BIRMINGHAM SAFEGUARDING ADULTS BOARD

EXECUTIVE SUMMARY

OF THE SERIOUS CASE REVIEW OF THE CIRCUMSTANCES CONCERNING THE DEATH OF

A3

Independent Reviewers

Mark Dalton

Nicki Pettitt

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1. Introduction to the Serious Case Review

Anonymising Convention

1.1 In order to preserve continuity with other Adult Serious Case Reviews, the subject of this Review in this case is designated as "A3". Out of respect for the victim and in order to aid ease of reading of this report she will be referred to as "Ms A" in the text. During the period under review Ms A was in a significant relationship with a medical professional, he will be referred to as "Dr W" in this report.

1.2 Ms A was 25 years old at the time of her death in August 2013. She was found dead in her home with her hands loosely taped behind her back and a drawstring bin liner secured over her head. She was discovered by her partner, who called an ambulance. Her partner was a doctor (referred to in the review as Dr W) employed in Birmingham. Although she was not his patient, there are concerns about various aspects of this relationship and whether professional boundaries were crossed.

1.3 An inquest was opened on 25 September 2013; a final hearing on 16 April 2014 recorded a verdict that she had taken her own life without the intervention of anyone else. The cause of death was recorded as being "consistent with plastic bag suffocation whilst under the influence of alcohol, methadone and diazepam".

The Decision-Making Process

1.4 Birmingham Safeguarding Adults Board (BSAB) formally agreed to commission a Serious Case Review on 3 June 2014.

1.5 Management Reviews were provided by the following agencies:

- Aquarius (addiction services)
- Birmingham City Council – Assessment and Support Planning
- Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) – Rapid Assessment, Interface and Discharge (RAID) services
- BSMHFT – Corporate Services

- BSMHFT:
  a. East Addictions Recovery Community Hub (ARCH)
  b. Yardley Home Treatment Team (HTT)
  c. O'Donnell Community Mental Health Team (CMHT)
- Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT)
- Heart of England NHS Foundation Trust (HEFT)
- Walsall Clinical Commissioning Group (CCG) – General Practitioner (GP) services
- West Midlands Ambulance Service NHS Foundation Trust (WMAS)
- West Midlands Police (WMP).

Engagement with the Family

1.6 Ms A's father and stepmother have been interviewed as part of this Review. Their contribution will be included in the report where relevant. They are supportive of the Review taking place.

2. Background Information

2.1 Services in Walsall were aware that Ms A was in a relationship with a medical professional who worked in Birmingham. Staff had seen his identity badge and although they did not know he was a mental health specialist, they accepted the fact that he was a Doctor employed in Birmingham. These concerns were not discussed with the Trust's Safeguarding Adults Lead. The Worker had raised concerns through the local multi-disciplinary meeting that Ms A was in a relationship with a Doctor.

2.2 Ms A had informed the Worker that she had met Dr W socially and not in any professional capacity. Subsequently, Dr W told the police that they met through a mutual friend.

2.3 The newly found stability in Ms A's life outweighed any professional curiosity about this unusual relationship; with her history of sex work and the obvious differences in age, status and cultural background, it would have been reasonable to consider whether there was an element of grooming in the relationship.

3. Key Practice Episode 1 – Ms A's Overdose, 13 June 2013

3.1 Ms A self-referred to the Emergency Department at Birmingham Heartlands Hospital, having taken a deliberate overdose, informing staff that she had overdosed previously and self-harmed two days prior to this presentation and had not sought treatment. Ms A also admitted to smoking heroin and cocaine.

3.2 Due to her medical condition and state of mind, Ms A was transferred to the acute medical unit, where she was reviewed by the RAID team.

3.3 Ms A was considered high risk of drug misuse and self-harm because of her previous history and had also mentioned that there were "issues at home", but she did not elaborate on what these were. Although they recognised that she was an "adult at risk"[1], in the absence of any background information to substantiate their concerns the Emergency Department staff came to the decision that they could not make a Safeguarding referral at this time.

3.4 The RAID assessment was undertaken by two staff; an experienced member of the RAID team and a Doctor who was on placement for the day as part of their professional development. Ms A stated that she had no intention of taking a further overdose or ending her life. She explained that she was engaging with addiction services and in the middle of transferring from Walsall to Birmingham and gave the impression of being positively

[1] Adult at risk – a person aged 18 years or over who is, or may be, in need of community care services by reason of mental health, age or illness and who is, or may be, unable to take care of themselves, or protect themselves against significant harm or exploitation. The term replaces 'vulnerable adult'.

engaged. She described herself as being in a relationship with a "Psychiatrist" and being married under Sharia law.[2]

3.5 The Workers noted that this was an unusual relationship; Ms A informed staff that her husband/partner was very controlling. However alongside of this, she described a number of positive aspects to her relationship with this individual, for example; she had a safe home, he looked after her and she had some stability in her life following her use of drugs and her life as a sex worker.

3.6 The outcome of the assessment was a referral to the HTT and an initial appointment was arranged. Ms A was happy to be seen by the HTT and agreed to see a GP as soon as possible.

3.7 At the end of the assessment, Ms A called someone to collect her; this was her partner – Dr W, although he did not introduce himself as such. The Doctor on placement thought she recognised Dr W because she had trained with him. The concerns and unease felt by the Doctor were not recorded on the electronic record system; as a visiting professional the Doctor did not have access to this system.

3.8 The concerns felt by the RAID staff were shared by the RAID Nurse with their Consultant Psychiatrist who contacted the General Medical Council (GMC) for guidance. The advice received from the GMC was that Doctors were entitled to form relationships with anyone they chose providing they were not in a professional relationship with them or use their position to exert influence over their care.

3.9 The HTT made contact on 15 June 2013, also present at the address was Ms A's brother. Ms A was reluctant to engage with Workers on that occasion, stating that she had been told by RAID that they would telephone beforehand. She eventually agreed to an appointment the following day. Again she was visited at home but did not answer the door and requested to be seen by a female Doctor when phoned. She was finally seen by a female Doctor and member of the HTT on 17 June 2013.

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[2] Whilst Ms A claimed at the time to be married according to Sharia law, there is no evidence of a formal ceremony witnessed by a third party and it would seem that this was an arrangement between Ms A and Dr W.

3.10 At this meeting Ms A's main concern seemed to be her accommodation and she was thought to be "sofa surfing"[3]. Ms A openly discussed her history of substance misuse and sex work. When the Doctor enquired about the "friend" who owned the house, Ms A informed them that he was a taxi driver. In the final HTT assessment there is no clarification about the "friend" with whom she had the argument that had prompted her overdose. Ms A's reluctance to discuss Dr W with the HTT may have been due to a number of factors, such as the pressure she felt being interviewed in his house, the presence of her brother (who her father described as having a friendship with Dr W) or an awareness that Dr W was more likely to be able to access records in Birmingham.

3.11 The overall impression was that her concerns were social rather than medical and the plan was to discharge her to the care of the ARCH team and CMHT with a follow-up visit from HTT a week later.

3.12 Ms A had cut short the appointment with the HTT because she had an appointment with the Primary Care Mental Health Nurse at her GP surgery in Walsall. This assessment states that Ms A *"…was agitated because her partner, who was a Psychiatrist in Birmingham, told her he can access any of her medical notes anytime he likes including these GP notes. She finds him controlling and this is adding to her anxiety. She denied him ever physically hurting her. She was seen by Birmingham services as she is currently residing with her partner in Birmingham. She took an overdose last week; she has no thoughts of taking one today. She says they are allocating her to the Community Psychiatric Nursing (CPN) service and will be transferring to a Birmingham GP. However, she is now worried about accessing Birmingham services due to her partner".*

3.13 In marked contrast to her earlier reticence to discuss Dr W with the HTT, she disclosed information about her partner's profession and crucially raised her fear that he was accessing her notes. The Nurse agreed to liaise with the Birmingham HTT, Ms A specifically asked the Nurse to restrict access to her notes to those who worked in the team.

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[3] "Sofa surfing" – at this time Ms A was thought to be moving between friends with no permanent accommodation of her own i.e. sleeping on sofas.

3.14 Following the interview the Primary Care Mental Health Nurse attempted to contact the HTT. Unfortunately she was unable to contact the specific team who had assessed Ms A and was told that she would have to provide Ms A's Birmingham address in order to direct her call to the appropriate HTT. The usual practice would be that a name and date of birth would be sufficient to direct the call to the right service and it is still unclear why there seemed to be a problem in this case.

4. Key Practice Episode 2 – East ARCH Initial Assessment, 28 June 2013

4.1 The East ARCH had been identified by Lantern House[4] in Walsall as the appropriate service to support Ms A once she had moved to Birmingham. This had been confirmed by the HTT who effectively discharged Ms A for home treatment to the East ARCH on 21 June 2013.

4.2 An initial assessment was undertaken on 28 June 2013. The Agency Worker who undertook the assessment raised concerns with the Practice Manager that Ms A had alleged she was worried that another Trust employee was accessing her medical records; the Practice Manager correctly advised the Worker that he should discuss his concerns with the Team Manager. The possibility of analysing the electronic record system (RiO) to identify all the individuals who had accessed Ms A's records was discussed.

4.3 The East ARCH Team Manager reported the allegations to an Eclipse[5] team member who advised him to report it using the "by-pass" function on the Eclipse system (the Trust's incident reporting system). This notification would normally go to the Associate Director of Governance; however he was on leave at the time and instead it was forwarded to the Deputy Head of Compliance for the BSMHFT.

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[4] Walsall Community Drug and Alcohol team

[5] Eclipse is the mechanism for reporting a serious or untoward incident which occurs within BSMHFT (see http://www.bsmhft.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=38488)

4.4 This alert should have been the trigger for investigating the unlawful access of Ms A's medical records and also for restricting access to these records. It was the assumption of the Manager at East ARCH that the referral would trigger the analysis of the electronic records and it remains unclear why this did not happen. It is possible there was a lack of confidence in Ms A's credibility as a complainant and this inhibited the issue being followed up adequately.

4.5 An alternative intervention would have been to discuss the case with the Information Governance team because of the alleged breach of the Data Protection Act 1998. This team would also have been best placed to advise on auditing Ms A's case records. Subsequent analysis showed that by 28 June 2013, Dr W had accessed Ms A's records four times without proper authority and would go on to view her records a further six times by 30 August 2013.

4.6 The by-pass notification system is effective in generating a confidential alert at a senior level, it does not however restrict access to case records. The East ARCH Team Manager was unaware of this and did not receive any feedback about the actions taken for five weeks.

4.7 With regard to the ongoing treatment of Ms A, the East ARCH Team Manager decided that a restricted group of clinicians should be aware of these concerns and avoid recording any detrimental comments in the notes. At this point Ms A had not named Dr W to her Worker at East ARCH and it was agreed that they would encourage her to name him which would enable her case records to be checked for unauthorised access.

4.8 The lack of information from RAID meant that Ms A was given the responsibility of having to name Dr W before protective action would be considered. This would have been unnecessary if East ARCH had known what the RAID Doctors knew.

4.9 Throughout July 2013, East ARCH made several attempts to contact Ms A to arrange a Doctors appointment to transfer the prescription of the drugs from Walsall to Birmingham. An appointment was eventually made for 5 August 2013.

4.10 When Ms A attended this planned appointment she was accompanied by a male. The Practice Manager believed that she knew him, but could not place where from. Ms A asked if her "friend" could come into the consultation. Another ARCH Worker observed the interaction between Ms A and her friend and offered to accompany her for the consultation instead of the "friend".

4.11 During the subsequent consultation, Ms A referred to the male as her "friend" and made no reference to being in a relationship with him or married. There were no Safeguarding concerns raised during the consultation, although Ms A discussed suicide with a plastic bag the Psychiatrist did not believe that she had any plans to harm herself at the time of the consultation.

4.12 The ARCH Worker who accompanied Ms A for the consultation intuitively felt that something was amiss and subsequently took her into a private room and initiated a conversation with her. During this conversation Ms A referred to "knowing lots of Doctors" but would not elaborate or explain any further, it was for this reason that she did not want all the information documented in her notes. She told the ARCH Worker that the man who had accompanied her to the appointment was a Doctor and also her "Islamic husband".

4.13 Both the Doctor and ARCH Worker observed Ms A leave with her friend from the reception area. The ARCH Consultant Psychiatrist identified Ms A's partner as a Doctor who worked for the Trust. None of the ARCH staff were aware of the previous concerns that have been raised with the Agency Worker on 28 June 2013. The Consultant Psychiatrist for the team undertook to take the matter forward, at this point there was no acknowledgement that this should now be treated as a Safeguarding issue and there is no evidence that any action actually followed.

4.14 On 9 July 2013, Ms A attended the CMHT – a routine appointment for patients discharged from Home Treatment. This was a standard 30 minute appointment although Ms A was unhappy that she was not seen for longer, so the Psychiatrist followed it up with a further telephone conversation.

4.15 The Psychiatrist diagnosed Ms A with a personality disorder, but did not refer her for treatment because there were social issues (chaotic lifestyle, illicit drugs and unstable accommodation) that needed to be addressed before treatment would be effective.

5. Key Practice Episode 3 – Self-Referral to Aquarius, 12 August 2013

5.1 Ms A self-referred to Aquarius[6] on 12 August 2013, she said that her motivation for making the referral was pressure from her friends and that if she did not get help, she would have to leave her accommodation.

5.2 There followed a week of telephone contact negotiating appointments and Ms A attended for a face to face assessment on 22 August 2013. Ms A reported that she was consuming up to three and a half litres of sherry each day in order to combat her cravings for crack and heroin. In the assessment, she mentioned that one of her friends was a Psychiatrist and the other a Nurse.

5.3 The Worker undertaking the assessment was sufficiently concerned to contact her Team Leader who offered Ms A a follow-up appointment the next day. Ms A confirmed the concerns she had mentioned the previous day and admitted to hearing voices telling her she was *"a crack head and shouldn't be living".*

5.4 Ms A disclosed a pattern of self-harming, which had existed since early adolescence and also discussed family relationships and some of her experiences as a child.

5.5 With regard to the current situation, Ms A stated she was not in a relationship and had no children. She claimed to be "sofa surfing" between friends in Birmingham and Walsall and that her Psychiatrist and Doctor friends had told her there was no help for the agitation she was experiencing.

5.6 During the interview, Ms A began to receive texts from her friend asking how long she would be. This added to her agitated state and she told the Worker that he was waiting outside and would go mad. Because of her level of agitation, a further appointment was made for 27 August 2013 (the next working day following the Bank Holiday).

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[6] Birmingham-based charity working with problems caused by alcohol, drugs and gambling.

5.7 Coincidentally, on the same day as the second appointment with Aquarius, a Drugs Worker from East ARCH referred Ms A to the SAFE Project[7] due to her history of sex work, although the evidence of domestic abuse did not prompt a referral to Domestic Abuse services. The concerns expressed by Aquarius about the fresh cuts to Ms A's arms prompted the East ARCH Worker to consider a Safeguarding Adults referral, however events overtook this discussion when Ms A presented again at the Emergency Department on 26 August 2013 following the second incident of self-harming in the period under review.

5.8 The differences in the information given to Aquarius and East ARCH by Ms A may be significant; she denied being in a relationship to the Workers at Aquarius, although she claimed to have friends who were Doctors.

6. Key Practice Episode 4 – Second Self-Harming Incident, 26 August 2013

6.1 A 999 call was received at approximately 10:40pm from an unnamed male asking for an ambulance to take a female to hospital following self-harm with a knife. The ambulance records note that she had cut herself with a knife because she was angry but she was adamant an ambulance was not necessary because the injury was not too serious.

6.2 Ambulance control dispatched a solo responder who waited for a police escort before approaching the address. The police arrived at the address 10 minutes after the solo responder was advised to "stand down" by the Emergency Operations Centre. Police records indicate that they had been informed that no ambulance had been dispatched because none was free (and not informed that a solo responder was waiting for them). This is confirmed in the police command and control log which states *"Ambo control say no ambo dispatched and none free presently"*. In fact, a second solo responder was dispatched to the incident and arrived

[7] The SAFE Project is an outreach health promotion service for women working in the commercial sex industry based in Birmingham

after the police had taken Ms A to Birmingham Heartlands Hospital.

6.3 The police took the pragmatic decision to transport Ms A to the Emergency Department, there was no suggestion of third-party involvement in the injuries sustained by Ms A. The police confirmed that Ms A was known to medical staff and that a mental health assessment would be conducted. The police had no further contact on this occasion.

6.4 Following medical treatment, Ms A was again seen by RAID and assessed. She gave specific information about the level of control exercised by her partner, who she identified as a Psychiatrist. The behaviour included locking her in the house, having to report her movements to him, not being allowed out and forced to inflict pain on herself. Ms A stated she felt trapped in the relationship and was no longer enjoying life and that her husband was buying her alcohol. The RAID Worker suggested women's refuge to Ms A which she refused. She also refused further intervention from the HTT and requested the Worker contact her husband to check he was at home to let her in, following her discharge from the Emergency Department.

6.5 Significantly, this is one of the few occasions when Ms A was seen without Dr W being in close proximity; for whatever reason he did not accompany her to the hospital or arrive to collect her.

6.6 Thoughts of suicide were explicitly discussed and Ms A seems to have assuaged any concerns that she wanted to end her life, but that cutting herself was *"her way of coping"*.

6.7 The explicit disclosure of the part played by Dr W in her mental health and self-harming behaviour prompted the hospital to make an adult Safeguarding referral. The Safeguarding referral was completed by the Charge Nurse who also informed the Emergency Duty Team Social Worker. It is important to note that the Safeguarding concerns identified at Birmingham Heartlands Hospital did not reach the City Council Assessment and Support Planning team (i.e. the intended recipients of the referral)[8] and

[8] The Assessment and Support Planning Team had no knowledge of Ms A until 30 August when they were contacted by East ARCH with regard to a second Safeguarding referral prompted by an interview with Ms A on 29 August 2013.

they had no knowledge of Ms A until a second Safeguarding referral made on the 30 August 2013.

6.8 The clinicians at Birmingham Heartlands Hospital felt some unease in discharging Ms A, however there was no medical reason for her to remain in hospital and she was assumed to have capacity under the Mental Capacity Act (MCA) and not considered to be suffering from any mental illness at the time. She had rejected the offer of the HTT or assistance in moving to a women's refuge. A Safeguarding referral had been made and there was awareness that she had engaged with Community Mental Health and Drug Treatment services at some level.

6.9 Ms A was discharged to her home address on 27 August 2013 by RAID. The plan was for East ARCH to be informed of her presentation at the Emergency Department, through reading the entries made on RIO.

6.10 Ms A's Key Worker at East ARCH was proactive in his attempts to refer her to the SAFE Project and to obtain further information about the Safeguarding referral and the decision not to involve the HTT. The Worker also received a call from Dr W on 28 August 2013 enquiring about her next appointment; the Worker appropriately declined to discuss her care with him.

6.11 Ms A failed to collect her prescription on 28 August 2013; due to the level of concerns the East ARCH Worker contacted the police that evening and requested that they undertake a safe and well check. The Drugs Worker gave the following reasons for his concern; Ms A had self-harmed the day before, she was a methadone user who had not collected her prescription and also because she talked about "an Asian male who she calls her husband who does not let her out of the house."

6.12 The police found Ms A at her home address and established that she appeared well and she informed them that she would collect her methadone that day. There was no discussion of the "Asian male". The inherent vagueness of "safe and well checks" and the lack of direct feedback to the person requesting the check is a flaw in the current system. As currently constituted it is not a robust or standard method of ascertaining an individual's safety or state of health.

6.13 In fact, Ms A missed two collections and did not collect her prescription on either 28 or 29 August 2013. Ms A attended an appointment with the Duty Worker from the CMHT and her

Worker from East ARCH on 29 August 2013. During this appointment, she stated that she was in a relationship with a Psychiatrist from Birmingham and alleged that he was using his contacts to access her notes and would then confront her with things that have been written. She requested that both Workers be careful about what they recorded because of this.

6.14 Ms A also informed the Workers that she had undergone an Islamic marriage to the Psychiatrist but now wanted to leave this relationship. Her attitude appeared to be ambivalent; in that she recognised that Dr W was trying to help but also felt he was controlling and alleged that he was using his contacts to access her notes and confront her with things that had been written. This was the first occasion that staff within the CMHT were aware of any concerns regarding the inappropriate access of Ms A's information.

6.15 Following this assessment, Ms A's situation was discussed with the Trust's Adult Safeguarding team and the second Safeguarding alert was sent on 30 August 2013. The written referral to the City Council's Assessment and Support Planning team was followed up by a telephone call from the CMHT, confirmed the case details and the primary concern that Ms A's husband/partner was a Psychiatrist working within the BSMHFT and he had accessed her records inappropriately. It was confirmed that the case would be allocated to a Social Worker on 2 September 2013.

7. Key Practice Episode 5 – Ms A's Death, 31 August 2013

7.1 Ms A's last day alive was not marked out by any particular events that gave any suggestion of what was to follow. Dr W told the police that Ms A awoke late and had been drinking heavily the night before. She had made plans to bake cakes with the neighbour's children later that day. Dr W last saw her alive at 1:30pm when he left the house. On his return, he thought that Ms A had gone out and went to look for her at a local park. On returning to the house, he discovered a note from the neighbour's children asking where she was and discovered her body in the lounge.

7.2 At approximately 5:50pm a 999 call was received by the ambulance service from unidentified male (later confirmed to be Ms A's husband/partner) asking for help with his partner.

7.3 An ambulance and support vehicle arrived within 10 minutes and Ms A was transported to Birmingham Heartlands Hospital. Attempts were made to resuscitate by ambulance staff and continued on arrival at the Emergency Department. These attempts were not successful and Ms A was pronounced dead at the hospital.

7.4 Post-mortem tests indicated that in addition to traces of some drugs, she had consumed alcohol that was consistent with mild to moderate intoxication.

7.5 As part of their investigation the police recovered a suicide note that implied desperation rather than anger and did not seek to blame anyone else.

7.6 Ms A had discussed suicide with plastic bags on three occasions with professionals in the past, although these were all occasions where she was not assessed as having any suicidal ideation.

8. Emerging Themes

a. Failure to Escalate Concerns

8.1 It is a noticeable feature of the Management Reviews from all of the health agencies who have contributed to this Review, that the concerns about the relationship between Ms A and Dr W were not appropriately escalated and followed up in a proactive and timely way. Ms A had expressed anxiety and fear of the consequences of Dr W accessing her records on four occasions to different agencies which did not respond adequately in terms of protecting her, investigating her complaint and recognising this as a Safeguarding issue.

b. Identifying the Nature of Risk

8.2 A further complicating factor for professionals working with Ms A was being clear about the basis of their concerns. The use of intuition or "a gut feeling" is mentioned on several occasions

where Workers felt that the relationship between Ms A and Dr W was implausible. It is to their credit that they were able to express these hunches to their colleagues and they served the purpose of prompting further enquiry.

8.3 It is worth noting that the concerns changed over time; initially there were concerns about professional boundaries e.g. if Ms A had ever been a patient of Dr W (although it would seem that Dr W had met Ms A when she worked as an escort).

8.4 Subsequently, when Ms A complained about Dr W accessing her records this constituted a separate and clear allegation of professional misconduct, a Safeguarding issue and potentially a criminal act.

8.5 The concerns about abuse by Dr W as a Person in a Position Of Trust (PiPOT)[9]; whilst the primary focus of this guidance is an individual using their status and/or employment to engineer situations where they can perpetrate abuse, its scope also extends into the individual's life outside of work. There is significant focus on the use of PiPOT to safeguard children, but its application to Safeguarding Adults, and in particular its extension into life outside of work, is less well-known.

c. Failure to Identify the Indicators of Domestic Abuse

8.6 The recognition that the treatment of Ms A by Dr W constituted emotional domestic abuse was relatively late in her care and did not occur as a separate concern until the interview with Aquarius in mid-August, although evidence of abusive behaviour was evident in earlier contacts with agencies. The reticence in enquiring into the nature of the relationship prevented an effective assessment. Alongside her other health issues and the inappropriate access of her medical records, the fact of her domestic abuse went unrecognised.

[9] http://www.bsab.org/media/Birmingham-Local-practice-Guidance-Notes-5.pdf – this was the guidance available at the time of the incident; BSAB will produce further updated guidance.

8.7 Emotional abuse that takes the form of controlling and coercive behaviour can be difficult to recognise and very few professionals saw any interaction between Ms A and Dr W so were dependant on her reporting her concerns. Ms A was only explicit about this in the final contacts with agencies before she died; where she had complained about being controlled and her anxiety about Dr W reading her notes. This could have been given more significance if workers had recognised this behaviour as abusive.[10]

d. Transfer of Information Between Areas/Services

8.8 This Review has highlighted the difficulty in effective information exchange across organisational boundaries (albeit close neighbours) and between different services within the same organisation. While this is a perennial problem highlighted in most reviews, nonetheless, it is also evident in this case.

8.9 Apart from the identification and concerns about Dr W discussed above, it is apparent that the DWMHPT had significant information about Ms A's childhood and adolescence, which could have had a bearing on the diagnosis and treatment in Birmingham. Ms A's early life was traumatic and troubled. The lack of any background information meant that assessments were dependent on self-reporting with little opportunity to challenge or corroborate information.

8.10 Within health services in Birmingham, the Review has identified information sharing difficulties between RAID, ARCH and CMHT. Information sent from RAID to ARCH could not be accessed by CHMT. It is important to bear in mind that several of these crucial exchanges of information would also involve night staff having to communicate with day staff – therefore a follow-up telephone conversation would not always be physically possible and there would have to be a reliance on written records and email communication.

[10] Birmingham Violence Against Women Strategy 2013 to 2015 p17. http://birminghamcsp.org.uk/wp-content/uploads/2013/06/BIRMINGHAM-VAW-STRATEGY-2013-15-FINAL-DRAFT.pdf

8.11 The interface between police and ambulance services when responding to 999 calls has also been raised in the course of this Review. In situations where the ambulance controller has assessed there is no need for ambulance staff to attend, the police can be left in an invidious position of deciding what to do with an injured person. Clearly they do not have the clinical expertise to make a decision and will err on the side of caution more often than not, transporting a patient to the Emergency Department – as happened in this case on 26 August 2013. Although resources can sometimes be an issue, ironically in this case two separate single responders were dispatched to Ms A; the first arriving and departing from outside the address before the police arrived and the second arriving after the police had transported her to Birmingham Heartlands Hospital. The facts of this incident are disputed by the Ambulance Service and WMP and a consensus could not be reached before the completion of this report. The Safeguarding Adults Board will oversee the resolution of this disagreement between the agencies.

e. Interface Between Substance Misuse and Mental Health Services

8.12 One of the areas of strength identified in this Review was the close working relationship between substance misuse and mental health practitioners across organisational boundaries. Exchange of records and formal notification processes are difficult – as mentioned above, but on an individual case level this case provided strong evidence of the personal care and responsibility that workers took to remain in contact with Ms A.

f. Diagnosis of Ms A

8.13 The diagnosis of Ms A with a personality disorder by the CMHT Doctor does not appear to have taken into account the history of abuse and trauma, but was based on Ms A's self-reporting. Having made the diagnosis it would seem that Ms A could have been offered support from primary care but would not have met the criteria for therapeutic treatment for her condition and she would have difficulty engaging in treatment because of her ongoing substance misuse and chaotic lifestyle.

8.14 Aquarius held out a prospect of meaningful engagement. The possibility that her lifestyle was exacerbating the symptoms of personality disorder could mean potentially that she would always be excluded from treatment. Closure of her case was premature and the CMHT could have invested further time in establishing a working relationship with Ms A due to her history of self-harm, substance use and domestic abuse and then made a diagnosis and come to a decision as to how best support her.

9. Key Findings incorporating the terms of reference

9.1 For all of the period under review, Ms A was not subject to a Safeguarding plan and therefore there will be inevitable deficits in recognising risk. Ms A was "at risk" in three distinct ways:

- Ms A was a vulnerable adult – a "vulnerable adult" is defined as a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"[11]
- by this definition Ms A was clearly an adult at risk and as such it can be argued that the level of risk met the threshold for Safeguarding at an earlier stage, but the failure to act decisively with respect to her concerns about Dr W led to this not being recognised for several weeks
- Ms A was the victim of domestic abuse – through the review period she had given some information that her relationship was controlling and coercive to the point of being abusive. In her final interviews on 26 August 2013 (RAID) and 29 August 2013 (East ARCH and CMHT), she was very explicit about the actual level of controlling behaviour by Dr W.

[11] No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. Department of Health (2000).

10. Conclusion

10.1 Whilst Ms A's decision to take her own life could not have been predicted based on the information available, a more timely safeguarding response may have given her other options and support

10.2 At the time of her death, services were beginning to co-ordinate and share information and the first Safeguarding referrals had been made. The failure to recognise the relationship as an abusive one was the result of several factors. Firstly the concern about Dr W accessing her confidential records dominated the analysis of risk to the extent that Ms A's experience of being in an abusive relationship was not fully explored or assessed. This task was made more challenging because of the difficulty she had in discussing the relationship and the fear she had that Dr W would find out.

10.3 Safeguarding would have been the appropriate forum for countering these difficulties; it would have prompted inter-agency communication and information sharing and this would have enabled a more accurate assessment of risk. This process would also have prompted more vigorous follow-up regarding the identity and activities of Dr W.

10.4 Two clear themes emerge from this Review: firstly, the need to emphasise the link between domestic abuse and adult Safeguarding. This is not an issue of procedures, but more of an issue of training and communication to ensure that all practitioners consider the possibility of an abusive relationship alongside other risk factors. In this case, the existence of psychological and emotional abuse should have been considered at an earlier stage.

10.5 Secondly, there was reluctance amongst some staff to challenge their managers regarding the actions that were taken following the identification of Dr W. If organisations want their whistle-blowing policies to be useful, they need to recognise that junior staff are likely to feel inhibited about raising concerns involving more senior colleagues. Also, these procedures are likely to be unfamiliar to staff because they are used infrequently, therefore their existence needs to be formally raised on a regular basis and staff members informed of how they will be supported when using these procedures.

10.6 Since Ms A's death. BSAB has put in place Position of Trust practice guidance[12] and there is an overarching West Midlands Safeguarding Adults Policy and Procedure[13] which is accessible and applicable to all agencies across the region.

11. Recommendations

Overarching Recommendations for Birmingham Safeguarding Adults Board

1. BSAB will work to ensure staff and its partner agencies are aware of how to recognise domestic abuse and how to respond appropriately.
2. The Board will commission an audit of key staff groups to ascertain their knowledge of domestic abuse pathways for responding to concerns and demonstrating risk assessments by December 2015.
3. BSAB will be assured that all members and partner agencies will have a robust positions of trust policy by December 2015 and will ensure these policies are referenced in all training packages by January 2016.
4. BSAB will obtain assurance via commissioning leads that single agency recommendations have been completed.

[12] http://www.bsab.org/media/Birminghams-Local-practice-Guidance-Notes-5.pdf

[13] http://www.bsab.org/publications/policy-procedures-and-guidance/

Abbreviations Used

ARCH
Addiction Recovery Community Hubs – treatment and support for drug and alcohol users

BSAB
Birmingham Safeguarding Adults Board

BSMHFT
Birmingham and Solihull Mental Health NHS Foundation Trust

CCG
Clinical Commissioning Group

CMHT
Community Mental Health Team

CPA
Care Programme Approach

CPN
Community Psychiatric Nurse

CQC
Care Quality Commission

DHR
Domestic Homicide Review

DWMHPT
Dudley & Walsall Mental Health Partnership Trust

GMC
General Medical Council – maintains the register of all Doctors licensed to practice within the public sector in UK. The GMC regulates and sets the standards for conduct and practice of Doctors

GP
General Practitioner

HTT
Home Treatment Team Crisis – support at home to people with mental health problems that are experiencing serious mental distress

IMR
Individual Management Review

IT
Information Technology

KPE
Key Practice Episode

PiPoT
Person in a Position of Trust

RAID
Rapid Assessment, Interface and Discharge – diagnosis, assessment and management of people with mental health issues in acute hospitals

RCA
Root Cause Analysis

SAFE Project
Seeks to promote the health and well-being of women involved in the commercial sex industry and reduce the harm associated with sex work

SCIE
Social Care Institute for Excellence

SILP
Significant Incident Learning Process