Safeguarding Adults Review

"Aziza"

Overview Report

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1. Introduction

1.1 Bournemouth, Christchurch and Poole Safeguarding Adult Board (BCPSAB) have commissioned this Safeguarding Adult Review (SAR) after "Aziza" was found dead in March 2021, having taken her own life.

1.2 Aziza came to Dorset in September 2020 to study animation at University 1. Very soon after arriving at university, Aziza's flatmates raised concerns that she was extremely distressed, banging in her room and screaming for hours. Aziza, who had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) told University 1's Wellbeing Service that she had held suicidal ideations since she was 12 years old, and intended to take her life once she had completed her degree, but only after her father died, as she did not want to distress him. University 1's Wellbeing Service supported Aziza in respect of her psychological wellbeing and provided practical support with finances, accommodation, obtaining prescriptions and access to statutory services. Following a risk assessment from the Wellbeing Service, Aziza's GP referred her to the Community Mental Health Team (CMHT) when she was diagnosed with Emotionally Unstable Personality Disorder (EUPD). Aziza was later discharged from the CMHT after missing an appointment and was subsequently re-referred by her GP, as was recommended by the CMHT if required. Over time, the Wellbeing Service were able to help to resolve some of Aziza's social stressors and believed that she was making positive progress. However, in early March 2021, Aziza's flatmates became concerned that they had not seen her for several days and entered her room and tragically found her dead.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Aziza from harm.

Key lines of enquiry

2.3. The BCPSAB prioritised the following key lines of enquiry for illumination through the SAR:

- How effective communication was between University 1 and statutory services, and whether this resulted in a timely response to Aziza's needs.
- An analysis of partnership working across the local mental health network to help University 1 to understand how to support Aziza.
- Agencies' understanding of the Care Act and adult safeguarding processes.

Methodology

2.4. The BCPSAB commissioned independent reviewers to conduct a SAR using a hybrid of the Social Care Institute for Excellence Learning Together and SAR In Rapid Time methodologies. This was to enable learning to be turned around more quickly than usual through a SAR, but with a more detailed report that would typically be produced for a SAR in Rapid Time. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

2.5. University 1, the GP Surgery and Dorset Police provided documentation to support the SAR. A copy of the Serious Incident Report completed by the NHS Mental Health provider (the Trust) was provided, which contained information in respect of the actions of the Community Mental Health Service (CMHT). It is understood that the Local Authority had no contact with or referrals in respect of Aziza. BCPSAB has taken a decision that the agencies involved should be anonymised for the purpose of this report.

2.6. A multi-agency learning event took place, with front-line practitioners who worked with Aziza and the managers who oversaw the services involved in supporting her. The authors are grateful to the professionals who attended the learning event for sharing their insight into her experiences. The efforts made to support her and try to keep her safe were very clearly apparent throughout the review process and practitioners expressed how devastated they were at her death.

Involvement of Aziza's family

2.7. The authors wish to express their sincere condolences to all members of Aziza's family and her flatmates for their loss and thank Aziza's sisters 'Nasran' and 'Laleh' for contributing to the review with such touching honesty. Although grieving, they were concerned for the welfare of other students at the university and were relieved to hear that support had been provided to Aziza's flatmates. They also expressed their appreciation for the "amazing" efforts of University 1's Wellbeing Service, which showed such commitment to caring for Aziza.

3. Pen Picture of Aziza

3.1. Aziza was a 23 year old British Iranian woman, a talented artist who was very expressive and loved to dance. She was intelligent and although her dark humour could be misunderstood by others, her sister Nasran shared how precious their shared satire had been. She was born in Bradford and grew up with her two older sisters until she was around 3-4 years old, when she and her mother joined her father in Iran, returning to Leeds 18 months later. She first saw a child psychologist at the age of 8 and was badly bullied in school. Aziza then moved back to Iran as a teenager, attending the international school, but dropped out of high school as she had trouble concentrating and was prescribed antidepressants at the age of 14. Aziza was diagnosed with ADHD in 2014 while living in Iran and was prescribed methylphenidate (commonly referred to by the brand name Ritalin) to treat this. However, this diagnosis in her late teenage years meant that she struggled socially during school without the tools to understand her condition. Aziza's mother was diagnosed with cancer and they returned to the UK for treatment, moving in with Laleh until her mother found a house a few months later. Aziza tried to take her GCSEs in the UK as an adult but had poor attendance and her sisters said the disruption to her schooling throughout her childhood and trauma of her mother's illness meant that she fell behind in her education, which impacted heavily on her self-confidence.

3.2. Her mother died in 2018 and this deeply affected Aziza, who attempted to take her own life by overdosing on her mother's morphine prescription in 2019, although she did not seek medical

attention at the time. She later told Wellbeing Service staff that she had first started to think about suicide at the age of 12, having felt profoundly socially isolated throughout her childhood. An assessment by the Leeds ADHD clinic noted that Aziza had reported being previously diagnosed with depression, personality disorder, psychosis and social anxiety, but disagreed with these diagnoses and believed that ADHD was her only mental health issue. Aziza said that she could feel judged because suicide is against Islamic beliefs[1] and international studies indicate that within many Muslim communities, "… *disclosure of mental illness is considered "shameful*"".[2] This cultural perception of stigma may have contributed to Aziza's resistance to her earlier diagnoses, which presented a barrier to accessing support for her holistic mental health needs at a point before she reached crisis.

3.3. Although Aziza told professionals that she was alienated from her sisters, she was in regular contact with them by telephone and social media. They provided her with both emotional and practical support where possible within the strictures of the Covid-19 lockdowns. Aziza's artistic nature and unique outlook meant that she had always felt very different from other young people at school and in her family's social circle and she was hugely looking forward to meeting friends who were more like her at university, where she could be her '*atypical self*'; friends who appreciated that there could be '*more than one type of normal*'. Unfortunately, on arriving at University 1 in September 2020, Aziza initially struggled to make friends or form meaningful relationships, doubtless exacerbated by the strictures of the Covid-19 pandemic and limited opportunities to socialise, and this was a bitter blow to her. However, she had a close friend in Leeds who continued to contact her and had helped her to travel to Bournemouth when she started university. She also had caring flatmates at the time of her death, who would leave notes for Aziza to encourage her to join them for meals and invite her to parties on the beach, where she could dance. Aziza wanted help with her mental health and practical support, but she wanted these on her own terms and at times, this could be an obstacle to support. She expressed that she felt isolated, unlovable and dislikeable, despite the love and support her family and friends constantly tried to assure her of. The depth of her loneliness was palpable.

> *"Weekends have always been hell since my mum died… I have no friends no personal relationships in my life at all besides dad, and one friend here. And I won't ever …The idea of how many years of these weekends - 104 days in a year! 1040 in 10. Until retirement - 5000 or so. Awful. Why should I put myself through that?" Aziza, November 2020*

4. Narrative Chronology

4.1. In September 2020, Aziza moved Bournemouth to attend University 1. She moved into private rental accommodation in a flatshare with two more senior (albeit possibly younger) students from University 2. Within weeks, they started to raise concerns about her welfare as Aziza often presented as overwhelmingly distressed, screaming and banging around in her room for hours. They noted marks on her arms that appeared to be due to self-harm, and were worried that on several occasions she had left food burning on the stove (a fire hazard) or left the front door open at night. Initially they spoke to the University 2 chaplain to obtain support for Aziza, before speaking to their landlord. Whilst they were very concerned to secure the help that Aziza needed, the situation was also impacting on their safety, their studies and must have been a frightening and stressful experience.

4.2. There was evidence of a caring and nurturing environment at both universities, as in addition to Aziza's flatmates, landlord and University 2 chaplain, a counsellor from University 1, a fellow

[1] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/suicide-and-religion/043882DA1BA91B7EACA132C84A5B6F6E

[2] Mental Health Stigma in the Muslim Community, Jones, N. & Corrigan, P., Journal of Muslim Mental Health, Volume 7, Issue 1: *Stigma*, 2012, https://quod.lib.umich.edu/j/jmmh/10381607.0007.102/--mental-health-stigma-in-the-muslim-community?rgn=main;view=fulltext

student on her animation course, a member of University 1's IT team and a member of the registry team (having noted concerns in Aziza's response to a student survey) all raised concern for her welfare with University 1's Student Services within the space of a month from late October. Student Services were proactive and thoughtful in their response. Aziza may have been unable to recognise this due to her psychological distress, but people around her noticed and cared for her.

4.3. University 2's chaplain contacted University 1's Student Services on 20 October 2020, who in turn contacted the Wellbeing team. They immediately tried calling, then emailed Aziza, asking if they could speak to her confidentially and offering support. Aziza responded that day:

> *"…I'm sorry I have caused concern to my classmates, but I'm not interested in looking for support. I've tried getting it in the past. My problem is a concrete, tangible one that makes life pretty much unbearable for me and is impossible to fix… I simply find life extremely painful to live. I've talked about it many times and it doesn't help. I'm determined to make the best out of the next few years, as I don't want to make my father unhappy…"*

4.4. A prompt response was sent, offering counselling, advice and support. Aziza's landlord notified University 1's Student Advice Service on 26 October 2020 of his concerns, both in respect of Aziza's wellbeing and the welfare of the other students in the flat, and they provided general information about how students could be supported but advised the landlord that they could not breach Aziza's confidentiality by telling him what was being done. Student Advice then asked the Wellbeing Service to contact Aziza, forwarding them the email sent by Aziza to ensure that they had a full understanding of her distressed presentation. The Senior Student Services Officer contacted the Head of Academic and Student Services in advance of a scheduled risk management meeting to flag the concerns about Aziza, who suggested contacting the Trust's Community Mental Health Services to see whether Aziza was in receipt of services, or the Early Intervention Psychosis services could contact her.

4.5. On 27 October 2020, Aziza visited Student Services for help with her student loan and the student adviser provided practical support with respect to progressing her loan as well as the details of the Trust's Mental Health Forum, (which provides support out of normal working hours) and contact details for other support lines. There was clear evidence of multiple efforts to contact Aziza, including through her course tutor.

4.6. On 2 November, Aziza's landlord notified Student Advice that the situation had deteriorated and that one of Aziza's flatmates had gone home for lockdown, the other flatmate was very worried about being a male alone with a woman who was vulnerable. The landlord advised he was reluctantly considering serving Aziza an eviction notice because of the impact on the other tenants and breaches of her tenancy agreement.

4.7. Aziza attended the Wellbeing drop-in centre that day and told the senior wellbeing officer that she was drinking heavily, self-harming, isolated and planning to end her life before she graduated. She was very worried about her finances as the Student Loan Company had only given her half her loan because they had not seen her mother's death certificate. She said that she had run out of ADHD medication 3 weeks previously, which appeared to have had a very serious impact on her mental health. She asked the wellbeing officer to call her landlord, who reiterated that he may need to ask her to leave. Aziza did not recall the behaviours reported by her flatmates.

4.8. To provide some respite from this situation, the wellbeing officer made urgent arrangements for Aziza to be provided with a studio apartment in the university's halls of residence from 2-10 November, and for welfare checks to be carried out morning and evening. This was laudable practice. The welfare officer contacted Aziza's GP to request an urgent appointment and

provided Aziza with details of support services, as well as arranging to meet with Aziza again the next day. Aziza had chosen to register with her own GP Surgery rather than the campus surgery. The wellbeing officer, who was a qualified mental health social worker, completed a detailed risk assessment, setting out that although Aziza had suicidal thoughts from the age of 12 and had experimented with ending her life, she was clear that she would not kill herself until she had graduated, or while her father was still alive. She was categorized as being at high (but not imminent) risk and this was sent to the GP at 6pm. The GP tried unsuccessfully to speak to Aziza on 3 November, so booked a telephone consultation on 6 November. Because of the Covid-19 pandemic, GP appointments were being conducted by telephone unless a face-to-face appointment was necessary, in accordance with Government guidelines.

4.9. Aziza presented more calmly when she attended the Wellbeing Service on 3 November, having met with her landlord and obtained agreement to remain in her flat as long as she complied with her medication. She showed details of her prescription from her ADHD Clinic and said she would contact her GP to obtain a prescription. She told the welfare officer that her finances were causing her real stress and talked about her difficulties making friends, including being bullied as a child in Leeds. Aziza agreed that she needed a psychiatric assessment and that her GP would need to refer her to the CMHT. This was duly followed up and the surgery confirmed on 4 November that they would arrange a GP to speak to her that week.

4.10. The GP tried unsuccessfully to speak to Aziza on 6 November, calling her twice and leaving voice messages on each occasion, as well as sending a text asking her to call, email or complete an e-consultation to arrange an appointment for a time that was convenient for her. Another GP from the surgery also tried to call her and a new appointment was offered for 11 November. Given the nature of the referral, it was good practice that the surgery continued to try to contact Aziza.

4.11. On 9 November, Aziza sent a lengthy email to the wellbeing officer, noting that she had been unable to get a prescription because she had missed a call from the GP and talked at length about her intention to end her life due to her extreme loneliness. The wellbeing officer offered an appointment that day and contacted the GP about the ADHD medication, asking for an urgent referral to CMHT. Aziza then spoke with the duty GP, who noted that she appeared "*well and chatty*" on the phone. He issued her with a prescription of her ADHD medication as she had run out three weeks earlier and reminded her to keep the appointment arranged for 11 November. The GP also responded to the Wellbeing Service by email confirming that Aziza had been contacted that day and given a prescription, noting: "*Can I suggest that you encourage her to contact the practice with her concerns herself in the future to promote self-care and allow her to take responsibility for her own problems".* The welfare officer reiterated her concern and explained that Aziza was struggling with day-to-day functioning, again requesting an appointment. The wellbeing officer was able to speak with Aziza later that afternoon, and although she was initially hysterical, calmed down and was assessed as not being at imminent risk.

4.12. Aziza spoke to the GP on 11 November, discussing her ADHD diagnosis and "*struggles with mood*" and that she had thoughts of suicide but would not try anything. Aziza said she was drinking regularly but asked for a month's ADHD prescription as she was having financial difficulties. The GP had also received a letter from Aziza's Leeds ADHD clinic, stating that she was under their care and in receipt of a regular prescription which would need to be continued, that she was "*making good progress*" but would require an onwards referral to a local ADHD clinic. Aziza agreed to be referred to the CMHT, including the referral from the wellbeing officer and confirmed that she knew how to seek help if she needed it.

4.13. On 17 November 2020, Aziza sent a further email to the Wellbeing Service, repeating her suicidal ideation:

"I have been suicidal on and off for the past 10 years but for about 14 months I have been quite firm on it. I'm not depressed or mentally ill, I just have conditions in my life which I haven't been able to change and which I am less and less able to cope with. Right now I do not see any point in going on with the year. I really don't want to live."

4.14. The wellbeing officer attempted to contact Aziza and emailed the CMHT directly. The CMHT confirmed that although they had received the risk assessment and were meeting that afternoon so intended to contact Aziza, but their initial view was that there was no imminent risk. The Wellbeing Service case notes record that the wellbeing officer was told "*CMHT are currently not taking on ADHD clients and would need reasons to assess her more widely. [CMHT practitioner] mentioned she needs to address her drinking…"*

4.15. Aziza's GP contacted CMHT the same day, advising of the concerns raised by the Wellbeing Service, noting that Aziza did not disclose any immediate plan or intent to harm herself but was clear that she planned to end her life at some point and that she had considered how she would do this. She had previously attempted to end her life in 2019 by taking her mother's morphine medication and had not self-rescued; she said she was disappointed when this attempt had not ended her life. She spoke strongly that she would not end her life whilst her father was still alive and indicated that she wished to graduate. The GP requested a further assessment of Aziza's mental health, given her impulsivity and significant mood fluctuations with suicidal ideation. The CMHT attempted to call Aziza, leaving a message on her phone to call them back.

4.16. Aziza's situation was discussed in the CMHT meeting on 18 November and it was recorded that she had a diagnosis of ADHD but also appeared to have underlying mental health problems which needed further review. The CMHT wrote to Aziza, offering her a video appointment (in accordance with Covid-19 restrictions) on 8 December, copying the letter to the Wellbeing Service.

4.17. On 19 November, the Wellbeing Service was unable to contact Aziza. Her landlord emailed her sister about his concerns both for her welfare and for the health and safety of the other tenants due to hob burners being left on. The landlord notified the Wellbeing Service that he would have to terminate her tenancy and wanted to ensure she had somewhere to go, enquiring whether she could move into the halls of residence. The wellbeing officer noted that usually first year students who had chosen privately rented accommodation did so because they could not afford to live in the halls of residence.

4.18. Aziza's sister Laleh contacted the Wellbeing Service on 20 November, expressing her concern for Aziza's welfare and that she was going to be made homeless. They were unable to provide Laleh with any information as they did not have Aziza's consent to do so. She requested that a welfare visit was carried out, and was advised to contact the police, which she did. The Wellbeing Service also spoke with the Head of Academic and Student Services, discussing that there was no indication that the original risk assessment had changed or evidence of imminent risk, but in light of the third-party concerns and as she could not be contacted, the police were asked to carry out a welfare visit.

4.19. Dorset Police consequently attended Aziza's address and the police officer called a 24/7 mental health phoneline provided by the Trust. Aziza spoke to the mental health practitioner, sounding 'jovial', saying that she felt as she always felt and did not wish to engage in conversation, so the call was graded low risk and a notification sent to the CMHT. Aziza was then supported by the attending police officer to speak with staff at the Trust's out of hours mental health service via video link (due to Covid-19 restrictions) during which she denied having any plan or intent to harm herself and did not appear to want help from services. Police sent a public protection notice to Aziza's GP with her consent, explaining that Aziza wanted help with mental health as she was having suicidal thoughts, but intended to finish her degree and graduate. The police

officer recorded a detailed social history and noted that although Aziza had self-harm marks on her arms, there were no open wounds requiring treatment. The officer's proactive approach to providing a safeguarding response was good practice. Aziza subsequently expressed her frustration that she had been "*forced*" to make contact by the police officer, and that she had not seen the value in this support at that time: "*The stupid services make you MORE suicidal…"* Wellbeing Services responded explaining that they had been worried they could not contact her.

4.20. When the CMHT contacted Aziza by telephone (as Aziza had requested this instead of a video call) on 8 December 2020, a full assessment could not be conducted due to her dysregulated presentation and lack of response to direct questions. She discusses specific plans to take her life after her father had died, but said she had no imminent plans to kill herself and agreed to attend an appointment the next day and was provided with contact details for the Samaritans, CMHT and out of hours service. Consequently, a face-to-face appointment was arranged for the next day, which accorded with best practice.

4.21. During the appointment with CMHT on 9 December, Aziza presented as distressed and talked about mood swings, suicidal thoughts, self-harm by superficially cutting (although these were not noted to require medical attention) and her previous overdose of morphine, and feeling "*empty and insecure that nobody likes [her]*". She was told that her presentation pointed to a diagnosis of emotionally unstable personality disorder and agreed to try some medication to see if this was beneficial to manage her ADHD symptoms, and to return for a review to continue the assessment of her mental health and to tailor a management plan. Aziza was assessed as having capacity to understand her mental health issues and consent to her treatment. This was confirmed in a letter to Aziza and copied to her GP. Although the clinical notes recommended a face-to-face review in one week and she was given a 7-day trial prescription, an outpatient appointment letter offered a follow up appointment for 21 December 2020. This may have been because the letter was typed on 14 December.

4.22. Aziza's case was discussed at the weekly Wellbeing Services' risk management meetings in December, noting that there was no indication of an increase in risk, but planning support for her over the Christmas period. The CMHT also discussed her case at their team meeting, taking a view that she was unlikely to be eligible for council housing support to address her accommodation problems. Over the next few weeks, there was significant correspondence between Aziza and Wellbeing Services, supporting her to resolve her problems with her student loan, risk of eviction and obtaining her prescription. Wellbeing Services were proactive in contacting the Student Loan Company and provided her with an email in support to evidence her financial situation to ensure she received the full maintenance loan. Aziza gave written consent on 18 December 2020 for the CMHT to share information about her treatment with the Wellbeing Service, and this was sent through to the CMHT with a request that they share details of any upcoming appointments arranged for Aziza, so that they could support her with these.

4.23. Aziza did not attend her CMHT appointment on 21 December 2020, and there was no answer when the psychiatrist attempted to telephone her. This was discussed within the CMHT and it was decided to discharge Aziza back to the care of her GP with information on how to access the Recovery Education Centre (REC), and that she could be re-referred if she wanted to engage with CMHT. Aziza was assessed to have low risk of harm to self in the immediate future. During the Serious Incident investigation, the CMHT advised that they wanted to encourage Aziza to take responsibility for her wellbeing, interaction with services and to show motivation to engage with treatment, which is key to therapeutic interventions. The CMHT sent a discharge letter to Aziza but did not advise the Wellbeing Service who were working with Aziza. In light of the fact Aziza had consented to the CMHT sharing information with the Wellbeing Service, there was an opportunity to contact this partner agency both to support her attendance at the meeting, and to see if they had information why Aziza missed her appointment, which could have facilitated a more nuanced assessment of risk, as well as to check that Aziza would be

supported over the Christmas period. The diagnosis of emotionally unstable personality disorder was also not shared with the Wellbeing Service, despite Aziza's consent to this.

4.24. In January 2021, Aziza contacted Student Advice, concerned about the fact her student loan had still not come through, particularly as she had to move in the next two weeks and had found a room in a shared house. Importantly, she noted that because she was not in receipt of additional maintenance grants, she was not entitled to free prescriptions and therefore believed that she would have to pay up to £70 per month for her ADHD medication, which she had been unable to afford. It appears that this may have been a misunderstanding by Aziza, perhaps based on the fact only one week of the new medication was initially prescribed while this was trialled, which may have led her to believe that all her medication would now be issued weekly, when in fact her ADHD prescription was issued monthly, at £9 per prescription. However, this information was passed to the Wellbeing Service, who supported Aziza with a hardship application until her student loan could be resolved. Aziza's hardship bursary was approved, and she received £2,000 split across January and February, although Aziza was still concerned this would not be sufficient to meet her rent and university costs.

4.25. Aziza also noted that she had missed her appointment with the CMHT on 21 December and the Wellbeing Service emailed the CMHT asking to reschedule the appointment. However, the CMHT responded that she was not currently under the care of the CMHT and that they should contact her GP. The Wellbeing Service followed this up and the CMHT sent a copy of the discharge letter. Although Aziza had only missed one appointment, the CMHT did not offer a further appointment without a re-referral. The Wellbeing Service advised Aziza to contact her GP to ask to be re-referred. Aziza confirmed that she would contact her GP, noted that she was struggling to take her prescription without any real schedule and raised concerns about failing her course as she had not completed her coursework. Again, the wellbeing officer offered practical, thoughtful advice and contacted Aziza's tutor to arrange a meeting to discuss her coursework. During that meeting on 20 January, Aziza's tutors praised the work she had completed and confirmed that they would support her to get a month's mitigation for her upcoming coursework.

4.26. On 29 January 2021, Aziza sent an e-consult request to her GP surgery, noting that she had missed her CMHT appointment in December "…*and wasn't able to get in touch with them, and found out via my school that I was discharged. I am requesting to be rereferred again as I am still in need of treatment*". However, Aziza had completed an administrative e-consult, not a GP e-consult, so the e-form only prompted her to complete limited information. Had she completed a GP e-consultation request, this would have prompted her to provide more information, including completing a suicide and mental health checklist. Consequently the surgery responded, noting that the e-consult request contained limited information, and relaying the information in the CMHT discharge letter that she should initially look at the REC resources online and if those did not help, or she wished to discuss her symptoms, to book an appointment with the GP.

4.27. Although the GP had given constructive advice including that she could ask for a GP appointment, Aziza appears to have misinterpreted the email and contacted the Wellbeing Service that day, saying that her GP had refused to re-refer her to CMHT. She also asked for advice about her student loan application. The Wellbeing Service offered to contact Aziza's GP to support her request for a rereferral and arranged an appointment with the Access and Participation team to secure further funds from the discretionary fund. Although Aziza missed the first appointment, this was immediately rearranged for 10 February and the funds were granted, and at the request of the Wellbeing Service, this was paid as a fast payment.

4.28. Aziza booked a telephone consultation with her GP on 1 February, who assessed that her symptoms were increasingly intrusive, albeit she did not present as obviously psychotic, Aziza acknowledged that she had been discharged from the CMHT as she had forgotten to attend her

appointment. She reported finding the new medication helpful, but had been worried about the cost of these as she had only received one week's prescription. She said that she had continued to hit crises over the past few months, which seemed to be getting worse, so was very keen to be under the care of the CMHT to receive medication and "*proper help for her difficulties*". The GP agreed to rerefer Aziza to the CMHT and as Aziza described having ongoing suicidal ideation but being "*too much of a coward*", she was provided with the contact details for Samaritans, and the Trust's mental health provision. The GP then confirmed this information in a text to Aziza, but due to an administrative oversight, unfortunately the referral to the CMHT was not made until 19 February. Aziza was offered an outpatient appointment on 16 March 2021, as the CMHT were of the view that there was no indication of an escalation of risk or urgency.

4.29. The Wellbeing team continued to discuss Aziza's case at their weekly risk management team meeting throughout this period. On 17 February 2021, they noted that Aziza's main concerns recently appeared to have been financial, her mental health appeared more stable and alternative accommodation had been arranged.

4.30. On 2 March 2021, Aziza's flatmates became concerned that they had not seen her for several days and when they entered her room they found that she appeared to have taken her own life. There was no information that professionals were aware of to indicate a significant change that may have triggered Aziza's decision to take her own life, but conversely, there had never been an indication of a reduction in risk either and Aziza had always been clear that this was her long-term intention. Her death is a tragedy and her sisters were anxious to ensure that lessons would be learned to ensure that other students received the care they needed for their mental health.

5. Analysis of Agencies' Actions

Relationship between early intervention and statutory services

5.1. University 1's Wellbeing Service provided Aziza with excellent care throughout the period under review and the reviewers were struck by their thoughtful, student-focussed approach. University 1 have trained over 350 staff in mental health first aid, the highest proportion of trained staff in any organisation nationally and this was reflected across Aziza's interactions with all university staff. From Student Services to tutors to laboratory staff, there was a consistent proactive approach to identifying and referring students in need of support to the Wellbeing Service. This holistic, multidisciplinary service is staffed by experienced mental health social workers, nurses and therapists. Although it is not a statutory mental health service and does not hold clinical responsibility for students, staff work in accordance with their respective professional standards and safeguarding duties, and have a duty of care to the students they work with.

5.2. Importantly, despite their expertise, the Wellbeing Service is not able to make referrals directly to the CMHT and consequently, when they quickly identified that Aziza's needs exceeded the remit of their service, the referral to the CMHT had to be made through Aziza's GP. This was not the campus surgery, but another GP of Aziza's choosing and consequently, may have had less experience in having students as patients, or working collaboratively with the Wellbeing Service. Due to the transient nature of students in Bournemouth and the fact Aziza had only just moved to university, the GP is unlikely to have built a relationship with her or have developed an understanding of how her emotional and psychological needs could act as a barrier to her seeking the help she needed.

5.3. This is reflected in the comments made by the GP after several attempts to make contact with Aziza and she had missed her appointment to renew her ADHD prescription in November 2020, that she needed to "…*take responsibility for her own problems"*. Whilst co-production is an important aspect of any clinical relationship to prevent a dependence, this may not recognise

that she was experiencing overwhelming psychological distress that impacted Aziza's executive functioning, exacerbated by her ADHD. The Wellbeing Service responded appropriately, explaining Aziza's situation to the GP and continuing to advocate for a service from the CMHT. Having had a telephone consultation with Aziza, the GP referred her promptly to the CMHT for an assessment.

5.4. The CMHT showed good practice by immediately offering Aziza a face-to-face appointment when their initial telephone consultation found her to be emotionally dysregulated and were unable to assess her. Aziza's sisters described the CMHT's diagnosis of EUPD as a 'bombshell' to Aziza and felt that she may have needed a follow-up call shortly after this appointment, to ensure she was coping with this news and that she was responding well to the medication, particularly as it took her a few days to obtain her prescription (it is not clear whether this was due to her financial situation or other difficulties obtaining the prescription, which had been provided to her electronically).

5.5. However, when Aziza then missed her follow-up appointment with the CMHT, she was discharged back to her GP. Unfortunately, this action was not shared with the Wellbeing service, despite Aziza having consented to this. This posed a risk, particularly in light of the timing as the Wellbeing Service was consequently not aware that Aziza was not in receipt of mental health support during a period when the university was on holiday and the usual protective factors such as contact with tutors, were not available. Although the Wellbeing Service had made plans to provide Aziza with support over the Christmas period, the CMHT was not aware of this.

5.6. One of the features of Aziza's situation was that she could be inconsistent in seeking support for her needs, at times seeking this urgently, at others telling people that she did not see the point of mental health support. She could also be very difficult to contact, not answering her phone and during the months relevant to the review, she lost her phone at least twice. It would have been helpful for this information to be passed to the CMHT, to ensure that they were aware that the Trust's policy for Difficult to Engage Patient may apply to Aziza, and that additional efforts may need to be taken to engage with her.

5.7. This policy states that if a person known to the CMHT does not engage in treatment despite attempts to work with them, then there should be a multi-disciplinary discussion and assessment of risk and if risks are low, referral back to primary care will be appropriate. All assessments and decisions should be clearly documented and communicated with other relevant professionals. Liaison with the Wellbeing Service as the partner agency most frequently in contact with Aziza would have been consistent with this policy and, as her 'trusted professionals' they may have been able to better support her engagement. A further challenge in this case was the fact that Government guidance moved most GP appointments to either video or telephone consultations, so the GP never had an opportunity to meet with Aziza face-to-face and the CMHT had only had one meeting in person, whereas the Wellbeing service were in regular contact with her, including a number of in-person meetings prior to Christmas. Again, their input may have better informed the CMHT's assessment of risk before taking a decision to discharge Aziza back to primary services.

5.8. This was of particular importance given Aziza's diagnosis of EUPD. One practitioner involved in the review commented that being signposted to web-based services could be very difficult for people with mental health conditions, ADHD or personality disorders, particularly when they do not yet understand how to manage their condition, but that this had become a necessity due to overstretched resources. Senior leaders responded promptly at the start of the pandemic to strengthen resources available to support people with mental health needs in Bournemouth and Devon, by moving the Trust's out of hours service to a virtual service and bolstering staffing for the phoneline, however, many people with mental health conditions may find virtual support less conducive to their needs. The out of hours service has now resumed face-to-face drop-in

sessions in addition to virtual appointments, which will allow people to seek the support that best meets their needs.

5.9. Following Aziza's death, steps have also been taken to strengthen the relationship between the CMHT and University 1, with regular meetings now taking place to coordinate case management and ensure that there is effective communication in respect of cases where risks may be escalating or University 1 requires additional support to meet the student's therapeutic needs. When students are being discharged from the CMHT, they will now notify the Wellbeing Service to ensure that staff are able to respond to their needs. Work was also currently progressing between the CMHT and three local universities to improve crisis support for students. Aziza's sisters felt greatly reassured to hear that these services had not only learnt from Aziza's death, but taken proactive steps to improve services and communication.

5.10. It is important to note that while the Trust is commissioned by the ICB to provide community mental health services, this does not explicitly include emotional dysregulation and leaders acknowledged that this could result in a gap in statutory services. There are significant benefits to fluid pathways for treatment and support of students between the CMHT and specific partner agencies such as the University 1's Wellbeing Service, in respect of providing continuity and consistency of care and the ability to obtain an urgent response when the person's needs escalate rapidly. The ability to make direct referrals to the CMHT (rather than all referrals being made through the GP) could enable the Wellbeing Service to safely manage escalating needs for a longer period before making a referral, knowing that they can obtain an immediate response when the risks exceed their remit. Staff from the Wellbeing Service were clear that they would be judicious in taking decisions to refer to the CMHT, as currently of the 500+ students they support each year, they only refer a very small number to their GPs for onward referrals to CMHT. In essence, because the Wellbeing Service is already established to provide mainstream therapeutic care, the 'triaging' normally carried out be GPs has already taken place. As such, requiring referrals to be carried out through GPs introduces delay which, in part due to administrative delays, in Aziza's case resulted in a 6 week wait before she was first offered an appointment with the CMHT, then a further 3 months delay before being offered an appointment after having to be rereferred. Although local practice requires a referral through the GP, this is a decision of the local medical committee and in other areas, such as London, patients can self-refer to the CMHT.

5.11. Practitioners at the learning event discussed use of safeguarding referrals to the local authority's Safeguarding Adult team, and whether this would have been appropriate in Aziza's case to draw together a multi-agency response to her suicide risk. However, the duty to undertake a safeguarding enquiry under section 42 of the Care Act 2014 only applies where an adult is experiencing or at risk of abuse or neglect, and while self-neglect is included in this definition, self-harm is not. A more appropriate mechanism to resolve this would be by escalating these concerns through the multi-disciplinary team. In circumstances such as Aziza's, where her case was closed to the CMHT, escalation to the Named Safeguarding GP and/or Mental Health Safeguarding Lead may have secured a more timely response to efforts to secure a service. The Welfare Service could also have requested a Multi-Agency Risk Management meeting (MARM),[3] to coordinate and strengthen the multi-agency response.

Systems finding

5.12. More effective communication in respect of fluctuating risks and how Aziza responded to contact from professionals could have secured a more urgent clinical response to her escalating mental health needs. Communication was not reciprocal despite the Wellbeing Services' role as Aziza's primary support and her consent being given to share information, which built delay into the re-

[3] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.bcpsafeguardingadultsboard.com%2Fuploads%2F7%2F4%2F8%2F9%2F74891967%2Fmarm_guidance_-_final_-_november_2021.docx&wdOrigin=BROWSELINK

referral process and weakened the safeguarding system. Although, subsequent measures to improve this relationship are reported to be effective, this could be further strengthened by the introduction of direct referral pathways for urgent clinical treatment between the Wellbeing Service and CMHT to manage crisis situations.

Recommendation 1: *The Trust and NHS Integrated Care Board (ICB) should consider the feasibility of direct referral pathways to the CMHT from trusted partner agencies with expertise in supporting mental health such as University 1's Wellbeing Service, with clear requirements for relevant communication with the GP.*

Recommendation 2*: The SAB should ensure that early intervention services are aware that if they perceive that an appropriate or timely response to referrals has not been received, concerns can be escalated to the relevant agency. The SAB should consider developing a policy in line with the Children's Safeguarding Partnership, to enable a formal route for professional challenge.*

Recommendation 3: *Where there is a discrepancy between the professional analysis of risk or need, a multi-disciplinary meeting should be convened to explore the rationale for each view and ensure that decision making is robust, using the MARM process.*

Recommendation 4: *When making and receiving referrals for a service, in particular in urgent or high risk cases, partner agencies should include information about whether the individual can be hard to contact and if so, how they can best be reached.*

Risk mitigation and trauma informed care

5.13. An important part of effective mental health care is the assessment of risk and development of crisis and contingency plans that seek to understand signs and symptoms of relapse, and to predict and prevent relapse and personal crisis. In accordance with NICE guidelines[4], self-harm needs to be responded to with a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. '*All managers and other professionals discuss, agree and continue to document the aims of longer-term treatment in the support plan with the person who self-harms or has suicidal idealisation, to help reduce and prevent escalation of self-harm or suicidal isolation*.' Support plans should be multidisciplinary and developed collaboratively with the person the plan relates to, with their family and carers, include a jointly prepared risk management plan and for this to be shared with the person's GP and any person considered to be important to them. Those designing local systems should have regard to research findings (and ensure practitioners are made aware of) all indicators of elevated risk particularly for young people with ADHD. Any system design should reflect NICE guidance and quality standards and a lot of work has taken place in Dorset to embed this approach.

5.14. When the CMHT made contact with Aziza in December, their initial assessment by telephone (at Aziza's request), identified that her presentation needed further assessment and arranged a face-to-face appointment the next day. When she missed her next appointment and did not respond to a telephone call following on from this, the CMHT discharged her from their service, advising her to request her GP re-refer her if she decided she would like to accept the offer of support. The Trust's representative at the learning event noted that this was not consistent with local policy, which advised clinicians that cases should not be closed after a single missed appointment. During the course of the Coroner's Inquest, the clinician who took the decision to close Aziza's case acknowledged that this was not consistent with local procedures and was highly remorseful. Aziza's chronic suicidal ideation and multiple attempts at self-harm from the age of 12, gave clinicians the false impression that the risk that she would complete suicide was low. The fact that she appeared to be making these definite plans for the future should have

[4] NICE Clinical Guidance CG113: Self-harm in the over-8s: long term management 2011

been taken as an opportunity to build a trusting therapeutic relationship over time to mitigate this risk, as opposed to indicating a level risk that was too low to trigger immediate support.

5.15. It was acknowledged during the course of the review that at this time, the CMHT was under considerable pressure, with just one team leader managing two teams. Throughout the period under review there was widespread concern about the impact that the Covid-19 pandemic and lockdown measures had on people's mental health. At a national level, by May 2020 there was a significant rise in patients accessing secondary mental health services needing urgent and emergency mental health care.[5] Delivery of complementary treatments such as psychological and occupational therapy and outpatient clinics had to be altered, for example through virtual consultations, to comply with legislation designed to prevent the spread of the virus.[6] This sits against a background of a mental health workforce that was already under considerable pressure. Practitioners attending the learning event noted that recruitment within the CMHT was highly problematic, as repeated efforts to fill vacancies had been unsuccessful in the face of a national shortage of qualified staff. There were also high levels of sickness and staff needing to self-isolate, further reducing staff capacity.

5.16. Aziza experienced this case closure as a rejection and told staff at the Wellbeing Service that she felt that she was back a 'square one' in terms of her treatment. Although the CMHT wrote her a letter advising that she could rerefer through her GP if she still required a service, Aziza had said that she was intimidated by letters and was too frightened to open them. In any event, she felt that her first attempt to be rereferred to the CMHT through the e-consult was rebuffed and the Wellbeing Service had to again intervene with her GP to secure this rereferral, which meant that she was not offered a further appointment until mid-March, by which time she had, tragically, already taken her life. Aziza's emails to the Wellbeing Service set out her belief that mental health professionals were 'going through the motions' of care and she had reported that she needed to trust the people providing her with therapeutic support before she could fully engage with them.

5.17. Whether Aziza's views of the efforts being made by practitioners across all the services involved in trying to support her were objectively fair, it is important to recognise that her perception of the agencies' actions impacted on her engagement with the support offered and willingness to reach out for further support. The 2004 NICE guidelines on self-harm state: *"With the risk of death by suicide being considerably higher among people who have self-harmed, whatever the expressed intent… it is no longer acceptable for healthcare professionals to ignore, or fail properly to address, the experience of care by service users and carers. Engaging service users in a therapeutic alliance and promoting joint clinical decision-making on the basis of understanding and compassion is essential, especially if further help and treatment are to be offered"*[7]

Systems finding

5.18. The decision to close Aziza's case after one missed appointment was inconsistent with local policy and meant that a psychosocial assessment and support plan were not developed to provide her with therapeutic support and mitigate risk. It appears that workforce pressures on CMHT staff at the time, particularly as a consequence of the Covid-19 pandemic may have reduced the flexibility and responsiveness of the service and leaders in the Trust will need to consider how they can support staff during periods of pressure to maintain a therapeutic service.

[5] Nuffield Trust Quality Watch blog, published 30.11.20 available at: https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services

[6] The impact of COVID-19 on acute psychiatric inpatient unit, Daniel Hernández-Huerta et al, 2020, NCBI, doi: 10.1016/j.psychres.2020.113107

[7] National Clinical Practice Guideline Number 16, Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care Self-harm (nice.org.uk)

Recommendation 5: *The SAB should obtain assurance from the Trust that the CMHT has improved its mechanisms for case closure to ensure this is consistent with NICE guidance.*

Recommendation 6: *The ICB should seek assurance from providers that they communicate with patients using their preferred method of communication.*

Engagement with family and friends in the absence of consent

5.19. One of the challenges when Aziza first came to the attention of the Wellbeing Service was that her flatmates were students from University 2, rather than University 1. This meant that staff felt it would not have been appropriate to contact them directly. Had the other students attended University 1, the Wellbeing Service would have considered a flat meeting to attempt to resolve the conflict between Aziza and her flatmates, although they noted that by the time Aziza was referred to their service, the situation had gone beyond resolution and their priority was finding alternative accommodation for Aziza that she could afford. Had this not been the case, it may have been appropriate for University 1 to liaise with University 2's wellbeing services to jointly convene a flat meeting. When Aziza moved into new accommodation, her flatmates attended University 1 so the Welfare Service was able to provide them with direct support and, in that context, secure a more holistic support network for Aziza.

5.20. Aziza was adamant that she did not want the Wellbeing Service to communicate with her family as she did not want to worry her pregnant sister, although her sisters advised that they were, in fact, in daily contact with Aziza. They had repeatedly contacted professionals in an effort to secure support for Aziza, including contacting the police to request a welfare visit in November, which took place and resulted in Aziza being supported to attend the Retreat. The police officer complied with their duty of care, ensuring Aziza accessed immediate mental health support and notifying Aziza's GP that she needed a referral for mental health services. The Wellbeing Service, having taken on board the family's heightened concern, also made a referral to the police that day, which was appropriate. However, because Aziza had capacity[8] to take decisions about information sharing, professionals could not override this by reporting confidential information back to her family.

5.21. When Aziza was re-referred to the CMHT by her GP on 19 February 2021, she was offered an outpatient appointment on 16 March 2021 as there was no indication of a change in risk or that the referral was urgent. Aziza's sister's dispute this, noting that she had posted a picture on the family WhatsApp group where they could see marks up her arms from cutting herself and said that she looked visibly ill. However, the GP consultation in February had been over the telephone at Aziza's request, and it appears that all of her appointments with the Wellbeing Service from early January had also taken place remotely, so professionals may not have been aware if Aziza's physical presentation had deteriorated. There is no record that these new concerns had been relayed to professionals by Aziza's family and it may be that their disillusion about what they perceived to be a lack of response in November meant that they thought this would not be purposive.

5.22. The Government's consensus statement on information sharing and suicide prevention[9] sets out: *"In order to assist practitioners to respect people's wishes, wherever possible, the person's view on who they would wish to be involved – and potentially, who they would wish not to be involved – if there is serious concern over suicide risk, should have been discussed and recorded. In cases where these discussions have not happened in advance, a practitioner may need to assess whether the person, at least at that time, lacks the capacity to consent to information about their suicide risk being shared… It is also clear that the duty of confidentiality is not a justification for not listening to the views of family members and friends, who may offer*

[8] pursuant to the Mental Capacity Act 2005

[9] www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

insight into the individual's state of mind or predisposing conditions which can aid care and treatment. Good practice will also include providing families with non-person specific information in their own right, such as how to access services in a crisis, and support services for carers."

5.23. University 1 has a policy, which was in place during the timeframe for the review, to agree advance plans with students about the circumstances in which family or friends can be contacted to provide support, who should be contacted and the type of information that can be shared. This policy is also consistent with new Universities UK national guidance, released in October 2022.[10] However, Aziza had explicitly refused consent for information to be shared with her family. It is possible that Aziza's perception of cultural stigmas around mental illness may have contributed to this decision. When Laleh contacted the university to following day seeking an update, staff explained that although they could not provide details about what steps had been taken, they were able to give Laleh assurance about their usual procedures.

Systems finding

5.24. Practitioners complied with the legal framework around the duty of confidentiality and data protection by complying with Aziza's expressed and capacitous decision that information should not be shared with her family. However, sharing non-person specific information may give families assurance that there will be a proportionate response to referrals in respect of escalating risk and improve communication.

Recommendation 7: *The SAB should seek assurance from partner agencies that they have accessible information available for family members and friends, to help them understand routes for obtaining help for those in crisis, when to make referrals or share information and the limits that may be placed on professionals in respect of providing information about the outcome of those referrals, in circumstances where a capacitous adult does not consent to information being shared.*

Recommendation 8: *Health and mental health partners should review their virtual consultation policies to ensure that where patients are known to be at active risk of self-harm such as cutting, measures are in place to ensure medical oversight of these issues during periods when appointments regularly take place remotely.*

Financial stressors and access to prescriptions

5.25. In January, Aziza's financial situation caused her overwhelming stress, due to the challenges she was having obtaining a full student loan because Student Loan Services had required additional information in respect of her mother's death and father's financial situation. This also meant that she struggled to find affordable accommodation that she could move to when her original tenancy became untenable.

5.26. The Wellbeing Service was proactive in their efforts to support her in obtaining her student loan, and provided an emergency payment from their own funding to help Aziza obtain her prescription. They also emailed the CMHT to advise that Aziza had been unable to obtain her prescriptions due to the costs as she appears to have misunderstood that all her prescriptions would now be issued weekly after her new medication was prescribed for a one week trial period. As discussed above, the CMHT responded that Aziza was no longer under their care, which may have been a missed opportunity to clarify this misunderstanding and there is no record that Aziza's GP was alerted to this or discussed the possibility of a prescription prepayment certificate with her. This is effectively a 'season ticket' for prescriptions, currently costing £30.25 for 3 months or £108.10 for 12 months for all NHS prescriptions, which, if Aziza

was paying to renew her prescription every week, would have meant a very substantial reduction in costs.

5.27. Aziza's sisters reported that she had found this ongoing financial uncertainty over so many months incredibly stressful and the repeated requests by the Student Loan Company for more and more evidence of her parents' financial situation, including asking for further evidence of her mother's death, then evidence of her mother's income - after she had provided her death certificate - traumatic. They believed that the impact of this protracted process seriously affected Aziza's mental health leading up to her death.

Systems finding

5.28. Although it is appropriate for the application process for student loans to be undertaken with probity and rigour, it is important that this allows flexibility and sensitivity in situations where a student has experienced a bereavement or has mental health needs known to their university. The financial pressure caused by the protracted delays in resolving this process led Aziza to believe that she was unable to afford her prescriptions, which may have further contributed to the deterioration in her mental health.

Recommendation 9: *The SAB should provide a copy of this review to the Student Loan Company and seek a response in respect of the escalation process in place to challenge decisions or delays during its application process, including any policy in place to make reasonable adjustments to meet the needs of people with mental health conditions, in accordance with duties under the Equality Act 2010.*

Recommendation 10: *University 1 and the ICB should ensure that information is made available to students who are in receipt of repeat prescriptions about how to apply for prescription prepayment certificates.*