Dudley Safeguarding People Partnership

SAFEGUARDING ADULT REVIEW

Report into the circumstances of the death of Helen

Report produced by Richard Proctor

Independent Reviewer and Author.

29/04/2022

ACKNOWLEDGEMENTS

This Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied by those agencies who provided care and support for Helen. This contributed significantly to the production of the final report and helped to identify recommendations for improvement.

This report reflects the combined views of the SAR Panel who have invested their time, commitment, and expertise throughout this process. The input and professional support provided by the Dudley Safeguarding People Partnership Development Officer was invaluable throughout this process.

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1. Introduction.

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the individual

c) the Safeguarding Adults Board knows or suspects the adult has experienced serious abuse or neglect and there is concern how the partner agencies have worked together to protect the individual.

The decision to undertake a Safeguarding Adult Review (SAR) in relation to this case was made by the Independent Chair of the Board who after considering the circumstances of the case was satisfied that the criteria to undertake such a review was met.

The timeline period for the review to consider was identified as the 28th January 2019 up to and including the 3rd April 2020.

2. Service Involvement

The review was informed by information provided by the following agencies.

Dudley Metropolitan Borough Council Adult Social Care (ASC)

Dudley Metropolitan Borough Council Homelessness Prevention

Black Country Partnership Healthcare NHS Foundation Trust, Dudley and Walsall Division (BCP)

Dudley and Walsall Mental Health Services (DWMH)

Black Country and West Birmingham Clinical Commissioning Group (CCG)

Dudley Group NHS Foundation Trust (DGFT)

West Midlands Police (WMP)

West Midlands Ambulance Service (WMAS)

Creative Support

Change Grow Live- Adult Substance Misuse Service (CGL)

For information since these events occurred:

- *BCP and DWMH have now merged to form Black Country Healthcare Partnership Trust (Dudley Division)*
- *Black Country and West Birmingham Clinical Commissioning Group is now called Black Country Integrated Care Board*

3. Pen Picture Helen.

At the time of her death Helen was a 50-year-old single female.

Helen had a difficult childhood spending periods of time within the Children's "Looked After" system. In her teenage years it was reported she began to misuse substances including amphetamines and alcohol.

Helen moved to the local area in 2016 where she became well known to agencies often as a consequence of the chaotic lifestyle she lived.

She had a long standing complex mental health history with clinical diagnoses of Emotionally Unstable Personality Disorder and Mental and Behavioural Disorder. The SAR is aware of Helen accessing two periods of mental health inpatient admission prior to the timeline of this SAR. Reports of deliberate self-harm through overdose and the display of risky behaviours were a regular feature in her adult life. These were reflected on occasions where she would walk or lay in the road and express suicidal ideations often described by agencies as impulsive acts influenced when intoxicated by alcohol.

Helen reported having a struggle with her own sexuality and there is evidence in the information provided to inform the SAR of DWMH signposting her to seek engagement and support from Lesbian Gay and Transgender Services.

Financially she was in receipt of income based upon Employment and Support Allowance and Personal Independence Payment and the SAR has identified her having financial difficulties in relation to existing debts where agencies worked with her in an attempt to address her financial hardship.

4. Summary of significant events

4.1 On the 28th January 2019 West Midlands Police (WMP) and West Midlands Ambulance Service (WMAS) attended Helen's home address after she reported struggling to breathe. Upon attendance she refused assistance from WMAS but then made contact later again this same date requesting help regarding her alcohol issues. Upon attendance Helen informed WMAS she no longer required their assistance, and she was discharged at the scene.

4.2 On the 10th March 2019 WMP were contacted by Helen in relation to concerns for her safety. Helen informed the WMP call taker that "she had had enough" and was

apparently intoxicated. Helen was verbally abusive to the call taker who after requesting an ambulance ended the call.

4.3 On the 11th March 2019 WMP were contacted by Helen in relation to concerns for her safety. She reported having attended hospital the previous day and had sustained bruises allegedly caused by hospital staff. Helen informed the WMP call taker she did not want WMP to attend and that she was intoxicated

4.4 On the 22nd March 2019 WMP were contacted by Helen in relation to concerns for her safety. Helen informed the WMP call taker that she had mental health concerns and required a HIV test following an alleged historical assault she had sustained. Helen informed the WMP call taker that she had been drinking alcohol and was contemplating taking her own life. In response WMP requested an ambulance to attend her home address. WMAS upon attendance found Helen to be intoxicated and she was verbally abusive towards them, refusing any assistance. WMAS assessed that Helen had Mental Capacity as per the Mental Capacity Act 2005 to make an informed decision regarding her treatment and having refused any support, WMP closed the incident log.

https://www.legislation.gov.uk/ukpga/2005/9/section/1

4.5 On the 5th April 2019 WMP were contacted by Helen regarding concerns for her safety. Helen informed the WMP call taker that she was contemplating self-harming and in response WMP requested an ambulance to attend her home address. WMP recorded that Helen reported speaking with Mental Health Crisis and that she was now going to stay with friends. The ambulance was cancelled, and the incident log closed.

4.6 On the 24th April 2019 Helen had a consultation with her General Practitioner (GP) and requested her alcohol detoxification programme be expedited. The alcohol recovery service supporting Helen contacted her in an attempt to reassure her that this action had been made a priority. However, several days following this event Helen contacted the alcohol recovery service to cancel the planned detoxification programme as she had now stopped drinking.

4.7 On two separate occasions on the 19th May 2019 WMP were contacted by Helen where she reported having concerns for her safety. On the first occasion she reported being scared to leave her home and that she had consumed two bottles of wine. She informed the WMP call taker that she was prescribed medication for anxiety. On the second occasion Helen reported to the WMP call taker that she is frightened every day of her life and is scared to leave her home. It was recorded by WMP it was suspected that Helen was intoxicated.

4.8 On the 30th June 2019 WMP received 3 separate contacts in relation to Helen. On the first occasion a report was received from WMAS that Helen had assaulted one of its staff after an ambulance had attended an incident. WMP did attend and found Helen heavily intoxicated. Owing to her intoxication WMP officers decided they would not arrest her and conveyed her home.

On the second occasion WMP attended Helen's home address following a report from WMAS that Helen was making threats to harm one of her friends. It was recorded by WMP that Helen had been drinking alcohol and an ambulance was requested so she may be conveyed to the local acute hospital.

Following Helen's attendance at hospital WMP received a report from one of the hospital doctors that whilst at the hospital she had been intoxicated, was aggressive towards staff and had self-discharged after making threats to take her own life. In response a WMAS ambulance was requested to undertake a safe and well check with Helen. Following attendance by WMAS, Helen was found to be safe, and she reported not requiring any help and that she was going to bed.

4.9 On the 24th July 2019 Dudley Adult Social Care (ASC) Multi Agency Adult Safeguarding Hub (MASH), received a safeguarding alert from Dudley Metropolitan Borough Council Housing Department. Concerns raised were that Helen was alleging that she had been raped two months previously and was subject to sexual abuse. She additionally reported being physically assaulted and that she was receiving threats from a neighbour. It was identified by ASC that Helen was currently being supported by Dudley and Walsall Mental Health Services (DWMH) and the concern was forwarded to the DWMH safeguarding team. In response the DWMH safeguarding team contacted the DWMH community recovery service (CRS) requesting they follow up on the concern raised and consider holding a professionals meeting regarding Helen's case. There is no information now held by DWMH to indicate the subsequent outcome of this request.

4.10 On the 25th July 2019 the MASH, received a safeguarding alert from housing in relation to Helen making multiple allegations of being a victim of sexual and physical assaults. The alert additionally identified issues relating to neighbours and housing.

The matters were investigated by WMP, and Helen alleged that she had been the victim of rape and sexual assault by two named individuals and then had been physically assaulted by a third named individual. However, Helen refused to provide any further information or to make a formal report and subsequently no further investigation in relation to the allegations was made by WMP. The incidents were recorded by WMP as crimes as per the National Crime Recording Standards.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/116269/ncrs.pdf

4.11 On the 27th July 2019 WMP received a report from Helen that she had been assaulted and that her phone had been stolen. Owing to there being insufficient evidence to investigate the matter further, the report was recorded as a crime as per the national crime recording standards and filed as no further action.

4.12 Between the 1st August and 5th August 2019 WMP received 3 calls for service related to Helen.

The first related to an allegation Helen had been stalked by a male who wanted to have a relationship with her. She informed WMP that she did not wish to pursue the complaint further.

The second and third incident related to Helen making threats to an individual after banging on their door in an intoxicated state. Helen subsequently contacted WMP informing them she was going to kill a named individual. It was noted by the WMP call taker that she appeared to be intoxicated. WMP officers attended the location and found Helen to be extremely intoxicated. After speaking to the occupant of the property who did not wish to pursue the matter further, the officers conveyed Helen to her home address. WMP officers made checks with the acute hospital, and it was confirmed she had been in attendance earlier this day and had been found to have sustained a cut to her head.

4.13 On the 7th August 2019 WMP received several calls relating to Helen. The first related to Helen reporting she could not gain entry to her home, that she had mental health issues and required her medication. In response WMP provided Helen with contact details of a locksmith.

The second call a short time later related to Helen threatening to take her own life and in response WMP officers upon attendance found Helen sat in the road in an intoxicated condition. WMP officers were able to facilitate entry to her home and Helen reported no longer having suicidal thoughts.

The third call that date related to Helen reporting that she had been assaulted and had been a victim of a theft. The WMP call taker recorded that Helen appeared to be intoxicated and WMAS were requested to attend.

The fourth call WMP received was from a member of the public reporting that Helen appeared to be out of control and was laid in the middle of the road.

The fifth call reported that Helen was now fighting and WMP officers attended the scene. WMP officers discovered that Helen had a kitchen knife concealed in the sleeve of her clothing. Helen was found to have head injuries and was conveyed to the local acute hospital. There is no information provided to inform the SAR as to the subsequent outcome regarding Helen's attendance at hospital.

4.14 On the 9th August 2019 Dudley MASH received a safeguarding alert from WMP identifying concerns that Helen is alleging she has been raped, has mental health issues and WMP have received in excess of 100 calls from Helen over the last 3 months where she has made allegations of being assaulted by neighbours and that they are stealing from her. It was identified by the MASH that Helen was currently being supported by DWMH and the safeguarding alert was forwarded to the DWMH safeguarding team. The DWMH safeguarding team contacted CRS to follow up on the issue of concern highlighted and to consider holding a professionals meeting in relation to Helen's case. There is no information now held by DWMH to indicate the subsequent outcome of this request.

4.15 On the 20th August 2019 WMP were called to assist WMAS in attempting to gain entry to Helen's home after locking herself out of the property. It was confirmed by WMAS that Helen had mental health issues and was having feelings of wanting to lay in the middle of the road. WMAS managed to gain entry to the premises and no further assistance was required from WMP.

4.16 Between the 20th and 28th of August 2019 ASC received a number of contacts from Helen who informed ASC that she was suicidal. Advice was provided by ASC that Helen should contact DWMH, and ASC provided Helen with the DWMH crisis contact telephone number. Helen further explained to ASC that she was awaiting a house move and that she was known to Creative Support. Creative Support is a local service that provide outreach services to support adults with mental health, learning disabilities, addiction, and people at risk of homelessness. ASC shared information with Helen' s GP of her suicidal ideation.

4.17 On the 30th August 2019 Helen contacted WMP where it was recorded, she was in a drunken state and was upset. Helen reported having concerns that WMP were intending to arrest her in relation to a historic assault. The WMP call handler identified they believed Helen was suffering from a mental health crisis and WMAS were requested to attend. WMAS attended but Helen refused to leave the property. After confirming they had no concerns and that she was with a friend WMAS resumed. It was recorded by WMP that Helen had made allegations that a man who lived nearby had raped her. There is no information to demonstrate this allegation was investigated further and there was no attendance made by WMP. It was recorded by WMP that a referral had been made the previous day relating to Helen, though it is unclear from the information provided to inform the SAR as to what the referral referred to or to where it had been directed towards.

4.18 On the 22nd December 2019 WMAS were contacted by WMP requesting their attendance at Helen's home address, following reports of her falling and sustaining a facial injury. It was recorded by the WMP call taker that Helen was intoxicated and was being abusive. It was recorded by WMP that WMP officers would not be attending. Upon WMAS attendance Helen refused to be assessed or engage with WMAS staff claiming that she only wants to speak to WMP. Whilst in attendance Helen physically assaulted one of the WMAS ambulance staff and consequently WMAS requested WMP attendance. Upon WMP arrival Helen was duly arrested by officers and taken into police custody. Helen when interviewed by WMP admitted the offence of assault and subsequently received a conditional caution with a requirement to liaise with the Liaison and Diversion Team regarding her alcohol dependency. The Liaison and Diversion Teams provide support and assessment for vulnerable detainees in police custody funded by NHS England, DWMH and the Black Country Partnership NHS Foundation Trust.

Subsequently when seen by the Liaison and Diversion Team Helen reported having been abstinent from alcohol for two days prior but had commenced consuming alcohol again identifying her alcohol consumption impacted upon her mental health and behaviours. Helen reported that a recent family bereavement of her mother dying had caused her alcohol consumption to increase. She reported having a condition of

agoraphobia which made it challenging to leave the house and integrate with other people which increased her anxiety, and she was experiencing panic attacks. Helen stated that she had fluctuating thoughts of death by suicide though had no present active plans to attempt suicide. Helen reported having a history of self-harming behaviour and had previously made attempts to take her own life. She reported feeling unable to cope and did not possess any coping skills.

In response a management plan for Helen was produced by the Liaison and Diversion Team to refer Helen to the DWMH Home Treatment Team for short term support with regards to deteriorating mental health and fluctuating suicidal thoughts, together with referring Helen for ongoing support from the Liaison and Diversion Team regarding alcohol issues, social care needs and mental health.

Liaison & Diversion Services (ipwm.org.uk)

4.19 On the 24th December 2019 Helen was assessed at home by the DWMH Home Treatment Team. It was recorded that she engaged well maintained good eye contact, presenting both subjectively and objectively and was euthymic in mood. Helen denied any thoughts of deliberate self-harm or suicidal ideation. Helen reported being frustrated in relation to the current medication she was being prescribed as she believed it was increasing her experiences of hearing voices, though had not reported this previously to her GP or DWMH. Helen requested that her DWMH consultant psychiatrist be informed she does not require a neurologist. Helen informed the Home Treatment Team workers that her support worker from Creative Support suspected that she may be suffering from autism, and it was recommended that consequently she should visit her GP regarding this query. Helen informed the Home Treatment Team workers that she would not consume alcohol any further and had destroyed any stock that she had. A decision was made by the Home Treatment Team workers that they would not take Helen's case on, but that her current DWMH outpatient appointment would be brought forward in time.

4.20 On the 26th December 2019 ASC received a telephone call from Helen who reported being suicidal and wished to return to Manchester where she allegedly previously resided. ASC in response requested an ambulance to attend at Helen's home address. However, this was subsequently cancelled after Helen stated that all was well. ASC advised Helen that she should contact DWMH and provided her with the contact telephone number.

Later on, this date WMP received a telephone contact from Manchester Social Care Services who informed them that a female believed to be Helen had contacted them stating that she wished to return to live in Manchester is regularly being assaulted and has been "gang raped." WMP and WMAS attended at Helen's home address and located her whom they found in a distressed state, and she reported being disorientated. There is no information recorded by WMP to indicate if the allegations of rape and assault reported by Helen were explored further or the reports of crime recorded as per the National Crime recording standards.

Shortly prior to midnight this date WMP received a telephone call from a member of the public reporting that a female dressed in pyjamas is walking in the middle of the

road attempting to stop vehicles. WMP officers attended this reported incident and discovered that the female was Helen. They recorded that she was heavily intoxicated. Helen informed the WMP officers she was alcohol dependant had no suicidal thoughts and was intent upon walking to Manchester. Helen was subsequently returned home by the WMP officers. There is no information provided to inform the review of a safeguarding concern being raised by WMP to the MASH in response to this incident.

4.21 On the 27th December 2019 Helen made multiple contacts to DWMH, WMP and WMAS.

Helen contacted DWMH Crisis on two separate occasions. On the first call she reported feeling isolated, lonely, and unable to cope with the impact of her past experiences. She discussed having been recently arrested and that she feared she would die. Helen was advised to recontact Crisis if she required help. A further call to Crisis was received where Helen requested information regarding her next DWMH appointment. DWMH later responded by leaving a message on her answerphone informing her of when her next appointment was scheduled for.

On this date Helen also made two contacts with WMP. The first report related to her requesting help but then clarified it was not WMP from whom she needed help. The second contact she informed WMP that she could not cope and wanted to die. She informed the WMP call handler that she had consumed a quantity of Vodka and an ambulance was requested. Upon WMP attendance Helen informed the officers in attendance that she wanted to go to sleep, had not overdosed or held any thoughts of self-harming. In response WMP cancelled WMAS attendance.

Additionally on this date WMAS received 3 separate contacts from Helen. The first contact was via a careline alert where when spoken to Helen reported no longer requiring any help. The second contact related to Helen reporting having a mental health crisis. It was established WMP were in attendance and an ambulance was not required. The third contact related to her again reporting having a mental health crisis and she stated she was not receiving any support from DWMH.

4.22 On the 28th December 2019 DWMH Crisis were contacted by Helen who reported she was drinking alcohol excessively and had attended the local acute hospital owing to withdrawal symptoms. Helen informed Crisis that she had been provided with Librium and Pabrinex drugs and then discharged. Librium is a drug commonly used to treat anxiety and alcohol withdrawal. Pabrinex is a drug often provided by clinicians prior to alcohol detoxification. Helen reported having thoughts of jumping into the canal but that her agoraphobia was preventing her from taking this action. In response Helen was provided reassurance by the Crisis call taker.

Later on, this date WMP were contacted by WMAS who reported being contacted by Helen reporting a historical assault but that she did not require medical attention. Attempts were made by WMP to contact Helen, but she did not answer the phone. It was recorded by WMP that Helen had contacted WMP on 26 separate occasions in the previous week, that she was intoxicated and had not been assaulted. It is unclear how this conclusion was drawn as no apparent further enquiries in relation to the assault allegation were undertaken and the incident log was closed by WMP.

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https://www.candi.nhs.uk/sites/default/files/Pabrinex%20Prescribing%20Protocol_PHA55_%20Mar%202020.pdf

4.23 On the 29th December 2019 DWMH Crisis and WMAS received multiple calls relating to Helen.

The calls to DWMH Crisis made by Helen included her informing Crisis of being unable to cope, of her making threats to take her own life by drowning and of her wishing to speak with Crisis staff. In response several attempts were made by DWMH Crisis to speak with Helen on the telephone following call backs, but contact could not be established.

Helen later this date self-presented at the local acute emergency department where she was seen by staff at the hospital to be staggering in the waiting area. DWMH Mental Health professionals attended the hospital emergency department to assess Helen in relation to her Mental Health. However, upon attendance they could not locate her and subsequently no Mental Health assessment was undertaken.

WMAS received 6 calls in total this date relating to Helen. These calls included Helen threatening to take her own life, of being intoxicated and feeling suicidal. WMP additionally requested WMAS assistance regarding Helen “hearing voices” and feeling suicidal. WMAS on one of the occasions conveyed Helen to the local acute hospital and on the others attended her home and medically assessed her after she refused to attend hospital. It was deemed by the WMAS staff in attendance that Helen had the mental capacity to make the decision to refuse treatment.

4.24 On the 30th December 2019 DWMH were in receipt of several calls from Helen. Helen reported to DWMH of having concerns relating to hearing voices and in relation to her alcohol consumption. Further contact this date was made with Helen by the DWMH Liaison and Outreach Team who recommended to Helen that she should contact the local alcohol recovery service which she agreed she would do. There is no evidence of Helen contacting the recovery service.

Additionally on this date Helen contacted WMP to inform them that she was experiencing withdrawal symptoms and had been drinking alcohol all day. In response WMP contacted WMAS requesting they attend at Helens home address. WMAS subsequently attended, medically assessed Helen advising her to visit her GP for a medication review and assistance with her alcohol intake. There is no evidence to inform the SAR of Helen following this advice.

WMP recorded that they had the previous day been in receipt of multiple calls from Helen and were considering blocking her telephone number from the emergency police call system owing to an alleged persistent misuse of the emergency “999” telephone system.

4.25 On the 7th January 2020 Helen was visited at home by the DWMH Liaison and Outreach Team. It was recorded Helen appeared euthymic in mood and in her mental state. Helen reported having fluctuating moods with no current thoughts of suicidal

ideation, self-harm, or suicide. Helen reported suffering from Post-Traumatic Stress Disorder (PTSD) owing to Childhood Experiences where she was an alleged victim of physical and sexual abuse. Helen reported her current medication of Aripiprazole, Diazepam, Fluoxetine, Pregabalin, Quetiapine and Zopiclone appeared to be effective although she reported "hearing voices." Helen reported having challenges relating to her sexuality and her current finances. Upon conclusion of the meeting DWMH agreed a management plan with Helen that included further contact and support being provided to attend an outpatient appointment, reviewing the potential of charity donations relating to home furnishings being accessed and accessing services with regards to self-esteem and sexuality.

https://bnf.nice.org.uk/drug/aripiprazole.html

https://bnf.nice.org.uk/treatment-summary/hypnotics-and-anxiolytics.html

https://bnf.nice.org.uk/drug/fluoxetine.html

https://bnf.nice.org.uk/treatment-summary/neuropathic-pain.html

https://www.nice.org.uk/guidance/cg113

https://bnf.nice.org.uk/treatment-summary/hypnotics-and-anxiolytics.html

4.26 On the 9th January 2020 the MASH received a safeguarding alert from Dudley Metropolitan Borough Council Anti-Social Behaviour Team regarding concerns for Helen. This following Helen receiving a letter from the Anti-Social Behaviour Team requesting she make payment of an outstanding fine. She was alleging hearing voices informing her to take her own life and was drinking alcohol to block out the voices. Helen additionally reported that no one was helping her that she was agoraphobic and could not leave her home. As Helen's case was open to DWMH, the MASH forwarded the case to them, and the case was closed to the MASH.

DWMH later this day received contact from Helen regarding the letter. It was agreed that Helen's DWMH outpatient appointment would be moved forward in time, and it was agreed that a follow up call with Helen would be made with a DWMH Community Psychiatric Nurse (CPN).

4.27 On the 13th January 2020 Helen's DWMH CPN sent an email to ASC requesting safeguarding information be shared so that effective and appropriate care could be provided for Helen. There is no information provided to inform the SAR as to the outcome of this request.

4.28 On the 15th January 2020 Helen's case was discussed at the Safer Estates multi-agency meeting. This owing to the high volume of calls Helen was making to WMP and making constant requests for help as she wishes to die. The Safer Estates meeting is a subgroup of the Dudley Community Safety Partnership. The aim of the Group is to reduce crime and disorder, anti-social behaviour and environmental crime whilst addressing the vulnerability at the root cause of these crimes. Agencies who contribute to the work of the group include WMP, the Local Authority, Fire and Rescue, the National Probation Service, Change Grow Live (Adult Substance Misuse Service)

and CCG. The methodology it employs to achieve its aim includes partner engagement, appropriate interventions being delivered, and appropriate enforcement action being undertaken. The group focuses upon high demand locations relating to repeat calls to agencies across the partnership where they take a problem-solving approach to reduce demand. It was reported at the meeting that DWMH had an appointment with Helen in the near future. An action was established for DWMH to provide an update following their meeting with Helen. There were no other actions allocated by the chair of the meeting or evidence of a multiagency plan being created so as to manage the issues highlighted.

4.29 On the 20th January 2020 ASC were contacted by Helen who reported that she was struggling. She reported recently falling, that she had no carpet or money and was in debt for her household gas and electric supplies. Helen advised that Creative Support were involved in her case but were imminently due to be withdrawing support. A referral was made by ASC to the Red Cross charity to seek support for Helen and the case was closed by ASC.

4.30 On the 21st January 2020 Helen attended her Mental Health outpatient appointment and she was accompanied by her CPN. It was confirmed from correspondence shared by Helen's GP that she had a diagnosis of emotional unstable personality disorder, with features of anxiety, PTSD, and depression. Helen reported being compliant with her medication but that she still heard voices in her head. Helen stated that she had a history of alcohol abuse, had been bullied by neighbours and allegedly raped by one of her neighbours. She reported having physical medical conditions which included arthritis, diverticulitis, fibromyalgia, irritable bowel syndrome and incontinence. She denied using alcohol or illicit substances for several months and that her imminent risk of self-harm and suicide she currently assessed as low. DWMH assessed that Helen's imminent risk of deliberate self-harm and suicide was low but that the risk would increase should she start to abuse alcohol again. It was recorded by DWMH that Helen had good insight in relation to her mental health illness and possessed mental capacity to make informed decisions regarding her treatment. It was discussed by Helen that she felt her needs were being met and that she continued to be supported by Creative Support. The CPN informed Helen that she would be discharged from the Liaison and Diversion outreach team as her needs had been met but that she should contact DWMH if she felt her mental health was deteriorating. Helen was reported to be happy at being discharged and a letter of the decision was shared by DWMH with her GP.

4.31 On the 28th January 2020 WMAS attended at Helen's home address after she reported that she was struggling to breathe and felt like she was "drowning". Upon attendance WMAS could not gain access to Helen's property as she stated she was unable to walk. WMAS contacted WMP requesting assistance in gaining access to the property and that warning markers of violence were recorded on WMAS systems. WMP initially refused to attend stating that as per their policies this was a medical issue and would only attend if it was to prevent crime and disorder. WMP advised WMAS they should contact the Fire and Rescue Service. WMAS contacted the Fire and Rescue Service who refused to attend stating as Helen had violence markers that

it was the responsibility of WMP to attend. Attempts were made by WMAS to contact Helen by telephone but there was no response. WMAS recontacted WMP who informed WMAS that they had the incident identified as requiring a response within 8 hours. 3 hours after the initial call to WMAS, the Fire and Rescue Service attended at Helens address and facilitated entry to the premises. Helen was then seen by WMAS, and she refused any treatment.

4.32 On the 31st January 2020 WMAS were contacted by Helen who informed them that she cannot stop drinking alcohol, that she wants to die after being raped and assaulted and has no support or help in relation to her mental health. WMAS conveyed Helen to the local acute hospital emergency department where she self-discharged before being assessed or medically treated. There is no information provided to inform the SAR of any follow up by DGFT following Helen's self-discharge or of a referral being made to DWMH following reports of her wishing to die.

4.33 On the 28th February 2020 WMAS attended at Helen's home address following a report of her having fallen. Upon attendance Helen reported having fallen and sustaining a graze to her head. She reported that she had been drinking alcohol, was suicidal as her mobile phone was not working and was contemplating running out in front of a car. WMAS conveyed Helen to the local acute hospital emergency department where she reported to medical staff of having suicidal thoughts after being confined to her flat for 4 days owing to mental health issues and that she had sustained a head injury owing to a fall. Following assessment Helen was discharged from the hospital and there is no information provided to inform the SAR to demonstrate any liaison being made by the hospital with DWMH mental health services.

4.34 On the 1st March 2020 WMP received a report from a member of public that a female who transpired to be Helen was wandering in the street in a confused state and had informed the member of the public that she had not eaten for 3 days. WMAS were requested by WMP to attend the report and Helen was conveyed by WMAS to the local acute hospital emergency department. WMAS in response raised a safeguarding referral. Upon attendance at the hospital, medical staff found Helen who was intoxicated crying, distressed, and frequently placing herself on her knees and the floor. It was recorded by medical staff that Helen was a frequent attender at the emergency department. Helen reported that she had been in contact with a man who no longer wished to be associated with her and in response to seek attention had placed herself on the ground outside her home. DGFT established a medical plan for Helen to be provided with anti-withdrawal medication and when sober to be seen by the Psychiatric Health Liaison team prior to discharge. However, Helen self-discharged before being seen by the Psychiatric Health Liaison team and there is no information recorded to demonstrate there was any follow up made by the Psychiatric Health Liaison Team to contact Helen.

4.35 On the 2nd March 2020 WMP and WMAS received multiple calls relating to Helen. The first call WMP received related to Helen reporting being an alcoholic who had been drinking for 4 days and had been trapped in her room. In response following contact by WMP, WMAS attended the address and spoke to Helen. She informed them that she was consuming approximately 2 bottles of wine per day and required

assistance to stop herself drinking. She was advised by WMAS following assessment that she should attend hospital but refused. WMAS advised her to visit her GP and reconnect with a local alcohol recovery service. WMAS raised a safeguarding referral to ASC highlighting concerns regarding self-neglect and alcohol independence. In response Helen was contacted by an ASC Access Team worker. Helen informed them upon returning home that she had "trashed her place" owing to alcohol withdrawal symptoms and that she currently had 20 bottles of alcohol in her home. It was confirmed by ASC that Helen's case was open to DWMH secondary mental health teams and consequently ASC closed the case. The DWMH safeguarding team made their Crisis Team aware of the safeguarding concern raised by WMAS and recommended short term care coordination. There is no information provided to inform the SAR if this recommendation was acted upon.

On this date WMP received a further call from Helen informing them she cannot stop drinking and is feeling suicidal. WMAS were requested to attend and upon arrival Helen was conveyed to the local acute hospital emergency department. At the hospital Helen informed the medical staff that she wanted help with her alcohol dependency and wanted to die. Helen left the hospital voluntarily and the medical staff informed WMP and the ASC Emergency Duty Team of this occurrence.

WMP received a further call from Helen reporting that she had "smashed her head open" and "smashed her flat up" and was withdrawing from alcohol. WMAS were requested to attend and upon attendance found Helen to be intoxicated. Helen refused to be conveyed to the hospital or be provided with any further assistance.

WMP received a further call from Helen who reported being a historic victim of child sexual abuse and had never spoken to anyone about this abuse before. She reported being unable to stop drinking. WMAS were requested to attend and once again following attendance Helen refused any support from WMAS staff. There is no information provided to inform the SAR that identifies any further enquiries or investigations were undertaken by WMP regarding the historical sexual abuse allegations reported by Helen.

WMAS received a further 6 calls in relation to Helen during that evening and into the early hours of the 3rd March 2020. The calls followed a similar pattern of Helen claiming that she cannot stop drinking and on occasions when WMAS attended at her home she demanded WMAS to leave her home after refusing treatment. On one occasion in an attempt to help Helen WMAS staff contacted the Alcoholics Anonymous helpline and Helen engaged with the call taker. This proactive approach by WMAS in attempting to seek help for Helen, the SAR identifies as good practice.

Alcoholics Anonymous Great Britain (alcoholics-anonymous.org.uk)

4.36 On the 4th March 2020 Helen had a telephone consultation with her GP. Helen informed the GP that she was consuming 2 bottles of wine per day and intends to stop drinking. The GP advised Helen to not stop drinking completely and reduce her intake gradually.

4.37 On the 22nd March 2020 WMAS received a call from Helen who reported having suicidal thoughts. In response after attending at her home address WMAS conveyed Helen to the local acute hospital emergency department. Upon attendance at the hospital, medical staff reported that she was intoxicated and had a plan how she would kill herself. This would be either through drowning or by running out in front of a moving vehicle. She was seen by an emergency department doctor who observed she was distressed. Helen demanded she be allowed to go home and insisted that alcohol she had brought with her upon attendance at the hospital be returned. Hospital staff undertook a mental capacity assessment. It was recorded that Helen was able to understand the implications of not waiting to be assessed and treated, together with being able to retain the information and relay it back to the hospital staff. Consequently, she was deemed to have mental capacity regarding her care and treatment. Helen refused to be seen by the DWMH Mental Health staff and was subsequently discharged from the hospital.

A short time later this date Helen was detained by WMP under Section 136 of the Mental Health Act after being found lying in the middle of the road and reporting that she wished to be run over and die. After initial attendance at the local acute hospital emergency department Helen was transported to the DWMH mental health designated place of safety.

Consequently, Helen was assessed under the Mental Health Act by DWMH where they agreed with Helen that she would be referred to DWMH Home Treatment Team. This with the aim of supporting her in the community so as to reduce the risks posed to herself and the reoccurrences of hospital admission. An assessment of Helen's Mental Capacity was undertaken by DWMH staff where it was deemed, she had the capacity to refuse or consent to accepting treatment. Helen was then subsequently discharged from Section 136 detention and returned home with support from her partner. DWMH undertook a risk assessment which identified that Helen's risks to herself were unpredictable due to her diagnosis and her alcohol dependence. A management plan was subsequently developed that detailed Helen had been discharged from the Section 136 detention with support from her partner, that a referral would be made to the Home Treatment Team and that Helen should contact the local alcohol recovery service together with contacting Alcoholics Anonymous.

4.38 On the 23rd March 2020 DWMH held a Multidisciplinary Team meeting to discuss the referral for support made the previous day to the Home Treatment Team. The request was declined, and it was recommended that Helen should continue to be supported by the DWMH Community Recovery Service. This team provides service to people who have a range of severe and persistent mental health problems and require ongoing treatment and interventions.

On this date WMAS received multiple calls from Helen. The first related to Helen reporting feeling suicidal. In response WMAS attended her home where she disclosed feeling suicidal and wanting to lay down in the road and be run over. She refused any assistance from WMAS and was discharged at the scene.

The second call was of a similar repeat nature as the first and Helen again refused assistance from WMAS.

The third call related to a request from WMP to attend Helen's home address after contacting the police reporting she cannot cope. WMAS upon attendance asked Helen how they may help her, but she declined to say how they could. She then became verbally abusive resulting in WMAS resuming as no apparent assistance was required.

The fourth call related to Helen reporting intending lying in the middle of the road. She informed WMAS staff upon attendance of consuming 3 two litre bottles of cider and was now willing to attend the hospital for further help. Helen was conveyed by WMAS to the local acute hospital emergency department. Upon arrival it was recorded by the hospital staff that she was suicidal and intoxicated and was making comments of her wish to lie down in the middle of the road.

In response Helen was seen by the DWMH Psychiatric Liaison Team based at the hospital who conducted a Mental Health Act assessment. Helen reported having a long history of alcohol and drug abuse. She confirmed she had a diagnosis of depression and anxiety but felt she had been wrongly diagnosed and had mild autism and potentially bipolar. She provided her family history and disclosed alleged Adverse Child Experiences of physical and emotional abuse. She described leaving school at 12 years of age and had been addicted to alcohol at 13 years of age. She described herself as a lesbian but had a recent sexual relationship with a man which had since broken down and triggered her actions to drink alcohol. She reported spending £100 per week on alcohol which she claimed she used as a coping mechanism to dissolve her childhood memories of abuse. DWMH undertook a risk assessment identifying Helen's risk currently as dynamic owing to past attempts to take her own life. A management plan was established which included Helen being referred to the Home Treatment Team once more, so they could monitor risk and review her medication. She was advised again to contact the local alcohol recovery service that support individuals with alcohol addiction. Helen was subsequently discharged to return home.

4.39. On the 24th March 2020 at 0016 WMP received a report that a female who subsequently transpired to be Helen was laying in the road claiming that she wants to die. WMP officers upon attendance established that Helen had only recently been seen by the DWMH Psychiatric Liaison Team and had left prior to collecting her medication. The officers returned Helen to the hospital to collect her medication and during this time she disclosed to the officers that she had non-consensual sex but refused to provide any further information. The allegation was recorded as a crime as per the Home Office Crime Recording Standards and filed as no further action owing to insufficient evidence to investigate the matter further. There is nothing recorded to indicate WMP taking any further action regarding the events of Helen laying in the road through making a referral to DWMH or raising a safeguarding concern to ASC.

At 0742 this date Helen attended at the local acute hospital emergency department. This after being discovered by a member of the public wandering in the middle of the road. Helen informed the hospital staff of her wish to die, that she was feeling low, was suicidal and required help. It was recorded that an email would be sent by staff to the

Frequent Attender Group so as to escalate Helen's vulnerabilities and care requirements. It was noted by the hospital staff that Helen had been seen the previous day by the DWMH Psychiatric Liaison Team and had been referred to the Home Treatment Team. When asked if she was aware of this plan Helen became abusive stating that she had seen no one. She then walked out of the department stating she did not wish to see anyone. DGFT recorded a description of Helen's physical appearance which could be used by the police or hospital security staff in the event of a later search being necessary. This was in line with DGFT's Adult Patients who Abscond Policy.

A short time later Helen was again found to be wandering in the road with no apparent concern for traffic and was brought back to the emergency department. She was seen by the DWMH Psychiatric Liaison Team and asked why she had been wandering on the dual carriage way. Helen reported to be experiencing palpations and suspected that she was withdrawing from alcohol. The Psychiatric Liaison Team requested her to remain at the hospital, but Helen decided she wished to leave. The Psychiatric Liaison Team were asked by hospital emergency department staff as to whether Helen had the mental capacity to make this decision and in response the Team stated owing to Helen not permitting them to assess her, they were unable to ascertain whether or not she had mental capacity to make this decision. The Psychiatric Liaison Team at this point decided to escalate their concerns to the DWMH Patient Sector Team as the multiple presentations to the Emergency Department over the previous 72 hours and potential repeated risk behaviours could not be supported by the Home Treatment Team which had been the original plan. Additionally, the Psychiatric Liaison Team liaised with their own Doctor who concurred that admission into hospital for Helen would be the best option and this decision was supported by Home Treatment Team consultant. There was however a delay in securing a hospital bed to facilitate admission owing to miscommunication regarding a bed management protocol, gatekeeping standards and COVID19 requirements which were required to be applied before admission could take place.

Shortly after Helen left the hospital WMP arrested Helen for an offence of causing a public nuisance. This following reports of her lying in the road on several occasions and refusing to remain at the hospital. During her arrest it was alleged that she assaulted one of the WMP officers. Helen was further arrested and detained under Section 136 of the Mental Health Act and conveyed by officers to the designated place of safety. Upon arrival Helen was released by WMP from the criminal offences pending further investigations.

Mental Health assessments were unable to be undertaken initially owing to Helen being intoxicated. Eventually when fit an assessment by DWMH identified that there was no current evidence of depression, suicidal ideas or psychosis being present. Consequently, Helen was discharged home and the Home Treatment Team were requested to make contact so as to consider providing support following discharge.

This event coincided with the United Kingdom the day previously (23/03/20) announcing a national lockdown to control the spread of the COVID19 virus.

Consequently, it was recorded by DWMH that home visits conducted by the Home Treatment Team could not be guaranteed.

A safeguarding alert was raised by the emergency department at the hospital to the MASH regarding concerns of Helen continually absconding from the hospital and laying in the middle of the road. The alert was received and assessed by ASC who identified support was already being provided by DWMH and forwarded the alert to them. The safeguarding alert was received by the DWMH safeguarding team who advised that the information was shared with the DWMH Mental Health Assessment Service, CRS and for the Doctors to carry out a robust assessment of Helen's mental health and mental capacity. This owing to her repeated presentation to emergency services and the outcome of the assessments shared with all professionals involved with Helen to ensure there is adequate follow up and support provided. There is no information now held by DWMH to indicate the subsequent outcome of this request.

4.40 On the 25th March 2020 Helen's GP made 4 unsuccessful attempts to contact her. This following information shared by DGFT regarding Helen's recent presentations at the local acute hospital emergency department.

4.41 On the 26th March 2020 WMAS received an emergency call from Helen who reported fearing she had contracted the COVID19 virus. Helen reported that she was not self-isolating as per government guidance at that time as she had left her home to purchase alcohol. An ambulance attended and Helen was advised she was required to self-isolate for 7 days owing to her symptoms. She became verbally aggressive towards the WMAS staff, and they decided due to her conduct to withdraw from the address.

4.42 On the 29th March 2020 DWMH Crisis Team received a telephone contact from Helen who reported not having drank alcohol for the 3 previous days and was now experiencing withdrawal symptoms. Helen reported being in contact with the local alcohol recovery service, but that they were limited in the support they could provide owing to the COVID19 pandemic. DWMH Crisis Team discussed with Helen her current medication and Helen reported not collecting her most recent prescription and being worried regarding a future prescription delivery. Helen was advised by DWMH Crisis to take her remaining 5 Milligrams of Diazepam to help ease her withdrawal symptoms and to contact her GP together considering calling "111" the NHS National helpline should her symptoms persist or worsen.

About diazepam - NHS (www.nhs.uk)

4.43 On the 30th March 2020 Helen had a telephone consultation with her GP. Helen explained that she believed she was withdrawing from alcohol having reduced her daily intake from 8 bottles per day of strong cider down to 3. She was advised by the GP that it would be unsafe to stop drinking completely owing to the possibility of her consequently suffering seizures. The GP confirmed with Helen that she was still in contact with the local alcohol recovery service. Helen reported to the GP of being worried regarding an impending court case in relation to an alleged assault on a police officer on the 24th March 2020.Helen requested that the GP provide her with a letter that would detail her medical unsuitability to serve a prison sentence.

4.44 On the 31st March 2020 WMAS received 2 calls from Helen requesting their assistance. The first call related to Helen reporting that she was experiencing breathing problems and had a "runny nose." WMAS attended and found Helen to be intoxicated. She then commenced to accuse the WMAS staff of not respecting her lifestyle choices and she refused to provide any information to WMAS staff or allow them to carry out observations. She then became verbally hostile towards the WMAS staff, and they withdrew from the address.

The second call WMAS received it appeared to the call taker that Helen was intoxicated, and she reported intending going out and laying in the road. WMAS upon attendance were informed by Helen that she did not require their assistance and was going out to meet a friend. The crew attempted to remind her of the current government guidance regarding staying indoors owing to the COVID19 pandemic, but it was apparent she ignored what they were saying and walked away.

After her calls made to WMAS, Helen attended at the local acute hospital emergency department following reports of her lying in the road intoxicated and claiming that she wished to die. Whilst being monitored by hospital staff on a one-to-one basis Helen became distressed and left the hospital. It was recorded by the hospital staff that they were of the opinion that Helen had the mental capacity to make an informed decision regarding her wishes to be assessed and treated by the hospital staff. The Psychiatric Liaison Team were made aware by the emergency department staff that Helen had self-discharged without being assessed and it was requested the DWMH Home Treatment Team be made aware.

4.45 On the 1st April 2020 WMAS received an emergency call from Helen requesting their assistance owing to concerns that she may have contracted COVID19. Observations were completed by WMAS staff, and she reported being lethargic but felt she could remain at home as her partner was present. She was advised by the WMAS staff to keep up her fluid intake and call 111 if she required any further help or guidance.

Additionally, later that evening WMP received a call from Helen who reported being assaulted by a male and that she was now hiding outside from him. WMP officers attended the report and requested WMAS support. Helen was subsequently conveyed by WMAS to the local acute hospital emergency department and the reported assault was recorded as a crime by WMP in line with Home Office Crime Recording Standards. At the hospital Helen reported to the emergency department staff that she had been assaulted after being punched in the ear by a "drug gang ringleader." She reported experiencing ringing in her ears and was fearful to return home in case her attacker returned once more. Helen informed the emergency department doctor that she was withdrawing from alcohol and required something to help her. Helen was subsequently discharged in the early hours of the 2nd April 2020 from the emergency department and advised by medical staff to report the assault to the police. Following Helen being discharged a short time later she was escorted back into the emergency department by a clinical support worker. They questioned if Helen was awaiting to be seen by the DWMH Crisis Team, but it was confirmed by the emergency department doctor that Helen had not been brought to the hospital for that purpose and had been

discharged. It was explained by an emergency department staff member that Helen had been found laying in the road. At this point an emergency department Doctor reinforced the information that Helen had been discharged. It was apparent to staff that Helen had overheard this comment and then left the hospital emergency department. A short time later Helen was brought back into the emergency department by a member of WMAS who had discovered Helen once again lying in the middle of the road. Medical staff at the emergency department enquired with an emergency department doctor if the DWMH Crisis Team were attending the department to see Helen. It was reported by the emergency department Doctor that she had not been at hospital for that purpose and had been discharged. Helen then left the hospital. Approximately 8 minutes later, Helen was discovered laying in the road having suffered massive head trauma injuries and a cardiac arrest. It subsequently transpired that Helen after being struck by a passing vehicle had died as a result of the injuries sustained.

5. Methodology

SAR methodology is non- prescriptive within the Care Act with the overall aims that the review is conducted wherever possible in a timely and proportionate manner.

The original chosen methodology to undertake this SAR was a blended approach of action learning with a more in-depth analysis of agency involvement. This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement.

This is achieved via close collaborative partnership working, including those practitioners involved at the time as well as key family members.

Unfortunately owing to the COVID19 pandemic and subsequent pressure upon frontline resources it was not feasible as planned to hold an action learning practitioner event.

The process undertaken was as follows.

5.1 SAR Panel Membership

A Safeguarding Adult Review panel was established consisting of senior managers from lead agencies with no previous involvement in the case to support the progression of the SAR. These individuals were identified to have authority to effect change in their own agency and have the appropriate level of professional knowledge to support the SAR.

The Dudley Safeguarding People Partnership have commissioned the Independent Reviewer and author of the SAR to produce an independent report. The author was not involved in the delivery of identified services; line management for any service or

any individual mentioned within the report. They are a former senior police officer experienced in undertaking SARs on a national basis.

The author and panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice; to identify whether this SAR indicates changes could and should be made to practice and if so, how these changes will be brought about.

5.2 Terms of Reference

Areas for analysis.

1. How effectively did services work together to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?

2. Did the increase in concerns leading up to the individual's death receive an appropriate and effective response from agencies?

3. How were historical allegations of sexual assault responded to?

4. Was there effective co-ordination of the individual's care and support needs throughout the scoping period?

5. How were concerns relating to substance misuse both responded to and considered in relation to the potential impact it may have had upon the individual's mental health and mental capacity?

6. How did emergency services work together regarding the frequent requests for assistance made by the individual?

7. Did the COVID19 pandemic inadvertently impact upon agency responses in relation to managing the perceived risks presented by Helen?

8. Were there areas of good practice?

5.3 Family Involvement

The SAR reviewer and author did have the intention of involving a family member in completing this review. However, owing to the lengthy time period between Helen's death and the commissioning of the SAR and the fact that there was no family involvement in the original coroner's inquest it was considered inappropriate to establish contact.

5.4 Practitioner and Manager event

Unfortunately owing to the COVID19 pandemic and subsequent pressure upon frontline resources it was decided it would not be possible as planned to hold an action learning practitioner event.

5.5 Documentary Review

- Relevant agencies provided chronologies of service involvement within the identified timeline.
- The chronologies were utilised to create a multi-agency chronology.
- Key questions relevant to the case were posed by the Lead reviewer and author to aid analysis and learning. (See Appendix 1.)
- Health Root Cause Analysis Report.
- The Dudley Adult Safeguarding Policies and Procedures.
- Care Act 2014.
- Mental Capacity Act 2005.
- Mental Health Act 1983.
- The Home Office Crime Recording Standards.
- National Health Services Act.

6. Analysis

Term 1. How effectively did services work together to safeguard the individual in light of the known risks, and was there evidence to suggest that agencies shared a common understanding of risk?

6.11 The Care Act 2014 which provides the statutory guidance for Adult Safeguarding describes an “Adult at Risk” as an adult having needs for care and support (whether or not the local authority is meeting any of those needs), is experiencing or is at risk of abuse or neglect, and as a result of those care and support needs is unable to protect themselves from the risk of, or the experience of abuse or neglect.

6.12 The SAR identifies that Helen had care and support needs in relation to her physical and mental health together presenting with several risks. These included intermittent apparent alcohol dependency, risks of physical assault in the community, potential self-neglect through not eating and apparent repeated attempts to self-harm by lying in the road in front of moving vehicles. During the timeline of this SAR multiple agencies were involved in supporting Helen in an attempt to safeguard her from her presenting risks.

6.13 WMAS attended at Helen’s home on multiple occasions following her requests for help. These requests included concerns for her physical health such as an inability to breathe and fears of contracting COVID 19, requests for help regarding apparent alcohol dependency, reports of falls, threats to take her own life and reports of being

in mental health crisis. On several occasions WMAS would convey Helen to the hospital emergency department only for her to self-discharge before assessment or treatment. Helen occasionally was verbally abusive and aggressive towards WMAS staff, on one occasion physically assaulting a WMAS member of staff. In several areas of the country NHS hospital trusts have established strategies and established processes to review and manage “High Impact” users who are regular attendees at acute trust emergency departments. The Royal College of Emergency Medicine recommends that emergency departments should have methods to identify frequent attenders to their department who may benefit from a bespoke emergency department care plan. The guidance recommends that case management may assist in identifying unmet needs which provides an opportunity of working with other agencies and services in relation to the patient’s ongoing care to help manage and reduce the risks posed through frequent attendance. The guidance recommends multidisciplinary case conferences being held to manage the risks presented by patients exhibiting risk behaviour involving such agencies including community mental health teams, primary care providers and Adult Social Care.

There is as described at **4.39** reference to consideration of an email being sent by the hospital emergency department staff to the Frequent Attender Group, highlighting Helen’s vulnerabilities and care requirements. There is no information provided to inform the SAR as to whether the email was sent or what the subsequent outcome was of this referral. The SAR has found no evidence to indicate the application of a process by DGFT in managing the issues created by Helen’s repeated attendance at the emergency department. The SAR understands that there is now in place a daily retrospective review undertaken by the Trust of patients who have absconded or self-discharged from the emergency department. The SAR understands however there is no current “High Incident” User Lead identified within the trust or an apparent established process on the management of high impact users of the emergency department.

Recommendation 1.

Drawing upon learning from this case 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.

Frequent_Attenders_in_the_ED_Aug2017.pdf (rcem.ac.uk)

6.14 WMP like WMAS attended Helen’s home on multiple occasions following requests for help. These included requests for assistance after she claimed being assaulted, concerns for her safety regarding her mental health and intoxication and issues of Helen being unable to access her property after locking herself out of her home. There were additional calls WMP responded to where it was reported Helen was laying in the road.

6.15 During the timeline of this SAR, Helen was a regular attender at DGFT local acute hospital emergency department after either being conveyed there by WMAS or through self-attendance. Helen would regularly upon attendance at the hospital self-

discharge before she could be assessed. On the occasions she chose to self-discharge there is evidence of DGFT staff as detailed at **4.37** and **4.44** assessing Helen's mental capacity where it was deemed, she had capacity to make an informed decision regarding assessment and treatment. When she was willing to remain at the hospital appropriate requests were made by DGFT for the DWMH Psychiatric Liaison Team to attend the emergency department to assess Helen's mental health. When Helen absconded from the hospital and was found walking in the middle of the road as detailed at **4.38** DGFT in accordance with the Trust's Adult Patients who abscond policy recorded a detailed physical description of Helen which could be used as an aid to WMP or hospital security staff in searching for her when she went missing from the hospital.

6.16 The DWMH Psychological Liaison Team (PLT) are dedicated to assessing individuals who attend at the DGFT local acute hospital who have self-harmed, attempted suicide or are presenting with symptoms which may suggest they are suffering from a mental illness. Helen frequently attended the emergency department often intoxicated and expressing thoughts of self-harm and suicidal ideation. She was referred on a number of occasions by the emergency department staff to PLT but then would regularly self-discharge before PLT could assess her. On the rare occasions she remained at hospital to be seen, for example as detailed at **4.38** PLT were able to conduct a mental health assessment and undertake a risk assessment. This assessment identified her risk as dynamic owing to her past attempts to take her own life. On this occasion a risk management plan was established, and she was referred to the DWMH Home Treatment Team so they may monitor her presenting risks and review her medication. Despite regular contacts with DWMH, including PLT and the Home Treatment Team there is no evidence of the identified risks being escalated by DWMH through the raising of safeguarding concerns to the MASH.

6.17 The regular attendances at the hospital were documented in Helen's GP record following the information being shared by DGFT. Upon receipt of the notification's attempts were made by Helen's GP practice to contact Helen. These however often proved unsuccessful owing to Helen not responding to telephone messages or changing her contact details without updating the GP practice. There was evidence in the GP records that demonstrate on several occasions her failing to attend prearranged appointments for medical reviews, although the GP practice did continue various methods in an attempt to establish contact including sending out letters requesting her attendance. A review of Helen's medical records evidenced her registering with three different GP practices in the space of four years and her engagement with the GP practices was intermittent. This made the establishment of a therapeutic relationship between Helen and the GP practice difficult as her first point of contact regarding her health often tended to be the hospital emergency department owing to her frequent attendance. During the timeline of this SAR, it is understood that the Primary Care Mental Health Teams were under the responsibility of the Black Country Healthcare NHS Foundation Trust. The Primary Care Mental Health Teams the SAR understands now work from GP practices in Dudley and with the GP's and other primary care health professionals. They can offer assessment and brief intervention to support individuals to be able to manage their symptoms effectively,

including engagement with medications that may be prescribed for their mental health needs. If Helen engaged with primary care services, this may have provided an opportunity for the GPs to secure better engagement with Helen by referring her to the Primary Care Mental Health Teams to provide support rather than as was then where she resorted to frequent attendance at the hospital emergency department.

6.18 During the timeline of this SAR a total of nine Safeguarding Concerns were raised by agencies to the Adult MASH. MASH receive safeguarding concerns for citizens of Dudley who do not have a social worker. The service looks to triage concerns and reach Care Act compliant threshold decisions. On each occasion when the nine Safeguarding Concerns were triaged it was identified that Helen's case was open to DWMH, and the concern transferred to them. The agreement at this time meant DWMH were responsible for reaching threshold decisions on adults open to secondary care services. The DWMH records demonstrate the DWMH safeguarding team suggesting courses of action to be considered by various elements of the DWMH team.

The SAR has identified these suggestions being implemented as detailed at **4.20** where a request to the Liaison and Diversion Outreach Team to bring forward Helen's mental health appointment was carried out. However, there were other occasions DWMH records were unable to evidence if the suggested courses of action recommended by the DWMH safeguarding team were completed or what the subsequent outcomes were. These are evidenced at **4.35** where concerns were identified regarding self-neglect and alcohol dependence and at **4.39** where medical staff from the hospital emergency department highlighted concerns regarding Helen constantly absconding from hospital and laying in the road. The SAR has been informed that during the timeline of this SAR there was an established Section 75 National Health Service Act agreement between Dudley Metropolitan Borough Council and DWMH. A Section 75 agreement is a legal framework which allows budgets to be pooled between local health and social care organisations, where resources and management functions normally undertaken by one service may be reallocated to the other. The SAR has been informed that any safeguarding concerns received during this time period where an adult was open to secondary Mental Health Services were not screened by the Local Authority Access and Prevention Social Work Team and passed directly to DWMH whose responsibility was to reach a threshold decision and start any relevant enquiry. This was in accordance with the Section 75 agreement. Section 42 of the Care Act 2014 details that where a local authority has reasonable cause to suspect an adult in its area has needs for care and support, is experiencing or is at risk of abuse and neglect and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it, the local authority must make or cause to be made whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adults case and if so what and by whom. Whilst the raised Safeguarding Concerns were passed directly to DWMH who had the responsibility to reach a threshold decision and commence relevant enquiries drawing upon learning from this SAR in cases such as Helen's where individuals regularly present to agencies leading to multiple safeguarding concerns being raised it is recommended by the SAR that the 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. The SAR has been informed that structural and procedural changes have occurred since January 2021 and no such Section 75 agreement now exists. Consequently, after seeking advice from the Dudley Safeguarding People Partnership the SAR has not made any recommendations in relation to this previous arrangement.

Recommendation 2.

Drawing upon learning from this case 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.

6.19 Whilst acknowledging DWMH were providing support to Helen regarding her mental health the SAR has identified multiagency involvement on a recurring and regular basis. The SAR has found no evidence of multiagency safeguarding meetings occurring so as to assess and respond to Helen's cumulative risks.

The SAR deems that owing to the number of agencies involved in both responding to the risks posed to Helen and providing care for her complex needs that in line with the Dudley Adult Safeguarding Policies and Procedures, that a safeguarding meeting should have taken place so as to share agency information where appropriate. This may have enabled a multiagency risk management plan to be established to manage and respond to the cumulative risks posed. The policy and procedures identify such a meeting should be held with relevant multiagency attendance involving complex and high-risk cases and are deemed beneficial when considering cases such as Helen's involving mental health and substance misuse.

Recommendation 3.

Drawing upon learning from this case 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.

Term 2. Did the increase in concerns leading up to the individual's death receive an appropriate and effective response from agencies?

6.21 From December 2019 the SAR identifies an apparent increased reporting of Helen walking or lying in the road in an intoxicated state and reporting to agencies of her wish to die. This resulted on several occasions WMP and WMAS responding to these events and conveying Helen to the local acute hospital emergency department so she may be assessed.

6.22 As detailed at **4.43** In the last week of her life the GP identified Helen had completely stopped drinking. The GP made Helen aware that this would be an unsafe course of action to take due to the possibility of seizures and recommended to Helen not to completely stop and they confirmed that she was in contact with the local alcohol recovery service.

6.22 As detailed at **4.37** WMAS conveyed Helen to the emergency department following her reporting having suicidal thoughts. It was reported she was intoxicated and informed hospital staff of a plan to take her own life through drowning or by running out into the road in front of a vehicle. On this occasion Helen refused to be assessed by the DWMH Psychiatric Liaison Team and her mental capacity was assessed by the emergency department staff. They recorded that she understood the implications of not waiting to be seen, was able to retain the information and relay it back to the member of staff and therefore deemed her to have mental capacity, subsequently self-discharging.

6.23 A short time later after self-discharge Helen was detained by WMP under Section 136 of the Mental Health Act 1983 and conveyed to the DWMH place of safety after being found laid in the middle of the road. Section 136 provides a power to the police to detain a person apparently suffering a mental disorder and remove them to a place of safety. Following the Section 136 detention DWMH were able to assess Helen's mental health, establish a plan for her to be supported in the community by the Home Treatment Team and consequently she was discharged from her Section 136 detention. DWMH undertook a risk assessment which identified her risk currently as dynamic as a consequence of past attempts to take her own life. The request for support to be provided by the Home Treatment Team was not supported following a subsequent DWMH Multi-Disciplinary meeting where it was decided support would continue to be provided by the DWMH Community Recovery Service.

Mental Health Act 1983 (legislation.gov.uk)

6.24 Within six hours later, Helen was transported back to the emergency department by WMAS after being observed to be walking in the middle of the road. A description of Helen's physical appearance was documented by DGFT so as to assist WMP or the trust security team in an event of a later search for Helen being undertaken if she absconded before she could be medically assessed. This was in accordance with the DGFT Adult Patients who Abscond Policy and the proactive approach of recording Helen's physical appearance by DGFT in anticipation of her potentially absconding is identified by the SAR as good practice.

6.25 During this continued episode of agency involvement Helen absconded on four occasions from the emergency department. Consequently, PLT escalated their concerns owing to multiple presentations to the emergency department and repeated risk behaviours to the Patients Sector Team. This owing to PLT's view that the Home Treatment Team could not support Helen as originally planned. Liaison between the PLT team appointed Doctor, the Patients Sector Team Doctor and Home Treatment consultant took place all of whom supported Helen's admission into hospital. However, there was delay in securing a hospital bed for Helen owing to the COVID19 pandemic

and a requirement for the suitability of all admissions to be considered. Upon PLT returning to the emergency department to undertake COVID19 screening measures it materialised that Helen had once again absconded from the hospital. The SAR deems the delay in securing a hospital bed for Helen's admission as a missed opportunity to complete a vigorous clinical assessment of her mental health together with undertaking a review of Helen's care and risk management plans.

6.26 Following Helen leaving the hospital she was arrested by WMP for an offence of causing a public nuisance. After spending several hours in police custody where she had been reviewed on multiple occasions and found to be intoxicated once sober Helen was detained by WMP under Section 136 of the Mental Health and conveyed to the nominated place of safety so she may be assessed. The outcome of the assessment of her mental health identified no evidence of depression, psychosis, or suicidal ideation. She was discharged home with a plan for support to be provided by the Home Treatment Team. This despite the fact that home visits owing to the COVID19 pandemic could not be guaranteed by the Home Treatment Team and PLT highlighting concerns that the Home Treatment Team would not be in a position to support Helen. Whilst the SAR recognises that this event coincided with the new restrictions imposed as a consequence of the COVID19 pandemic and that agencies were encountering unchartered territory, the plan for Helen to be supported upon discharge by the DWMH Home Treatment Team was 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 with.

Recommendation 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.

Term 3. How were historical allegations of sexual assault responded to?

6.31 During the timeline of this SAR Helen alleged being a victim of sexual assaults on five occasions. As previously detailed in the significant events section Helen refused to support investigations into the alleged sexual assaults on two occasions. These involved allegations of being a victim of rape as detailed at **4.9** and being a victim of non-consensual sex as detailed at **4.39**. On both of these occasions WMP registered the reports as crimes in line with the Home Office Crime Recording Standards and owing to Helen's desire not to support a criminal investigation no further action was taken. The Home Office Crime Recording Standards promote a victim-oriented approach to crime recording. This means that a belief by the victim that a crime has occurred is in most cases enough to justify recording the incident as a crime.

6.32 There were however, three other occasions when Helen alleged being a victim of sexual assaults which were not recorded as crimes and there is no information provided to the SAR to demonstrate these allegations were ever investigated by WMP. These events are detailed at **4.17, 4.20 and 4.35.**

6.33 WMP when receiving calls for service utilise the THRIVE assessment process (Threat, Harm, Risk, Investigation, Vulnerability, Engagement). Each of the six areas provide guidance to WMP staff as to how calls for service should be assessed. All the areas of assessment are relevant to this SAR in analysing the WMP response to these three incidents.

6.34 Regarding **4.17** there is no evidence to demonstrate WMP considering the threat posed to Helen after she reported the alleged offender lived nearby, considering the harm she may have suffered from being sexually assaulted, considering the risk from the likelihood of the event reoccurring, there was no apparent investigation into the alleged report of the assault, any consideration of Helen's vulnerability owing to her intoxication and a lack of utilising this engagement opportunity by WMP to build a positive relationship with an alleged victim of crime.

6.35 Regarding **4.20** there is no evidence to demonstrate WMP considering the threat posed to Helen after she reported being gang raped and assaulted, considering the risk from the likelihood of the event reoccurring, there was no apparent investigation into the alleged report of the assault, any apparent considerations of Helen's vulnerability by WMP responding to the call for service and discovering her in a distressed state or is there any evidence to demonstrate the allegations made were investigated.

6.36 Regarding **4.35** when Helen disclosed to WMP being an alleged victim of child sexual abuse which she claimed had never disclosed previously, there is no evidence to demonstrate these allegations were investigated further or whether the potential trauma Helen had experienced in her life was fully considered by agencies in potentially influencing some of her behaviours and alcohol use. The impact of non-recent sexual abuse is recognised to be associated with mental health problems including self-harm behaviour and suicidal thoughts together with problems with dependency upon drugs and alcohol. All of which were prominent in Helen's life.

Non-recent abuse | NSPCC

6.37 On two of these three occasions, references are made of Helen being intoxicated at the time of making these reports and the SAR recognises communication with Helen by WMP must have been challenging owing to her intoxication. However, the SAR has identified no evidence of WMP engaging with Helen after the initial reports so as to investigate these matters further or re-establish contact when hopefully she may be sober. The Victims Code provides victims with a right to have the details of their reported crime recorded without unjustified delay and the College of Policing Approved Practice identifies the reporting of such matters to the police should be the commencement of the investigative process.

Recommendation 5.

Drawing upon learning from this case the 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.

https://foi.west-midlands.police.uk/wp-content/uploads/2021/01/THRIVE.pdf

Code of Practice for Victims of Crime in England and Wales (Victim's Code) - GOV.UK (www.gov.uk)

Investigation process (college.police.uk)

Term 4. Was there effective co-ordination of the individual's care and support needs throughout the scoping period?

6.41 The Care Programme Approach (CPA). CPA is a key component of the mental health delivery system in England and is a package of care used by secondary mental health services to support individuals with mental health problems. It promotes the establishment of a care plan for the individual concerned, that is subject to regular review that includes the consideration and assessment of risk. It promotes joint working and communication between health professionals who are supporting the individual. It provides the basis for multi-agency case conferencing and triggering of safeguarding action as well as co-ordinated planning of care and future moves of accommodation. The CPA may lead to an individual being supported by mental health services such as Helen to be allocated a care coordinator. The care coordinator coordinates and monitors the persons care which would be written into a care plan, have regular contact with the individual, work with other health professionals to assess the individuals needs and regularly review the care plan to check progress. The allocation of a care coordinator was considered by DWMH on several occasions during the timeline of this SAR the last occasion being on the 21st January 2020 when Helen attended her mental health outpatient appointment. On each occasion following review it was decided by DWMH that there was no role for a care coordinator. This owing to her clinical presentation and primary risks of alcohol misuse and reluctance to engage in therapeutic activities were not felt to justify the allocation of a care coordinator in accordance with the CPA.

https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

6.42 Helen was supported by Creative Support and her allocated support worker did accompany her to medical appointments, helped Helen to move accommodation and attend group events and participate in community activities.

6.43 As detailed at **4.28** Helen's case was discussed at the Safer Estates meeting. This meeting operates under the responsibility of the Dudley Community Safety

Partnership. The aim of the Safer Estates meeting is to focus upon high demand locations relating to repeat calls made to agencies so that agencies may take a problem-solving approach to reduce demand. Information was shared at the meeting by DWMH of an intention to meet with Helen in the near future. However, despite the many other issues of concern that existed in relation to Helen's case there was no evidence of agencies present working together to develop a multi-agency coordinated plan to manage the complex issues she presented with. There are examples of good practice nationally where an adult presenting with complex needs and traditional methods of intervention have not worked and resulted in the issues of concern remaining unresolved, of agencies coming together to develop a multiagency plan of support, by building a "Team around the Adult." The SAR understands that a similar approach has now been introduced in Dudley that was not in existence during the timeline of this SAR, with the creation of the Adults at Risk Team. This team 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. The cohort of people the team would support are those who repeatedly refuse assessments and intervention and considered to be putting themselves at risk when making decisions with evident mental capacity or where their mental capacity is difficult to assess. The Adults at Risk Team work with the individual for an initial 12-week period ensuring the interventions that are applied are proportionate and based upon an individual's needs and circumstances. However, Helen would not have met the criteria for support from this team if it had been in existence at the time as her case was open to secondary community mental health services. Following the end of the Section 75 agreement safeguarding concerns would be screened by MASH [instead of going direct to secondary care] and any enquiry now of this type would be held within the Local Authority mental health team. The SAR does consider though that promoting the existence and access pathway to the Dudley Adults at Risk Team would be beneficial to assist agencies in considering how to manage future complex cases of a similar nature to Helen's.

Recommendation 6.

Drawing upon learning from this case Dudley Safeguarding People Partnership should promote the existence and access pathway to the Dudley Adults at Risk Team.

Term 5. How were concerns relating to substance misuse both responded to and considered in relation to the potential impact it may have had upon the individual's mental health and mental capacity?

6.51 Helen during the timeline of this SAR received two periods of support from a local alcohol recovery service. The service works with the individual concerned to develop a recovery plan and support the individual through a variety of interventions including one to one sessions, group, and recovery work. The first period of engagement commenced on the 25th March 2019 and ended on the 24th October 2019. The SAR has identified during this period some difficulties in the service

engaging with Helen. Initially she engaged regularly with the service in relation to her alcohol issues, but her engagement deteriorated in August 2019 when it was decided that Helen had to make her own way to the recovery service after previously being provided with free transport. There is no information provided to inform the SAR of the rationale for the decision in ending Helen's free transport to the recovery service, but it was apparent that following this decision it coincided with a deterioration in her engagement. During the remainder of this first time period of engagement whilst there was no further attendance made by Helen to the recovery service there was telephone contact. On one occasion she called to report having alcohol withdrawal and was advised by the service to attend the hospital. On another occasion she reported not having drank alcohol for three weeks and was experiencing abuse from other people who were banging on her windows at home. On the 17th September 2019, the recovery service Outreach Team completed a safe and well check at her home where she reported to the Team that she was fine. On the 24th October 2019, the recovery service made telephone contact with Helen who informed them that she had now moved home and is continuing to engage with her Creative Support worker and GP and no longer wished to engage with the recovery service. As a result, her case was closed to the recovery service, and she was advised she may engage with them at any time.

6.52 The second period of support commenced on the 20th March 2020 following Helen self-referring for support. On the 26th March 2020 following several unsuccessful attempts to establish contact by telephone, the service was able to establish contact so a personalised assessment could be undertaken. An alcohol use disorders identification test (AUDIT) was carried out. AUDIT is a Public Health England screening tool and is used to assess a service users' level of risk to alcohol harm. This resulted in an AUDIT score of 38. Any individual scoring 20 or above Public Health England recommend being referred for a specialist alcohol harm assessment. Additionally on this date a Severity of Alcohol Dependence questionnaire was also completed, which resulted in a score of 45. A score of 31 or above may indicate according to NICE guidance a high dependence to alcohol. Helen reported to the recovery service worker that she was drinking four large bottles of cider per day and suffering from blackouts and confusion due to her drinking. She reported having made recent suicide attempts together with having thoughts of self-harm. On the 1st April 2020 Helen made telephone contact with the recovery service and reported wanting to stop drinking and that she wanted a detoxification from alcohol. On the 2nd April 2020 it was agreed that a nurse alcohol assessment would be completed with a view to Helen receiving an inpatient detoxification programme and the assessment was arranged to take place the following day. Sadly, Helen died before the nurse alcohol assessment could be completed and consequently did not have the opportunity to receive an inpatient detoxification programme.

How to screen | Diagnosis | Alcohol - problem drinking | CKS | NICE

https://www.gov.uk/government/publications/alcohol-use-screening-tests/guidance-on-the-5-alcohol-use-screening-tests

6.53 NICE guidelines recommend individuals such as Helen who have coexisting severe mental illness and substance misuse issues often referred to as dual diagnosis should as recommended by the Care Programme Approach be provided with a care coordinator working in community mental health services. The care coordinator acts as a point of contact for the individual. The care coordinator should identify and contact the individual's family or carers together with developing a care plan with the person. The care coordinator should coordinate the delivery of the care plan by working with other agencies including substance misuse services, primary and secondary health services, social care, and other organizations such as housing and employment services. The SAR identifies that the appointment of a care coordinator in Helen's case may have been beneficial so as to coordinate the care that was required in managing the complex issues she presented with and promote joint working between secondary mental health services and the alcohol recovery service. The allocation of a care coordinator was examined in detail by the Black Country Healthcare NHS Foundation Trust Root Cause Analysis investigation commissioned following Helen's death. The investigation identified that the Care Programme Approach Framework had not been fully adhered to and that Helen owing to her complexity of issues, history of trauma and social issues did meet the criteria to be supported within the Care Programme Approach. The investigation concluded that the absence of an allocated Care Coordinator under the Care Programme Approach process impacted on the availability of an individual professional to ensure the continuity of care and oversee engagement of the full care package that was available to Helen. It was subsequently recommended that the Black Country Healthcare NHS Trust should ensure that the Care Programme Approach should be adhered to throughout the patient care pathway.

Dual Diagnosis NICE Guidelines: Recommendations | Dual Diagnosis Hub

Recommendation 7.

Dudley Safeguarding People Partnership should seek assurance from the Black Country Healthcare 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.

6.54 There are several references where Helen whilst being reportedly intoxicated has been assessed to have Mental Capacity to make informed decisions relating to her refusal to accept care and treatment from health services. These include at **4.4** and **4.23** where Helen refused to accept support from WMAS and at **4.44** following her attendance at the hospital emergency department. Principle 1 of the Mental Capacity Act 2005 identifies a person must be assumed to have capacity unless it is established, they lack capacity. The Mental Capacity Act states that to have mental capacity to make a specific decision at a specific time the person must be able to understand the information relevant to the decision, including the reasonably foreseeable consequences of deciding one way or another or in failing to make the decision and retain the information and use or weigh that information to communicate their decision. According to the NHS the excessive consumption of alcohol can reportedly affect the

health of your brain and may lead to an individual having fluctuated mental capacity where a person's ability to make a specific decision may frequently change. There is evidence at **4.37** where it was recorded that Helen understood the implications of not waiting to be assessed and treated at the hospital. However, on the other such highlighted occasions there is no evidence to indicate Helen's mental capacity was assessed by agencies that demonstrated her ability to make an informed decision with evidence of her understanding the reasonably foreseeable consequences of her making or not making a decision regarding her treatment.

6.55 Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions.

Indications of executive impairment are often characterised in an individual's behaviour through being unable to translate intention into action, being full of promises to complete actions and then displaying an inability to initiate, plan and complete activities as promised. There is evidence of such displayed behaviour in relation to Helen's case for example as detailed at **6.52** where after previously disengaging with the local alcohol recovery service she self-referred for help owing to her alcohol issues where diagnostic assessments identified she had an apparent self-dependence on alcohol. Impulsivity is a behaviour which affects an individual's ability to make decisions and often observed within people with executive dysfunction. The SAR has identified on several occasions Helen acting impulsively for example at **4.37,4.39** and **4.45** characterised by her behaviour in engaging with practitioners but then before treatment and support could be provided putting herself at the risk of harm by deciding to lay in the road. 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 in these situations can expose a vulnerable person to substantial risk. It is recommended that Dudley Safeguarding People Partnership develop practitioner guidance to assist practitioners in identifying the signs and response to individuals displaying signs of executive impairment.

Alcohol misuse - Risks - NHS (www.nhs.uk)

Mental Capacity Act 2005 (legislation.gov.uk)

Managing Executive… | NHS Physical Health Psychology Cumbria

Recommendation 8.

Dudley Safeguarding People Partnership should seek assurance through the application of its quality assurance framework that consideration of fluctuating

capacity as per the Mental Capacity Act 2005 is being consistently applied across the Dudley Safeguarding Adult's partnership.

Recommendation 9.

Dudley Safeguarding People Partnership should develop Practitioner Guidance to assist in the identification and response to individuals displaying signs of executive impairment.

Term 6. How did emergency services work together regarding the frequent requests for assistance made by the individual?

6.61 During the SAR timeline WMP received in excess of 60 calls for service regarding separate incidents involving Helen, whilst WMAS received in excess of 42 calls for service during this time period. There were several occasions where WMP attended in support of WMAS owing to Helen's alleged aggressive behaviour and WMAS supporting requests from WMP where concerns for Helen's health existed. Whilst operationally there is strong evidence of the two emergency services working together in responding to Helen's calls for service, the SAR has not identified the two agencies working together to create a joint multi-agency response plan in managing the risks Helen presented with where each agency would have a clear understanding as to which agency was responsible to take what action in what particular set of circumstances. This would have been beneficial for example in the situation as detailed at **4.31** where there were apparent disputes regarding which agency was the most appropriate to respond to Helen's assistance when she was allegedly laid on the floor of her home for approximately 3 hours and WMAS could not gain access to assist her.

Recommendation 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.

6.62 As detailed at **4.28** Helen's case was discussed at the Safer Estates multi-agency meeting. Whilst the SAR acknowledges the purpose of the meeting is to seek to reduce demand upon agencies, this was one of the rare occasions agencies apparently came together to discuss Helen's case. The SAR identifies this event as a potential missed opportunity for agencies to work together and develop a joint multi-agency plan to respond to the issues of concern. When Helen's case was discussed at the meeting despite multiple concerns being highlighted regarding her mental health, incidents of self-harm and alcohol misuse the only action allocated regarding Adult Safeguarding was for DWMH to provide an update at the next meeting of the outcome of her next mental health outpatient appointment as detailed at **4.30.** There is no reference of any consideration being made by the Chair of raising a Safeguarding Concern to ASC so the identified concerns may be assessed and responded to.

6.63 The SAR having considered the protocol for the Safer Estates multiagency notes it references that some cases considered potentially beyond the remit of the group will need to be dealt with via a specialist forum and in such cases a referral is expected to be made to the respective forum via the chair of the Group.
It is unclear in relation to this meeting as to what the reporting and accountability arrangements are so as to ensure that when safeguarding adult concerns are identified they are appropriately raised to ASC for assessment as per Section 42 of the Care Act 2014.

Care Act 2014 (legislation.gov.uk)

Recommendation 11.

Drawing upon learning from this case 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.

Term 7. Did the COVID19 pandemic inadvertently impact upon agency responses in relation to managing the perceived risks presented by Helen?

6.71 DWMH when providing information to inform the SAR detailed as a consequence of the pandemic having to consider new ways of working so as to minimise the risks to patient care. Evidence to this affect is detailed at **4.38** where following Helen being referred to the Home Treatment Team to manage the risks, she presented with the referral had to be declined as home visits could not be guaranteed and the level of presenting risks safely managed.

As detailed at **4.39** it is apparent the pandemic influenced the timeliness of decision making relating to Helen's admission into hospital. This after it had been earlier concurred her admission would have been the best option according to the DWMH Home Treatment Consultant and Psychiatric Liaison Team Doctor.

6.72 Information provided to inform the SAR indicates that support provided by the Alcohol Recovery Service during the pandemic continued on a face-to-face basis and there is no evidence to indicate the new restrictions imposed impacted inadvertently in their efforts to support Helen with her alcohol issues.

6.73 It was identified by DGFT that the pandemic had placed increasing pressures on the whole of the emergency department where COVID19 had created a complex operating environment owing to the implementation of restrictions in some areas of the hospital to contain the spread of infection from COVID19 positive patients. Helen during this time period of restrictions did abscond from the emergency department and the current restrictions in place at that time were recognised may have impacted upon the management of such occurrences.

6.74 There were no adverse consequences identified in relation to the pandemic as to how Helen's GP was able to support her as reviews were conducted by telephone which had already been adopted as standard practice.

6.75 There were no adverse consequences identified in relation to how WMP and WMAS responded to calls for service during the pandemic where "business as normal" was maintained.

Term 8. Were there areas of Good Practice?

6.81 There were several areas of good practice identified during the timeline period of this SAR.

6.82 As detailed at **4.35** where WMAS in attempting to seek support for Helen's alcohol issues contacted the Alcoholics Anonymous helpline so Helen may speak with an individual from the organisation.

6.83 As detailed at **4.29** where Helen reports to ASC to be suffering from financial hardship a referral was made to the Red Cross charity to seek support for Helens financial concerns.

6.84 As detailed at **4.39** where DGFT in anticipation of Helen potentially absconding from hospital they recorded a physical description prior to any such report to aid WMP or hospital security staff in searching for Helen in the eventuality of her absconding.

6.9 Equality and Diversity Considerations.

6.91 The Equality Act 2010 protects people from discrimination in society owing to the protected characteristics they may display as described in the Act.

There are several references made of Helen having challenges with her sexuality and identifying occasionally to agencies as a gay woman.

The SAR has not identified any evidence to indicate that Helen did not receive the appropriate level of care and support from agencies owing to this potential protected characteristic.

7. RECOMMENDATIONS

Recommendation 1.

Drawing upon learning from this case 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.

Recommendation 2.

Drawing upon learning from this case 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.

Recommendation 3.

Drawing upon learning from this case 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

Recommendation 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.

Recommendation 5.

Drawing upon learning from this case the 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.

Recommendation 6.

Drawing upon learning from this case Dudley Safeguarding People Partnership should promote the existence and access pathway to the Dudley Adults at Risk Team.

Recommendation 7.

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Recommendation 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.

Recommendation 9.

Dudley Safeguarding People Partnership should develop Practitioner Guidance to assist in the identification and response to individuals displaying signs of executive impairment.

Recommendation 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.

Recommendation 11.

Drawing upon learning from this case 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.

Appendix 1

Question 1.

Information provided to inform the review indicates that Helen frequently misused alcohol. Can you detail both how as an agency you responded to this issue and worked with others in managing the risks posed to Helen, through her apparent addiction to alcohol?

Question 2.

How as an agency did you respond and work together with other agencies in responding to the risks posed to Helen, which included the occurrences of her laying in the road with an apparent desire to self-harm?

Question 3.

Information provided to inform the review indicates that Helen made frequent calls to the emergency services, together with presenting on numerous occasions at the acute hospital emergency department. How as agencies did you work together in relation to managing and responding to these recurring calls so as to minimise the risk posed to Helen?

Question 4.

How were reports of sexual and physical assault towards Helen recorded and responded to?

Question 5.

How did the COVID19 pandemic impact upon your agency response in relation to providing Helen with care and support, together with safeguarding her from abuse or neglect?