Adults policies and procedures are in place but were not considered as relevant to be used in this case in terms of adding to the understanding or ongoing management of the case either at the point of an AMHP assessment or at other points of ongoing involvement. Risks were managed within the integrated care programme approach and were well known with clear management plans and responses in place that met the needs of LW and her partner. No indicators of abuse or neglect were identified within this case except within the context of ongoing risk, mainly to herself, that LW both expressed and exhibited.

- The SW Ambulance Service Trust Safeguarding Policy was passed by the Trust Board in July 2007 and is reviewed annually. Ambulance clinicians have access to the safeguarding team including the paramedic safeguarding lead at all times. There is scrutiny at the point of referral and the effectiveness of the Safeguarding Policy is continuously monitored in terms of the quality and timeliness of referrals and monitoring of complaints and incident reports. In respect of LW, the Trust had no information regarding any care plans or adult protection processes. In terms of the Pan Dorset procedures, the Trust

records that it would have been expected that some of these contacts (re LW) would have resulted in a safeguarding alert. There were no referrals made from the emergency clinicians.

- The GP service has recorded that the surgery does not currently have an adult safeguarding policy, with the current procedure being to speak to the CMHT or social services if there are concerns. LW was viewed as a vulnerable adult although not formally labelled as such 'as she had full capacity 99% of the time and was aware of her actions and outcomes even when trying to overdose'.

- Dorset Police do not give any specific information about Safeguarding Adults policies and procedures in their report.

3.5.2 These reports illustrate a varying picture across agencies with a common view that the formal procedures did not apply in this case. Only one report refers to LW's risk to herself, as the other agencies rather narrowly interpret the procedures as applying only to vulnerable adults at risk from others. This indicates a need to develop further training across agencies on the wider remit and value of Safeguarding Adults policies and procedures, particularly in relation to complex cases where several agencies are involved. Joint agency training (perhaps using this case or a similar case) would be of particular value. There is also no indication that LW's death was reported under the Safeguarding Adults Procedure nor that there was any consideration at any point during her history of whether the multi-agency risk assessment conference (MARAC) procedures should be have been applied in this case. However it is not necessarily the case that more formal implementation of such procedures would have significantly affected the outcome.

4. Conclusions

4.1 The purpose of this report is not to attribute blame but to learn the lessons resulting from LW's untimely death and make recommendations to improve practice.

4.2 LW's history of severe and frequent self harm, suicide attempts and episodes of violent behaviour meant that she was a high management risk both in hospital and in the community, and the nature of her demands on statutory services tested them to the limit. She had made numerous attempts to kill herself over a period of several years and it was recorded in January 2009 that 'accidental suicide is a probability in the light of (her) history'. However in spite of this and although she was often distressed, angry, volatile in mood and tortured by voices or uncontrollable urges to harm herself or others, she had managed with support to maintain herself in the community for several years and latterly to hold down a steady relationship.

4.3 Working to support people with this range of needs is very challenging for agencies and research shows that children and young people who have suffered

sexual abuse lack access to appropriate services and there is limited evidence and information on the range and effectiveness of different types of therapeutic support for them (*Ref: Sexual abuse and therapeutic services for children and young people NSPCC 2009*). This makes consideration of treatment options very challenging for statutory services. Childhood sexual abuse has also been associated with both short and long-term mental health problems such as anxiety, phobic reactions, guilt, substance abuse, difficulty trusting others, low self-esteem, and dissociation (*Walker 1988*), depression and even suicide (*Briere and Runtz 1987*). The *Corston Report* (Home Office 2007) highlights criminality as a very real consequence of these problems, revealing that a high proportion of female inmates have a history of sexual abuse. Research also suggests that individuals with a history of sexual abuse and victimisation are at a greater risk of re-victimisation (*Messman and Long 1996; Roodman and Clum 2001*). These findings relate closely to the experiences of LW both as a child and young person and as an adult.

4.4 There are also very real difficulties in working with people who present with risky and chaotic behaviours, and who manage their environment to suit their needs. The summary of events in this report clearly illustrates the genuine efforts made by a wide range of agencies to respond appropriately in managing LW's care. All the agencies involved in this Review have been thorough in their analysis of their contact with LW and the circumstances surrounding her death. The report from DCHS under the Serious Untoward Incident Review Procedure was also sufficient in its analysis and recommendations and had already recognised many of the points raised in the Coroner's Narrative Verdict.

4.5 The records show that there were some issues in providing consistent care for LW including diagnosis and treatment issues, her behaviour and response to care, and decisions made about treatment in hospital and in the community and the impact of this on a wide range of agencies. Information sharing was also not always as good as it could have been in spite of the fact that the importance of this was recognised and great efforts were made to achieve good communication.

4.6 Nevertheless the facts beg the question, was LW's death inevitable at some point due to her long history of self harm and frequent suicide attempts, or could it have been avoided, at least on this occasion? Should it have been expected that as she was detained under the Mental Health Act in hospital at the time of her death that this reduced the risk of her killing herself or in the light of her history was the reverse the case? These questions are not easy to answer. The events leading up to her death show an escalation in her distress, with a reported increase in her psychotic symptoms and three overdoses between 31 December 2010 and 10 February 2011, and an eventual informal admission to hospital on 17 February saying she was hearing voices asking her to harm herself. There is a question about whether the decision to detain her compulsorily in hospital for a longer period increased her risk of suicide, but this was in the context of serious concerns about

her wellbeing during the preceding few weeks and a set of circumstances in the community that would also have placed her at high risk at that time. There is no doubt that professionals believed they were acting in her best interests by detaining her, and it is now impossible to know what the outcome would have been had a different decision been made. The findings of the Coroner outlined in section two of this report do not criticise the decision to compulsorily detain LW but do conclude that LW's level of observation and supervision was insufficient and that the decision made regarding allowing LW access to towels, a flannel and bath plug were inappropriate. The findings also state that where LW was found, the jury believed showed her intention to leave the bathroom. However as the bathroom had been cleaned up before the police arrived there is no forensic evidence to confirm this.

LW's history showed she was at significant risk of killing herself, and it is possible or even likely that the frequency of her attempts increased the likelihood of her success, even if this was not fully intended at that time.

4.7 The final question about the decision regarding the level of supervision in hospital is a difficult one. The Coroner's narrative verdict states clearly that the level of observation was inappropriate, particularly on 23 and 25 February due to the circumstances at that time. Nevertheless there were well documented reasons for maintaining the agreed management plan during this admission, and allowing LW access to items that could be used as ligatures. However DCHS have accepted the findings of the Coroner in respect of the specific circumstances of LW's death and already taken actions to improve services.

We will never know for certain whether LW fully intended to kill herself on this occasion or whether she had hoped to be rescued, although we do know that she had talked on 7 February of her anger about surviving her most recent suicide attempt.

4.8 Individuals with this level of need will remain very difficult to manage and to treat both in the community and in hospital due to the limits of what services can offer. There seems to be a reluctance for mental health services to admit that all risks cannot be managed, and in retrospect it may have been helpful if the agencies had been able to recognise this and to 'own' the chaos created by LW and their inability to control it, and therefore accept the very real risk of her untimely death.

4.10 Although no case is 'typical' this Review process and the scrutiny given to practices and decision making across all the agencies have enabled important lessons to be learned and services will be improved as result. The recommendations and how these will translate into action, as well as examples of good practice, are set out below in sections five and six.

Views of Relatives

Both LW's father and her partner were approached to ask if they would like to meet with the author and contribute their views to this report. LW's partner declined to do this but her father and his partner did take up this offer and made the following comments in respect of LW's treatment and support during the period of the Review and the circumstances surrounding her death.

Mr W had been the main carer for LW for significant periods of her life including the period in 2004-2005. LW moved in with her partner D eighteen months before her death. Mr W acknowledged the heavy demands LW placed on her carers but in spite of this he remained very attached to LW and kept in regular touch with her after he moved to the north of England and continued to make regular trips to visit her and other members of his family who live in Poole.

On the whole Mr W felt LW had received good care from the mental health teams both in the hospital and the community. However he felt that at times the support from the crisis team in the community could have been improved as some staff did not know LW well enough to make appropriate responses – for example at times refusing to respond when she called them in distress. He was also concerned that staff out of hours did not always have access to LW's history and current care plan which made it difficult for them to respond appropriately.

Mr W said that LW did not want people to know she had mental health problems and struggled to be seen as normal and wished to lead a normal life, but was unable to do this. He believed that her condition worsened in the years before her death with her periods of stability reducing. He described successful holidays abroad two years ago where LW had accompanied him and his partner and had been relatively untroubled, whereas he did not believe she had been able to remain stable for this length of time in more recent years.

Mr W understood and partly accepted LW's diagnosis of Borderline Personality Disorder but also felt her psychotic symptoms were increasing (e.g. such as hearing voices, feeling insects crawling over her skin, and feeling paranoid) and that her condition needed further assessment and review. He also felt strongly that the belief of some professionals that LW's suicide attempts were not serious and she always enabled herself to be 'rescued' was misguided. He described two occasions when LW had by chance survived a suicide attempt. One occasion was in 2006 when LW was living on her own, and her brother visited unexpectedly and found her hanging from the banister with a belt round her neck. Another occasion was when LW had saved medication and took an overdose in the toilet of a hotel and was not found for some time.

Mr W felt that LW's condition was worsening prior to her death. She was increasingly distressed by her psychotic symptoms and her periods of stability were becoming shorter.

Circumstances of LW's death

Mr W felt that in the period leading up to her death LW's distress was becoming more acute. She took a serious overdose in December 2010 and nearly died, and afterwards said she was angry that she had survived. Prior to her admission to psychiatric hospital in February 2011 she had made comments to family members such as 'I need you all to know how much I love you'. LW had also telephoned her aunt during this period for no apparent reason but which her aunt interpreted as her 'saying goodbye'. LW was very distressed by the stillbirth of her niece on 9 February and a few days later she was admitted informally to hospital. Mr W felt strongly that his daughter needed to remain in hospital at this time and would be at risk if discharged.

Subsequent to LW's death a suicide note to her partner dated 20 February was found. This date was the birthday of LW's deceased Nan, to whom LW had been particularly attached. Mr W spoke to LW on 24 February. LW was distressed and asked Mr W 'if we all really loved her' to which she was told that 'we all loved her very much'. The day on which LW made the suicide attempt which led to her death (February 25th) was the day of the funeral of her niece. Mr W believes these factors are significant and indicate a real intention on LW's part to kill herself. In retrospect he feels the fact that the ward was busy, that LW was at first tired and 'down' and then apparently cheered up and was laughing and wanting a bath, may have indicated that she had something in mind but was making sure she would not be suspected to be a risk at that time.

Mr W is unsure as to whether the decision not to transfer his daughter's medical notes when she moved to Weymouth made a difference to the outcome in relation to the risks of her being held under detention. He felt it was too risky to allow her to leave hospital at that point and that if she had not been detained she would have left hospital straight away – she was therefore at risk either way. Mr W did feel it was unhelpful that the hospital staff had cleared the bathroom in which LW was found before the police arrived, thus preventing the collection of evidence which may have indicated whether LW was trying to leave the room and seek help. The information from the inquest was inconclusive on this matter.

5. Recommendations, Lessons Learned and Good Practice

5.1 In summary, the improvements made include improving multidisciplinary working through a more robust Integrated Care Programme Approach (ICPA) process; better support and training for staff; improvements in information sharing protocols and better management of information sharing; clearer information for patients and more

involvement of carers in decision making; a stronger focus on recovery based care; a more integrated care pathway for people with personality disorder including specialist training in this area; a wider roll out of safeguarding training; better access to skilled supervision, and introduction of a complex case review and crisis and planning team in DCHS to co-ordinate management of cases with complex behaviours.

Two further recommendations in addition to those submitted by the agencies are also made:

1. Improve the understanding of the wider remit and value of Safeguarding Adults policies and procedures, across all the agencies represented on the Board.

2. Improve information sharing and co-ordination of care and support across all agencies including emergency and 24 hours services for the small number of people identified with multiple and highly complex needs, to ensure all relevant agencies can work together effectively and overcome the general and specific difficulties service boundaries create.

5.2 There are no specific recommendations for action or lessons learned put forward from the Dorset Police, nor from the GP Practice. Dorset Healthcare University Foundation Trust did not make specific recommendations as 'LW's death occurred two years after she had been discharged from the Trust and there have been many changes to practice that have occurred since 2004 when she was first referred' but they have highlighted some points which are included in the table below. The two action plans submitted by the Dorset AMHP service and by DHUFT/DCHS are to be considered as works in progress which will be continually updated. The action plan in respect of the two generic recommendations above is included at the end of the next section.

5.3 Recommendations and Lessons Learned

Agency	
Dorset Healthcare University Foundation Trust	1. There was evidence of risk being rated incorrectly at the beginning of LW's involvement with the Trust however the assessments were appropriate from 2005 onwards reflecting changes in culture and continuous training. All clinical staff now attend an update training every 3 years. 2. There was evidence that the GP had prescribed medication for period without CMHT being aware. This was addressed at the time with the GP.
Dorset Community Health Services	Lessons Learned 1. The investigation highlighted the importance of a robust and integrated multidisciplinary team approach to all aspects of patient care, particularly when managing high risk and complex cases such as LW's. It is recommended that the ICPA review process should play a bigger part within inpatient management plans and when a challenging patient who is known to community teams is admitted an MDT - ICPA review meeting take place as soon after admission as possible and include the ward and community team. If staff are absent because of annual leave or other demands, this could be managed by the use of telephone conferencing or other electronic communication facilities and the use of nominated deputies during absence. 2. The investigation recommends that this is reviewed by the Trust and systems for care management protocols, the ICPA management process and joint working arrangements are commenced. Given the complexity of such cases, decisions should never be made in isolation by individual practitioners and decisions regarding management of care, in any arena, should be shared between ward staff, community staff, therapists and other agencies at the beginning of a patient's pathway. Recommendations

	1. The trust should review the Integrated Care Programme Approach (ICPA) review procedures. ICPA review processes should play a bigger role within inpatient management plans. When a patient who is known to community teams and is subject to ICPA is under urgent care an ICPA review meeting should take place as soon as possible and include the ward and the community teams and fully review and outline the intention of the admission. 2. The patient should be given clear written information about care pathways, care plans and the rationale for decisions made. Carers should be involved in any decisions whenever possible. 3. Recovery based care should be a central feature of all care plans and management both in the community and within inpatient units. The essential component of such plans should be the installation of hope for recovery. 4. An integrated care pathway for the treatment and management of patients diagnosed with or presenting with personality disorder should be completed. The pathway should be formulated and completed by representatives from nursing, medical and psychological services from both inpatient and community services. 5. A complex case review and crisis planning team, to include members of the psychological therapy service, nursing, allied clinicians and medics should be established to provide advice, supervision and co-ordination of the management of patients who exhibit risk laden and complex behaviours. This service would also offer psychological approaches to supervision and management support to our inpatient facilities, and be expected to assist in the management of inpatients as part of the MDT meetings, handovers and ward rounds. 6. Increased professional training in the management of personality disorder and complex, risk laden behaviour should be provided to all staff involved with patient care. All qualified members of staff should have a basic training in one form of psychological therapy for people with a personality disorder. This training should be

	delivered as formal face to face training and make up part of individuals Personal Development Plan objectives or become part of the mandatory training requirements. 7. All staff should be aware of information sharing protocols. Clear guidance on when and how information should be sought and clear protocols of when and whom to seek advice about sharing information without a patients consent needs to be completed and disseminated to all staff.
South Western Ambulance Service NHS Foundation Trust	<u>Lessons Learned</u> 1. The case has highlighted a need to remind staff of the importance of the referral process. The clinicians involved who did not refer information back to the safeguarding team have been spoken to about the importance of the referral process. They have taken this on board and will endeavour to correct this. 2. The safeguarding team intend to highlight the issue of feedback from alerts raised, in order to improve practice. An audit will be undertaken and local teams engaged with to contribute to local work about why feedback is not more common. <u>Recommendations</u> 1. The need for Out of Hours call takers to do the safeguarding training. 2. A reminder to all SWAST staff about the importance of referrals being completed for all vulnerable people that take an overdose.
Dorset County Council Adult and Community Services/DHUFT (AMHP Service)	<u>Recommendations (Best Practice)</u> 1. Ensure competent regular skilled supervision from experienced senior practitioners for AMHPs alongside ongoing access to refresher training and other support mechanisms. An audit of current arrangements to map current practices should be undertaken and action plan

	developed if any areas fall short of requirements. 2. Ongoing access to Safeguarding training targeted at all mental health professionals to ensure awareness of identification of potential situations requiring investigation and the utilisation of policies and procedures. This should include on how care planning and safeguarding processes complement each other in practice. 3. All CMHT staff and AMHPs have access to training and skilled supervision in the ongoing management of individuals with emotionally unstable borderline personality disorder.
Dorset Police	Lessons Learned 1. Whilst there may have been minor friction on occasions between agencies, this had no impact on the life or death of LW.
Dorset County Hospital NHS Foundation Trust	Lessons Learned Patients with mental ill health are not routinely assessed by the Psychiatric Liaison Service until ready for discharge.

5.4 Good Practice

Agency	
Dorset Healthcare University Foundation Trust	LW had an intensive treatment package and she was seen regularly by Consultants and CMHN's and had a plan for elective admission.
Dorset Community Health Services	1. All the members of staff interviewed throughout the investigation process expressed positive feelings towards LW and their role in supporting her. 2. In the main LW's care was appropriate and well managed

	and had been for many years.
Dorset CC/DHUFT CMHT	1. The effective work offered by CMHT's should be recognised despite the tragic outcome.
GP Practice	1. Ensured patient seen by the same doctor wherever possible for continuity of care. 2. The patient was phoned when appointments were missed. 3. When the patient's partner contacted the practice with concerns, this was followed up with an appointment or telephone call.
Dorset Police	1. Police provided an immediate response to a crisis affecting LW in each instance .
South Western Ambulance Service NHS Foundation Trust	1. True professionalism showed by ambulance crew and staff who attended LW at Forston Clinic on 25/02/11 when she was in cardiac arrest. The quick response, good CPR and treatment from all the clinicians involved resulted in an initial improvement in LW's condition. 2. Early contacts made by the OOHs Doctors to the on call psychiatrist and the Crisis Response Team. 3. The ambulance clinician safely netted LW's care by contacting medical staff at Dorset County Hospital for further advice on medication taken as overdose.

6. Action Plans

6.1 Dorset County Council/DHUFT AMHP Service

Recommendation 1	2. Key Worker	3. Action (required or taken)	4. Timescale	5. Barrier to implementation	6.Progress	7. Evidence
1. Ensure competent regular skilled supervision for AMHPs	DCC Head of Specialist Services Adult Social Care	Audit of current supervision arrangements and practice over the last year (numbers of meetings, evidence of discussions held)	By December 2011	None identified	Action Plan in place by January 2012	Robust supervision in place for all AMHPs by April 2012

Recommendation 2	**2. Key Worker**	**3. Action** **(required or taken)**	**4. Timescale**	**5. Barrier to implementation**	**6.Progress**	**7. Evidence**
2. Ongoing access to Safeguarding training targeted at all mental health professionals	Head of Service Adult Specialist Care/Director of Operations (NHS)	Learning and Development Teams for Agencies within integrated Mental health services to ensure that information on relevant courses is circulated to all mental health staff and local managers prioritise and ensure staff attend as required	To be completed by April 2012	None identified	Completed audit will lead to assuring that training meets the needs of specialist staff	staff confident about when adults safeguarding procedures require implementing

Recommendation 3	**2. Key Worker**	**3. Action** **(required or taken)**	**4. Timescale**	**5. Barrier to implementation**	**6.Progress**	**7. Evidence**
3. All CMHT staff and AMHPs have access to training and skilled supervision in the ongoing management of individuals with emotionally unstable borderline personality disorder	Head of Service Adult Specialist Care/Director of Operations NHS	Learning Development Centres in DHUFT and DCC undertake needs analysis of staff and design and deliver training to meet assessed need	Training Needs Analysis to be completed by March 2012 to inform training from April2012onwards	The need for the relevant Agencies to recognise the importance of this training and prioritise its delivery	Establishment of Training Needs Analysis Process Inclusion of appropriate training in integrated training programme	Audit of Training Programmes and access of staff to them

DORSET HEALTHCARE UNIVERSITY FOUNDATION TRUST DORSET COMMUNITY HEALTH SERVICE DIRECTORATE

RECOMMENDATIONS FROM INTERNAL INVESTIGATION, INQUEST HELD ON 27/29 SEPTEMBER 2011 AND CQC COMPLIANCE REPORT ON THE DEATH OF A SERVICE USER ON MINTERNE WARD, FORSTON CLINIC, HERRISON, DORCHESTER DT2 9TB ON 28 FEBRUARY 2011

ACTION PLAN

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
1.	The Trust should review the Integrated Care Programme Approach (ICPA) review procedures. ICPA review processes should play a bigger role within inpatient management plans. When a patient who is known to community teams and is subject to ICPA is admitted to inpatient units an ICPA review meeting should take place as soon as possible and include the ward and the community teams and fully review and outline the intention of the admission.	Present findings of this inquiry to Acute Care Forum	Briefing took place at Acute Care Forum on 7 July 2011	Allison Howard	Completed
		Inform staff of this recommendation	Senior Managers and Team Leads briefings completed	Deborah Howard	Completed
		Review inpatient review process and associated documentation as part of the enhanced recovery services redesign	Initial review planned for 19 July 2011	Ian Rodin/Allison Howard (Lynsey Maunder)	Completed
		Audit revised process/ paperwork	Audit Tool in development.	Ian Rodin	December 2011
	• **Inquest Recommendation** • As previously advised, LW's medical records do not include any substantial reference to ongoing risk assessment and review of levels of observation. Whilst every witness gave evidence as to their reasons for keeping LW on Level 3 observations and gave strong evidence that these issues were considered at each	Recommended that the ward (and wider Trust) urgently reviews its approach to reviewing and recording risk assessment/levels of observation. Discussions regarding these issues must be recorded in the notes; where any decision is made to allow a patient to participate in an activity such as bathing (i.e. in a	Risk assessment is now clearly recorded as part of weekly MDT. and will be shared Bathing assessment now forms part of care plan and is therefore regularly reviewed	Ally Howard/Lynsey Maunder	Completed Completed

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
	handover and the reasons why they considered higher levels of observations to be inappropriate, they were unable to support this with any objective evidence in the notes. • The medical records did support the fact that LW's behaviour and presentation improved/settled on 24/25th. However, staff gave evidence that they were not aware of LW's niece's funeral that day. • However, the Jury were not satisfied that appropriate consideration was given to allowing LW to take a bath alone on 25th. The medical records contained a risk assessment for bathing, which states that the decision to allow her to bathe alone should be reviewed every day (this was due to her reckless self-harming behaviour); there was no evidence that this was done. • As previously advised, the Observation Policy is confusing: there were problems in articulating the levels of observation and how this differed from raised awareness in the evidence.	locked room out of sight) unsupervised, the reasons for that decision should be recorded. The development of a ward based pro forma to assist in assessment of risk/levels of observation is recommended. The Observation Policy should be reviewed and the description/levels of observation reconsidered. I understand that this is likely to take place as a result of the re-organisation in any event and would recommend that this process is undertaken as soon as possible. Training on the use of a different approach to observations will be required to ensure consistency across the organisation.	Staff were aware of the importance of the date in question, however, may not have clearly articulated this at court A new pan Dorset DHUFT observation policy has been agreed. Staff are aware of the proposed changes.	 Allison Howard	Completed Completed
	CQC Compliance Report Treatment of disease, disorder or injury. Diagnostic or screening procedures. Assessment or medical treatment of persons detained under the Mental Health Act 1983. **How the regulation is not being met:** People generally receive safe and appropriate care and treatment based on the assessment	All patients are risk assessed on admission using the electronic record system. This is now printed off and enclosed in the patient's paper notes. Patients' risk assessments are reviewed 3 times a day and at handover, including records of level of observations (also reassessed 3 times a day). Evidence of this and of	Now in place. Risk assessments and observation levels each shift and documented, printed out for records. Records in place to review by MD team.	Lynsey Maunder	Completed .

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
	of individual risks and needs but the risk assessment process needs review. The length of stay, the delayed transfer of some people and the range of needs on Minterne Ward may impact on the care that can be provided.	any changes made to level of risk and observation are documented in the notes. A weekly MDT meeting now also reviews all risk assessments and patient care plans. Further work on the function and model of care for Minterne Ward is currently being agreed and is part of the staffing level review and skill mix work. Please also see Regulation 22 outcome 13; staffing actions and target date relating to this compliance action. The outcome of this more detailed work is end of November 2011.	The Trust has looked at inappropriate admissions and taken the following actions: an admission/discharge policy is in place covering all the adult mental health units and all units are within one management structure. Length of stay and delayed discharges are reported through the operational management systems. Potential areas of risk highlighted through internal adverse incidents and governance systems	Brian Goodrum/Allison Howard/Lynsey Maunder	30 November 2011
2.	The patient should be given clear written information about care pathways, care plans and the rationale for decisions made. Carers should be involved in any decisions whenever possible.	Involve Mental Health Forum in revision of documentation of inpatient review meetings Ensure that information provided to carers of people admitted to inpatient units makes clear how they can be involved in care planning	Initial review held on 19 July 2011 and project plan in place Updating and streamlining of the handbook in conjunction with Dorset Mental Health Forum underway. (Incorporate best practice protocol for carers) and then taken	Ian Rodin/Allison Howard (Lynsey Maunder) Lynsey Maunder/Dorset Mental Health Forum	December 2011 December 2011

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
			on as PDU project with forum		
3.	A recovery based approach, of which the instillation of hope is an essential feature, should underpin all work carried out by the mental health service	Present findings of this inquiry to The Recovery and Wellbeing partnership Develop programme of coaching for psychiatrists by people with lived experience of mental illness through a phased approach	Learning event took place on 31 October and agreed actions added to the implementation plan Coaching programmes started for some Psychiatrist to be rolled out to all medical staff	Brian Goodrum/Ian Rodin Phil Morgan/Ian Rodin/ Dorset Mental Health Forum	Completed December 2011 and onwards
4.	A care pathway for the treatment and management of patients diagnosed with or presenting with personality disorder should be established and completed. The pathway should be formulated and completed by representatives from nursing, medical and psychological services from both inpatient and community services.	Set up Task and Finish Group to complete the care pathway, building on work already completed, so far separately, in West and East Dorset	Complex Care Network and pathways was presented at the Acute Care Forum on 7 July; the Practice & Quality meeting in August; the Team Leads Network on 14 September and to inpatient units on 6 and 12 September. Care pathways presented to teams presentation to psychiatrist's meeting on 5 December. For each of the acute care areas the Lead	Julia Deadman-Spall/Bev King Julia Deadman-Spall/Allison Howard Julia Deadman-Spall/Allison Howard Julia Deadman-Spall/Allison Howard	December 2011

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
		Implement use of integrated pathway and audit use	Psychiatrist and nursing pairings will be agreed and will be operational within these areas by the end of October 2011. Clinical Lead will link with Stuart Purcell, Consult in East Dorset to share this practice.	Julia Deadman-Spall/Allison Howard Julia Deadman - Spall	Completed January 2011
5.	A complex case review and crisis planning team, to include members of the psychological therapy departments, senior nursing and allied clinicians and medics should be established to assist in the advice, supervision and co-ordination of the management of patients who exhibit risk laden and complex behaviours within the Trust. This service would also offer psychologically minded supervision and management support to our inpatient facilities, and be expected to assist in the management of inpatients as part of the multi-disciplinary team meetings, handovers and ward rounds.	Set up complex case discussion group to provide a formal support group for staff working with people with complex care and high risk behaviours to build upon the informal support processes in place. Link this group with consultation groups and networks in the larger Dorset HealthCare NHS Foundation Trust. Audit how this group is used by care coordinators Ensure this work is connected to Primary care	Complex Care Team Leads network meeting on 7 July agreed action on the pathway a Hub and Spoke model. Initial Hub & Spoke meeting held on 4 August - membership of Hub agreed along with Terms of Reference and second meeting on 1 September. This will constitute a formal supervision process and will complement informal processes and specialist advice in complex case management.	Julia Deadman-Spall Julia Deadman-Spall/ Ian Rodin/Phil Morgan	December 2011 December 2011

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
			Hub meetings taking place monthly. Half day event for Spokes took place on 13 September to set up these groups. Each locality identifying 'fellow spokes' and aiming to set up local meeting for Jan 2012 or earlier. Establishing reflective practice meetings.	 Julia Deadman-Spall	 Completed
6.	**`Inquest recommendations** The trust should provide increased professional training in the management of personality disorder and complex, risk laden behaviour to all staff involved with patient care. All qualified members of staff should have a basic training in one form of psychological therapy for people with a personality disorder. This training should be delivered as formal face to face training and make up part of individuals Personal Development Plan objectives or become part of the mandatory training requirements.	Incorporate this training need into the personal development plans of all qualified members of staff and identify those in need of further training Use existing clinical supervision processes to consolidate training already received Review and enhance existing training programme. Hub sub-group to meet to look at inpatient unit training.	Complex Care Network Leads meeting on 7 July 2011 to scope out the work needed to enhance the training for clinical staff. Immediate actions agreed were to establish action and learning set for inpatient units. Consider inpatient staff complexity training. On basis of current discussion, likely to reframe as reflextive	 Julia Deadman-Spall/Mark Humphries	March 2012 December 2011 December 2011

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
			practice oninpatient units with teaching slots as necessary.		
		Agree training resources internally/externally including associate programme Prioritised staff to receive training	Discussions ongoing with regard to reviewing the complex care training for the wider mental health staff. Business plan proposal for knowledge & understanding framework training (SW/PD scoping Group) Training plan to be revised to include training for staff on complex needs	Mark Humphries/Brian Goodrum	March 2012
	The lack of mandatory training for staff on BPD was criticised by the Jury. They acknowledged that staff did take specialist advice from other sources when needed.	Recommend that the Trust revisits this issue given how much interaction NA's have with patients and consider a programme of raised awareness as well as considering a more formal system of supervision designed to support NA's in their management of PD individuals.	Staff have accessed DBT training. Staff have the support of PTS staff on a weekly basis in managing complex needs The Trust accepts the suggestion that NAs for acute care should have PD training relevant to their role	Allison Howard/ Mark Humphries Allison Howard	November 2011 Accepted

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
7.	All staff should be trained in the Data Protection Act and information sharing protocols. Clear guidance on when and how information should be sought and clear protocols of when and whom to seek advice about sharing information without a patients consent needs to be completed and disseminated to all staff.	Prepare guidance and disseminate to all staff	Guidance to be written	Claire Onions/Deborah Howard in conjunction with Dave Walker	Dec 2011
	• **Inquest Recommendation** • There were a number of references to problems associated with Medical records throughout the inquest including difficulties in accessing documents on Sepia, which lead to important information not being considered. I understand that Sepia will be replaced by RIO, but the provider arm will continue to operate Sepia for some time	Ensure that staff across the Trust understands the principles of accessing patient records without consent where to do so would be in the patient's best interests. Review the use of SEPIA in light of the comments made by staff and in light of the potential risks associated with running two records management systems across one organisation; consider an earlier introduction of RiO across all sites to ensure proper information sharing across all sites	Use learning event to cascade this learning. Printed copies of SEPIA notes were available on the ward, and ward staff could access SEPIA without problem	Claire Onions/Deborah Howard/Allison Howard	Dec 2011
8.	**Inquest recommendation** The Jury found the staffing levels on the ward on the day of the incident to be inadequate. • This finding principally arose from the written statement of a staff nurse on the ward that day. Whilst it was not her intention to convey this message, the statement clearly implied this was an issue. Despite strong evidence to the	Recommend that in light of the comments of the Jury, the Trust review whether the staff levels on Minterne are appropriate. The Trust are now however obliged to change the staffing levels on the ward in light of the Jury's verdict and should only do so if the review considers that levels or skill mix of staff on the ward should be altered.	Staffing levels on the ward on the date of the incident were appropriate for the rota 4 staff on Minterne, plus 3 OT staff plus 2 staff from Melstock. However, staffing review is being discussed and is part	Allison Howard/Sharon Waight/Joanna Neilson	30 November 2011

	RECOMMENDATIONS	ACTIONS AGREED	PROGRESS REPORT	RESPONSIBLE PERSON/DATES AGREED	
	contrary from the ward manager and the nurse in question, the Jury still arrived at this view. • The witness statements in this high profile and his risk case were disclosed to HMC directly by the Trust without staffing levels being challenged/investigated.	Recommend that in all high profile cases that draft witness statements which are critical of Trust systems and practice are reviewed for accuracy and that consideration is given to involving the Trust's legal advisors prior to their disclosure to HMC. This will provide an opportunity to ensure that statements are clear and relevant to HMC inquiry and provide staff with additional support in drafting.	of the service review for the enhanced recovery service Accepted	Nigel Barrow	30 November 2011
9.	**Inquest Recommendation** The Jury felt there should be alarms on the ward in the event of an emergency. From the questions asked by the Jury, this comment arose from the lack of alarms in the bathrooms. Staff hold personal alarms that can be sounded in the event of an emergency. There is no evidence that an alarm would have made a difference in this case, but the Jury clearly formed the view that, even if LW changed her mind about her actions, she would not have had the opportunity to alert anyone in the absence of an alarm cord.	The Trust should review whether an alarm in the bathrooms/ward should be installed. This will need to be balanced against the benefit that this would have and the potential for abuse given the nature of the patients on the ward. The Trust is not bound by the Jury's comments and is free to arrive at its own decision as to whether the introduction of an alarm system would be appropriate.	Each staff member has a Pin point alarm. Incidents can take place in any room on the ward, it would not be feasible, practical or sensibly to place alarms in every location that would be accessible at al times, other than the bathrooms, al rooms have vision panels.	Allison Howard/Nigel Barrow	Completed
10.	**Inquest Recommendation** The Jury were critical of the decision to clean the bathroom and not to preserve the scene of	All staff should be reminded that in circumstances where a patient is seriously injured/dies whilst on the	This was not a causative factor to the death. SOP now in	Allison Howard/Nigel Barrow	Completed

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	the incident. LW had not died at this point and it is clear the staff did not consider the bathroom as a 'crime scene. Their intentions were simply to ensure that the bathroom became functional again. Unfortunately this seemed to have left the Jury with an impression that there may have been something to hide and also seriously impeded the investigation as to how LW came to suffer the injury that she did, albeit that there was no suggestion of third party involvement	ward, the scene should not be disturbed until reviewed by the Police.	place clearly stating need to preserve a potential crime scene, staff acted in shock not ambivalence		

DESIGNATION OF RESPONSIBLE PERSONS

Brian Goodrum – Director of Operational Services

Allison Howard - General Manager Acute Care Recovery Services and Professional Head of Mental Health Nursing

Deborah Howard - General Manager Community Mental Health Recovery Services

Ian Rodin - Consultant Psychiatrist/Clinical Director

Julia Deadman-Spall Consultant - Psychologist/Head of Psychological Therapies

Phil Morgan - Recovery Lead and Professional Head of Mental Health OT

Mark Humphries - Practice Development Manager

Nigel Barrow – Risk Manager

Claire Onions - Clinical Services Support Manager

Dave Walker – Team Leader, Prison Inreach

Joanna Neilson – Clinical Services Development Manager

Sharon Waight – Head of Professional Practice & Quality

Lynsey Maunder – Hospital Manager

Dorset Mental Health Forum User Lead Recovery Partners

Updated 21 November 2011

Generic Recommendations

Recommendation	Action	Timescale	Lead
1. Improve the understanding of the wider remit and value of Safeguarding Adults policies and procedures, across all the agencies represented on the Board.	Use existing fora and mechanisms to develop a full understanding of the wider remit of Safeguarding adults policies and procedures and how these should be applied in a range of different scenarios and settings.		Jane Ashman Independent Chair Dorset Safeguarding Adults Board
2. Improve information sharing and co-ordination of care and support	Learning from elsewhere -		Mary Smeaton Safeguarding

across all agencies including emergency and 24 hours services for the small number of people identified with multiple and highly complex needs, to ensure all relevant agencies can work together effectively and overcome the general and specific difficulties that service boundaries create.	agree a multi-agency protocol and facilitate the development of a multi-disciplinary forum for the wider Dorset area to provide a multi agency commitment to resolving complex issues and to support all agencies and services to identify and provide timely and realistic support and care to people with multiple and highly complex needs whose behaviour may present a risk to themselves and/or others.		Manager SW Ambulance Service NHS Foundation Trust