Dudley Safeguarding People Partnership

Safeguarding Adults Review

Practitioner Briefing

Helen – a case involving long standing complex mental health

WHO SHOULD READ THE BRIEFING?

Any practitioner and manager whose work brings them into contact with adults.

For further information on our safeguarding reviews visit the Dudley safeguarding website.

CASE BACKGROUND

Helen had a long standing complex mental health history with a clinical diagnosis of Emotionally Unstable Personality Disorder, and Mental and Behavioural Disorder. Reports of deliberate self-harm through overdose and the display of risky behaviours were a regular feature in her life. These were reflected on occasions where she would walk or lay in the road and have thoughts of ending her life, often described by agencies as impulsive acts influenced when intoxicated by alcohol.

Following attendance at hospital for alleged physical assault Helen was discharged. She was returned to the hospital emergency department twice by practitioners who found Helen lying in the road, but left again on both occasions. A short while later Helen was found to have been struck by a vehicle and later died as a result of injuries sustained.

OVERVIEW OF LEARNING

- There were several areas of good practice identified during the timeline of the review period, including agencies trying to seek support for Helen's alcohol issues, referral to seek support for financial concerns and actions taken in relation to Helen being a frequent absconder from hospital.
- It is recognised that the Covid19 pandemic impacted on the support some agencies were able to provide at the time and may have impacted upon agencies ability to manage the perceived risks presented.
- A joint multi-agency response plan would have been beneficial to emergency services in managing the risks Helen presented, allowing each agency to have a clear understanding as to who was responsible and what action was required in a what particular set of circumstances.
- The appointment of a care coordinator may have been valuable to coordinate the care required in managing the complex issues Helen presented with, which could have promoted joint working between secondary mental health and alcohol recovery services.
- It is recognised that practitioners assessing the mental capacity of individuals who may lack executive functioning are faced with several challenges that make determination of capacity more challenging. This can have significant implications because failing to carry out a sufficiently thorough capacity assessment can expose a vulnerable person to substantial risk.
- There is no evidence of agencies working together to develop a multiagency plan of support, or building a "Team around the Adult". Dudley now have the Adults at Risk Team, who work with a variety of people who are deemed to require intervention as per Section 42, 9 or 11 of the Care Act 2014, and have care and support needs including those who primarily have needs in relation to alcohol or substance misuse.
- Helen made a number of reports of assault/sexual assault while intoxicated. The SAR has identified no evidence of agencies engaging with Helen after the initial reports so as to investigate these matters further or re-establish contact when hopefully she may be sober.

- Leading up to the time of her death agencies identified an increase in reports of Helen walking or lying in the road in an intoxicated state and reporting her wish to die. Following a mental health assessment the plan for home treatment was found to be unrealistic with a probability that crisis management would be required without an effective plan being established to manage the dynamic nature of risks that Helen presented.
- The SAR identified learning in relations to agencies working together to respond to the risks posed and providing care for Helen's complex needs. A multiagency risk management meeting and plan would have enabled agencies to consider the cumulative risk posed by this complex and high-risk case.

RECOMMENDATIONS

1. Dudley Group NHS Foundation Trust should ensure it has an established policy and process to manage and respond to the associated risks posed to "High Incident" users of its emergency departments, as recommended by the Royal College of Emergency Medicine.
2. Where individuals regularly present to agencies leading to multiple safeguarding concerns being raised Dudley Metropolitan Borough Council Adult MASH should continue to provide oversight of such cases when the responsibility to undertake safeguarding enquiries is transferred to other agencies.
3. Dudley Safeguarding People Partnership should promote the benefit of holding multi-agency safeguarding meetings, to develop a risk management plan in response to the cumulative risks posed by complex and high-risk cases. This can be achieved by the revision and promotion of the Multi-Agency Risk Management Protocol.
4. Mental Health Services should ensure when formulating support plans upon discharge from Section 136 Mental Health Act detention that they are both realistic and achievable, so as to best safeguard the individual subject to the plan.
5. Dudley Safeguarding People Partnership should seek assurance from West Midlands Police that it consistently applies its THRIVE assessment process so as to safeguard potential victims of crime and that investigations into such reports are instigated in line with the College of Policing Approved Practice.
6. Dudley Safeguarding People Partnership should promote the existence and access pathway to the Dudley Adults at Risk Team.
7. Dudley Safeguarding People Partnership should seek assurance from the Black Country NHS Foundation Trust that the recommendation relating to the adherence of the Care Programme Approach as identified within the Trust Root Cause Analysis investigation is embedded within its operational practice.
8. Dudley Safeguarding People Partnership should seek assurance through the application of its quality assurance framework that that consideration of fluctuating capacity as per the Mental Capacity Act 2005 is being consistently applied across the Dudley Safeguarding Adult's partnership.
9. Dudley Safeguarding People Partnership should develop Practitioner Guidance to assist in the identification and response to individuals displaying signs of executive impairment.
10. WMP and WMAS should work together to establish a joint protocol that promotes the development of a mutually agreed response plan in response to multiple calls from individuals with complex needs.
11. Dudley Safeguarding People Partnership should work with the Dudley Community Safety Partnership to review the protocol of the Safer Estates meeting to ensure that when adult safeguarding concerns are identified such concerns where appropriate are raised to ASC for assessment.

MORE INFORMATION

The DSPP training offer and further information for practitioners relating to learning from reviews is available via the Learning Zone