Northamptonshire Safeguarding Adults Board

Learning from Safeguarding Adult Reviews

Key findings and learning from a Learning Review - Ref 020 'William'

The Purpose of a Safeguarding Adults Review (SAR) is to review a specific case to promote learning and improve practice where there is concern that partner agencies could have worked together more effectively to protect the adult at risk. A SAR will not investigate or apportion blame but supports professionals to adjust practice in light of the lessons learnt from the review.

Safeguarding Boards also carry out non-statutory reviews where it is thought there is valuable learning for partners. It is under this provision that this briefing is provided.

Sharing Learning from both local and national Safeguarding Adult Reviews (SAR) and other reviews is a key priority for Northamptonshire Safeguarding Adults Board (NSAB). Following a review, a detailed action log is developed and the progress is monitored via NSAB's Quality and Performance Sub Group.

This learning briefing summarises the key findings and recommendations arising from an initial review of information gathered and a Coroner's inquest.

Managers should discuss this briefing with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded.

The Learning Review relates to the sad circumstances of a man who died through suicide in 2018. He is referred to here as 'William', a pseudonym. Details have been redacted to protect his privacy.

William was supported by his GP and through Increasing Access to Psychological Therapies (IAPT). Ten days before he died, he had been referred to the Primary Care Liaison Worker (PCLW) but was not seen.

Two days before his death, William was seen in another county by a Hospital Emergency Department, Police custody and assessed by the Criminal Justice Liaison Service.

SAR Sub Group members and the NSAB Independent Chair initially agreed that the criteria for a SAR was met. However, from the information gathered by agencies in Northamptonshire and out of county, it became apparent that the case did not in fact meet the criteria for a SAR, but nonetheless, there was important learning that could be disseminated and a table top exercise was undertaken by the Independent Author.

The Learning Review

This briefing was written by the Independent Author who was commissioned following the referral for a Safeguarding Adult Review. The reviewer had access to agency chronologies; initial reports relating to events; statements provided to the Coroner and final summations from the inquest.

Outline of the Circumstances of William's Death

William was a man in his thirties. He had a loving and supportive family and was in a relationship at the time of his death. He had a large group of friends and a successful career. However, he struggled with anxiety and depression. William was receiving treatment for his anxiety and depression through his GP with whom he seemed to have a good relationship. He was treated with a combination of medication and psychological interventions from the IAPT stage 2 service.

During 2018, William's GP felt that his mental health was deteriorating, increasing his risk of self-harm or suicide. The GP made a referral to Primary Care Liaison. The Primary Care Liaison Worker (PCLW) did not make direct contact with William, but spoke with an Increasing Access to Psychological Therapies (IAPT) stage 2 worker. They agreed that the IAPT worker would assess William at his next appointment. When William was next seen by IAPT, he described fleeting thoughts of suicide, some intent to act on these thoughts and that he was not able to guarantee his safety. William was offered a waiting list appointment for Step 3 Cognitive Behavioural Therapy (CBT) that he had previously benefited from. He was also provided with emergency contacts including the Mental Health Crisis Team.

Outline of the Circumstances of William's Death

Those that knew William, thought he was improving. Sadly, what is now known is that William was researching where he could go to end his life. He travelled down to the south coast and was picked up by police due to his erratic driving and on suspicion of drunk driving. He sustained a minor injury during a police chase and was taken to the local Emergency Department (ED).

William described to the ED Doctor that he had been feeling suicidal for three to four days and had made a plan to drive to the coast to drown himself; he also admitted to drinking alcohol. He was referred to the Dorset Healthcare University Foundation Trust Mental Health Liaison Nurse but could not be seen due to their workload.

As William was medically fit for discharge, he was released to police custody with a discharge letter. The information William had given to the ED Doctor does not appear to have been shared with the police.

William was risk assessed by the Custody Sergeant and by the Custody Health Care Professional as he complained that he had pains in his chest. It was reported that he was very anxious and tense. No significant risks were identified. He asked to speak to his father but when called, there was no reply.

The Criminal Justice Liaison Service (CJLS) were asked to assess William and he informed them of his anxiety and depression and that he was receiving treatment by his GP and having CBT. William minimised his recent behaviour as 'having had a few drinks after work and deciding to drive down the motorway to clear his head' and he denied he had ever self-harmed or felt suicidal and denied current thoughts of suicide.

The CJLS opinion was that William was not depressed or psychotic. He had a clear plan to return to Northampton by train where he was already receiving support services. CJLS did not review his electronic Primary Care records. This assessment was shared with the Police Custody Sergeant.

Meanwhile, William's father had reported his son as a missing person to Northamptonshire Police. Dorset Police responded to say he was in their custody. Police concluded their interview with William and confirmed he had the financial means to return home and that his plan was to get the next train back to Northamptonshire. He was duly released from custody.

The following night, Northamptonshire Police contacted Dorset Police again as William's father had subsequently found a note on his computer that appeared to be a suicide note written two days before he went missing. However, William had already been released from custody. As no mobile phone had been recorded in his belongings, there was no means to contact him. Both police forces made efforts to trace William, but sadly, the following day, William's body was found; he had ended his life by hanging himself in a local wood.

Conclusions

The Coroner concluded that William had died by suicide. The Coroner must judge whether any actions or omissions contributed to the person's death. This is based upon a test of whether on the balance of probabilities, the actions or omissions made more than a minimal difference to the final outcome. The Coroner's view was that the 'evidence does not allow me to find any act or omission that taken separately or aggregated together that on balance contributed to William's death. Nonetheless, in reviewing the evidence, there was valuable learning for agencies and that changes had occurred as a consequence'.

What has been Learned by Services in Northamptonshire?

Direct Assessment:
An urgent referral was made to PCLW but was not responded to within the standard of two working days. Custom and practice had developed to gather further information without always making direct contact with the service user.

Working within Professional Limitations:
It was inappropriate to expect the IAPT worker to risk assess William. The stage 2 IAPT worker had not the training or skills to do so. It was a missed opportunity for the PCLW to carry out an assessment, engage with him and encourage him to disclose his suicidal thoughts.

Avoiding Assumptions:
When William saw his IAPT worker, there was clear evidence of a marked deterioration, but the worker's supervisors did not view a referral to PCLW was required. This was based on an assumption that William had already been assessed by PCLW. This should have been verified rather than assumptions made.

What has been Learned by Services in Northamptonshire?

Northamptonshire Healthcare NHS Foundation Trust (NHFT) have since completed a Serious Incident Investigation and actions have been put in place. *Assurance and evidence will be sought from NHFT via the Quality & Performance Sub Group that actions have been completed.*

What has been Learned by Services in Poole and Dorset?

Sharing Information

Poole Emergency Department staff held key information regarding William's suicidal thinking. Had this been communicated to police, it would have informed their risk assessment of William and provided the CJLS with important information for their clinical assessment. In the absence of this information, it was not unreasonable that CJLS assessed William's risk as low.

Accessing Records and Involving Families

CJLS practice at that time was not to interrogate Systm1 electronic records. This was largely due to the number of different electronic record systems that could potentially be relevant to a person in custody and the constraints on resources. Also, CJLS did not seek permission to speak with his family. Had Systm1 been viewed and information gathered from the family, this is likely to have provided a very different picture of William's risk to himself. Electronic record systems vary between different parts of the Health system and creates barriers to effective communication between key services such as mental health teams and staff in general hospitals. This calls for greater attention to developing mechanisms to share information across the system.

Pressures in the System

William described to the Emergency Department (ED) Doctor that he had been feeling suicidal for three to four days and had made a plan to drive to the coast to drown himself; he also admitted to drinking alcohol. He was referred to the Mental Health Liaison Nurse but could not be seen within the hospital setting in a timely way. Local protocols are such that a full mental health assessment would take place via the Criminal Liaison Justice Service, so although he was not seen by psychiatric liaison in the hospital, he was medically fit for discharge and the decision was made for him to be discharged into police custody where an assessment took place.

The local ED had information regarding William's suicidal thinking was communicated to the police; and the expectation was, as is local policy, that the Criminal Justice Liaison Team would assess William's mental health whilst in custody. Subsequently and whilst in custody William minimised how he was feeling.

Bournemouth, Christchurch and Poole Safeguarding Adults Board will monitor agency actions and confirm to Northamptonshire Safeguarding Adults Board when these have been completed.

Agency Learning from the Incident

Key learning identified: The Coroner was satisfied that agencies had made changes following the lessons learned during the time since the suicide occurred including:

- NHFT has strengthened their policy and protocol relating to response times and direct assessment.
- At the time of the incident, it was not routine practice for the CJLS to access Systm1 for adults, but CJLS staff are now trained in Systm1 and routinely check electronic records for people they are assessing and they also contact families (where appropriate).

Additional learning identified in this review:

- It was wrong to assume that an assessment had been carried out by the Primary Care Liaison Worker. This was a missed opportunity.
- Poole Emergency Department had information regarding William's suicidal thinking, but this wasn't communicated to the police; instead there was an expectation that the Criminal Justice Liaison Team would assess William's mental health whilst in custody. Subsequently and whilst in custody, William minimised how he was feeling.

Good Practice

William had a good relationship with his GP and his GP had built a good rapport with him. The treatment was in line with national guideline (NICE), combining medication with psychological therapy. His GP was attuned to signs of deterioration and referred on appropriately.

Key Points for Learning

This sad event highlights once more, the importance of communication between agencies and gathering and collating all of the relevant information. No one agency or professional will have a full picture of a person, their needs and risks or have all the solutions to help a person in mental health crisis.

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