Swindon Safeguarding Partnership
Executive Summary
Safeguarding Adult Review – Alison

Introduction

Alison was a 49-year-old woman who was found collapsed in a stream in woodland near her home in July 2020. It was determined that she had taken her own life.

On the 2nd July 2020, the Police received a report from Alison's GP Surgery that she had visited to say goodbye. Alison had stated she was going to woods to hang herself. Police made phone contact with her and she reported that she was tying a ligature.

It transpired that she had consumed a quantity of alcohol, before placing the strap of her bag, around the back of her neck, with the strap being attached to the branch of a tree, causing a compression of the neck structures by the ligature.

Approximately 50 minutes later the National Police Air Service located Alison, adjacent to and half-in a river. Police and paramedics attended but were unable to resuscitate her. She was pronounced dead at the scene.

Alison reported a history of trauma as well as chronic mental health problems and a pattern of alcohol misuse. She had been engaged with the local Mental Health Services for at least 25 years. Her mental health history included: anxiety and depression, a diagnosis of emotionally unstable personality disorder, self-harm episodes including cutting, burning and overdoses, alcohol abuse and drug use. In particular she had an extensive history of previous suicide attempts and practitioners often found her difficult to help. Nonetheless, she had received extensive support and interventions.

She also had poor physical health with chronic liver disease (she was hepatitis C positive) and asthma. Evidence provided to this review suggests that Alison may have been subject to exploitation by her neighbours. She mentioned this issue in the final phone call to the surgery just before she died.

She lived alone and although she had family, contact was limited by the fact that they lived about ninety miles away. However, she had, at least, one friend who supported her and on occasions accompanied her to appointments.

Staff who knew her described her as "well-liked"; they worried about her and felt sorry for her. She is described as having a love of animals, walking and music and it is clear that pets were very important to her.

Key Findings

Alison took her own life and did so in a period of huge and unavoidable disruption to service provision. Nothing suggests that Alison was failed by any particular service, or that any particular decision could have significantly changed the course of these events. However, the case does raise a number of wider practice points which agencies need to consider.

- The management of complex clients with emotionally unstable personality disorder, substance use and suicidality is identified by both Mental Health Services and Adult Safeguarding as an issue that needs development. Both identify the lack of services for this client group. This is far from being a new issue, but the care of Alison suggests that this issue needs renewed attention and a new pathway in the area.

- Any pathway for clients like Alison is likely to be structured around the principles underpinning the Care Programme Approach: a consistent, coordinated and multi-agency approach which through relationship building over time identifies the best approach to Alison's needs.

- The boundary between primary and secondary care mental health support appears blurred in this case and was highlighted as an area requiring attention in the practitioner event.

- There are failings in risk assessment. The hospital in a minor but specific way seems to have wrongly assessed the risk associated with Alison on two occasions. More generally, but more importantly, Mental Health Services seem to have failed to recognise the level of risk of with Alison and have discharged her or not taken her on to the caseload. This is acknowledged in the Trust's own Patient Safety Report.

- Alison's repeated discharge by Mental Health Services was a specific concern of the SAR referral form submitted by her GP practice. It has been argued that this approach was justified by her negative reaction to closer working relationships. However, balanced against this are Alison's own comments, the GP's comments, and the issues of familiarity and risk highlighted in the Patient Safety Report. This is an approach which needs to be considered carefully and lessons learned about its effectiveness for any future work on the development of services for this client group.

- The impact of hepatitis C on the cognitive functioning and mood of clients should be considered when assessing clients with mental health problems.

- The safeguarding of people with serious mental health problems including suicide is a potentially blurred boundary with the risk of conflicting and overlapping responsibilities. This is acknowledged by the Safeguarding Team. This is another area that could benefit from multi-agency discussion and pathway development work.

- Practitioners using the two-stage test in the Mental Capacity Act should ensure that, in the second stage, they consider whether clients can *use or weigh*

information as well as *understand*, *retain* and *communicate* information. Complex clients with repetitive self-harming behaviours may be able to understand and recall information about the risks associated with, for example, going home and keeping themselves safe, but will be unable to *use* that information to keep themselves safe.

- All services should be using the AUDIT alcohol screening tool to identify and record the level of alcohol related risk for clients. This provides a standardised and readily communicated way of talking about alcohol related harm.

- Alison is a reminder that mental health services need to have a focus on smoking cessation with this client group.

- It is clear that the Covid-19 lockdown had an effect on the ability of services to support this patient.

Recommendations

A. The CCG, Mental Health Trust, Adult Safeguarding, Adult Social Care, Substance Misuse Services and other relevant agencies should develop a clear approach and pathway to complex clients with emotionally unstable personality disorder, substance use and suicidality. This should identify the need for further service development.

B. The SSP should seek assurance from Mental Health Services that they are applying the principles dynamic risk assessment informing care plans and multi-agency working to complex and mentally disordered individuals, including those with emotionally unstable personality disorder and suicidality.

C. The SSP should remind all partner agencies of the need to ensure that risk assessment procedures are regularly reviewed and training updated.

D. The SSP should ensure that risk assessment training reminds practitioners of the danger that familiarity with a client can lead to an unjustified minimisation of the risks they pose.

E. The Public Health team should ensure that all services are aware of the impact of hepatitis C on the cognitive functioning and mood of clients.

F. The SSP should initiate work to clarify the boundary between primary and secondary mental health care including the development and implementation of a new process for managing patients who have significant long term suicidal ideation.

G. The SSP should ensure that mental capacity training emphasises that those using the two stage test in the Mental Capacity Act should consider all four

criteria in the second stage of the test when assessing people, in particular the third criterion: *can someone use or weigh information*.

H. The Public Health Team should ensure that all frontline services use robust alcohol screening tools such as the AUDIT tool to identify and record the level of alcohol related risk for clients.

I. The SSP should seek assurance from the Public Health Team that smoking cessation work is targeted at the clients of Mental Health Services.

J. The SSP should share this SAR report and its recommendations with the Public Health team.

K. With clients like Alison, agencies should ensure that regular multi-agency meetings are taking place, to put in place a risk-mitigation plan and ensure that all risks are mitigated as far as possible.