REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health, Richmond House, 79 Whitehall, London SW1A 2NS** **2. NHS England, NHS England, Legal Team, 4W08 4th Floor, Quarry House, Leeds LS2 7UE**
1	**CORONER** I am André J A Rebello, OBE, Senior Coroner, for the area of Liverpool and Wirral Coroner's Area
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 14th October 2014 I commenced an investigation into the death of **Linsay BUSHELL**, who was aged **37** when she died on the 13th October 2014. The investigation concluded at the end of the inquest on 24/25 April 2017. The Jury found that Linsay had died from: Ia Asphyxia Ib Compression of the neck Ic Ligature Strangulation The Jury Concluded that Linsay Bushell died as a result of an accident due to the unintended consequence of a deliberate act.
4	**CIRCUMSTANCES OF THE DEATH** Linsay Bushell was a 37 year old woman who detained under S 3 Mental Health Act 1984 from January 2014 at the Brunswick Ward of the Broadoak Unit. She had an extensive history of self-harm. On the Evening of the 13th October 2014 she was found having self-ligatured under her bed in a 4 bedded dormitory. In spite of attempts at CPR she was certified as having died at 21.39 at the Royal Liverpool University Hospital the same day. She had suffered all her adult life from a borderline emotionally unstable personality disorder for which psychological therapies had not been commissioned. Mersey Care NHS Foundation Trust has taken the initiative from lessons learnt from this tragic death to develop therapies to treat EUPD in both hospital and in the community in Merseyside and Lancashire.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –
The Court heard evidence that 40% to 50% of mentally disordered female patients suffered from EUPD rather than mental illness and yet there was no provision or priority for therapeutic psychological services to be commissioned in the NHS England Area.

The Jury found:
Para 3

1. Linsay Bushell was certified as having died on the evening of 13th October, 2014. at the Royal Liverpool University Hospital.
2. Linsay Bushell came by the fatal event that caused her death at 20.20 at room 2 on the Brunswick Ward at the Broad Oak Unit on 13th October 2014.
3. The medical cause of Linsay's death was Asphyxia due to Compression of the Neck due to Ligature Strangulation.
4. Linsay put herself in the position in which she was found however her intention was unclear.
5. At the time of her death and for most of her adult life, Linsay had suffered from a form of mental disorder namely an unstable borderline personality disorder.
6. The real and imminent risk of self-harm or suicide was recognised during Linsay's care at the Broadoak Unit in the time leading up to her death.
7. The risk was managed adequately and effectively during Linsay's period as an in-patient.
8. We the jury accept the admissions of Mersey Care NHS Foundation Trust and adopt the findings that the Trust has made.

a. In the Trust Position Statement
1. Mersey Care considers the death of any service user with the utmost seriousness and care. As an organisation it is committed to providing a high standard of care to service users generally. If, in connection with any patient under its care, mistakes have been made whether in the form of individual errors or as a result of system or structural defects, then the Mersey Care Trust Board is committed to uncovering those errors, correcting them and learning lessons from them.

2. Following the death of Linsay Bushell on 13th October 2014, Mersey Care instigated an investigation into her death, including the wider circumstances of her death, to find out whether there were shortcomings in the care provided to Linsay and, if so, devise ways of improving practice. That investigation was an internal review and root cause analysis by a multi-disciplinary panel which included an external medical reviewer. Its Terms of Reference were agreed by the Trust Board and were deliberately wide so as to pick up deficits in care or indeed examples of good practice throughout Linsay's involvement with the Trust and so enable as deep a learning exercise as possible in what was acknowledged to be a complex clinical picture. The review panel considered relevant documents and interviewed members of staff and the investigator's report was provided to Mersey Care Trust Board in December 2015.

3. Following the internal investigation, the Trust Board instructed [redacted] the Chief Operating Officer of the Local Services Division to consider the report of the internal investigation and undertake her own review and appraisal of the circumstances of the death. She was also instructed to devise a workable and practical strategy to address the issues which were raised by the internal review and her own consideration of the material.

4. The Trust is committed to transparency and accountability. The purpose of this Position Statement is to advise the Court and Linsay's family of the Trust's response to the work which has been undertaken internally by the Trust and of the approach which will be taken to the forthcoming inquest into Linsay's death. It is hoped that, by doing so, the Court's case management task in respect of the forthcoming inquest will be facilitated; also and importantly that Linsay's family will be reassured by understanding that an approach which is consistent with the conclusions of the internal review of the death is to be adopted at the inquest.

5. The conclusions of the internal review include some examples of good or

notable practice and many areas where the service or care provided to Linsay fell short of the desired standards. Following concerns raised by a member of staff, the Review Team considered the contents, including the conclusions, of the internal review undertaken. Having done so, the Review Team adheres to the conclusions which were expressed in the report. The Trust Board fully acknowledges that mistakes had been made in Linsay's care when she was a resident on Broadoak Unit and that these mistakes afforded Linsay the opportunity to ligature on 13th October 2014. The Trust accepts responsibility for Linsay's death. Whilst understanding that no apology will fully assuage the feelings of Linsay's family and those who were close to her, the Trust nonetheless offers that apology. It is made with sincerity.

6. The review panel considered that Linsay's psychiatric condition was complex. Her condition fluctuated in response to stressors such as bereavement and illicit drug use. However, a main theme to emerge from the internal review panel report was the failure of the Trust to provide Linsay with a service that was psychologically driven at all levels of care. The Trust accepts this criticism.

a. It is accepted that psychology interventions were not available on a consistent basis throughout Linsay's residence on the Unit and that ward staff were inadequately supported in their provision of such care and treatment.

b. Whilst an attempt to understand the motivation for self-harming behaviour is apparent from the Acute Care Plans (which were not available to the panel) the Trust accepts that this was inadequate. The Trust also accepts that the record keeping and standard of documentation was inadequate so that a more detailed picture of Linsay's self-harming behaviour and its triggers was not available. As a result, staff were hampered in considering the best ways of limiting and controlling Linsay's self-harming behaviour.

c. Whilst understanding that patients suffering from Personality Disorders may present a complex management problem, a focused and co-ordinated approach to finding the most appropriate establishment to meet Linsay's needs was not adopted. It was recognised that Brunswick Ward did not meet Linsay's short or long-term needs. Although efforts were made by the Care Co-ordinator to locate the most appropriate placement for Linsay, funding was not immediately available. This had the effect of causing Linsay distress and disappointment. The Trust accepts this criticism.

d. Staff were not sufficiently trained and supported in their understanding of Emotionally Unstable Personality Disorders and the high suicide rate associated with this condition particularly during long term hospital stays. Again, the Trust accepts this criticism.

7. Further themes to emerge from the internal review included the lack of implementing a co-ordinated approach to checking patients after handover; that handover documentation was scant; that documentation of observation levels was insufficiently clear; that there were limited interventions regarding substance misuse and its effect on Linsay's self-harming behaviour and that ward management needed greater support. All of these observations and criticisms are accepted by the Trust.

8. [redacted] has been tasked with reviewing Linsay's care during her residence on Brunswick Ward and reviewing the conclusions of the internal report. She is involved in the wider Trust initiatives which include reducing the risk of suicide by patients and enhancing the understanding and treatment of those patients who suffer from Personality Disorders. She has set out the steps which have been taken in her statement. The key points are as follows:

a. Given the wide understanding that those suffering from Personality Disorders are best managed in the community, a Personality Disorder Hub has been established in the community. This is now led by [redacted] a Consultant Psychiatrist in Psychotherapy, and is intended to co-ordinate and manage the care of patients with Personality Disorders within the community. The objective is that, where possible, admissions to hospital are kept short, or avoided altogether. This involves close and collaborative working by all of those involved in the patient's care. This is facilitated by the PD Hub.

b. Case managers have been recruited and assigned to service users who attend the emergency services regularly (as a consequence of self-harming behaviour). These

case managers work closely with the PD Hub and focus care on the individual. The care given is psychology based. It is targeted at enabling the patient to devise strategies to limit self-harming behaviour.

c. Borderline Personality Disorder Guidelines have been devised which stipulate that meetings of professionals should take place in complex cases and a specific Extended Care Plan devised which anticipates and considers care both in the community and in inpatient units. The objective is to provide a coherent and co-ordinated plan of care which is tailored to the particular needs and challenges posed by the particular patient.

d. Nursing staff have received training in Personality Disorders. Complex Case discussions take place on all wards. This is intended to enable multi-disciplinary team discussion between professionals in particularly challenging cases.

e. A daily Bed Management system has been introduced which, amongst other objectives, is intended to ensure that patients with Personality Disorders are discharged back into the community with minimum delay and with an appropriate support package.

9. Although [redacted] describes in her statement the various responses which have been made by the Trust to improve the management of patients with Personality Disorders, the individual elements are intended to work as only part of an integrated model. The strength of the structure lies in its overarching objective of transforming the approach generally to meeting the needs of those with Personality Disorders, recognised as presenting a particular set of challenges to any healthcare organisation.

10. [redacted] also addressed in her statement the further steps which have been taken to support staff in complying with Trust policies, including the Care Programme Approach, observation levels, suicide prevention and training, record keeping and shift handover documentation. Regular audits for compliance and ongoing support is undertaken. There has been a review of leadership roles within the Unit generally including Brunswick Ward and support and guidance for those occupying a leadership role is regularly provided.

11. As [redacted] has stated, although much has changed since Linsay's death, there is no room for complacency. She and others within the Trust will continue their work and undertake a regular evaluation of service levels.

12. It is hoped that Linsay's family are encouraged in their understanding that the Trust have taken Linsay's death very seriously indeed. Lessons have been learned. Her death has been a catalyst for change for the better.

b. In the implementation of Lessons learnt the Trust further accepts

1. The review team identified this as "a very complex case" and noted that "it is unclear whether or not LB harmed herself with a view to achieving death or in an effort to gain help from staff which had happened on many occasions before during her in-patient stay".

a. The review team reached a number of critical conclusions relating to the care which Linsay received during the course of her involvement with the Trust. The principal conclusions were as follows:-

b. Limited understanding and analysis of self-harming behaviour. The review team noted that Linsay was described as undertaking self-harming behaviour on many occasions and that her 'ligaturing' was used in the notes in a generic sense with no specific details given on many occasions. The review team concluded that despite repeated attempts at self-harm with the same behaviour, insufficient effort was made to look at this particular risk. They also concluded that the notes did not pick up exploration of the reasons behind many self-harm attempts. Instead, they thought it was generally assumed that Linsay's self-harming behaviour was as a result of either drugs or some form of stress or 'loss' and that a more detailed exploration of her episodes of self-harm might have proved useful in terms of developing preventative strategies. Linsay did not have a "safety plan" as this was not Trust policy at the time. However, she did have a Care Plan.

c. Failure to implement a co-ordinated approach towards checking the safety of patients following handover. Staff told the reviewers there was no co-ordinated

approach to allocating tasks on the night in question. On that night there was no formal "walk around" process by a qualified member of staff as required by policy. The review team concluded that it was essential that generic safety systems such as the handover check are implemented very robustly as they are the alternative to individual observations being used which in this case were thought to have a negative effect on Linsay.

d. Poor quality of handover information. The handover notes were frequently scant in content. There was no standard template as to what should be included in handover. The review team was unclear how the nursing handover was quality controlled. On just one occasion it was mentioned in handover that Linsay had ligatured during the day but despite the frequency of this behaviour the handover notes did not capture this at all.

e. Confusion about observation levels. There were occasions when it was unclear what level of observation Linsay was on. On the day of the incident staff told the reviewers they were informed that Linsay had been on leave with a member of staff and that it had gone very well, that she was settled and had just had a take- away meal. There was no discussion as regards any risk that Linsay may have been at, taking into account previous behaviour after leave. Recording of changes in observation levels were frequently unclear.

f. No process to monitor the completion of CPA documentation. The review team could not identify the processes that were in place to ensure that all patients had an up to date risk management plan and care plan hence they found that the plans in place for Linsay were not current although Linsay did in fact have a current care plan.

g. Limited content and poor quality of documentation. Documentation of observation levels was not as clear as it should have been and given her very high risk it was important to document any observation changes and the reasoning behind this. This might help build up a picture of the best way of mitigating any potential risk from any form of self-harm, particularly with that associated with ligaturing. It would also help staff adopt a more "psychological" approach to care rather than using physical intervention like high observation levels or PRN medication if "agitated", the latter of which was similar in a way to her substance misuse. The review team noted that staff did spend a lot of time talking to Linsay but the notes did not capture any questioning as to why she had tried to self-harm at a particular time.

h. Limited interventions regarding substance misuse as an inpatient. Linsay's highest risk of suicide seemed to be in the aftermath of substance misuse. Whilst this was commented on, specialist measures to try and mitigate it were not put in place. The addiction case worker did not attend multi-disciplinary team meetings whilst on the ward, though they did see Linsay whilst she was an inpatient in Childwall Brook Nursing Home. The reviewers noted that the care appeared to be fragmented in that different parts of the services did not plan or deliver the care that was needed together.

i. Poor coordination of referral to a specialist provider. The team pursued a variety of specialist placements in an attempt to meet Linsay's care needs going forwards. One of them, Cambrian Care, undertook an assessment and accepted Linsay as they felt that they had the ability to provide her with the appropriate care required. When the funding was requested it was rejected by the Clinical Commissioning Group (CCG). It was at this time that the funding of Out of Area Placements was being changed with the Trust being given the delegated responsibility for allocating recourses on behalf of the CCG. Consequently Linsay's future needs were re-assessed and internal placements were considered in the Trust's own services. The review was completed a short time before Linsay's death, and recommended that an Out of Area specialist placement should be supported. The review team felt that the whole process of having Linsay assessed externally and then the process being stopped would have raised her expectations inappropriately. The significant delay in undertaking a review process was felt by the review team to have kept Linsay in an area that was recognised as not being able to meet all her short and long term needs.

j. Ward Management. Brunswick ward was a very busy admission ward. The Ward Manager did not have a background in leading such a ward nor did the Modern Matron who came from a community background. This meant that senior challenge and specific clinical guidance for staff was not available. During interviews it was suggested that there had been some friction between nurse management on the ward that may have contributed to a background of poor team working. The review team advised that it was important staff were led by experienced managers who understand both the management processes and the clinical area they are responsible for.

k. Transfer of Patients from one organisation to another. The review team identified an understanding amongst staff that patients could not be transferred from one organisation to another until they were "stable". This was impracticable for cases like Linsay's as she was rarely, if ever, stable. She lived in an area inaccessible to her treating psychiatry service when she lived in Kensington whilst remaining under 5 Boroughs Partnership NHS Foundation Trust's care. The review team concluded that regular engagement with local Mersey Care services might have avoided Linsay's final admission.

l. Lack of implementing a clear care pathway. Linsay had a diagnosis of Emotional Unstable Personality Disorder which is associated with a high suicide rate long-term. This is particularly increased during extended in-patient stays. Staff stated during interview that they had not had training related to self-harming behaviour or in the care of people with an Emotionally Unstable Personality Disorder. The reviewers could not identify a clear pathway that was being followed to care for Linsay which took into account her complex needs. Whilst staff appeared to have worked hard at building a relationship up with Linsay the review team concluded that it was generally at a superficial level. The review team noted that the Trust had a Borderline Personality Disorder strategy and guidance but could not find that it was implemented or understood by staff. The review team recognised the national view is that admissions for people with a Borderline Personality Disorder are often counterproductive to improving the mental state of a patient and at worst contribute to difficulties and worsening of the condition. How and when clinicians feel able to take managed and considered "positive" risks is important. How these issues are factored into an extended care plan and the support that clinicians can receive on these cases needs to be clear and thought through by the Trust. The review team were aware that this work was on going within the organisation.

m. Lack of specialist psychological work/guidance to staff. The review team found that psychological interventions were not available on a consistent basis. The review team found that there was inconsistent availability of psychology on the ward environment during the last period of Linsay's admission. The review team were told that Linsay was not amenable to psychological interventions and had tried different modalities in the past. It was a concern that whilst Linsay may not have wanted or been able to avail herself of therapy the overall strategy of care should have been directed and guided from a more psycho- therapeutic perspective.

2. The review team could not identify one specific root cause but felt that the contributory factors interacted together to create a situation whereby Linsay remained distressed on the ward , with limited up take of psychological therapy to help reduce the distress seemingly enhanced by her recent losses. The staff clearly tried hard to work with her but with limited knowledge. There was a sense of fragmented care in that specialist services such as those offered by the addiction team were not engaged in the ward discussions despite Linsay engaging with them during her short stay at Childwall Brook Nursing Home. The period to identify a suitable placement for Linsay seemed overly protracted and seemed to focus staff's thoughts on an external answer to the escalating situation.

Discontinuity of Care/Management of Care

3. The Trust has done a lot of work looking at how to develop the service it offers to service users with a diagnosis of personality disorder. It has developed Guidelines for the management of these individuals and established a Personality Disorder Hub (PD Hub) headed by [redacted] a Consultant Psychologist, in November 2014. These Guidelines are produced at pages 311 - 355 of the Inquest Bundle B.

4. The Trust's Borderline Personality Disorder Guidelines advise that in complex cases there should be a meeting of professionals followed by the development of a specific Extended Care Plan (ECP). The ECP starts with a formulation/summary of the history and care provided, and then describes the type of care that should be provided in different settings including inpatient units.

5. Evidence suggests that prolonged or repeated hospital admissions are not helpful for service users with a diagnosis of personality disorder. The PD Hub aims to keep admissions to hospital as short as possible and to avoid them altogether where appropriate. The Trust has recruited individual psychologists and nurses trained and qualified in managing patients with a personality disorder diagnosis to work as case managers for this group of service users. They are responsible for managing the care of the most complex service users regardless of where the service user goes and thus they

	are able to provide continuity of care and work with other care teams to provide consistency of approach. 6. The team initially identified 40 service users who attended A&E on a regular basis and allocated these to the 4 case managers then in post so that each case manager was responsible for 10 service users. Given the success of this work more case managers have been recruited so that the most complex service users who have increased need now have a specialist case manager. 7. The case managers arrange focussed care for the individual. The approach to care is psychologically based and will include the case manager working with the service user to look at their risk taking and what triggers it. They will then work with the service user to develop strategies to enable the service user to cope with these triggers. Triggers may include memories of past abuse. 8. The Trust is working towards extending the recently introduced day service available for people with personality disorder as part of our evidenced based PD pathway. 9. The aim is to help the service user to manage their condition differently and thus avoid hospital admission if possible. Risk Assessment/Care Planning 10. Linsay's mental state, level of distress, reported symptomology and self-harming or suicidal behaviour fluctuated quite markedly during her admission. I accept that there was an unstructured approach to reviewing and exploring incidents with Linsay which meant there was no collaboratively developed understanding of her risk. 11. Staff are expected to reassess the risks following each ligature incident and episode of self-harm and document the fact that an assessment had taken place and the conclusions reached. Such reviews ought to have included a detailed exploration of Linsay's mental state, her thoughts and feelings and the level of observation she required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action to commission appropriate services.
7	**YOUR RESPONSE** **You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd June 2017**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Linsay Bushell's family Mersey Care NHS Foundation Trust V7 Kings Business Park Prescott L34 1PJ I have also sent it to The Care Quality Commission MIND 15-19 Broadway, Stratford,

	London E15 4BQ. BPDWORLD Silicon House Farfield Park Manvers Rotherham S63 5DB who may find it useful or of interest I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 **André Rebello** **Senior Coroner for the** **City of Liverpool and the Wirral** **Dated: 25th April 2017**