WOLVERHAMPTON SAFEGUARDING TOGETHER
7 MINUTE BRIEFING: AMELIA

Background

Amelia was a young woman with a complex traumatic background of abuse from an early age, witnessing domestic abuse in the home and a victim of familial sexual abuse. Amelia had a diagnosis of Paranoid Schizophrenia and Emotionally Unstable Personality Disorder (EUPD) with a history of self-harming behaviours. Amelia was in a relationship where domestic abuse and substance use were prevalent. She was under the care of a mental health team, with input from a Consultant Psychiatrist and a community psychiatric nurse (CPN) who was her Care Coordinator. Due to deteriorating mental health the CPN referred Amelia to the Home Treatment team, who would be able to provide more intensive support. This referral was not accepted based on Amelia requiring a face to face appointment with a Psychiatrist which could not be facilitated over a weekend. Alternative support was provided over the weekend.

Background 2

Amelia was admitted to an acute hospital following an overdose of medication. The overdose led to significant weakness in Amelia's legs, requiring physiotherapy and occupational therapy input and severe kidney injury requiring dialysis. During the admission to the acute hospital Amelia continued to experience episodes of low mood and made attempts to harm herself. An initial referral to a rehabilitation hospital was declined in line with their admission policy that did not accommodate individuals with active mental health concerns.

Background 3

Amelia was reviewed by the Mental Health Liaison Service on one occasion during her admission to the Acute Hospital. Ward staff also liaised with Amelia's CPN team and she was medically reviewed by her psychiatrist whilst an in-patient on the ward. Amelia was later transferred to the rehabilitation hospital. A verbal handover of Amelia's mental health and self-harm was provided, however, it was not documented on the transfer form. Whilst in the rehabilitation hospital Amelia was seen several times by a psychologist and her mental health risk assessment was updated and placed in her medical notes. Amelia was nursed in a single room under the close supervision of ward staff.

Background 4

Amelia had been nursed in the rehabilitation hospital for some weeks and a meeting was convened to discuss discharge plans. Amelia expressed that she was feeling very low and upset. Shortly afterwards Amelia was found on her bed with a ligature around her neck. Unfortunately, attempts to resuscitate Amelia were unsuccessful.

WST partners undertook a Learning Lessons' Review, to ensure that any learning from Amelia's death was appropriately identified and disseminated amongst agencies. Root Cause Analyses conducted by both Trusts had identified key areas for learning which formed the basis of the Lessons Learnt review.

Recommendations 1

- The Mental Health Trust risk assessment policy to be reviewed to ensure consistency in approach. To consider a more flexible approach for patients to be reviewed via video consultations to enable referrals to the service when patients can't be seen face to face.
- Rehabilitation hospital to review its access policy criteria to ensure it is robust, and to consider adding contingency planning requirements to the policy around what might be required to clinically support patients with mental health issues.
- Clinical staff on the identified acute trust wards to re-engage with the suicide prevention training programme, to ensure that staff have an understanding of the significance of patients' expressed feelings, and the correlation with self-harming behaviours.

Recommendations 2

- The Acute Trust to revisit the clinical handover processes through training and supervision. Information around self-harm and psychological factors must be documented on ward handovers to ensure staff are aware of any presenting risks..
- Joint review of the Mental Health Liaison Service covering identified acute trust hospital wards and revisit service specifications and clinical processes with staff. This is to ensure that there is a proactive response to any urgent referrals, and to inform decision making following any self-harm attempts.

Recommendations 3

- The Acute Trust to revisit the Enhanced Care Score policy with staff through training and supervision, specifically the importance of recognising, recording, and acting when patients express feeling and thoughts relating to self-harm, this includes joint working with MHLS.
- There should be clear specific guidance in the appropriate policies outlining communication standards, especially relating to the management of risk. This includes the responsibilities of community mental health services in providing ward based staff with information and clinical guidance around managing self-harm thoughts and feelings expressed by the patient.