Executive Summary

“Ella”

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February 2024

Executive Summary

This executive summary and report has been anonymised to protect the confidentiality of the person who is the subject of the report and their family.

Background

Ella was a 33-year-old woman who took her own life on 13th October 2018 while an informal inpatient at the Abraham Cowley Unit in Chertsey, run by the Surrey and Borders Partnership NHS Foundation Trust (SaBP).

This review looks at the care and support received by Ella during 2018, in the ten months leading to her death. It looks briefly at her background and issues of relevance outside that timescale, and Ella's parents have provided a short piece to describe their child from their perspective.

Ella had several episodes of care under the local mental health service during the 2010's and was diagnosed with anorexia nervosa in 2016. She had taken an overdose in 2016 with the reported intention of ending her life and was drinking alcohol to excess.

Circumstances leading to Ella's death

During the first half of 2018, Ella was receiving support from the secondary mental health services mainly in the context of her excessive alcohol use. She was referred to i-access, the local drug and alcohol service and also spent four weeks in a private alcohol rehabilitation placement in Guildford. Despite giving her consent to share information, there appears to have been little liaison between the programme and the mental health team.

While on holiday with her parents in July, Ella disclosed a historic sexual assault by someone she knew, and this appears to have been a watershed moment for her mental health. Following her return from holiday, she experienced an increasingly intense mental health crisis, leading to her being found three times by the police in an intoxicated and distressed state, expressing suicidal ideation and exhibiting intent.

On the latter two occasions, the police detained Ella under the Mental Health Act (MHA) section 136. On both occasions she agreed to admission to hospital but no female beds were available, leading to her remaining in the assessment suite for at least 30 hours each time. On the first occasion Ella changed her mind and left the hospital, only to become more distressed and intoxicated within hours. On the second occasion she agreed to stay beyond the limits of the detention period until a bed was found.

Ella received support from an Independent Sexual Violence Advisor, referred by the police, but extremely limited input from the mental health service. At the first appointment after Ella's disclosure, the nurse decided not to discuss the disclosure with her, as she felt it was not appropriate. This was despite Ella's own statement that she felt that her mental health problems stemmed from this assault.

Ella remained an informal patient following her admission to hospital. Consideration was given to detention under the MHA but following discussion with Ella and her father, it was decided not to proceed down that route. Ella continued to leave the ward and become intoxicated, including putting herself in sexually vulnerable situations.

At the point of Ella's final departure from the ward, she was reported missing and it was reported that she was suicidal, but the police recorded her as medium rather than high risk. there was a considerable delay before a police unit attended the ward, and

a further delay before her notes were reviewed and her risk level was increased to high.

Key Themes

The main factors regarding the circumstances of Ella's tragic death relate to short-, medium- and long-term issues.

In the period immediately following the missing person's report, the risk to Ella was wrongly reported as medium, despite substantial evidence of a high risk of suicide. This contributed to a considerable delay before the police attended the ward, and the risk level was not amended until 12 hours later.

On the two occasions that assessments determined that Ella required hospital admission, no female beds were available and a considerable delay took place. On the first occasion Ella changed her mind and decided to leave the hospital, putting herself at further risk. On the second occasion she remained despite the fact that the authority to hold her, provided by the MHA, had expired.

In the longer term, the report identifies a failure by the mental health service to respond to a very significant disclosure by Ella, which appears to have been a significant factor in her developing mental health crisis during the second half of 2018, and which she herself identified as a factor in her mental health problems.

In the context of this developing crisis, there is evidence of a lack of strategic planning in relation to the care being offered to Ella. On more than one occasion, internal discussions imply that Ella's case was about to be closed to the secondary service and she would be discharged back to her GP. Other records are considering ongoing work. While Ella was described as calm and engaging on the ward, there was limited recognition of the high and increasing risk of suicide when under the influence of alcohol, which continued to occur when she left the ward.

Recommendations

These recommendations are made in the knowledge that each agency has already completed their respective internal management reviews and has made their own conclusions and recommendations for practice.

This review will reference some of the actions proposed or taken within the various reviews.

Recommendation 1
Surrey Police has recommended that duty officers should always research the Niche recording system when carrying out risk assessments relating to missing persons, including those missing from hospital. This is in order to fully inform risk assessment and grading.

- **Comment from Surrey Police on actions taken since the incident**: The requirement to conduct historic research before completing a risk assessment on a missing person is now embedded in policy and a reminder about this was circulated by internal communications in 2020 and is reinforced in Continuous Professional Development (CPD) Training. To support the process, it is now practice for the Force Control Room or Contact Centre to copy/paste the missing person history onto the incident record for a missing person to assist in 'live' decision making and a question about suicide risk is specifically included in the risk assessment template for missing people

Recommendation 2
Surrey Police has recommended that 'flags' or 'alerts' are created on the Niche recording system as per policy, following incidents involving suicidal behaviour.

- **Comment from Surrey Police on actions taken since the incident**: Since 2020 Surrey Police have employed a Suicide Prevention Officer who is responsible for managing our response to all suicides, attempted suicide and potential suicide incidents and one of her roles is to ensure that the appropriate markers are placed on NICHE (our primary computer system) and the Police National Computer.

Recommendation 3
SaBP has recommended a review of safeguarding adult reporting for the now non-integrated teams. [the mental health service was integrated with the local authority at the time of the incident, under a section 75 agreement which came to an end in November 2019.]

Further recommendations are made by this review

Recommendation 4
The County Council and SaBP are supported in addressing the issues of sexual violence and the impacts of historic abuse and trauma on individuals' well-being and mental health, beyond the immediate physical risks.

Recommendation 5
The learning from the work on sexual violence and trauma is shared across the SAB partners.

Recommendation 6
Staff at Primrose Lodge are supported to work with service users/patients to manage issues of confidentiality and discuss the advantages of information sharing between agencies for the purpose of coordination of support plans.

Recommendation 7
SaBP develops a monitoring process to identify delays in admission to hospital and an escalation process to respond to delays. In the light of the data the mental health trust reviews its processes to minimise delays in admissions

Recommendation 8
The SAB takes the issue of delays to admission to the national SAB Chairs Network, to raise it as a national issue.

Recommendation 9
SaBP Inpatient care planning processes are reviewed to ensure that risks are adequately covered and plans appropriately updated.

Recommendation 10
SaBP ensures there are clear guidelines on 'leave' and 'escorted leave' for informal patients, and that any patients whose risk requires that level of supervision and restriction are subject to the appropriate legal framework.

Recommendation 11
In the context of the 'Right Care Right Person' policy being extended nationwide, the County Council, SaBP and police ensure a clear multi-agency understanding of each other's roles, and the importance of effective understanding of the need to respond to a 'real and immediate risk to life or serious harm'.

Recommendation 12
The SAB ensures that the learning from the development of the 'Right Care Right Person' policy is shared across the multi-agency.