

# Safeguarding Adult Review Executive Summary – Laura

AN ADULT WITH CARE AND SUPPORT NEEDS WHO DIED IN THE  
WARRINGTON AREA (OUT OF HER HOME AREA) IN A PSYCHIATRIC  
INTENSIVE CARE UNIT

<b>Learning</b>	Timely recording and sharing of risks, independent scrutiny through safeguarding, making safeguarding personal, information sharing, shortage of support for people with complex mental health support needs, availability of treatment services for people diagnosed with Personality Disorder, development of a team approach
<b>Summary recommendations</b>	Promotion of learning around inpatient suicide, timely information sharing between agencies and risks associated with unmanaged observation levels.  Agreed protocol in place for local providers to identify high risk behaviour incidents and/or patterns of self-harming behaviours, to include thresholds for reporting safeguarding concerns.  Promotion of learning in relation to trauma informed practice.  WSAB in collaboration with NHS England leads should consider how communication should be improved for out of area placements where NHS England Commissioning services are involved.

Assurance that practitioners understand the importance of factual and accurate record keeping.

Promotion of Laura's report within the SAR Library with NHS England and other SAB's to escalate concerns about pressures within the mental health system and risks if unresolved.

Assurance that service provision for individuals with personality disorders meets NICE guidelines and be available without waiting times that put individuals at risk.

Assurance that providers are aware of the Carers Trust standards and have adopted, or have plans in place to adopt those standards.

**Keywords** Mental health, commissioned placement out of borough, self-harm, missing incidents, sexual assault, suicide, personality disorder.

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# Introduction

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The decision was made by Warrington Safeguarding Adult Board (WSAB) not to publish the full review report. It was agreed that an Executive Summary of the Safeguarding Adult Review (SAR) report be produced for the purposes of sharing with the SCIE Library. The full report can be made available upon application to the WSAB.

This document is the Executive Summary of the review report which was ratified in August 2020 by the WSAB. The summary also makes reference to the additional recommendation the WSAB identified which was not included in the original report.

In accordance with her family's wishes, Laura's real name has been used throughout this report.

## Summary of the case

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At the time of her death, Laura, aged 22, was residing in a Psychiatric Intensive Care Unit (PICU) in Warrington, whilst awaiting the availability of a low-secure placement where she could access therapeutic interventions. She had been diagnosed with borderline (emotionally unstable) personality disorder with antisocial and schizotypal aspects.

Laura had faced a number of challenges throughout her life, with patterns of self-harming behaviours from the age of thirteen noted, and it was understood she had experienced at least three sexual assaults.

As a result of a self-harm incident in June 2016, Laura was admitted to a facility in Gloucestershire and lived there under a series of voluntary and enforced detentions. Whilst in Gloucestershire there had been a number of incidents of Laura absconding, suicide attempts and self-harm incidents, including the use of ligatures.

In November 2016 Laura was transferred to a PICU in Warrington, where she lived until her death in February 2017. Shortly after her arrival in Warrington, she was assessed as needing a low-secure placement where she could access therapeutic interventions to address her maladaptive coping strategies.

During her stay at the PICU in Warrington Laura continued to present as a high risk in relation to her self-harming behaviours. The day of her death she was able to use plastic bags and a ligature to cause asphyxia.

A SAR was commissioned by the WSAB Chair in response to the referral with the following core areas agreed as the focus for the SAR:

- The decision to place Laura in Warrington - to explore the decision-making, information sharing and monitoring of the placement, with the purpose of identifying lessons that can be learnt by all Warrington, Gloucestershire and National Health and Social Care commissioners.
- The response to self-harming behaviours and particularly to those service users diagnosed with personality disorders residing within mental health facilities, with the purpose of identifying good practice methodologies that could be implemented in relation to de-escalation and also identifying thresholds for reporting of safeguarding concerns.

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

## Findings

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As a result of reviewing Laura's case, the WSAB have summarised the multi-agency learning as follows:

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

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

Making Safeguarding Personal: When service users have a history of trauma, it is important that this is taken into account when responding to current presentations and needs. In Laura's case, the history of trauma related to allegations of sexual assaults without supported access to justice through the criminal justice system and ongoing therapeutic support. Although standard legal processes appear to have been followed, the cumulative impact on her self-worth was not recognised. Additional support could have been offered to Laura that was responsive to her capacity to engage as this changed over time.

Information Sharing: There were difficulties evident in this case in relation to the sharing and recording of information. These difficulties existed across agencies, localities and with Laura and her family. There were occasions where information shared between agencies was not clear and/or sufficiently supported by evidence leading to the inaccurate interpretation of Laura's records by assessing providers, which delayed Laura's discharge. There was a missed opportunity to communicate safeguarding actions robustly between geographical areas to lead commissioners. There was also evidence that, due to the range of agencies involved, the communication pathways that were in place were not sufficient to ensure all parties were informed and updated in relation decisions around assessment and discharge. As a result of this, there was a lack of clarity for Laura and her family in relation to her discharge, which undermined their confidence in the care being given.

National Shortage of Safe, and Treatment-Evidenced, Support for People with Complex Mental Health Support Needs: Laura's placement within Warrington was an emergency response to increased aggression and risk to others. Laura and her family were informed this would be a short-term out-of-area placement, due to the lack of suitable beds in the area in which she was ordinarily resident. A decision was taken to reduce the number of required discharges to change this to a long-term treatment placement by discharging directly from her placement. As a result, Laura stayed within the Warrington area for over three months. Efforts were made to transfer her to placements that could offer more appropriate treatment options, but the time taken was impacted by a scarcity

of suitable available placements and the information sharing issues highlighted above which led to providers assessing Laura as not suitable for their service.

#### Availability of Treatment Services for people diagnosed with Personality Disorder

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

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

## Recommendations

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The SAR report identified some single agency recommendations and the following multi-agency recommendations:

1. WSAB should promote learning around inpatient suicide, timely information sharing between agencies, and the risks associated with unmanaged observation levels with all inpatient services in Warrington. WSAB will need to be assured that this has made an impact on practice.
2. WSAB should be assured that local providers have an agreed protocol in place to identify high risk behaviour incidents and/or patterns of self-harming behaviours, to include thresholds for reporting of safeguarding concerns.
3. WSAB should promote learning in relation to trauma informed practice. This is to encourage staff to take account of an individual's history of trauma to inform response decisions.
4. The WSAB, in collaboration with NHS England leads, should consider how communication should be improved for cases with out of area placements where NHS England Commissioning Services are involved. This should include designated points for contact, frequency of contacts, expectations for minimum information sharing in relation to safeguarding concerns and nearest relative details.
5. WSAB should be assured by all agencies that practitioners understand the importance of factual and accurate record-keeping. All information recorded should be clear, sufficiently supported by observations and evidence, and opinions should be clearly identified.
6. The WSAB should promote Laura's report within the SAR library, with NHS England and with other SABs with a view to escalating concerns about pressures within the mental health system and the potential risks that exist if they remain unresolved.
7. WSAB and Gloucestershire SAB should seek assurance within their areas that local service provision for service users diagnosed with personality disorders should meet NICE guidelines and be available to all those in need of such services without waiting times that put individuals at risk.

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