Stockport Safeguarding Adults Board

Safeguarding Adult Review

Executive Summary

Jo

JUNE 2021

Independent Chair & Reviewer
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Acknowledgement of Thanks and Candour

In very difficult circumstances and in acknowledgement of an exceedingly tragic incident, involving this young woman, the Panel and myself, want to thank the agencies and family members, who have taken part in this process. As the Independent Reviewer, Chair and Author, I give credit to all involved, for the candour and transparency that has been expressed.

Privacy and Confidentiality

The subject of this Safeguarding Adult Review is referred to as Jo, as chosen by her family and agreed by the Review Panel. The Panel holds concern about the subject and their family's right to confidentiality and privacy and referring to this Safeguarding Adult Review as 'Jo' provides some measure of protection in this regard. In addition, agencies and their staff, have been referred to with role descriptors, as opposed to names.

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1.DECISION, DUTY, SCOPE AND CONTRIBUTORS

At a Panel Meeting on July 10th, 2020, Stockport Safeguarding Adults Board (SSAB) decided that the criteria set out in section 44 of the Care Act 2014, were met in relation to a Safeguarding Adult Review for the case of Jo. The Review period was set from January 2018 to the 26th of March 2020. Contributors have been:

- Jo's Family (Mother, Father and Sister)
- Pennine Care Foundation Trust (CMHT West; CMHT East and Mental Health Liaison Team-MHLT)
- Stockport NHS Foundation Trust (SNHSFT)
- Stockport Clinical Commissioning Group (CCG)
- Stockport Adult Social Care (ASC)
- Stockport Metropolitan Borough Council (SMBC)
- Northwest Ambulance Service (NWAS)
- Greater Manchester Police (GMP)
- Stockport Without Abuse (SWA)

2. CIRCUMSTANCES

Jo, 34, was a young woman living alone, with her companion dog. She had two siblings, and at the time of her death, was in touch with her father, possibly her sister, but not her mother. Jo was a talented artist who had struggled with mental health problems, for about 18 years. A bright, intelligent woman, she preferred same sex relationships, owned a business and had been a homeowner, but had faced bankruptcy. Subsequently she had held several tenancies with a Housing Partnership from 2017. Jo was regarded as a good neighbour and wanted to help others.

She regularly expressed suicidal ideation and had attempted suicide from 2018 to 2020 on eight known occasions, having made a very serious attempt in 2017, when diagnosed with bipolar disorder and PTSD. Jo questioned her diagnosis, and had tried various mood stabilisers and anti-depressants, with little effect. She had been placed on a waiting list for Eye Movement Desensitisation and Reprocessing (EMDR) Therapy, to reduce symptoms of PTSD.

Following her own research, Jo believed she had been misdiagnosed and advised her Consultant Psychiatrist that she had borderline personality disorder. In September 2019, she was diagnosed with Emotionally Unstable Personality Disorder (EUPD). Seven safeguarding referrals had been made during the scoping period, by various services about her suicidal intent; thoughts or actions.

As a child, Jo had been sexually abused for several years, by an older male, known to the family. She disclosed this to a counsellor at the age of 16, but information was not shared with Children's Services, and Jo did not access or receive any help as a survivor of child sexual abuse.

In February 2018, she decided to report the historic child sexual abuse to police, which led to an investigation. This was filed, twice owing to a lack of substantive evidence. Jo struggled to accept the decision, developing a rapport with the Senior Investigating Officer. Jo subsequently disclosed her mental health issues and the impact of the Police decision - which led the Officer to seek assistance, to refer Jo to a charitable trauma-informed counselling service.

During the scoping period, Jo was supported regularly by two CMHTs; the counselling service and she made a self-referral to a Sexual Abuse Referral Clinic (SARC). She attended ED on many occasions, mainly owing to her mental health issues, but was deemed to have mental capacity. She had been known to use alcohol and drugs to cope with symptoms but had been largely abstinent prior to her death. Jo could have positive and negative relationships with agencies and was highly critical of statutory mental health services. At some points Jo cut contact with her Mother and Sister and re-engaged with her Father.

Jo had advised various services about her protective factors (Mother; Sister; companion dog and various friends), but the continuing protective factor was always her dog. On 10th March 2020, following a serious illness, her dog was put to sleep and Jo went into crisis. She attempted suicide by cutting an artery in her groin and taking an overdose. She survived, called for an ambulance, and after ED attendance absconded; returned by police and stayed overnight. Most services involved with Jo, strongly believed that she would always seek help when she needed it, but during March there was an increase in her reference to suicidal ideation and intent.

On 26th March 2020, Jo's father, was concerned about her lack of contact and visited her home. Having entered, with police assistance, he found a note taped to a bedroom door, advising anyone entering the room that they would find Jo had taken her life, using a hood and helium. Police who attended found three letters addressed to different people, in envelopes, demonstrating Jo's tragic intent.

3. TERMS OF REFERENCE (TOR) AND KEY LINES OF ENQUIRY

1) What happened when Jo repeatedly presented at ED with suicidal ideation? Was she appropriately supported, especially in relation to her mental capacity, complex mental health issues and possible intoxication from drugs and alcohol?
2) How well do Board agencies understand Emotionally Unstable Borderline Personality Disorder and is the consequent support offer visible and valid?
3) Did all agencies have clarity of their role and responsibility in, and with Jo's care plan?
4) How does the integrated care pathway for suicide flow and is this fit for purpose?
5)How had the impact of the current Covid-19 pandemic been considered by agencies when interacting with high-risk individuals, such as Jo and how were risk incidents managed during this period?
6) Was there agency understanding regarding the depth of Jo's childhood trauma and did this have any influence on the delivery of services, or not, and why was a Learning Disability Service referral made?
7) Were there any missed opportunities to trigger a Team Around the Adult meeting and use of the Multi Agency Assessment System?
8) How did agencies respond to the loss of Jo's advised protective factors?
9) Was Jo subject to CPA, and if so, how was this deployed in relation to multi-agency risk management?
10) How much did Jo's faith in mental health services decline as a result of the problems she encountered when making an unsuccessful complaint against them and apparently being advised this could lead to a Judicial Review?
11) Was medication considered to assist Jo with her apparent change in mood and apparent impulsivity; was there a consideration of alcohol and substance misuse, and what risk assessment was put into practice?
12) What is the policy for the PCFT in relation to referrals for an increase in patient counselling services, particularly when a patient demonstrates suicidal behaviours?

4.SAR MANAGEMENT, METHODOLOGY AND STRUCTURE

This methodology is rooted in systems learning and action research, aiming to understand the context within which professionals made complex judgments and decisions about risk and vulnerability. A SAR Panel was contributed to by all partners involved and it was chaired by Deborah Stuart-Angus. Individual Management Reviews (IMRs) were requested, received and shared, as were family views. Given the complexity of this case and the need for learning to be maximised, the Overview Report reflects case and system findings which have instructed learning, thematic analyses, conclusions and recommendations. This report will represent a summary of the same.

5. FAMILY PERSPECTIVE

In the spirit of Making Safeguarding Personal, family members were identified, and Jo's Mother, Father and Sister pro-actively contributed and participated with the Review. The family were advised about the SAR purpose and method; and how they may be involved. Good communication links were set up by e-mail, text and phone, and contact was maintained throughout the process and family views were compassionately sought and provided great insight into Jo as a person, daughter and sister.

6. GOVERNANCE, PARALLEL PROCESES AND CIRCULATION.

Th final Overview Report was sent to the Panel and Chair of SSAB on 6th April, prior to listing as a confidential Board agenda item (for approval at the next convened Board meeting).The Overview Report was shared with the family week commencing April 19th and shared with the Coroner for the Inquest, which took place on the 26th.

7. SUMMARY OF CASE AND SYSTEM FINDINGS

7.1 January - March 2018

A breakdown in Jo's relationship with her Consultant from CMHT West, had commenced in late 2017, with Jo questioning her Bi-Polar diagnosis and by November that year, she disengaged with the service. Jo had been taking various prescribed medication, including meds for Bi-Polar Disorder, depression and anxiety. In January 2018, Jo was experiencing ongoing neighbour problems, and made Police aware. She was also very close to her grandmother, who sadly died that month.

Following an ED emergency attendance, owing to suicidal thoughts, Jo failed to attend a CMHT West follow up appointment. Previously she had been placed on the EMDR therapy waiting list, as part of the primary care pathway and was looking forward to receiving the therapy, but later in the month was removed from the list.

She told Police she was not receiving the help she needed and briefly referred to the historical child sexual abuse. Her GP noted she was not sleeping but showed no suicidal intent. Jo told CMHT West she did not want any contact with them, subsequently they closed her case and Jo continued to call police to say she was suicidal; on one occasion saying she had a rope around her neck and that the NHS were not helping her.

A few days after this, she disclosed in more detail to Police, that she had been sexually abused by a male family 'friend', for three years, from age 5, and that her mental health issues, anxiety and depression, were a direct consequence. She acknowledged having sometimes made poor choices, using alcohol and drugs to cope and advised that at 16, she disclosed the sexual abuse to a CBT Therapist, but information was not shared. Jo was also sexually assaulted by a taxi driver at 17, who was prosecuted, but memories of this too affected her mental health, and she felt she had not received appropriate support. Police believed it was unlikely that an investigation of the child abuse would lead to a prosecution but opened the case.

Jo's pet insurance company later contacted police saying that they had an email from her saying she did not want to live and was threatening to hang herself. Police visited her address, where Jo said she felt better; declined to go to ED and promised to see her GP, who referred her to a different mental health team, which was good practice in trying to problem solve.

7.2 April - August 2018

Jo sought an update on the investigation, which seemingly had been closed as the alleged perpetrator did not recall any incidents and Jo became very upset by this. Later police decided there was no rationale for closing the investigation and that PACE[1] had been ignored, subsequently the case was reopened. In the meantime, PCFT decided CMHT West could arrange a second diagnostic

[1] Police and Criminal Evidence Act 1984 (PACE) codes of practice which regulate Police powers and protect public rights

opinion and the GP became aware she Jo was drinking heavily. Jo was finding it difficult to cope and told police again, that she wanted help for her mental ill health but did not know where to go. Police made appropriate referrals to housing and the mental health access team, and updated her on their activity, which was good practice.

By July, Police decided that the offences of sexual assault against Jo as a child, had taken place, were corroborated by another person, and that it was true that Jo had made her first disclosure to a counsellor in 2011, and the investigation continued.

CMHT West offered Jo a different psychiatrist and care-coordinator - who tried to contact her, and albeit Jo accepted the offer, she did not receive a visit until September, owing to the care co-ordinator having a brief period of sick leave.

7.3 September - December 2018

Jo initially engaged well with the care-coordinator, expressing her history; that she had EUPD; that she wanted to move house; that wanted the EMDR Therapy reinstating and that she was a Carer for her Mother, citing her Mother, her dog and friends as protective factors. She had suicidal thoughts, but no intent and said she was seeking criminal injuries compensation, following a court case against a former perpetrator of sexual abuse, but that the case was closed due to the failure of Police to follow due process (which was not accurate). She also advised that she wanted to fund her future from the compensation, she hoped to receive. She was coping with distress by tattooing herself; self-medicating with alcohol; using over the counter medication and getting support from drug and alcohol services. She also wanted to self-refer for trauma-informed therapy. CPA documentation was completed, and it was concluded that Jo was at low risk of self-neglect, harm to others and exploitation, but at high risk of self-harm, suicide and accidental death, due to impulsive behaviour and alcohol use, '*triggered by her EUPD diagnosis'*, however an EUPD diagnosis had not been clinically confirmed at that point.

The care co-ordinator noted Jo had difficulties coping with '*the Judicial Review for criminal injuries*' and felt '*let down'* by mental health and therapy services. (There was no evidence however to suggest that a Judicial Review was to take place and, in this respect, the care-co-ordinator's assessment was not factually accurate). A risk assessment and management plan were completed, and a consultation with the team psychologist was planned. A care plan, under CPA, was to be compiled, all of which was good practice.

By the end of September Jo was diagnosed with EUPD. Prescribing medication was deemed unlikely to be beneficial and therapy assessed as the most suitable treatment for her. A care plan was discussed with her GP, but no written plan was provided. Dialectical Behavioural Therapy (DBT) and local Democratic Therapeutic Community referrals were discussed with Jo by the care co-ordinator, which was also good practice. What followed was confusion in health services about Jo '*going through a court case'* and the impact of therapy on her whilst this was happening – which was unfortunate because a court case was not planned to go ahead and did not occur. By November Jo reported daily suicidal thoughts; continued sleep disturbance; increased anxiety and substance abuse. She advised the co-ordinator she was caring for her Mother and her dog, which prevented her from taking her own life, however Jo's family advise she had '*backed off*' from her Mother and Sister, after the 2017 suicide attempt.

At the end of November police updated Jo that their investigation would not be proceeding, and Jo reported increased anxiety, increased alcohol abuse and more neighbour problems to the care co-ordinator, who offered to help her to move to a new house, which was good practice. By mid-December Jo seemed bright and advised the care co-ordinator she was '*preparing herself for therapy',* and practising mindfulness, despite feeling absorbed with anger about the closure of the investigation. However, her family advise that this was one of several examples, where Jo deliberately mislead the care coordinator, because at this point, she told her sister she was not and would never practice mindfulness; was staying in bed all day and had such little motivation, that her

Mother was having to visit her flat to care for the dog. Her family advised the Review that Jo could be devious, and tell people and professionals, what they wanted to hear, particularly if it brought benefit or gain.

7.4 January – April 2019

By January Jo's suicidal thoughts and desire to self-harm increased. She maintained a pattern of emotional dysregulation. Following a meeting with a Senior Manager from the Housing Partnership, Jo's mood was '*uplifted'* (unbeknown to the co-ordinator, Jo had developed feelings for a Housing Officer) but a few days later her mood lowered, when she found out she had not been assessed as meeting a '*higher band'* of need, by the Housing Partnership, leaving her with a strong urge to self-harm; drink alcohol and take her life, but she denied intent. The Housing Partnership seemed unaware Jo had mental health issues, (which had been known, a different housing decision may have been made). Jo wanted to *'fight for justice'* and reiterated if she lost her dog, her suicide risk would escalate.

By the end of January, a mental health assessment advised that Jo seemed to have had improved, was free of suicidal and self-harm thoughts, had reduced alcohol intake; seemed more motivated, given that a therapy decision was being progressed; that she had re-engaged with friends and that a criminal injuries claim had commenced. (This latter point however was inaccurate because the claim had started in 2018 and family advise Jo had cut herself off from friends and contacts).

Jo was prescribed anti-depressants in March and had almost stopped drinking. She was due to be assessed for DBT; was reported as stable and wanted help to stop smoking, which she subsequently achieved. By April a period of improvement appeared to have developed and Jo was placed in amber zone for risk, by CMHT West.

7.5 May - July 2019

The improvement period was short lived and sadly at the beginning of May, Jo consumed alcohol and attempted to hang herself with a wire cable. She attended ED and was subsequently moved to red zone by the CMHT. She wanted therapy; was willing to continue to work with CMHT West and agreed to reduce alcohol intake, and subsequently she was discharged.

Jo received a screening appointment for DBT, but the following day, she called police, having overdosed, and was found with ligature marks on her neck. She was taken to ED and a Mental Health Liaison Team referral was made. PCFT advised Jo that the DBT therapy group, due to start June, would now start in August - it is not clear why this was the case. Jo was discharged from the Mental Health Liaison Service with a safety plan in place. Anti-depressants were stopped at some point and the Review is advised that clinically, this was best practice. Following a clinical review Jo was moved back to amber zone for risk, later Jo identified *'alcohol was a trigger'*.

At the end of the month, the Housing Partnership contacted ASC as because Jo sent a 'goodbye text' to a staff member, from a hotel in Huddersfield. Local police were contacted. Family advise Jo had developed strong feelings for the staff member in question, but when Jo was located and interviewed by police; she denied suicidal intention. A local *mental* health professional advised that Jo had mental capacity and was not at any immediate risk and Jo said she felt safe. Police raised a safeguarding alert and relevant emergency contacts were supplied, which was good practice. After they left, they were informed that Jo was admitted to Huddersfield Hospital, having taken a mixed overdose of prescribed medication, cocaine and alcohol; and had been sectioned under s5(2) of the Mental Health Act 1983, as she had threatened to take her life, but was later discharged back to the care of CMHT West in Stockport. A safeguarding alert was made to ASC and sent to CMHT. Later it was confirmed to Jo that DBT would start mid-August.

In early June, CMHT moved Jo's risk level to red zone and a visit arranged. On the same day she self-harmed with needles; engaged in excessive alcohol use; attended ED and was assessed as high risk

but with low level risk of intentional suicide, due to 'help seeking behaviours. Jo was subsequently discharged.

Later that night, Jo attempted to hang herself, and called an ambulance. She left a suicide note and called a friend to collect her dog. At ED she advised she had also overdosed on '*over the counter*' medication. (Jo's family advise that during this period, she was '*not herself* ', and that her attitude towards her Mother had totally changed, never speaking with her and proactively cutting her out of her life). Jo was reviewed by MHLT at ED, who contacted CMHT West to plan follow up support, which was good practice. Jo requested an admission, but the team did not think it was necessary, and she became angry, saying she would use a ligature on her return home. The GP was advised, who reduced medication quantities to weekly, which was good practice. Jo was due to see the alcohol support worker, the GP and the care coordinator later that week and remained in red zone. Jo advised the care co-ordinator she would take her life in June.

In the meantime, Jo accepted a housing offer, which enabled her to change CMHT, from West to East Team. Jo wanted to discuss anti-psychotic medication; however, a clinical decision was made not to prescribe this for her. When Jo moved house, her GP kept Jo on as an 'Out of Area' registration, which was a considerate decision reflecting the importance of continuity of her care. In the meantime, the care coordinator was made aware that Jo had changed her surname.

7.6 August - October 2019

Jo reported being low in mood because her CMHT outpatient appointment was moved without her agreement to September. She had a start date for DBT for the 14th. August. On the 12th Jo called the DBT Therapist who was on leave for a day, and phoned again next day, to advise she would not be attending DBT, as her call had not been returned, but agreed to attend the following session – however she did not, because she had feelings that wanted to harm the staff.

The CMHT transfer was planned for the 23rd of September, following an out-patient appointment offer at CMHT West for the 19th. Jo discharged from drug and alcohol services.

Jo felt the need to further discuss with police as to why the investigation had been closed the year before and met with the DCI. From records made after the meeting it was evident that police believed Jo was high risk of suicide. Jo advised the police however, that she was being supported by the MHLT; which was not accurate, and that CMHT West were not expediting the transfer as quickly as they could, which was also not accurate.

The DCI contacted CMHT West and requested Jo's transfer be prioritised seemingly unaware that the transfer was due to complete after Jo's outpatient appointment on September 23rd. (It is probably fair to say, that Police may also have been unaware that Jo had refused to attend the DBT Therapy Group in August and that she had been very involved with the care coordinator from CMHT West, but 'fell out' with her, after the care coordinator had had to take a short period of sick leave).

The DCI informed Jo about counselling from the Sexual Assault Referral Clinic (SARC) and gave her contact details for MIND, SANE, SAMARITANS and the Mental Health Access Team. Police intelligence reports were set out and Jo later self-referred to SARC. The DCI was impressed Jo was actively seeking support. A warning signal was added to Jo's Police record, which was good practice.

Jo told her GP she had met with lawyers and Police to discuss the historic case and criminal injury compensation; that she had not heard from her care-co-ordinator or the DBT Therapist, and she was now keen to join a different group. (At this point Jo's Family thought she had *'lost herself'*; that her illness '*consumed her' and that Jo believed she was psychotic).*

Prior to the 23rd Jo threatened to cut her throat and groin outside the DBT Group Therapy Office, her family advising that they believe she did this in order to expedite a more speedy transfer to CMHT East. Jo attended ED seen by MHLT and complained of "*feeling neglected by mental health services*" and that her pleas to transfer to CMHT East were being ignored by CMHT West - which was not

accurate. Jo's family believe she should have been sectioned at this point. Her mental health was assessed and MHLT felt that admission was unnecessary. CMHT West were informed.

After this incident, Jo talked to her GP but refused to meet with CMHT West, complaining to them about the timescale of transfer, later advising the MHLT that she did not want them to visit her; that she would end her life when she had rehomed her dog, and that she had prepared '*pre-written suicide notes'* to various people and agencies. Later she contacted the Housing Partnership saying she was waiting for '*Police to attend to section her',* the latter not being true. She also told them she had no family contact and the only reason she was *'still here'*, was for her dog, whom she was '*trying to rehome so she could end her life."*

The Housing Partnership state they contacted '*the Mental Health Team'*, however according to records, it would appear they contacted Adult Social Care, advising what Jo had said. It is not clear why there was a four-day delay in doing this. ASC advised The Housing Partnership that they would not take the referral, and the caller should tell Jo to contact her GP. This was not the best advice, given that Jo was an open case to CMHT West, and it was the second time during the scoping period, that the Housing Partnership had referred Jo with safeguarding concerns to ASC.

Jo saw her GP who noted she had self-harmed and that she was frustrated about the transfer. The GP offered a new referral to DBT, which Jo declined. CMHT West tried to re-engage with Jo by email, But Jo advised the care co-ordinator she was '*under strict instruction from a Detective Inspector*, '*not to go anywhere near that CMHT West Centre'.* This is considered to be untrue. In a later contact with the DCI, Jo continued to refer to the alleged inactivity of CMHT West in expediting the transfer to East, which was not accurate. This was reiterated again a few days later, affirming to the DCI that she was safe, but expected to commit suicide one day in the future. The DCI self-referred to local the Professional Standards Branch (PSB)- an expected action when there may be a death or serious injury, following contact with a Police officer - however PSB criteria were not met.

On 26th September, the DCI contacted the Head of Strategic Safeguarding at SMBC, with concerns about Jo and it was decided to make a referral to a local charity that provided a trauma informed counselling service, albeit Jo's case was closed to ASC. PCFT advise they were unaware of this, but SMBC have advised that PCFT were informed. Counselling was due to start in November. On the 30th, Jo seemed to have improved to her GP, advising she had: '*turned things around*', especially after her contact with the Police.

On the 2nd of October CMHT East accepted Jo's transfer and a few days later, she attended her first counselling session at the Charity. The Review is advised that Jo made it clear from the start of her counselling work, that she planned to take her life at some point, as she had made it plain that she did not want to live with the trauma that she had experienced in the past. She was initially offered 8 sessions. By the 17th she informed the DCI she was considering suicide. The DCI later contacted the SMBC Safeguarding Lead who advised she would ask for a Team Around the Adult Meeting[2], later establishing that Jo would not consent to this. A few days later Jo was allocated a new care co-ordinator from CMHT East and she was seen by the Consultant on the 29th, who confirmed Jo's diagnosis and her continuing dissatisfaction with her former Consultant.

The East Consultant advised the GP about the importance to Jo of her dog as a strong protective factor and that further psychological therapies were to be discussed.

7.7 November - December 2019

Jo was fully attending counselling sessions and informed the DCI that they were '*invaluable',* however her Counsellor felt the need to discuss Jo's high risk of suicide with her supervisor. Jo also engaged with her new care co-ordinator, referred to her counselling sessions and her former issues. Access to various therapies was discussed and Jo planned to attend additional counselling at SARC.

[2] A Team Around the Adult Meeting is a a multi-agency meeting held by SMBC where all professionals involved with the subject decide on the most appropriate care package and support

Three days later, Jo took a mixed overdose of prescribed medication and attended ED. Jo had significant reduction in consciousness and required clinical intervention. A safeguarding concern was raised by the ambulance service to ASC. Jo was discharged the next day, and advised to see her care co-ordinator from East, and she left before she was assessed by the MHLT. The Care Co-ordinator contacted Jo who advised that her Consultant had allegedly refused to give information to her solicitor for the Criminal Injuries Compensation Authority claim - which was not accurate. A review was arranged, and Jo advised the GP that appointments had been cancelled with both the care co-ordinator and counsellor, however the CMHT had not cancelled the appointment.

During December, Jo continued to engage with CMHT East and counselling. On the 13th her Counsellor met again with her supervisor to discuss Jo's last suicide attempt and how to strengthen her safety net. At a later point Jo's counselling sessions were increased to 28, due to the level of complexity that Jo was challenged with.

7.8 January - March 2020

Jo continued to engage with her care co-ordinator, reporting she was not using alcohol, and how this was affecting her social confidence. She started feeling low, remaining angry with the CMHT East Consultant, as she now blamed them (mistakenly) for delaying her claim to criminal compensation. As a consequence, she refused to attend the next out-patient's appointment, unable to see that the meeting may have provided the opportunity to resolve the issue, and she would now have to wait some months for a new appointment. On February 4th Jo saw the care co-ordinator advising that her hormones affected her mood. A support worker visit was planned for the 10th, which did not take place, nor re-arranged.

On 16th Jo texted the DCI saying her dog was ill, and it transpired that the dog had a fatal condition.

Her Counsellor reported to her supervisor that it was proving difficult to separate trauma from Jo's own identity, in an attempt to create reasons for Jo to want to live, and Jo's high risk of suicide was raised, but consent was not sought to raise with Jo's care-coordinator services, and nor was a safeguarding referral raised. Jo later that month advised the GP that her dog was in hospital, and she was prescribed some Diazepam, for anxiety but the CMHT were not informed about the about the dog's illness and impact.

Later that month Jo self-harmed and a safeguarding alert was made by NWAS to ASC. This was the 6th contact made with ASC, regarding Jo's welfare and self-harm[3] incidents. Following triage, ASC sent the safeguarding adult notification to CMHT East. Jo reiterated to the ambulance crew she would end her life if her dog died. No drugs or alcohol appeared to be involved and she was taken to ED - again reinforcing that she would end her life if her dog died, adding that she was not currently suicidal, and nor did she not want to see MHLT. The GP and CMHT East were informed, which was good practice, and Jo had already e-mailed her care co-ordinator to tell him what had happened. She was subsequently discharged without a mental health assessment. The next day the care co-ordinator was unable to contact Jo because of conflicting work priorities, e-mailing her on the 2nd of March. It is acknowledged by PCFT that a more assertive approach was warranted.

The care co-ordinator wanted to visit Jo on the 2nd, but she refused, saying she had to take her dog to a hospital. On the same day, Jo attended counselling, later texting saying her dog '*was home'* which puts into question the information she gave to the care co-ordinator. On the 9thof March the

[3] It is important to note that ASC are of the view that issues identified in this SAR, with regard to, the response to safeguarding alerts and enquiries made about Jo from other organisations, appertain to the responsibility of case management by CMHT as the lead mental health agency, and the associated obligations that sit under the Care Programme Approach, (which Jo was subject to). This is because, following triage and initial information gathering (in accordance with s42 Care Act duties) the professional opinion of ASC, was that referrals received did not fulfil the criteria for a Section 42 Enquiry to be carried out, and an alternative response was to be sought, thus the decision was made to pass the information to the CMHT, in relation to each referral received.

care co-ordinator reported in team zoning meeting that Jo was at high risk of suicide as her dog was ill and may die and on the same day. Jo re-arranged her counselling session, as she had cared for her pet throughout the night. Sadly, Jo's dog was put down the next day.

The DCI became increasingly concerned about Jo taking her life, contacting Jo on the 10th and 11th when Jo promised to '*keep safe'*. The next morning on the 12th Jo contacted the DCI several times, saying that she had attempted suicide and was in the ED. GMP advised MASH and raised a safeguarding concern about Jo's mental health and self-neglect concerns. PCFT have advised that this information was not received by them.

On the same day the care co-ordinator emailed Jo, unbeknownst to him that her dog had died and that she had attempted suicide early hours of the 12th. The e-mail asked after her and her dog and requested a visit on the 16th of May. Jo emailed back saying she was currently in '*resus'* following '*several suicide attempts'*, and that her dog had died, expressing she would complete her suicide when she left hospital.

Jo did not want to be seen by MHLT and was kept in hospital owing to the need for cardiac monitoring; administration of a Parvolex infusion and the need to suture a thigh laceration. On the same day, a seventh safeguarding concern, regarding Jo was received by ASC, from NWAS, advising them that Jo had made a '*deep laceration to her left groin*'; had attempted to hang herself and had taken an overdose. There was a noose and blades found at her home. Jo had also sent a suicide note to her pharmacist and her GP about her intent.

The same day the pharmacy raised their concerns with the Police. The police attended Jo's address, where another note was found, asking for her father to be contacted when her body was found. After contact with her Father, he advised about Jo's actions, and that she was in ED where Officers then visited her, where she told them that she was suffering after the death of her dog and that she was leaving the ED. She then stayed but told the ED staff she would self-discharge and later jump in front of a train. Security was increased, and later stepped down, as Jo was deemed to have mental capacity. PCFT advise that a Mental Capacity Act assessment was in place, but it would appear that a psychiatric assessment was not. Her GP was informed and advised that she had refused assessment from MHLT. The GP was aware she had been admitted to the Clinical Decisions Unit (CDU), needing a Parvolex[4] infusion, however there was no letter sent from CDU detailing what happened whilst Jo was there, but CDU did advise on site MHLT.

The GP has advised this Review that: ''*following such a significant suicide attempt, with a detailed suicide note and the ambulance crew noting the presence of a noose at her home, I would think a psychiatric assessment would be mandatory, not something she* (Jo*) would be able to refuse, and that the Mental Health Act could have been used to detain her if required, pending this assessment''*. The fact that a psychiatric assessment was not deemed mandatory warrants question.

Jo later absconded from the hospital and was reported missing on the 13th. She was quickly found, returned and then she discharged herself to the care of her friends. Later GMP were informed by the hospital that Jo was '*very high risk'* but '*retained full mental capacity.'* On the same day, the DCI received the posted suicide letter, saying '*thank you and goodbye'.*

PCFT recorded that Jo had been assessed as medium risk. Four concerns were received and logged at PCFT, but it was not clear how, or if they were processed under the former s75 agreement in accordance to safeguarding policy and procedures. PCFT have since commented that from the four safeguarding referrals received, two were followed up. However, PCFT and ASC agree that when information was sent from ASC to PCFT, it was regarded as '*information sharing*', as opposed to a safeguarding referral, as all referrals received by ASC had been triaged, and none were regarded by ASC as warranting a s42 Enquiry.

[4] Parvolex is medication used in an infusion for paracetamol overdoses

PCFT contacted Jo on the 14th, and her mental health and risk profile was reviewed, and she was to be seen on the 16th. Jo did not report any suicidal plans or intent (yet she had reported the same on the 12th and the 13th.

On the 16th Jo discussed her suicide attempt with the GP and on the same day was moved into red zone by CMHT East, but a documented care plan was not put into place; nor is it evident that a zoning discussion took place, or that a written rationale existed, and nor is it evident that this information was considered in relation to the safeguarding alert that had been raised. It would appear that a CPA Review was also not considered. On the same day the UK Government advised on preventing non-essential contact owing to the pandemic of Covid -19.

The care co-ordinator was unable to visit Jo on the 16th but telephoned her twice. On both occasions, she did not want to speak, but did agree a visit, at a later date. On the 17th Jo declined a home visit and a telephone call from the care co-ordinator, who offered to e-mail her again on the 18th. Jo requested that her next of kin be changed on records as she had not spoken to her Mother for a year. The reason for this and changing her name did not appear to have been explored.
On the 18th the care-co-ordinator e-mailed Jo again, to arrange a visit on the 20th, but Jo would not agree. On the 19th Jo declined a further offer of a visit from the CMHT. It is not evident that a zoning update was shared with the CMHT daily meeting.

On the same date, a GMP incident log stated that police were informed by a customer relations advisor from a mobile phone company that she Jo was planning to commit suicide. The DCI spoke to Jo and who spoke with her GP.

On the 20th the care co-ordinator emailed Jo.

The DCI met with Jo on the 20th and Jo wanted to talk about how to die but gave assurance that all of her support services knew how low she was feeling and that she would not do these things. Jo referred to the intensity and frequency of her emotional pain and how hard it was to live with but promised to keep herself alive that night. She referred to getting drunk, despite knowing this was a trigger. It is not clear if the CMHT or MHAT were advised about this information.

The next day Jo contacted the DCI to say she had tried unsuccessfully to hang herself again. The DCI raised relevant checks, made a referral to the *'Mental Health Access and Crisis Team/MASH'*, but PCFT advise that this was never received by them.

On the 23rd, the day of national lockdown, the care co-ordinator contacted Jo to explain about reduction in face-to-face contact due to national restrictions, and that he was unable to visit her until the pandemic was over. At this point, it would appear that Jo had not seen her care co-ordinator since February 4th, a period of nearly 7 weeks. She had also not seen a Consultant Psychiatrist for 5 five months. An e-mail was sent to her, advising that he would stay in touch by phone/e-mail, and give support to her whenever she needed it. Jo replied saying she was fine for essentials and that he was not to worry about visiting her; that she was feeling unwell and was '*trying to avoid everyone just to be safe'.* (It is not clear how high-risk patients in red zone, in the community could be best helped, during the start of the pandemic, given professionals entered unchartered waters and new situations, which PCFT have advised '*had not had time to be rehearsed or tested').*

On the same day Jo referred to lockdown as a time to reflect; to think about her future and to work out her issues, telling the DCI that she needed space: "*when this isolation is over I might have had real time to think."* She referred to having hurt those who had cared for her and said: *"When I try and explain this feeling, I get overwhelmed with guilt even though it's just explaining what's inside my head. Gonne gives you guys a break for a few days…. I just need to try and work it out".* However, the DCI advised the Review that these were not unusual messages to have received from Jo.

That night Jo contacted police referring to a previous suicide attempt and appropriate actions were taken.

The care-coordinator later called and e-mailed Jo, with no response and was unaware of events of 21st and 23rd March. (Information was passed by GMP to the MHAT Manager, who sent it to CMHT West, who later sent it to CMHT East. This information was recorded on the 27th with regard to events as the 24th, which was likely to have meant the 23rd). After the care co-ordinator was made aware of the events of the 21st and 23rd March, it would appear that no further attempts were made to contact Jo.[5] It would also seem that this information was not shared as an update to the daily zoning meeting. The fact that Jo failed to respond on the 25th seemed unusual, compared to her regular, previous response levels. On the 25th Jo also failed to respond to her Counsellor, from SWA who also had tried to make contact. At midday on the 26th the DCI contacted Jo, with no reply.

Due to no contact from Jo, her Father attended her address but got no response. He flagged down a passing police community support officer and entry to the flat was gained. When her Father entered there was a note taped to a bedroom door warning anyone who entered, that the person who had written the note had committed suicide using a hood and helium. Jo was found dead and an ambulance was called.

PCFT advise that the family were signposted to relevant post suicide support services by phone, in line with their standard offer; but that they did not provide an information leaflet, and that the family were advised that they could phone CMHT East to discuss this matter further, if required, however the family do not recall this offer being made.

8. CONCLUSIONS FROM ANALYSIS[6]

8.1 Mental capacity, decision making and the consideration of continuing risk

If a person is at imminent risk of suicide there can be doubt about their mental capacity at that point in time and professional judgements must be based on knowledge of the person, and what is in their best interests. When, on the many occasions Jo presented at ED, post each of eight individual suicide attempts (one having taken place out of area), she was not assessed as being at 'imminent 'risk of suicide. It is not clear if Jo was assessed in relation to the consideration of her high risk of **repeating** suicide attempts, and **repeating the presenting risk** - particularly in the light of her frequent advice to ED staff regarding her future plans to take her life. Keene reminds us, that if a person is at '*real and immediate risk* 'of suicide, then '*real'*, means more than '*remote or fanciful'* and '*immediate*' means *'present and continuing' (*see *Rabone & Anor v. Pennine Care NHS Foundation Trust* [2012] UKSC 2)[7]. It can be concluded therefore, that Jo would appear to have remained at risk of suicide because the risks in question, were both '*present*' - and had '*continued'*, but in March 2020, assessment under the Mental Health Act 1983 was not considered during the escalation of her risk profile. This was heightened by the fact that her risk was not systematically discussed at zoning meetings at CMHT East, and her move to red zone, did not occur until March 16th - which was not supported by a reviewed risk management plan.

[5] 16th Care Coordinator (CC) telephoned Jo twice, and Jo not wanting to talk but agreed to a visit at a later date
17th CC e-mailed Jo offering a home visit and call, Jo declined
18th CC e-mailed Jo offering home visit for 20th, Jo declined
19th CC offers home visit, Jo declined
20th CC emailed Jo and about a previous housing visit, which was the reason Jo gave CC as to why he cold not visit. Jo tells CC there was no housing visit and she went out instead (*dates continued on next page in footnote*)
23rd CC e-mailed Jo regarding lockdown restrictions, advising he could not visit until pandemic was over. At this point, Jo had not seen CC since February 4th -nearly 7 weeks.
25th CC emails Jo with no response.

[6] Please note all conclusions are derived from the comprehensive analysis set out within the main Overview Report.

[7] *Rabone & Anor v Pennine Care NHS Foundation Trust* ditto

8.2 Transfer of information and recording

Several agencies working with Jo seemed unaware that the CMHT was responsible for managing safeguarding and safeguarding referrals were sent to ASC; MASH and the Mental Health Access Team (MHAT)/Single Point of Access (SPOC). (GMP have advised that advising MHAT/SPOC was their standard and expected practice). Some agencies lacked shared knowledge regarding Jo's mental health care/risk plan and who was providing what, which caused some delays and confusion in the effective transfer of information regarding risk. This was exacerbated by pathways and systems not always aligning and poor co-terminus outcomes, thus effecting seamless information transfer and its receipt.

Recording at SNHSFT, and CMHT West and East, had occasional gaps and Jo's history of childhood sexual abuse was recorded by SNHSFT on one system, but not another, which meant ED staff were unlikely to have been aware of Jo's trauma. This could have affected decision-making on the occasions, when Jo had refused to be assessed by the on-site Mental Health Liaison Team (MHLT, (PCFT), based at the hospital.

It is not particularly evident that recording case follow up in decision making, in relation to PCFT's receipt of safeguarding notifications, was clear, or followed any particular process, making it difficult to understand some of the decisions that were made by CMHT East.

8.3 Lack of case leadership, multi-agency risk management, information sharing and processes such as: 'a team around the adult meeting'.

i) There was an absence of a planned multi-agency approach to shared risk management for a known high-risk, community-based patient, cared for under the Care Programme Approach, which increased the opportunity for silo working and the ability for some professionals to develop behaviours which may have reinforced Jo's EUPD symptoms.

ii) Jo retained some control of some information, in her relationships with both professionals and family, and decided on what she wanted to share with whom and when. This resulted in some professionals knowing some things, some of the time, with gaps in their knowledge. This increased the impact of the lack of information sharing, and professionals not being clear on individual agency actions, or intent. This in turn enabled Jo to further develop 'splitting'[8], possibly effecting professional collaboration, resulting in agencies collectively (and some individually) being unaware about the levels or type of support, that were being offered, received, or rejected by Jo. On occasions when information was shared, it was not always responded to, or responded to appropriately, and this was exacerbated by the lack of any one service, taking leadership to explore and or co-ordinate Jo's support systems, (however the Review acknowledges that it is important to note that individuals can directly refer themselves to non-statutory services, and may not give consent to share their information, outside of their selected service).

iii) Local policy and process for multi-agency risk management (TAA and MAARS) failed to contain provisos where an individual's consent could be over-ridden. Oversight of safeguarding; senior levels of professional curiosity and safeguarding leadership, was lacking in relation to the number of repeat safeguarding referrals received and subsequent action. (ASC advise that all of the seven safeguarding referrals received about Jo, were triaged and decisions were made that none of them required a s42 Enquiry response, and so were sent to PCFT as notifications. However, PCFT advised their systems only denoted receipt of 4 of the notifications and could evidence direct, recorded response to 2, but 4 were shared with the CMHT team).

[8] The Review is informed by PCFT that 'splitting" is when a person with EUPD makes a subconscious attempt to protect themselves against intense negative feelings such as loneliness, fear of abandonment and isolation, and they may deploy a defence mechanism referred to as splitting, which is when an individual can present one agency as being 'bad' and another as being 'good', without the person being able to realise that no agency, is either.

iv) There was no alert regarding Jo's childhood abuse on her risk profile at SNHSFT, and no indication, that historical abuse assessments were completed in line with risk criteria. There was reliance on agreements with other agencies to share information, outcomes of which were frequently poor. There was also no evidence of any engagement with Jo's family, or with any other significant contact she had, which failed to furnish SNHSFT with critical information, about her history. Given the 'Urgent Mental Health Care Pathway' that existed in the area in 2020, and the poor relationship between Jo and the hospital based mental health liaison team (MHLT, PCFT), this sometimes prevented Jo from receiving emergency assessments.

8.4 The Joint impact of the loss of protective factors, the breakdown in preventative intervention and the impact of the start of the Covid-19 Pandemic

Not all professionals were aware of Jo's protective factors and how these factors changed over time. Most, but not all were aware that her dog was a consistent protective factor. There was a lack of awareness on knowledge about the depth of attachment that Jo had to her 'companion' dog'[9] and the impact that the death had on her. She was continuous in her claim (to many) that she would take her life, if her dog died, yet no assessment was considered as to how she may have conceptualised or managed her grief, if, or when, her dog died[10], even though services knew of the dog's serious illness. When Jo attended ED on the 12thMarch a psychiatric assessment should have taken place before she absconded (and following here return, after which she later self-discharged), because this was the point when the impact of the loss of her protective factor was greatest.

PCFT were unaware that Jo's dog had died until 12th March and Jo had been refusing contact with her care co-ordinator. Information about her penultimate suicide attempt was not sent to the CMHT team generic email, which seemingly impacted, and a review of her risk profile did not take place. It appears that CMHT East over relied on e-mail contact. There was a lack of 'a sense of urgency 'about seeing Jo in March, particularly after her dog was put to sleep, albeit she was declining access to herself, a more assertive approach should have been taken to see her.

An updated CMHT East risk assessment was not in place or a revised plan, following the dog's death and when Jo was moved to red zone on March 16th - her case was not discussed in a daily zoning meeting either then, or on 23rd, 25th or 26th. Many professionals involved with Jo's care seemed to have held on to the strong view, that she would *'always seek help'* when she needed it. This alongside PCFT community risk management policy, particularly when Covid-19 restriction management was not strongly established, should have raised Jo's risk profile, and effected a re-assessment and a revised care plan.

There was recognition by CMHT East that the pandemic would increase risk of harm to self and risk from others, but it is not evident there was any particular contingency in place for Jo, in the face of an ongoing breakdown with her care co-ordinator. She found herself in the environment of the Covid-19 pandemic, facing self-isolation and the accumulative, negative impact of a variety of factors, along with the opportunity that the isolation gave her, potentially increasing the possibility of an unhindered chance, to take her life. When she presented as unable or unwilling to be seen by her care co-ordinator, there is no evidence that contact was made with her GP or her family.

8.5 EUPD care and support pathway and understanding EUPD

There is no defined care and support pathway or defined offer for a person with EUPD in the local area. As previously described, there are various services that may be able to be accessed, but pressure on resources impacts their availability. It is evident that there is a lack of specifically focused EUPD resources and training for multi-agency practitioners and the third sector. GMP, and ASC and GHP appear to have lacked knowledge about how EUPD affects a person's communications

[9] Toray, T., The Human-Animal Bond and Loss: Providing Support for Grieving Clients *Journal of Mental Health Counselling* (2004) 26 (3): 244–259.
[10] Toray, T., ditto

and actions, and how particular professional behaviours and decision-making can reinforce a person's EUPD symptoms.

8.6 The impact of child sexual abuse on Jo's life and agency understanding

There was not a clear understanding between the professionals supporting Jo, that she had experienced and suffered from child sexual abuse, and the long-lasting psychological impact of this, for example at least two agencies were unaware that she was a victim/survivor. Given that one of these agencies was ED at SNHSFT, (where Jo had attended on many occasions), it raises the issue that different decisions may have been made by ED in relation to admitting Jo to the Clinical Decisions Unit, where deploying s5(2)[11] could have taken place, particularly when Jo was either threatening to discharge herself and or refusing assessment by the onsite MHLT (PCFT).

Jo's EUPD diagnosis was not confirmed until September 2018, which puts into question whether her previous mental health treatment and medication had been informed by the depth of her childhood trauma.

8.7 Integrated Care Pathway for Suicide Prevention

It would appear evident that there was no local integrated care pathway for suicide prevention in the area, during the scoping period of this Review, nor was a mental health crisis response team in place. Urgent mental health needs were met by the GP, ED response and ED based Mental Health Liaison Services and the 'system' was supported by the drawing up of a care and safety plan. PCFT were aware of GMP, NWAS; SARC; GHP and SWA involvement, however they seemed to be unaware of the significance of that involvement, in relation to the support Jo was receiving from those agencies.

People with urgent mental health needs having to attend ED, can be off putting, and very difficult for a patient experiencing a mental health crisis.

8.8 Support for families post suicide

There was little support provided to the family post Jo's suicide, however PCFT advise that the family were advised to call the CMHT East Manager if they needed help, (which they dispute). They were given limited signposting, and no offer of bereavement counselling. Families in Stockport would very much benefit from a more proactive approach to post suicide family support, given that suicidal death causes severe, family distress, and carries a very traumatising and long-lasting impact[12].

8.9 Did Not Attend Policy (PCFT)

The PCFT Did Not Attend Policy, needs improvement, review and update in relation to a) guiding practitioners when patients themselves (or another person), prevents face to face meetings, (albeit they may be socially distanced) b) defining *'follow up'* and '*urgency*' c) the impact of Covid-19 restrictions d) clarity about where and how practitioners raise a safeguarding alert and when the PCFT Safeguarding Lead should be contacted.

8.10 Oversight of CMHT management and practitioner supervision

Performance management, supervision and oversight for CMHT managers and practitioners requires improvement as it did not detect a) that information about Jo's increasing risk in March b) the fact this was not shared with zoning meetings c) following several suicide attempts in March Jo's risk level was revised and moved to red zone, but a zoning meeting did not take place d) lack of contact with the GP and family when Jo was declining visits, in accordance to PCFT DNA policy e) raising consequent safeguarding alerts f) that CPA Reviews did not occur when Jo transferred to CMHT East,

[11] Mental Health Act 1983

[12] McDonnell S, Hunt IM, Flynn S, Smith S, McGale B, Shaw J (2020). From Grief to Hope: The Collective Voice of those Bereaved or Affected by Suicide in the UK. Manchester: University of Manchester. November 2020

in October 2019 or following the significant suicide attempt in November 2019, g) that it could be argued that Jo was ultimately self-neglecting in March and i) that safeguarding notifications received inconsistent response.

8.11 Care Act Duties, safeguarding and self-neglect

It is evident that in March Jo was self-neglecting by declining services and offers of help, and that some agencies appear not to have considered the self-neglect advice and guidance as set out in the Stockport Multi-Agency Procedures for Adults at Risk, and the consequent safeguarding duties set out in the Care Act 2014. It would appear self-neglect was only considered as a feature of Jo's situation by SNHSFT. However, albeit that they acknowledged this, it is not clear if a safeguarding referral was considered.

8.12. The s75 Agreement

It would appear to be that the s75 Agreement in place between PCFT and ASC was not monitored in relation to adult safeguarding notification outcomes, and it could be argued that this lacked governance, oversight and quality assurance.

8.13 Systems

i) Systems that are in place regarding patient contact at PCFT, with particular reference to 'opt-in' letters, and when there is a lack of response from a medium to high risk patient, did not seem to consider, that patient choice can be impacted by patient illness, and risk management risk management consequently needs to be considered, particularly when patient disengagement occurs at a time of escalating suicide attempts.
ii) Safeguarding alert management from PCFT, CMHT, MASH and ASC does not follow a very clear pathway, and it is not very clear to the Review, how the parties work together. It is also seemingly not evident to partners.
iii) Care Programme Approach (CPA) policy was not always followed by PCFT, resulting in relevant partners not receiving necessary information and some patient reviews not taking place**.** The 2008 Practice Guidance[13] sets out key groups of people whose needs should be fully explored, examined, understood and addressed when deciding if support under the revised CPA arrangements is required.[14] The groups referred to, include a dual diagnosis with substance misuse; people with a history of self-harm and people with unsettled accommodation. In this case Jo's mental health profile fitted these criteria and CPA procedure should have been followed, as well as the national guidance on the positive practice in deployment of CPA[15], as it would appear it was not adhered to.

8.14 Jo's loss of faith in mental health services

It is fair to say that Jo did, and had lost faith in mental health services, albeit she did work well with CMHT West, up until August 2019, and engaged with CMHT East. Faith in a service can only be judged by the individual in receipt of it, and in Jo's case she had an intelligent and enquiring mind, despite the context of her illness. She rightfully questioned her longstanding diagnosis of Bi-Polar Disorder and PTSD, and self-diagnosed. Various factors caused Jo to lose faith in various services, but this Review concurs with the view from the SWA Counselling service: *that due to the trauma she had experienced in her past, her faith and trust in people, and services had already declined.*
Strengthening links; clarifying expectations and increasing collaborative working with non-statutory third sector agencies, would be of benefit to both provider services and patients.

[13] Refocusing the Care Programme Approach, 2008, Department of Health
[14] Guidance states: '*the default position for individuals from these groups would normally be under (new) CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records.*[14]
[15] ditto

8.15 Medication and the therapeutic offer

Medication was appropriately managed and administered, with conscious efforts made by the GP to offer a careful and flexible prescribing regime, as well as consistent care, providing an out of area offer of support and appropriate referrals made to PCFT for DBT. In relation to assisting Jo to decrease risk, the GP referral to an alcohol management programme for Jo, resulted in her engaging reasonably well and to some degree, the programme seemed relatively successful.

In relation to the provision of therapy for Jo, CMHT East supported the DBT request and offered therapy, which Jo refused and she refused a second GP referral for the same. Jo accessed Trauma Informed counselling, facilitated by a decision made by the Strategic Head of Safeguarding at SMBC, and agreed with by GMP, and albeit this was an unconventional approach, Jo seemed to genuinely value it. (It's not to say however that an earlier approach would have prevented her death). PCFT do not have a policy appertaining to the review of therapeutic offers in relation to suicide and advise all decision making is based on risk assessment. In this case risk assessment was not up to date, particularly when in March, Jo had the greatest period of risk escalation.

Jo was deemed at a high risk of suicide by SWA, continually stating she did not want to live with the long-term impact of the historic sexual abuse, reiterating many times, that she did not wish to battle with the daily thoughts that had haunted her, for nearly 27 years.

8.16 Reference to a Learning Disability Referral

No trace of a Learning Disability referral can be found, which is not say it did not happen, but if it did, there are no evident reasons as to why it should have occurred.

8.17 Reference to a Judicial Review

There was no Judicial Review, ever planed or intended. The ideology, and records that were consequently written by professionals regarding this matter, were done so from misunderstanding and consequent professional inaccuracy.

8.18 Carer's Assessment

CMHT West did not provide a Carer's Assessment, when they were made aware in 2018 about Jo's alleged caring responsibilities for her Mother. The information provided by Jo may have been true or not, as the case maybe, but had a Care's Assessment been offered to Jo, more would have been learned about her situation; along with any care issues that her Mother may have had, and any potential risk her Mother may have faced by Jo reducing contact. This also could have provided a base further down the line from which to explore with Jo why she eventually cut contact with her Mother and why she changed her name.

9. RECOMMENDATIONS

Stockport Safeguarding Adults Board seeks assurance that:

1. A clear, revised plan is considered in relation to the current Stockport Suicide Prevention Strategy, where the findings and learning from this Review are considered; and organisations deploy any necessary and associated actions.
2. Appropriate training is in place regarding Emotionally Unstable Personality Disorder; multi-agency working; information sharing; Mental Capacity Act deployment; self-neglect issues and mental ill health.
3. A clear pathway for EUPD exists where there are shared, mutual partner responsibilities in relation to managing information and patient risk.
4. The multi-agency partnership continues to review and revise Safeguarding Adult Policy, Procedure and Complex Case Guidance to enable effective safeguarding activity and safe outcomes.
5. Section 42 Safeguarding Adult Enquiries and safeguarding adult referrals are managed effectively and dealt with appropriately by the partnership, as part of a robust system, able to withstand audit and testing, for safe outcomes.
6. SNHSFT review their use and knowledge of the Mental Health Act 1983, and Mental Capacity Act 2005, in relation to detaining a patient sufficiently long enough in a safe place, to enable mental health assessment.
7. Organisations make appropriate responses to people with care and support needs and deliver in line with Care Act 2014 legal duties and obligations.
8. Commissioners consider the learning from this Review and act accordingly, to assure contracting delivers systemic risk management, which is quality assured.
9. Those responsible for safeguarding adults at PCFT are able to make defensible decisions by having the necessary skills and knowledge to deploy safe practice for patients.
10. The Board should deploy an annual quality assurance audit across the safeguarding adult partnership and ensure that suicide prevention is a fundamental part of the audit framework.
11. That Health partners give consideration as to how mutual expectations can influence communications with third sector services, when a patient is part of a secondary care pathway.

APPENDIX 1 – LEARNING ALREADY ACNOWLEDGED

Learning already acknowledged and changes already made:

SMBC and ASC

- will promote the TAA model and hold a workshop session to review current guidance and develop outcomes to support embedding practice
- want to try and gain greater understanding of a Suicide Prevention Pathway having requested information from CCG and Public Health, (*however this Review has established that an integrated suicide prevention pathway is not in place in Stockport*).
- have established a joint working group with PCFT and CCG, to develop guidance, to form part of a Multi-Agency Policy Review, which is underway.

Stockport NHS Foundation Trust

- have recognised the importance of using effective tools to capture possible antecedents and indicators of harm by historical or current issues
- have recognised that processes such as a 'TAA' Meeting' and use of MAARS may have given an opportunity to alert key partners in relation to significant risk factors for Jo, and required particular responses, when she presented at ED
- have recognised that that increased understanding and awareness of assessment tools is necessary, when engaging with, and trying to understand a vulnerable adult's needs, in the context of child sexual abuse.

General Practice

- has recognised the importance of GP records holding a copy of a clearly documented suicide crisis safety plan
- has recognised there is no Integrated Care Pathway for Suicide Prevention and albeit a Crisis Pathway is being launched, there is the desire to ensure all GPs are aware of this and how to access it, possibly requiring reiteration when physical hubs go live.

Pennine Care Foundation Trust

- have acknowledged that when Jo's dog became ill, it should have triggered a review of her risk assessment and risk management plan. Whilst there was evidence that her risk of suicide had increased, this was not supported by documented evidence of any change to her care plan. The zoning process was not used as effectively as it could have been in February and March 2020, which would have given opportunity for team discussion and management oversight of risk management plans. An assertive approach to meet with Jo was not taken and when offers of appointments were declined, her reasons were too easily accepted, given the increase of risk she faced. Contact with family had not been adequately explored, and they also could have provided additional support.
- have acknowledged that clinical leadership skills are to be developed with CMHT Managers, and Practitioners are to be involved in a review of zoning. A series of clinical leadership development sessions for a new management team will also take place.
- will provide themed learning within CMHTs and develop a Structured Clinical Management Pathway for people with EUPD within Community Mental Health Services and will maintain involvement in the work being completed across Greater Manchester, alongside Stockport CCG, to support future investment.
- acknowledge that there was an over-reliance on the use of Jo's personal email to maintain contact, which should not have been relied on, owing to the changing situation around the availability of care coordinators and their ability to respond.
- note that a reduction in support from services at the start of COVID-19 had occurred and regular visits ceased, and despite the increase in risk, no change to her risk plan was made.

- are currently reviewing the volume and type of referrals received by the Mental Health Access Team.
- have made changes to zoning documentation and the decision-making process, about existing safety plans, to assess if strategies currently in place continue to be effective.
- will introduce CMHTs to *the stayingsafe.net* safety plan to support existing care planning mechanisms
- have reviewed and audited the volume and follow up of safeguarding referrals for two former weeks, to enable improved management and the partner referral process.
- A 24-hour phone-line has been set up for patients known to PCFT.
- There has been an extension of an overnight 'safe place' for 6 people.

Greater Manchester Police

A revision of the Adult at Risk policy was launched 26th May 2020 and a mandatory training package delivered online to staff attending adult safeguarding incidents, (September to January 2021). In addition, this new policy gives officers a greater understanding of how to deal with vulnerability and risk to individuals and outlines a plan that they must follow.

SWA - Trauma Informed Counselling Service

- The service will adapt their offer to ensure that there is a more co-ordinated response with other agencies, whilst maintaining client empowerment and policies will be developed to share information. Additional roles that practitioners could adopt will be explored.

Guinness Housing Partnership

- Recognising the importance of how adverse child experience (ACEs) can impact on people in their adult lives will be adopted into training to include Trauma Informed Practice for Housing Providers.

Clinical Commissioning

- A high intensity user project provided by British Red Cross, in collaboration with SHH ED will offer targeted support to frequent attenders with mental health problems.
- Fortnightly Suicide Prevention/Covid response multi-agency meetings (in addition to the quarterly multi-agency Suicide Prevention Forum) will be put into place.
- A fortnightly Mental Health Forum will exist for the voluntary sector.
- Production of an electronic 'leaflet' sharing the mental health offer, has been widely distributed across the partnership (to include pharmacies, shops etc.) with a 'door to door' leaflet drop in Autumn 2020; and signposting of mental health services in ED is to be put into place.
- Production and dissemination of a comprehensive directory of mental health services is being worked upon.
- A media and text campaign based on 'Mental Health'; 'Stay Safe' and 'Help is available' will exist.
- Advice from IAPT services to enable conversations between Primary Care staff and distressed patients will be put into place.
- A Primary Care Masterclass on Suicide Prevention was held (November 2020) focusing on safety planning and service offers, with more sessions planned.
- The promotion of Suicide Awareness training (via Public Health) to Health and Social Care staff colleagues, and Conversational Skills training for non-clinical staff will be put into place.
- A Public health campaign: 'Shine a Light on Suicide' is in progress.
- A new Mental Health Crisis pathway has been implemented and is open and fully functioning. This includes both the Safe Haven (Open Door) and the telephone line (Mental

Health Matters). There is also a 24/7 telephone line being provided by Pennine Care which is open to everyone.

- The CCG Mental Health commissioning team is working closely with the police to support and pilot new ways of working.
- There is current work across our communities to work with new 'front doors' to support people who work in crisis i.e., foodbanks. This is work which has been developed in response to the impact of the pandemic.

APPENDIX 2 – DOCUMENTS, WEBSITES AND BIBLIOGRAPHY

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APPENDIX 3 - ABOUT THE AUTHOR

Deborah Stuart-Angus BSc (Hons) CQSW Cert.Ed. Dip.App.SS

A senior executive, and registered social worker, with a background in mental health and a rich experience of leading safeguarding, learning and organisational development across the public sector, health, charities, and a local authority trading company. A keen focus to safeguard vulnerable adults and children, delivering strategic and operational excellence, developing efficient and effective systems.

Produced the National Domestic & Sexual Violence Service Standards for the Home Office, and (former) Office of the Deputy Prime Minister; a Lead Safeguarding Consultant to the Local Government Association and the Social Care National Institute of Excellence, and an active member of the South East, Eastern and National Adult Safeguarding Chairs Networks and a member of the National Chair's Executive.

Managed high levels of acute risk and designed and delivered large scale systems, practice and performance improvement strategies, having led high profile local and national investigations, involving both children and adults across a broad spectrum. Held executive directorships at Laser Learning and Assess for Care and a non-executive director at the Social Care Association, as national Mental Health Convenor. A previous Trustee, a former Judge for the National Training Awards; a former Department of Health Quality Assessor and member of the Performance Action Team.

A published author on preventing abuse and delivering care principles and responsibilities; an adept trainer and a frequent public speaker. Awarded many specialist commissions, including training the Metropolitan GMP Murder Squad; and conducting various safeguarding business reviews for care and health partnerships; supported housing, and several safeguarding partnership executive boards. Since the implementation of the Care Act in 2014, implemented in 2015, appointed as Independent Chair for the Adult Safeguarding Board of Kent and Medway, having now overseen over 60 Safeguarding Adult Reviews, focusing on self-neglect; mental health, suicide, secondary, nursing and residential care.

In 2018, Deborah was appointed as Independent Chair for Surrey Safeguarding Adult's Board Safeguarding Adult Review, for a case concerning residential care and mental health, and in 2019 she was appointed as Independent Chair and Reviewer for Bexley Adult Safeguarding Board's Safeguarding Adult Review, involving the young suicide of a person subject to detention under the 1983 Mental Health Act.

Later that year Deborah was appointed as Hertfordshire's Independent Reviewer for a Partnership Case Review, where two young people receiving mental health support took their own lives, and in 2020, was appointed as the Independent Chair of the Essex Safeguarding Adults Board and the Independent Chair of Southampton City's Adult Safeguarding Board. In 2021 Deborah was appointed as Chair and Independent Author for Stockport Adult Safeguarding Board, involving a case where a young person with EUPD took their own life, and she has recently been appointed by Bexley's Children's Multi-Agency Safeguarding Arrangements, for the Review of Child S - involving a young person with mental health needs.

APPENDIX 4 - GLOSSARY

ADASS Association of Directors of Social Services
ASC Adult Social Care
CMHT Community Mental Health Team
DBT Dialectical Behavioural Therapy
ED Emergency Department
EMDR Eye Movement Desensitisation and Reprocessing
GHP Guinness Housing Partnership

GMP Greater Manchester Police
HoS Head of Safeguarding
LGA Local Government Association
MAARS Multi-Agency Assessment of Risk System
MHAT Mental Health Access Team
MHLT Mental Health Liaison Team – also known as REACH
NWAS North West Ambulance Service
PCFT Pennine Care Foundation Trust
SMBC Stockport Metropolitan Borough Council
SAB Safeguarding Adults Board
SCCG Stockport Clinical Commissioning Group
SHH Stepping Hill Hospital (SNHSFT)
SNHSFT Stockport NHS Foundation Trust
SPOC Single Point of Access
SSAB Stockport Safeguarding Adults Board
SWA Stockport Without Abuse
TAA Team Around the Adult Meeting