Appendix 3 – Family response to the Safeguarding Adult Review Report

This report adds to the existing body of evidence[1] arising from the circumstances of our daughter's treatment and death.

We are very grateful to the Lead Reviewer for the diligence and attention she has displayed in conducting this review and for providing additional evidence and explanation.

Her review has considered why and how Ruth's treatment failed on numerous occasions with tragic consequences, one can only hope and pray such failings will never be repeated.

Our response is one which is set against our loss, in circumstances which we now know were avoidable and our daughter need not have died.

Our response:

- The over-riding perceptions which emerge from our reading of the report are those of professional indifference and an absence of compassion at a corporate and clinical level, by those who had a responsibility and a duty of care for a very vulnerable patient suffering from a chronic and enduring mental illness.
- The events leading to our daughter's demise reach back to 2006/ 2007, when we first witnessed our daughter's deterioration and increasing reclusiveness and social isolation.
- Our concerns were not listened to then and we were forced to make a formal complaint regarding the effectiveness of Ruth's treatment plan and the clinical decision to discharge her to the care of her GP.
- It should be noted that Ruth's decline led to total reclusiveness, as far as any contact with us, her sibling, her son and her extended family was concerned.
- Until her death Ruth did not allow us to visit her at her home, shunned all attempts to maintain contact with her, and apart from an hour a year when she agreed to meet us in the weeks before Christmas, we had no other contact with her despite many attempts on our part to maintain contact.
- Ruth avoided any contact with her sister or other family members and refused to maintain any visitation or contact with her son.
- This was all explained to the clinicians treating Ruth who were made very aware by us of our desperate concern for Ruth's well-being and safety. She was totally isolated from anyone she knew or cared for her and was extremely vulnerable and at risk.

[1] Dr C McEvedy Independent report and HSO findings

- However, despite this, and meeting with senior clinical and executive management members of the Trust to press for Ruth's Enhanced Care Programme Approach (ECPA) to remain in place, the decision to discharge from the ECPA was adhered to.
- The care coordinator's role was removed from Ruth's treatment and she was 'stepped down' to standard care.
- This action took place even though Ruth's consultant HP2, expressed the need for a second opinion to test Ruth's mental capacity, which was never carried out, and his concern that he felt Ruth still needed a care coordinator, was apparently never discussed with the local mental health team.[2]
- We have never understood or accepted how clinicians could allow someone as vulnerable as Ruth, who was so isolated, to be 'stepped down' in such circumstances.
- To obviously placate us, a compromise was outlined in May 2008 by HP4, which indicated that HP4 would attend Ruth's out- patient quarterly appointments (OPA's) to address Ruth's familial and situational circumstances.
- This treatment plan did not follow normal clinical practice, and although approved and put in place by Trust senior management, it was implemented without any of the normal requirements needed to ensure clinical supervision, inspection or management of the CPN involved, or the plan.[3]
- No record was entered in Ruth's medical notes of the HP4's role, neither was it part of the electronic record of her treatment.
- In other words, other clinicians and clinical managers did not know about the plan and no one supervised HP4 or ensured the plan was being implemented effectively.
- Even so, as Dr McEvedy points out in his report, this arrangement may have worked, if everyone did want they said they would do; but HP4 did not honour her professional commitment, and consultant psychiatrists did not follow through on their own recommendations.[4]
- The lack of supervision and clinical management procedures allowed this situation to develop and continue.

[2] Source: - internal e mails PPCTT May 2008

[3] Correspondence from Mr D O'Toole (Deputy CEO) PCH dated 19 Sept 2014

[4] Dr C McEvedy report page 19 Para 91 lines6/7 – *"The difficulty came when neither of these appeared to be fulfilled" relating to the 08/05/08 letter from HP4 etc and speaking of the OPA frequency and HP4's attendance*

- Other issues and concerns about Ruth were recognized over the ensuing 5 years which signalled that Ruth was not coping well and was in decline.
- Three consultants highlighted concerns for Ruth's well- being and her ability to cope, referring matters to either HP4, MDT meetings or other clinicians.
- No action was ever taken and our daughter continued to decline.
- The review report outlines these instances and points to the lack of continuity in consultants treating our daughter - 5 different consultants were engaged with Ruth over the review period. (2007-2012)
- This report indicates that there was a lack of 'ownership' for Ruth's problems.
- The most notable instances when this neglect is evident can be seen in the circumstances of: -

  (i) Ruth's OPAs on - 24th March 2009; 21st July 2009; 4th May 2010;11th Jan 2011; (lack of further action)

  (ii) Failure to action consultant's e mail request for intervention in Ruth's situational circumstances on 12th Jan 2011;

  (iii) Failure to action parental concern re DWP support (DLA payments) November 2011;

  (iv) Failure to instigate 'vulnerable adult' policy on 6th December 2010 and December 2011;

  (v) The 4 years our daughter had no access to heating or hot water within her flat which was never questioned;

- The review report is also significant by its explanation of individual and corporate failings and professional disregard and indifference to good practice, for example, the failure to follow agreed policy regarding the Vulnerable Adult Risk Management (VARM) process; failing to maintain good interagency communication; failing to follow through on clear indications of a patient in decline; and failing to challenge Ruth's reluctance to claim Disability Living Allowance (DLA) which so critically impacted upon her ability to cope. [5]
- The review points to a period of organizational change effecting local mental health provision at that time, as another factor which may have worked against the proper care of a Ruth.
- In our opinion, this cannot excuse corporate or individual failure in the treatment of vulnerable socially isolated patients.

[5] McEvedy report Pages 17 & 18 Paras 84,85 & 86

- However, what is significant and important, is the fact that clinical managers were made aware in 2009 by HP4, that her commitment to the treatment plan was compromised by her promotion, during this change period.
- HP 4 reported her inability to fulfil her commitment to Ruth due to work related relocation and added job responsibilities following that promotion.
- Area management did not heed her warning and took no action to remedy the situation and expected HP4 to maintain the commitment - which is unforgivable.
- It is equally unforgivable that as a result, HP4, an experienced nurse, allowed her commitment to Ruth to lapse by non-attendance to our daughter's OPAs.[6]
- Instead, HP4 relied upon an arrangement with the consultant, that if our daughter did not attend 2 consecutive OPAs she would then become involved, which could mean that our daughter could remain unseen by any clinician, for up to 1 year.
- Dr McEvedy is critically unsure of the clinical correctness of such an arrangement [7]
- Throughout this period (2009-2012), we as parents were totally unaware that the regular attendances of HP4 to Ruth's OPA's had in fact ceased.
- For us, it is yet another example of the gross neglect and professional indifference to the plight of a vulnerable patient and those who were concerned for her.
- As the report indicates, since 2010 it should have been obvious to clinicians, that Ruth was very ill and was in severe personal decline, and yet nothing was done; no consideration was given to any form of intervention or change in her treatment plan.
- This was despite a consultant's direct request for intervention in Ruth's situational circumstances on the 12th January 2011.[8]
- When Ruth died on the 2nd September 2012, it was following at least 2 years of self-neglect, albeit we feel that process started when she was "discharged" in 2007.
- She was living in quite appalling and unacceptable living conditions.

[6] See below OPA record – source FOIA and Ruth Mitchell's medical records.
[7] McEvedy report Page 19 Para 91 lines 7-11
[8] Internal email Jan 2011 - request to HP4, an assistant clinical manager and a community MH social worker for social intervention and financial support

- No immediate internal investigation was carried out by mental health services following her unexpected death.
- Furthermore, we believe no such investigation would ever have taken place, but for the instigation of our NHS complaint and our persistence in trying to find out why our daughter had been allowed to decline to such a poor state.
- Following recent events at the Southern Health Care Trust, it seems to be an 'industry norm' that vulnerable patients can die suddenly and unexpectedly, and no clinical investigation is conducted as to the circumstances leading to those deaths by the health care provider.
- Our daughter was failed by mental health services not once but many times during her treatment period and the indifference and disrespect shown to her whilst she was alive and to her following her death is appalling.

Conclusion:

NHS Litigation Authority have stated in a letter of response following litigation proceedings by Ruth's son for a breach of a duty of care, with the following admission of fault: -

"*in so far as the care provided to Ruth after October 2011, but for the admitted failings, a full package of care would have resulted in an improvement in the Deceased's mental state and negative symptoms that would have, in turn, lead to an improvement in her insight and collaboration with the clinical team and on the balance of probability the continual decline that led to the Deceased's death would have been averted."*[9]

The statement sums up not just the last 12 months of Ruth's life, but the reality of 5 years of missed opportunities, misguided clinical judgement and indifference to her situation and personal circumstances by 3 mental health service providers, being Plymouth Primary Care Teaching Trust, followed by Plymouth Community Healthcare and latterly Live Well SW

This Review Report adds to this finding by showing how it is possible and apparently acceptable, for a vulnerable and chronically ill patient to be allowed to decline and die, within the sight of and with the consent through indifference, of those very health professionals who had a professional duty to prevent such neglect and self-harm happening, and nothing is investigated and nothing is said thereafter.

R & A.E Mitchell

[9] NHS Litigation Authority correspondence dated 15th October 2015 – independent litigation action **not** involving Ruth's parents – breach of care by:- 1 Failure to carry out any systematic social care assessment; 2 failure of CPN to attend all OPA's and liaise with parents on regular basis;3 Failure to trigger social care assessment; 4 Failure to provide assistance in claiming DLA; 5 Failure to liaise adequately with police and social services; 6 Failure to ensure consultant's recommendations for increase support were implemented.

[6]**See attached OPA record – source FOIA and Ruth Mitchell's medical records.**

OPA RECORD of ATTENDANCE (*Source: FOIA & Patient A's medical records)*

	Ruth Mitchell	**HP4**
2008		
10/06	YES	NO
23/09	NO	NO
11/11	YES	YES
Total	**2**	**1**
2009		
24/03	YES	YES
21/07	YES	NO
Total	**2**	**1**
2010		
26/01	NO	YES
04/05	YES	NO
19/10	YES	NO
Total	**2**	**1** (does not include house visit on 06/12/10)
2011		
11/01	YES	YES
29/03	NO	NO
05/07	YES	NO
01/11	YES	NO
Total	**3**	**1**
2012		
14/02	YES	NO
17/07	NO	NO
21/09	Patient A deceased on 02/09/2012	
Total	**1**	**0**
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OVERALL TOTAL	**10**	**4**