SANDWELL SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

CHRISTINE

Died 2019 – 47 years of age

OVERVIEW REPORT

Independent Author: **Chris Brabbs**

Date: **April 2022**

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1. CIRCUMSTANCES LEADING TO THE REVIEW

1.1 Christine's decomposed body was found in the bathroom at her home in mid August 2019 by home carers. They had been asked that day to carry out a welfare check by Adult Social Care who had not been able to make telephone contact with Christine over the previous 6 weeks. Tablets were found next to Christine's body, but no suicide note was found. From the extent of the decay, paramedics attending the scene believed that Christine may have been dead since the end of June.

Background Information

1.2 Christine had a long history of significant physical health issues which included a diagnosis of heart failure (2018), poor mobility, a lung tumour due to treatment for Hodgkin's Disease (1997), and ongoing investigations for a lump in her throat which meant she was unable to eat normal meals.

1.3 In addition, Christine had a history of suicidal ideation and self-harm which resulted in 5 admissions to A&E between 2016 and 2019 - five of these when she was under the influence of alcohol.

Parallel Processes

1.4 The circumstances of Christine's death did not give rise to suspicions of criminal conduct and therefore a sudden death form was submitted to the Coroner with no further investigation by the police required. The conclusion of the inquest held in October 2019 was open and the cause of death was unascertained.

2. THE REVIEW PROCESS

2.1 The decision to establish a SAR was made by the Independent Chair of the Sandwell Safeguarding Adults Board on 12th November 2019 on the recommendation of the SSAB Protection Sub Group who had concluded that the criteria for a SAR were met taking account of the circumstances leading up to Christine's death. [1]

Purpose of the Review

2.2 The purpose of the review is not to hold any individual or organisation to account but to:-

- determine what agencies and individuals involved might have done differently to prevent the harm or death;
- review the effectiveness of multi-agency safeguarding arrangements and procedures;
- identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

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[1] *Under Section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must carry out a Safeguarding Adult Review (SAR) where an adult with care and support needs has died, and abuse or neglect is known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.*

Time period covered by the review

2.3 The SAR covered the period from November 2018 to the discovery of Christine's body in August 2019.

Key Issues to be explored by the review

2.4 The main question that the SAR sought to establish was how Christine's body could remain undiscovered for several weeks given that she was in receipt of a package of home care support, there had been recent contact with mental health services, and had twice been taken to the hospital emergency department.

2.5 The scoping panel meeting agreed that the review would focus on:-

1. Whether assessments applied a holistic approach, and identified the impact of Christine's physical health issues on her mental health, and vice versa;

2. Whether assessments of Christine's mental health were timely, and the support offered appropriate;

3. The robustness of risk assessments, and whether these took account of the history of Christine's previous suicide attempts, suicide ideation and self harm;

4. The effectiveness of multi-agency working and information sharing to ensure a co-ordinated response to Christine's physical and mental health needs;

5. The circumstances, and outcomes, of her attendances at the hospital emergency department which were the last occasions when there was agency contact with Christine.

6. Whether safeguarding concerns were identified and the multi-agency safeguarding procedures applied appropriately.

Agencies Involved

2.6 The Independent Chair and Overview Report Author was Chris Brabbs, a former Director of Social Services and experienced chair of SARs and DHRs. The LLR Panel, which held 3 online meetings, comprised representatives of the following agencies who submitted Individual Management Reports (IMRs):

Sandwell Council Adult Social Care
Sandwell CCG
Dudley Group NHS Foundation Trust
Russell's Hall Hospital
Black Country Healthcare NHS Foundation Trust (BCHFT)
West Midlands Police
West Midlands Ambulance Service
Elite Care Limited (home care service)

Involvement of Family Members

2.7 Information about the review was sent to Christine's sister with an offer to speak to the SAR Chair to share her experiences and perspectives. She was also asked to share the contact details if there were any other family members who should be approached including her father. It was felt best not to approach him direct because agencies had no information about his situation, and it was established that he had not attended the inquest into Christine's death.

2.8 Christine's sister did not respond to the letter. However, the SAR was able to take into account the history and perspectives that she provided to the HM Coroner at the inquest.

3. NARRATIVE OF AGENCY INVOLVEMENT

NOVEMBER 2018

3.1 During a consultation in late November, Christine sought help from her GP because of her worsening mood saying that she had recently attempted to commit suicide but had decided not to go through with it. The main reasons for low mood were her medical condition and her fear as to what the future held. She was also lonely, and was having no contact with family or friends. Christine was unwilling to try anti-depressant medication as she felt this would make the problem worse. Christine said she had no active plans to self-harm.

3.2 The GP made a referral to the BCHFT Single Point of Referral (SPOR) [2] for Christine to access Cognitive Behavioural Therapy (CBT) and she was offered an assessment with the Single Point of Referral Team (SPOR) during January 2019. However, Christine cancelled the appointment the week before saying her situation had resolved.

JANUARY / FEBRUARY 2019

3.3 At the end of January, the GP made a further referral to the SPOR for counselling with Christine's agreement after she reported that she was still struggling with her mental health. The referral was allocated to the Kaleidoscope Plus Improving Access to Psychological Therapy (IAPT) Service (Kaleidoscope) one of the independent providers of CBT services for Sandwell patients. [3]

3.4 However, from an initial discussion with Christine, Kaleidoscope concluded that its service would not be appropriate for her because the suicide risks were assessed as high. Kaleidoscope therefore contacted the BCHFT Crisis Home Treatment Team (CHTT) [4] for an urgent assessment and development of a risk management plan.

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2 *The SPOR team is the "front door" for receiving all referrals made to BCHFT. The SPOR will carry out assessments and / or pass referrals on to appropriate mental health teams within and outside of the Trust where further input is required.*

3 *Kaleidoscope Plus Group and the Wellbeing HUB, Improving Access to Psychological Therapy (KPGWH IAPT)*

4 *The CHTT offers short term crisis intervention to prevent individuals needing a hospital admission to keep them safe, the patient is then discharged back to the team they are receiving treatment from, for ongoing treatment to be delivered.*

CHTT assessment

3.5 The CHTT arranged to carry out an assessment the following day having established through an immediate telephone call with Christine there were no immediate risks.

3.6 During the assessment, carried out by a doctor and senior community mental health nurse (CPN), Christine did not report any intent to self harm or that she was in crisis. Christine admitted she had previously tried to end their life by using helium but had blacked out. Christine confirmed that she was taking the medication prescribed for her physical health issues and denied any drug or alcohol misuse. She described herself as a happy go lucky person who enjoyed looking after her pets and keeping fit. Her main problem was her poor sleep pattern which she had experienced since her teenage years – between four to six hours a night.

3.7 Christine said she had had no contact with mental health services since receiving counselling whilst in the sixth form at school and requested a course of counselling to address feelings around losing her job. In the light of this, and the absence of any acute mental health concerns, the outcome of the assessment was that further involvement by the CHTT was not required and she would be discharged back to the care of her GP, and the CHTT would re-refer Christine to Kaleidoscope work in respect of Christine's low mood and motivation. [5]

Outcome of Kaleidoscope re-assessment

3.8 During Kaleidoscope's subsequent telephone assessment Christine said she did not understand why she had been referred back to their service given that she was still having suicidal thoughts and this had not been addressed. Christine became frustrated during the telephone call, and asked to be discharged, stating that she did not wish to pursue support, and that she felt she was being passed "from pillar to post".

3.9 Kaleidoscope then spoke to the GP to share the outcome of the contact with Christine, and its view that their service was still not appropriate because of Christine continuing to have suicidal thoughts.

3.10 The GP followed this up through a telephone consultation with Christine who described how she was having suicidal thoughts each day. She also provided further details about her previous attempt to take her own life in November 2018 using 2 cans of nitrogen gas, but had aborted the attempt after becoming scared when she felt herself becoming unconscious. Christine stated that she had no current intention to try it again because of her fear of what might happen after death.

3.11 Christine said she was tired of being bounced between different mental health services. Although she agreed to the GP making a further referral to the SPOR with a view to talking therapies being reinstated, Christine was unsure whether she would engage if treatment were to be offered as she did not like the way she had been spoken to. In the meantime, Christine was trying some home cognitive behavioural therapy (CBT) as she wanted to change her mindset.

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[5] *The telephone referral was followed up with a written report 2 days later.*

GP Referral to the SPOR

3.12 The GP immediately spoke to the SPOR requesting that further consideration be given to offering Christine CBT, and shared Christine's perception that nobody in mental health services seemed to be taking responsibility for her care. The GP followed this up with a lengthy referral letter providing full details of the consultation and the key issues. While acknowledging that there was probably not an imminent suicidal risk because of Christine's fear of dying, the GP made the observation that might change, and her mental health might deteriorate if she was unable to access support. The letter also referred to Christine having suicide ideation on a regular basis and she had the means to carry this through.

3.13 The SPOR carried out an immediate telephone screening assessment with Christine and an appointment was offered for the start of April. Christine was provided with the emergency contact numbers should she require additional support in the meantime.

Referral to Breast Cancer Clinic

3.14 Shortly after the referral to the SPOR, the GP re-referred Christine to the Queen Elizabeth Hospital Birmingham (QEBH), following previous missed appointments, as Christine wanted to explore the issues around having a mastectomy. The GP recorded that it was unclear whether this wish was due to Christine's concerns about the risk of breast cancer due to previous radiotherapy, or was related to issues around gender identity.

APRIL 2019

SPOR assessment

3.15 At the SPOR assessment in early April Christine again shared her frustration that she felt she was being bounced between services. Although Christine reported no change in her mental health since the CHTT assessment, she did continue to have thoughts about ending her life. She was also continuing to experience symptoms of anxiety and depression, including poor memory, reduced motivation and poor sleep. Christine explained that if her physical health deteriorated, then her thoughts of suicide would return. The assessment did not identify any risk to either herself or others and concluded that Christine was at moderate risk, linked to her "living resources".

3.16 During the assessment, Christine described her previous difficulties regarding her sexuality, and stated that her main issue was her wish to pursue gender reassignment and obtain hormone treatments. The outcome of the assessment therefore was Christine agreeing to being referred to the psychiatric outpatients' department (OPD) for further assessment in respect of this request. The GP could then be advised on the referral pathways for this to be pursued if considered appropriate. Christine was also given contact details for the LGBTQ community. The OPD assessment would also enable further assessment of any other mental health concerns. The referral was sent through the same day.

3.17 Christine declined the offer of any ongoing talking therapy, and also the option of commencing antidepressant medication. Christine did agree that an assessment from Adult Social Care (ASC) would be beneficial and she was provided with the contact details as she said that she wanted to make the referral herself rather than by the SPOR. A crisis plan was also agreed should Christine require support around her mental health pending the OPD appointment.

Self referral to Adult Social Care

3.18 A week later, Christine referred herself to Adult Social Care (ASC) for an assessment with a view to a package of care being provided. Christine outlined her health history, and explained that she had poor mobility, was bed bound most days and not able to eat normal meals due to lump in throat as she tended to choke. Consequently, she was using meal replacement shakes. Christine opted for a face to face assessment rather than taking up the offer of a non-chargeable home care service of up to 6 weeks.

3.19 A referral was also passed through to the ASC Therapy Team to carry out an assessment for equipment. Their telephone discussion with Christine established that she could no longer use the bath having had a fall some months earlier. Her case was categorised as low priority and a home assessment booked for a month later. [6]

3.20 A referral was also made to the fire service which carried out a Safe and Well Visit the next day when 2 smoke alarms were fitted. It was noted that Christine would not be able to evacuate the property without assistance.

Involvement of the Cancer Psychology Service

3.21 In mid April, Christine was assessed by the Cancer Psychology Service at QEH following the GP's referral to the Breast Screening Service. The detailed report sent to the GP highlighted how Christine felt she was a male trapped in a female body which was the reason for her desire for Testosterone prescriptions. During the consultation, there was an acknowledgement that her request for bilateral breast mastectomy would address her gender identity issues as well as reducing the potential high risk of breast cancer. Christine also explained that she had an upcoming appointment with a specialist consultant in a Gender Identity Clinic. The letter also referred to Christine having a plan, and the means, to end her life.

3.22 When Christine informed the GP about this consultation, Christine explained that the psychologist had suggested that Christine be referred to the Palliative Care Team (PCT) because she was struggling with her feelings around her mortality. However, in a subsequent discussion with the GP, the PCT did not consider this would be helpful as it might worsen Christine's thoughts about death, and instead input from mental health services or continued input from clinical psychology would be more appropriate. The PCT explained its willingness to talk to mental health services if required to explain this advice.

Adult Social Care Assessment

3.23 The ASC assessment carried out towards the end of April established the following issues. Christine was no longer able to work due to her heart failure and dizziness, and her concentration being limited because of fatigue, anxiety and breathlessness. Christine therefore needed support to manage these, and also in coming to terms with her circumstances. It was identified that Christine was unable to perform personal care tasks independently due to the lack of dexterity in her hands. Christine was also unable to have a bath or shower due to the risk of blackouts and falls as she could not stand for long periods. The outcome of the ASC assessment was that approval for a twice daily package of home care would be requested.

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[6] *The target timeframe for low priority referrals is 10 weeks. This assessment was completed 4 and a half weeks after the initial contact.*

ASC Therapy Team Assessment

3.24 At the visit by the Prevention Assessor, it was identified that Christine was having difficulties in respect of bathing, negotiating stairs and access to the property. However, Christine declined the offer of various options offered to resolve the bathing issue because she was fearful of the risk of drowning if she had a blackout, and would only use the bath if she had support. Christine also declined the offer of a commode to address the accidents Christine reported she was having.

3.25 Following this visit, the assessor consulted an occupational therapist to discuss whether support from a physiotherapist might help to build Christine's confidence. The outcome was that the Prevention Assessor should determine exactly what Christine was expecting from the bathing assessment, and to establish if she should be placed on the Occupational Therapist waiting list.

Cardiac Outpatient Appointment

3.26 At the end of May, Christine attended a cardiac outpatient appointment where her cardiac status was assessed as stable and no concerns were noted. Christine reported that she was now cycling 20 miles most days, and was weight lifting again.

GP Consultation

3.27 At a consultation in early June the GP explained to Christine that it would be negligent to prescribe testosterone as requested given the risk of cancer and previous malignancy in addition to the cardiomyopathy problem.

Outpatient Psychiatry Department Appointment – June 2019

3.28 Christine was seen by a Locum Senior House Officer (SHO) who noted that Christine had been under the misapprehension that her appointment was not with the OPD but with a gender identity clinic, and the main reason for Christine attending was to obtain a prescription of testosterone. Christine explained that she had gender dysphoria, [7] was clear that she considered herself to be male within a female body, and was planning to have a mastectomy in August 2019.

3.29 Christine referred to the increased anxiety she had been experiencing since the diagnosis of heart failure which had led to the GP discontinuing the prescribing of testosterone due to the risks. However, she had since sourced this online which had reduced her symptoms of anxiety. Christine was open about having a suicide plan in place in the event of a deterioration of her physical health, and that her belief was that this would not improve.

3.30 The assessment concluded that Christine did not appear to have any acute mental health concerns nor had she reported any intent to self harm. In addition, her symptoms of depression and anxiety were stable, and that she had good insight and had capacity to make decisions about her health and care needs. Christine's fear of dying was seen as a significant protective factor. However, it was documented that although Christine's risk of self harm was low to moderate, there was the potential for the risk to increase in the event of any deterioration in her physical health.

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7 *Gender dysphoria is the feeling of discomfort or distress that might occur in people whose gender identity differs from their sex assigned at birth or sex-related physical characteristics.*

3.31 The outcome of the consultation was a treatment plan whereby Christine's care was discharged back to the GP who would be requested to make referrals to the IAPT service and to a specialist service dealing with gender re-assignment where her request for testosterone could be considered.

Commencement of Home Care Support

3.32 Two week later, a month after the ASC assessment, the home care service commenced delivery of the care package of support comprising a morning and evening 30-minute call. From the outset the carers were concerned about Christine's behaviour and the condition of the home - several empty bottles of alcohol having been observed.

3.33 On the first evening, the carer found Christine was sat in the dark and not wanting the lights on. When helping Christine to have a strip wash, Christine burst into tears asking the carer for a cuddle. The carer also noticed a lot of hair in the sink. The manager agreed to do a joint visit the following day in response to the carer stating that she did not feel safe.

3.34 The following morning, a different carer reported that she had been unable to gain access as Christine would not open the door, and had kept putting the phone down when the carer rang her from outside. This carer also reported that Christine had been crying the previous morning. When the manager rang Christine to check on her welfare, Christine again terminated the call.

3.35 The home care manager provided a full update to the ASC practitioner and raising the possible need for a reassessment because Christine may have underlying mental health issues and might require additional support. Approval was also sought for two carers to carry out the visits to ensure staff safety as the carers had reported feeling scared and on edge at each visit.

3.36 At the evening visit, all Christine wanted was for the carer to sit with her so she could just talk about life. Christine said she was very unhappy with her family situation and that she did not speak to any of her family. The following morning, the home carer reported feeling startled because Christine was wearing hospital scrubs, and that the only support Christine was accepting was administration of her medication. Later that day, the manager updated the ASC practitioner who said a review would take place six days later.

3.37 When the home carer and manager arrived for the evening visit, Christine was naked from her top half and helped to get dressed. Christine stated that she had been feeling suicidal for the past 3 days because her true love was not with her, and the last time she had seen her was when she was 15 years old, and she had felt heartbroken ever since. Christine repeated the explanation of how she would end her life by smoking cannabis, put a bag over her head and use the two helium tanks.

3.38 The manager also noticed blood on Christine's fingertips, the kitchen worktop and floor which Christine said that was because she had been self-harming using an injection knife. Attempts to calm Christine down proved unsuccessful and she became more agitated and was crying hysterically. The manager then called the paramedics, the Emergency Duty Team, and the agency's registered manager.

3.39 During the paramedics' attendance, Christine had periods of calm and was coherent, but then had episodes when she was hallucinating and getting upset. Christine confirmed that she had consumed alcohol that day and had stabbed herself in the right leg with a syringe, but would not let them examine her leg. Police assistance was requested when Christine refused to go to A&E and the Street Triage Team attended as they were in the area.

3.40 On arrival, Street Triage was informed that the 'blood' in the kitchen was actually beetroot juice. The team was unable to carry out an assessment of Christine's mental health as she was too intoxicated, but it was clear that Christine needed a medical review to check for injuries and injection of substances that might compromise her physical health.

3.41 When attempts to persuade Christine to go to A&E were unsuccessful, assessments of Christine's mental capacity were carried out by the paramedics and the Street Triage Team which concluded that she lacked mental capacity to make the decision not to go to hospital and a best interest decision was made that it was not safe for her to be left at home. Eventually, around 1am, Christine agreed to be taken to hospital.

Outcome of attendance at the Emergency Department (ED)

3.42 An hour and a half after arrival, and being seen by the Triage Nurse, Christine insisted on leaving before a medical assessment could be carried out. She stated that she no longer felt suicidal, she had no future intention to take her own life, and that she had been intoxicated at the time she made those threats. Hospital staff documented that Christine was lucid and had capacity to make this decision. Christine agreed to call 999 if she felt vulnerable and would also contact her GP for further support. A discharge letter was sent to the GP who recorded that Christine had been seen at A&E after feeling suicidal.

Update provided by the home care agency to ASC

3.43 The following morning, the ASC practitioner received a detailed account of the previous evening's events from the home care manager who asked whether a safeguarding referral would need to be completed given the agency's view that Christine was not safe in her own home. The ASC practitioner said that this was not required because Christine had been taken to hospital where she would get the appropriate treatment.

3.44 The home care manager recorded that the ASC practitioner would notify the agency when Christine was likely to be discharged from hospital. The ASC practitioner recorded that the home care manager would keep ASC updated in relation to any information that the agency received regarding Christine.

Second WMAS Attendance

3.45 2 days later paramedics attended after Christine made a 999 call during the night that she was having trouble breathing. When Christine declined the advice that she should be taken to hospital, the consequences of her refusal were explained to her that this could result in her death. Christine was deemed to have full capacity to make that decision. Further advice was given and Christine was advised to call 999 if she had any further concerns and to see her own GP for further assessment.

Third WMAS Attendance

3.46 A second 999 call was received the following morning as Christine was still having difficulty breathing and experiencing chest pain. Christine stated she had been taken to hospital a couple of days ago but discharged herself without being seen. On assessment Christine was struggling to speak in full sentences, but after oxygen she said she felt much better and was able talk normally. Christine was conveyed to A&E for further assessment.

3.47 At A&E, staff noted that alcohol was a feature of Christine's presentation. When Christine decided to leave the department before she could be assessed, staff tried to persuade her to return but she refused. The A&E doctor documented that Christine had capacity and was 'orientated'. The GP recorded the information received from WMAS about the paramedics' attendance with the comment "early de-compensating heart failure".

Fourth WMAS Attendance

3.48 The following day, WMAS responded to a 999 call made by Christine who had a nosebleed and difficulty in breathing. It was noted that Christine had been previously diagnosed in A&E as having a lower respiratory tract infection but she refused to the antibiotics prescribed as she did not believe in them. Following assessment, Christine declined to act on the paramedics' advice to be taken to hospital. Christine stated she would see her own GP and call back if required. Christine was therefore discharged by WMAS at the scene. The paramedics informed the GP who recorded in the notes the outcome of their attendance and Christine's refusal to go to A & E.

JULY / AUGUST 2019

Adult Social Care action following Christine's first admission to A&E

3.49 Adult Social Care first made telephone enquiries to the hospital about Christine's circumstances 2 weeks after the first admission to A&E which revealed that Christine had taken her own discharge soon after arrival. Unsuccessful attempts were then made to telephone Christine on 3 occasions over the next week. When the calls were all redirected to voicemail, a message was left asking Christine to ring back.

3.50 At the start of August, the Therapy Team ended its involvement after two unsuccessful attempts to contact Christine to seek her consent to write to the GP for further information.

3.51 In mid August, in the absence of the ASC practitioner who was on annual leave, the duty social worker rang the home care agency and discovered that the service had not been recommenced following Christine's admission to hospital. The home care manager agreed to carry out a safe and well visit as Christine had not answered the duty officer's telephone call. On arrival, the front door was unlocked and they found Christine's body on the bathroom floor.

3.52 The carers immediately informed the paramedics and the Emergency Duty Team informing the latter that the agency would be raising the incident as a safeguarding concern due to what it considered to be the negligence of the ASC practitioner. The home care manager then called the hospital to find out the exact date of when Christine was discharged but were told there were no notes on the system in regards to that admission.

3.53 On arrival, the paramedics found Christine's de-composed body in a supine position, dressed in a t-shirt and jeans. There were tablets by her left leg but no suicide note was found. Their initial perception was that Christine may have been deceased since the end of June. The crew called for police who took charge of the scene.

4 THE REVIEW FINDINGS

4.1 The following sections will set out the findings arrived at in the individual reports from agencies about their involvement, the learning identified for their own organisation, and action already taken, or planned to implement this. These findings will then be pulled together to set out the multi-agency learning from this review.

4.2 First, however, it is important to provide a brief profile of Christine to ensure that her situation and how she experienced this, remain the central focus of the review.

5. INFORMATION ABOUT CHRISTINE

Education and work

5.1 Christine obtained a university degree in Biomedical Sciences and had successfully applied to medical school. However, she had to abandon this after being diagnosed with cancer. Christine was able to resume work and had a number of office jobs over the years and was still in employment at the start of at the period covered by this review. However, she was then forced to give up work on health grounds, and she found the consequential adjustment to this difficult.

Family and relationships

5.2 Christine told professionals that she experienced a difficult childhood, and there were issues about the behaviour of both parents towards her. However, she did have a good relationship with her younger sister. She also reported being bullied at school.

5.3 The review established that Christine did not have any contact with her parents but the continuing contact with her sister, and her niece and nephew were important to her. Beyond that, Christine was quite isolated as the friendships she formed at work were not maintained.

5.4 Christine never married, and it appears that the only significant relationship in her life had been with another female around the time she was studying for her A Levels.

Physical and mental health issues

5.5 The strain of dealing with her significant physical health issues took its toll as seen by the insights she shared with health professionals. The in-depth discussion with the Psychologist from the Cancer Service was particularly revealing as Christine opened up about a number of issues and feelings that she had not felt able to disclose before.

5.6 In exploring her fears around death and dying, it was noted that Christine had conjured a very frightening picture of how her life would end. This was one of the main contributing factors to Christine having developed a plan to end her life at some future point when the burden of living with her symptoms became too great, and she had lost her quality of life. Christine's perspective was that this would give her control as to when and how her life would end. In the past, drinking excessively to the point of passing out had been a regular coping strategy.

5.7 It was the fear of dying however that had led her to abort the last of previous attempts to end her life in 2018. At that time, Christine was experiencing increased symptom burden as a result of her heart failure. Christine explained that when she was living with cancer, she was able to live with the fear of it returning by putting it at the back of her mind.

5.8 That had not been case living with heart failure because she could feel the symptoms which caused her to experience palpitations and feel breathless. [8] Although Christine had not been given a prognosis, her expectation was that death would happen in the next few years. In the meantime, she was open to exploring whether heart surgery was a possibility, and shared the view that rather die during surgery having tried, rather than not.

5.9 Christine explained to the psychologist her need to be self reliant and independent, and that she had found it difficult to place trust in other people because in the past her experience was one of being let down. This perspective appears to have been added to by her feeling that her work colleagues could have offered her more support in relation to her health difficulties.

5.10 During appointments in 2019 Christine explained how she was trying to remain goal focused. These included her motivation in keeping fit, often cycled long distances to appointments, looking after her cats, and continuing with writing a book. She was more optimistic about the future with the plan to have breast reduction surgery which would not only reduce the risk of the cancer returning but also bring the other benefit of addressing her issues around gender identity and her wish to "live truer to herself".

Gender identity issue

5.11 From the consultations with the SPOR and Cancer Psychologist, it emerged that Christine had struggled with her gender identity since her teenage years. Although the family were aware of this, they found it difficult to approach Christine about this and she in turn found it difficult to talk about her feelings.

5.12 Christine was pleased that when she thought a referral had been made to a psychiatrist within a Gender Identity Service when she was assessed by the SPOR in April 2019 which would enable her to move towards masculinity and live in a more authentic way – with the top surgery / breast removal being part of this. It is possible that Christine experienced considerable disappointment when she attended the appointment with the psychiatrist in June 2019 and discovered that this was not with the gender identity service clinic as she had expected.

6. ANALYSIS OF AGENCY INVOLVEMENT AND KEY EVENTS

Introduction

6.1 The following sections will cover, in turn, the findings in respect of the involvement of each agency. These are based on the conclusions contained in the reports (IMRs) submitted by each agency, supplemented by additional perspectives which emerged during the subsequent panel consideration of these.

[8] *Christine informed the psychiatrist in June 2019 that her heart function has been assessed at 57%.*

7. PRIMARY CARE

Introduction

7.1 The IMR produced by the CCG was drawn from the electronic summary GP records, correspondence and referral letters contained within the patient records. It was not possible to hold a face to face discussion with the GPs but they undertook a table top review of Christine's care and treatment. In addition, the author had email correspondence with the Head of Governance for the Primary Care Network (PCN) for the GP practice.

Overview of GP involvement

7.2 The overall conclusion of the IMR was that the GP practice [9] met the required standards for the care and treatment of this patient.

7.3 The GP practice made appropriate and prompt referrals into specialist services in respect of Christine's physical health issues. These included the referral into the fast track cancer pathway, breast services and ENT specialities. The GP also requested early follow up by the cardiac service because of Christine's reported symptoms. The GP also took prompt action to follow up issues arising from Christine's contact with these services.

7.4 Referrals were also made referrals at appropriate points to the BCHFT SPOR for mental health assessments, and the GP showed persistence in trying to secure support for Christine when the KPGWH IAPT took the view that its service was not appropriate, and sharing Christine's experience of feeling she was being "bounced" between mental health services. The record of the GP's approach to the SPOR in February showed a measured approach in setting out the current level of risk and how that might increase if she did not access support in a timely manner. In addition, Christine was provided with appropriate safety advice at all stages of the GP's efforts to secure support to address Christine's mental health issues.

7.5 The record of all the above actions not only evidences the GPs' responsiveness to Christine's various physical and mental health issues, but also the rapport that the GPs appear to have developed with Christine. The extent of her trust in the GPs is shown by how open she was in talking about her symptoms, her mood, her fears for the future, and her recurring suicide ideation.

7.6 The only area where the GP was not willing to accommodate Christine's wishes related to the prescribing of Testosterone. The GP explained to Christine that it would be negligent, to prescribe this because of the significant health risks arising from the diagnosis of Testosterone induced Cardiomyopathy, the history of cancer, and the complications that arose from treatment for that.

Response to notifications received from A&E and WMAS

7.7 Christine was last seen by the practice at the start of June 2019. The IMR established that there was no follow up action by the GP practice in response to the letters received regarding Christine's 2 attendances at A&E in June, or the notification from WMAS of the 2 occasions when Christine declined paramedics' advice to be taken to A&E for further assessment of the breathing difficulties she was experiencing.

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9 *The GP Practice is part of the "Your Health Partnership" which is a single GP Practice covering six sites across Sandwell.*

7.8 The IMR finding was that the notifications of Christine's first A&E attendance at A&E in June should have been followed up because its policy requires proactive contact to be made within 7 days to offer support where notification is received that a patient has had contact with another service provider, and a risk of suicidal intent or deliberate self-harm has been identified.

7.9 In exploring the possible reasons as to why this did not happen, the IMR author wondered whether a possible factor was that 2 discharge notifications were received for that attendance which contained a significant difference. One indicated the need for GP follow up with the comment "at risk for deliberate self-harm", but the other did not include any GP alert. Although the hospital had no record of 2 letters being sent.

7.10 The IMR author speculated that the decision not to follow up the notification may have been influenced by Christine having attended the OPD appointment earlier in the month, and an assumption being made that a follow-up management plan had been put in place by the OPD to address this risk. If that was the case, that assumption proved to be misplaced because at that point the GP Practice had not been informed of the OPD appointment outcome.

7.11 As regards the notifications of the subsequent WMAS attendances, the IMR explained that the outcome of the GP Practice's table top review was that they would not routinely follow these up. One of these related to the second occasion when Christine took her own discharge from A&E before treatment could be provided, and the other when she refused to go to A&E against the paramedics' advice.

7.12 In the light of the issues relating to this case, the GP practice has altered its approach and all the reports of WMAS attendances are screened by the duty GP to identify if follow up action is required.

Delay in receiving the outcome of the OPD assessment

7.13 The IMR noted that the letter to the GP setting out the outcome of the OPD appointment in early June was not received until the end of July almost 2 months after the appointment. The IMR makes the observation that for a high risk vulnerable patient this was an unacceptable delay and meant that the GP was unaware that Christine had been discharged back to their care, and that the GP was being asked to progress a referral to an appropriate specialist transgender service.

7.14 As soon as the letter was received, the GP was again proactive in immediately trying to telephone Christine to discuss the referral. When there was no reply, a letter was quickly sent asking her to contact the GP. As is now known, Christine was most probably deceased by that point.

7.15 Had that letter arrived promptly, then the GP might have been successful in making contact and been able to explore how she was feeling about the outcome of the appointment given that from the comments she had made to the psychologist at the QEH, she mistakenly believed that the appointment arranged by the SPOR was with specialist gender identity services. It will remain unknown as to the impact on Christine's mental health of her discovery that this was not the case. It is possible that the deterioration in her mental health that was encountered by the home carers may have been in part related to disappointment about this.

8. BLACK COUNTRY HEALTHCARE FOUNDATION TRUST (BCHFT)

Introduction

8.1 In addition to its IMR, BCHFT helpfully shared the report of the Root Cause Analysis that it had previously carried out which provided a detailed account of the involvement of its different services, and the rationale for decisions made as to what support would be appropriate to meet Christine's mental health needs. The 2 documents identified 4 areas of learning for its own agency which are outlined within the following analysis of the Trust's involvement with Christine.

8.2 The findings in the IMR and RCA were supplemented by the SAR Chair having a discussion with the IMR author to explore some issues around the organisational arrangements for mental health during the period covered by the review.

Overview of the appropriate response to Christine's mental health needs

8.3 In respect of both the CHTT and SPOR assessments, the IMR made the point that Christine had reported experiencing suicidal ideation for many years, which indicated that ongoing treatment for her mental health was the need, rather than short term crisis intervention. Assessments concluded that the risk was stable and that CBT from Kaleidoscope IAPT would have been appropriate.

SPOR Assessment – April 2019

8.4 The IMR finding was that this assessment was unbalanced, and did not address all the relevant issues, because it was too narrowly focused on the issues raised by Christine about her gender identity which the IMR noted was not something that had cropped up in any of the previous contacts with her. The focus on this meant there was insufficient consideration of the mental health issues which had led to the original referral despite the Trust's standard common assessment tool being used. [10]

8.5 The SAR was informed that since this case, the Trust has implemented the use of the Steve Morgan Assessment Tool which ensures the required depth to assessments. This includes questions that not only cover the immediate presenting issues but also focuses on the patient's previous mental health issues, and explores whether these have changed or resolved. All staff have received training videos, and crib sheets, to support their use of this.

Outpatient Psychiatry Appointment – June 2019

8.6 The consequence of the SPOR referral majoring on the gender identify issue was that this also became the main focus of the OPD appointment and how that might be progressed. The IMR made the further observation that while it is possible that the issues around gender identity may have been underpinning some of Christine's previous distress, her mental health problems were wider than just this presenting issue. Consequently, a more thorough assessment should have taken place to gain a fuller picture of the causal factors of her mental health issues, and her needs. This should have included attempts to explore further Christine's disclosures of a difficult childhood which included physical abuse from a family member.

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10 *The SPOR assessment was completed using the Clinical Risk Tool 1 Threshold Assessment Grid (TAG). The TAG contains domains covering safety, risk, needs and disabilities. If the TAG identifies significant risks, then a more comprehensive Sainsbury's risk assessment is completed but as Christine did not present with severe risk to herself, the TAG was deemed to be sufficient.*

8.7 The IMR attributed the lack of focus on other mental health issues on the fact that no formal assessment tool was used to structure the assessment. This gap has been picked up the in the Trust's single agency learning, and the plan is that the OPD will also adopt the use of the Steve Morgan Assessment Tool.

Arrangements for provision of IAPT services during this case

8.8 The IMR explains that the major reason for Christine's experience of having to undergo multiple assessments, and feeling she was being "pushed between services" was that at that time the IAPT services were provided by several external agencies covering different types of support. Therefore BCHFT had no control over decisions as to whether Christine was eligible for that kind of service.

8.9 At that time, there were 2 possible service pathways for CBT or counselling services depending on the outcome of the SPOR's initial referral screening or assessment. Referrals for low mood, depression, anxiety and stress were re-directed to the Sandwell Healthy Minds Wellbeing Hub [11] which was responsible for screening and allocation of the patient to the appropriate provider – in Christine's case the Kaleidoscope IAPT.

8.10 Alternatively, where the SPOR identified that the history and presenting issues were more serious, for example those related to OCD behaviours or trauma such as PTSD, these would be referred to the BCHFT's own IAPT service which had the necessary skills to deliver more structured and intensive counselling.

8.11 The consequence for patients such as Christine who was identified as required talking therapy, is having to go through 2 initial assessments – first with the SPOR, and then with the Wellbeing Hub.

8.12 A key factor for Christine feeling bounced between services was that the standard approach taken by Kaleidoscope was not to stay involved when its view was that their service was inappropriate and a different service was required. This meant that on each occasion when Christine was referred back to them, the full referral process to that service had to be repeated which added to the poor experience for Christine.

Changes in the arrangements for the provision of IAPT services since this case

8.13 The SAR heard that the recurring difficulties and adverse consequences for patients arising from Kaleidoscope's policy of not retaining involvement and the barriers to effective liaison to resolve issues, were key factors in the decision to end the existing arrangements and bring delivery of all CBT services into the Trust in October 2019.

8.14 This change has ensured a smooth interface between different BCHFT services to ensure positive experiences for the patient and referring agencies. Clinical decisions about how best to treat each patient are made jointly by clinical leads which avoid multiple assessments, and the dialogue between clinicians in each team enables patients to access the care they need in a timely manner. A significant change is that a patient is not discharged from the IAPT when the need for a SPOR or CHTT assessment has been identified, and the IAPT will continue to provide support.

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Time interval between referral and appointments

8.15 With the exception of the immediate response of the CHTT in February 2019 to the referral received from KPGWH IAPT, there was a considerable time interval between the referral being received and Christine being seen.

- 8 week interval between the November 2018 referral and the date of the SPOR appointment offered;
- 6 week interval between the February 2019 referral and SPOR assessment in early April;
- 8 week interval between the April SPOR assessment and the OPD appointment in June.

8.16 BCHFT confirmed that the above intervals were in line with target time for a patient to be seen within 8 weeks where the screening of referrals has identified the situation as non urgent as was the case in respect of the referrals received for Christine. [12]

8.17 The SAR noted that the faster target response time of 4 weeks for the Trust's IAPT service stems from the recognition that delivering this preventive service of 6 to 8 CBT sessions as quickly as possible will usually result in the presenting issues being resolved and the need for longer term support avoided.

Access to records of previous involvement

8.18 The discussions with the IMR author identified that a significant issue affecting the quality and depth of assessments was the fact that during this case, with the exception of the Trust's own IAPT service, its electronic record systems only held summary information about patient contacts and the outcomes of assessments. All the detailed information was contained in paper records which in Christine's case meant that there were 3 paper files compiled by the SPOR, CHTT and the OPD.

8.19 Therefore in order to gain a full picture of the issues that arose during other services' previous involvement, it would have been necessary for practitioners to seek out the paper files. While this was not a major challenge for the SPOR and the CHTT who are located in the same building, that would not be straightforward for the OPD who are on a different site.

Single agency learning

8.20 BCHFT identified two areas of learning for its own agency.

Records quality

8.21 The first is the need for action to ensure that the clinical notes meet the required standards with inclusion of the rationale for clinical decision making and the risk management plan drawn up, including any protective factors identified. To address this, a series of bitesize record keeping briefings were delivered to all teams in June 2020 and feedback from these is supporting the development of further briefings. A qualitative record keeping audit tool has also been implemented since November 2019 which Matrons complete monthly and feedback the findings to operational managers, staff teams, and the monthly Quality & Safety meeting.

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[12] *BCHFT uses 3 categories to prioritise referrals – red for immediate high risk, amber for medium risk, and green for non urgent cases. The target response times are set by the CCG.*

Awareness of the risks related to the combined use of alcohol and cocaine

8.22 The second area of learning is the need to raise awareness of the potential significance of the combined use of alcohol and cocaine when completing risk assessments. Consequently, information for staff on the risks associated with substance misuse is being distributed across teams.

9. ADULT SOCIAL CARE

Introduction

9.1 The ASC IMR was completed by the manager of the Safeguarding Team who liaised with the Community Team Manager to obtain answers to the specific questions addressed to ASC to establish the factors underpinning the actions taken by that team. It was not possible to hold a discussion with the allocated practitioner as she has since left the authority.

ASC Assessment of Christine's needs

9.2 During the initial telephone contact, Christine presented as an intelligent person, fully aware of her physical and health conditions that had limited her ability to self care and maintain her home.

9.3 The detailed record of the subsequent assessment visit shows that full information was gathered about her various health conditions which had led to her seeking support. The assessment did not refer to any indications of the mental health issues that Christine had previously shared with the GP and mental health services. There is no evidence that the practitioner enquired with Christine whether she had had contact with other agencies, or sought her consent to speak to the GP about her situation or medical issues.

Commissioning of the Home Care Service

9.4 Although the assessment was carried out within the 15 day target, there was then a gap of almost 2 months weeks before the package of care commenced. ASC procedures require the proposed support plan to be produced within 3 days.

9.5 There were 2 reasons for this delay. First, the record of the assessment was not completed and signed off until the end of May. Then the brokerage team had difficulty in identifying an agency that had availability to provide a service at the early time Christine had requested for the morning call.

9.6 As was usual practice, the agency was provided with a copy of the support plan which provided a detailed breakdown of the care requirements from the assessment. However, in this case, the support plan did not include any issues around Christine's mental health because none had been identified by the social care assessor other than a brief reference to Christine experiencing some anxiety.

Response to issues raised by the home care provider

9.7 The initial assessment visit proved to be the ASC practitioner's only contact with Christine. The IMR finding was that the social worker should have carried out a reassessment in response to the concerns about Christine's behaviour, the agency's recommendation that the package of support be increased, and the request for approval for double staffing. Given the level of concerns being reported during the first 3 days of service, a home visit would have been expected to discuss the concerns with Christine and see at first hand how Christine's situation and presentation had changed since the initial assessment.

9.8 Contact should also have been made with the GP, mental health services, and substance misuse services to seek there advice, and possible involvement, given the indications of the rapid decline. Even if it was not considered necessary to involve other agencies when the concerns were first raised, it would certainly been expected following receipt of the information about the crisis response which led to Christine's admission to A&E.

Safeguarding Issues

9.9 The advice was flawed that was given to the home care agency that here was no need for a formal safeguarding concern to be raised when the agency provided feedback about the circumstances of Christine's admission to A&E. A formal safeguarding concern should have been raised at that point given the clear risk to Christine's safety given the self harm, her disturbed mental state, and the threat to commit suicide. The IMR makes the point that even if a response had not been made prior to Christine discharging herself from A&E, it would have ensured a co-ordinated response to the concern raised. The follow up action would have established that Christine was no longer at the hospital, and might have triggered rapid enquiries to establish her situation and if she was safe. It might also have resulted in intervention by the appropriate mental health service.

Action following Christine's admission to A&E

9.10 In its introduction to the analysis of actions taken by ASC following that admission, the IMR raises the issue that the hospital had not informed ASC of Christine's discharge. Notwithstanding this, the IMR was critical of the fact that no approach was made to the hospital for information about the outcome of Christine's admission to hospital until 13 days later. ASC was unable to establish from the case record what prompted the practitioner's first contact with the hospital at the start of July but it is assumed this was because of the unsuccessful attempt to telephone Christine that day to make arrangements to carry out the usual review that is required within a month of the commencement of a package of care.

9.11 When that call was made, no further information appears to have been sought, particularly as to whether a mental health assessment had been carried out prior to Christine taking her own discharge. Establishing that this had not taken place might have injected the required urgency to check on Christine's welfare. However, apart from the 2 further unsuccessful attempts to telephone Christine over the next 5 days, no further action was taken to establish Christine's situation until mid August some 4 weeks later when the duty social worker telephoned the home care agency to check if it had recommenced the service.

Management oversight

9.12 The delay in checking Christine's situation raises questions about the degree of management oversight. ASC established that at no stage were any issues raised by the practitioner, including the supervision session held shortly before the practitioner went on annual leave when the team manager sought an update on cases which might require input while the practitioner was away. Consequently, the team manager was said to be unaware of the hospital admission. The learning that has emerged from this case about management oversight will be picked up later in the report.

Single agency learning

9.13 The conclusion reached through the IMR was that there was little evidence of learning being implemented from previous SARs in relation to self-neglect, mental capacity, collaborative working and information sharing.

9.14 Consequently, regular staff briefings have been introduced which look at lessons learnt to develop thinking around what constitutes good practice, including the need to apply greater professional curiosity. In addition the SILP process [13] has been introduced to analyse serious incidents and draw out the learning.

9.15 Further actions planned include:-

- Multi-agency risk assessment meetings to be chaired by managers;
- The introduction of a Risk Management Panel where discussion can take place with more senior managers about cases that are considered to be high risk;
- Reinforcement of the need for a longer term approach to establish relationships with hard to engage service users;
- The requirement for face-face visits for all cases when information is received that there is deterioration in a service user's situation and / or their mental health.
- Reminding managers of the need for evidence of managerial oversight to be entered on case records.

10. THERAPY SERVICE

Introduction

10.1 The report provided by the Therapy Service was based entirely on the case record. The fact that there was no discussion with the practitioner, or the OT, meant that several of the IMR findings were speculative as to the possible reasons for actions taken.

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[13] *SILP is one of the methodology options for Child Safeguarding Practice Reviews, Safeguarding Adults Reviews, Domestic Homicide Reviews or any other form of learning activity. SILP explores the professional's view of the case at the time the events took place. It analyses significant events and deals not only with what happened but why it happened.*

Response to the referral

10.2 The duty officer's telephone call with Christine resulted in the referral being categorised as low priority with an assessment visit booked for a month's time which was well within the target timeframe of 10 week for the assessment visit to be made. The record of that subsequent assessment did not identify any issues in respect of Christine's mental health, or her capacity to make decisions about the options offered to her. The assessment of risk was also recorded as low, and no safeguarding issues were identified.

Liaison with the ASC social worker

10.3 The prevention assessor did provide feedback to the social care practitioner after the assessment, but the case record did not include any details of what information was shared other than Christine's not reacting to the prevention assessor making a comment that the children in a photo looked cute. It is not known whether this feedback was because the assessor thought Christine's lack of reaction was strange and the social worker needed to know, or the assessor wanting to check the position about possible family involvement as Christine had referred to her wheelchair having been provided by a family member.

10.4 The IMR made the observation that while it would have been helpful to have obtained more information from Christine about the family situation, it appears that the assessor assumed that Christine did not want to talk about this, and respected that decision. In response to the enquiry by the assessor, the ASC practitioner stated that Christine was not in contact with her family.

Plans to approach the GP

10.5 Although it is not known why the OT recommended that contact be made with the GP, the IMR explained that there are occasions when further information is required about the service user's health conditions, and prognosis, in order to inform any further risk assessment and ensure that appropriate and safe equipment or adaptations are provided. The assumption is that in Christine's case, further information should be sought on the cause of Christine's blackouts, and the likelihood of this happening again. However, that approach to the GP was never made because the assessor was unable to make contact with Christine to obtain her consent to this which the IMR explained is always required before the GP will share information.

10.6 In respect of the 2 month gap between the 2 recorded attempts to contact Christine to seek her consent, the IMR commented that it is possible that this was due to pressure on the service, and the organisational arrangements whereby prevention assessors may have to spend weeks on duty and are therefore unable to work on their own cases except where there is an urgent matter that is cleared with the line manager. Although procedures do not set out any specific timescales for these to be made, the IMR author's view was that the gaps between contacts should not exceed 1 month.

Decision to close the case

10.7 The service's policy is that there needs to have been 3 unsuccessful attempts to contact the service user before a decision can be made to close the case, and that there should be a sufficient gap between these attempted contacts to allow time for the service user to call back. If there is no response, a letter should be is sent giving another 14 days for the service user to respond. However a letter was not sent to Christine but the reasons for this were not established.

10.8 The records do not indicate that any consideration was given to contacting the ASC practitioner to report the difficulties in making contact with Christine before the decision was made to end involvement. The IMR author's view was that an approach should have been made which might have promoted the ASC practitioner to follow this up.

10.9 The IMR explained that the service does not set down any expectations that feedback should be provided to referring agencies on the outcome of contacts with the service user unless there are concerns about the service user's well-being. In Christine's case, no concerns had been identified within the original assessment. The IMR also made the observation that the ASC team share the same record system and would have been able to see the Therapy Service's unsuccessful attempts to contact. This observation assumes that ASC practitioners will routinely view the Therapy Team's records. This leads to learning which will be picked up later in the report.

Learning / Action

10.10 The IMR sets out 4 actions to address the learning from this case:-

- to clarify that practitioners should make 3 attempts to contact a service user who does not respond, and that these should be no more than 6 weeks apart;

- reminders to be given to staff about the need to consult their line manager for guidance if they have any concerns about the service user;

- practitioners should inform the allocated ASC team that the case has been closed;

- the need for full recording of any discussions with other professionals.

11. ELITE HOME CARE

11.1 The home care agency provided a full description of its involvement with helpful detail about each visit to Christine and the contact with ASC to report the concerns about Christine's behaviour and raise the fears for the safety of staff.

11.2 A key issue explored during the review was why the home care manager accepted the view of the ASC practitioner that it was not necessary to raise a safeguarding concern following the crisis admission to A&E. However, the agency was unable to answer that because the manager at the time has since left the agency. However, the agency provided reassurance that the decision did not reflect the agency's usual practice and that a safeguarding concern should have been submitted in line with its written safeguarding policy.

12. WMAS

12.1 The finding of the IMR was that practice met WMAS standards for each of the 5 attendances during the review period, and picks out several examples of good practice to achieve the best possible outcome for Christine. This was particularly evident in respect of the first attendance when the paramedics were on the scene for almost 2 hours dealing with a very challenging situation before successfully getting Christine to accompany them to A&E.

12.2 The IMR also highlighted the similar amount of time that paramedics spent at the next attendance 2 days later and the lengths they went to secure Christine's agreement to go to hospital, and in explaining to Christine the potential fatal consequences of remaining at home without further assessment when she continued to decline the advice given to be taken to A&E. Appropriate safety advice was given when Christine was discharged at the scene.

12.3 The input during that visit possibly contributed to Christine's agreement to be taken to A&E when she called for assistance later that morning. During that 25 minute attendance, Christine stated she had been taken to hospital at some point in the past but could not remember when, and that she had discharged herself without being seen.

12.4 During the paramedics' attendance the following day after Christine reported having difficulty in breathing, her problem quickly settled. Again, Christine declined the advice to go to hospital, but stated that she would contact her GP who was sent the usual notification of the attendance and outcome.

12.5 At each attendance, WMAS clinicians assessed Christine's mental capacity. On the occasion when it was deemed she lacked capacity to make decisions about the health needs, appropriate steps were taken to ensure her safety and that she received the appropriate medical help at hospital. On the other occasions, when Christine was deemed to have capacity, WMAS clinicians respected Christine's wishes and feelings when she refused any further medical help or intervention.

12.6 The IMR made the important observation that on each occasion, the attending paramedics had no prior knowledge of Christine and previous attendances. Therefore, their intervention and decisions were necessarily based solely on the information given them at each incident. The challenge that this lack of prior knowledge creates for paramedics has been highlighted in previous SARs and will be picked up in the learning later in the report.

12.7 The IMR confirmed that no safeguarding concerns were raised by any attending WMAS clinicians, but did not provide any comment as to whether a safeguarding concern should have been raised following the first attendance given the circumstances that led to Christine being taken to A&E. This again leads to some learning which will be picked up later in the report.

13. THE DUDLEY GROUP NHS FOUNDATION TRUST

Cardiology appointments

13.1 The DGFT findings was that at the two outpatient appointment in January and May 2019, there was little evidence of any holistic approach to the assessments, and her mental health was not discussed. In the light of the information that had emerged through the SAR process, this was a missed opportunity to explore other aspects of Christine's overall situation.

First attendance at ED – June 2019

13.2 The triage document for Christine included the information that her admission was via 'emergency services', that she had told her carers she wanted to kill herself and that she had injected something into her leg. It was also noted that she had consumed alcohol, lived alone and that she had 'mental health problems'. Under the safeguarding subcategory, Christine was documented to be 'at risk of self-harm' and that there was no concerns regarding her capacity.

13.3 However, the IMR identified that there were significant gaps in the triage document because it did not include the difficulties encountered in conveying Christine to hospital which resulted in assistance being sought from the police, the existence of the helium tanks which Christine intended to use to take her life, or the paramedics' assessment that the risk of suicide were high. These findings raise some issues about the handover processes from WMAS to ED staff which will be picked up later in the report.

13.4 However, the DGFT IMR made the observation that even if staff had been aware of the full circumstances and events leading to Christine's first attendance, it is likely that Christine would have still been assessed as having capacity to make the decision to self-discharge. However, having the full picture could have enabled a more informed and robust risk assessment in relation to that decision.

Mental health and alcohol issues

13.5 The IMR explains that individuals younger than 65 who attend ED with issues relating to their mental health are initially triaged, and if there are no medical concerns or possible intoxication, they can then be referred directly to the Mental Health Liaison Team (MHLT) for assessment with the patient's consent. If the patient does not have capacity to consent at that time, it may be appropriate for a medical assessment to be carried out first to ensure there are no reversible causes.

13.6 The IMR established that no referral was made to the MHLT, but it was unclear from the records if the need for an assessment of Christine's mental health was identified, and if so whether the Triage Nurse decided that Christine first required a medical assessment either due to the alcohol consumption or because she had injected something into her leg.

13.7 The ED triage documents include a mental health / self harm screening tool which assesses whether an individual requires increased observation, or 1 to 1 care, to reduce the risk of self-harm or absconding. The form for Christine included her intention to take her own life, but did not identify any concerns around Christine's behaviour, or that she was extremely agitated or restless.

Christine's decision to self discharge

13.8 The IMR finding was that this would have been an opportunity to discuss alcohol with Christine and if this was having a negative effect on her wellbeing. However, the triage document did not include any details as to how much alcohol Christine had drunk, when, and what type. Exploring this might have resulted in her being sign-posted to alcohol cessation services.

13.9 In terms of mental capacity to make the decision to self discharge, it appears that an assumption of capacity was made in line with the Mental Capacity Act (MCA) principles. The absence of any further reference to this in the record was consistent with the Trust's Assessing Mental Capacity Policy which only requires staff to evidence why they have come to the conclusion that a person lacks capacity to make a particular decision.

13.10 Although Christine accepted the advice to contact her GP for support with her mental health, there was no evidence that further risks for Christine were considered. There was also a lack of professional curiosity to explore why someone young and physically independent required carers, and whether they needed to be notified to reinstate support.

Discharge letter

13.11 Every ED attendance results in an electronic discharge letter being sent to the GP [14] providing a brief notification of the presenting complaint, diagnosis, discharge details and any actions for the GP. The content is mostly computer generated, and auto-filled, from the information that has been entered into the ED medical assessment, and the ED discharge forms on Sunrise, the electronic patient record system used in ED.

13.12 The discharge letter created on this occasion was drawn solely from the triage document as no medical assessment had been carried out. The information included was insufficient because although it mentioned that the reason for attendance was 'suicidal', it did not include any information about the circumstances of her attendance and that she had self discharged prior to any assessments being carried out.

Notifications to other agencies

13.13 DGFT confirmed that usual practice is to ensure that home care agencies are notified of a patient's discharge so any package of care can be recommenced without delay. However, although the triage document had noted that Christine had carers, and the WMAS EPRF also included a contact number for the home care agency, there is no evidence that any attempts were made to contact the care agency to inform them she was returning home, or to clarify if Christine would do this.

Safeguarding Issues

13.14 The IMR finding was that there was a missed opportunity to recognise and follow up the potential safeguarding issues related to Christine having been assessed as being at high risk of suicide. Raising a safeguarding concern should have been considered when Christine self-discharged before being seen by the MHLT.

13.15 The overall conclusion of the IMR was that the expected standards of care were not entirely met in respect of the following issues:-

- there was either an oversight by ED to consider whether action was required to inform the care agency of her discharge, or an over-reliance on Christine to arrange this;

- a lack of clarity about how the MCA framework was used in concluding that Christine had capacity to make the decision to self discharge;

- the missed opportunity to recognise and act upon safeguarding concerns when Christine self-discharged.

Second attendance at ED

13.16 When Christine self discharged before treatment of could be provided, [15] unsuccessful attempts were made to persuade Christine to stay, including a member of staff following her out to the car park.

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14 *The discharge letters are automatically sent electronically 6 hours after a patient has being removed from the ED tracking board on Sunrise.*

15 *The plan was for intravenous antibiotics and fluids to be provided*

13.17 Unlike the attendance 2 days earlier, staff did not pick up that Christine had a package of care. The IMR finding was that there was no evidence that staff explored with Christine her home circumstances and whether she had any additional care and support needs. The IMR noted that this appears to have been due to Christine appearing to be quite independent, as shown by her walking out unaided. In his Coroner's statement the ED doctor recalled that Christine did not mention or disclose any social or safeguarding issues 'despite having a good conversation with her'.

13.18 The ED notes did not document Christine's reason for wishing to leave before treatment. In the statement prepared for the inquest however, the doctor recalled that Christine had mentioned that she had a dog at home on its own, but she did not give any other reason. The doctor recalled that Christine was counselled on the risks of leaving without treatment, including the worst possible medical outcomes. Christine continued to be adamant about her 'need to leave' and was deemed to have capacity to make the decision to self-discharge as she was lucid and coherent at all times.

13.19 On this occasion, the GP discharge letter was said to be of good quality. It contained all the relevant information, including the fact that she had left against medical advice, but that no additional actions or requests had been identified for the GP.

Access and use of records of previous attendances

13.20 During the SAR exploration of what use is made the ED of records of previous attendances, the challenge faced by ED staff is that the volume of patients needing to be seen rapidly means that there is often not time for the Triage Nurse to review any historic ED attendances because the process of opening up each document, or ED note entry, is time consuming.

13.21 A second challenge is that ED Staff can only view the electronic records held by the main hospital which include hospital discharge letters, clinic letters, and results from certain investigations. Access to the full records in not possible because these are paper records. This problem has been eased since DGFT added additional software to its IT system which enables staff to access electronically some key information held by their patient's GP.

Self Discharge Policy

13.22 On both occasions that Christine self-discharged, the Trust's policy for Discharge Against Medical Advice (DAMA) was not entirely followed as this information was not included in the discharge letter for the first attendance, and on neither occasion was Christine asked to sign a self-discharge form. [16] In addition, an internal incident form via Datix should have also have been completed which is then reviewed by appropriate senior staff that enables a further check as to whether any further action is required. This could include the incident being forwarded to the Safeguarding Team for an additional review.

[16] *The self-discharge form includes a section which the patient takes and provides them with generic safety advice to attend ED or call 999 if they become concerned or unwell.*

Single Agency Learning

13.23 DGFT identified 3 areas where action is planned that will address the issues arising from this SAR.

13.24 The DAMA policy is to be reviewed, with an audit to be completed by the Safeguarding Team to identify if there are any emerging themes surrounding DAMA patients Trust wide. One process already implemented is for the ED Consultant to review all he notes of any patient who self-discharges, or absconds, the following day after their arrival. This provides an additional safeguard to ensure that there are no further actions required, and that any concerns are appropriately communicated to any health professions involved.

13.25 With regard to ED discharge letters, this SAR has identified that the current IT system does not enable the ED discharge form to generate a GP letter. These letters can only be generated from the clinical notes or the triage document. Therefore, in Christine's case, the discharge document was drawn solely from the triage document. This gap has been added to the ED risk register and is to be actioned immediately to address the potential significant clinical risks arising from this.

13.26 The final planned action is to develop a discharge checklist for adults with care and support needs, including those who self discharge, to ensure their safety post discharge. The use of this checklist will prompt staff to ensure they notify the appropriate health or social teams of the discharge.

14. OVERVIEW OF MULTI-AGENCY WORKING

14.1 In respect of that finding, it is important to highlight that there were some good examples of joint discussions to address Christine's issues, particularly:-

- the detailed correspondence, and discussions involving the GP, the psychologist in the cancer service and the consultant in the palliative care service.

- the home care service reporting their concerns to the ASC practitioner.

- the IAPT discussion with the SPOR about its assessment of risk and Christine was not appropriate for the IAPT service at that point.

14.2 Beyond that multi agency working was markedly lacking as shown by the following examples where it would have been expected that contact would be made to share information.

BCHFT mental health professionals

14.3 Mental health professionals did not discuss the findings from their risk assessments with the GP but instead wrote to the GP to share their conclusions and proposed way forward. The only telephone discussion was that made by the GP to the SPOR in February 2019. Given that the GP had raised the issue about Christine feeling she was being bounced between the different mental health services, a discussion would have been helpful to problem solve how Christine's needs for mental health support could best be met.

14.4 There were no discussions between the SPOR or CHTT with Kaleidoscope to talk through the differences in professional opinion as to what service might best meet Christine's needs.

14.5 The SPOR did not alert ASC to the plan for Christine to make a self referral. This might have been expected to alert ASC to the mental health issues that would need to be factored into any assessment of her health and care needs.

Adult Social Care

14.6 No contact was made with the GP by the ASC practitioner when carrying out the Care Act assessment to gain more information about Christine's physical health conditions and the prognosis. Had that contact taken place, it may have resulted in ASC being alerted that Christine had a history of mental health issues which needed to be factored into the completion of a well rounded assessment.

14.7 There was no liaison between the ASC practitioner and the therapy service despite being in the same organisation, other than the latter sending an email to raise the concern about Christine's lack of response to the comment made about the children's photograph. The Therapy service did not inform ASC of the difficulty in re-establishing contact with Christine and made a unilateral decision to close the case.

14.8 The lack of contact with the hospital after Christine's crisis admission. Immediate contact would have been essential to check the outcome and share information to inform an urgent re-assessment. Linked to this was the delay before contact was made with the home care service to check that the service had been re-instated after the ASC practitioner learned of Christine's self discharge.

Hospital

14.9 The hospital did not make a referral to the Mental Health Liaison Team which meant that mental health services were unaware of this crisis admission and enable a decision to be made about any necessary follow up in the community.

15. KEY FINDINGS AND LEARNING

Introduction

15.1 The learning from this review span a number of overlapping themes, many of which stem from the gaps in multi-agency working summarised above. A number of these are not new and were highlighted in previous SARs. Therefore it will be important that the learning, and proposed actions from this review focus on how agencies can embed the learning this time around the following:-

- applying a holistic approach to assessments;
- achieving a shared understanding of when safeguarding concerns should be raised;
- the hospital triage process including the transfer of information from WMAS;
- the response to disclosures of self harm and suicide ideation;
- arrangements for re-instating services following hospital discharge;
- improving the quality of hospital eDischarge letters;
- ensuring effective management oversight;
- development of a shared care record.

16. ASSESSMENTS

16.1 Three agencies, ASC, BCHFT and DGFT, identified gaps in the assessments undertaken by their staff who focused on the presenting issue rather than using the opportunity to apply the necessary holistic approach. This meant that each had a piece of the jigsaw but none had gained the full picture of Christine's situation and support needs.

16.2 This finding leads to two actions needing to be taken. First, each agency should therefore review its guidance to ensure that this includes the type of situations where contact with other agencies should become standard practice. Second, to provide assurance that the guidance is being applied, agencies should carry out monthly dip sampling of assessments, and Sandwell SAB should include an evaluation of assessments in its programme of multi-agency audits.

Applying professional curiosity

16.3 There were several examples in Christine's case where it might have been expected that professionals should have displayed more curiosity about her situation. These included:-

- the Therapy Team practitioner not pursuing further Christine's lack of response to the practitioner's comment about the photo of 2 children;

- hospital staff not questioning why a woman in her 40s, who appeared physically well and mobile was receiving support from home carers;

- the GPs not exploring further why Christine preferred testosterone for her anxiety rather than anti-depressants. This might have drawn out Christine's issues about gender identity.

16.4 The lack of professional curiosity being applied by professionals continues to be a recurring theme in safeguarding reviews nationally as highlighted in a strategic briefing paper published by "Research in Practice" in December 2020. [17] This briefing provides advice on steps that can be taken to promote practical arrangements and an organisational culture which enables professional curiosity to flourish. Their suggestions are organised around the following issues:-

- Involving people
- Time and capacity
- Structure and working practices
- Recording, processes and procedures
- Supervision and support
- Legal and safeguarding literacy
- Learning and development
- Open culture
- Partnership work

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17 *"Professional curiosity in safeguarding adults" – Research in Practice Dartington Hall Trust)- December 2020.* *https://www.osab.org.uk/cms-data/depot/hipwig/Professional-Curiosity-in-Safeguarding-Adults-Research-in-Practice-Strategic-Briefing.pdf*

16.5 In addition to using the briefing paper to inform its development work, it is recommended that consideration is given to developing specific guidance similar to that produced by Solihull SAB. [18] This describes the many types of situations where professional curiosity and persistence should be applied, and includes practical advice on how to probe further and hold difficult conversations. The issues covered in the Solihull guidance include:-

- dealing with disguised compliance;
- avoiding the rule of optimism;
- Normalisation
- Not seeing the whole picture
- Managing tensions with service users
- Confirmation bias
- Dealing with uncertainty
- Managing professional differences
- Cultural competence.

Consent to share information

16.6 Linked to the gaps within assessments is the issue of how and when practitioners seek consent from service users to enable approaches to be made to other agencies to obtain or share information. This was an issue particularly related to the approach taken by the Therapy Service when difficulties were experienced in trying to seek Christine's consent to talk to the GP, and ultimately resulted in the case being closed before that conversation had taken place. This problem could have been avoided if written consent had been sought from Christine as part of the assessment process.

16.7 Given that the need to contact the GP or other health professionals to gather more information to inform safe assessments of equipment or adaptations to be provided can be a recurring and necessary feature of the work, it is recommended that service users should be asked if they are willing to give written consent when the assessment is carried out. This will avoid the kind of delay that featured in Christine's case through having to seek consent at a later stage.

17. SAFEGUARDING ISSUES

Self Neglect

17.1 This review has highlighted the need for further work to develop a shared understanding across the safeguarding partnership around the recognition and appropriate response to possible self neglect. This issue stemmed from the different views shared within the review discussions as to whether the circumstances of Christine's first admission to hospital should have prompted safeguarding concerns being raised.

[18] *"Something does not feel right" – Guidance on professional curiosity and persistence. Solihull SAB.* *https://ssab.org.uk/media/upload/practitioners_document/Guidance%20on%20Professional%20Curiosity%20and%20Persistence.pdf*

17.2 The ASC view was that safeguarding concerns should have been raised at that point of admission because there were issues around self neglect that were possibly linked to Christine's mental health. The ASC perspective was that this would have ensured a co-ordinated response, and the initial information gathering would have established that Christine was no longer at the hospital, and might have triggered rapid enquiries to establish her situation and if she was safe. It might also have resulted in intervention by the appropriate mental health service.

17.3 The view of health professionals was this was principally a mental health issue, which did not require a safeguarding response. This was because the paramedics had followed the appropriate care pathway and by making a best interest decision to take Christine to hospital, this would enable Christine's mental health to be assessed. In addition, the GP received the usual notification which would enable any necessary follow up. It was therefore only at the point when Christine took her own discharge before a mental health assessment that consideration should have been given as to whether a safeguarding concern should be raised.

17.4 On balance, having regard to all the information gained by agencies during their involvement in 2019, the review finding was that self neglect was not an issue in this case given the evidence that Christine:-

- had continued to engage with the GP, and attended secondary care appointments, to address her health needs;

- had actively sought support for her mental health and attended all appointments;

- was proactive in exploring with Adult Social Care what care package and equipment she might be eligible for;

- remained motivated to exercise when her heart trouble allowed, including cycling long distances to appointments;

17.5 Having regard to that conclusion, it is important to acknowledge that it was quite understandable why the home carer agency reached the view from Christine's presentation and behaviour that she was a risk to herself and not able to look after herself properly. Their observations of course were drawn from just two days involvement when Christine was clearly experiencing one of the more stressful periods when she was becoming overwhelmed by her overall situation. In terms of the observation about the empty bottles, the SAR established that the use of alcohol had long been one of the coping mechanisms Christine would fall back on.

17.6 One key message which needs to be reinforced by the SAB stemming from the contact between the home care agency and the ASC practitioner, is that agencies must make their own professional judgement as to whether to raise safeguarding concerns, particularly in situations where they are not confident as to whether any risks they have flagged up will be followed up promptly.

17.7 The SAR heard that ASC is carrying out a review of the safeguarding procedures, and that there will be consultation with partner agencies during the process. It was unclear whether this single agency led approach has been endorsed by the Safeguarding Adults Board, and whether it provides the opportunity for partner agencies to shape the agenda. Given the multi-agency nature of the issues that have emerged from this SAR, it will be important for the SAB to assure itself that the development work reflects a fully inclusive approach across the partnership.

17.8 The SAR noted that the current West Midlands multi-agency guidance on self neglect is currently being reviewed. The existing version does not include any coverage of the debate from this SAR where there is the potential need for mental health and safeguarding referral pathways to be followed in parallel where there is a possible issue of self neglect. Therefore, Sandwell may wish to feed this issue into the regional work.

Vulnerable Adult Risk Management

17.9 A recent development which is designed to improve the response to the risk such as those that featured in this case, is the planned implementation from October 2021 of the new Vulnerable Adult Risk Management (VARM) Framework which is an addition to the existing safeguarding procedures and processes.

17.10 The framework provides detailed guidance on the arrangements for multi-agency meetings to be convened to identify and manage risk in cases that either do not meet the criteria for Section 42 safeguarding enquiries to be initiated, or where safeguarding processes have been invoked but are no longer considered to be the appropriate response. Having regard to Christine's case, the framework extends the range of adults who may be in need of safeguarding to include those at risk as a result of self-harm.

17.11 A key objective of the VARM framework is to secure clear accountability across organisations when dealing with complex situations that require more in-depth assessment. An important benefit of the framework is that it addresses concerns about existing practice where information is shared between agencies about risks but that there is little ownership or proactive multi-agency activity taking place to mitigate these.

17.12 The framework is intended to be used where single agency plans have not effectively addressed the presenting risks, and in cases where the adult has been assessed as having the mental capacity to understand these. In these situations, a VARM meeting should be convened which includes representatives from any agency that is currently engaged with the individual and also identify any agency that could support the process. It is important to note that any agency can lead on the VARM process and this does not need to be Adult Social Care.

17.13 The framework includes detailed guidance and templates for the scoping and conduct of the initial VARM meeting and for follow up meetings to review progress. Crucially, the guidance is clear that there must be agreement by all professionals involved in the case that intervention through the VARM process is no longer required before this is ended.

7.14 The new framework has the potential to address the gaps in multi-agency working that have been identified in this case, and that have also featured in the findings of previous SARs. It will be important for the Sandwell SAB to receive regular reports on the results of the planned evaluation of the impact of the framework in securing effective multi-agency working and positive outcomes for service users.

18. HANDOVER FROM WMAS AND HOSPITAL TRIAGE PROCESS

18.1 This SAR has drawn out some important learning about the handover arrangements from WMAS and the use that is made of the Electronic Patient Record (EPR) completed by the paramedics.

18.2 On arrival at hospital, the paramedics provide a verbal handover to the Triage Nurse which is then summarised by the latter in the triage document. The EPR is also uploaded on to the electronic ED system by the ward clerk, and can be accessed to provide more detailed information as required to supplement the verbal handover.

18.3 However, DGFT explained that because of the volume of patients and time pressures to complete the triage process, the Triage Nurse would not normally view the EPR to complete the triage document unless there are exceptional circumstances. Usually, the EPR is viewed later during the attendance to inform the any subsequent clinical assessments carried out.

18.4 The expectation therefore is that all the vital information will have been shared at the verbal handover. However, the DGFT IMR hypothesis was that this may not have happened in Christine's case, and this contributed to the gaps in the triage document. In addition, the DGFT observation was that the information contained in the EPR was limited.

18.5 However, the WMAS view was that it would be unlikely that a full handover was not provided given the history, and level of risk, that had been included in the EPR. The observation was made that this not a "run of the mill" attendance given the 2 hours spent on site and a request for assistance being made to the police.

18.6 In order to understand the reason for these different perspectives, DGFT and WMAS each provided the Author with a copy of the EPR to back up their findings. It became apparent from an examination of these that there was a significant difference between the 2 copies because the copy supplied by DGFT did not include the "notes" in section 4. This included the information that:-

- the patient has stated to carers that she wants to kill herself, with helium and a bag over her head;

- on scene, the patient had periods of calm and was coherent, but then having episodes of seeing things and upset;

- the patient has consumed alcohol today;

- the patient states she has stabbed herself in the leg (right) with a syringe, one she uses to inject steroids - she would not let us examine her leg.

- the patient refused to come to A&E willingly but lacks capacity and is not deemed safe to be left at home.

- the police were requested to assist with removal of the patient but the mental health car came instead.

18.7 As to why the copies were different, WMAS explained that once the crew leave the scene of an incident, and select their destination, the EPR is automatically sent to the EPR portal at that hospital. This gives an early indication to the receiving hospital of the patient that is on route to them. Therefore when the EPR was first uploaded, the crew would have still been adding their notes about the history and clinical findings whilst on route. Therefore, if the EPR had been opened by the hospital after arrival the updated information would have been visible.

18.7 However, in response to this explanation, DGFT provided the following timeline from the ED system to support their conclusion that the above notes were added after the verbal handover

00.22 WMAS arrived at the hospital;
00.25 the EPR was uploaded onto the ED system;
00.26 the triage process was documented as completed;
00.56 the clinician sign-off on the EPR by the paramedics.

Conclusions and learning

18.8 Although it was not possible to reconcile the different conclusions reached by DGFT and WMAS about the handover process in this case, and the time the EPR was completed, the SAR drew out that the issues around the handover processes and use of the EPR are complex.

18.9 There was agreement that in situations such as Christine's where effecting conveyance to hospital has been problematic, and high risk of suicide has been identified, it is essential that the EPR includes full details of the circumstances of the attendance and the assessment of risk. These should be included in the verbal handover to the triage nurse who in turn must ensure that these are included in the triage document.

18.10 On a final note on this issue, the DGFT IMR noted that there was no documentation to indicate that any information was received from the Street Triage Team about its involvement which would have been important given their specialist knowledge of mental health issues. Again, where other services have been involved in an admission, it is important that they provide their own report to the hospital and not rely on others to do this, to ensure the hospital receives full information to inform their subsequent risk assessments.

19. RESPONSE TO SELF HARM AND SUICIDE IDEATION

19.1 The SAR was unable to establish whether the ED was informed about Christine self-harming when the verbal handover took place during the first admission in early June.

19.2 Sharing this information would have been important given that national reports have identified that self-harm is one of strongest predictors of suicide, including among older people. Where self harm is identified and should lead to application of guidance issued by the National Institute for Health and Care Excellence (NICE). [19]

19.3 The 2020 report published by the Royal College of Psychiatrists [20] made the observation that while most cases of completed suicide are linked to mental illness, at-risk patients are not being identified and / or offered the mental health treatment that could have prevented their death. It also highlights that people with a physical health long term condition (LTC) are more likely to have poor mental health, and vice versa, and that suicide occurs more frequently with the coexistence of psychiatric and physical illness. Significantly, having regard to Christine's case, the report stresses the need to be particularly alert to the risk of suicide in younger physically ill women, especially those with multiple physical health conditions.

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[19] *NICE 2011 guideline Self-harm: longer-term management* https://www.nice.org.uk/guidance/cg133/chapter/1-Guidance

[20] *"Self-harm and suicide in adults"- final report of the patient safety group - July 2020 - CR29 – Royal College of Psychiatrists*

19.4 In support of these observations, the report cites the evidence that in the month before people take their life by suicide, 50% had seen a general practitioner, 30% had seen a mental health professional, and in the 60 days before death, 10 per cent had been seen in a hospital emergency department. Consequently, it has been acknowledged that active support for people who present with self-harm is essential in preventing suicide.

Learning

19.5 Consequently, NICE guidance includes comprehensive advice for professionals working in different health settings on mitigating risks where incidents of self harm may be identified, and the importance of providing a timely and comprehensive psycho-social assessment. Research has shown that providing this type of assessment is associated with a 40 per cent reduction in the risk of repeated self-harm. [21]

19.6 Having regard to presentations at ED as in Christine's case, the guidance explains the need to develop close links with mental health services to assist in the initial assessment, and ensure the necessary follow-up post discharge. During the ED episode, staff should gather:-

- a detailed history of the self-harm including relevant triggers, an assessment of mood and the level of continuing suicidal intent;

- relevant information about the person's psychiatric history, family, and personal circumstances

19.7 Had an assessment been carried out that point, it may have identified that there were a number of social and clinical factors in her situation that are listed in the RPS report as key factors:-

- lack of social support, living alone, no confidants;
- loss of job;
- alcohol misuse - particularly related to the loss of a relationship;
- access to lethal means;
- previous self-harm or suicide attempt(s);
- long-term medical conditions;
- high degree of emotional pain and negative thoughts (hopelessness, helplessness);
- suicidal ideas with a well-formed plan and/or preparation.

Onward referrals by the Mental Health Liaison Team

19.8 Although the Mental Health Liaison Team (MHLT) was not involved in Christine's case, the SAR discussions identified a wider issue as to what happens when a patient is referred to the MHLT but is not seen prior to discharge. DGFT shared its experience that on occasions, there is a delay of up to 4 hours before the MHLT is available to see the patient and this contributes to patients being discharged before they can be seen as they do not want to wait any longer. This was said to be a particular issue in respect of attendances during the night.

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21 "Does Clinical Management Improve Outcomes following Self-Harm? Results from the Multi-centre Study of Self-Harm in England" - Kapur et al. 2013

19,9 DGFT shared its perspective that where this occurs, there needs to be more ownership by the MHLT in terms of what happens next, and that the MHLT should take responsibility for ensuring there is appropriate follow up in the community by the relevant mental health service.

19.10 The response provided by BCHFT illustrated why this continues to be a concern for DGFT. BCHFT explained that if the patient is an open case to mental health services, the relevant team will be informed, but if not, the onus is put back onto ED staff to consider if they should contact the police to request a safe and well check. The rationale for this approach is that the police will ask for details about the patient that the MHLS would not be able to answer if they have not seen the patient.

19.11 BCHFT also explained that the GP will always be informed of the referral and that patient has not been seen, regardless of whether the patient is an open case to mental health services or not. The observation that flows from this is the likelihood that for cases where there is no current mental health service involvement, the outcome will be the GP making a referral to the BCHFT SPOR to request an assessment. This is likely to build in a delay which could be avoided if the MHLT had contacted the SPOR direct to arrange this.

Learning

19.12 In the light of the above observations, the SAR includes a recommendation that the MHLT should take responsibility for making the necessary referrals to the SPOR for follow up assessments to be carried out where the MHLT has not been able to see the patient prior to discharge from hospital.

Safety Plans

19.12 Early identification and intervention can minimise distress and reduce the likelihood of self harm being used as a maladaptive coping mechanism and becoming entrenched. NICE and RCP guidance therefore explains the need for every person who self-harms and/or has suicidal thoughts to have a safety plan co-produced with the service user. This should make explicit reference to the removal and/or mitigation of the means to harm themselves, list activities and coping strategies, and provide information on how to access social, psychological and emergency support.

19.13 It is unclear from the descriptions of the crisis plans drawn up by mental health professionals in their contacts with Christine that all of these issues were covered, or that professionals discussed, or tried to seek her agreement to the removal of the helium tanks.

20. RE-INSTATEMENT OF SERVICES FOLLOIWNG HOSPITAL DISCHARGE

20.1 A key factor in this case was that contact was not made with the home care agency to inform them of Christine's discharge and ensure that the support was reinstated. Within the panel discussions, each of the agencies involved in Christine's care said it was their responsibility to notify the carers, and explained the usual practice as follows:-

- ASC's expectation is that the ASC practitioner would immediately contact the hospital to establish the situation once it becomes aware that a service user in receipt of a care package has been taken to hospital. Again for reasons that could not be established this did not happen.

- the home care agency's standard practice is to contact the hospital to check the situation so that they are aware of when the service needs to recommence. However, in this case for reasons the agency could not establish, this was not done.

- the hospital's normal practice is for staff to check if there are carers involved, and if so notify the agency. In this case, the hospital had the contact details for the home care agency.

20.2 In Christine's case therefore, there was a complete breakdown of the usual processes applied by agencies to check that services were reinstated which appears to be related to oversights by the different agency personnel involved.

Learning and recommended actions

20.3 From the SAR discussions, it does not appear that there is any shared understanding of roles, responsibilities and processes for ensuring services are re-instated.

20.4 To minimise the risk of this occurring in the future, it will be important that discussions take place between ASC and the relevant hospitals to ensure there is a system wide agreement on roles, responsibilities and processes to ensure information is shared with care providers when services need to be reinstated. Steps will then need to be taken to ensure these are disseminated to all relevant staff, and for the effectiveness of the process to be kept under review.

20.5 For hospitals, this means a patient's home circumstances need to be explored in sufficient depth to ascertain what support will be available post discharge, and whether this appears sufficient. When there is an indication that the patient, or anyone living with her, has carers, this must act as a trigger to probe further. It is acknowledged that it can sometimes be a challenge for hospital staff in trying to find out if a patient is in receipt of care support, and which agency is providing that - especially in respect of admissions during the night.

21 HOSPITAL eDISCHARGE LETTERS

21.1 National guidance requires an electronic discharge summary being sent to the GP following each ED or hospital attendance. As set out in the guidance published by the Royal College of Physicians, [22] this should contain a brief summary of the reason for admission, the hospital episode, and include all investigations, new diagnoses, and why medications have been started or stopped. It should also flag up any follow up actions required by the GP.

21.2 Earlier in this report, there was detailed coverage of the DGFT findings that the discharge summary from the first ED admission was inadequate, and the problems that can arise from the IT system not enabling the ED discharge form to generate a GP letter. Action is therefore being taken immediately to address the potential significant clinical risks arising from this, and to develop a discharge checklist to ensure staff notify the necessary health or social teams on discharge.

21.3 The SAR Panel agreed that given the implications for multi-agency working, it will be important for the SAB to receive assurance from DBTH and the CCG that these actions are resulting in the production of summaries that deliver the required quality.

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[22] *https://www.rcplondon.ac.uk/guidelines-policy/improving-discharge-summaries-learning-resource-materialshttps://www.rcplondon.ac.uk › file › download*

22. MANAGEMENT OVERSIGHT IN ADULT SOCIAL CARE

22.1 One of the pivotal developments in Christine's case was that the practitioner never informed the team manager about Christine's admission to A&E. Nor was it picked up by team manager in any supervision meeting with the practitioner. This raises the question as to why this was not picked up despite there being clear expectations in respect of management oversight of progress on open cases.

22.2 In exploring this issue, it is important to provide a brief explanation of the LiquidLogic Adult Social Care System (LAS) that is used to record all activity in respect of service users. [23] The system guides users through a case and reacts to information it is given, prompting appropriate action and pathways.

22.3 The guidance on the use of the LAS [24] explains that all tasks are come through work trays not thorough any external means of communication such as email. Within LAS, there are three different types of work tray for individual practitioner, the manager and the team group which includes tasks for each case. Each task must have a priority rating attached for the time allowed for completion. [25]

22.4 Practitioners are responsible for reviewing, managing and completing tasks in their work trays.

22.5 Managers have access to the practitioner's trays for the purpose of workload management and performance monitoring and are required to review the practitioner's work tray during supervision to ensure effective workload management. This oversight should include checking compliance with the requirement for all case recording to be completed within one working day of any contact or new development. [26]

Learning and recommended action

22.6 Given that neither of these "safety net" arrangements were applied in this case, it will be essential for senior managers to consider what steps should betaken to assure themselves that the agency's standards for oversight of work is being adhered to.

22.7 Within the actions identified by ASC to address the learning included providing a reminder to team managers of the need for evidence of managerial oversight, the view of the Independent Author is that further steps will be required to provide that assurance, and that this might be best achieved through implementation of a combination of a planned audit and monthly dip sampling of supervision records.

22.8 An instruction should also be issued which makes it clear that the supervision record completed by team managers must not only includes a record of cases discussed in more depth, but also confirmation that a check has been made of the situation in all cases held by the practitioner, and lists actions that are outstanding. The latter should then be sent through to the practitioner's work tray to confirm what action needs to be taken and within what timescale.

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[23] *This includes contacts, referrals, assessment, plans, care commissioning, personal budgets, self-funders, safeguarding, financial management and financial assessment.*

[24] *LAS Principles and Standards Guidance issued in October 2016*

[25] *High – 2 hours; Medium – 2 days; Low – 2 weeks*

[26] *Managers should also check the completeness of the records at the point of closure or if the case is reassigned.*

22.9 Senior managers should also consider whether it should introduce a requirement that practitioners must inform the team manager immediately of any admissions to hospital involving a mental health crisis.

23. DEVELOPMENT OF A SHARED CARE RECORD

23.1 The review has highlighted that a major gap in Sandwell is the absence of a shared care record to enable health and social care providers to view information about each other's involvement.

23.2 While the hospital, including the ED, can now view some of the information in the GP records, they cannot access the records of other NHS providers such as mental health trusts. In addition, there is no facility for ASC to view any information in health records and vice versa. Lack of access is a particular challenge for WMAS when trying to gain more information about a patient because their own records only include information about previous call outs to an address not the occupant.

23.3 These difficulties would be resolved through the development of a shared care record such as those being implemented in other parts of the UK for example the partnership between agencies in Birmingham and Solihull, [27] and in Greater Manchester where roll out is more advanced. [28]

23.4 This allows health agencies and social care to view information about each others' involvement. This includes involvement of primary care, community health services, mental health services, hospitals, the ambulance service and social care with a patient / service user.

23.5 The objective is that the shared care record provides sufficient information to enable agencies to make direct contact to gain more information to inform their work with that person. Therefore, each agency has control over what level of information is added to the database which as a minimum would usually include:-

- a summary of their involvement and most recent contact;
- the dates of any assessments carried out – but not the content in order to maintain confidentiality;
- contact details for any current allocated worker;
- contact details for any care provider, the description of the service, and its frequency.

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27 *https://www.livehealthylivehappy.org.uk/birmingham-and-solihull-shared-care-record/*

28 *https://healthinnovationmanchester.com/thegmcarerecord/*

24. MULTI-AGENCY RECOMMENDATIONS

1. Sandwell Safeguarding Adults Board should seek assurance from Sandwell MBC Adult Social Care and Black Country Healthcare Foundation Trust that through audits and dip sampling of cases, there is evidence that their staff are applying a holistic approach in carrying out assessments of the health and care needs of service users, and that these routinely include contact with other agencies involved to gather all relevant information to ensure a well rounded assessment.

2. Sandwell Safeguarding Adults Board should seek assurance that:-

   (i) multi-agency guidance has been developed which enables professionals to acquire the necessary skills in applying professional curiosity and managing "difficult" conversations with service users;

   (ii) all agencies are using the strategic briefing paper published in 2020 by "Research in Practice" to identify any changes to working practices to promote an organisational culture where the application of professional curiosity can flourish.

3. Sandwell Safeguarding Adults Board should seek assurance that the current review of its multi-agency safeguarding procedures and processes addresses the findings from this SAR, and in particular:-

   (i) reflects an inclusive approach that enables all member agencies to shape the change agenda;

   (ii) has achieved a shared understanding across the wider safeguarding partnership about the indicators of possible self neglect, and when these should lead to a safeguarding concern being raised;

4. Sandwell Safeguarding Adults Board should recommend that the multi agency VARM working group, with the support of the SSAB Business team, develop a thematic data set that will support assurance being provided to SSAB on how effectively the Vulnerable Adult Risk Management Framework is being applied.

5. The Sandwell Safeguarding Adults Board should collectively assure themselves that there is evidence that whenever a professional carries out an assessment of a person's mental health, a safety plan is agreed with the patient which includes:-

   - steps to remove and/or mitigate the means to harm themselves;
   - activities and coping strategies to mitigate the risk;
   - information on how to access social, psychological and emergency support.

6. The Sandwell Safeguarding Adults Board (SSAB) should seek assurance that where a patient who attends the hospital emergency department has self-harmed, and / or has expressed an intention to commit suicide:-

   (i) WMAS staff ensure that the verbal handover to the hospital triage nurse provides full details of the circumstances of the WMAS attendance, and the assessment of risk, and these are included in the WMAS electronic patient record (EPR);

   (ii) the hospital triage nurse includes this information in the triage document to inform both clinical assessments and assessments of risk.

   (iii) hospital staff always make a referral to the Mental Health Liaison Team (MHLT) so that a timely and comprehensive psycho-social assessment is carried out as set out in national guidance issued by the National Institute for Health and Care Excellence (NICE);

   (iv) where the MHLT is unable to see a patient prior to discharge from hospital, it will send a letter to the GP to confirm this, and explain the circumstances leading to the referral to the MHLT so that the GP can take this into account in considering what follow up action is required.

7. Dudley Group NHS Foundation Trust and Black Country & West Birmingham CCG (Dudley Place) should jointly assure themselves that hospital eDischarge letters are meeting the standards set out in national guidance and provide a clear description of:-

   - the reason for admission;
   - the hospital episode, all investigations carried out and new diagnoses;
   - why medications have been started or stopped;
   - any follow up actions for the GP and / or other agencies.

8. The Sandwell Safeguarding Adults Board (SSAB) should seek assurance from Sandwell MBC Adult Social Care and Dudley Group NHS Foundation Trust that they have jointly agreed clear processes which set out the roles, responsibilities and processes to be followed by their respective staff to ensure:-

   - the home circumstances are explored with patients to identify whether appropriate support is in place post discharge or referrals need to be made;

   - information is shared with existing care providers when services need to be reinstated at the point of discharge from hospital;

9. The Sandwell Safeguarding Adults Board should seek assurance that Sandwell Adult Social Care is applying effective quality assurance processes to check that management oversight is being applied of all open cases through supervision and checking of case records.

10. The Sandwell Safeguarding Adults Board proposes that the Sandwell Health and Wellbeing Board consider asking for a report from the CCG and the local authority to identify steps that are being taken to develop a shared care record that enables health agencies and social care to view information about each others' involvement, ensuring better information sharing and communication.