Practitioner Learning Brief Safeguarding Adults Review (SAR): Miss J

April 2016 - Nov 2017

In April 2016, Miss J was admitted to Private Mental Health Hospital 2 (this unit has since closed, but at the time was a secure inpatient psychiatric hospital for adolescents). It appears that this move was initially intended to be a short-term admission.

Throughout her admission, Miss J demonstrated periods of stability, alternating with periods of challenging behaviour, including episodes of severe self-harm and interpersonal violence. The clinical team working with Miss J appeared caught in a pattern of making plans for her discharge, and then subsequently making plans for responding to increased behavioural and clinical challenges.

Whilst at Private Mental Hospital 2, Miss J was assessed for a potential Learning Disability, resulting in a diagnosis of Learning Disability, and plans were made to transfer her to a specialist secure unit for people with a Learning Disability. However, because she turned 18 before such a bed became available, she was admitted temporarily to a mainstream Low Secure Unit (LSU) at Private Mental Health Hospital 3.

March 2018 - April 2019

Miss J was admitted to Private Mental Health Hospital 4, a Low Secure Unit (LSU) providing care for people with a Learning Disability, in March 2018.

Again, Miss J's behaviour remained relatively unchanged throughout this admission. However, her clinical team expressed the view that Learning Disability was not an aspect of her clinical presentation that required specialist care and treatment, so she was subsequently transferred to Private Mental Health Hospital 1.

April 2019 - February 2020

Miss J was admitted to Private Mental Health Hospital 1, a 'mainstream' secure unit, in April 2019, where she would spend approximately ten months before her death.

Unfortunately, a period of behavioural and emotional destabilisation had commenced towards the end of 2019, which appeared to be connected to stress experienced in relation to three key potential issues (a relationship breakdown, her sister's illness, and a period of leave to visit her family which she ultimately felt was proceeding too quickly). The unavailability of Dialectical Behaviour Therapy (DBT) treatment unfortunately also coincided with the experience of these stressors.

On 5th February 2020, whilst still an inpatient at Private Mental Health Hospital 1,Miss J died in Hospital after tying a ligature.

Background

- 20-year-old female, family were from Africa although she had grown up with her family in London.
- Several adverse childhood experiences, including referrals for abuse, possible involvement in gangs and reports of being the victim of sexual abuse.
- Removed from the care of her parents and ultimately became subject to a Care Order under the Children's Act.
- Lived in a range of locations, but in April 2016 was detained under the Mental Health Act (and remained detained continuously until her death in 2020).
- Various clinical diagnoses attributed, but most consistently given a diagnosis of borderline personality disorder (leading to behavioral challenges including serious and repeated episodes of self-harm, commonly ligating, and interpersonal violence).
- Prescribed antipsychotic medication for most of her period of detention (with little evidence of systematic assessment of the benefits of this medication).

November 2017 – March 2018

Miss J was admitted to Private Mental Health Hospital 3, for approximately four months. There do not appear to be any fundamental changes to the clinical or behavioural aspects during this admission (i.e., periods of stability alternating with periods of challenging behaviour), however there was also evidence of a significant potential safeguarding concern involving a staff member which was responded to and investigated by the hospital.

Good Practice:

It is understood that one positive change which has already occurred in Essex Police is the establishment of embedded Police Constables within all Criminal Justice Mental Health Units (Low and Medium Secure Units) in the region. These officers are intended to act as a 'first point of contact' for criminal justice issues and may potentially mitigate against the risk of errors such as those which occurred in the present case.

The Independent Author notes that the IMR produced by Essex Police is itself an example of good practice; it is clear, thorough, and conducted by an independent author with significant expertise in the area. Essex Police are to be commended for the high quality of this report.

100 Tied ligatures on 100's of occasions prior to the incident which led to her death.

4 Admitted to 4 different in-patient units between April 2016 – February 2020.

6 areas for improvement that were identified:

1. Assurance required around clinical leadership and appropriate staffing in Private Mental Health Hospital 1, to include qualified psychology staff and appropriate Responsible Clinician cover. This should include both current staffing levels and strategic workforce plans.

2. Recommendation that a formal mechanism exists to ensure that inpatient mental health providers are required to provide appropriate staffing to allow them to deliver the clinical services, therapies and treatments which form the principal basis by which the service aims to support the patient's recovery.

3. Transfers of Care:
a) Quality of Clinical Assessment: Ensure that when a person is detained under the Mental Health Act (and transferred between units for any clinical rationale) that the problem or diagnosis has been assessed in line with both professional and national guidance.

b) Ability of Receiving Unit to Provide Care and Treatment: Ensure that where an inpatient mental health unit is identified by commissioners to address a particular clinical need, that there are clear audit mechanisms that allow rapid identification of any failure of a unit to meet that identified need.

c) Information Sharing: Recommendation that a standard set of minimum documents are identified which are expected to be shared for all transfers of care; hospitals should not accept referrals without these documents being provided prior to admission.

4. Recommendation that providers of inpatient mental health care are supported or encouraged to undertake an audit of the use of antipsychotic medication in people whose primary diagnosis is of personality disorder.

5. Ensure that Essex Police are held to account for a) the recommendations made within the Essex Police IMR (joint review of safeguarding practice) and b) the staffing in the ASAIT. Also, a recommendation for all partners to conduct an audit of the use of the A901 form.

6. Recommendation that the board consider responding to the expected second consultation of the proposed Mental Health Bill following the previous White Paper (specific point about the determination of the Nearest Relative for care leavers).

Click here to view the recommendations from this review, which have been themes alongside 5 other concurrent reviews.

Essex Safeguarding Adults Board