Thematic Safeguarding Adults Review in respect of

Suicide prevention

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Contents

Glossary

BIA	Best Interest Assessor
CMHRS	Community Mental Health Response Service
CPA	Care Programme Approach
EDT	SCC's Emergency Duty Team
IMCA	Independent Mental Capacity Advocate
JSNA	Joint Strategic Needs Assessment
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983, as amended
NSCN	National Safeguarding adults Child's Network
RCRP	Right Care; Right Person
RMN	Registered Mental Health Nurse
SAM	Surrey Adults Matter
SAR	Safeguarding Adult Review
SaBP	Surrey and Borders Partnership NHS Trust
SCARF	Single Combined Assessment Risk Framework
SCC	Surrey County Council
SPOC	Single Point of Contact
SSAB	Surrey Safeguarding Adults Board
TAP	Team Around the Person

1. Introduction

1.1. In December 2024 the Surrey Safeguarding Adults Board [SSAB] commissioned a thematic safeguarding adult review [SAR] following the death by suicide of two adults, known by the pseudonyms 'Agatha' and 'Nick' for the purposes of anonymity to protect the privacy of their surviving relatives. Both Agatha and Nick experienced serious mental ill-health, and both died shortly after they had attended local A&E departments in crisis where they were assessed by psychiatric liaison.

1.2. The SSAB and the SAR subgroup recognised that the circumstances of both Agatha and Nick's death met the criteria for a mandatory SAR under s44 Care Act 2014. However, cognisant of previous reviews conducted by the SSAB which included similar characteristics for the adults at risk, the scope of this review was focused on additional learning for the partnership. Partner agencies involved in providing care, treatment or responding to identified risks intended to safeguard Agatha and Nick submitted chronologies. In addition we have drawn from information provided by partner agencies, to support focus group discussions with practitioners, senior leaders across partner agencies and the SAR Panel to inform the findings of this review. The learning produced through this SAR concerns 'system findings'. System findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

1.3. SSAB and review author gave very careful consideration to the involvement of Agatha and Nick's family into this review. Mindful of the time that had passed since their deaths, the proximity to both Inquests and that these reviews were commissioned to provide an overview on the additional lessons for partners following recently published SAR reports, the reviewer was asked to draw on information available from case records and publicly available material to voice their views where these were available to avoid further distress to their families. SSAB are committed to working with families and adults who have lived experience including those bereaved by suicide, to take forward the recommendations from this report and support effective implementation of Surrey's suicide prevention strategy.[1]

1.4. The review was asked to explore:

- What has changed locally following the recent SAR learning for adults experiencing multiple disadvantage? Are multi-agency, multi-disciplinary approaches more common?
- Have policy or procedural changes since both deaths (including the implementation of 'Right Care; Right Person') improved practice for sharing concerns between emergency responders and other relevant agencies?
- How does the system protect staff against compassion fatigue or normalisation of risk?
- What more needs to be done to develop communities of practice with regards to suicide prevention?
- Is it harder to embed such approach where adults at risk are accommodated out of area?

2. Local and National Context

2.1. Set out in detail below at appendix A are the multifaceted considerations practitioners, seeking to intervene to prevent suicide, must consider when employing legal powers to provide treatment. Key to weighing up when, how and what legal powers might apply requires professional judgement based on the foreseeability of harm[2] which is formulated on an

[1] Full details of which are available at: https://www.healthysurrey.org.uk/mental-wellbeing/professionals/suicide-prevention-strategy#section-3

[2] It is recognised that targeted safeguarding duties arise (under s42 Care Act) where there is reasonable cause to suspect abuse or neglect. In addition to those duties, failure to act to prevent foreseeable harm could, in a legal context, amount to a breach of a duty of care and it is for this reason that this term is used within this report.

understanding of multiple factors, such as indicators of need and/or distressing events that might mean someone is at imminent risk of harm.

2.2. Sadly, national data indicates that death by suicide has increased in recent years, though Surrey has seen a slight reduction and remains below national comparators.[3] It is important to recognised that deaths from suicide are preventable and equally acknowledge the wider adverse impact felt by families and communities. Details of local and national support available for those affected by suicide is detailed in Appendix B below. In 2023 a national suicide prevention strategy was published. Locally Surrey Council and the NHS partnership (Healthy Surrey) also published their suicide prevention strategy. Both recognise there is no single risk factor for suicide and that prevention does not sit with any single organisation; rather a successful strategy requires agencies and communities to work together '*through identification of risk, public health interventions and high quality evidence-based care'*.[4]

2.3. Local data highlights that people who die by suicide are more likely to have complex needs, including disability, history of abuse, history of previous suicide attempts or serious self-harm.[5] Just over half of people who die by suicide share their suicidal thoughts with someone. The majority did so with a family member, closely followed by a health professional. The strongest risk factor for suicide is a previous suicide attempt - 37% of individuals who died by suicide had a previous suicide attempt. As such, this should be considered an indicator of high risk which is likely to require immediate response from those with public law obligations to protect life,[6] especially if there are other additional risk factors. Common risk factors include a diagnosis of a mental health disorder (e.g. depression) or other long-term conditions (including chronic pain or addiction), recent relationship breakdown or bereavement, poverty or debt, experiencing coercive and controlling forms of abuse or social isolation/ loneliness.[7] In common with Agatha and Nick's experience, locally a quarter of individuals who died by suicide were in contact with mental health services at the time of their deaths.

2.4. In 2024 the SSAB published 10 Safeguarding Adults Reviews following the deaths of adults with care and support needs in circumstances which suggested there was learning for agencies about how they could work more effectively together to protect adults experiencing abuse and neglect. Many of the findings of those reports are pertinent to this review and the SSAB confirmed they are currently overseeing agencies actions plans to enable:

- Development of Making Every Contact Count [MECC] guidance, including a 'Team Around the Person' [TAP] approach for adults experiencing multiple disadvantage - recommended in the Peter SAR.
- Improved contingency planning for patients at higher risk of absconding, given s4-5 MHA does not apply to A&E settings. Partners are also asked to report on steps taken to address workforce capacity issues to improve timely MHA assessments within A&E settings - recommended in the Aulia SAR.
- Better systems responses so organisational neglect does not contribute to preventable deaths - identified in the Eddie and Sam SARs.

[3] In 2023 the national rate was 11.4/100,000 (increased from 10.7/100,000 in 2022. Surrey report 8.8/100,000 in 2023 compared to 9.5/100,000 in 2022. Taken from ONS data available at:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/latest

[4] Taken from Healthy Surrey's suicide prevention strategy available at: https://www.healthysurrey.org.uk/mental-wellbeing/professionals/suicide-prevention-strategy

[5] The Healthy Surrey strategy reports 'One in five of those who died by suicide in Surrey between 2017-20 were recorded to have a disability, one in three had a history of violence and abuse (either as perpetrators, victims or both), and one in three had a previous history of self-harm. 57% acknowledged either alcohol or substance use before death. This largely covers individuals who had a combination of long established alcohol use and/ or drug misuse. However, only 3% of the individuals who died by suicide were in contact with specialist substance misuse service prior to death

[6] In line with positive obligations under the Human Rights Act 1998 (article 2).

[7] Public health's research identified that to address social isolation, those at high risk of suicide require meaningful connection. They explained in practical terms this requires agencies to report on actions they have taken in response to risk, to overcome any sense of hopelessness or abandonment.

- Better systems responses so poor coordination between agencies, including information exchange where missing persons are at risk of suicide are addressed, recognising a lack of available mental health beds also was a factor in the Ella, Louise and Aulia SARs.
- Better use of support (including services offered by SaBP) for adults with co-exiting mental health conditions and substance dependency as recommended in the Zahra SAR.
- Improved recognition that exploitation, domestic abuse and the adverse impact of past experiences on long-term psychological harm to women must be reflected in risk assessment and treatment plans - as recommended in the Tracy and Laura SARs.
- Access to treatment options so these are available to support adults who have survived adverse childhood experiences or sexual abuse. Partners recognise the need for treatment options to also reflect additional needs arising from neurodiversity, post-traumatic stress disorder and personality disorders and/or who present with self-harming/neglect in light of findings from the Eden and Rose SARs.

2.5. The challenges of providing quality, trauma-informed care to individuals with complex or co-occurring conditions is well recognised, including by SSAB partners as these are set out in detail within the SSAB's April SAR report, published in 2025.[8] National guidance, including NICE clinical quality standards, already exist to support practitioners and clinicians apply good practice. The April report references these national guidance, practice briefings, local policy and case law to evaluate what, if anything, makes it harder for practitioners to meet expected standards of care. This report therefore provides further evidence of the urgent need to address system issues which remain to further encourage SSAB partners to act on the recommendations, both locally and nationally to prevent future harm.

3. Case Narratives

Agatha

3.1. Agatha died in April 2023 by suicide. She was 46[9]. Prior to her death, Agatha had lived most of her life in Reading. Two months before her death, she had moved to a domestic abuse refuge in Surrey following release from prison.[10] Agatha had a history of drug and alcohol abuse, she had also experienced trauma throughout her life. She had disclosed sexual abuse (both as a child and more recently from another resident in hostel accommodation in Reading). She disclosed suffering physical and psychological abuse from an ex-partner, reported to Thames Valley police between 2015-2020. It was also known she had lost children into the care system and had no on-going contact.

3.2. Recognising her need for support, the refuge staff had referred her to Surrey and Borders Partnership's [SaBP] I-access service[11]. They assessed her in March 2023 and intended to refer her to SaBP's Community Mental Health Recovery Services [CMHRS] for support. Sadly this referral was outstanding at the time of her death, and the I-access staff explained this was due to pressure of work. Refuge staff also repeatedly raised concerns regarding her mental ill health. In mid-March due to presentation of paranoid delusions she was taken by ambulance (with police support as she was carrying a nailfile 'for her own protection') to A&E. There she was seen by a psychiatric liaison nurse but discharged with no follow up plan. However, as she was already known to I-access, they were informed of the discharge and tasked with following up. It does not appear, however, that I-access robustly reviewed the information from Psychiatric

[8] Available at: https://www.surreysab.org.uk/wp-content/uploads/2024/09/April-SAR-shortened-report-for-publication-Final-February-2025.pdf
[9] In light of recommendations from the national SAR analysis to report all relevant protected characteristics, Agatha was a white British woman, had a known disability (mental ill-health and substance misuse). Details of her religious belief, if any, are not recorded
[10] This was following a charge for carrying a knife which she claimed was for her own protection
[11] Though it is worth noting that, in February 2023 (prior to her move), staff from Reading's drug and alcohol services had transferred her care so she was already known to the I-access service.

liaison. The refuge staff continued to seek intervention from SaBP single point of access [SPA], I-access, CMHRS and CRISIS line but received no response.

3.3. In late March Agatha attended a police station exhibiting signs of mental ill health and paranoid, concerned for her own safety. During their conversation with Agatha, the police officer couldn't review her police record as Agatha presented in a distressed state, so was unaware that she had previously been arrested for carrying a bladed article. They did, however, recognise Agatha may require additional support. After she had left the station, the officer completed a Single Combined Assessment of Risk Form [SCARF] to notify the local authority of their concerns. Unfortunately, this was not submitted until after 5pm so not processed until after her death. Police did not share concerns or risks with refuge staff. Later that day Agatha attended A&E but was assessed by psychiatry liaison nurses[12] and offered a home treatment team assessment. She declined and was discharged in early April 2023, the on-call psychiatrist subsequently entered a note of the case records confirming they agreed with the assessment and plan. Her body was found the following morning. The Inquest concluded she died by suicide, but found her death was contributed to by neglect as she '*should have been admitted to hospital for a diagnosis and treatment of her mental health condition'.*[13]

Nick

3.4. Nick died in September 2022 following a road collision. He was 25 at the time of his death[14]. He had a long history of poor mental health, including two compulsory in-patient admissions during 2017-19. He had been diagnosed with schizo-effective disorder. Initially, on discharge from the in-patient unit he was subject to a Community Treatment Order, but was discharged from that in June 2021. He remained subject to ongoing outpatient care (in line with the Care Programme Approach[15]) and consented to medication (Trifecta) via depot every three months. His treating team were unable to confirm if, in the year prior to his death, he was compliant with the depot. His daily support was provided via a Hampshire supported living placement. Shortly prior to his death, the provider had raised concerns his behaviours were more aggressive as his alcohol and drug use had recently increased, following a backdated benefits payment[16]. He had also missed appointments with his mental health support worker and GP and the accommodation support staff had raised concerns he was not taking his medication as prescribed.

3.5. In September 2022 Nick was reported to the police as missing by the supported living provider. He was located by the police two days later at his mother's home (so their s136 MHA powers were unavailable). However, as he had disclosed taking an overdose, police staff persuaded him to allow them to take him to A&E where psychiatric liaison completed a risk assessment, noting he was disoriented in time and place, lacked insight and capacity, and that he was at high risk to himself as was self-neglecting (impacting on his sleep, appetite and non-compliance with medication). They noted he was unable to remember where he had been for the last two days and that his use of drugs and alcohol would increase his risk of acting on impulse and his vulnerability. This concluded that the local authority's Emergency Duty Team [EDT] should complete an urgent assessment under the Mental Health Act 1983 [MHA] to consider if compulsory powers could be used to detain him for treatment as he was at high risk of harm due to suicidal ideation. The psychiatric liaison assessment also recommended he should be subject to 1:1 supervision by a Registered Mental Health Nurse [RMN] due to risk of absconding. Due to workforce pressures, EDT staff did not complete the assessment under MHA, there were

[12] The assessment noted "*no evidence of mood disorder, no depressive features, no anxiety, and no mania. [Agatha] said that she was fleeting suicidal ideation when under stress. Denied suicidal ideation during the assessment. [Agatha] seemed to have good insight into her problems. She said that she recognised that she was struggling due to some social stressors and mental health… appeared to be drug seeking and or was seeking to move from the Sanctuary. [Agatha] said that she was no longer happy staying at the Sanctuary and needs be admitted into hospital. There was no clinical indication for an admission. PLAN- Discharge from psych liaison, inform the GP, encouraged [Agatha] to use Safe haven and the crisis line, RASAC information given but declined. Contact Mind matters for therapies."*

[13] Taken from the Coroner's narrative verdict

[14] Nick's relevant protected characteristics are that he was white British, had a known disability (mental ill-health) and was Roman Catholic.

[15] More information is available about this approach at: https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[16] He had received backdated payment from the Department for Work and Pensions of his Personal Independence Payment.

also no mental health beds or 1:1 RMN support available at that time. To mitigate his risk of absconding, Nick was moved to a bed near the nursing station. His mother was also present (until 6.45pm). Shortly after his mother left the hospital, Nick confirmed to staff that he was willing to go voluntarily to a mental health in-patient unit for support. Hospital security staff were instructed to support staff to prevent him from leaving at 7.18pm, but by 7.51pm he had absconded. Police were informed he was missing, but he was not located until the fatal accident.

3.6. Following his death, an enquiry undertaken by the local authority (in line with duties under s42 Care Act) found 'evidence of neglect' by hospital staff citing the lack of a contingency plan for 1:1 and failure to consider an alternative legal frameworks to detain (e.g. under s4B MCA). The enquiry also queried if there were missed opportunities for community based mental health support teams to intervene to support Nick prior to A&E attendance in September.

4. Case Analysis

KLOE 1: Supporting Adults Experiencing Multiple Disadvantage

This section will explore what has changed recently in response to wider learning (including from published SARs) to better support adults experiencing multiple disadvantage. It will explore if multi-agency, multi-disciplinary approaches more common and what, if anything, might be needed to further enhance these approaches?

4.1. Both Nick and Agatha experienced multiple disadvantage, both had been known to services as at high risk of abuse or self-harm/neglect. Surrey Adults Matter [SAM][17] is the local process used to reduce the risk of poor outcomes often associated with adults experiencing multiple disadvantage. The good practice of SAM was recognised in the Peter SAR, but there was recognition this approach was not fully embedded across partner agencies. Whilst SAM report they have worked with over 180 individuals in the first 5 years of this programme, neither Agatha nor Nick had been referred. During the learning events, practitioners recognised that the SAM approach could have wider application beyond those who would be directly supported by SAM.

4.2. In response to learning from the Peter SAR, SSAB have succeeded in providing comprehensive guidance on the safe admission and discharge for care of prisoners into acute hospitals. This 'prison pathway' guidance focuses primarily on safe transfers of care between prisons and acute hospital settings. At the time of this review's learning events, the guidance had not been finalised or widely disseminated. Partners really welcomed this work as they were cognisant of the significant and diverse health needs of prisoners, including high rates of mental health problems, substance misuse and chronic diseases, as well as health inequalities experienced by prisoners. The work provides a clear pathway for transferring care between the settings both for planned and emergency admissions and offers practical guidance on resolving common continuity of care and security issues. It is therefore likely to have wider, national importance and should be shared with the NSCN as evidence of good inter-agency partnership policy development.

4.3. This work could also help strengthen local practice in planning prison releases for those who have care and support needs. Research undertaken by the Prison and Probation Ombudsman[18] into deaths occurring within 14 days of prison release (of which at least 14/137 were by suicide) recommended HMPPS improve the release planning process to include health and homelessness needs, so that those needs are considered early especially where plans to address these might be complex. Agatha, prior to her move to Surrey, had been held within the prison estate. She had moved to Surrey to access refuge accommodation as a survivor of domestic abuse. During the learning events, staff from the refuge explained they received very

[17] Full details of the approach and offers under this programme are available at: https://www.healthysurrey.org.uk/community-health/making-every-adult-matter
[18] Available at: https://ppo.gov.uk/news/post-release-death-investigations-reveal-homelessness-on-release-is-a-considerable-issue/

little information about Agatha's needs or likely risks at the point of referral. Given the nature of their work, most people they support have complex needs linked to trauma (often resulting in long-term psychological and physical conditions). Whilst they are confident to assess such needs and make appropriate referrals, they wished to use this report to remind partners they do not have expertise to treat mental health or addiction conditions so require help to access such expertise. It is commendable that Agatha was quickly referred and supported to attend appointments so she could access SaBP's I-access service.

4.4. Practitioners from housing support services reported often there was a misunderstanding by other professionals about the nature of support available, with many assuming their housing support staff have responsibilities to manage care need or monitor for signs of worsening health. They explained their staff have often developed an understanding of how to support access to information and assistance regarding entitlements to welfare benefit, housing, immigration, health and social care. However, it is usually prohibited (because housing related support will not be registered with the Care Quality Commission) to provide personal care. As such housing related support workers will usually only be expected to encourage residents to seek help (e.g. from other providers or their GP) and support them to do so. Providers will have no legal powers to compel residents to seek assistance. Too often, they reported, assumptions about the support they can provide results in statutory services downgrading their risk assessments of individuals in receipt of their support.

4.5. Equally frustratingly, though many support staff have gained practical experience of identifying escalating risks (especially those relating to deteriorating mental health and suicidal ideation) they reported far too frequently their representations are not given sufficient weight by statutory services. These concerns mirror the issues raised by the Coroner in Agatha's inquest, particularly the apparent disregard for the safety of refuge staff following Agatha's disclosures which suggested her paranoid delusions and hostility might be targeted towards refuge staff in response to the support they had offered. During learning events practitioners were keen to find practical ways, given resource and workforce capacity issues across all partners, to explore how the framework for multi-agency 'team around the person' approach could be socialised more widely. They spoke of parallels with how safeguarding enquiry practice had changed in the last few years, so that there was less expectation to hold in-person multi-agency meetings, but that strategy discussions could happen quickly across organisations and disciplines using on-line virtual platforms. They hoped that, rather than wait until concerns reached safeguarding thresholds, it would be possible to adopt the same approach to respond to risks at an earlier stage. Key to this would be to ensure recommendations already identified from SSAB's published SARs are actioned and that information is disseminated to frontline practice, including within provider and third sector organisations. Particular regard should be had by SSAB partners when developing the contingency planning guidance in response to the Aulia SAR recommendations as to how housing support and third sector organisations will be involved in risk evaluation and management.

4.6. It is noted that in September 2024, following Agatha's death, SaBP updated their standard operating policy for the psychiatric liaison service, this aims to improve clinical practice by ensuring suitable efforts are made to collect collateral information and formulate a safe discharge plan as advocated by the Royal College of Psychiatrists and NICE guidance[19]. Given the Coroner's prevention of future death concerns, SaBP should also clearly articulate within that guidance the expectation that collecting collateral information should also extend to a requirement clinicians share information with relevant organisations (ideally through a TAP approach) to enable housing support providers' risk assessments given their duties to the adult at risk, other vulnerable residents (including children) and their staff. In response to the Coroner's request, SaBP reported an audit had seen a 10% rise in compliance with the new

[19] See guidance available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/htas/practice-guidelines-for-crisis-line-response-and-crhtt%27s-2022.pdf?sfvrsn=b0bd5805_2

expectations to gather collateral information, SaBP should also consider repeating the audit exercise and reporting to the SSAB the compliance rate for their clinical staff sharing information (including with CMHTs and housing support staff) to support safe risks assessment by providers in community settings.

4.7. Those involved in the learning events were unaware if progress had also been made to review 'dual diagnosis' pathways, i.e. the provision of integrated care and treatment for adults with both addiction and mental health conditions. In March 2025 SaBP produced a Co-occurring Substance Ise and Mental health Guidance for their staff. They hope to work with the local authority so that this guidance can also inform practice within social care going forward. Given Agatha and Nick's experiences, this review should serve to remind senior leaders within SaBP, Surrey Council and ICB commissioners of the importance to ensure that there is clarity between teams designed to provide crisis or initial interventions (such as the I-access, Crisis line or psych liaison within acute hospitals) and community mental health teams. These areas for improvement were recommended within the Rose SAR[20]. Sadly, the finding of this thematic review again amplifies the need for policy improvement to be socialised into practice across health, criminal justice and social care organisations and for SaBP to provide assurance to SSAB that action taken has improved timely access to personalised care. We have not made further recommendations in order that this does not duplicate or dilute the actions agreed from earlier reviews.

4.8. Within their response to the Coroner, SaBP advised they have also enabled referrals into the single point of access from third sector organisations[21]. Practitioners and senior leaders from third sector organisations reported that they had seen some improvement within their community, early intervention provision but that adherence to guidance was patchy. They reported some third sector service managers have recently found it easier to refer for SaBP teams for urgent interventions, but that this wasn't the experience of those providing housing support (such as refuges). During learning events practitioners explained it could still feel very siloed. They explained whilst there is now a 'common language' across organisations regarding risks arising from domestic abuse, the same isn't true of mental health. Staff reporting they did not know the 'golden words' needed to get past gatekeeping for services. They wished to see a 'grab guide' for frontline practitioners (aimed at third sector and emergency responders) to assist them articulate that risks had urgently escalated to better inform clinical decision making, particularly within community mental health teams. Recommendation 3 relates to this request.

KLOE 2: Interagency Urgent Safeguarding Risk Assessment Processes.

This section will explore whether changes to local policy and procedures made following Nick and Agatha's death have improved inter-agency communication of urgent risk. Given the concerns raised during Agatha's Inquest, particular regard is given to communication between emergency responders within the police and organisations supporting adults at high risk, particularly if they leave A&E.

4.9. Both Agatha and Nick, shortly before their attendance at A&E, were in contact with police staff. Police responded to the provider's concerns that Nick was missing demonstrated compassionate risk management, utilising their skills (because they were unable to use legal powers under s136 MHA) to get him to hospital following an overdose. Similarly, the officer responding to Agatha recognised her distressed state and submitted a referral (according to local procedure at the time) through SCARF. The Coroner raised concerns that the SCARF process was inadequate to address the risk that Agatha, in her distressed state, posed to herself or the public given her offending history. In response to the Coroner's concerns, Surrey Police have reminded staff that they are able to request support from the Force Control Room to complete checks whilst officers engage directly with those in distress. They accepted this should

[20] Recommendations 9,10,11 in Rose review.
[21] That is voluntary, charity, faith and community sector organisations

have been done whilst Agatha was present to inform the officer's decision making. Although Surrey Police' contact centre no longer has a dedicated mental health advisor, frontline officers do have handheld devices to review police records, they are also able to make contact (24/7) with SCC's EDT and SaBP's SPA for advice. Sadly, the intended service for 2025 Guildford town centre to have a mental health triage streetcar service has been placed on hold, due to limited resource with SaBP.

4.10. It is important to note that the officer responding to Agatha completed research after Agatha had left the station and raised concerns via the SCARF process. Their assessment at that time was that Agatha didn't require immediate mental health support without which she would pose a risk to herself or others. The officer's decision to report their concerns via SCARF was supported both at the time by their supervisor and, following Agatha's death, by the mental health lead. Surrey police, in their response to the Coroner, explained the officer did not suspect she may have been carrying a weapon, so would not have had legal grounds for searching Agatha.

4.11. Surrey Police, SCC and SaBP all confirm that the SCARF policy and process was never intended as a tool for immediate crisis management to address unmitigated risk. This should be done via immediate contact with SaBP's and SCC's SPAs.

4.12. In October 2024, alongside the introduction of the 'Right Care; Right Person' policy nationally, Surrey Police revised their guidance to frontline staff (following consultation and agreement from SCC's adult and children social care teams) to ensure information shared with social care regarding safeguarding risks better identified and prioritises risk in a manner that enables increased automation. The new format follows similar principles to SCARF but asks specific questions around risk and key safeguarding issues, requires confirmation that the adult at risk knows about the notification and indicates if they have consented[22]. As with the SCARF process, any officer completing the new 'SIGNs' form, then submits this for triage to Surrey Police's SPA who check and include any relevant information held on previous SCARF forms within the preceding 90 days to inform social care's risk assessment.

4.13. During the learning events Police reported the 'Right Care; Right Person' [RCRP] policy had become business as usual and is demonstrating positive impacts for police and partners. They explained that this is predominantly a policy to assist call handlers triage calls from the public and partners, but that it has a built in immediately review process if callers disagree with decisions not to deploy officers in any situation. Police staff involved in this review explained whilst they have had very few cases where such a review has been requested, they do review every referral for an Inquest, SAR or similar mortality review to explore if, where appliable, the RCRP policy was properly applied. Any issues identified are referred to His Majesty's Inspectorate of Constabulary for independent oversight; to date this has only be necessary in 2 cases.

4.14. It is noted that, in common with the practice at the time, a s42 safeguarding enquiry was conducted following Nick's death which concluded neglect had contributed to his death. It is understood the s42 enquiry was undertaken by SCC social care staff who may not have had access or considered the clinician guidelines when reaching their determination. For the avoidance of doubt and for the reasons explained below, this report rejects that finding. Staff within the A&E department were not negligent of the risks and sought to manage these mindful of the legal duties owed to him and the available resources and legal powers at their disposal. During the learning event discussion there was widespread agreement that it was often extremely difficult (due to limited resources beyond the control of SSAB partners) to ensure

[22] It is important to note that there is no requirement that they consent, as information is shared legally if the officer believes it is proportionate and necessary to prevent or address a safeguarding risk. It is simply good practice, that helps to develop trust in police and support services to inform the adult and, where possible, seek their agreement.

MHA assessments can always be completed within the 'urgent' timeframe of 4 hours advocated within national guidance. In part this is due to national shortage of staff to complete the assessment, given that demand is increasing[23]. Skills for care estimated there to be 1500FTE Approved Mental Health Professionals in England. Over 50% of local authorities have a singular duty system covering the provision of AMHPs for emergency mental health assessment. The number of AMHPs per head count is the lowest in South East England and is falling. Their report[24] advised the Government that to fully staff a 24-hour response service there would need to be an uplift of 35% against this figure, yet currently there was a vacancy rate of 12.7%. The report also warned that succession planning is essential and urgent, given a likely 25.5% reduction (from retirement) of professionals in the next 5 years.

4.15. Whilst Nick had been assessed as lacking capacity it would not have been lawful or practical to use s4B MCA powers to deprive him of his liberty, as staff did not intend to apply to the Court of Protection for an order to treat him 'in his best interests'. Instead, it had been agreed he would require an admission into an in-patient mental health bed. Nick had indicated he would accept an admission voluntarily to a mental health bed, but also arrangements had been put in place to conduct an urgent MHA assessment. Case law is very clear where practitioners have powers under both MHA and MCA, the MHA must prevail. Weighing up multifarious factors so responses reflect the least restrictive options to provide care is extremely difficult in any situation. It is made more difficult within busy departments set up to deliver emergency treatment predominantly for physical health issues. During learning discussions staff from across the partnership recognised limited resources within A&E to support adults in mental health crisis. They were very aware that such demand has significantly increased and that trying to mitigate risks within A&E settings was less than ideal. There was also recognition that local decisions to mitigate this risk by increasing crisis beds had not fully addressed this, as what was needed was improved flow (similar to the issues within acute hospitals). They wanted to see a change in practice to prevent frequent re-attendance for adults with severe and enduring mental ill-health, but ensuring through policy that discharge planning started (as it is required to do for physical health conditions) very soon after any admission. Such practice change would, they believed, enable better strategic planning to improve provision of step-down beds and sufficient resource for onward referral to support someone in their mental health recovery. This issue has already been identified as requiring urgent strategic attention and featured in the 'Ella' SAR, published after Agatha's and Nick's deaths. Those reviews recommended changes were made to police recording systems following incidents which indicated suicidal behaviours and also that SaBP develop a monitoring process to identify delays in mental health admissions so that risks could be escalated both in real time and used strategically to inform local Joint Strategic Needs Assessments [JSNA]. Again, this review has not made additional recommendations to address this but would strongly endorse the need for urgent, coordinated action by SSAB partners to action those earlier recommendations.

4.16. Practitioners from acute trusts attending the learning events reported they work hard to mitigate risks that adults at risk of suicide might leave hospital without getting the assistance needed. They explained they look to use side rooms to offer calmer environments, though (as these are set up to provide emergency physical treatment and monitoring) this practice also carries risk as they cannot be made 'ligature free'. Staff understood why the psychiatric liaison recommended Nick be supported by 1:1 RMN provision but explained this would be the responsibility of the acute trust but it is not a service that either SaBP or any acute trust was commissioned to provide. As such, this needed to be authorised on a case-by-case basis, meaning it was also not always feasible to arrange this at short notice. Within some settings, staff can call on trained healthcare staff to offer this, but it must be understood that anyone providing care within an A&E setting may not have expertise, practical resources or legal powers

[23] It is estimated this has risen by at least 2.5% in 2023-24, taken from NHS Digital report available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures

[24] AMHP workforce in the social care sector, DHSC (2024) available at: https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/AMHPs-Briefing-2024.pdf

to compel an adult to remain for treatment[25]. Practitioners involved in this review also highlighted how they work is very different to how support would be offered by a psychiatric intensive care unit, e.g. search policies are very different. They recognised the need for local guidance to assimilate best practice to support those at high risk of suicide as, very often, adults at risk will also present with physical injuries which does require their expertise. Recommendations 1,2 and 3 are intended to address this issue.

4.17. It is understood that in 2022 patients would only be admitted into an acute hospital if they had a physical health issue, now there is agreement to admit those at highest risk to wards if there are available beds and it is necessary for their safety. This enables ward-based staff to utilise s4 MHA to temporarily detain someone at high risk, but everyone involved recognised this was not an ideal solution. As noted above, the lack of urgent mental health resource is compounded locally and nationally by poor discharge planning for adults at risk who are admitted and require ongoing step-down provision to reduce risk to a level that would constitute a safe discharge. Again, this thematic review only serves to reiterate concerns raised in numerous SARs published by SSAB and nationally. The NSCN has also escalated this issue to the DHSC as this is beyond the capacity for local SABs and partners to rectify alone.

KLOE 3: Protecting Against Normalisation of Risk and Compassion Fatigue

Drawing on the learning already identified in SSAB's published SARS, this section explores opportunities for SSAB partners to improve organisational support in identifying and rectifying circumstances that increase risks of organisational neglect.

4.18. As noted above, this issue has featured heavily in several SARs already published by SSAB and nationally. It is important to clarify that more detailed review of both Nick and Agatha's case files demonstrates practitioners acted mindful of their duties, where there were limitations in safe care this was because those responding to Agatha and Nick in crisis had limited resource or sufficient collateral information to manage the urgent risk. Equally, in both cases housing support staff had raised repeated concerns to CMHRS asking for additional support prior to crisis emerging. What is needed, therefore, is greater oversight and accountability for decision making, not only at the point of crisis but also across care management pathways so that notifications of changes in a person's presentations trigger appropriate review by those teams. Recommendations 3 and 4 are intended to complement earlier recommendations to address this issue.

4.19. Practitioners involved in this review welcomed the idea of toolkits to help staff better articulate needs which are beyond their ability to safely manage. They also welcomed work done by relevant partners nationally to prevent harm from foreseeable risks, such as the work done in response to national SARs by the Department for Work and Pensions to support safer practice when making large back payments of benefits.

4.20. SCC's framework of need[26] differentiates between 4 levels of help available. The 'Rose' SAR recommended amendments to this document (since undertaken) to reflect that an assessment under the Care Act may not be the most appropriate response to a safeguarding risk. As with recommendations within the 'Eddie' SAR what is needed to protect against normalisation of risk is for organisations involved in assessment, care or treatment pathways to collaborate, offer flexible appointments to encourage pro-active engagement and/or for those with relevant expertise to have flexibility within their own organisational operational policies to offer ongoing guidance to practitioners providing the daily care. Multi-agency, systemwide quality assurance frameworks (such as those overseen by SSAB) should have mechanisms in place to secure oversight and hold organisations to account, identify where gaps in services or insufficient

[25] See appendix A.
[26] Available at: https://www.surreysab.org.uk/wp-content/uploads/2023/07/Adult-Social-Care-Levels-of-Need-V6-June-2023.pdf

resource is exacerbating foreseeable risks so these can be escalated to national or local bodies accountable for funding allocation. Recommendation 4 is intended to address this issue.

4.21. There is also a need to explore how partners could work together to protect the workforce exposed vicariously to trauma. During the learning events those practitioner spoke honestly about the impact Nick and Agatha's death had on their staff, including long-term psychological trauma. They explained that sense of isolation from continued siloed approaches left their staff notably anxious to offer support to adults presenting with complex mental health conditions, addiction and/or offending history. Some teams, including third sector providers, reported they were well supported with supervision and bereavement support. Similarly, Police Care UK have undertaken extensive research and provided tools to support officers who have been exposed to traumatic events aware of the impact this has on their own wellbeing.[27] Surrey Police reported the loss of colleagues to suicide, so they were acutely aware of long-term impact to exposure of trauma. In response their wellbeing team plan actions including mental health first aid training and trauma-informed approaches for all staff. Sadly, such offers are not universal across partner agencies.

4.22. Building on those initiatives, emergency responders and staff working within A&E settings would also benefit from clearer organisational support to ensure their professional decision making is fairly evaluated, accepting that it will not always be possible to eliminate all risk that a patient might abscond or go missing whilst waiting for crisis mental health support. There is also a need to explore how partners could work together to protect the workforce exposed vicariously to trauma. Some teams reported they were well supported with supervision, bereavement support etc, but this was not universal. Recommendation 1 is intended to support SSAB partners to explore systemwide offers.

KLOE 4: Developing Communities of Practice to Enable System-Wide Suicide Prevention Activity

This section explores support currently available to enable multi-agency risk management and delivery of suicide preventative approaches.

4.23. It was widely understood that survivors of adverse childhood experience, multiple exclusion or domestic abuse almost always present with complex needs and, because of the intersectionality of multiple disadvantage, are at far higher risk of suicidal ideation. As noted above, it should not be assumed provider staff or emergency responders can manage this risk alone. Staff spoke with confidence about using local escalation policies to raise concerns in individual cases, but reported they were less confident this led to systemwide improvements to practice.

4.24. There is specialist support available locally, including through voluntary sector organisations, to provide early intervention for people at higher risk of suicide, including for women who (like Agatha) had children removed from their care. As was evidenced by Nick and Agatha's experiences, voluntary sector and housing related support often provide a crucial first line of defence for suicide prevention. SCC public health currently collect data and provide a JSNA in respect of multiple disadvantage across Surrey. Historically this provided a clear evidence base for funding housing related support as part of a wider prevention legal duty (under s2 Care Act) and the legal duties to prevent homelessness (in line with duties introduced through the Homelessness Reduction Act 2017). Present funding pressures that all local authorities, including Surrey, are experiencing will likely jeopardise continued funding for services seen as 'non-statutory' including housing related support despite the very real needs these address and the reduction in demand for acute services these provide. This review has recommended urgent representations are made so the implication of adverse impacts on funding decisions are fully understood by executive and political leaders.

[27] More information is available at: https://www.policecare.org.uk/help/ptec/

4.25. During learning events staff from across partner agencies spoke of how their organisations were working to develop organisational support to improve responses to suicidal ideation. SaBP report they have a suicide prevention lead who is working towards implementing across their organisation a suicide risk assessment framework that reflects national NICE guidance and the learning from recent reviews into deaths where domestic abuse was a factor. Surrey Police reported all new officers receive awareness training regarding mental health and on suicide prevention. It is also proposed that all officers also receive dedicated mental health first aid training.

4.26. The Police also have a suicide prevention advisor who is working closely with SCC's public health department to monitor real time suicide surveillance to offer immediate prevention and post-intervention support to those bereaved by suicide. This work has also enabled mapping of local 'hotspots' and key themes so that awareness raising activity is appropriately targeted. Sadly, they reported to this review that funding for this initiative is due to end in October 2025. This will likely reduce capacity for ongoing senior leadership to facilitate improvement to practice. It is also noted that presently there is no service funded to provide bereavement counselling in Surrey, nor one that offers welfare assessments, advocacy or support to children bereaved by suicide though both these issues are identified as actions under the strategic plan for 2023-26. The Healthy Surrey partnership also intend to offer training to frontline professionals and community members to support awareness of suicide bereavement. This could provide an opportunity to also raise awareness of higher risks for people experiencing multiple disadvantage and local guidance or tools for frontline and community members so that changes in a person's presentation trigger multi-agency TAP responses to review and offer wider, preventative support.

KLOE 5: Encouraging Preventative Practice when Adults At Risk are Accommodated Out of Area?

There is already a very large number of SARs, case law and academic research that highlights the increased risks for adults placed out of area both nationally and locally. Previous SSAB SAR's have already made recommendations aimed at improving cross boundary risk management, including for those required to move for their own safety (as Agatha was) or subject to s117MHA legal duties (as Nick was). This section, therefore, focuses only on additional concerns raised so that these can influence actions already underway in response to earlier recommendations.

4.27. Practitioners attending the learning events from Berkshire agencies explained within their area the NHS provide a RECONNECT service to assist anyone leaving prison for the first 28 days[28]. Currently this is only available to those residing in Hampshire and the Thames Valley. SaBP also offer a RECONNECT service so this should be available within Surrey. Given the problems identified in Agatha's case, SSAB (perhaps through their prison group) may want to explore the potential for positive impact this service could have if practitioners across SSAB partners are aware of this offer.

4.28. During the learning event, housing support staff explained failures to advise them that Agatha had made previous suicide attempts and her arrest for carrying a weapon ahead of her placement posed real dangers for other vulnerable residents (including children) residing within the refuge. It was common, they reported, for crucial information to not be included within a referral form, for example information about their experience of domestic abuse or complex needs. They felt this might be done by partners on the assumption that a referral would be rejected, but the real-life consequence for housing related staff is that it becomes impossible to offer suitable, safe support within their environment. This requires strategic leadership, from SSAB partners working with community safety leaders regionally (or, ideally, nationally).

[28] More information is available at: https://www.berkshirehealthcare.nhs.uk/our-services/mental-health-and-wellbeing/liaison-and-diversion-service/reconnect/ and https://www.england.nhs.uk/commissioning/health-just/reconnect/

4.29. Police staff explained their officers would still find it difficult to share information with third sector organisations even within Surrey as they have no central point of contact for providers and so would be reliant on the adult at risk to share this information or on SCC to share this following the SCARF notification.[29] Senior leaders should explore how greater oversight, now available under the Police's SIGNs process (which enables Surrey Police to report a richer dataset on the nature and types of risks, involvement of adults at risk and outcomes, providing a clearer picture of the strategic needs addressed by police staff) could be utilised to ensure information is shared and multi-agency risk management plans are agreed. This should be prioritised, in line with recommendations arising from SSAB's Rose, Eden and Ella SARs.

2. Conclusions and Recommendations

2.1 There are examples throughout this report of innovative work being undertaken across SSAB organisations and provider services to support the suicide prevention strategy and provide better care to adults experiencing multiple disadvantage. Sadly a significant proportion of that work is likely to see funding withdrawn or not renewed because of demand for public sector efficiency savings. SSAB partners will need to seriously consider, in light of those pressures and the previous recommendations in respect of improvements to care pathways and suicide prevention noted in other published SARs, if there is sufficient resource within SSAB organisations to meet the statutory duties under s44(4) to demonstrate they have acted to reduce risks of future harm.

2.2 Within this report we have already endorsed previous SAR recommendations and clarified that we do not intend to duplicate these here. As such only the following additional recommendations have been put forward.

2.3 **Recommendation 1**: Surrey and Heartlands ICB and acute trusts, working with SSAB to develop a protocol or guidance for practitioners undertaking serious incident or statutory review functions to ensure that attention is paid to the timeline leading up to any emergency response. Equal weight should be given within any investigation to duties to prevent harm as well as crisis responses. The guidance should clarify how public law and natural justice principles engaged with relevant organisations and ensure they provide contextual information and have a right to response before findings are finalised. This should also address how staff will be protected against vicarious trauma.

2.4 **Recommendation 2**: SaBP and the ICB should provide assurance that it has reviewed the local provision for psychological liaison and ensured those undertaking this role have sufficient resource to arrange voluntary admissions and, if not, there is a local plan for practice improvement. Where gaps continue, these should be raised (via ICB/SaBP senior leadership) to DHSC and included on SaBP and ICB organisational risk registers.

2.5 **Recommendation 3**: Locally SSAB should explore with partners whether the work undertaken by the SSAB Prison pathway task and finish group could also act as a blueprint to assist in the development of similar multi-agency pathway and guidance to aid effective multi-agency cooperation to prevent harm to those at higher risk of mental health crisis awaiting assessment or a mental health in-patient bed. For example, SSAB could adapt tools or produce a 'grab guide' to reflect local pathways and contact details to enable staff providing crisis care in A&E or police stations to more easily share information with community providers to protect against siloed working or minimising of behaviours associated with multiple disadvantage and suicide risk.

[29] This assumes SCC's ASC department would also have access to information about where someone was living. Agatha had been referred to the refuge from another area. It is highly likely therefore that SCC would not have sufficient information to address this risk.

2.6 **Recommendation 4**: Given the finding in this review and previously published SARs, SSAB partners should make representations to relevant local and national decision makers to highlight the danger that funding cuts to such services without strategic risk analysis of how current and future residents' needs will be met could prove counter-productive in terms of cost reductions and will very likely reduce capacity for operational staff to mitigate foreseeable harm to adults at risk experiencing multiple disadvantage.

Appendix A: Relevant Legal Considerations Practitioners must consider when seeking to intervene to reduce risks of suicide

All public bodies must exercise their legal powers in an ethical way that complies with duties to the adult under the Mental Capacity Act, Human Rights Act 1998 and Equality Act 2010. While Article 2 of the European Convention on Human Rights (ECHR) places a duty on public bodies to prevent avoidable deaths, this must be balanced against the right to freedom from inhumane treatment (Article 3), the right to liberty (Article 5) and respect for your private and family life (Article 8). The right to life is not an absolute right and a series of high-profile legal cases[30] show how the courts weigh these different, and at times competing human rights to take decisions, if necessary, in the individual's best interest.

Section 1 of the Suicide Act 1961 repealed the rule that made suicide criminal, although it did not make suicide lawful. "*It follows inevitably that our law does not penalise the decision of a competent person to take their own life. Moreover nor does the law prohibit them from so doing*…"[31] In recent years additional guidance has underpinned the importance of avoiding criminal sanctions or enforcement powers as a means to reduce risk from suicide. For example, NICE published updated self-harm guidelines in September 2022 advising practitioners must not use "*aversive treatment, punitive approaches or criminal justice approaches such as community protection notices, criminal behaviour orders or prosecution for high service use as an intervention for frequent self-harm episodes*."[32] In March 2023, NHS England published its position on the use of the Serenity Integrated Mentoring and similar models to manage mental health, explicitly stating that these approaches should not be used and that three key elements should be eradicated from mental health services. Firstly, avoiding the involvement of police in delivery of therapeutic interventions in planned, non-emergency community mental health care. Secondly, that the NICE guidance against use of sanctions, withholding care or other punitive approaches must be followed. Thirdly prohibiting discriminatory practices and attitudes towards patients who express self-harm behaviours, suicidality and/or those who are deemed 'high intensity users', including the labelling of patients by professionals as 'manipulative' and 'attention seeking'.

Practitioners should give careful consideration of the adult's ability to keep themselves safe, in light of the impact of presenting needs and emotional dysregulation. But, in doing so, practitioners must also have regard to duties under Article 5.1 ECHR which provides: *"Everyone has the right to liberty and security of the person. No-one shall be deprived of his liberty save in the following cases and in accordance with a procedure proscribed by law ...(e) the lawful detention of persons of unsound mind ...".* There are two primary pieces of UK legislation that provide a legal framework to deprive someone of their liberty because they are of 'unsound mind', the Mental Health Act 1983 [MHA] and the Mental Capacity Act 2005 [MCA].

Under section 2 MHA a person can be detained for the purpose of assessment for up to 28 days if an application for admission is made by an Approved Mental Health Practitioner [AMHP] or the patient's nearest relative. Two doctors must confirm that: a) The patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and b) He or she ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others. If they are assessed as needing to remain in hospital for treatment, a further application can be made under s3 MHA. The MHA contains mechanisms for a patient subject to detention to request a review before the Mental Health Tribunal and, provided powers are properly used, treatment and care plans will comply with Article 5 ECHR.

[30] For example see Barts Health NHS Trust v Dance & Ors (Re Archie Battersbee) [2022] EWFC 80 (15 July 2022) (bailii.org)
[31] Local Authority v Z [2004] EWHC 2817 (Fam) (03 December 2004) (bailii.org)
[32] Available at: https://www.nice.org.uk/guidance/ng225

Outside of treatment under the MHA, the provision of care and treatment is only lawful if the person receiving the care/treatment has either given capacitated consent or, if the person lacks capacity, acts are done in accordance with the legal obligations under the Mental Capacity Act 2005 and the Human Rights Act 1998. Case law has frequently made clear that "*every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be a criminal assault"*[33]

Where the adult is assessed as without capacity to decide care or treatment, the MCA provides a legal framework to make decisions on their behalf provided these formulated in the best interest of the adult. Best interest considerations are *'not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms. To state the obvious, the wishes, feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would be wrong in principle to apply any automatic discount to their point of view.'*[34]

Section 4B MCA '*permits a deprivation of liberty, but only for limited acts for limited purposes whilst a decision is sought from the court'*.[35] More generally, the MCA provides powers to local authorities (acting as the 'supervisory body') to arrange for the assessment and authorisation of a deprivation of liberty for a person lacking capacity provided they are residing in a hospital or care home – the Deprivation of Liberty Safeguards procedure (DoLS). Under DoLS a 'managing authority' namely the relevant care home or hospital must request authorisation from the 'supervisory body', namely the Council in whose area the hospital/care home is situated. The supervisory body then commissions six assessments to determine whether the deprivation can be authorised, three of which are particularly important. Firstly, the person's mental capacity to take a decision to agree to reside in the proposed placement must be assessed (the capacity assessment). A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is unable to make a decision for himself if he is unable to understand, retain, and weigh the information relevant to that decision, or to communicate this. The fact that a person is only able to retain the information for a short period does not prevent them from being able to make the decision. There is a presumption of capacity unless otherwise evidenced and a person cannot be treated as lacking capacity, merely because someone else considers their decision to be unwise.

The second key assessment is the Best Interest assessment, which is completed by the supervisory body to determine that the deprivation is in person's best interest, determined according to the principles set out in s4 MCA. This requires demonstrating that the least restrictive options were considered. Best Interests are not defined in the MCA, rather it sets out a checklist of factors to be considered when making a Best Interests decision. This is not just the person's medical best interest, but rather the person's welfare in the widest possible sense, and considers the individual's broader wishes and feelings, and values and beliefs. All decisions should follow careful consideration of the individual circumstances of the person and focus on reaching the decision that is right for that person – not what is best for those around them, or what the "reasonable person" would want. Rather, "*…the purpose of the best interests test is to consider matters from the patient's point of view. Where a patient is suffering from an incurable disability, the question is whether he would regard his future life as worthwhile."*[36]

The person who lacks capacity to make a decision should still be involved in the decision-making process as far as is possible. The Best Interest Assessor [BIA] is also expected to consult with family, friends and carers who know the person well in order to determine their best interests. Those people

[33] Aintree University Hospitals NHS Trust v James [2014] AC 591
[34] Peter Jackson in *Wye Valley NHS Trust v B* [2015]
[35] SJ Hilder in *Re AEL* [2021] EWCOP 9
[36] Local Authority v Z [2004] EWHC 2817 (Fam) (03 December 2004) (bailii.org)

who don't have family or friends who can represent them have a right to the support of an Independent Mental Capacity Advocate [IMCA] during the assessment process.

Finally, a person is ineligible for DoLS if they are detained for assessment or treatment under the MHA, in accordance with Schedule 1A of the MCA, so a mental health assessment should also be completed.

Public bodies have positive obligations under Art 5 so must ensure not only that they do not unlawfully deprive the person of their liberty but must also intervene in circumstances where they know or ought to have known that the person is being unlawfully deprived of their liberty. The DoLS procedure requires the appointment of a relevant person's representative ['RPR'] to maintain contact with the person, represent and support them in matters relating to or connected with the authorisation. It is crucial that the BIA is satisfied that a suitable person is identified as part of the application. Usually this will be a family member or friend who agrees to take this role. But the BIA must ensure that the suitable person meets the criteria for this role,[37] that they have clearly explained the role to the suitable person. Where the person is deprived of their liberty under the DoLS procedure but remains objecting to the placement it is primarily the role of the RPR to initiate a review or, if necessary, apply to the CoP to challenge the authorisation. Therefore, as part of any review a BIA should consider whether the RPR has been able to undertake their functions appropriately and, if not satisfied they have, consider whether there is another person who could be appointed to support person as RPR. If there is no-one who would undertake this role (including issuing proceedings) the BIA or authoriser must refer the case to the local authority's legal services setting out the reasons why the RPR or IMCA cannot act. Section 4B of the MCA also allows that in an emergency, if there are reasonable grounds to believe that the person lacks capacity, they can be deprived of their liberty to be given life-sustaining treatment or to act to prevent a deterioration in their condition, while authorisation is sought from the CoP or through DoLS.

In *A* Local *Authority v Z* [2004][38], Hedley J gave helpful guidance on a local authority's duties in a case where a person had stated an intention to take her own life:

i. "*investigate the position of a vulnerable adult to consider what was her true position and intention;*
ii. *To consider whether she was legally competent to make and carry out her decision and intention;*
iii. *To consider whether any other (and if so, what) influence may be operating on her position and intention and to ensure that she has all relevant information and knows all available options;*
iv. *To consider whether she was legally competent to make and carry out her decision and intention;*
v. *To consider whether to invoke the inherent jurisdiction of the High Court so that the question of competence could be judicially investigated and determined;*
vi. *In the event of the adult not being competent, to provide all such assistance as may be reasonably required both to determine and give effect to her best interests;*
vii. *In the event of the adult being competent to allow her in any lawful way to give effect to her decision although that should not preclude the giving of advice or assistance in accordance with what are perceived to be her best interests;*
viii. *Where there are reasonable grounds to suspect that the commission of a criminal offence may be involved, to draw that to the attention of the police;*
ix. *In very exceptional circumstances, to invoke the jurisdiction of the court under Section 222 of the 1972 Act*" (by seeking an injunction)

[37] Set out in the Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008
[38] Local Authority v Z [2004] EWHC 2817 (Fam) (03 December 2004) (bailii.org)

Appendix B: Additional Local Suicide Prevention Resources and Support

Please click on the links below for more information:

- Surrey Suicide Prevention Strategy 2023 - 2026 | Healthy Surrey
- Surrey Support After Suicide Service
- Suicide bereavement support | Healthy Surrey
- Surrey Suicide Bereavement Service
- Suicide Prevention: Surrey and Borders Partnership NHS Foundation Trust
- Support through a mental health crisis - Surrey County Council
- Emerge: self-harm and suicide support: MindWorks Surrey