SAFEGUARDING ADULT REVIEW

Executive Summary

“Louise”

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1. Introduction

This Executive Summary Of the full SAR Report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of Surrey Safeguarding Adults Board (SSAB), relating to the care of an adult (referred to as Louise throughout this report to preserve her anonymity). The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Surrey in the future.

1.2. Brief Summary of the case

On the 31/03/21 Louise was discovered by Surrey Police to have died at home, with some evidence to suspect that this was caused by an overdose of medication. She had been known to mental health services and had recently been discharged from a psychiatric hospital admission under S2 (MHA '83) (25/03/21) less than a week before she died. This hospital admission arose following a previous overdose attempt on 23/02/21, whereby her son found her at home and called an ambulance, leading to her hospital admission in Epsom, initially to the High Dependency Unit and subsequently to her transfer to psychiatric hospital for her final admission on 04/03/21.

Louise had been in a relationship for over 10 years with a man whom she lived with (Tom), she had a son (Owen) and daughter (Elaine) from a previous relationship, while Tom had a daughter. Tom had suffered a stroke 2 years previously and Louise reported his behaviour had changed since this time. Louise had made some allegations about domestic abuse from Tom, but these were disputed by both her children and his daughter. She was referred by the police to both Adult Services and subsequently to MARAC and local domestic abuse services following these allegations. Tom had been arrested and bailed with conditions not to return to the family home. Louise had previously been referred for both counselling and medication by her GP for depression and stress. Louise had also identified a legal dispute with tenants of a flat she owned as a significant cause of stress for her, which she was struggling with.

1.3. Terms of Reference for the SAR

1. How well did agencies work together to assess and manage the risks of suicide associated with Louise's mental health and alcohol use?
2. When concerns were raised about domestic abuse for Louise and Tom, what do the responses in this case tell local services about the complexities and pathways used to explore this area of practice where an adult may be the source of harm rather than at risk?
3. When Louise and Tom came to the attention of local services with long standing health issues, were services sufficiently thorough in gathering and sharing information about these?
4. How well were the whole family involved in assessments and services offered to both adults during the period subject to review?
5. What was the effectiveness of responses using the Care Act responsibilities to Louise and anyone else involved with the situation (including those to Tom)?

2. Analysis of Practice against Terms of Reference

2.1. How well did agencies work together to assess and manage the risks of suicide associated with Louise's mental health and alcohol use?

Considering the information gathered during this review for Louise; (that she had taken an overdose while living alone and police found her at home. She was subsequently admitted to

hospital, assessed, and detained under S2 MHA'83, spent 2 weeks in a mental health unit before being discharged and then 6 days later died by another overdose). The question arises whether risk of this was sufficiently assessed & managed at several points during the period when she was in contact with services, before, during and after her admission for assessment of her mental health.

"Borderline personality disorder (BPD) is associated with both suicidal behaviours and self-harm. Up to 10% of BPD patients will die by suicide. However, no research data support the effectiveness of suicide prevention in this disorder, and hospitalization has not been shown to be useful. The most evidence-based treatment methods for BPD are specifically designed psychotherapies"[1].

The suitability of mental health treatment at home for socially isolated people in suicidal distress, or those with limited perceived social support, needs to be reviewed and considered on a case-by-case basis. Additionally, home treatment may not be appropriate if the home environment has the potential to exacerbate a mental health crisis. For Louise this was significant as she was thought by her son to be at additional risk if sent home to live by herself, and she continued to be stressed by her court case. She had no support at home and was no visited by any agency apart from police, prior to her death.

In terms of multi-agency work, it was significant that Louise was discussed at the MARAC on the same day that she was discharged home, although only the IDVA seemed to be initially aware of both events occurring almost simultaneously. The IDVA also shared concern about Louise's future risk of suicide at the MARAC and requested a safety plan before her discharge. However, no safety plan was put in place for her.

The history of Louise's previous suicide attempts and contact with mental health services in Tolworth was not explored after her son shared this, to inform any suicide risk assessment at the point of discharge to the community.

For patients who are at risk of suicide, the care plans will need to include a Safety Plan, co-produced with the patient. This should have explicit reference to removal and/or mitigation of means to harm themselves and information on how to access psychological and social support'[2].

(Relates to Finding 1 and Recommendations 1 & 2)

2.2. When concerns were raised about domestic abuse for Louise and Tom, what do the responses in this case tell local services about the complexities and pathways used to explore this area of practice where an adult may be the source of harm rather than at risk?

The contact with services around the relationship between Louise and Tom was clearly complicated by Louise's statements concerning violence from Tom at the time, or after incidents. There were several incidents of violence however these were not sufficiently clarified to determine the nature of risk of domestic abuse and whether she had fabricated her accounts to police and health services. These were all shared with ASC, either as a SCARF from police, which were passed to the ASC MH team, or as a safeguarding concern, which were passed to the ASC MASH team.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6632023/

[2] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10

The ASC MASH Team triaged a referral as eligible for a S42 Safeguarding Enquiry, which was undertaken by a social work student from a locality team. The outcome following contact with her son, (based on this it was determined that Louise had fabricated her version of events and there had been no Domestic Abuse from Tom), the S42 Enquiry was closed on 16/03, by which time Louise was detained in psychiatric hospital.

- Neither Tom, nor Louise had been spoken to during this S42 Enquiry, which was a significant gap in practice and did not meet expectations for a person led enquiry, as set out in the statutory guidance.
- Paragraph 14.15 Care and Support statutory guidance states: "Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."

Tom was then identified as a potential adult at risk rather than Louise following the above S42 Enquiry and the charges/bail conditions were dropped by police on 15/03. However, there was no safeguarding work done nor attempted with Tom.

Louise's case was then discussed at a MARAC meeting on the 25/03, where she was still viewed as an adult at risk rather than a source of harm to Tom. ASC MASH records for the MARAC noted "it was complicated", but it was unclear whether this informed any consideration of risks from Louise to Tom at the MARAC. This highlights how different information about DA was held by the various agencies and a review of the MARAC practice could better inform multi agency safeguarding discussions, especially if representatives from agencies working with the adult were not represented at the meeting. There are also now IDVAs in Emergency Depts to provide specialist DA consultancy, advice and training to health staff. This would have assisted with support to nursing staff who saw Louise when she was brought to hospital, to explore the complexities of her relationship with Tom prior to raising him as an alleged perpetrator with MARAC.

(Relates to Finding 2 and Recommendation 3)

2.3. When Louise and Tom came to the attention of local services with long standing health issues, were services sufficiently thorough in gathering and sharing information about these?

Louise lived with Tom for over 10 years prior to the period subject to review and had not come to the attention of services until the incident in 2018, when Louise alleged Tom had punched her. Louise stated that his behaviour had changed following a stroke in 2016, becoming more violent since this time. He was arrested but Louise refused to make a statement and he was released. Police shared information about the incident with ASC via a SCARF and attempts were made to offer Tom an assessment, which were refused by him, and the case was closed in line with Section 11 (1) of the Care Act 2014.

Information regarding Louise's mental health history prior to the period subject to the review was given by her family at several points; her son reported her history of depression and suicide attempts when she was taken to ED. Due to the seriousness of the overdose the recommendations of psychiatric liaison included preventing Louise leave hospital prior to a MHA assessment and gathering background on her history from her family and South London Mental Health Services. As part of the subsequent MHA assessment, her family did report a

history of contact with a CMHT, prior admissions under the MHA and suicide attempts During her subsequent admission the senior ward nurse did gather some more information on her mental health history from her family. This included some details of admission to Tolworth Hospital in 2000, having been found at Beachy Head, found unconscious with a noose round her neck and a previous overdose. The context of these were reported to be stressful life events and alcohol intoxication.

No further details of her history of contact with services were sought by any mental health practitioner directly from the previous mental health services, which may have informed the current inpatient care plan, medication, or other treatment and also a pre-discharge risk assessment/safety plan. There were multiple opportunities to do this as set out above, by ED Psychiatric liaison services, by the AMHP and then by the inpatient team of Spenser Ward. This does indicate a possible system issue about whose responsibility this is and at what point it would be expected practice?

(Relates to Finding 3 and Recommendation 4)

2.4. How well were the whole family involved in assessments and services offered to both adults during the period subject to review?

Louise did have an AMHP assessment, and her son was consulted as part of this assessment, which resulted in an admission under S2 MHA'83, which he agreed with. Both her son and daughter were spoken with during her subsequent formal mental health admission and her son was invited to participate in ward rounds, including the discharge CPA. This consultation identified her mental health history, the violence and control to Tom and her history of excessive alcohol use. This therefore provided useful information for mental health services, however as explained above it was not pursued for more details at the time.

It was also significant that her son expressed a lot of concern about the risk of Louise being discharged home from hospital. Louise's son was involved in the S42 Enquiry and his view that her version of domestic abuse from Tom was fabricated was used as the major reason to conclude the outcome of the enquiry that this was unsubstantiated, as she had not suffered any abuse. The complexity of their relationship and his removal from the home led to the loss of a protective factor for Louise, which was not considered as part of her discharge from hospital, prior to her death by overdose. Tom was not contacted, nor involved in the work done with Louise either during or after her admission and he felt excluded by professionals when he knew her best.

(Relates to Finding 4 and Recommendation 5)

2.5. What was the effectiveness of responses using the Care Act responsibilities to Louise and anyone else involved with the situation (including those to Tom)?

Neither Tom, nor Louise had a formal assessment under the Care Act 2014, for an assessment of needs for care and support (Section 9), or for a carers support need (Section 10). Tom was offered an assessment at 2 points during the chronology, but he declined this on both occasions. The question arose as to whether there was an appearance of needs which should have prompted a S9 assessment for Louise, arising from her mental health problems and for Tom following information about his previous stroke and change in his behaviour/mobility.

There was a Section 42 Safeguarding Enquiry undertaken for Louise and her son was consulted during that process. It appeared from the information provided that the decision to close the S42 was appropriate on the basis that no abuse was thought to have occurred to

Louise, according to Louise's son, however there were missed opportunities to involve both Louise and Tom prior to this decision.

Furthermore, given that a S42 Safeguarding enquiry was undertaken for Louise this would give rise to a duty to assess her needs, given that the decision that s42(1) Care Act criteria were met on the basis that her alcohol issues may have caused her to have care and support needs, which then should have prompted a formal duty to assess her needs, under s11(2)(b) Care Act 2014[3], so the assessment should have been carried out even it if it were in the face of objections by Louise.

Also, given that following discussions with Louise's son about violence and control from Louise to Tom, this also could have given rise to a consideration for both a S42.1 Safeguarding duties for Tom as a potential adult at risk. This would be expected to have been undertaken, which could have given rise to subsequent equivalent duties for him under the S11 (2) (b) duties to assess his needs, whether or not he objected to this.

As this was an extremely complex situation, where there were concerns about both Louise and Tom, if a thorough assessment had been undertaken with Louise and Tom in line with both Safeguarding duties and Care and Support needs being explored this would have helped clarify the risks for both adults. The fact that Louise's case was allocated to a student social worker to undertake the S42 Enquiry appears to have been extremely challenging for them to fully appreciate and meet all the potential Care Act responsibilities for her and the subsequent concerns arising about Tom.

Social Work England's guidance on Practice Placements does not specify whether a Student can undertake a S42 Enquiry, while on placement, however it does set out clear expectations around level of complexity of cases which are appropriate, depending on the experience of the student and with sufficient support and supervision from a work placed supervisor/practice educator.

(Relates to Finding 5 and Recommendations 6 & 7)

[3] https://www.legislation.gov.uk/ukpga/2014/23/section/11/enacted

3. Findings and Recommendations from the Review

Finding 1

Risk assessment and management of suicide for adults is a complex process requiring careful consideration of both relevant risk and protective factors prior to discharge from formal hospital admission, following a suicide attempt. Where these factors are not collated and adults are discharged home alone without a suitable safety plan being formulated and agreed with relevant agencies, the adult and their family, adults may be left at high risk of further imminent suicide attempts.

Recommendation 1

SSAB to receive assurance from partner agencies that their suicide risk and prevention strategies include a commitment to develop suicide risk and safety plans with adults and their families (where appropriate), (in line with NICE guidelines on self-harm 2022) by a lead professional, following a serious incident of self-harm or a suspected suicide attempt.

Recommendation 2

SABP to share learning with the SSAB of an audit of the pre-discharge planning process as part of the Trust suicide prevention strategy, in line with NICE Guidelines. The audit should include a review of how well all known risk factors for suicide (such as substance misuse and domestic abuse) are documented in a person-centred risk assessment. Also, whether a risk of suicide safety plan/crisis plan was done with sufficient input from relevant agencies and whether this was led by the SABP Care Coordinator in line with the Trust Clinical Risk Assessment and Management Policy and Procedures.

Finding 2

MARAC meetings are an important forum for information sharing and action planning to manage complex cases of domestic abuse. For the MARAC to be effective all agencies are expected to both provide relevant single agency information and where currently involved with the adults, the allocated workers are also expected to attend. If this does not happen it is likely that there will be gaps in the information available to the meeting and this can negatively impact on the quality of subsequent measures taken to manage complex and high-risk cases.

Recommendation 3

For MARAC Lead Agencies (Surrey CC and Police) to report to the Domestic Abuse Management Board on all agencies' meeting attendance, with a robust process to manage attendance and to include whether key practitioners currently working with the adult are also invited to attend the meeting.

Recommendation 4

For SABP to report to the Safeguarding Adult Board on how they can seek to improve both the awareness of MARAC and representation at MARAC meetings from inpatient services for adults in mental health and acute hospitals at the time of MARAC meetings.

Finding 3
Where adults who become known to mental health services in Surrey and have a history of previous contact with other mental health services as reported by family members, it is important that this background information is sought directly from previous services. This may help inform current diagnoses, treatment plans and risk assessments.

Recommendation 5
SaBP to review their procedures and provide assurance the SSAB that these include a process to gather previous contact directly with other mental health services and that this is sought by the relevant mental health professional, where this is reported as part of initial assessments for new patients.

Recommendation 6
SaBP to review their procedures and provide assurance the SSAB that these include a process to gather previous contact directly with other mental health services and that this is sought by the relevant mental health professional, where this is reported as part of initial assessments for new patients.

Finding 4
The meaningful involvement of the adult and their family is an important part of statutory responsibilities, under the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 1983. Effective consultation requires careful consideration of information sharing both with and in some instances without the consent of the adult, which poses complex decisions and challenges for staff in Adult Social Care and Mental Health services.

Recommendation 7
SSAB to seek assurance from Adult Social Care and SABP following a review of how decisions are made regarding who to consult with and involve from the adult's informal support network during key decisions and statutory duties, including whether the adult was involved in these decisions.

Finding 5
The duties for local authorities undertaking Care Act Assessments of Need and Safeguarding Enquiries provide a helpful structure for the involvement of adults and their families in a process of multi-agency assessments. This is particularly valuable in complex cases, where adults have not previously known to local services and present with multiple risk factors, such as mental health, substance misuses, domestic abuse and risks of suicide. Where these processes are not undertaken, based on a presumption on the outcome or eligibility, this opportunity is lost. If the thresholds are met it is important that Surrey ASC are able to both suitably identify and meet their duties under S9, 10, 11.(2) (b) and 42 irrespective of the anticipated outcome of these processes.

Recommendation 8
SSAB are assured by ASC that all qualified staff are aware of their Care Act responsibilities and that ASC are able to meet these duties for all adults at potential risk of abuse and/or appear to have needs for care and support, through a review of current knowledge and competencies of the workforce.

Recommendation 9

For ASC to further review the practice of allocating Safeguarding Adults Enquiries to Student Social Workers on placements, to assure the SSAB that sufficient support, supervision and guidance is in place to ensure that Care Act duties are being met and that students do not hold high risk statutory cases, which exceed their level of experience and competence.