Meeting notes

Thanks for meeting with me. Currently raising awareness as you know and advocating for me to get the support I need, and change based on my experience to date. Email campaign, petition and social media campaign. 'Hope to better understand my concerns' - a step forward, appreciate the opportunity to meet.

https://www.change.org/p/investigation-into-swansea-bay-mental-health-services-and-call-for-me-to-get-dbt (1100 signatures)

https://www.walesonline.co.uk/news/health/teenager-says-nearly-died-after-31717467

https://www.express.co.uk/news/uk/2059502/nut-allergy-man-almost-dies-in-hospital-suicide-attempt

My experience to date:

Part 1

- I was initially referred to the crisis team following assessment at Port Talbot Hospital, I was told I would be receiving daily visits to my house. However, this form of support did not come into place. This is appalling considering this is what I was promised by the team at Port Talbot and the purpose of the team is to help me whilst in crisis which I was in when I presented at Port Talbot Hospital and continued to be in whilst under their care. The lack of support by the team resulted in me being hospitalised. I believe that if support had been given the first instance this could've been avoided. This is the very purpose of the crisis team. It literally states the word home in the name home treatment team. I was then allowed on leave from the ward and was informed by a nurse on the ward I could have access to home visits however this again was not enforced. Also, rang on occasions in distress and just had the phone put down on me.

- Hospitalised at Ward F on 11th Feb due to out of control suicidal ideation. Sertraline a factor - incorrect dosage prescribed. 100mg when 25mg is stated on NHS guidelines usually, 50mg on BMF guidelines.

Part 2

- Safety concerns to start - I like to raise safety concerns regarding the care at Ward F. Whilst on the ward I was able to bring brazil nuts onto the ward which I ate in an attempt to take my life. This resulted in me going into anaphylaxis and nearly succeeding with taking my life. I would've died had it not been for the intervention of the ambulance service who were called on red alert. I suffer with severe suicidal impulsivity as part of

my diagnosed emotionally uncontrollable personality disorder. Staff are meant to check the contents of any deliveries to the ward and were aware of my allergy as well as suicidal ideation. Therefore, I question why the bag containing brazil nuts which I'd ordered on the Just Eat app was handed over to myself without it being checked following delivery. I would like safety measures going forward to be looked at to ensure that an incident such as this does not occur again whereby inpatients such as myself could also get high risk items onto the ward.

- Additionally, on one night whilst actively suicidal the nurses on duty that day had left the office door open. This allowed me to act on a suicide impulse by escaping through the window of the office on the ward whilst actively suicidal. I had intentions of finding a bridge to jump off or walking on train tracks to be killed by a train. However, it was fortunate that police were able to find me and bring me back to the ward preventing me from carrying out these plans which all staff were aware of.It is shocking that I was able to escape so easily and I am concerned other high risk patients at Ward F could also escape if safety measures regarding the escapability of the ward are not improved. I would like acknowledgment of this incident and safety standards to be improved to prevent this from occurring again. This incident needs to be investigated with staff retrained on safeguarding for patients such as myself as I never should've been able to escape so easily whilst in the state of mind I was in at the time.

- Also, I would like to raise concerns regarding an unsecured wardrobe in one of the rooms of Ward F. Ward F is an acute assessment ward so many patients such as myself present in a highly suicidal state. I was able to nearly get the wardrobe in my room on top of myself due to it being unsecured in an attempt to take my life but a health care assistant intervened. I spoke to the nurse Gloria on duty after this. However, following nurses being aware of this incident no safety measures were put in place to protect myself from the risk the unsecured wardrobe posed to me. I remained in the room with the unsecured wardrobe which posed a direct risk to myself as I had further suicidal ideation regarding the waredrobe and this could have resulted in further attempts. I would like the safety standards at Ward F in relation to furniture in rooms on the ward to be investigated.

Part 3

- On one ocassion, I attempted to jump the fence of the ward in order to escape and commit suicide. Prior to this I had alerted the on duty nurses that day of my distress and requested access to lorazepam which I have available on a PRN basis. However, I was rebuked for being rude and told I was not anxious despite my hostile nature showing I was agitated and anxious so required attention. I was consequently refused access to my prescribed lorazepam which Dr. Provan had stated I could have as and when required. I would like to question why nurses were going against the advice of a psychiatrist who has greater authority than them. I would also like to question the lack of support that was given to me as a patient on the ward when I was distressed by intense

emotions. I am diagnosed with eupd and gad so should've been given support whilst distressed but this was not given. My Mum then raised the incident with a nurse called Stephanie Williams who proclaimed that 'I tried to jump the fence because I didn't get my own way'. She also claimed that notes from a meeting with Dr. Provan would not have been made and that Dr. Provan had not given lorazepam on a PRN basis despite this being the case. Mental health nurses are supposed to show compassion towards patients and support them so I should not have been spoken about critically and false assumptions behind the reasons why I jumped the fence should also not have been made. Also, it is a legal requirement for notes to be made in any mental health meetings so Stephanie directly lied to my mother in an attempt to mislead her.

- There were clear discrepancies regarding nurses discretion and what had been stated by Dr. Provan when I saw him. When I left the ward on planned leave myself and my mother had been promised by Dr. Provan that if there were to be any issues with my mental state during leave I could return to the ward at any point in time. However, following a few days of leave I became very distressed in the home and wanted to self harm by pouring boiling water on myself. Myself and family rang the ward to request that I come back. Stephanie Williams answered my call. However, I was refused access to return to the ward despite this having been the agreed arrangement between myself and Dr. Provan which put my safety at risk.

- My main concern to conclude with remains the poor communication by staff at Ward F. Whilst on leave, I was forced to come back and forth to meetings in which I was told by staff that my referral for care coordination and dbt was being chased. It had been agreed with Dr. Provan prior to his sudden departure that I would have a care coordinator in place prior to discharge 'within a week or so', and DBT would be arranged. This was a promise that was made to myself by Dr. Provan which I expected to be upheld. However, many nurses then told me I might not get a care coordinator despite this being what Dr. Provan had stated I would receive. Also when coming back and forth to meetings nurses stated they had been chasing my referral yet when I contacted the community mental health team alongside my advocate I was informed that their position was that I needed to be discharged in order for assessment to take place. I feel I was constantly given conflicting information in meetings, which did not put me at ease considering that I suffer terribly from anxiety. I also am not satisfied that nurses clearly communicated the high magnitude of risk to myself including self harm tendency and suicide attempts to the community mental team from the offset. Also, CHMT said they only sent a referral saying 'I needed help' with no further details of what sort of help I needed. Also, told Dr. Provan never said this - lied to. Might not get it, never said, lack of chasing referral. 'Might not meet criteria'

- I had a generic care and treatment plan created by one of the nurses Holly which actually stated there was no psychological concerns despite me having been diagnosed with a severe mental health condition of eupd and being very suicidal with several suicidal attempts having been made. This was not amended until several weeks later.

(Middle of the night - asked to sign at late notice) Therefore, due to the incompetence of nurses on the ward my much needed help has been delayed whilst I am struggling significantly with suicidal thoughts daily and regular self harm. This directly put my life at risk due to the delay in me getting the help I need.

- If I asked for help ‘told to go to my room’ in distress. Accused of being ‘rude’ for asking basic questions about my care or ‘hostile’ Same for my Mum too and others.

- Stephanie Williams. On Monday 21st April I left the ward as an informal patient and became highly suicidal whilst out which resulted in police having to bring me back to the ward. My mother was also in attendance at the ward when I returned. My mother was understandably distressed following the incident that occured. This was further heightened by the hostile nature that Stephanie Williams spoke to my mother in. She did not allow my mother to raise her factually correct point regarding my treatment at Ward F and immediately rebuked her views and attempted to place blame on my mother for the incident that had occured which was not the case. There was very little empathy towards my mother. The job of a mental health nurse is to listen to and acknowledge the views of a patient and their family including my mother. Instead, Stephanie completely neglected by mother’s views and disregarded them. This caused additional distress to my mother and myself. My mother was then told to leave as Stephanie could not handle hearing factual details regarding my care at Ward F. Following this incident, I was shocked to hear nurses discussing my mother in a negative manner and when I raised concerns regarding Stephanie’s conduct to another nurse it was immediately stated to myself that Stephanie had allegated in the morning handover following the evening that my mother ‘tipped a table towards staff’ so was asked to leave as a result of this. This is a false allegation which should not have been stated in the morning handover or stated in any notes for the morning handover. My mother has a physical disability as she has an ileostomy bag so she would not even have had the strength to be capable of doing such a thing. The police were also present and the police report makes no reference to this false allegation, and had my Mum attempted to tip a table towards staff then police would’ve intervened which again did not occur. This lie can be backed up by police witnesses, police footage from police recordings at the scene due to police having to record myself due to my distressed mental state which resulted in me being 136’d. My step father was also present alongside myself so witnesses can prove this allegation is a lie as this did not occur. This false allegation and discussions about it by nurses caused me additional psychological distress when I was already struggling under the care of Ward F and vulnerable due to my mental health conditions. It caused me to lose all trust in Ward F staff completely. This is not the first time Stephanie Williams completely failed to act in conduct with nursing standards as this was a regular occurrence. I believe she should be suspended pending investigation as she is not following the nursing standards she has been trained to comply with which could result in further psychological distress to other patients at Ward F in an acute mental state like myself.

- Additionally, following my mental health assessment when I came back to the ward in distress on an evening following a near suicide attempt on a walk which required police intervention I did not have any support from nursing staff that night despite the social worker who had conducted the assessment having told me someone would come and speak with me after for support. This not occur. I was left in distress following the events of the night. What is even more shocking is that I was not checked upon once in that night despite me having been placed on regular checks as part of standard procedure by my psychiatrist. Staff were just sat in the office all night. Another older woman on the ward also complained about this.

- Also, other nurses should be investigated for their conduct. I was told by another nurse after raising the infactualty of this statement that 'my relationships with staff have broken down completely'. This is a shocking statement to make and in the evening when I raised this with another nurse on duty she said this was not the case. This statement resulted in me feeling very low about myself and me going off into the room and attempting to hang myself. I felt that I could not be supported by Ward F after this statement and that there was no way of helping me. Fortunately, I was prevented from doing so but again nurses professionalism failed here. I am the patient who is struggling so I should be helped by staff and enabled to feel better about myself, not worse about myself. Also, a patient should not be regarded as having a relationship with staff as this indicates inequality in regard to patient treatment.

Part 4

- I will address the shocking professionalism of the psychiatrist, Dr Robertson, on the ward. I found Dr Robertson's manner when discussing my mental health with her to be incredibly unprofessional. I came out of her meetings feeling worse off than I when I went on. This is due to her mannerism in the way that she handles discussions regarding my mental health. On one occasion she was very negligent in listening to my Mum's views on my care at Ward F and told her three times in a meeting 'to get out'. This was because she could not face being confronted with questioning about why plans for my care were not being followed. She was very unsympathetic towards myself and my mother in meetings.

- Dr Robertson is very flippant in the way that she makes comments. This was not something that I only recognised as even other nurses stated this to be the case in discussions with myself regarding her mannerisms. On one occasion, myself and my mother were very distressed in a meeting regarding my self harming behaviours. As a result, Dr Robertson flippinitly stated that 'we'll have to look into making homeless then'. This resulted in me becoming very emotional and having to leave the room to calm down. A psychiatrist does even have the ability to make me homeless yet she stated this. Due to my diagnosis of eupd, I am very vulnerable to comments that I view as being a criticism of myself and this was clearly a very offensive comment to make. Additionally, Dr Robertson also stated to my mother in a meeting that 'she has come to the reality that

I could kill myself and won't get any help'. I have been left traumitised by this comment and this comment in fact resulted in me making a near suicide attempt after replaying her comments whilst out on a walk. Additionally, whilst attempting to undertake given mindfulness techniques which is a way of managing my disorder this comment keeps replaying in my mind which has previously caused me great distress and heightened my anger towards myself which is something I suffer with significantly as part of my eupd diagnosis. Nice guidelines state to explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable. These comments regarding 'looking into making me homeless' and 'that I could kill myself and get no help' do the complete opposite. I would like her mannerisms and the way that she conducts herself towards patients including myself to be investigated with appropriate disciplinary action taken. Additionally, after going on leave and returning due to the fact I was sent out into the community she stated 'we predicted you'd be back'. This indicates she predicted I'd make another suicide attempt yet I was allowed to remain in the community after reviews with herself. - Nurses told me not to raise concerns also as 'I'd bring mental health services down'.

- Crisis team - tried to jump off bridge in school. Went to Orchard Street stating directly I needed to go back to hospital direct and active plans to end life. Let me go, didn't even call Mum to pick me up. 5 minutes later - police - 4 storey car park. Haven't even documented properly what I said.

- To add to this, in a mental health assessment in which the psychiatrist Sian Heake was present I believe the assessment was unlawfully conducted as Sian Heake unlawfully coerced me. This is because in the assessment I was incorrectly told if if sectioned under section 3 I would never be able to have a career in pharmacy or travel. Sian Heake failed to look at the positive aspect that if sectioned I could actually still do pharmacy after a given period of stability. Following further research, I have noted that there are medicine students who have done medicine following being detained under the mental health act. Also, this would be discrimination. This comment resulted in me being unable to discuss my feelings completely with her which resulted in thoughts that were playing on my mind not being disclosed. Therefore, the assessment was influenced negatively by her preventing me from discussing suicidal intentions fully. I did however state suicidal ideation I had if I were to leave the hospital but despite this I was not detained following the assessment. Raised with nurses - told 'this was never said'. Nurse deemed to be present wasn't even there.

- Furthermore, following the assessment it was placed on the system that I would not be allowed to have leave despite them giving me informal status. This is de facto detention which is illegal. I raised this with nurses and this was then changed but this shows the poor conduct of the assessment which should've been conducted lawfully. If they felt I should not have leave then I should've been detained. It was obviously their view that I

should not have leave as this was put on the system despite them having not detained me which is clear de facto detention.

Part 5

- Med records - When I rang the office that handles release of medical records I was informed that there had been communication from ward F that I could not have my records whilst an inpatient. This should not have been communicated as I had been informed by Dr. Sidiqui that I would be able to access my records for my own assurance and to help me raise concerns. Therefore, I have been withheld from accessing my records which is highly illegal given that Dr. Sidiqui had consented in a meeting and I am legally entitled to my personal data under the GDPR act.
- Notes - have wrong diagnosis stated several times. Wrong address. Wrong phone no. for Mum. (Asked to change several times!). Basics! Staff contradict themselves - one thing said and then later they say never said. Clearly not reading notes nor following through on what is written in notes. Exaggerated lies about myself, shocking statements. Not been nice for me to go through shouldn't have to be needed to in order to evidence needs.

(View notes here - https://docs.google.com/document/d/1MJutSNWbvms29pv7B7oND9_SENgDsMJwD-dgLbzqgx4/edit?tab=t.0)

Part 6

- Current situation - Michelle Bidder and community mental health team. V. unprofessional even nurses here stated it. Told me she was my care co. but now not the case. Being assessed 12 weeks to see whether I need care co. Clearly needed been told by several psychiatrists it's required - Dr Provan, Dr Robertson, Dr. Sidiqui, Dr Sian Heke, Dr Yuhandra and Dr. Menen. Plus 3 social workers. Why should I have to be assessed to see whether needed? Community mental health team also know underlying difficulties - been assessed in hospital since Feb and have clear diagnosis. GAD, PTSD and EUPD. Complex so needs care co. No reason for a further 12-week assessment for care planning when I have a confirmed diagnosis, high risk presentation with multiple self-harming behaviours yet further investigations recommended to establish my precise formulation?
- I continue to be let down - Michelle Bidder CPN from Swansea Community Mental Health team had arranged to meet with me today and this was agreed at my last meeting but now she cannot come now as 'she's on leave'. Last week she couldn't see me due to 'being on duty'. Also, in my last meeting 'she had to go' as she couldn't give me answers to basic questions I was asking about my care. She also mislead me - one minute 'I'm too out of control for DBT' and now apparently 'I'm too in control and need to be aggressive in the community for DBT'. Qualified psychiatrists have said I need DBT so this needs to be upheld - a nurse should not dismiss my treatment needs!. Also, played

down diagnoses ‘only 18.. Just say these things, another one been added onto the list now’.
- Wrong dosage of medication down - sertraline from Feb!
- Only works 2 days a week.
- Rang CHMT yesterday - told will have ‘short term’ support after assessment. Need long term - Dr. Provan 1 year of therapy, Dr. Robertson year and a half worth.
- Told I’d been accepted for DBT but now being denied. Been told by Dr. Provan, Dr. Robertson, Dr Siduiqui and Dr Menan I need DBT. This is the treatment for my condition recognised by NICE guidelines as being most effective.

<u>What I need to know</u>

- When can I have a care coordinator appointed? Needs to start now - need a continuous point of contact to work me with consistently, and support me and my needs. Needed in hospital as an inpatient and long term in the community for therapy.

If a multidisciplinary team and care plan approach is not considered suitable now, what is the reason for this? In your answer please include consideration of my recent history and NICE recommendations that:

Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person),

and that a care planning approach

…is particularly important if there are communication difficulties between the service user and healthcare professionals,

and that

When managing the risks posed by people with borderline personality disorder in a community mental health service, risks should be managed by the whole multidisciplinary team with good supervision arrangements …

Be particularly cautious when:

- *evaluating risk if the person is not well known to the team*
- *there have been frequent suicidal crises.*

In your answer, please consider the complexity of my presentation – confirmed EUPD and GAD with further investigations for PTSD and ADHD recommended and bearing in mind the following guidance from NICE:

When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user?

- Can I have a full time care co. - not just 2 days a week. Someone available as a regular contact who I can reach in times of distress for support.

- Can I have a support worker - Carly social worker recommended.

- Direct payments - social worker to fund needs on CTP.

- Can I have a care and treatment plan created by the community mental health team? - Refused so far. 'Michelle Bidder - hmm when I asked'

- How will my established risks be mitigated by the support plan I am being offered?

- Why am I being told the emotional regulation skills group first? - Nice guidelines for eupd state 'when considering a psychological treatment take into account the choice and preference of the service user'. It is my choice and preference to undertake dbt therapy, over emotional regulation skills which has been offered to me. I have no willingness to engage with the emotional regulation skills group but do have the will to engage with DBT therapy.

- NICE guidelines state to take account the 'person's willingness to engage with therapy'. Also NICE guidelines state to 'work in partnership with people with eupd to develop their autonomy and choice'. I have reasons for only being willing to undertake DBT therapy. Firstly, it is the treatment, which is clearly most recommended and recognised by NICE guidelines as being the most effective treatment to manage my condition. I have been advised psychiatrists historically that this is the treatment I require. Also, 3 AMPH social workers from mental health assessments have stated that this the treatment I require. My aunty who has a degree in neuroscience has also said the same, as well as a clinical psychologist Eve Bowyer who I was seeing privately prior to being hospitalized in February. The CMHT should note the 'Not so NICE guidelines for eupd by Laura Quinn and Eik' state do not 'Because DBT is the only therapy in NICE guidelines ensure DBT is not available' and do not 'dilute the model until barely recognisable e.g. 1 year treatment condensed into a 12 week group'. This exactly what the CMHT are doing by only offering a 12 week short term course. Michelle Bidder literally stated in a recent professionals meeting this is 'basically dbt we're offering'. Dr Provan stated that I need 1 year worth of DBT and Dr. Robertson stated a year and 6 months worth of DBT would be needed. The

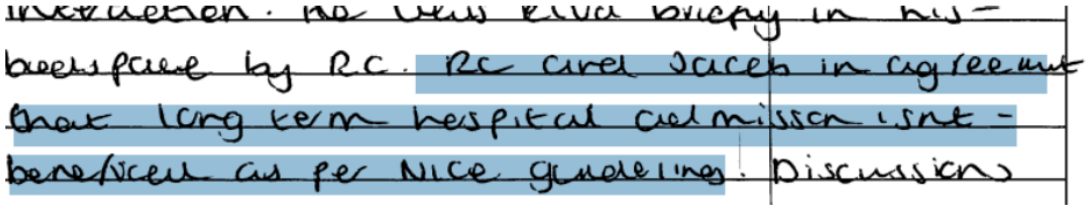
community mental health team are only offering me a brief psychological intervention, which does not give me an opportunity to develop and utilise all the skills that I need to be able to manage my condition and symptoms. Also note, NICE guidelines state 'not to use brief psychological interventions'

- Can I start DBT therapy in hospital as an inpatient and then continue long term in community? Dr. Menan given name of book - said psychologists could start the process on the ward.

- Can a clear plan be created to ensure adequate support for me in the community? Note:

07/03/2025

****MH3****



Ironic. Don't follow so called 'nice guidelines' only used when it suits them.

- Can Swansea Crisis team be held accountable and do better for me in future? When a person with borderline personality disorder presents during a crisis, consult the crisis plan and: • maintain a calm and non-threatening attitude • try to understand the crisis from the person's point of view • explore the person's reasons for distress • use empathic open questioning, including validating statements, to identify the onset and the course of the current problems • seek to stimulate reflection about solutions • avoid minimising the person's stated reasons for the crisis

- If interventions are required before DBT is considered appropriate, or to prepare for DBT, what are these interventions, how long will they be in place, and who has decided these interventions are necessary? If there is a delay in deciding what interventions are required – what support will I be given during this period?

- Will failures in Ward F be investigated and my concerns be taken seriously - urgent change needed for just for myself but others too. Jean Pike coroner's report ref to internal investigation by Swansea Bay Health board which found there is 'evidence of regular and effective communication between support staff, community staff and hospital staff' which has certainly not been my experience to date, nor others. Improved communication between ward and CHMT needed, improved safety standards. Staff need to be reminded of nursing standards,

disciplinary action, increased training and professionalism. Better management. Can you commit to using my experience as an example for much needed change?

- Can I give compliments to Cefn Coed nurses - excellent listen to me, acknowledge my views and support in times of distress. Don't further heighten me and agritave me as staff did on Ward F. Comparison is clear - if you see notes too less emotionally heightened here and calmer. Can you use Cefn Coed Fendroed as an example by Ward F as to how struggling patients should be treated by staff?

- Can Cefn Coed staff commit to continuing to support me? - view of nursing, clear presentation and how I should be supported. Can she seek?

- Evidence of regular and effective communication between support staff, community staff and hospital staff' - where is the evidence?

https://docs.google.com/document/d/1wGHmDiRMiD0Q_8WZA6dtdpBvSlK_w6kbvJdxQXqiAl8/edit?tab=t.0 - Finally others experiences too. Not just me alone. Services need to do better. Would be keen to meet again. Hopeful for a positive outcome. Plan of arrangements going forward and what is going to be done for me.