Safeguarding Adult Review - Alison

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Acknowledgement

Members of the Swindon Safeguarding Partnership (SSP) and the independent reviewer express their sincere regret at the death of Alison. Sincere condolences are offered to her relatives and friends.

The reviewer, working with SSP members, hope and intend that this review will enable lessons to be learned and will contribute to service development and improvement.

January 2022

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1. 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.

2. Safeguarding Adult Reviews

Swindon Safeguarding Partnership (SSP) has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SSP knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SSP knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the SSP, its members or others worked together to safeguard the adult.

(Adapted from sections 44(1)-(3) & (5), Care Act 2014)

The SSP also has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect include self-neglect.

SSP members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

The referral for consideration of this case for a SAR was sent by Alison's GP practice on 8th July 2020. The referral indicated concern that Alison committed suicide following long term mental health issues, and possible criminal exploitation from her neighbours. It was reported that Alison had been seen to be terrified of the neighbours when she saw them in the GP surgery just prior to her death. She disclosed that they had some of her money at that time. In the Practice's SAR referral, under the heading *characteristics of the case,* drug abuse, alcohol abuse, and mental health were indicated.

The SAR referral commented that: *The mental health team repeatedly discharged this lady who was actively suicidal on a background of exploitation by her neighbours.* The referral raised parallels with DHR5, which involved the same surgery and, in particular, the mental health team repeatedly discharging someone who was actively suicidal and saying they were unable to help them.

After discussion both the chair of the SSP and the SSP's Practice Review Group agreed that a review would take place because the case raised issues in relation to:

1. Agency and practitioner safeguarding responses to adults who are being coerced, controlled or exploited, including via s42 enquiry process.
2. The effectiveness of multi-agency arrangements to implement and review protection plans e.g. did all agencies know about the safeguarding plan and what support did it provide to Alison and by whom?
3. Impact of Covid-19 on service delivery to adults with care and support needs.
4. Co-ordination of support to adults with mental health needs e.g. a clear plan and a lead agency.

The independent overview report writer was commissioned to undertake the review in January 2021.

It was agreed that the period under review would be from 7th October 2019 (when a safeguarding referral was made) through to 2nd July 2020 (the date when Alison died).

The following agencies which had commissioned or provided services to Alison contributed to the review alongside the independent overview report writer.

- SSP Development Manager
- Swindon Borough Council MCA/DoLS Team

- Swindon Borough Council Adult Safeguarding Team
- Avon and Wiltshire Mental Health Partnership NHS Trust AWP
- GP Ridgeway View Family Practice
- Great Western Hospitals NHS Foundation Trust
- South Western Ambulance Service Foundation Trust
- Mike Ward (Independent overview report writer)

The Practice Review Group received administrative support from the SSP Business Support Officer.

3. Review Process

The independent overview report writer was supplied with a series of relevant documents:

- Patient Safety Investigation Report 2020/12882
- Swindon DHR 5 (for comparison)
- A standard information form from each agency involved (including nil returns)
- Terms of Reference for the SAR

A SAR Panel Meeting Group was held on 19/02/2021 to discuss the process and timeline of the review.

A Practitioner Reflection Day was held on 18/05/2021 and was attended by 11 practitioners from 7 different agencies. At this event, the report writer presented a series of initial thoughts about the response to Alison. These were discussed and agencies were given another two weeks to send further information and thoughts that flowed from the reflection day.

All this information was analysed by the report writer and an initial draft of this report was produced and this went to the Practice Review Group on 6th July. Further changes were made over the next two months, particularly as a result of family input and a final draft was completed in September 2021.

4. Family involvement

It was initially reported that Alison had a distant relationship with her family and had very little contact with them. Therefore, it was believed that no family members, nor anyone outside of a professional setting, were able to provide a perspective on Alison's life. The practitioner event challenged that perception and it became clear that Alison's sister and parents were all alive and had had ongoing contact with her up until a relatively short time before her death e.g. Christmas 2019.

Contact was made with the family and Alison's sister provided a very powerful, seven page letter largely describing their childhood but also commenting on her as an adult. This letter inevitable gives a much more rounded picture of Alison than emerges from the case notes. For example, her sister writes: *Alison was reserved but confident, clever, sharp, sarcastic, physically strong, an amazing artist and musically gifted…Alison enjoyed art and could replicate drawings and paintings and spent many hours doodling with a biro creating impressive pieces of work…One year she was*

given a small Casio keyboard for her birthday, and she taught herself different tunes without any guidance or tuition. She later taught herself to play guitar. She would sit in her room and practice until she had mastered the tune and then perform it to everyone…Alison always enjoyed being outdoors; she would cycle for miles and be out for hours on her Raleigh Racer bike. She was happy doing this on her own. I recall her taking me on a cycle ride and we took a picnic. I was not as confident as Alison, and I didn't like to be too far away from home, but I would return feeling like we had been on a real adventure...

However, the letter also presents a picture of the more challenging aspects of Alison's personality. This includes criminality such as theft and shoplifting, calling in a bomb hoax, and ultimately burning down her parents' house. It goes on to say that: *Growing up it felt like she could be unpleasant at times for no accountable reason. When it was targeted at me, I felt that maybe there was resentment for not being adopted. I loved Alison but I have found it difficult to trust her and felt the need to keep her at arm's length.*

The letter provides less of a picture of Alison as an adult, but one paragraph highlights two aspects of her personality. *Alison enjoyed being waited on whilst she stayed with us, she never helped in communal jobs such as laying the table, loading the dishwasher although one Christmas I bought Dad a greenhouse and Alison pretty much built this for him on her own, she was very capable.*

The author and the Partnership are very grateful to Alison's family, her sister especially, for the insights that they have provided. The full letter was shared with those who worked directly with Alison.

5. Chronology

5.1 Information on the pre- review period

Alison was brought up in an adoptive family. She expressed some negative views to professionals about her upbringing; but others have described her adoptive parents positively, for example, one professional described them as "extremely caring and concerned". She left school with 5 GCSEs and worked for three years in a fast-food outlet. She seems to have had few relationships and had no children. Clinical notes suggest that she had experienced various traumatic events but the detail of these is not recorded. What is certain is that one of her two sisters was murdered by a boyfriend.

Alison had a long history of deliberate self-harm, in the form of cutting, burning her stomach, arms and legs, punching walls and overdosing. She took her first overdose at the age of 15 and her arms were badly scarred from self-harm. Mental Health services considered her to have had very low self-esteem, to have been unable to develop adaptive coping skills and a low tolerance to stress. By the end of her life Alison was also known to have Hepatitis C, liver disease and severe asthma.

May 2004 to September 2014 10 recorded contacts with Swindon Borough Council Emergency Duty Service. Eight of these contacts relate to Alison being placed by

Police under section136 of the Mental Health Act; of these contacts, seven concern self-harm and suicidal ideation.

2004–2019 Alison had an extensive mental health history, which predates the introduction of electronic records in 2011. She was referred by her GP to the local mental health team for treatment and support on many occasions. She had also attended A&E on numerous occasions following self-harm episodes and asthma symptoms. She had a diagnosis of borderline personality disorder (Emotionally Unstable Personality Disorder), and presented with obsessional thoughts, which dominated her daily routine. Between 2016-2019 she was managing in the community, contacting Mental Health Services for support as and when it was needed.

2003-2011 Alison had a forensic history, including a drunk and disorderly conviction in 2003, a prison sentence at the age of 18 for arson when she set her parents' house on fire, and also set fire to a till roll at work. In 2007-8, Alison twice reported being a victim of crime (criminal damage and then robbery). In May 2011, Alison disclosed to the Mental Health Crisis Team that she was raped by her neighbour; however, she refused to make a statement. A Safeguarding Vulnerable Adult professionals meeting was held in June 2011. Police officers spoke to Alison about the disclosure of rape and she stated she had flashed back to a historic event of abuse due to not taking her medication. No further action was taken.

2011 - 2015 Alison came to the attention of Wiltshire Police on a regular basis. The main concerns were the concealing of razor blades and crisis calls to Police about her mental health. The chronology suggests that her local Neighbourhood Policing Team was in constant contact with Mental Health Services to try and establish appropriate ways of safeguarding Alison. During this period Alison submitted intelligence reports to the Police about her neighbours.

2017 Alison twice called 999 with regard to overdose or self-harm incidents. On both occasions the incidents were attended by Police and Ambulance Services. On both occasions she was difficult to engage when services arrived but in the first incident she was conveyed to hospital because of concerns about an overdose and apparent lack of capacity.

31/10/2018 Alison called 999 to her home as she had self-harmed by cutting her arm with a razor blade. On arrival Alison's flat was empty with a pool of blood on the floor and smears of blood on the walls in the bathroom. She was found in a shed watching TV with her dog, locked from the inside. She was intoxicated and very unsteady on her feet. She had deep cuts to her left arm and razor blades were found on her and in the flat. She was alert and initially refusing admission. However, concerns about her health led to her being conveyed to the Emergency Department.

03/12/2018 A Safeguarding Concern was reported by Alison's GP alleging that she had disclosed that a local female resident asked for sums of money and that Alison was given cocaine in lieu of repayment. The Concern focused on exploitation and deterioration in mental health. The concern was not progressed to a S42 (2) Enquiry. Instead, it was referred to Mental Health Services to address 'risk taking' behaviours related to Alison's mental health.

5.2 The review period

October 2019 The Police received a report from Alison's GP that Alison had been sexually assaulted by a male and female who lived in her village. Officers made multiple attempts to speak with Alison about this allegation however she would not cooperate with the investigation. Mental Health Services assisted with the visits and contact with Alison. Intelligence reports at this time also indicated that Alison may have been borrowing money from neighbours although this was not confirmed.

07/10/2019 A Safeguarding Concern was reported by Alison's GP about this incident. Alison alleged that she had been sexually abused by two neighbours while under the influence of alcohol on two occasions. The Concern met S42 (1) Criteria and progressed to S42 (2) Enquiry. Two multi-agency meetings were held and a Safeguarding Plan was implemented with a review date of 31/03/2020.

18/10/2019 Alison called 999 because she had taken an overdose of 6 x dosette boxes of Aripiprazole, Clonazepam, Lisinopril, Omeprazole and Trazadone. She had also cut her right forearm causing around nine full thickness lacerations (through the skin to the sub-cutaneous layer). On arrival the crew found her on her bed with reduced consciousness, with her phone next to her and the Ambulance Service call taker still on the phone. The wounds were dressed and she was taken by ambulance to the Emergency Department.

18/10/2019 Once in the Emergency Department her wounds were dressed again. It was known that she had a history of psychosis, depression, and previous deliberate self-harm. The plan included a review by the mental health team once she was medically stable. The plan also included a review by the Alcohol Nurse: the only documented specialist alcohol intervention. However, Alison self-discharged stating she was not suicidal and could take care of herself. The notes indicate that Alison: *Self-discharged and refusal of treatment form completed and signed by Healthcare Professional and Alison. Alison understands the medical treatment, consequences of refusing treatment, able to retain information long enough to make an effective decision.*

October 2019 The Primary Care Liaison Service (PCLS) determined that a referral to Recovery Services would be appropriate. There were concerns that her symptoms and risk could escalate if she felt unsupported in relation to the alleged assaults. Alison needed prompting for medication, food and fluids, and was asking for those supporting her to be registered clinicians. She was experiencing flashbacks and hearing voices, which affected her routine and ability to sleep.

21/10/2019 the Recovery Team referred Alison to Intensive Services (IST) for intensive short-term oversight and delivery of medication. However, IST questioned the value of this referral as previous experience suggested that Alison would derive little benefit, and it would escalate her distress at perceived abandonment when intervention ended, and instead agreed to offer support focussed on supporting her coping strategies and medication management.

December 2019 Christmas 2019 was spent with her family in another part of southern England.

January 2020 A multi-agency meeting was held in January 2020, attended by the Police, GP, mental health and safeguarding representatives. The mental health team felt Alison was stable and discharged her.

08/01/2020 A CPA review was held, where it was agreed Alison would be discharged from the Recovery Team due to no role for them having been identified. Alison was ambivalent about this, but was reported to have understood the rationale. The Recovery Team's rationale for discharge reflected how longer-term continuous mental

health intervention and support had been re-evaluated in favour of more episodic crisis resolution. The Recovery Team's view was that Alison had managed better with this approach for three years and it was unable to identify clear goals for further Recovery Team intervention.

15/01/2020 A gastroenterology appointment identified hepatitis C and liver cirrhosis. Alison was commenced on 12 week treatment for hepatitis C. An arrangement was reached with the dispensing team within the GP surgery so that Alison could collect two days of hepatitis C medications three times per week. An appointment was arranged for Alison to attend the hospital on the 09/03/2020, and an appointment was arranged at week 4 for a review of any concerns and to re-check her hepatitis C viral load.

31/01/2020 Alison was called by a liver specialist who then became concerned that she would self-harm and called an ambulance to her home. Alison greeted the crew at the door. She was alert with no injuries but was crying. There was no shortness of breath. She reported that she had drunk one rum and coke and was not intoxicated. She said she did not want an ambulance. The crew felt she had capacity. Instead of transporting her, the crew spoke to an on call specialist at the Crisis team who agreed with the crew's concerns and said they would pass details to Alison's support worker at the Recovery Team, due to her non-cooperation. Alison said she just wanted to sleep and signed the refusal form. The Recovery Team contacted Alison by phone, but she denied any current intention of self-harm and said that she would contact the Crisis team if she felt the urge to do this. The Care Co-ordinator satisfied themselves that Alison's risks were within her stable risk profile and it was safe to proceed with discharge as planned on 31/01/2020.

02/02/2020 Alison called the Ambulance Service to report that she had taken an overdose and had left her home address on foot. Alison was located by the Police in woods near to her home a short time later. She stated she had been sleeping, and felt like she had a hand on her head holding her down. She had taken 21 of her hepatitis C tablets, drunk two ciders and had gone for a walk. She did not have any of her mental health phone numbers with her so she called 111. She was alert but very low in mood. She felt tired and sleepy but had a good skin colour. She was reluctant to attend hospital but was assessed to lack the capacity to make that decision. She was accompanied to hospital by a Police officer because she kept trying to unbuckle the seatbelt. In the Emergency Department she was noted to be under the influence of alcohol and was described as "combative but settled". It was noted that the Police should be called if she tried to leave. However, she left before clinical assessment. She self-discharged and the refusal of treatment form was completed and signed by a Healthcare Professional and Alison. It was reported that Alison understood the medical treatment, the consequences of refusing treatment and was able to retain information long enough to make an effective decision.

5/02/2020 Alison was referred to the Primary Care Liaison Service (PCLS) by her GP. She reported suicidal ideation: using a rope in the woods. She had not slept for the previous three to four days, and not eaten for two to three weeks. She was feeling exhausted and helpless and felt that she needed to go to hospital to be sectioned. Alison declined the Intensive Services (SIS) number and assured staff she would be safe; she would take one sleeping tablet and be ready for PCLS call the following day. The plan was for a triage discussion regarding referral back to the recovery team.

07/02/2020 PCLS contacted Alison. She explained that she has begun to reduce her alcohol intake. She reported rapid changes in mood and suicidal ideation throughout the day. However, there were no 'imminent' suicide plans.

12/02/2020 PCLS contacted Alison. She was out in town, which was seen as a positive sign. She said she had replaced alcohol with an unnamed substitute, but was nonetheless going to buy cider. She was with a friend and said she would call PCLS back later.
13/02/20 PCLS contacted Alison. She reported not sleeping for three days despite drowsiness from her Hep C medication. She admitted using Class A drugs recreationally to compensate for reducing alcohol intake. She had an upcoming appointment with MIND and was encouraged to attend as possible mitigation against increasing drug use. PCLS concluded that any recommendations from an assessment would be to engage with MIND and Turning Point if drug use increased, so closed the PCLS referral.
17/02/2020 The GP referred Alison again to PCLS expressing concern about the risk of suicide and self-harm. The GP was requesting advice and support as Alison was self-harming, was unsafe and had razor blades. The GP had wanted to call an ambulance but Alison had prohibited it. PCLS contacted Alison within 20 minutes to triage safety concerns, and spoke to her about 30 minutes later when Alison rang back. She disclosed that she had strong thoughts of suicide, disclosed having a rope and did not feel safe. She stated that she believed she would hang herself at some point. She was also having flashbacks about past harm, violent dreams, and thoughts of wanting to hurt people. Alison agreed to return home. The PCLS Nurse then called an ambulance as they could not agree a plan to keep her safe until the Crisis team came for an assessment (four hours). Alison told the ambulance crew that she had taken some bale twine home from her horses which she intended to use to kill herself. She let the crew remove this to keep her safe until the Crisis Team arrived. Alison said that she was desperate for help but no-one seemed to be helping. She said she was happiest when she was with the horses and missed having her dogs. She was not lonely for human company. She said her new tablets for Hepatitis C and liver cirrhosis were not working despite her cutting back on her drinking and that all the past memories were coming back. She had drunk several cans of cider. She said she was discharged from the mental health team three weeks ago but felt she needed to be back in the scheme as she had no-one to turn to. The crew suggested she should go to hospital but she refused saying she didn't want to be around other people with bright lights and the noise. She said she would be happy to go to Green Lane in Devizes (a mental health unit) where she felt safe. She agreed to take her medication and get dressed for bed. She cried when being spoken to about certain things which appeared to have been her trigger. She said there were a man and a woman who took her money from her every couple of weeks after she received her benefits and they used it for drugs. The Crisis Team were contacted who said they could offer telephone support that evening. The night team would call at 10pm and assess the situation with a view to visiting her that evening. They said they were aware of Alison and her presentation. Alison then signed the refusal form. A safeguarding referral was completed which was shared with the Police, Adult Social Care and her GP. SIS phoned her for support twice more that day, and encouraged her to contact Mind in the morning, and to phone them back if she needed further support overnight.
18/02/2020 The Ambulance Service reported the disclosure of financial and sexual abuse to the Police. Alison was spoken to by officers the day after this report and she stated that she made up the allegation about her neighbour for the benefit of the Ambulance Service. She also stated that she couldn't remember what she had said.
19/02/2020 A Safeguarding Concern was received from Wiltshire Police following the concerns reported by the ambulance crew. The form commented that Alison withdrew

the disclosure when visited by Police and had made it up to get better treatment from the ambulance staff. The Concern did not progress as it was assessed as not meeting S42 (1) Criteria on the basis that criterion 'b' "at risk of or experiencing abuse or neglect was not evident". The screener noted that there was a Safeguarding Plan in place.

28/02/2020 Alison presented to Police with self-harm wounds and expressing the intent to end her life. At the ED, a Nurse Led Initial Mental Health Triage form was completed. All of the mental health risk screening questions had *No* circled, (one or more Yes Answers denotes initial Risk of Red). This was discussed with an ED Consultant who spoke to the Intensive Team. They were happy for Alison to self-discharge and the Intensive Team would follow up in the community the next day. Alison self-discharged and the refusal of treatment form was completed, however, not signed by Alison. A referral for SIS was received from the GP on the same day. This was requesting home support, medication review and crisis management. This referral was accepted.

01/03/2020 Police officers attended the home address of Alison to complete a welfare check following recent missing person episodes. It was noted that Alison had deep wounds on her arms from self-harm and was stating that she wanted to take her own life. Alison was seen and assessed at home by SIS. She was described as warm in engagement but disclosed she was struggling with mood and thoughts. She had been self-harming and was unwilling to go to A&E by herself. She disclosed that she was scared of her neighbours, that she gave them money every two weeks which left her with little or none for food and electricity. She was too scared to go to the Police. SIS made a safeguarding referral, but did not accept her onto their caseload as the primary concern was her vulnerability to local drug dealers exploiting her – this was impacting on her mental health but was not a situation that Mental Health Services could change. She was informed that she could still contact the team for support when needed. Risk was formulated as ongoing risk of self-harm and suicide though no active suicidal plans.

02/03/2020 A Safeguarding Concern was reported by Mental Health Services. Alison had disclosed that every fortnight on payday local drug dealers visit her and ask for money. She reported that she was unable to say no. Alison initially reported that she ensured she had enough for electricity and food but later in the appointment reported that she sometimes goes days without electricity. Alison reported that she had approximately 10p left to last her 10 days. She reported that they were coming to her home every few days and asking her for things e.g. tobacco, toilet roll, rizlas etc. Alison reported feeling unable to say 'no' due to fear. She reported that she knew a lot about what they had been doing and what they were capable of and did not want anything to happen to her. Alison reported that she had given them over £1000 and this had been happening for months (she would not divulge exactly how long). Alison knew the men but would not give any details about them other than it was two males that came to her property. Alison denied using drugs and denied that they were exploiting her sexually. Alison wanted it to stop but did not know how to make it stop. She was afraid of the repercussions of her talking to anyone about it. Alison stated that she did not want Police cars at her address as her address was watched by dealers and there was someone that lived locally that was also involved but she was aware that the outcome of a safeguarding referral could be Police involvement. The concern did not progress to S42 (2) following a welfare and information visit to Alison by an Enquiry Officer. The information provided identified that Alison had lent money (£50 not £1000) to a neighbour. Alison was able to meet her basic needs but reported that the loan had

left her short. There were concerns regarding the deterioration in her mental health. The concern was screened as not meeting S42 (1) on information gathered in relation to criterion 'b'. Information was shared with other agencies.
05/03/2020 PCLS phoned Alison following contact from SBC Safeguarding regarding suicidal ideation. She was with a friend. She reported not feeling safe at home and wanted psychiatric admission. PCLS discussed security options and advised her to call 999 if necessary regarding her personal safety and home security. Alison did not disclose any suicidal intent and the call ended on a lighter/ humorous note.
18/03/2020 Alison was detained under Section 136 of the Mental Health Act after calling the Police to say that she was going to pour petrol over herself. She also said she was hearing voices which was not normal for her. She was found in a field threatening to set herself on fire. Alison was transported to Green Lane Hospital by ambulance and accompanied by Police. She was smacking her head during the journey and was handcuffed for her own safety. She was not willing to talk and could not tell the crew what had triggered her that day. On arrival at Green Lane she became very agitated resulting in her being put in seclusion.
18/03/2020 An ambulance was called to Green Lane for Alison. Staff had noticed that she had episodes of a persistent dry cough and low oxygen saturations. The doctor on call spoke with a registrar at Royal United Hospitals (Bath) to discuss her case in light of Covid-19. The registrar was happy to accept Alison at a new respiratory ward. The crew arrived wearing PPE as were the staff at Green Lane. Alison was asleep and on oxygen. A surgical mask was placed on her immediately due to the possibility of Covid-19. She was not orientated to time, date or place and was not very communicative. She was pale but not clammy. She felt she had a slight increase in work of breathing. She had a cough but her chest sounded clear.
19/03/2020 Alison was assessed at RUH by a Bath and NE Somerset AMHP who liaised with the Consultant prior to Alison being discharged from the place of safety the following day as she was no longer presenting as a risk of self-harm or suicide and stated she wanted to go home. She was referred to SIS, who assessed her. She was described by Mental Health Services as bewildered by recent events and unsure what she should be doing. She was also suffering from a severe productive cough. Alison had experienced a sudden drop in her mood leading to suicidal thoughts and intent. She could not identify a trigger. She was risk assessed as medium in the risk summary, chronic risk of self-harm, no immediate suicidal ideation or intent. SIS again did not take her onto the caseload due to the primary issue being concerns of exploitation which Mental Health Services cannot change. Alison was given a phone number and encouraged to make contact if her mood destabilised. SIS chased the previously made safeguarding referral and were informed that this had been looked into and the case was now closed.
23/03/2020 Alison phoned PCLS saying goodbye. She was next to a tree and had plans to hang herself. They were unable to agree a safety plan and Alison terminated the call. They sent the Police to her house. She did not disclose intent to end her life to the Police. The Mental Health Crisis Response Team (MHCRT) advised Police to leave when appropriate, that there was a risk of self-harm but that Alison would be able to seek mental health support, as she had done previously. No further role for MHCRT was identified.
30/03/2020 (13.07) PCLS called Alison following contact from her GP receptionist. She was noted to be coughing violently and attracting negative public attention, (likely due to COVID anxieties). She was planning to go back and look after her animals. PCLS agreed to call her later in the day

30/03/2020 (afternoon) Alison was on a motorway bridge, and Police were called to the scene by the public as she had been sitting on the edge and expressing suicidal intent. The MHCRT were contacted by the Police. They spoke to Alison who denied any current suicidal intent and said she was intoxicated. She felt she should be detained under Section 136. But there was no indication of a need for further assessment or detention. At 16.44 the PCLS contacted Alison who said she may as well hang herself to meet the criteria for Section 136 detention. PCLS attempted to explore the significance and outcome of Section 136 but Alison was unable to think about it. She said she needed to get hay for her chickens and that she also needs to look for her asthma pump as her chest felt tight. Alison was aware PCLS would be requesting SIS make a welfare telephone call to her that evening and to create a safety plan for the night. PCLS spoke to her, and she stated that she felt abandoned due to the lack of face-to-face contact with services. The team arranged to call again later in the day. At 21.00 SIS contacted Alison, she was struggling to breathe and refusing to call 111 for advice. The SIS team called an ambulance, which Alison turned away.
31/03-06/04/2020 She had daily support calls from SIS, with food vouchers also arranged and sent to her.
02/04/2020 An ambulance was called to Alison's home address for breathing difficulties. She had asthma and had been experiencing a productive cough for the past 5 days. She was talking in complete sentences prior to being nebulised. Her respiratory rate was elevated, saturations of 94% on air. She was described as having a *global wheeze with basal crackles heard on auscultation. No photophobia or headaches. No evidence of alcohol, drugs or head injury.* She refused to go to hospital as she was concerned about her animals. She was given advice on what to do if the situation worsened and was left at home.
07/04/2020 From April 7th, the plan was for PCLS to phone Monday, Wednesday and Friday to offer Alison support, and SIS were to phone Saturday and Sunday. Alison was also told to phone in between if she needed support. There was intermittent contact following this plan, with multiple calls not answered and messages left but calls not returned by Alison. Sometimes she answered and engaged. She appeared to be struggling with the lack of social contact during lockdown.
08/04/2020 Alison reported to PCLS the receipt of her NHS COVID-19 Severe Risk Group shielding letter (her underlying conditions being Hepatitis C, Liver disease and Severe Asthma), and was distressed by its contents and the prospect of 12 weeks enforced isolation. She asked for PCLS not to call her and said that she intended to buy quantities of cider. The plan was to share information with SIS, look into medication delivery and discuss her in the PCLS multi-disciplinary team.
10/04/2020 PCLS contacted Alison who was coughing, exacerbated by speaking. She declined support with medication delivery as a vicar had collected it. She remained distressed by COVID-19 restrictions but planned to go out and avoid others.
11/04/2020 SIS were unable to make contact with Alison after multiple attempts during the day.
12/04/2020 SIS phoned Alison who was reported as tired and uncommunicative.
13/04/2020 PCLS left a message for Alison to contact them.
17/04/2020 Alison reported to PCLS that her GP had instructed her to stay indoors which made her feel fed up. She was not sleeping well and felt physically drained. She planned to catch up on sleep. The plan was for SIS to call over the weekend
18/04/2020 SIS attempted to contact Alison and were successful on the second attempt. She was planning to go out and buy cider. She was advised not to and alternatives were suggested. She denied any suicidal / self-harm ideation but it was

recognised that her risk increased when intoxicated. She was assessed as having capacity. The plan was for PCLS to call and offer support on Monday, Wednesday and Friday of the coming week.
20/04/2020 PCLS attempted to contact Alison – no response.
22/04/2020 PCLS attempted to contact Alison – no response a message was left.
24/04/2020 PCLS attempted to contact Alison. She had just woken and requested a later call.
25/04/2020 SIS attempt to contact Alison - no response, message left.
26/04/2020 SIS made several attempts to contact Alison.
27/04/2020 Last phone call attempted by PCLS on 27th April.
11/05/2020 PCLS was contacted by her GP as Alison had been contacting volunteers from Good Sam (transporting medication during lockdown) saying that she was feeling suicidal and had rope and tablets. SIS contacted Alison. She was tearful throughout the call. She had been upset by receiving a third NHS COVID-19 letter. She said she was feeling suicidal and seeing faces in trees. She wanted a review of her anti-depressant medication and was advised to contact her GP. She reported that she was intimidated into giving money to drug dealers, but said the police were aware. She declined an offer to phone emergency services but agreed to a SIS support call later that evening. SIS called again at 22.50, Alison was concerned that she would not be able to sleep as she only had medication for the next day. She had gone without medication all weekend. She was expressing that she 'can't go on anymore' and was 'just so fed up'. She was tearful and unable to respond to suggestions to relieve her distress. She said she was seeing faces and hearing voices in her head but knew that they were not real. The plan was for her to phone SIS for further support if needed.
12/05/2020 The next day she presented at the GP to collect her medication, she was feeling suicidal and saying that she was not getting support from Mental Health Services and needed face to face contact. SIS spoke to Alison, she did some breathing exercises and agreed to speak to practice staff. SIS received a call from her GP who reported that Alison had called the Surgery saying she was suicidal and not getting help from Mental Health Services. She wanted face-to-face contact. SIS planned to discuss her case the next day.
13/05/2020 She was contacted by PCLS. She informed them that the support calls were helpful but she needed face to face support, which she was advised was not currently essential and they could continue with phone support. No further role was identified for PCLS. Following a PCLS MDT meeting it was agreed that a professionals' meeting should be arranged due to the volume of contacts Alison was having with services and the number of referrals that were continually made to PCLS by her GP, a shared risk management response was required to ensure all services were providing a uniform response to Alison including the GP.
28/05/2020 A letter was received by the Mental Health Trust from the GP asking for Alison to be put back on the caseload as she was distressed following discharge. The GP also informed them that another safeguarding referral relating to her neighbour was being opened.
29/05/2020 A Safeguarding Concern was reported by the GP. Alison was noted by surgery staff to be visibly shaking with fear when approached by her neighbour. Alison disclosed that she was upset by her discharge from Mental Health Services. She also disclosed that the negative influence of her neighbours was contributing to her mental health deterioration. Alison reported that a neighbour had borrowed large sums of money from her and was refusing to repay it. Alison reported feeling very low and was not sure how to keep herself safe but appreciated past input from the Crisis Team and

the Police. Alison agreed to keep her door locked and call the Police if she felt intimidated. Alison agreed to be referred to Mental Health Services. The Concern progressed to S42(2) as S42(1) criteria were met and the screener noted repeat concerns re financial abuse/exploitation. The Concern was screened, and was allocated to an Enquiry Manager within 48 hours.

03/06/2020 PCLS was contacted by Safeguarding following the GP's referral. Information was sought on Mental Health Service's input. They were informed that she was not under the service but contacted for phone support when needed, which was provided. Safeguarding was informed of a multi-agency care planning meeting that was due to be arranged, and expressed a wish to attend. Safeguarding requested PCLS to establish her views/objectives, and to assess her capacity to manage her finances.

04/06/2020 An ambulance was called to Alison's home address for a possible asthma attack and breathing difficulties. She had a five day history of a productive cough. She had had two cans of cider and was a smoker. She had been feeling achy in her joints but had not been self-isolating. She stated that she felt she was struggling to breathe. She denied any recreational substance use. She was speaking in full sentences and was a good colour. The crew explained the significant risk of deterioration with a history of asthma and she was not on steroids. The paramedics advised that she needed to go to ED to which she agreed. She asked a neighbour to take care of her animals. The crew nebulised her but without warning she vomited inside the nebuliser after about 5 minutes. The hospital was given a pre-alert. When transferring onto the hospital bed she presented with stridor (wheezing) and a reduced level of consciousness. The crew called for a doctor and whilst waiting there was continuous stridor which caused the crew to raise the alarm and Alison was rushed into resus at Great Western. However, she eventually decided to self-discharge. Staff warned her of the risk of leaving, i.e. deterioration, respiratory arrest and death, Alison said she understood this. She said she would call her friend or 111/999 if she felt worse. It was felt that she was able to weigh / understand / communicate information. She also understood the need to wear a mask and self-isolate. Alison left in a taxi The GP was contacted and informed hospital staff of Alison's social and mental health issues. The GP also stated that Alison had not been shielding effectively and had erratic behaviour. The Crisis Team were also informed.

09/06/2020 Alison attended the COVID Assessment Unit as a result of possible life threatening asthma. She was admitted to Woodpecker Ward.

10/06/2020 She was discharged from Woodpecker Ward. The discharge summary was similar to the 4 June 2020 attendance. She had breathing problems but Alison refused any further investigations or examination and self-discharged with the understanding of:

1) the above findings (refused to believe in possibility of covid as had previous negative test 2 weeks before admission and had allegedly been self-isolating);

2) the recommendation of admission for O2 and monitoring and:

3) The risks associated with self-discharge, namely: further deterioration of breathing/collapse, respiratory arrest or even death.

The GP was again contacted. Alison left in a taxi after having signed self-discharge papers.

15/06/2020 Alison had a virtual Hepatology clinic appointment. She had successfully completed treatment in mid-April 2020. Unfortunately due to the COVID-19 pandemic situation, Alison was unable to be seen at the end of her treatment. However, Alison had some bloods taken at her GP to review her hepatitis C viral load and liver

enzymes. It was decided that Alison would be reviewed in clinic in September 2020 with bloods to re-check her hepatitis C viral load, a repeat FibroScan and then a discussion of the longer term management of her chronic liver disease.

23/06/2020 The ambulance service received a 999 call from Alison's GP surgery as she had phoned them due to breathing problems. The crew reported that the flat smelt of cigarettes and alcohol. Alison was on the sofa hyperventilating and coughing. She was answering questions with hand signals. There were noticeable self-harm scars on her arms. She had an increased respiratory rate and a bilateral wheeze, but no cyanosis (bluish discoloration of the skin). She said she'd had chest pain all day. An ECG was carried out. Her heart rate and blood pressure were normal. The crew nebulised Alison due to asthma and her inability to control her respiratory rate. She was taken to the ambulance in a carry chair. The crew discussed her with Shalbourne Hospital who said they would accept her as she had had a negative Covid-19 test. Alison became less responsive in the ambulance and the crew were unsure if she had taken an overdose. It was decided that ED was more appropriate and she was conveyed to Great Western, straight into resuscitation. In ED she was reviewed, it was noted that she smelt of alcohol. She stated that she was low mood, she was isolated and had not seen psychiatry for six months. A mental health risk assessment and referral was completed. She was green on the risk matrix, and was discussed with Psychiatric Liaison. She was given the phone number for SIS or PCLS and advice about contacting her GP. Alison was happy to go home and was discharged because she had mental capacity do so.

24/06/2020 Alison was intoxicated and had taken an overdose. She called SIS from the woods near her home. Her speech was slurred, difficult to understand and she was unable to give a precise location but named a field she may be in. SIS ended the call to ring the Police. The Police called an ambulance as Alison had also called them to say she was going to kill herself. When the ambulance crew arrived at a car park near the woods, the Police were using a drone to locate another officer who was with Alison. She had been found in the woods, non-responsive with a bottle of vodka in her vicinity. Alison was in and out of consciousness and would not disclose if she had taken anything. The Police put her in the recovery position. Alison said she had been drinking and was very tired - otherwise she would not engage. The Police described her as grubby and unkempt. She was saying that she needed to get home to her cat and chickens. The woodland area was unsuitable for the ambulance, so the HART (Hazardous Area Response Team) was alerted. The paramedics found her unresponsive and not responding to pain stimuli; however, she had good respiratory effort and a strong pulse. She would occasionally murmur incomprehensible words. She would cough and roll around on the floor then go back to being non-responsive. Oxygen therapy and Narcan were given to little effect. HART arrived and Alison was taken to ED at Great Western. Once she was at GWH, she was taken to the Covid assessment unit. However, she presented staff with management problems.

25/06/2020 The Covid assessment unit contacted Mental Health Liaison requesting attendance. They were informed that she was presenting with a viral infection and delirium and was trying to leave and that the doctor did not believe she had capacity. The Mental Health Liaison nurse consulted with a manager, who advised against attendance because: Alison was not open to Mental Health Services and there was a potentially high risk of exposure to Covid-19. Mental Health Liaison considered it was appropriate to contact ward security and would await a negative Covid swab before seeing her for a face to face assessment. It was suggested that the ward use a Deprivation of Liberty Safeguards (DoLS) or Section 5(2) of the Mental Health Act.

Swindon Borough Council MCA/DoLS Team received a request dated 25/06/2020 from GWH. The request stated that Alison had been admitted earlier that day due to experiencing a fall and that at the time the hospital Doctors had assessed Alison to lack capacity to consent to her accommodation at the hospital to receive care and treatment. The hospital detailed evidence of "confusion, alcohol misuse and intoxication" as the relevant medical history. They were recommending IV treatment and hydration that she was refusing to accept. The request also detailed that Alison was experiencing episodes of agitation and was trying to hurt herself resulting in the need for 1:1 close support for 24 hours. The GWH had granted themselves an Urgent DoLS authorisation and were requesting a standard authorisation be completed.

26/06/2020 An assessment was undertaken at GWH. Alison engaged well, informed staff that she had been drinking all day and had gone for a walk, had taken tablets with her and had thoughts of taking them. She had phoned SIS as she knew they would ring an ambulance. Alison was tearful at times and said that she was struggling during lockdown and found it hard only having telephone contact with professionals. The impression was that she was struggling to regulate her emotions, and was using alcohol as a coping mechanism which was making her situation more difficult. The risk review was updated and she was rated medium for short, medium and long term risk. There was no further input from the Liaison Team, and she was to be discharged from GWH when medically fit. A letter was sent to her GP to refer her for LIFT Psychology, she was signposted to websites with Cognitive Behavioural Therapy resources, signposted to alcohol misuse support, and told to contact SIS if her mental health deteriorated again. On the same day, the MCA/DoLS Team Assistant Team Manager contacted the GWH referrers to complete a triage process and explore the reason for referral further. They were informed that Alison had been assessed by the Mental Health Team who concluded that she had capacity to consent to her hospital admission and be discharged home. The DoLS referral was subsequently closed as Alison no longer met the DoLS eligibility criteria.

01/07/2020 SIS received a phone call from a Police officer who knew Alison, expressing concern that she may be drinking and suicidal. Alison's phone was reported to be broken and unable to make calls, so the officer requested SIS make contact with her. This was done, but Alison appeared upset at the phone call and did not want to engage. Alison disconnected the call, and did not pick up attempts made at calling back. This was handed over to the night team who again tried to make contact at 10pm. There was no answer and an answerphone message was left.

02/07/2020 (am) Alison rang the surgery in distress, stating she wanted to end her life and was too frightened to go back to her flat. The patient was kept talking on the telephone whilst an ambulance and the Police were called via 999.

02/07/2020 (pm) The ambulance crew were unable to locate Alison and Police were searching for her. The Police helicopter and drones were being utilised and she had been found in the woods. Police had been on the phone to her until 12:30pm and she had told Police she had asthma and she sounded very out of breath. She was found at 12:50 on a riverbank with her feet in the water and her body on the bank. Her bag was tied to a tree. The route to the location took the crew approximately 5-10 minutes and involved the crew walking through a river, over barbed wire fences, boggy grounds and hip height grass. The Police had attached a defibrillator and were doing CPR. Alison was cold to the touch. Advance Life Support was provided. There was evidence of alcohol around her but no evidence of ligature marks to her neck. Those in attendance discussed with a Doctor from the Air Ambulance and agreed that, after 60 minutes of Advance Life Support, any further attempts were futile.

23/03/2021 The coroner reached a verdict: *On the 2 July 2020, following a period of low mood and suicidal ideation, aggravated by the restrictions imposed in response to the Covid 19 pandemic, Alison entered a wooded area in … Swindon, having 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. Alison was found and released from the strap, whilst assistance was sought, which unfortunately, whilst it was ongoing for some time, did not affect the outcome and Alison died from the injuries sustained. Conclusion: Suicide.*

6. Analysis

Alison's suicide would not have been a surprise to anyone involved in her care. She had a long history of suicide and self-harm attempts and, given that a history of such attempts is a powerful predictor of the risk of completed suicide, such an outcome was always very possible. Therefore, there may have been opportunities for services to have helped her in ways which could have impacted on this outcome and which could offer lessons for future service provision.

Alison's death also took place against the backdrop of the first Covid-19 lockdown which meant that services were far more limited in the help that she could be offered. The coroner's verdict specifically identified that her suicidal intent was *aggravated by the restrictions imposed in response to the Covid-19 pandemic.* This report will consider what impact the pandemic had on both client and services. However, it needs to be recognised that for a crucial part of Alison's history, all services were struggling with the twin impact of their usual caseload and the Covid crisis.

This is a safeguarding adults review, as a result, particular focus needs to be placed on the efforts that were taken to safeguard her from abuse and, possibly, self-neglect. This analysis section is structured around the issues identified as the reasons for pursuing this review:

- The support to adults with mental health needs.
- Agency and practitioner safeguarding responses.
- The effectiveness of multi-agency arrangements.
- The impact of Covid on service delivery.

In addition, it highlights three other issues that emerge from this case:

- Mental capacity assessment
- The response to her alcohol use
- The response to her smoking

7. The support to adults with mental health needs

Alison had contact with a number of services, including the Police, Ambulance Service, Hospitals and the Safeguarding Team. However, the key contacts were Primary Care and, most extensively, the adult Mental Health Services provided by the local Mental Health Trust. This section focuses mainly on the Mental Health Service response. The Safeguarding response is considered in a separate section.

7.1 The Mental Health Service response

Alison had been in contact with the Mental Health service for most of her adult life and many staff in the Trust knew her and liked her. This review is only considering a small window of time and it needs to be recognised that she had been with the service for at least 25 years, and had received extensive and intensive support and a variety of interventions. This report cannot comment on the care Alison received over most of that period, but there is no reason to doubt the quality of the support: Alison herself seems to have valued the interventions.

During the period under review, Mental Health Services viewed Alison's mental health presentation and needs as static and the plan in place at the time of her death was for her to remain under the care of Primary Care with the ability to come in and out of Mental Health Services as needed. The Mental Health Service view was that at periods of intense input from services, her risk increased. It was argued that the more input received by Alison the greater her risk.

However, for the bulk of the period that is the focus of this review, this plan appears to have led to an episodic response from services. The SAR referral from Alison's GP surgery specifically refers to the pattern of the Mental Health Service "repeatedly discharging" Alison despite her being actively suicidal. There is a lack of the consistent, coordinated and supportive response that someone in repeated crisis would need: an approach that is at the heart of the Care Programme Approach. At times this work does not appear to have heard the voice of Alison herself who was often asking for ongoing support. The following paragraphs track the broad pattern of involvement with Mental Health Services. The detail of this involvement is in the chronology.

On the 08/01/2020, following a CPA review it was agreed that Alison would be discharged from the Recovery Team due to no role for them having been identified. Alison was described as ambivalent about this, but was reported to have understood the rationale. However, 23 days later a liver specialist became concerned she would self-harm and called an ambulance. This led to an alert to the Crisis Team and the Recovery Team, she denied a desire to self-harm and the planned discharge went ahead.

Within 5 days she was re-referred to the Trust's Primary Care Liaison Service (PCLS) by her GP. The PCLS had contact with Alison (4 phone calls in a 10 day period) but discharged her as no role was identified.

She was back in contact again, two days later, on 17/02/20, she was reported to be desperate for help but said no-one seemed to be helping despite her requests. She was referred to SIS who made contact but there is no evidence that this contact persisted. By 28/02/20 she was re-referred to SIS by her GP. Alison was seen at home on the 01/03/20 by SIS but they did not accept her onto their caseload as the primary concern was her vulnerability to local drug dealers exploiting her – this was impacting on her mental health but was described as a situation that Mental Health Services cannot change. However, they did make a safeguarding referral.

At this point, it should be remembered, the Covid-19 lockdown began.

On 18/03/20, Alison was detained under Section 136 of the Mental Health Act after calling the Police and stating that she was going to pour petrol over herself. She was transferred to Royal United Hospital Bath because she was exhibiting Covid symptoms. Alison was assessed at RUH by an AMHP who liaised with the Consultant prior to her being discharged from the place of safety the following day as she was no longer presenting as a risk of self-harm or suicide and stated she wanted to go home. She was referred to SIS, who assessed her but again did not take her onto the caseload due to the primary issue being concerns of exploitation which Mental Health Services cannot change.

Then just four days later, Alison phoned PCLS to "say goodbye". PCLS were unable to agree a safety plan and Alison terminated the call. SIS phoned 999 and Police were sent to her house. She did not disclose an intent to end her life to the Police, and the advice from the MHRCT was given that she was known to services and that she should contact them when she was in crisis, and as she was in her home and not currently expressing suicidal ideation to withdraw when this was appropriate.

Eight days later, on 30/03/2020, Alison was on a motorway bridge, and Police were called as she was expressing suicidal intent. The Mental Health Crisis Response Team were contacted by Police, but as she was no longer presenting in this way and appeared to have capacity, and no threat to self or others, it was agreed that action under Section 136 of the Mental Health Act was not appropriate. The team arranged to call again later in the day.

Between 31/03/2020 and 06/04/2020, Alison had daily support calls from SIS, with food vouchers also arranged and sent to her. From 07/04/2020, the plan was for PCLS to offer phone support on Monday, Wednesday and Friday, and for SIS to phone Saturday and Sunday. Alison was also told to phone in between if she needed support. There was intermittent contact following this plan, with multiple calls not answered by Alison, messages left but calls not returned. Sometimes she answered and engaged. She appeared to be struggling with lack of social contact during lockdown. The last of these phone calls was attempted by PCLS on 27/04/2020.

On 11/05/2020, PCLS was contacted by her GP as Alison had been contacting a voluntary service saying that she was feeling suicidal. SIS contacted Alison, who was upset, and when asked what support she wanted she asked for a medication review. She was advised to contact her GP. She was contacted later the same day by SIS for support and the plan was for her to phone SIS for further support if needed. The next day she presented at the GP, to collect her medication, feeling suicidal and saying that she was not getting support from Mental Health Services and needed face to face contact. SIS spoke to Alison and gave her some support and planned to discuss her case the following day.

On 13/05/2020, she was contacted by PCLS. She informed them that the support calls were helpful but she needed face to face support, which she was advised was not currently essential and they could continue with phone support. No further role was identified for PCLS. Following a PCLS multi-disciplinary team meeting it was agreed that a professionals meeting should be arranged due to the volume of contacts Alison was having with services and the number of referrals that were continually made to

PCLS by her GP, a shared risk management response was required to ensure all services were providing a uniform response to Alison including the GP. This meeting did not occur.

On 23/06/2020, there was a possible overdose and she was taken to hospital but discharged. The next day there was an overdose in local woodland. Eight days later, Alison took her own life.

As has already been said, Mental Health Services had a long-term engagement with Alison which she appears to have valued. There is solid evidence of concern about her and efforts to meet her complex needs. It would also be wrong to make any negative judgements about the period from late March 2020 when all services were having to adjust and curtail responses because of the pandemic. Nonetheless, there are lessons to be learned for future practice.

As the original SAR referral commented, the constant closing of her case in early 2020 (pre-pandemic) appears inappropriate given the continued and predictable evidence of need that she presented to services. It is an axiom of risk assessment (e.g. The 1994 Clunis Inquiry) and in particular assessment of suicide risk that past behaviour is the best predictor of future behaviour and that previous suicide attempts are predictive of a risk of completed suicide. In Alison's case the presence of a pattern of heavy alcohol use added to the level of risk. Given this it would seem straightforward to justify a more consistent approach to her case.

It is understood that the mental health service view was that too intense an involvement with Alison worsened her situation. In the wake of the practitioner reflection event Mental Health Service staff commented (in a written response) that: *In around 2012/13 the community mental health team attempted to adopt an assertive outreach model of working with…Alison…she was allocated two further support workers and at times was visited daily. She would be assisted with activities of daily living, including shopping, going for drives… and supported to engage or reengage with other activities she enjoyed i.e. horse riding and to attend Swindon MIND. At this time, Alison's extreme self-harming behaviours appeared to increase and she began to engage in severe burning of self, requiring intensive support from care coordinator to attend burns unit appointments and surgeries. Alison struggled very much with engaging with new people, often bringing someone new into her care would result in deliberate self-poisoning or self-harm, which made it difficult to balance managing her risks by increasing support from a range of individuals. Alison would then get extremely attached to any individual she did manage to form a therapeutic relationship with and if they departed her care team, this would also lead to extremely risky behaviour from Alison. Increased use of alcohol and extreme self-harm.*

It is also appropriate to note that at one point during the period in question Alison said that she was *happiest when she was with the horses and missed having her dogs. She was not lonely for human company*.

Against this needs to be balanced against:

- the already stated Primary Care perspective on repeated case closure;
- Alison's own requests for more help; and
- the view of the Trust's own analysis of the case.

The Mental Health Trust undertook a patient safety report into the case. The report appears to accept that the response to Alison may have been based on over-familiarity with the case: *Confirmation bias and wider situational awareness amongst staff who had become very familiar with her presentations over time may have been compensated for if guidelines, for example regarding structured risk formulation, had been prioritised.* This seems to suggest that staff had become used to Alison's repeated crisis presentations and were not accurately assessing Alison's risk and the need for action.

Alison also argued for the need for more help. On multiple occasions in the last few months of her life she told professionals that she wanted more support:

- 17/02/20 she was desperate for help but no-one seemed to be helping despite her requests.
- 30/03/20 she felt abandoned due to the lack of face-to-face contact with services due to Covid-19.
- 12/05/2020 she was not getting support from Mental Health Services and needed face to face contact.
- 26/06/2020 she was struggling during lockdown and found it hard only having telephone contact with professionals.

A further issue which is not considered by any of the agencies in the case is the impact of her hepatitis C and liver cirrhosis. These conditions will make people tired, confused and, as some patients call it, "brain fogged". This may have impacted on her situation in the period in question and should have been another consideration in any assessment or risk assessment.

The patient safety report looks at the root causes of the problems managing this case and appears to suggest that the problem lies with *the complexity of the Service User's condition, including co-morbidities, and limited options available for treatment.* This appears to say, in part, that the problem lies with Alison and the challenges she posed. It may be a more accurate analysis to say that the root cause is that the Mental Health Service did not have responses that met Alison's complex needs. This is not a criticism of Mental Health Services but rather highlights a commissioning need.

Alison was mentally disordered and it was to be expected that her comments and actions would at times be contradictory or inconsistent. It would have been difficult to pick a path through her conflicting requirements. However, it is hard to see repeated discharge as the most appropriate response and straightforward to argue that a personalised care co-ordination approach is the best way to identify the degree of support that would best benefit her.

7.2 The hospital

Alison was frequently conveyed to hospital after self-harming or due to physical health crises. Alison appears to have received good and responsive care even during the Covid-19 crisis. One specific issue related to the hospital emerged from the chronology: risk assessment.

On two occasions in the Emergency Department, a Nurse Led Initial Mental Health Triage form was completed (28/02/20 & 23/06/20). On both occasions Alison is

graded low-risk. Such an assessment is hard to understand given Alison's presentation and suggests some form of problem with this system that should be considered by the NHS Trust and, possibly, its partners. Nothing suggests that this risk grading impacted on Alison's care.

7.3 Primary care

Primary Care appears to have been very responsive to the needs of Alison and were strong advocates for better care, especially with Mental Health Services. The plan envisaged for Alison by Mental Health Services was for her to be cared for by Primary Care with support from the Primary Care Liaison Service. This does not seem to have worked as intended and raises questions about the interface between mental health and Primary Care. This was raised at the practitioner event as a boundary that needs more clarification. Both the chronology above and the analysis of the mental health service input highlight the repeated referrals between the two services.

7.4 The response from emergency services

The Ambulance and Police services were frequently called out to Alison's crises. The evidence provided does not identify any lessons or areas for change in their responses.

8. Safeguarding

Safeguarding Concerns were raised about Alison on five occasions between December 2018 and May 2020. Four of these are in the time period covered by this review, the earlier referral is included because it focused on the same issue as the other four i.e. concerns that Alison was being abused and exploited by neighbours.

- 03/12/2018 A Safeguarding Concern was reported by her GP alleging that Alison had disclosed that a local female asked Alison to give her sums of money and that Alison was given cocaine in lieu of repayment. Concerns were identified re exploitation and deterioration in mental health. The concern was not progressed to S42 (2) Enquiry. The concerns were referred to Mental Health Services to address 'risk taking' behaviours related to Alison's mental health.
- 07/10/2019 A Safeguarding Concern was reported by her GP. Alison alleged that she had been sexually abused by two neighbours while under influence of alcohol on two occasions. The concern met S42 (1) Criteria and progressed to S42 (2) Enquiry. Two multi-agency meetings were held and a Safeguarding Plan was implemented with a review date of 31/03/2020.
- 19/02/2020 A Safeguarding Concern was reported by Wiltshire Police following concerns that every two weeks upon receipt of benefits people attend her address and make her hand it over to them and that they also sexually assault her. However, Alison withdrew the disclosure when visited by Police and stated that she had made it up to get better treatment from an ambulance crew. Therefore, the Concern did not progress. The screener notes that there is a Safeguarding Plan in place.
- 02/03/2020 A Safeguarding Concern was reported by the Mental health Services. This repeated the previous information that Alison disclosed that every two weeks on payday local drug dealers visited her and asked her for money. She was concerned about the repercussions if she identified the people. However, Alison denied using drugs and denied that they were

exploiting her sexually. The concern did not progress to S42 (2) following a visit to Alison by an Enquiry Officer to whom she changed her account, playing down what had happened.

- 29/05/2020 A Safeguarding Concern was reported by her GP. Alison was noted by surgery staff to be visibly shaking with fear when approached by her neighbour. Alison disclosed that the negative influence of neighbours was contributing to her mental health deterioration. Alison reported being unsure about how to keep herself safe. The Concern progressed to S42(2) as S42(1) criteria were met and the screener noted repeated concerns about financial abuse/exploitation. The Concern was allocated to an Enquiry Manager within 48 hours. However, Alison died during the course of the Enquiry.

On the first occasion, although the concern did not progress, action was taken by referring Alison for mental health support. Arguably, this is a reasonable approach at that initial point. Ten months later similar concerns emerge and a safeguarding plan was implemented. The plan appears to have consisted of multi-agency meetings, an assessment of her capacity in relation to "concerns and risk areas", and a person centred risk assessment. The latter were tasked to the Mental Health professionals involved. The plan had a review date of 31/03/2020. The outcome of the capacity assessment was that Alison had capacity for the decisions tested, however, there is no record of the assessment. The risk assessment appears to have been limited due to non-engagement from Alison with the assessment process.

The review on 31/03/2020 did not happen. The safeguarding team explain this as follows: *A review date was set for this but not completed. On investigation of why the plan was not reviewed it was identified that usual practice is for the Enquiry Manager to keep the case open and review the plan. However, this Enquiry Manager was in the process of leaving the team. A Locum had been appointed and a handover period arranged. Alison was not part of this handover. At the time the team were working under the EM workflow system and the worklist was moved into the Green EM s42 worklist rather than a worker's worklist. This was a systems issue that was compounded by human error. Both systems have been reviewed and have been replaced and streamlined.*

On the third and fourth occasions the same concerns about exploitation were raised but this time they were then retracted by Alison. However, it is reported that the fourth (02/03/2020) enquiry resulted in sharing of information and follow up action by other agencies. It is also fair to note that both of these concerns were raised at a point where there is already a safeguarding plan (from the second safeguarding referral and due for review in March) in operation.

The fifth concern was raised during the Covid-19 lockdown and just over a month before Alison's death. The enquiry was in progress when she died. This enquiry is acknowledged to have moved slowly. The Safeguarding team commented that:
The Enquiry Manager for the May 2020 enquiry did achieve telephone contact with Alison and was able to obtain that Alison did want an enquiry to take place but that she did not wish to engage with him as Enquiry Manager because he is male. The enquiry Manager reached out to the mental health professionals involved with Alison and was advised that a formal MACP (multi-agency care planning) meeting was due to be convened. The safeguarding actions are requested via this route and Mental

health contact with Alison. It needs to be considered that remote working, restrictions and priorities caused by the pandemic are likely to have impacted on the pace and decision making of the enquiry. This impacted on the enquiry moving forward at a reasonable pace.

Efforts were made to safeguard Alison. However, it is acknowledged by the Safeguarding Team that there were shortfalls in the response. The team have recognised the slow progress of the May enquiry. The author is reluctant to pursue this criticism too far because it was happening against the backdrop of the pandemic; however it is important to ensure that clients can continue to be safeguarded even in times of crisis.

The October 2019 enquiry led to an intervention plan and the local authority have acknowledged technical shortfalls in this process. The third and fourth enquiries happened during the period of the ongoing safeguarding plan for the October 2019 enquiry and would also have been affected by the problems identified above.

However, perhaps the most important point to emerge from this case is, as the Safeguarding Team has acknowledged, the challenge of implementing effective safeguarding with adults with challenging diagnoses such as Emotionally Unstable Personality Disorder alongside substance misuse issues. It poses questions about the interface between self-harm and suicide and safeguarding. It is clear that further multi-agency work is required to determine both best practice and lead responsibility for these complex clients. This reflects the point made by Mental Health Services about the adequacy of the responses to these complex clients.

9. The need for a multi-agency approach

Alison would have benefited from a multi-agency approach to her care. This comes out in the chronology and is supported by the Trust's patient safety report which acknowledges that it was problematic that the decision in May to convene a multi-agency professionals meeting was not followed up.

The Safeguarding Plan from the October 2019 safeguarding enquiry included two multi-agency meetings, although the first of these was not held within the timescales of a Planning Meeting in line with Swindon's Policy and Procedure for Safeguarding Adults, there was good participation from Primary Care, Mental Health Services and Police within the meetings held. This process faltered, however, because of the problems identified above.

In May 2020, the PCLS Multi-disciplinary Team meeting agreed that a professionals meeting should be arranged due to the volume of contacts Alison was having with services and the number of referrals that were continually made to PCLS by her GP.

Given that this decision was at the height of the pandemic, it may be understandable that no action was taken on this. However, it is surprising that such a step had not been taken much earlier. Alison was a woman who had long had a multi-agency impact and been difficult to manage. A multi-agency perspective could have improved risk assessment and identified opportunities and approaches that could have improved

interventions. This would have been facilitated if Mental Health Services had, as suggested above, pursued the principles of the Care Programme Approach with Alison. However, this approach could have been initiated by other agencies including Primary Care. In the discussion of the report it was highlighted that the local Risk Enablement Panel could have been a framework for these multi-agency discussions.

10. The impact of Covid-19

The coroner was specific that Covid-19 had impacted on Alison and felt that this contributed to her ending her own life. Covid-19 certainly impacted on:

- The nature of her contact with Mental Health Services
- Her isolation
- The treatment of her hepatitis C and liver disease and
- Her engagement with hospitals.

Alison's life was specifically impacted by Covid-19 and the lockdown at several points between March and July 2020:

- In March 2020 Covid concerns impacted on her stay at Green Lane under S136
- In April 2020 there was a move to telephone support.
- In May and June 20200 the GP noted that Alison had not been shielding effectively and had erratic behaviour.
- In June 2020 Covid-19 interrupted her hepatitis care because she was unable to be seen at the end of her treatment.
- In June 202 there were two admissions re Covid

The Patient Safety Report commented that: *the impact of the COVID-19 pandemic was significant for distracting staff…and for the Service User herself who had been distressed by official advice to shield herself from social contact, and for services who had been instructed to limit face-to face contact….It appears that the impact of COVID-19 on the Service User directly and the disruption to her support systems, significantly compromised her fragile resilience.*

Covid-19 undoubtedly had an impact on Alison's care and well-being. However, this cannot be seen as a reflection of poor practice, and cannot be subject to recommendations, it is simply the reality of an unprecedented situation.

11. Other themes - Mental Capacity Act

Decisions about mental capacity were not central to the care of Alison. However, the case raises general questions about the application of the Act to these complex clients.

The Safeguarding Team report that in both the two main enquiries, the enquiry managers question Alison's ability to make informed decisions about the concerns being raised. The October 2019 enquiry sets actions for Alison's capacity to be assessed by Mental Health staff in relation to concerns and risk areas. The outcome of this is that Alison has capacity for the decisions tested, however, there is no record of the assessment. This is clearly a practice failing.

The more general question is about the assessment of capacity with these complex clients. At three points, Alison seeks to self-discharge from hospital, leading to questions about her mental capacity to take that decision.

On 18/10/2019 Alison attended the Emergency Department to have self-harm wounds dressed. However, Alison self-discharged stating she was not suicidal and could take care of herself. The chronology notes that Alison: *Self-discharged and refusal of treatment form completed and signed by Healthcare Professional and Alison. Alison understands the medical treatment, consequences of refusing treatment, able to retain information long enough to make an effective decision.* A very similar scenario plays out on 02/02/20 and 28/02/20. It is not clear how many times this had happened prior to the review period. A somewhat similar situation occurs on 30/03/20 when she was on a motorway bridge threatening to jump.

This does raise questions about whether clinicians considered all the elements of the mental capacity test. Certainly, Alison could understand and retain information about the health risks of going home at this point in her treatment. She could communicate her decision about going home. However, could she use that information to safely return home? This is less clear. If it is the first time that this question has arisen, then Alison's choice should be respected but as there are repeated failures to go home and maintain her safety, then questions must arise about whether she has the mental capacity to *use* information about the risks she will run if she returns home. This approach is supported by section 4.30 of the Mental Capacity Act Code of Practice which states that: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.*

It is fair to note that changing the decisions about her mental capacity at the points indicated above are unlikely to have significantly changed the course of her care. However, it is important that all elements of the mental capacity test are considered fully at assessment.

In addition, it should be remembered that the Code of Practice comments that:

> *2.11 There may be cause for concern if somebody:*
> *• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…*[1]

Even if Alison did have the capacity to care for herself, the Code suggests that professionals seeing this repetitive behaviour by Alison should certainly have explored what lay behind this pattern.

12. Other themes - Alcohol

Alcohol misuse is a frequent feature of Alison's presentation. The patient safety report describes her as having *"chronic moderate alcohol misuse"*. At another point it

[1] Mental Capacity Act 2005: *Code of Practice 2.11*

describes her as using *alcohol as a maladaptive coping mechanism in the context of Emotionally Unstable Personality Disorder*.

She had both hepatitis C and cirrhosis. The relationship between the alcohol use and the cirrhosis is unclear; one professional suggested it was causative, but at the very least the alcohol use would have worsened her liver problems.

Alcohol use often accompanied her self-harm and she was intoxicated when she died. On one occasion, intoxication was mistaken for a drug overdose. At the practitioner reflection event, it was reported that, prior to the period under review, a multi-disciplinary meeting had been held because of concerns about her alcohol use and self-harming behaviour. This led to local licensees agreeing to not sell to her.

Her GP and the Mental Health Services both discussed her drinking with Alison. Attempts were made to encourage her to engage with alcohol services. She never pursued this.

This complex picture suggests two areas for consideration:

- The use of alcohol screening tools
- The specialist alcohol service response

Best practice with this client group would ensure that the AUDIT alcohol screening tool is being used in Primary Care and other adult services including Mental Health Services. This would enable a much clearer assessment of her alcohol use: a phrase such as *"chronic moderate alcohol misuse"* has no diagnostic meaning. If identified as potentially dependent on the AUDIT tool, consideration should be given to using a tool such as the SADQ (Severity of Alcohol Dependence Questionnaire) to identify the level of dependency. It will be important to ensure that these tools are routinely being used by all relevant professionals.

Because of the lack of clarity about the nature of her alcohol use, it is unclear what the alcohol service response could or should have been in this case; however, it is important to ensure that such services can and will respond assertively to people like Alison, where alcohol misuse is part of a presentation that is leading to both significant risk and a significant impact on public services.

13. Smoking

Alison was a smoker and this may have contributed to or worsened some of her physical health problems e.g. asthma and liver disease. There is no suggestion that smoking had any role in her death. However, reducing smoking among people with mental health problems is a Public Health England priority, it contributes to the worsening of lung disease but also liver disease and raises the risk of fire hazards. Therefore, it is important that professionals recognise the need to address this issue with people with mental health problems.

The practitioner learning event discussed this issue and suggested that in both the Primary Care and Mental Health Trust notes there was evidence that efforts had been made to encourage her to give up smoking. However, she was unable to do so.

14. 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.

15. Good practice

Although there were undoubtedly examples of good and committed practice with Alison across all services, the only individual example that this report wishes to flag up is her GP who was a strong advocate for Alison and argued for better care for this complex individual.

However the report would like to acknowledge the efforts of all staff to keep services functioning in a time of unprecedented pressure on health, emergency services and social care.

16. 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 infoming 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.