South Gloucestershire Safeguarding Adults Board

'HOLLY'

The review was led by an independent facilitator - Rosie Buckland

What Happened?

The Safeguarding Adults Review (SAR) Sub group received a referral for Holly*, a lady in her late 50s who had died by suicide. The group reviewed records from the organisations who had worked with Holly and although there was some learning identified this did not meet the criteria for a SAR under the Care Act, however the Independent Chair of the Safeguarding Adults Board agreed with the SAR sub group that there should be a discretionary SAR – to help share the learning.
A practitioner event took place in October 2021.

Professionals from Multiple agencies across two local authorities took part

What Can we do Differently?

- Ensure a mental health referral takes place when someone makes a suicide attempt
- Not everyone working with Holly knew about her background of depression and suicide attempts. This sharing of information could have helped with care planning, and including Holly would ensure her voice was heard and her consent considered.
- Multi agency care planning meetings which include the adult and their family ensure a more holistic and effective approach
- Discharge plans from hospital should include both physical and mental health
- Practitioners should make contact with people who know the adult well and have a good relationship established for effective multi agency working
- Holly had told professionals she was worried about medication increasing her suicidal thoughts – make sure the adults voice is heard clearly and acted on
- Being aware of the impact of changes to practice for an individual– for example because of the pandemic greater quantities of medication were prescribed at a time
- Holly had experienced some major traumatic events in her life, make sure a trauma informed approach is used to working with adults
- Ensure risk assessments are updated and communicated at transition points

Evidence of Good Practice

- Practitioners working well despite the difficult circumstances, exacerbated by Covid-19 Pandemic and associated restrictions
- Evidence that organisations kept consistent practitioners working with Holly to help build a relationship with her
- Concerns raised by professionals when they were worried
- Rapid response to referral with a next day visit by AWP
- Good support provided to Holly's family after her death

When Holly transitioned from hospital to home the mental health risk assessment was not updated or shared

Care Providers need to be informed about any relevant risks for an adult – for Holly they were the organisation who spent most time with her following discharge, but knew the least

Although Holly hadn't consented to this, there isn't evidence to show the implications were explored with Holly, or consideration given about whether this could have still happened for Holly's safety

Holly* had experienced depression and anxiety for many years and was known to self harm. Prior to her death she had made multiple suicide attempts, following one of these, Holly had a long hospital stay for a physical condition, and had been discharged two weeks before her death

Dual referrals to different teams within mental health led to a lack of ownership and Holly fell through the gap between two systems

Theme for Learning – 'Retelling the Story'

Holly had a lot of different professionals in her life
The number of visits, calls and appointments was overwhelming and may have led to her declining support
As professionals we need to co-ordinate our care and support and wherever possible provide a single point of contact to avoid an adult having to retell their story over and over
Professional intervention should always help and not increase the burden for the adult
The onus is on us to work together and ensure our support does not overwhelm the adult

Holly had family members who supported her regularly – but it is not clear how well they were included in care planning by some organisations

Think 'Suicide Prevention' - consider possible powers under the Mental Health Act and your duties under the Human Rights Act alongside someone's capacity to make decisions

Holly is a pseudonym chosen to protect anonymity