West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of 'Adult B'

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Foreword

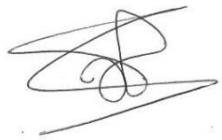
The West Sussex Safeguarding Adults Board has today published the Safeguarding Adults Review in respect of the death of Adult B, a lady in her early thirties who had been supported at a number of services throughout the country due to her complex mental health, learning and physical needs.

The review examines the actions of various agencies that had been involved in supporting Adult B and identified ways of changing and improving current systems across the Health and Social Care economy to reduce the likelihood of a similar event happening again in the future. Recurring themes from other reviews, both locally and nationally around information sharing and the implementation of Mental Capacity assessments are identified and which have been highlighted as a key issue for action.

This particular Safeguarding Adults Review highlights the need to ensure that contracts with placements are appropriately 'quality assured' and that the support needs of the individual are regularly reviewed. Adult B spent time in a number of services across England and Wales, and there was evidence to suggest that information was not always consistently shared to new placements. The review also highlights the importance of focussing on the health and wellbeing of the whole person, ensuring that professionals look holistically at the support and wellbeing needs of the individual.

The purpose of a SAR is not to reinvestigate or to apportion blame but to establish where and how lessons can be learned and services improved for all those who use them and for their families and carers.

The West Sussex Board and the Safeguarding Adults Review subgroup of the board will monitor progress on implementation of recommendations so the Board is assured services are improving overall.



Annie Callanan, Independent Chair

1. The Reason for the Safeguarding Review

1.1. Adult B was a young woman who died in her early thirties and who since childhood had been known to and treated by various mental health services and who at the time of her death was detained under Section 3 on the Mental Health Act 1983.

1.2. In her early teenage years Adult B became a Looked After Child[1] and was placed in a residential home in Wales. On leaving the care system Adult B remained in Wales and therefore, provision of care and responsibility of commissioning for Adult B's placements varied between Betsi Cadwaladr University Board and The Welsh Health Specialised Services Committee.

1.3. Adult B had a combination of both mental and physical illnesses. Her particular needs around self-harming - resulting in the formation of a stoma[2] and fistulas[3] - generated a challenging picture for professionals especially in finding a suitable placement that could meet her highly complex physical and mental health needs.

1.4. Adult B received treatment from the local hospitals prior to her death where the significance of her raised potassium level and high output stoma was not fully recognised and responded to.

1.5. On the 18th October 2015, whilst being cared for at The Dene Medium Secure unit in West Sussex, Adult B was reported to be found unresponsive. Despite resuscitation attempts Adult B could not be revived.

1.6. The cause of death was recorded as 1a: Sepsis 1b: Acute Pyelonephritis.

1.7. In addition to the recorded cause of death there is agreement between two independent renal Consultants that the acute cardiac arrhythmia developed as a result of raised potassium and was the most likely cause of Adult B's death. The raised potassium was the result of Acute Kidney Injury caused by dehydration secondary to high output stoma/fistula.

1.8. A safeguarding alert was raised by paramedics from South East Coast Ambulance Service raising concerns about the resuscitation response observed on the day of her death. A safeguarding episode was opened and a meeting was held on the 23rd of October 2015 at The Dene, attended by staff from the hospital, a social worker and police. It was decided at the time that there was not enough evidence to trigger a safeguarding enquiry.

1.9. Subsequently, West Sussex County Council (WSCC) received a report of the initial investigation carried out internally by Partnerships in Care, which raised a number of concerns regarding The Dene's response to Adult B's physical health needs. It was decided after consultation with the Care Quality Commission that a further meeting was required to discuss the new information.

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[1] The definition of looked-after children (children in care) is found in the Children Act 1989. A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

[2] A stoma is an artificial opening made into a hollow organ, for example to the bowel from the surface of the body.

[3] A fistula is an abnormal passageway between two organs in the body or between an organ and the exterior of the body.

1.10. A Safeguarding Meeting was held under Sussex Safeguarding Adults Policy and Procedures (2015) on the 24th of February 2016. The meeting concluded that there were concerns identified around the management of physical health care needs for the patient in relation to wound management. One of the actions identified was to refer Adult B's case to West Sussex Safeguarding Adults Board for consideration for a Safeguarding Adult Review.

1.11. Adult B's case was felt to meet the criteria for a Safeguarding Adult Review to be commissioned by West Sussex's Safeguarding Adult Board as there were features of neglect, and the case highlighted difficulties in how effectively agencies worked together.

The Review Process

1.12. The author of this report was commissioned in August 2016 to undertake a review in line with the guidance set out in the Care Act, 2014:

- Good practice in relation to case reviews suggests that they should be conducted in line with certain principles:
- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively." (DoH, Care Act Statutory Guidance 14:138)

1.13. Whilst the review is not written with the intention of apportioning or attributing blame, its terms of reference allow for the panel to comment where it feels organisations or professionals could learn in respect of responsibilities in relation to patient care.

Independent Review

1.14. The author is June Hopkins, a recently retired health professional with over 30 years' experience. 15 of those years were spent working in the field of safeguarding in both provider and commissioning organisations. She has experience of leading learning together reviews, participation in Serious Case Reviews, Individual Management Reviews, Domestic Homicide Review and Serious Incidents. Since retirement in 2016, she has undertaken an independent review for a charity, was appointed as lead reviewer for Serious Case Reviews and recently acted as a safeguarding advisor to an Ambulance Trust in special measures.

Methodology

1.15. Terms of Reference were produced and agreed (Appendix 1). The following agencies were identified as having involvement with Adult B or knowledge pertaining to The Dene Hospital within the timeframe under review:

- Betsi Cadwaladr University Health Board(BCUHB)
- Brighton & Sussex University Hospitals (BSUH)
- Calverton Hill Hospital
- Care Quality Commission (CQC)
- Cygnet Hospital, Derby
- The Dene Hospital, West Sussex
- Derby Royal Hospital
- General Practitioner
- Nottingham University Hospital, Queens Medical Centre
- Recovery First
- Rethink
- South East Coast Ambulance Service NHS Foundation Trust (SECAmb)
- Sussex Police
- Sussex Community Foundation Trust (SCFT)
- Coastal West Sussex, Horsham and Mid Sussex Clinical Commissioning Groups (CCG's)
- Welsh Health Specialised Services Committee (WHSSC)

1.16. Each organisation was asked to either produce an Individual Management Review (IMR) or Statement of Involvement (SOI) as appropriate to their level of direct or indirect involvement with Adult B.

1.17. A Safeguarding Adult Review panel was appointed to work alongside the reviewer and consisted of senior professionals from the following agencies:

- Head of Safeguarding, Betsi Cadwaladr University Health Board
- Interim Safeguarding Lead for Mental Health and Learning Disabilities, BCUHB
- Deputy Director Social Work - Principal Social Worker, Sussex Partnership Trust
- Social Care Professional Lead Safeguarding, SPFT/West Sussex County Council
- Deputy Designated Nurse, Coastal West Sussex, Horsham and Mid Sussex CCGs
- Deputy Chief Nurse, BSUH
- Detective Chief Inspector, Sussex Police
- Medical Director, The Dene
- Safeguarding Lead, South East Coast Ambulance Foundation Trust
- Board Manager, West Sussex Safeguarding Adults Board
- Named GP Coastal West Sussex, Horsham and Mid Sussex CCGs

1.18. Where the panel felt it would be beneficial to talk with individual practitioners to understand why actions were or were not taken in the context of the knowledge known at the time, organisations were approached to allow conversations to take place.

Review Timeframe

1.19. The panel agreed that the period for review should be from 1st October 2014 to 31st October 2015. However, agencies were asked to provide a summary of either significant events or relevant knowledge outside of the specific timescale in order to inform overall understanding of this review.

Parallel Process

1.20. In addition to the Safeguarding Adult Review there were several other investigations either recently completed or in progress namely;

- Coroner's Inquest
- Criminal Investigation into this case and 2 other separate cases connected with The Dene Hospital
- Health:
  - Serious Incident Report (Brighton & Sussex University Hospitals)
  - Serious Incident Report (Cygnet Hospital)
  - Initial Investigation Report (The Dene)
- Safeguarding Investigation

Family Involvement

1.21. Adult B's mother and father were invited to contribute to the review and both parents spoke with the author on several occasions. Whilst in general their views are represented within the report, both parents felt strongly that Adult B had a very happy childhood up until the point she went into care.

1.22. Adult B's parents have been able to give a holistic view of Adult B the person, who had a great love of music, poetry and art which was not apparent from the professionals' reports.

1.23. Both parents commented that much of the information contained within this report was not known to them before her death and highlights the challenges for professionals working with adults who wish to maintain their individual right to confidentiality against sharing information with parents/next of kin.

1.24. Both parents have read the final report and following a telephone conversation with them, they both endorse this final version.

Report Structure

1.25. This report has been written with publication in mind. Therefore, names have been changed and some facts omitted for confidentiality purposes. The report contains information which will ensure that the facts can be understood in order for lessons to be learnt.

How Learning will be Disseminated

1.26. The Safeguarding Adults Review (SAR) subgroup is responsible for ensuring that all named agencies agree ownership of actions following the recommendations from this review.

1.27. Each agency that identifies actions based on the review will be asked to provide regular reports to the SAR subgroup to monitor the progress made and report to the full Board as required.

1.28. Once all actions have been completed the monitoring of the recommendations will be moved to the Quality and Performance Subgroup for testing, to measure the impact of recommendations and to ensure that learning and actions have been embedded effectively.

1.29. The learning from this Safeguarding Adults Review will be cascaded through single and multi-agency learning and development opportunities and Safeguarding Adults Board bulletins.

2. Case Summary

2.1. Individual agencies were requested to provide a chronology of their involvement with Adult B and to either undertake a Individual Management Review or provide a Summary of Involvement.

2.2. Not all agencies responded to the request and this will be commented on further in section 3.

2.3. A comprehensive chronology was produced and a summary of the most significant events produced.

2.4. In addition, it was felt that to understand the case better a brief background history of Adult B would be beneficial.

2.5. Adult B had a long-standing history of self-harm and institutional care from the age of 14 years. She experienced domestic violence in childhood and parental separation.

2.6. On leaving her care home she lived for some time with one of her previous carers. The breakup of this relationship appears to coincide with a deterioration in Adult B's mental health.

2.7. There was a history of assaulting staff, other patients and colleagues. One episode of affray and threats to kill resulted in a remand period in prison.

2.8. Adult B had several diagnoses related to both mental and physical illnesses. At the time of her death Adult B was diagnosed with a Personality Disorder (see appendix 2), Asperger's Syndrome, epilepsy and asthma in addition to being morbidly obese.

2.9. In addition, Adult B's self-harming episodes had contributed to some of her complex physical needs primarily in relation to the care required to manage her stoma and fistulas.

2.10. Adult B had been detained on a Section 37 Hospital Order under Mental Health Act 1983 / 2007 for 9 years. Since 2010 Adult B had been detained under Section 3 of the Mental Health Act (see appendix 3) and her history includes frequent moves

between different mental health hospitals requiring either low or medium secure placements interspersed with attendance and/or admissions to acute hospitals. Adult B's mother recalls there being around 80 placements for Adult B since childhood; the longest placement was for 5 years and the next longest 10 months.

2.11. Adult B's family kept in touch by phone and visits. However, Adult B's placements were not always near her family.

June 2014 to 17th October 2015

2.12. In June 2014 Adult B was an inpatient at Recovery First[4], a low secure provision commissioned by Betsi Cadwaladr University Health Board, the health authority responsible for Adult B's mental health needs.

2.13. On the 10th of July Adult B's care coordinator and a Commissioner from Betsi Cadwaladr University Health Board carried out a joint visit to see Adult B at Recovery First following the notification of a serious incident which involved Adult B assaulting another patient and allegedly trying to instigate a riot on the unit.

2.14. The following day a Care Management team meeting was held and it was concluded the current placement was inappropriate following the recent violent incident which involved the local police which resulted in Adult B having to be managed alone in an empty ward area.

2.15. Adult B was referred to Calverton Hill Hospital, a medium secure service in August. A preadmission assessment was undertaken by the Hospital Director and Registered Mental Nurse on the 5th of August. A further assessment was undertaken by the Consultant Psychiatrist on the 12th.

2.16. On the 14th of August Adult B was admitted to Calverton Hill Hospital[5]. Unfortunately, Recovery First only sent one stoma bag with Adult B when she was transferred, so when staff went to change the dressing and bag there wasn't one. Calverton Hill Hospital raised this as a concern with the local safeguarding team.

2.17. Three days later on the 17th of August Adult B attended the Accident and Emergency Department at the Queens Medical Centre due to concerns from the nursing staff that Adult B was interfering with her abdominal wound. However, Adult B discharged herself before bloods could be taken and returned to Calverton Hill hospital on the same day. Adult B was deemed by staff to have the capacity to make that decision at the time.

2.18. On the 18th Adult B's stoma was reviewed by a local stoma care nurse and a referral was sought to tissue viability and colorectal surgeons through the GP.

2.19. Within twenty-four hours Adult B attended the Emergency Department for treatment of a foreign body in her left arm. A metal zip was inserted into an old

[4] Recovery First is a joint venture between the Priory and Greater Manchester West Mental Health Foundation Trust.
[5] Calverton Hill Hospital is a medium secure facility run by partnerships in care organisation at that time

self harm wound. The foreign body was removed and the wound treated. Adult B was then discharged.

2.20. Two days later (20th) Adult B was back in Queens Medical Centre with cellulitis[6] to her left arm wound. Adult B was admitted for brief stay on a short stay ward with 3 carers present. She stayed for 2 days before being readmitted to Calverton Hill Hospital on the 22nd of August.

2.21. On the 2nd of September Adult B was taken again to the Emergency Department, following another deliberate self-harm injury. On this occasion, foreign stones were found in her stoma. Following treatment Adult B was discharged.

2.22. Three days later, on the 5th of September, Adult B was back in Queens Medical Centre and this time was admitted onto the High Dependency Unit (HDU) due to self-induced trauma to abdomen and the development of life threatening septicaemia. During her time on HDU there were reports of Adult B displaying threatening and assaultive behaviour towards staff.

2.23. Adult B was transferred from HDU to a Gastroenterology ward on 14th of September. On this day, the Social worker at Calverton Hill Hospital raised a safeguarding referral with the safeguarding team regarding confusion over administration of antipsychotic medication.

2.24. On 30th of September Adult B attempted to leave the ward and handcuffs had to be used to restrain her.

2.25. A Consultant Colorectal Surgeon met with Adult B's family on the 2nd of October and the family supported the medical view not to operate on Adult B's abdominal wounds. The family requested that a place for Adult B be found nearer to their home area.

2.26. At this time Dr M, who is employed as Gatekeeper[7] on behalf of Welsh Health Specialised Services Committee, visited Adult B in hospital and following a Psychiatric assessment, concluded that Adult B no longer met the criteria for a Medium Secure Unit.

2.27. During late November and mid-January 2015, various meetings and correspondence occurred between Commissioners and providers regarding the ongoing provision of care for Adult B and there was discussion regarding the need for legal advice around a Court of Protection application.

2.28. An assessment by the team from Cygnet Hospital was undertaken with a view to suitability for admission. Adult B was declined for low secure services at Cygnet. It was recommended by staff at Cygnet Hospital that when medically fit for discharge Adult B be initially transferred back to a medium secure unit and then

[6] Cellulitis occurs when certain types of bacteria enter through a cut or crack in the skin.

[7] The Gatekeeper is a health care professional, usually a primary care physician or a physician extender, who is the patient's first contact with the health care system and triages the patient's further access to the system

assessed in a more appropriate environment for suitability for step down to low secure provision.

2.29. On the 12th of January 2015 there was discussion between the care coordinator and the Learning Disability Services Manager around development of a bespoke package of care. However, this was not progressed as assessments and profile were indicating the need for Adult B to be placed in a Medium Support Unit, and not a Low secure unit.

2.30. An email dated 13th of January questioned the Multi-disciplinary team's (provider's) view that Adult B no longer required a Medium Support unit placement. This decision contrasts with her Care Manager's and other providers' views. Adult B herself did not believe she was a risk to herself.

2.31. Dr M confirmed by email on 15th of February that he stood by the assessment carried out in June 2015 that Adult B no longer met the criteria for Medium Secure Unit.

2.32. During February considerable effort was made by the commissioners in trying to find a placement in a low secure unit. However, this was proving difficult. Cygnet Care did not have a bed available and six other providers were also unable to offer placement. In addition, at this time there was a flurry of emails between the commissioners and care coordinator pushing for responses in relation to legal representations for the Court of Protection Process and funding queries.

2.33. A Court of Protection hearing was held on 18th of February 2015. As part of the procedure it was requested that an independent psychiatrist assessment be undertaken.

2.34. The independent psychiatrist assessment was undertaken on 24th of March 2015. Adult B was assessed in relation to her Mental Capacity regarding Court proceedings, abdominal treatment options and post-operative and subsequent care and accommodation decisions. The Court of Protection proceedings were eventually stopped when it became apparent that surgery was no longer an option as no surgeon would operate due to the extent of abdominal damage and high risk of continual interference with the wound post operatively which would prevent healing.

2.35. The Dene was contacted to see if a placement was available there on a low secure unit. The team at The Dene reviewed the clinical information and they did not feel this patient was suitable for The Dene. Hospital notes record "a 33-year-old woman with lifelong emotional instability, self-harm ++ Now in very poor physical condition due to self-harm and interfering with wounds. Requires high level of supervision and medical input. Will need psychological therapies, ward with high staffing level and intensive medical support due to her very serious needs".

2.36. During May 2015 staff at Cygnet Hospital prepared for Adult B's admission, including training staff on stoma care. Adult B was registered with a local GP practice.

2.37. Adult B was admitted to the Cygnet Hospital on 1st June and placed on a low secure ward. Adult B was supported by staff to take more responsibility in her stoma care.

2.38. On 4th of June, Adult B asked to speak to her boyfriend (with another provider). Staff checked this out and it was subsequently discovered that the alleged boyfriend was actually a member of staff. The alleged relationship had previously been investigated as a safeguarding enquiry and the allegation against the member of staff was found to be unsubstantiated.

2.39. During her stay it was recognised that Adult B was at risk of abuse from other patients and a safeguarding plan was put into plan to help stop Adult B feeling bullied and giving away her property.

2.40. The Care coordinator and her previous psychotherapist visited on 19th of June. That night Adult B made two deep cuts to her arm which required suturing at the local acute hospital.

2.41. On 1st of July Adult B's care plan was updated, but, later that day Adult B made two deep cuts on her arm which required attendance at Derby Royal, the local acute hospital. Surgery was required the next day to treat the wounds, and then Adult B was returned to the Cygnet Hospital.

2.42. On 6th of July, Adult B once again reopened her abdominal wound and inserted a foreign object. However, she refused to be examined and assessed.

2.43. Two days later on 8th of July Adult B complained of abdominal pain again. Due to the extent of her abdominal wounds the appendix was visible and seen to be inflamed.

2.44. 5 days later on the 11th, blood was seen in the stoma bag and Adult B admitted to tying of the distal part of her appendix, pulling it out and eating it. The registrar decided to remove the rest of the appendix under local anaesthetic.

2.45. On the 14th Adult B attended a manager's panel meeting. It was recognised that the risk in relation to her self-harming had increased since admission. On the same day, the care coordinator advised the providers that the Safeguarding of a Vulnerable Adult threshold had been met in relation to the inappropriate removal of the appendix at the hospital and they requested the staff to refer appropriately to ensure adequate safeguarding measures are in place.

2.46. Subsequently the surgical incident was reported as a Serious Incident[8] and a full investigation was undertaken. It was found that there was poor professional practice and the doctor was referred to the GMC.

[8] Serious Incident Reporting and Learning Framework (SIRL)
National Framework for Reporting and Learning from Serious Incidents requiring Investigation

2.47. Adult B was given an apology in relation to the surgical procedure. She declined a written apology and agreed to the matter being referred to the local authority team.

2.48. Adult B was taken to A&E again on the 16th after interfering with her stoma site. Suturing was not required, however an abdominal X-Ray revealed the presence of four foreign bodies in her abdominal cavity.

2.49. Adult B was treated for a rash by the GP from the local practice on the 24th of July.

2.50. On the 25th the extensive harming of the stoma area was so severe that the stomach was visible. Adult B was transferred to the Royal Derby Hospital where she was treated for Septicaemia. At this point, due to the concern regarding the level and frequency of self-harming a referral was made to the hospital safeguarding team.

2.51. At the MDT meeting held on the 27th it was decided that Adult B needed a level of care beyond the scope of a low secure unit and an escalation plan was put into action.

2.52. On 3rd of August, Adult B was discharged back to the low secure ward at Cygnet Hospital with additional staffing resources in place. Meanwhile, the search for an appropriate placement continued. Dr M, the Gatekeeper, confirmed that Adult B now had the need of a medium secure placement.

2.53. A referral was made to The Dene Hospital in early August.

2.54. A Consultant Psychiatrist from The Dene visited and assessed Adult B's needs on the 14th of August. It was felt by the Psychiatrist that Adult B appeared willing to engage and based on the assessment Adult B was accepted by The Dene for admission.

2.55. On 20th of August 2015, the Stoma Care Clinical Nurse Specialist, at Royal Derby Hospital contacted the stoma nursing team at Brighton & Sussex University Hospitals (BSUH) regarding Adult B's transfer to The Dene. It was confirmed Adult B had an open wound and fistulas caused by self-harm. The referral did not specifically suggest that managing the fistula was potentially problematic. The stoma specialists agreed that a Stoma Care Clinical Nurse Specialist from BSUH would review Adult B on the 27th of August.

Transfer to The Dene Hospital in West Sussex

2.56. On 24th of August Adult B was admitted to The Dene and placed on the medium secure unit. Immediately care and treatment plans were completed in relation to mental illness and insight into mental illness as well as a risk management plan.

2.57. Personal care and physical treatment plans were completed by The Dene on 25th of August and again on the 26th.

2.58. A nurse from the stoma team visited Adult B at The Dene on 27th of August. She reported that the staff felt unable to cope with managing the fistula and made

arrangements to undertake a further review and to provide a photo care plan and teaching. A written care plan was produced.

2.59. On 1st of September, A carer from The Dene rang the stoma care team for advice as Adult B's skin around the stoma was sore and the pouches were not secure. They were informed that stoma nurse would be visiting the next day.

2.60. Later that day Adult B was taken to the Emergency Department with abdominal pain and a leaking stoma for which the Doctor at The Dene did not have enough equipment to change the bag. The x-ray showed a foreign object in her body, and Adult B disclosed that she had swallowed an MP3 player previously.

2.61. Two nurses from the stoma care team visited on 2nd of September and reported that skin around stoma was very excoriated. The stoma care clinical nurse specialists recorded that they found the staff from The Dene appeared reluctant to undertake the complex fistula care required or to be trained to do so. The stoma care clinical nurse specialist decided to refer the matter to the District Nursing team to see if they could visit twice weekly to support The Dene staff with stoma care.

2.62. The local District nursing team employed by Sussex Community Foundation Trust (SCFT) were contacted but did not accept the referral as they had not employed a Registered General Nurse, and they felt that The Dene staff should provide the care needed.

2.63. On 8th of September, a call was made to South East Coast Ambulance Service (SECAmb) reporting that Adult B had a possible bowel obstruction. She was taken to the Emergency Department at the Royal Sussex County Hospital.

2.64. Doctor A from The Dene provided a summary of Adult B's history for the acute hospital and highlighted that "for the last three days she has been feeling unwell and nauseous. Today she has increased abdominal pain and is vomiting faecal fluid". Also, when in a state of distress and refusing care, she lacks capacity to make such a decision. Today she is upset about the vomiting and understands that she needs to be assessed in hospital".

2.65. The letter also stated that Adult B was a former medical student (not in fact true) and had a very good understanding of her surgical condition.

2.66. Adult B was assessed and referred to the Surgical Team for abdominal assessment. They noted from the information provided that Adult B had previously been under the care of the surgical team at Queen's Medical Centre, Nottingham, who had advised that Adult B was unfit to have her colostomy reversed until she had lost weight.

2.67. The Emergency Department staff noted copious faecal output. Blood results indicated a mild renal impairment. No evidence of bowel obstruction was found, and the abdominal x-ray identified foreign bodies as per the x-ray taken on 1st of September. Dehydration was noted. As a result of the findings, Adult B was admitted and prescribed IV fluids.

2.68. The next day (9th September) Adult B was reviewed on the ward round and the plan was for her to be discharged to The Dene if she could eat and drink.

2.69. Later that day, Adult B was reviewed by a junior doctor as she was reporting not passing urine for a day. A bladder scan was ordered & IV fluids and fluid balance chart commenced.

2.70. Adult B's high stoma output was noted. An hour later, Adult B was seen by another doctor who documented that she did not appear clinically dehydrated. A bladder scan showed 200ml in her bladder. Her high output stoma was again noted. The plan was for discharge if Adult B passed an acceptable amount of urine. She was then discharged back to The Dene the next morning (10th September).

2.71. Adult B was readmitted to Acute Medical Unit at Royal Sussex County Hospital on 14th of September. A Stoma clinical nurse specialist recommended that the doctors review the high output stoma guidelines. It was arranged for a stoma care clinical nurse specialist telephone review to be carried out the next day. Staff recorded that Adult B said that she had swallowed the MP3 player as a cry for help as she did not want to be at The Dene.

2.72. Adult B's mother contacted the care coordinator on the 15th highlighting her concerns that a staff member at The Dene had informed her that they were unable to work with Adult B any longer. The care coordinator contacted the WHSSC case manager to inform him of all the information. The care coordinator contacted Doctor A who was in charge of Adult B's care at The Dene - a discussion was had around the fact that The Dene no longer had a Registered General Nurse or a Health Care Assistant on the ward to help with Adult B's physical needs. Doctor A requested that a Gatekeeping meeting and case conference be convened.

2.73. Adult B was transferred back to The Dene on the 16th and on the following day the stoma care clinical nurse specialist attempted to ring The Dene to make an appointment to arrange a training session on stoma care for staff. After the phone was not answered for 10 minutes they gave up ringing.

2.74. During this time, BCUHB were looking to transfer care coordination to BCUHB Community Forensic Team. On 18th of September, it was confirmed that the Rehabilitation team would remain involved for a further three months rather than the immediate transfer to BCUHB Community Forensic Team as was the usual practice within Wales.

2.75. On 21st of September Dene Dr A recorded in Adult B's record: "Discussed the fact that she's spending more time in General Hospital than on the psychiatric ward. Perhaps a different approach needed to be considered, for example liaison psychiatry associated with General Hospital. I advised Adult B I had spoken to her care coordinator, who was discussing this with the funders. She seemed pleased about this and again said that she preferred not to be at The Dene, but didn't mean to be angry with staff because she knew they were working hard on her behalf"

2.76. On 28th of September there was further contact between Dr A and the care coordinator, this time by email. Once again, the lack of general nursing support

was highlighted and there was mention of the possibility of hiring an agency registered general nurse. Dr A once again requested that a case conference and gatekeeping assessment be undertaken.

2.77. Dr A recorded on the 28th in Adult B's record that a referral would be made to the appropriate surgical consultant at the Royal Sussex County hospital, in the hope of planning her care, to avoid the frequent Emergency Department attendances.

2.78. Also on the 28th Adult B requested advocacy support from the independent advocate working at The Dene[9]. Adult B shared her concerns regarding her physical symptoms of dehydration (dry lips) and care needs. She also disclosed a self-harming incident to the advocate.

2.79. The Advocate discussed Adult B's concerns and signs of dehydration with the ward manager and it was agreed that the concerns would be shared with the stoma nurse who was expected to visit Adult B that afternoon.

2.80. The Stoma clinical nurse specialist arrived at The Dene later the same day to deliver the scheduled training. Only 1 carer attended the session. When examined, Adult B's pouch was leaking and the fistula output was explosive and type 7 on the Bristol Stool chart[10]. Adult B was complaining of feeling dehydrated. The stoma clinical nurse specialist spoke with the deputy ward manager and advised that blood test for Urea and Electrolytes, magnesium and calcium should be undertaken. The stoma clinical nurse specialist recorded in her records that she expressed her concerns that Adult B's care was being fragmented. The next day she spoke with a member of staff and requested that a case conference be held.

2.81. On the 30th a phone call was made from The Dene ward manager to the stoma care team. Adult B wanted to come to hospital to have fistula pouch changed. The stoma care nurse advised The Dene ward manager to contact the community nursing team to see if a District nurse would visit.

2.82. On 1st of October the Independent stoma nurse contacted a member of staff who they believed was the Director of Nursing at The Dene regarding Adult B's blood results, and the need to arrange a case conference; The Dene report that at that time there was no Director of Nursing in post.

2.83. Dr A recorded in Adult B's notes "Her demands for medical attention centre around her perceived failure to pass urine she loses copious fluid through her stoma bag and is repeatedly advised by me and general hospital team to drink more fluids".

2.84. On 2nd of October, an ambulance was requested again, this time for a self-harm injury to her arm. On arrival at the Princess Royal Hospital Emergency department, Adult B was complaining of painful kidneys/urination in addition to her arm injury. Adult B declared that she was self-harming to get attention

[9] Advocacy means getting support from another person to help patients express their views and wishes, and to help make a individuals voice is heard.

[10] The Bristol Stool Chart or Bristol Stool Scale is a medical aid designed to classify faeces into seven groups.

regarding her poor urine output. Adult B is reported to have requested a blood test as she stated that last time she had these symptoms she was suffering from kidney damage. Adult B again reported that she had tried to raise her concerns with The Dene but without success.

2.85. Blood tests were taken, and Adult B was discharged the same day.

2.86. On 12th of October, SECAmb were requested to attend again, Adult B was taken to the Royal Sussex County Hospital due to cuts on her right arm. In addition, the stoma bag had burst and was leaking. Adult B was also reported to be drowsy.

2.87. Adult B was kept in hospital as the plan initially was to surgically repair the wounds as there was possible tendon damage. Meanwhile, bloods taken by the anaesthetist indicated that Adult B was in renal failure.

2.88. Adult B was then assessed by a Medical Registrar who concluded that Adult B was suffering from an Acute Kidney Injury (AKI) due to dehydration secondary to high output stoma/fistula. A Consultant in acute medicines recorded that the blood results confirmed AKI.

2.89. The Orthopaedic team continued to manage Adult B's care and she was treated with Intravenous fluids to correct her electrolytes. She remained nil by mouth in anticipation of surgery the following day.

2.90. By the following day (14th) Adult B's blood results showed that although the general trend was of improvement, there was a rise in her potassium level. At the Orthopaedic daily trauma round it was decided to treat her arm injury conservatively.

2.91. Despite the rise in her potassium level, Adult B was discharged back to The Dene later the same day with a one week follow up appointment in the fracture clinic. Adult B was given a discharge letter, but the letter did not document her underlying acute kidney injury and high potassium levels. In addition, there were no follow up arrangements in place for her renal concerns. There was no follow up advice provided for The Dene. A copy of the discharge letter was also sent to her registered GP in Derby.

2.92. A Care and treatment plan was completed by The Dene on 14th of October.

2.93. On the 16th, the Independent Stoma Care Nurse Specialist had not heard back from The Dene regarding a case conference. She attempted to contact the Director of Nursing, and was informed that this member of staff had now left The Dene. Instead she liaised with Nurse N who agreed to arrange a multi-disciplinary team meeting.

2.94. On the 17th Adult B was visited by her mother. Adult B was feeling sick and for most of the day was carrying around a vomit bowl, although she did not need to use it.

Events of 18th of October 2015

2.95. Whilst being assisted to have a shower, Adult B complained of feeling unwell. Whilst initially still conscious she rapidly deteriorated and went into cardiac arrest. Staff responded immediately and Deputy Charge Nurse A made the emergency call to SECAmb.

2.96. In addition to the 10 members of staff from The Dene, the resuscitation attempt was also attended to by 2 staff members of a Private Ambulance Service (UKSAS) who happened to have been at The Dene after dropping off another patient. The trainee bank technician actively supported hospital staff in the resuscitation procedure.

2.97. SECAmb received a 999 call from The Dene in relation to a reported 50-year-old unresponsive female who was breathing. The call was made by the Deputy Charge Nurse who did not appear to have a clear picture of the patient's condition. Initially, based on the discussion between the Nurse and the Call handler, a 30-minute response disposition was agreed. However, after further discussion regarding Adult B's condition the response was subsequently upgraded to a Red 2 call.[11]

2.98. On arrival at The Dene the SECAmb ambulance crew's perception that there was no sense of urgency in the process of taking them to the patient's bedside. To reach Adult B, the crew had to go through several locked doors as this was a secure area and it took a total of six minutes from staff arriving at the hospital to being with Adult B.

2.99. Once with the patient, the crew observed that Adult B was in cardiac arrest. Up until that point they had not been made aware of this fact. They observed resuscitation taking place on a soft mattress placed on the floor. The patient had an oxygen mask in place, and, although compressions were being applied, it did not appear to the Paramedics that they were being carried out in an effective manner.

2.100. SECAmb paramedics took over the resuscitation attempt once they had transferred Adult B to a hard service. The ward defibrillator was found to be not working - the battery was flat reportedly due to its extended use.

2.101. At 15:30 a second set of SECAmb personnel arrived to aid with the resuscitation. Unfortunately, despite all the attempts, an hour and forty-five minutes after the initial 999 call, Recognition of Life Extinct was declared (ROLE)[12].

2.102. Sussex Police were informed by SECAmb of a sudden death. Furthermore, SECAmb staff expressed their concern at the time that this case was a possible neglect issue.

[11] Red call. A method of prioritising emergency calls based on level of time critical response.

[12] ROLE. Recognised guidelines used by SECAmb

2.103. SECAmb staff completed and submitted a Vulnerable Person's Form[13], recording the concerns they had regarding the quality of the resuscitation attempt they had witnessed.

3. Analysis of Agency interaction with Adult B

Agencies who had direct interaction with Adult B

3.1. Betsi Cadwaladr University Health Board (BCUHB)

Context

3.1.1. BCUHB are the commissioners for patients registered in Wales with mental health needs requiring services from a low secure facility. The community rehabilitation team manager and care coordinator were both employed by BCUHB.

Summary of Involvement

3.1.2. Commissioners work closely with health providers in sourcing appropriate placements for patients.

3.1.3. The Individual Management Review Author (IMR) highlighted that the Community Rehabilitation Team manager and care co-ordinator liaised regularly with Gatekeeping Case Managers from WHSSC, who were sourcing the Medium Secure assessments/provision.

3.1.4. The IMR author reports that telephone contact between the care coordinator and The Dene took place on a weekly basis.

Analysis of Involvement

3.1.5. The Individual Management Review (IMR) reports that no evidence could be found in respect of the Clinical Care Team's views on Adult B's capacity to make decisions in relation to her physical treatment. Also, there was little evidence of Independent Mental Health Advocacy involvement. (WHSSC contracts state that the responsibility for this lies with the provider.)

3.1.6. The IMR author comments that, whilst Mental Health Measures, Care and Treatment Assessments and Plan were in place, it is not easy to identify how the commissioning care plan and direct support plan by providers align and are monitored by anyone other than a care coordinator, as there are separate monitoring arrangements between Local Health Boards clinical care coordinators, Local Health Board Commissioners and WHSSC Commissioners.

3.1.7. The IMR author concludes that the complex mental and physical health needs of Adult B appear to have exposed gaps in the interface of existing guidance for both the Welsh Local Health Boards and Health Commissioning Wales.

[13] Vulnerable Person Form is a method used by SECAmb staff to share information when there are concerns identified.

3.1.8. The Care coordinator[14] is central to the patient's journey through secondary mental health services and has specific responsibilities (See appendix 4). For Adult B and her family, the care coordinator was a key professional in overseeing her care needs. The care coordinator and the community rehabilitation team manager made themselves available to any placement assessing a patient for admission via the telephone. For a patient with such specific needs, the review panel[15] felt that in the patient's best interest a more proactive approach could have be taken by the care coordinator to contact The Dene.

3.1.9. The Care coordinator records that they liaised with WHSSC, ensuring all relevant information was shared with The Dene. WHSSC confirmed to the care coordinator that at the time of the assessment The Dene had provided assurance that they could meet the needs of Adult B and that her care needs were fully understood. Information about the high level of dressing requirements had been shared, which BCUHB felt would have supported The Dene to understand her ordering needs clearly.

3.1.10. The Care coordinator was informed on 16th of September 2015 that The Dene did not have a registered general nurse in place. The Consultant had to follow this up again on 28th of September as they had not received a response. The consultant record mentions the possibility of hiring an agency general nurse, although further states that this is unlikely to happen soon.

3.1.11. The Care coordinator and The Dene do not appear to communicate again until 13th of October. It is agreed that a meeting of professionals will take place but the earliest date that The Dene could agree to was 24th of November 2015. Again, the review panel felt that, for a patient where it was clear her needs weren't being met, the Care coordinator and Community Rehab team manager could have been more insistent on progressing a meeting sooner.

Learning Identified

3.1.12. BCUHB identified the following actions from undertaking their IMR:

- Review services for people with Personality Disorder with specific regard to support services (accommodation) within North Wales.
- Review commissioning arrangements, roles and responsibilities between BCUHB clinical care managers, CHC & WHSSC. Specific attention to criteria and where Physical Disabilities (and perhaps other) diagnoses cross boundaries. This should take account of roles and responsibilities of practitioners/teams within the Mental Health Division.
- Review the use of the Mental Capacity Act and Best Interest decision making processes for people with Physical Disability (and potentially other groups). Consider specific processes for Mental Health Division up to and including access to Court of Protection.

[14] Care coordinator is an appointed professional who works collaboratively with the relevant patient's mental health providers and are the principle source of information for the patient.

[15] The review panel was made up of senior professionals from agencies that worked with Adult B

- Review the patient information/record keeping/case note system.

Additional Review Panel Recommendations

3.1.13. The panel felt that the supervision and support for the Care coordinator and Community Rehabilitation Manager should be revised to ensure that staff managing cases that are highly complex and demanding should receive frequent high-level supervision, and the consideration should be given to cases being rotated to avoid potential burnout.

3.2. Brighton and Sussex University Hospital

Context

3.2.1. Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital working across two main sites:

- Royal Sussex County Hospital in Brighton
- Princess Royal Hospital in Haywards Heath

3.2.2. The Trust provides district general hospital services to the local populations in and around the Brighton and Hove area, Mid Sussex and the western part of East Sussex as well as more specialised and tertiary services for patients across Sussex and the south east of England.

3.2.3. The Dene Hospital is located within the catchment area of BSUH and therefore Adult B was taken to both hospitals when treatment was required.

Summary of Involvement

3.2.4. Adult B received treatment on five separate occasions between 30th of August 2015 and 14th of October 2015 from both Royal Sussex County Hospital and The Princess Royal Hospital.

3.2.5. In addition, Specialist Nurses from the stoma service saw Adult B either on the ward or visited her at The Dene.

3.2.6. Apart from the stoma care nurses who had received contact from their counterparts in Derby prior to Adult B's move to The Dene, hospital staff had no information in relation to Adult B or her previous extensive medical history before she first presented to the Princess Royal Hospital on 30th of August 2015.

3.2.7. The history of Adult B's attendances outlined in section 2 clearly identifies that BSUH failed to fully recognise, investigate or treat Adult B's life-threatening Hyperkalaemia (High Potassium) which arose because of acute kidney injury with severe renal impairment. Adult B was presenting with a repeating pattern of abnormal blood results which were worsening and did not receive the attention the blood results warranted such as a referral to a renal physician.

3.2.8. The significance of the high output stoma was not fully addressed. The hospital's own guidance for High Output Stoma[16] was only partially followed and therefore whilst there was recording of input and output, as well as referral to the stoma care nurses, there was an inadequate treatment plan regarding management of Adult B's fluid balance, high output stoma and future monitoring of her renal function and serum potassium.

3.2.9. Failure to seek specialist renal input especially on 12th of October was a significant missed opportunity to treat Adult B.

Analysis of Involvement

3.2.10. Common to other agencies treating Adult B there was a lack of holistic care, with attention focused on her immediate presenting complaint.

3.2.11. It should be acknowledged that staff working on the wards are under a degree of organisational pressure to discharge patients as soon as they no longer require acute care, due to a lack of bed capacity within acute hospitals. The fact that Adult B was being discharged to a hospital - albeit a mental health hospital and not home - may have influenced the decision to keep admission time short. In addition, BSUH report workload pressures at the time which may have affected the quality of decision making.

3.2.12. There is little evidence of discussion around Adult B's Mental Capacity.

3.2.13. Whilst the Serious Incident (SI) report is very detailed in the analysis of medical care received and lessons learnt, the potential missed opportunities in relation to safeguarding were not explored fully. On at least two occasions Adult B reported self-harming as a method of ensuring her concerns regarding her poor urine output and treatment by The Dene were highlighted, yet these do not appear to have been explored further with her. Whilst it is recognised that Adult B had a history of self-harming and complaining of poor care going back years which may have meant that staff gave less attention to her comments, staff at BSUH would not have been aware of this history.

3.2.14. Due to the risk to herself, Adult B always had carers with her. This meant that BSUH did not have the opportunity to speak with her alone and staff did not explore her concerns in private. This may well have been due to the fact that she had a history of violence and they did not feel safe being alone with her. Sussex Safeguarding Adults Procedures advise professionals to speak to patients in a private place if safeguarding concerns are suspected.

3.2.15. The stoma care team recorded their concerns about the complexity and extent of the abdominal wounds and The Dene's staff ability to manage all aspects of care and monitoring of a patient with a high output stoma. They recognised that the staff needed training and arranged two training sessions which resulted in 2 members of staff being trained. In addition, they record requesting a multi-disciplinary meeting to be held. However, despite their concerns regarding care

[16] High Output Stoma Guidelines BSUH 2015

and their request for a meeting not taking place, they did not consider formally raising a safeguarding concern.

Learning Identified

3.2.16. Prior to being part of this Learning Review, BSUH undertook a Root Cause Analysis Review which was externally reviewed and monitored as part of the Serious Incident Process.

3.2.17. The following the actions arose from the Root Cause Analysis Review:

- Automatic safety nets have been introduced to support clinicians on receipt of abnormal blood results, with the recognition and management of this scenario (raised potassium levels and acute kidney injury) including input from the renal team.

- Patients attending on multiple occasions with a recurrent pattern of concerning blood results need an ongoing community management plan to ensure concerning changes are identified and acted upon.

- The process of the Orthopaedic Consultant ward round has been reviewed. Advanced Nurse Practitioners are being employed to be permanently based on the ward ensuring results are available and other concerns highlighted.

- This case highlights the potential benefits of multi professional's meetings or case conferences for patients with complex care needs.

3.2.18. Immediate actions taken include:

- Changes to trauma meeting handover sheets to include blood results
- Review of the use of the high output stoma guidelines
- Development of a mandatory human factors learning model

3.2.19. In addition BSUH has introduced more specific safeguarding adult training for specialist nurses which is being undertaken, to highlight their role in safeguarding and chronic illness.

3.3. Calverton Hill Hospital

Context

3.3.1. Calverton Hill Hospital is a medium secure service, at the time of Adult B's admission the hospital was operated by Partnership in Care.

Summary of Involvement

3.3.2. Adult B received a mental health service from the Hospital from 14th August of 2014 to 1st June of 2015. During that period, Adult B was admitted to Queens Medical Centre (QMC) on several occasions and in fact after her admission to QMC on 5th of September she did not return to Calverton Hill Hospital, but was discharged to Cygnet Derby.

3.3.3. The team at Calverton liaised closely with medical professionals at QMC and Adult B was escorted by a minimum of two Calverton Hill staff on each occasion she attended.

3.3.4. It was concluded by some professionals working with Adult B at the time that she had not presented as a significant risk to others, and that the strict regime of an acute medium secure setting served paradoxically to increase her risks. She had a lengthy history of boundary pushing and seeking pathological degrees of attention for the purpose of receiving reassurance from care givers. Having to manage the boundaries within a medium secure setting and compete with 14 other patients in an acute environment for staff attention was challenging for her and contributed to her self-harming behaviour. The team at Calverton Hill reported this to her care coordinator, QMC and her secure care commissioner, NHS Wales. Adult B was reviewed by a Consultant Psychiatrist from NHS Wales who supported the team at Calverton Hill's view and recommended transfer to a low secure setting.

3.3.5. Prior to her transfer from Calverton Hill to Cygnet Derby there was a period of joint working between the two teams to help facilitate the transfer of her care.

Analysis of Involvement

3.3.6. There appears to have been a concerted effort by the team at Calverton Hill to work in partnership with QMC and with the team at Cygnet Derby to assist in her subsequent transfer of care to that hospital.

3.3.7. The review panel were interested in understanding how Calverton Hill Hospital concluded that the strict regime of a medium secure unit was not in Adult B's best interest and even increased her risks. Although it may have been based on the view that Adult B was being managed for much of the time on a general acute ward, there would have been a strict regime in place and she was supervised by 2 to 3 carers.

Learning Identified

3.3.8. Calverton Hill Hospital did not identify any learning for their service.

3.4. Cygnet Hospital

Context

3.4.1. Cygnet Health Care provides a national network of specialist mental health services. Adult B was treated at the Derby Hospital.

Summary of Involvement

3.4.2. Adult B spent 12 weeks under the care of the Cygnet hospital, following an initial settled period Adult B increased in risk taking behaviour and significant self-harm, requiring multiple admissions and interventions in the Derby Royal Hospital.

3.4.3. Adult B's mother recalled that Adult B loved being at the Cygnet and she appeared happy, in fact she hadn't seen her daughter like that for years. She felt that her

daughter was moved to another hospital following the fallout from the surgical incident.

Analysis of Involvement

3.4.4. There is evidence within the IMR to demonstrate that staff were mindful and sensitive to the needs of Adult B, and recognised that she needed to be safeguarded. Action was taken when there were concerns Adult B was feeling bullied.

3.4.5. Care plans and risk assessments were frequently reviewed. Regular team discussions took place.

3.4.6. An example of good practice was to arrange to train staff in stoma care prior to Adult B's admission. In addition, members of staff worked as one of her carers whilst she was still in QMC which helped build therapeutic relationships.

3.4.7. Although Cygnet Hospital provided a comprehensive written discharge summary, it did not arrive until 2 days after Adult B had been admitted to The Dene. With such a complex history and specific physical care needs a more timely transfer of information would have been expected.

3.4.8. This review did not explore the inappropriate surgical procedure that took place, as this has been addressed through the Serious Incident process which was overseen by established local NHS processes. It has been confirmed that the relevant learning and action plan have been implemented.

Learning Identified

3.4.9. IMR Recommendations:

- Ensure professionals when completing documentation clearly and legibly, sign, print and denote their designation.

- Mental Capacity Act Assessments to be undertaken for patients and documented in line with organisational policies and procedures.

Additional Review Panel Recommendations

3.4.10. The review panel recommends that Cygnet review how information relating to patients with complex health needs and specific equipment requirements is handed over to a new provider.

3.4.11. The review panel recommends that Cygnet ensures discharge summaries are shared at the time of discharge or even in advance when a patient has specific health needs.

3.5. The Dene

Context

3.5.1. At the time of the review The Dene was part of the Partnerships in Care organisation. The Dene provides medium secure, low secure and inpatient service for women with high dependency needs (HDU).

Summary of Involvement

3.5.2. The Dene was first contacted in April of 2015 to see if they could offer a low secure placement for Adult B. The Dene declined this request after reviewing the clinical information. It is noted that Adult B required high levels of supervision and medical input and would have needed Psychological Therapies; a ward with high staffing levels and intensive medical support due to her very serious self-harm. It is also noted that the family had commented that they wanted to be nearer to her in Wales.

3.5.3. Following admission on 24th of August 2015, Adult B remained at The Dene (excluding visits and short admissions to BSUH) until her death on 18th of October 2015. During her short stay at The Dene, Adult B was treated at local hospitals on 5 separate occasions and admitted on 4 occasions.

3.5.4. Adult B's mother recalls Adult B saying that she was very unhappy at The Dene, and she felt no one was taking notice of her poor urine output. She phoned her mother on three occasions in a very distressed state, begging her mother to come and get her. Following one call Adult B's mother tried to ring the ward to speak to the nurses but eventually gave up when the phone was not answered.

Analysis of Involvement

3.5.5. The Dene's first contact with Adult B was when the Consultant Psychiatrist went to Derby to undertake an assessment. It is not clear why the Psychiatrist went alone and was not accompanied by a nurse, which was the standard referral process. If a nurse had been present, there may have been a greater exploration of Adult B's physical needs, especially in relation to her stoma care requirements.

3.5.6. There was also no evidence to suggest that, as part of the assessment, contact was made with other organisations who would have information which could have revealed the extent of Adult B's complex needs, and which may have indicated that the facilities at The Dene were not suitable. Information would have been available on the Carenote system[17], from her stay at Calverton Hill Hospital which was a partner hospital of the Partnership in Care organisation.

3.5.7. The assessment process and the conclusions drawn from it are only as good as the information obtained. Crisp et al. (2003) state that assessment 'involves collecting and analysing information about people with the aim of understanding their

[17] Carenote system an electric form of records used across Partnership in Care services

situation and determining recommendations for any further professional intervention'[18].

3.5.8. The Dene offered a bed because they felt they could meet Adult B's mental health needs based on the assessment undertaken. However, in relation to her physical needs The Dene maintain that the extent of the abdominal care required was not known to them prior to transfer. However, both the Cygnet Hospital and the Welsh Commissioners felt that information had been shared detailing Adult B's physical needs.

3.5.9. The lack of understanding of the level of care Adult B would require in relation to her stoma may explain why, in contrast to the other hospitals Adult B had been admitted to, staff did not receive any training in stoma care prior to her admission. At the time of her admission The Dene also had a registered general nurse in employment. Unfortunately, the nurse left the hospital soon after Adult B arrived and a replacement was not recruited until after Adult B's death.

3.5.10. Adult B was referred to the GP at The Dene to support her care. The GP at the time was not accepting new patients, but was visiting weekly. There is no record of Adult B being seen by the GP at The Dene. This could have been because she was spending more time in the general hospital than at The Dene, and was not present when the GP visited. However, The Dene's physical health care model in use at the time was expected to be mainly led by the GP, complimented by the Physical Health Assistant Practitioner and it is of concern that a patient with a high need of physical care did not receive a service from either practitioner. If senior management were informed of this situation it is not clear what actions were taken to address the issue, apart from informing the care coordinator that a Physical Health Assistant Practitioner was not in place.

3.5.11. Whilst at The Dene, Adult B told other professionals and her mother that the hospital was not addressing her worries, which included not passing urine. This, however, contrasts with her medical records from The Dene which frequently record that staff had noted her concerns around a reduced urine output, and confirming that they were giving her advice on drinking extra fluids. Adult B herself was also recorded to have told staff that she had taken on less fluids to reduce the output from her stoma. Without the recording of input and output it is hard to support either viewpoint.

3.5.12. The IMR reports as an example of good practice, that Adult B was always accompanied by staff who understood her mental and physical needs when she was admitted to the local hospital. Evidence from the chronology would suggest that not all staff understood her health needs e.g. BSUH records state that Adult B's carers from The Dene report that have restricted her fluids in order to reduce her stoma output.

3.5.13. Within the IMR It is highlighted as good practice that staff sought support from the stoma nurse specialist. However, the Stoma care nurse specialists from

[18] Crisp, B.R., Anderson, M.T., Orme, J. and Lister, P.G. (2003) Knowledge review 01: Learning and teaching in social work education – assessment, London: Social Care Institute for Excellence.

BSUH record that they felt nurses at The Dene did not appear to fully engage with the support on offer. There are episodes where the hospital is reported to have run out of stoma products. Adult B's mother recalls that on her last visit to see Adult B, on the day before she died, an incontinence pad was being used on Adult B's abdomen. Adult B had a history of frequently interfering with and removing her dressings, and the ordering of supplies should have anticipated this high demand of products.

3.5.14. Compared to the proactive training of staff in stoma care prior to admission demonstrated by other hospitals, The Dene did not have any pre-admission training for staff. This could be explained by the admission process not fully exploring Adult B's physical requirements in detail, and the short period of time from referral to admission. Once admitted, training was arranged by the Stoma nurse specialist, but in total only 3 members of staff were trained. Generally, based on support given to other hospitals with similar stoma support, it would be expected by the Stoma team that at least 5 members of staff would attend per session to allow for enough staff to be trained to cover different shifts, holidays etc.

3.5.15. The IMR does not include the day of her death and the care she received prior to her death. As concerns had been raised by SECAmb in relation to the sense of urgency and quality of information shared during the 999 call and the quality of resuscitation attempt observed, the author would have expected this area to be reviewed as part of the IMR.

3.5.16. It is unfortunate that the senior mental health nurse making the emergency call was not near the patient and so could not relay when Adult B had gone into cardiac arrest. Initially this led to a degree of confusion around the level of response being requested from the ambulance service. If a cardiac arrest had been known about, the response would have immediately have been prioritised to 8 minutes and Cardio Pulmonary Resuscitation instruction given to staff immediately. SECAmb staff would also have known to have taken their defibrillator onto the ward on arrival.

3.5.17. The level of resuscitation witnessed by the ambulance trust would suggest that staff (including the trainee technician from a private ambulance service) although recently trained in intermediate life support training were not confident in dealing with the situation. Although cardiac arrest in a mental health setting is less common than in an acute setting, it is important that staff know what is expected of them.

3.5.18. Whilst with hindsight, the cause of Adult B going into cardiac arrest (high potassium) meant that resuscitation alone would not have been successful, it is still important that lessons are learnt from this episode for the benefit of other patients or visitors who may one day need resuscitation whilst at The Dene.

3.5.19. It is important to record that there were differing views on whether the quality of the resuscitation response was appropriate. The review team with the exception of the representative from The Dene, are of the opinion that the standard of resuscitation care given was not of the quality expected of trained hospital staff. However, The Dene, having consulted their independent trainer, are not in agreement.

3.5.20. The author requested to meet with some of the staff who worked directly with Adult B.

3.5.21. After careful consideration, the request was declined by the Priory who since the start of this safeguarding adult review have taken over the ownership of The Dene, for the following reasons:

- Most of the staff who knew and cared for Adult B no longer work at The Dene.
- If the meeting was to go ahead there was a concern that the panel would only be given partial information (due to not seeing all the staff involved).
- The current ongoing police investigation in relation to The Dene Hospital. In respect of this, the understanding of The Dene is that the police investigation takes primacy over other investigations and reviews and further meetings with 'witnesses' will have the potential to cause them anxiety and complicate matters.

3.5.22. Witness statements provided for the Coroner's Hearing from staff working on 18th October have been shared with the author of this report and where relevant, information has been added to this report.

Learning Identified

3.5.23. IMR learning

- Admission Assessments to be undertaken by a multi-disciplinary team with a minimum of a doctor and nurse present.
- A physical health assessment form has been created for new admissions
- The General Practitioner contract has been reviewed and all secure patients and longer term HDU patients are registered with The Dene GP. Also, acute or shorter term HDU patients can access the GP clinic every Thursday.
- Review of provision of Physical health practice nurse and assistant practitioner service
- Stoma care and tissue viability nurse provision have been reviewed and strengthened.
- A mobile phone is now available for use in such emergencies which will allow the caller to be nearer the patient and therefore be able to convey more accurate information regarding a patient's current condition.

Additional Review Panel Recommendations

- To review quality of resuscitation training available to staff. Include learning identified from this case.
- Review how specialist requirements are commissioned for patients who have needs outside the expected skills of the existing staff workforce and/or require special dressings.
- Ensure patients who have specific physical needs have a clear physical health plan that clearly outlines how the condition is managed i.e. How a wound is cleaned, dressed and ordering of supplies is managed.
- Review the resources allocated for patients with physical health needs i.e. general registered nurse and a visiting GP to ensure robust support is

available to mental health staff and patients which covers annual leave, holidays and sick leave.

3.6. Derby Royal Hospital

Context

3.6.1. The Derby Royal Hospital is part of Derby Teaching Hospital Foundation Trust.

3.6.2. The Trust provides both acute hospital and community based health services, serving people in and around Southern Derbyshire.

Summary of Involvement

3.6.3. Adult B was treated by Derby Royal Hospital on 5 separate occasions during a 7-week period from 1st of July 2015 to 19th of August 2015. There was one prolonged admission of 10 days after Adult B carried out a self-inflicted laparotomy. All but one of the admissions was because of a self-harming incident.

3.6.4. There are occasions where staff had to use restraints to prevent Adult B from putting her hands into her abdomen.

Analysis of Involvement

3.6.5. Hospital staff treating Adult B were concerned about the level of self-harming Adult B is able to commit despite being under 3:1 supervision and as a result made a safeguarding referral into Adult Social Care. It is recorded that Adult B was allocated a mental health social worker for further investigation.

Learning

3.6.6. The Derby Royal Hospital did not identify any learning for the Trust.

Additional Review Panel Recommendations

3.6.7. The Panel felt that the hospital as well as raising a safeguarding referral could have highlighted their safeguarding concerns about her frequency of self-harming incidents to Adult B's commissioners.

3.7. General Practitioner (GP)

Context

3.7.1. A GP is a medical doctor who treats acute and chronic illnesses and provides preventive and health education to patients.

Summary of Involvement

3.7.2. Adult B was registered with a GP in Derby from 25th of May 2015 until the time of her death. She was seen once in person, although another attempt at a home visit was made without success due to Adult B seeing another professional at the time.

3.7.3. The practice was actively involved in prescribing stoma products whilst she was an inpatient at the Cygnet.

3.7.4. The GP in Sussex providing services to The Dene at the time of Adult B's admission was not accepting new patients, and therefore did not register Adult B to their practice.

Analysis of Involvement

3.7.5. The reasons for the Sussex GP not accepting new patients is not fully understood by the panel. It would appear to have been a contractual issue between the GP and The Dene at that time.

3.7.6. It is regrettable that even though there may have been contractual issues, the Sussex GP did not acknowledge that there was a patient who had significant physical health needs and recognise this as a risk for the patient.

3.8. Queens Medical Centre (QMC)

Context

3.8.1. Queens Medical Centre is part of Nottingham University Hospitals Trust who provide services to residents of Nottingham and its surrounding communities. They also provide specialist services for people from across the region.

Summary of Involvement

3.8.2. QMC had a contact with Adult B from 6th of August 2014 to 1st of June 2015. During that period Adult B was treated on numerous separate occasions and discharged the same day, but there were also admissions to the wards including time spent in both the Intensive Care and High Dependency Units.

3.8.3. The Trust legal team and solicitors were involved in Court of Protection proceedings in relation to Adult B's future treatment and management.

Analysis of Involvement

3.8.4. The hospital identified early on that Adult B's case was likely to be very complex and would require multi-professional working. The IMR reports that there was evidence that Adult B's psychiatric team were heavily involved throughout this admission, and her care was reviewed on a regular basis.

3.8.5. As with her other placements whilst in QMC, Adult B continued to self-harm, despite having 2 to 3 carers with her. The risk that Adult B posed to herself was addressed by ensuring her clinical environment was cleared of non-essential equipment.

3.8.6. Whilst in QMC it was assessed that Adult B did not have capacity in relation to making decisions about her physical health. At one point surgery to correct the stoma wound was tabled. Adult B gave ambivalent responses in respect of this and her mental capacity was questioned with involvement from legal departments

across the agencies involved: the Official Solicitor; independent experts and the Court of Protection. The case reached the Court of Protection, but the surgical view at that time was that surgery could not be performed due to Adult B needing to reduce her weight, stop/reduce smoking and improve her exercise tolerance. Due to this, there was no decision to be made and the Court of Protection therefore decided not to pursue the case.

3.8.7. There was active discharge planning with the nursing staff at Cygnet, areas discussed included wound management, who to escalate to if a wound leaked, recognising infection, pain management, nutritional support and ongoing medical/psychiatric plans.

Learning

3.8.8. QMC did not identify any learning points for their organisation.

3.9. Recovery First

Context

3.9.1. At the time of this review, Recovery First was a joint venture between the Priory and Greater Manchester West Mental Health Foundation Trust, based in Widnes. It provides services for women with complex mental health needs and personality disorder.

3.9.2. Recovery First is now operated by Elysium Healthcare.

Summary of Involvement

3.9.3. Adult B was an inpatient in a locked rehabilitation service from January 2014 to August 2014.

Analysis of Involvement

3.9.4. Two requests for information were sent to Recovery First. However, the panel received no response, and therefore we have been unable to analyse the involvement of Recovery First with Adult B.

Review Panel Recommendations

3.9.5. Recovery First should review how they respond to requests for being part of Safeguarding Adult Reviews in line with both Statutory, and Local Safeguarding Adult Board requirements.

3.10. Rethink Mental Health Advocacy Service

Context

3.10.1. Rethink is the largest voluntary sector provider of mental health services in England.

3.10.2. Advocacy services are designed to support those who are vulnerable or need help to make informed decisions and secure the rights and services to which they are entitled.

3.10.3. Rethink provided the independent advocacy service at The Dene Hospital.

Summary of Involvement

3.10.4. Adult B approached the advocate at The Dene requesting support in relation to her physical health needs on 2 occasions.

3.10.5. On the first occasion, Adult B clearly indicated that she wanted to be taken to the acute hospital so that she could receive appropriate treatment. Nurse A discussed Adult B with the ward manager who admitted that there was only one member of staff trained to care for the stoma. As the stoma nurse specialist was due to visit Adult B the next day no further action was taken.

3.10.6. The next contact was on 28th of September when Adult B once again approached the advocate with concerns about her poor urine output and was also displaying signs of dehydration i.e. dry mouth. On this occasion, Adult B admitted to swallowing a wire the previous night. Whilst there is evidence that the advocate shared information with the charge nurse regarding the poor urine output, there is no evidence from the records that the information regarding the self-harming incident with the wire was passed on.

Analysis of Involvement

3.10.7. The IMR produced by Rethink is very thorough and highlights areas of practice that fell short of their expected standards.

3.10.8. The advocate does not appear to have been proactive in following up whether actions were followed up on behalf of her client. The advocate appears to have deferred to the staff on the ward, and not represented her client's fears.

3.10.9. It is not clear why the self-harm incident was not reported. In addition, there is no documented evidence as to whether this was considered a safeguarding matter or even that the case was discussed with the advocate's line manager.

3.10.10. The IMR author concluded that opportunities were missed by the advocate to make safeguarding referrals. The IMR report concludes that the advocacy service provided was poor and ineffective and did not provide any support to the client.

3.10.11. As the advocate left the organisation before the review took place, it has not been possible to explore further why actions were taken or not taken at the time.

Learning

- Advocates to identify and attend local authority safeguarding training to support their Rethink training.

- Additional training to be provided to advocates around the management of risk, specifically in relation to physical health.
- Automatic review of service to be initiated following the death of a client.
- Analyse quality of service provided and any learning.

Additional Review Panel Recommendations

3.10.12. The panel highlighted the fact that there is currently no national governing body for advocates which could amongst other functions monitor the practice and competencies of individuals via a registration requirement, and it was therefore suggested that West Sussex Safeguarding Adult Board draw this apparent 'gap' in oversight to the attention of the relevant central Government department for consideration.

3.11. South East Coast Ambulance Foundation Trust (SECAmb)

Context

3.11.1. South East Coast Ambulance Service NHS Foundation Trust is part of the National Health Service (NHS). It responds to 999 calls from the public, urgent calls from healthcare professionals and providing NHS 111 services across the region.

Summary of Involvement

3.11.2. Overall SECAmb had three separate contacts with Adult B. The first contact on 8th September was in relation to a possible abdominal obstruction. The second on 2nd of October was following a self-harm episode. The final contact was on 18th October when a 999 call was received from The Dene.

3.11.3. 999 calls are received along the NHS pathway system which is centrally run. At the time responses to calls made by a Health Care Practitioner was responded to in a different way compared with a call made by a member of the public. Rightly or wrongly there was an assumption that a Health Care Practitioner would have a greater understanding of the presenting emergency.

3.11.4. The first ambulance arrived 15½ minutes after the initial 999 call on the 18th. This is outside of the eight minutes' target for call of this nature.

Analysis of Involvement

3.11.5. There was difficulty triaging the call based on the information shared by the referrer who was not with the patient at the time of the call. There was no indication that the patient was in cardiac arrest.

3.11.6. Although the call was difficult, key pieces of information provided indicated the patient was critically unwell, although not necessarily in cardiac arrest. However, The European Resuscitation Council Guidelines for Resuscitation 2005[19],

[19] G.D.Perkins et el./Resuscitation 95 (2015) 81–99

state that patients who are reported to be unresponsive and not breathing properly should be assumed to be in cardiac arrest.

3.11.7. The completion of a vulnerable person report on 18t of October in relation to their concerns, which included delay in being informed Adult B was in cardiac arrest, being kept waiting in the reception area, observing poor practice by those performing CPR namely no effective ventilation taking place and still on a soft mattress, was felt by the panel to be an good example of safeguarding practice.

3.11.8. The IMR did highlight that there does not appear to have been an assessment of Adult B's capacity on either of her two transfers to hospital. On 8th of September consent for treatment and capacity are noted on the clinical notes. However, there is no supporting evidence of a capacity assessment being undertaken.

Learning

- Revision of Patient Care Record
- Development of a capacity assessment form.
- The NHS pathway system has been changed so that calls from Health Care Practitioners are triaged in a way more similar to a non-Health Care Practitioner.

3.12. Welsh Health Specialised Services Committee (WHSSC) hosted by Cwn Taf University Health Board

Context

3.12.1. The WHSSC is responsible for funding and contracting commissioning services for medium secure placements on behalf of the 7 local Health Boards in Wales. Access to services is controlled via Clinical gatekeepers in the 2 NHS Wales NHS Wales Medium secure units.

3.12.2. Commissioning is managed within an agreed formula and a Welsh framework where providers are required to meet set criteria.

3.12.3. The quality of services commissioned by WHSSC is monitored by the Quality Assurance and Improvement Team (QAIT).

3.12.4. Contracts require providers to notify WHSSC commissioners of any safeguarding concerns regarding their patients, so would pick up if there was a trend such as a number of safeguarding referrals being made to the local authority amongst Welsh residents, but not any trends relating to other residents who may make up the majority of the inpatients within a hospital.

Summary of Involvement

3.12.5. Commissioners do not have direct contact with patients. Based on information provided by the Clinical Gatekeeper and the Quality Assurance Improvement Team, The Dene was commissioned as a suitable medium secure placement for Adult B.

Analysis of Involvement

3.12.6. The Commissioning service is reliant on the quality of information supplied by other professionals (i.e. the Gatekeeper) or Quality Assurance Improvement Team.

3.12.7. Whilst Contracts require providers to notify them of any safeguarding concerns, this is only in relation to their own commissioned patients, so whilst this would alert them to any trends in information about Welsh residents they would not be aware of trends relating to others. This is not a major issue where the placements are either within Wales or near the Welsh borders where there will be a higher percentage of Welsh patients. However, this will have an impact on placements where there are relatively fewer Welsh patients.

3.12.8. There was a disagreement arising from two gate keeping assessments carried out in June and November 2014 (one advising low secure placement, one medium secure placement) which compromised a return to Calverton Hill MSU and a decision to provide medical management/conservative treatment only led to greater difficulty in finding an appropriate provider.

Learning

3.12.9. Although not as a direct result of this review, it has been recognised that:

- The current structure requires extending to ensure communication is strengthened;
- The need to audit compliance has been highlighted and
- Challenge of placing an individual with additional physical health needs within a mental health framework recognised.

Additional Review Panel Recommendations

3.12.10. The Panel felt that commissioners should review the section on reporting serious incidents within contracts. At the present time, there is an expectation that independent hospitals would undertake a review of the care provided, this area needs to be more explicit stating which investigation framework is to be followed.

3.12.11. Consider clarifying the process for resolving differences of opinions in relation to Gate keeping assessments.

3.13. Quality Assurance and Improvement Team (QAIT)

Context

3.13.1. The Quality Assurance and Improvement Team provides assurance in respect of the 7 local Welsh health boards and WHSCC using the Commissioning Care Assurance and Performance System.

Summary of Involvement

3.13.2. QAIT carried out an assurance visit and completed an assessment of The Dene Hospital in 2014. Based on the assessment The Dene was awarded a maximum quality score of 3.

Analysis of Involvement

3.13.3. Whilst the QAIT assessor may look at local inspection reports such as those from the CQC, this is not routine practice, and the emphasis is on meeting the standards set out in the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

3.13.4. When assessing a hospital, evidence of meeting standards is gained by looking at the records of other Welsh patients resident there. Whilst this method may work well within Wales or hospitals near the Welsh border where the number of Welsh funded residents will be high, it is not a robust method for placements out of area.

3.13.5. The quality assessment is not designed to be patient specific. QAIT expects the care coordinator to ensure the placement meets any specific needs.

3.13.6. It is not routine to check with local authorities regarding any intelligence they may have regarding a hospital. Generally, QAIT have close working relationships with Welsh providers, commissioners and local authorities so would pick up any soft intelligence regarding concerns about a particular hospital more readily in Wales.

Learning

3.13.7. None specifically identified by QAIT.

Additional Review Panel Recommendations

3.13.8. The Panel recommends that QAIT review what information is gathered to assure themselves of the quality of care for out of area placements. Checks of CQC inspection rating, local authority safeguarding and commissioning, and local CCG commissioning should be routine.

3.14. UK Specialist Ambulance Service (UKSAS)

Context

3.14.1. UK Specialist Ambulance Service (UKSAS) provide specialist ambulance transport. They provide specialist vehicles for A&E Emergency Ambulance, High Dependency Ambulance, Bariatric Ambulance and non-urgent patient transport journeys within the United Kingdom and parts of Europe.

Summary of Involvement

3.14.2. Two members of staff, whilst at The Dene after transporting another patient, were asked to assist Dene staff in the resuscitation attempt underway. One was a bank Trainee Technician and the other was a Emergency Care Assistant. The Trainee Technician actively supported The Dene staff with the resuscitation attempt. When SECAmb staff arrived they continued to act as a support person.

Analysis of Involvement

3.14.3. The crew from UKSAS responded readily to a request for support made by staff from The Dene. However, it would appear that staff from The Dene assumed that the crew from UKSAS were fully qualified paramedics and therefore took their lead from the UKSAS staff members. Dene staff assumed the SECAmb personnel were just further backup and did not appreciate the urgency of getting the trained paramedic to Adult B's bedside as quickly as possible.

Additional Review Panel Recommendations

3.14.4. Staff should make it clear to other professionals whom they are called on to assist, that they are not fully trained paramedics.

3.14.5. In view of the safeguarding concern raised by SECAmb staff where they observed that "resuscitation was taking place on a soft mattress placed on the floor. The patient had an oxygen mask in place, and although compressions were being applied it did not appear that they were being carried out in an effective manner", UKSAS may want to review the training given to HCA in relation to resuscitation.

4. Summary of other agencies' knowledge of The Dene

4.1. Care Quality Commission (CQC)[20]

Context

4.1.1. CQC is an independent body that monitors, inspects and regulates health and social care services in England. It ensures that health and social care services provide people with safe, effective, compassionate, high-quality care and encourages care services to improve.

4.1.2. Findings are published, including ratings in order to help people choose sources of care.

4.1.3. Prior to our timeframe The Dene had been inspected on 30th of April 2013 and 30th of October 2013. The report in relation to the 30th of October inspection was

[20] CQC: The independent regulator of health and social care in England

published in November 2013. This publication was the one on the CQC website at the time of the QAIT assessment.

4.1.4. The most recent inspection undertaken by CQC in 2016 and published in January 2017 has judged all areas are good except the area named 'safe', which remains 'requires improvement'.

Summary of Involvement

4.1.5. CQC undertook a responsive inspection of The Dene at the end of January 2015. This inspection led to enforcement action by way of a Warning Notice.

4.1.6. In July 2015 CQC carried out another inspection and as a result of this visit The Dene was issued with 5 improvement notices in relation to:

- Safe staffing;
- Supervision and appraisal arrangements;
- Risk assessments and physical healthcare;
- Personalised care plans and
- Effective governance systems.

4.1.7. The report highlights high vacancy rates, as well as high use of regular agency staff, short term agency staff and bank staff.

4.1.8. It also reports that recording of physical healthcare checks are inconsistent and that risk assessments are not updated.

4.1.9. The findings were given initially via verbal feedback to The Dene immediately following the inspection, with written feedback via the draft inspection report.

4.1.10. However, the inspection report was not published until May 2016.

Analysis of Involvement

4.1.11. It is regrettable that the inspection report was not published and therefore not available on the CQC website until 10 months after the inspection. The delays in writing the report were due to several factors including other urgent inspection work taking place, and changes to the report template during the inspection reporting process.

4.1.12. CQC have explained the delay in publication, but the panel felt the significant delay in publication was poor practice. CQC itself urges commissioners to ensure people receive high-quality and effective care and treatment under the MHA, yet did not publish important findings that may have influenced a commissioner or individual's decision to place a patient with complex physical health needs at The Dene.

4.1.13. CQC does not typically inform other stakeholders of the ratings of an inspection prior to publication of the report. However, if there are ongoing concerns about a provider and CQC are currently working with other organisations on a specific issue (such as an investigation), then they will provide headline feedback following the inspection.

4.1.14. CQC meet with CCGS and NHSE four times a year and as part of that meeting there is discussion around any hospital or service that has been rated "Requires Improvement."

Additional Panel Recommendations

4.1.15. CQC to review how delays in publication are monitored and addressed to avoid delays of 10 months in the future.

4.1.16. CQC to ensure workloads are prioritised when there are known areas of risk and need for improvement, and ensure this information is shared and published in a timely manner.

4.2. Coastal West Sussex, Horsham and Mid Sussex Clinical Commissioning Groups

Context

4.2.1. CCGs have a responsibility to monitor the quality and safety of services they commission for the local population.

4.2.2. However, as they do not commission services from The Dene, the hospital was not included in the Sussex-wide safeguarding accountability and assurance self-assessment exercise carried out in 2015.

Additional Panel Recommendations

4.2.3. Whilst the CCG's currently only require completion of the accountability and assurance tool of those services they directly commission, the panel recommend that this tool be sent to all providers of health care operating within their localities.

4.3. NHS England

Context

4.3.1. NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform national debate to improve health and care.

4.3.2. The specialist commissioning department of NHS England is responsible for commissioning specialised services to meet a wide range of health and care needs.

4.3.3. NHS England was informed of the Overarching Safeguarding Adult Review (OSAR)[21] and as a result introduced into commissioning contracts with providers the need for a safeguarding lead nurse or named doctor.

[21] OSAR Method of investigation before the introduction of the Care Act

Additional Panel Recommendations

4.3.4. Although not approached in this case, NHS England/Wales could consider in future that if such a case was escalated to them, there might be an option of setting up an emergency Service Level Agreement to ensure the patient receives the care they need.

4.4. Sussex Police

Context

4.4.1. Sussex Police Force serves the populations of East and West Sussex and the city of Brighton & Hove.

Summary of Involvement

4.4.2. Sussex Police did not have any direct contact with Adult B until the day of her death. SECAmb contacted the Police whilst at The Dene expressing some concern around possible neglect.

4.4.3. The Police attended along with the Coroner's officer which is routine practice.

4.4.4. At the time of writing this report Adult B's death and the deaths of 2 other patients from The Dene are being investigated by Sussex Police.

Analysis of Involvement

4.4.5. The police have carried out previous investigations on behalf of the Coroner at The Dene as inquestable deaths. The investigation into Adult B's death is the first criminal investigation of this nature.

4.4.6. Police also had a record of frequent contacts with The Dene, prior to and during Adult B's time as an inpatient, but these were not in relation to Adult B and the majority of this contact related to reports of assault by patients towards staff or another patient.

Additional Panel Recommendations

4.4.7. The initial safeguarding meeting held at The Dene and attended by various professionals following the referral from the ambulance crew was not clear in its purpose or who was leading the meeting. On reflection the review panel felt the lack of clarity highlighted a learning for Sussex Police and West Sussex County Council to review professionals' understanding of the purpose of the meeting being held and their roles and responsibilities within that meeting.

4.5. Sussex Community Foundation Trust (SCFT)

Context

4.5.1. SCFT is the main provider of NHS community health and care services across West Sussex, Brighton & Hove and High Weald Lewes Havens area of East Sussex. The trust provides a wide range of medical, nursing and therapeutic care.

Summary of Involvement

4.5.2. The Community Nursing Team was contacted by the Stoma nurse requesting support for the nursing staff at The Dene who were reported not to have the nursing skills to support the stoma care required by Adult B. The referral was turned down as Adult B was being cared for within a hospital environment and it was felt the hospital staff at The Dene Hospital could manage Adult B's stoma.

4.5.3. There is no record to confirm if the referral was discussed at handover with a senior nurse to determine whether this decision was appropriate.

Analysis of Involvement

4.5.4. Although the referrer - a specialist stoma nurse - had stated that The Dene staff could not manage the stoma, it would appear without any further enquiry the nurse subsequently decided that the hospital staff could manage. There is also no recorded evidence of the referral being discussed with a senior colleague who may have had a different view of the level of input required.

4.5.5. Neither the specialist nurse nor The Dene challenged this response or considered escalating either internally or externally, for example to the local CCG regarding their concern that Adult B would benefit from support from the community nurses (but the referral had not been accepted).

4.5.6. As the Community Nursing Team do not appear to have been contacted again by either The Dene or the Stoma nurses they had no reason not to assume that the issue was resolved.

Learning

4.5.7. Although not as a direct response to this case, different systems are now in place. Furthermore, since the introduction of Community of Practice teams, there is a more robust procedure in place where complex patient care is discussed at the weekly Multi-Disciplinary Team meetings or following the daily huddle in place in some of the teams. Today, this referral would have to be triaged with a senior clinician and any identified issues would be raised, discussed and action in place to support complex referrals and assessment.

4.6. West Sussex County Council (WSCC)

Context

4.6.1. West Sussex County Council has many responsibilities including provision of social care services and a responsibility in keeping adults and children safe.

Summary of Involvement

4.6.2. Although the contact West Sussex County Council had with The Dene during the timeframe of the review is minimal, the Panel felt it was important to include the intelligence known to the local authority, local CCG's and CQC in the period leading up to Adult B's placement.

4.6.3. An Overarching Safeguarding Adult Review enquiry (OSAR) was undertaken in 2013 and looked at the overall concerns raised via safeguarding enquiries in relation to 26 patients at The Dene. The enquiry was concluded in 2014.

4.6.4. There were 5 main themes covered: -

- Secretion of medication: Concerns about patients who were able to hide or hoard medication;
- Inappropriate behaviour by permanent and agency staff: The outcome of concerns relating to staff were either inconclusive or unsubstantiated;
- Lapses in patient supervision and ward security: It was acknowledged that The Dene often took difficult patients that the NHS declined.
- Management of physical health problems: Concerns were identified around emergency response. Local Authority Contracts with providers were changed to ensure that staff received training in Intermediate Life Support;
- Risk and incident management: - Risks at the unit were not always managed.

4.6.5. During 2015 there were 74 safeguarding concerns raised in relation to 46 patients. 56 episodes were consequently opened under the category of physical abuse.

4.6.6. WSCC had identified the need to have a named professional to work closely with The Dene and hold regular meetings.

Analysis of Involvement

4.6.7. Whilst the concerns that had led to the OSAR and the findings from that review were held on WSSC information system and shared with mental health services, this knowledge would have only been known locally and unless an out of area agency directly contacted the Local Authority this background information would not be known to them.

Additional Panel Recommendations

4.6.8. WSCC to review if the current systems in place for recording and sharing information relating to specific safeguarding concerns regarding organisations, includes consideration for this knowledge being shared outside of the local partnerships.

5. Analysis of areas specified in Terms of Reference

5.1. The following is a brief summary of the findings as they relate to each individual Term of Reference set for this review.

5.2. Establish what lessons are to be learned from the case about the way in which professionals and organisations work individually and together to safeguard vulnerable adults.

5.2.1. Adult B's case has highlighted the challenges professionals and organisations have when a person has both complex mental health and physical health needs; and where due to lack of available beds nationally for such needs, the person is frequently moved between organisations. Sections 3 and 4 look in detail at how professionals and organisations worked either individually or together. Organisations had difficulty in protecting Adult B from herself; even when receiving high levels of supervision Adult B continued to obtain objects with which to self-harm.

5.2.2. Whilst professionals recognised her vulnerability and at times had concerns in relation to her care provision, very few considered this to be a safeguarding issue for which a safeguarding alert/referral would be appropriate.

5.2.3. There were several opportunities where a safeguarding alert/referral were missed. A alert/referral would have brought professionals together and could have brought a more timely response to the concerns various professionals had.

5.2.4. Organisations shared with their care coordinator worries about the appropriateness of placements as soon as they were apparent but the process of reassessment and finding a new placement was a challenge.

5.2.5. The report found evidence of good liaison between hospitals and the interaction between QMC and Calverton Hill Hospital demonstrates how organisations can work well together to plan and deliver care in partnership.

5.2.6. The report also found evidence of poor liaison and joint working between hospitals, namely between The Dene and BSUH.

5.3. Identify clearly what changes need to be made both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

5.3.1. All agencies that submitted an IMR identified lessons that they had learnt from this case. These lessons are outlined within the relevant agencies' analysis. It is recommended that West Sussex Safeguarding Adults Board agrees how this report is shared with those authorities who are responsible for monitoring agencies outside of West Sussex to ensure that actions identified within their respective IMR are acted upon.

5.4. Review the interface between primary, secondary and tertiary care

5.4.1. At times the interface between primary, secondary and tertiary care appeared to work in a more cohesive manner. The coordination of care appeared to have been more proactive whilst Adult B was being treated between Cygnet, Nottingham and Derby GP (in suppling stoma products) which contrasts with the lack of coordinated care between The Dene and BSUH.

5.4.2. This review highlights the challenges of monitoring of a placement some distance from the location of the commissioning health authority. This is further complicated when placements have to be frequently changed.

5.4.3. The interface between providers can be additionally complicated when it is between the NHS and a private provider and where specialist services are required that may require a separate service level agreement. In this case, the District Nurses would not visit Adult B as she was an inpatient in The Dene where it is expected a registered general nurse is employed. Also, the contractual issues between The Dene and the West Sussex GP meant that Adult B was not registered locally.

5.5. Explore the ability of agencies to meet both the physical health needs, as well as mental health needs of patients.

5.5.1. There is evidence that placements represented a genuine attempt to meet Adult B's physical needs to a different level of success, but, ultimately there appeared to be no service that could adequately meet both Adult B's physical and mental health needs. This was acknowledged by her Care coordinator who in an email states that a suitable placement may not exist.

5.5.2. Adult B's mother in a conversation with the author recalled that "every home could manage her mental health needs but not her physical ones".

5.5.3. The complexities of Adult B's stoma wound and treatment requirements were uncommon, and required a joint approach. Unfortunately, when Adult B moved down to West Sussex, care was fragmented and the opportunity for Adult B to be seen and managed by a renal specialist was missed.

5.5.4. For Adult B the impact of physical health on mental health was significant. Adult B was cared for in a Mental Health environment where there was no apparent plan of care of her high output stoma which was at one point managed with an incontinence pad. On the day before she died she had walked around carrying a sick bowl and called her mother in a distressed state. The fact that she was still able to get out for a cigarette may have been the only positive (to her) thing she was able do that day.

5.5.5. It is clear that the extent of Adult B's physical care in relation to her stoma was highly complex and a challenge even for an experienced stoma care nurse specialist. It is therefore surprising that for this case there appeared to have been at times a lack of comprehensive care plans for stoma and fistula care.

5.5.6. Even when it was recognised by individuals and organisations that for various reasons the quality of care Adult B received was not in accordance with best practice guidelines, and their requests for specialist support, further assessments or requests for meetings did not happen, professionals still did not consider this a safeguarding issue and refer appropriately.

5.6. Examine the responsibility of commissioners in ensuring placements are meeting the needs of their clients.

5.6.1. The scope of Commissioning Services refers to the whole process of planning the full range of services, ensuring they are available, and that they are monitored and reviewed. Current systems are based generally on meeting the needs of a patient requiring a level of secure placement, it is not commissioned on the requirement of an individual person.

5.6.2. Commissioning for physical health services and mental health services in Wales are currently separate processes. This means that individuals with comorbid physical and mental health needs often fall through a funding gap between physical and mental health commissioners.

5.6.3. The assessment carried out by QAIT only looks at the information in relation to other Welsh patients within that hospital and does not take in to account information that may be held in relation to a hospital's overall performance. For Welsh patients who are placed either within Wales or close to the borders the QAIT team has more local intelligence about these hospitals due to established relationships with partner organisations.

5.6.4. In this case the Commissioners from Wales did not have the benefit of information relating to the CQC findings, Local Authority safeguarding investigation and Police inquiries which could have informed their decision making.

5.6.5. Current commissioning arrangements in Wales do not appear to have the flexibility to provide bespoke person-centred packages of care.

5.6.6. Given the extensive history of repeated placement breakdowns commissioners have a responsibility to examine why placements keep failing and explore ways to reduce the risk of future placement breakdowns.

5.6.7. Whilst the Court of Protection upheld the decision that surgery was not appropriate, this was one aspect of Adult B's care. Her physical health had not improved and there was no evidence her physical needs were considered further. The panel were puzzled as to why this aspect was not addressed at this time.

5.7. Review if organisations have sound governance arrangements in place that monitors staffing levels, skill mix, risk assessments and quality assurance.

5.7.1. Adult B was cared for by numerous organisations during the timeframe under review. All organisations report having governance systems in place that the internal IMRs did not identify as requiring improvement.

5.7.2. Adult B was often receiving 2:1 or 3:1 supervision; the process of providing staff to care for Adult B's mental health needs has not been identified as an issue. One of the challenges for The Dene was the absence of a Registered General Nurse soon after Adult B arrived. This was highlighted to the care coordinator but the matter was not resolved by the time of Adult B's death.

5.7.3. As mentioned previously, the quality assurance method used by the Welsh QAIT highlights potential gaps in the type of evidence gathered especially in relation to patients placed outside of Wales.

5.7.4. The IMR author for BCUHB reports that they were going through a reorganisation at the time, with vacancies and personnel changes that may have affected the timeliness of decision making.

5.7.5. The report has not identified staffing levels as being an issue in this case. However, the recognition that the skills required to care for Adult B's stoma were specialist in nature was responded to in different ways by different organisations. Some organisations clearly recognised their limitations and sought specialist training and support for staff.

5.8. Review if mental capacity was assessed at each physical intervention.

5.8.1. As a patient detained under section 3 of MHA 1983 / 2007, treatment for Adult B's mental disorder was authorised under section 58 MHA, either as prescribed by her Responsible Clinician if she consented , or if without her consent or capacity by a Second Opinion Authorised Doctor (SOAD) after the first 3 months of the treatment. This applied to the hospitals that she was detained in, and for her earlier treatment when she was detained under a s37 Hospital Order.

5.8.2. The issue of treatment for her complex physical conditions would either be with Adult B's consent or as defined under the Mental Capacity Act 2005.

5.8.3. The Act states that there must be a presumption of capacity until it is assessed that an individual is lacking capacity and that is defined by:

5.8.4. The person having an impairment or dysfunction of the mind or brain and being unable to do 1 of the following:

- Being able to understand information about the condition and proposed treatment.
- Being able to retain the information.
- Being able to weigh up the options.
- Being able to make an informed decision.
- Being able to communicate that to others.

5.8.5. Adult B should have been assisted to do this, but only needed to fail one element to then be assessed as lacking capacity.

5.8.6. Every proposed treatment, hospital move and conveyance by ambulance should have had a capacity assessment undertaken and recorded if Adult B was refusing or not. At times, significant decisions were being taken and they should have been evidence tested. When Adult B was moved to a new placement it is not always clear whether she consented to the decision or the decision was taken in her best interest. The person who was responsible for assessing capacity should have been the person who was proposing the treatment or action proposed.

5.8.7. Even if Adult B had fluctuating capacity this should have been taken into account, yet few IMR's or SOI's could evidence this was taken into account. At times Adult B was expressing that she did not want to be somewhere or wanted something else done, the panel felt these were opportunities for the care coordinator to challenge whether a capacity assessment had been undertaken.

5.8.8. Capacity is decision specific which means that Adult B may have had the understanding and capability to consent to one proposed action but not another.

5.8.9. Where the person is assessed as lacking capacity, treatment or action would be taken in her Best Interest under MCA.

5.8.10. From the review it is clear that for some professionals, assessing mental capacity and recording that such capacity has been assessed is still not fully understood.

6. Key findings

6.1. This case has highlighted the lack of suitable provision for psychiatric patients with complex health needs. In addition, the current ways of separate commissioning of mental health and physical health services do not support this type of joined up provision. Current commissioning arrangements and responsibilities are complex even for professionals to navigate round and understand. For the public, the challenge is even greater.

6.2. Ensuring patients receive treatment which is in their best interest can get overlooked in the complexity of commissioning and providing different services. The individual patient with specialist care requirements can get overlooked as professionals focus on whether they are contracted to provide a specific service. In this case, the commissioning organisations failed to recognise and learn from the repeated failure of placements and create a bespoke package of care based on Adult B's specific requirements.

6.3. The systems in place to monitor and evaluate the quality of care for patients placed out of their commissioning area do not generally have the benefit of local intelligence and therefore their assessment can be lacking important information.

6.4. This report has highlighted the challenge faced by staff in deciding when a patient's standard of care and failure to meet their care needs become a safeguarding issue.

6.5. This case has highlighted not only how important gathering and information sharing is, but also how important it is to clarify that the information shared has been understood fully. There were many occasions where there was confusion regarding what information was shared. The recording and interpretation of the same conversations and communications differed.

6.6. There was evidence of assessments being undertaken and decisions made based on incomplete and on occasion incorrect information. Handovers from one agency to another differed in their quality.

6.7. Patients with complex and or serious physical health needs who attend different hospitals for whatever the reason are at risk of not having their full histories understood by each individual hospital. Although medical summaries are shared the full history stays within the medical notes retained by each hospital. If a

system such as a hospital passport[22] is used the information stay with the patient and therefore moves with them around the country.

6.8. There is currently no national governing body for advocates which could amongst other functions monitor practice and competencies of individuals via a registration requirement.

6.9. Agencies' understanding of and engagement in the Safeguarding Adult Review process has varied. There was a noticeable difference amongst contributing organisations to their approach to using this case as an opportunity to reflect on their practices and identify wider learning which would inform practice in the future. The panel were surprised that some organisations could not identify any learning for themselves after reviewing the case compared with the response of others who demonstrated by their commitment to attend meetings and produce reflective IMR's.

7. Conclusion

7.1. Adult B was a young woman with highly complex mental health and physical health conditions, with an extremely challenging interplay of self-harm, insertion of objects into her stomach, and frequent moving between low secure and medium secure placements interspersed with frequent attendance and admissions at local acute hospitals. Since 2010 she had been detained under s3 of the Mental Health Act.

7.2. Added to Adult B's complex conditions there was a history of abuse and occasional violence towards staff in various care settings, all of which contributed to the highest level of complexity for managing Adult B's situation.

7.3. It is important to acknowledge how Adult B's early experiences in life may have influenced her challenges faced in adulthood. Persisting mental health problems are a common consequence of child abuse and neglect in adults. Mental health problems associated with past histories of child abuse and neglect include personality disorders, post-traumatic stress disorder, dissociative disorders, depression, anxiety disorders and psychosis[23].

7.4. Children's early experiences have a significant impact on their development and future life chances. As a result of their experiences, both before and during care, looked after children are at greater risk than their peers. Research has highlighted that children who have been in care have poorer outcomes in mental and physical

[22] The aim of the hospital passport is to assist people with specific health needs in providing hospital staff with important information about them and their health when they are admitted to hospital. The passport stay with the patient and therefore moves with them around the country.

[23] Afifi, Boman, Fleisher, & Sareen, 2009; Cannon et al., 2010; Chapman et al., 2004; Clark, Caldwell, Power, & Stansfeld, 2010; Maniglio; 2012; McQueen, Itzin, Kennedy, Sinason, & Maxted, 2009; Norman et al., 2012; Springer et al., 2007).

health and educational attainment compared to comparative peers who have not been in the care system[24].

7.5. It is therefore not surprising that Adult B presented with many of the issues outlined in 7.3 and 7.4 in adulthood.

7.6. The complexity and combination of mental health needs and physical health needs provided a significant challenge for commissioners in finding a mental health hospital who could meet her needs and offer a bed. As time went on this became more difficult and it was acknowledged by the care coordinator that there may not be any hospital available that could offer the specialist support that Adult B required especially in relation to her stoma care.

7.7. When the decision was taken to refer to The Dene the Commissioners in Wales had no knowledge of the concerns known locally within West Sussex that had been raised in relation to the care offered by The Dene at that time, especially in relation to the ability to meet the physical needs of patients. The Commissioners were not aware the CQC had issued an improvement notice for The Dene. If this information had been known to the Commissioners they may have reconsidered their conclusion that The Dene was a suitable placement for a patient with highly complex physical needs, or at least ensured specialised support services were agreed and in place before admission.

7.8. As has been evidenced in this report, clear communication and handover of care between agencies did not always take place. Towards the end of her life the extent of the wound care required was beyond the general expertise of both mental health and general health nurses. Whilst there were clearly individuals who worked hard to care for Adult B they often did not have the skills, knowledge or support from their organisations to provide the level of specialist physical care she required.

7.9. The Dene, following their initial assessment which did not follow their own procedures, felt they could care for Adult B and admitted her. It was soon apparent that they were unable to fully meet the physical care she required unsupported by local hospital services. The initial referral assessment process did not follow due process and did not gain enough information regarding physical health needs to gain a full and accurate view of her requirements. Consequently Adult B, who had a high level of physical health needs, was admitted to a hospital that CQC had judged as requiring improvements.

7.10. Whilst under the care of BSUH Adult B's situation lacked an holistic approach; attention was focused on her immediate presenting concern which was due to an acute injury and the significance of the blood results and high output functioning stoma were not fully recognised.

7.11. BSUH did not give clear discharge instructions to The Dene regarding monitoring fluids and day to day monitoring requirements for a patient presenting with acute

[24]McCann J., James A., Wilson S. and Dunn G. (1996) 'Prevalence of psychiatric disorders in young people in the care system', British Medical Journal 313, 15, 29-30.

kidney injury and high stoma output. Equally, The Dene do not appear to have considered monitoring fluids or to place Adult B on special health observations.

7.12. The Review Panel acknowledge the complexity around commissioning arrangements and responsibilities; however, it is felt that for Adult B the system failed her. Unfortunately, the commissioners from Wales could not attend in person the review panel meetings (although they did phone in for some of the meetings and corresponded by email), and the panel were concerned that, with the lack of engagement with the Safeguarding Adult Review process, we could not be confident that this system failure would not happen again.

7.13. It is unfortunate that it was not possible to establish a more person-centred package of accommodation and support nearer to her family and established networks and services.

8. Review Recommendations

8.1. The following section sets out the recommendations arising from the findings of this review.

8.2. Findings and recommendations relating to individual agencies have been addressed in sections 2 and 3 of this report.

8.3. Recommendations specifically for the West Sussex Safeguarding Adults Board (WSSAB):

- Share this report with the chair of the All Wales NHS Safeguarding Network who will disseminate across NHS in Wales for their own learning and also so they can follow up and be assured that actions identified by individual Welsh agencies are implemented.
- Share this report with NHS England & Wales which highlights the lack of mental health beds for patients that also have complex physical needs, and be sighted on the responses.
- NHS England and Wales to consider reviewing their monitoring arrangement of commissioners.
- Share this report with CQC for their own learning.
- Seek assurance from Recovery First that actions identified have been implemented.
- Write to Rethink Mental Health Advocacy Service seeking assurance that the action plan has been carried out.
- The panel felt that it is unfortunate that currently there is no national governing body for advocates which could amongst other functions monitor practice and competencies of individuals via a registration requirement. WSSAB to write to the Department of Health to highlight this issue.
- Seek assurance from West Sussex Commissioners and NHS England that commissioning arrangements for West Sussex patients with bespoke requirements are in place.
- West Sussex to consider developing a Passport system for those patients with specific health needs. If not a Passport system, then to identify how they can be assured the needs of patients with specific health needs are recognised and met.

- Seek assurance from all agencies providing services across the locality that they have safeguarding training in place that addresses the issues of when does poor care become a safeguarding matter.
- The information in relation to staff safeguarding competencies which is gathered as part of the West Sussex Safeguarding Adults Board annual assurance tool is analysed to identify single and multi-agency learning/training requirements for staff in relation to recognising safeguarding incidents.
- Seek assurance that organisations across West Sussex can demonstrate that their staff understand their responsibilities in relation to assessing Mental Capacity. West Sussex Adult Board may want to consider undertaking a multi-agency audit on the subject.
- Hold a learning event regarding this case to which all representatives from the agencies are invited including the commissioners from Wales.
- Seek assurance from local CCG commissioners and NHS England that when placing West Sussex clients out of area, local CCG's and Local authorities are contacted for any information they may have regarding the allocated hospital.

8.4. Recommendations from page 20 specifically for Betsi Cadwaladr University Health Board (BCUHB):

- The panel felt that the supervision and support for the Care coordinator and Community Rehabilitation Manager should be revised to ensure that staff managing cases that are highly complex and demanding should receive frequent high-level supervision and the consideration of cases being rotated to avoid potential burnout.

8.5. Recommendations from page 25 specifically for Cygnet Hospital:

- The Panel recommends that Cygnet review how information relating to patients with complex health needs and specific equipment requirements is handed over to a new provider.
- The panel recommends that Cygnet ensures discharge summaries are shared at the time of discharge or even in advance when a patient has specific health needs.

8.6. Recommendations from page 29 specifically for The Dene:

- To review quality of resuscitation training available to staff. Include learning identified from this case.
- Review how specialist requirements are commissioned for patients who have needs outside the expected skills of the existing staff workforce and/or require special dressings.
- Ensure patients who have specific physical needs have a clear physical health plan that clearly outlines how the condition is managed i.e. how a wound is cleaned, dressed and ordering of supplies is managed.
- Review the resources allocated for patients with physical health needs i.e. general registered nurse and a visiting GP to ensure robust support is available to mental health staff and patients which covers annual leave, holidays and sick leave.

8.7. Recommendations from page 30 specifically for the Derby Royal Hospital:

- The Panel felt that the hospital as well as raising a safeguarding referral could have highlighted their safeguarding concerns about her frequency of self-harming incidents to Adult B's commissioners.

8.8. Recommendations from page 36 specifically for Welsh Health Specialised Services Committee (WHSSC) hosted by Cwn Taf University Health Board:

- The Panel felt that commissioners should review the section on reporting serious incidents within contracts. At the present time, there is an expectation that independent hospitals would undertake a review of the care provided, this area needs to be more explicit stating which investigation framework is to be followed.
- Consider clarifying the process for resolving differences of opinions in relation to Gate keeping assessments.

8.9. Recommendations from page 37 specifically for Quality Assurance and Improvement Team (QAIT):

- The Panel recommends that QAIT review what information is gathered to assure themselves of the quality of care for out of area placements. Checks of CQC inspection ratings should be routine.

8.10. Recommendations from page 38 specifically for UK Specialist Ambulance Service (UKSAS):

- Staff should make it clear to other professionals whom they are calling to assist that they are not fully trained paramedics.
- In view of the safeguarding concern raised by SECAmb staff where they observed that "resuscitation was taking place on a soft mattress placed on the floor. The patient had an oxygen mask in place, and although compressions were being applied it did not appear that they were being carried out in an effective manner", UKSAS may want to review the training given to HCA in relation to resuscitation.

8.11. Recommendations from page 39 specifically for the Care Quality Commission (CQC):

- CQC to review how delays in publication are monitored and addressed to avoid delays of 10 months in the future.
- CQC to review workloads are prioritised to ensure when there are known areas of risk and need for improvement and that this information is shared and published in a timely manner.

8.12. Recommendations from page 40 specifically for Coastal West Sussex, Horsham and Mid Sussex Clinical Commissioning Groups:

- Whilst the CCGs currently only require completion of the accountability and assurance tool of those services they directly commission the panel recommend that this tool be sent to all providers of health care operating within their localities.

8.13. Recommendations from page 40 specifically for NHS England:

- Although not approached in this case, NHS England could consider in future if such a case was escalated to them, whether there might be an option of setting up an emergency Service Level Agreement where needed to ensure the patient receives the care they need.

8.14. Recommendations from page 41 specifically for Sussex Police and West Sussex County Council:

- Sussex Police and West Sussex County Council to review professionals' understanding of the purpose of the meeting being held and their roles and responsibilities within that meeting.

8.15. Recommendations from page 43 specifically for West Sussex County Council:

- WSCC to consider if the current systems in place for recording and sharing information relating to specific safeguarding concerns regarding organisations, includes consideration for this knowledge being shared outside of the local partnerships.

9. Glossary

AKI	Acute Kidney Injury
BCUHB	Betsi Cadwaladr University Health Board
BPD	Borderline Personality Disorder
BSUH	Brighton & Sussex University Hospitals
CCGs	Clinical Commissioning Groups
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
GP	General Practitioner
DoH	Department of Health
GMC	General Medical Council
HDU	High Dependency Unit
IMR	Individual Management Review
MCA	Mental Capacity Act
MHA	Mental Health Act
MSU	Medium Secure Unit
NHS	National Health Service
NHSE	National Health Service England
OSAR	Overarching Safeguarding Adult Review
QAIT	Quality Assurance and Improvement Team
QMC	Queens Medical Centre, Nottingham University Hospital
ROLE	Recognition of Life Extinct
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
SECAmb	South East Coast Ambulance Foundation Trust
SCFT	Sussex Community Foundation Trust
SI	Serious Incident (Report)
SOAD	Second Opinion Authorised Doctor
SOI	Summary of Involvement
UKSAS	UK Specialist Ambulance Service
WHSSC	Welsh Health Specialised Services Committee
WSCC	West Sussex County Council
WSSAB	West Sussex Safeguarding Adult Board

10. Appendix 1: Terms of Reference

It was agreed by the SAR panel that the purpose of the review is to:

1. Establish what lessons are to be learned from the case about the way in which professionals and organisations work individually and together to safeguard vulnerable adults.
2. Identify clearly what changes need to be made both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
3. Review the interface between primary, secondary and tertiary care
4. Explore the ability of agencies to meet both the physical health needs, as well as mental health needs of patients.
5. Examine the responsibility of commissioners in ensuring placements are meeting the needs of their clients.
6. Review if organisations have sound governance arrangements in place that monitors staffing levels, skill mix, risk assessments and quality assurance
7. Review if mental capacity was assessed at each physical intervention.

In addition, the following areas will be addressed in the Individual Management Reviews (IMR's). Each agency is asked to:

- Provide a comprehensive chronology of involvement.
- Review policies and procedures for safeguarding vulnerable adults, were they in place and were they followed?
- Consider if there was a clear plan of care in place which met Adult B's needs holistically.
- Review if practitioners and managers actions and practice accord with the standards of care they are required to provide.
- Examine if all appropriate services were offered and/or provided.
- Consider if specific safeguarding arrangements were required and put into place.
- Review if requirements of the Mental Health Act 1983/ 2005 were met.
- Examine level of senior oversight and scrutiny.
- Was practice sensitive to any equality and cultural issues?

11. Appendix 2: Personality Disorder

Introduction

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

Changes in how a person feels and distorted beliefs about other people can lead to odd behaviour, which can be distressing and may upset others.

Common features include:

- being overwhelmed by negative feelings such as distress, anxiety, worthlessness or anger
- avoiding other people and feeling empty and emotionally disconnected
- difficulty managing negative feelings without self-harming (for example, abusing drugs and alcohol, or taking overdoses) or, in rare cases, threatening other people
- odd behaviour
- difficulty maintaining stable and close relationships, especially with partners, children and professional carers
- sometimes, periods of losing contact with reality

Symptoms typically get worse with stress. People with personality disorders often experience other mental health problems, especially depression and substance misuse.

When and why personality disorders occur

Personality disorders typically emerge in adolescence and continue into adulthood.

They may be mild, moderate or severe, and people may have periods of "remission" where they function well.

Personality disorders may be associated with genetic and family factors. Experiences of distress or fear during childhood, such as neglect or abuse, are common.

Types of personality disorder

Several different types of personality disorder are recognised.

Cluster A personality disorders: A person with a cluster A personality disorder tends to have difficulty relating to others and usually shows patterns of behaviour most people would regard as odd and eccentric. Others may describe them as living in a fantasy world of their own. An example is paranoid personality disorder, where the person is extremely distrustful and suspicious.

Cluster B personality disorders: A person with a cluster B personality disorder struggles to regulate their feelings and often swings between positive and negative views of others. This can lead to patterns of behaviour others describe as dramatic, unpredictable and disturbing.

An example is borderline personality disorder, where the person is emotionally unstable, has impulses to self-harm, and has intense and unstable relationships with others.

Cluster C personality disorders: A person with a cluster C personality disorder struggles with persistent and overwhelming feelings of fear and anxiety. They may show patterns of behaviour most people would regard as antisocial and withdrawn.

How many people are affected?

Personality disorders are common mental health problems.

In England, it is estimated that around 1 in 20 people has a personality disorder. However, many people have only mild conditions so only need help at times of stress (such as bereavement). Other people with more severe problems may need specialist help for longer periods.

Borderline personality disorder (BPD) is a disorder of mood and how a person interacts with others. It's the most commonly recognised personality disorder.

In general, someone with a personality disorder will differ significantly from an average person in terms of how he or she thinks, perceives, feels or relates to others. The symptoms of BPD can be grouped into four main areas:

- emotional instability – the psychological term for this is 'affective dysregulation'
- disturbed patterns of thinking or perception – ('cognitive distortions' or 'perceptual distortions')
- impulsive behaviour
- intense but unstable relationships with others

The symptoms of a personality disorder may range from mild to severe and usually emerge in adolescence, persisting into adulthood.

Causes of BPD

The causes of BPD are unclear. However, as with most conditions, BPD appears to result from a combination of genetic and environmental factors.
Traumatic events that occur during childhood are associated with developing BPD. Many people with BPD will have experienced parental neglect or physical, sexual or emotional abuse during their childhood.

Treating BPD

Many people with BPD can benefit from psychological or medical treatment.

Associated mental health problems. Many people with BPD also have another mental health condition or behavioural problem, such as:

- misusing alcohol
- generalised anxiety disorder
- bipolar disorder
- depression
- misusing drugs

- an eating disorder – such as anorexia or bulimia
- another personality disorder – such as antisocial personality disorder

BPD can be a serious condition, and many people with the condition self-harm and attempt suicide

Source: NHS Choices www.nhs.uk

12. Appendix 3: Mental Health Act

The Mental Health Act is a law which tells people with a mental health disorder what their rights are and how they can be treated. The term "mental health disorder" is used to describe people who have:

- a mental illness
- a learning disability
- a personality disorder

Being detained (also known as sectioned) under the Mental Health Act is when you are made to stay in hospital for assessment or treatment.
The Mental Health Act Code of Practice tells everyone how to use this law and what they must do.

Source: www.nhs.uk/NHSEngland/AboutNHSservices/mentalhealthservices

13. Appendix 4: Role of Care Coordinator

The care coordinator is central to the patient's journey through secondary mental health services. The care coordinator is responsible for the following:

- Working collaboratively with the relevant patient and the relevant patient's mental health service providers, with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
- Ensuring that a care and treatment plan is developed and written;
- Providing advice to service providers on the effective coordination of care which is delivered and
- Keeping in touch with the relevant patient. The care coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

Care coordinators have a significant role in managing relationships with a wider range of partners in the care and treatment process. A local care coordinator can be appointed if an eligible health professional is identified and there is the agreement of the local health provider.

Source: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010