South Gloucestershire Safeguarding Adults Board

Safeguarding Adults Review Adult K

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1.Introduction and overview

1.1 The purpose of this report is to describe the process and outcomes of a Safeguarding Adult Review (SAR) commissioned by South Gloucestershire Safeguarding Adult Board (SGSAB) on 19 January 2023. This was in response to information sent by Kensington & Chelsea/Westminster SAB regarding the death of Adult K. Adult K was found deceased by the tracks at Victoria station on 23 October 2022, after absconding from St Marys Hospital whilst detained on Section 2 of the Mental Health Act. Adult K was a 22-year-old woman with a history of mental health difficulties, risk taking behaviour, drug and alcohol misuse and ADHD. She was known to several organisations in South Gloucestershire and London. The SAR identifies how professionals worked with Adult K and proposes improvements to the system for the future.
1.2 A SAB has duties under Section 44 of the Care Act 2014, requiring that a SAR must be arranged when:

- an adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or
- an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.3 The Bi-Borough Safeguarding Adults Executive Board for the Boroughs of Kensington and Chelsea and Westminster received information from the Metropolitan Police regarding Adult K's suspected suicide in November 2022. This was considered under Section 44 of the Care Act 2014, and, after due process, a decision was reached that the SAR criteria were not met on the basis that given Adult K was not living or receiving services in the Bi-Borough, and they considered there was no indication of multi-agency learning for the Bi-Borough partnership.

1.4 Imperial College Healthcare completed a Serious Incident Investigation[1] into the events leading up Adult K's death. Their Report used by this SAR to provide a complete picture and identify how South Gloucestershire and London organisations worked together.

1.5 Adult K had been living mainly in the South Gloucestershire area in the months prior to her death and was involved with local agencies. She travelled to London on occasions and received services from the police, health, and social care there. SGSAB identified there would be multi-agency learning from what happened to Adult K and decided to commission a review, despite not being mandated by the Care Act. A recommendation was subsequently made to the SGSAB chair to undertake a Safeguarding Adults Review. This was agreed and the process for the SAR commenced in March 2023.

1.6 The focus of the SAR would be on the following:

- Multiple contacts with agencies and multiple attendances and the impact this had on practitioners and the service provided to Adult K.
- How risk was managed when there was a known risk of suicide and self-harm
- Interplay between substance misuse and mental health services
- Whether there were opportunities for organisations to work better together

1.7 This Report provides an account of the work carried out to understand the events leading up to Adult K's death, focussing on the period between I July 2022 and 23 October 2022 (the Review Period). Reference is made to related research and literature. Good practice and improvements made since the incident are identified. The Report concludes by making multi-agency recommendations to the Board and single agency recommendations where appropriate.

2. Process of Review

2.1 The Terms of Reference were set out prior to the work beginning by the members of the Panel and were updated as work progressed.

2.2 The purpose and underpinning principles of a SAR are set out in their Multi-Agency Safeguarding Adults Policy and Procedures. All SGSAB partner organisations agree to comply with these. The SAR identifies lessons to be learned across the partnership and in London, but not about establishing blame or culpability. The SAR will take a broad approach and will reflect the current realities of practice ("tell it like it is") and what information was known to practitioners making decisions at the time.

2.3 A Panel consisting of representatives of organisations involved was established to oversee the work. The Panel met virtually on 8 June 2023 and on 7 September 2023.

Chair and Independent Reviewer
Avon & Somerset Police
BNSSG Integrated Care Board (for GP)
South Gloucestershire Council Adult Social Care
North Bristol Trust- Southmead Hospital
University Hospitals Bristol and Weston- Bristol Royal Infirmary
Developing Health and Independence (DHI)Bristol (Drugs and Alcohol)
Avon & Wiltshire Mental Health NHS Trust
Metropolitan Police Service
South West Ambulance Service NHS Foundation Trust (SWASfT)
Imperial College Healthcare NHS Trust- St Marys Hospital
Central and North West London NHS Trust

[1] Imperial College Healthcare: Serious Incident Investigation Report 01.11.2022

Safe Link/Next Link
Business Manager SGSAB

2.4 The organisations above were requested to provide Independent Management Reports. The following were also asked to do so:

- Somerset SAB was approached to identify key agencies involved but Adult K was not living in Frome during the period under review.
- Sirona (no contact in Review Period)
- A Serious Incident Investigation report was provided by Imperial College Healthcare NHS Trust- St Marys Hospital

2.5 SAR Principles

The guiding principles for a SAR are set out in the Care Act 2014 and listed below:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard.
- It should promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Each partner organisation must co-operate in and contribute to the carrying out of the Safeguarding Adult Review. The purpose is to identify the lessons learnt from the specific case and to apply these to future cases to prevent such circumstances occurring again.
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. The time covered by the SAR is **23 June 2018 until 23 October 2022.**

2.6 Methodology

2.6.1 There are a range of methods for conducting a SAR and SGSAB determines which method suits the case best, ensuring that it is proportionate and appropriate to the situation and makes effective use of resources. This decision was delegated to the Panel.

2.6.2 This SAR used a hybrid methodology, using Individual Organisation Reports submitted by each organisation together with a Practitioner Workshop and conversations with key individuals. It is underpinned by principles of 'Learning Together', a validated systems methodology produced by the Social Care Institute for Excellence and in which the Lead Reviewer is trained and experienced. This focuses how the different parts of the system work together, avoiding hindsight bias. The process is confidential, although the Lead Reviewer will raise any issues she believes may result in harm to any individual. The professionals participating will be advised to seek support from their organisations as it can be a distressing process.

2.6.3 An Independent Reviewer was commissioned to lead the process and to write the Report. She has the appropriate skills, experience, and qualifications to carry out this process and has no links to any of the organisations involved.

2.6.4 The Practitioner Workshop was held online on 28th June 2023 to obtain input from people who knew Adult K directly or who were closely involved. It was attended by practitioners from South Gloucestershire and London and was based on an analysis of Strengths/Opportunities/Risks

and Barriers across the system. There was excellent engagement and willingness to reflect on the interventions and services involved with Adult K. As a result, a clearer picture of Adult K as a person emerged and several suggestions for improvement to services were made. These will be considered further in this Report.

2.6.5 The Kensington and Chelsea/ Westminster Safeguarding Adults Executive Board ran a well-attended and informative conference as a response to the circumstances of Adult K's death and of another person in their area. This covered the following themes:

- Multiple contacts with agencies and increased attendances at A&E
- Escalation in self-harming/self-neglecting behaviour and suicide threats/attempts
- Interplay between substance misuse/self-neglect/domestic abuse/mental health
- Impact of childhood trauma and abuse
- Multi-agency responses in managing risk and working with complex needs.
- Understanding barriers to engagement

2.6.6 The Care Act 2014 requires that the individual and their family are involved if possible. A meeting with Adult K's mother was arranged but was cancelled as it created anxiety and distress.

2.6.7 SGSAB will decide on publication of the Report.

2.7 Glossary

AMHP	Approved Mental Health Professional
AWP	Avon and Wiltshire Mental Health Partnership Trust
CAMHS	Child and Adolescent Mental Health Service
MHA	The Mental Health Act 1983/revised 2007
SGC	South Gloucestershire Council
MHAA	Mental Health Act Assessment
BNSSG ICB	Bristol, North Somerset & South Gloucestershire Integrated Care Board
NBT	North Bristol NHS Trust - Southmead Hospital
UHBW	University Hospitals Bristol and Weston- Bristol Royal Infirmary
DHI	Developing Health and Independence Bristol (Drugs and Alcohol)
AWP	Avon & Wiltshire Mental Health Partnership NHS Trust
HBPoS	Health Based place of Safety
SWASfT	South West Ambulance Service NHS Foundation Trust
ICHT	Imperial College Healthcare NHS Trust- St Marys Hospital
CNWT	Central and North West London NHS Trust
IDVA	Independent Domestic Violence Advocate
ED	Emergency Department

3. Background Information

3.1 Adult K was 22 years old, a graduate in Psychology, studying with the Open University. She was intelligent and motivated, working when she could in local restaurants and bars. One professional recalled her as 'very likeable, personable, honest and reflective', another said that her demeanour was 'friendly, bright, kind and engaging', and another said of her 'a bright woman, very pleasant, affable. She was insightful, resourceful and took responsibility, often expressing embarrassment and regret at the incidents she caused. A Police Officer noted that she was reading a psychology textbook whilst awaiting a Mental Health Act Assessment. She was keen to change but found it difficult to sustain engagement in treatment programmes to address her mental health and substance misuse.

3.2 Adult K's parents are separated. Her mother lives in Bristol with a new partner and family. She was supportive of Adult K, although Adult K did tell a professional that she felt didn't fit in with her new family. Adult K's father lived in Somerset. Adult K lived with him for a while but had to leave

after a series of incidents there. Records state that Adult K had a challenging upbringing, with inconsistent and chaotic parenting; that her father had alcohol problems.

3.3 Adult K experienced mental health difficulties as a child and received treatment from Child and Adolescent Mental Health Services (CAMHS) from age 14. Records state that Adult K was sexually abused at the age of 8. She was diagnosed at age 15 with attention deficit hyperactivity disorder, defined by the NHS as 'a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse'. Adult K was prescribed medication, following which her mother described her as 'a different child'. She continued this until 2021 when it was stopped due to her drugs and alcohol intake, the combination causing serious health risks. This marked the start of a series of crises for Adult K, each triggered by drugs or alcohol, with the frequent need for interventions from emergency services. Without ADHD medication, Adult K was restless and lacked concentration which prevented her from studying or working.

3.4 Significant events and information prior to Review Period (1 July - 23 October 2022)

It is useful to understand some of Adult K's history of involvement with services prior to the period under Review.

3.4.1 Avon and Somerset Police. Adult K had minimal contact with Avon & Somerset (A&S) Police before May 2021 but over 70 occurrences were linked to her from May – Dec 2021 and around 40 occurrences between January – June 2022, mostly related to concern for welfare/ adult safeguarding but also due to Adult K being a victim of crime or having committed offences.

3.4.2 Avon and Wiltshire Mental Health NHS (AWP) Adult K was known to AWP from 26/05/21. She received support and treatment from several parts of the service. She was an inpatient on Section 2 twice during this period. She had contact with the South Bristol Crisis Team, the Advice and Support in Custody and Court Team, the Response Line, and the Safeguarding Team. Adult K was opened to South Bristol Recovery in September 2021 (and closed on 12th September 2022 during the Review Period)

3.4.3 South Gloucestershire Council – Approved Mental Health Professionals. Adult K had 37 recorded detentions under S136 of the Mental Health Act (MHA) from the period she became known to Adult Mental health services in 2021 until the Review Period.

3.4.4 Grange Road GP Surgery Adult K was registered at Grange Road Surgery in June 2021. Between January and July 2022, multiple emergency notifications were received from partner agencies, including health and police' relating to her mental health and alcohol misuse. Adult K had 2 face-to-face appointments in the surgery and 9 telephone calls booked, 3 of which took place.

3.4.5 Adult K's GP reviewed her treatment in June 2021, following several suicide attempts made under influence of alcohol. Adult K had attended some AA meetings. Antidepressant medication was continued, and referrals made the Practice mental health nurse and to the Drug and Alcohol Service, with a telephone review planned after two weeks. This did not happen as Adult K was detained under Section 136 and a psychiatric admission.

3.4.6 Adult K called her GP twice in September 2021 saying life was chaotic and had deteriorated since her ADHD medication had stopped. She wanted to restart it, so the GP sought advice from the Adult ADHD Team. However, formal re-referral and reassessment was required, and Adult K had to complete a form herself, which was challenging for her. She did this on 1st February 2022 at a GP appointment attended with her mother. Adult K's alcohol consumption had decreased but she was struggling to concentrate or sit still. The GP documented that Adult K presented as articulate and showed insight into her difficulties.

3.4.7 Discussion took place at two professionals' meetings regarding Adult K's ADHD medication. In February 2022, it was felt safe to recommence it. At the subsequent meeting in May 2022, following numerous presentations at the Royal United Hospitals (RUH) Bath ED under the influence of alcohol, the decision was reversed due to concerns that Adult K was misusing substances (alcohol and drugs) again. This was a contraindication for prescribing her ADHD medication and was a multi-professional decision. Adult K was not engaging with the Bristol Drug Project (BDP), and the GP (based in South Bristol) was finding it difficult to access services in the area that Adult K was now living in (Somerset).

3.4.8 In July 2022, her GP tried unsuccessfully to contact Adult K to encourage her to re-register with a practice in her new home locality. She was advised by letter that she would be removed

from the Grange Road GP Surgery patient list. The intention was to encourage re-registration at a different practice closer to home where she could access the support that she needed.
3.4.9 NBT- Southmead Hospital and UHBW Bristol Royal Infirmary. Adult K was admitted to the Emergency Departments many times and was referred to the High Impact User Team, a multi-disciplinary team within ED to support patients who frequently attend more than 3 times a month. A Personal Support Plan for Adult K was put in place in November 2021 to support her to utilise ED appropriately, and to access other support networks she had. This was discussed in 3 High Impact User meetings prior to 1st July 2022.
3.4.10 Safe Link and Next Link. Adult K met with the hospital Independent Domestic Violence Adviser (IDVA – a role to support victims of domestic violence or abuse) in August 2021 at Bristol Royal Infirmary ED following disclosure of a sexual assault from an acquaintance. The Police were informed. Adult K declined support but was given advice and information.
3.4.11 Adult K met with the Southmead Hospital IDVA in September 2021 after admission to ED after disclosing sexual assault from a male living in her accommodation and this was reported to the Police. Adult K asked for support and options information to be texted to her. This was done, plus multiple attempts to contact her, but she did not respond.

3.5 Significant Events During the Review Period 1 July-23 October 2022. A timeline (Appendix One) has been compiled from information provided by Avon and Somerset Police, Metropolitan Police, South Gloucestershire Council's Approved Mental Health Practitioners (AMHP), UHBW, NBT, Avon and Wiltshire Mental Health Trust (AWP) and Developing Health and Independence. It illustrates the high level of activity regarding Adult K over the 4-month period prior to her death. Key points from the timeline are included below, plus contributions from other organisations.
3.5.1 Grange Road Surgery Adult K had no direct contact with the GP Practice beyond 7th August 2022 and was removed from the surgery list on 25th August 2022, having moved to Somerset. However, during the Review Period, the Practice received multiple notifications regarding urgent care services, all related to Adult K's mental health and substance misuse.
3.5.2 South West Ambulance Foundation Trust (SWASfT). There were 28 emergency calls to SWASfT during this period. Crews had 26 contacts with Adult K, all 26 documented as mental health related. 25 included self-harm or overdose/suicide, 19 involved alcohol intoxication and 16 involving recreational drugs. 50% of attendances required Police attendance for support, safety, and management. On 24th August 2022, two markers were added to the SWASFT Computer Aided Dispatch system, asking ambulance crews to:

- "Consider signposting Adult K to the Recovery Team on 01275796200 or the 24-hour response line 08009531919 for mental health concerns."
- "Please allow Adult K time to express herself; when she is in crisis, she can become overwhelmed and begin to dysregulate emotionally which can lead to her engaging in more harm."

3.5.3 Avon and Somerset Police were involved in most of the incidents involving Adult K, analysed as follows:

- There are 43 Storm logs (command and control system) and 31 Niche logs (crime recording database use to record police contact, action, and investigation, which allows records information sharing) linked to Adult K, relating to 36 different incidents. These were received from: Adult K (14), Ambulance Service (7), Acute hospitals (6), Third party (12), Network rail (1), other professionals (2). 38 calls were attended by the police.
- A Police Mental Health Liaison Officer (MHLO) is co-located with the Ambulance Service to support dispatch decision making and to ensure appropriate and timely response. The MHLO input to logs regarding Adult K for 10 incidents.
- Adult K was detained under S136 of the MHA 7 times by A&S Police and 3 times by the Metropolitan Police.
- Police Mental Health Monitoring Forms (completed after Section 136) show Adult K was only conveyed to hospital by ambulance once. The risk was deemed too high twice and on four occasions an ambulance was not available within 30 minutes, so Police took her to the Health Based Place of Safety (HBPOS) in line with policy.

- Adult K was taken to the Emergency Department (ED) rather than a HBPoS on 3 occasions - twice because she needed also medical intervention and once because a place at HBPoS was not available.
- On the occasions when Police did not detain Adult K under S136, records show that they consulted Mental Health Professionals on almost every occasion it was deemed appropriate (14 times).
- Adult K reported being a victim of crime 3 times – drink spiked, theft of her laptop and date rape.
- Adult K was arrested for assault on an emergency worker (nurse) and for a public order offence after an incident at Southmead on 30/09/2022.

3.5.4 UHBW (Bristol Royal Infirmary) and NBT (Southmead) Adult K had multiple attendances for self-harm to the Emergency Department, mostly by ambulance following overdoses of paracetamol and alcohol. She rarely remained in the department for assessment and treatment and would most often self-discharge. Her High Impact User Personal Support Plan (4.3.7), completed in conjunction with Southmead Hospital, remained in place. The risks included overdose, jumping from height and train tracks. In August 2022 a warning letter was sent to Adult K by UHBW for unacceptable aggressive behaviour towards staff.

3.5.5 Chelsea and Westminster Hospital. Adult K was taken on Section 136 by the Metropolitan Police to Chelsea and Westminster Hospital Emergency Department on 15 and 16 August 2022 and on 6 September 2022 following overdoses. She was detained under Section 2 on the second two occasions and was transferred to a mental health unit in Bristol.

3.5.6 Imperial College Hospitals Trust (ICHT) St Marys Hospital, Paddington. On 22 August 2022, Adult K was found by a canal threatening to take her own life and was taken to St Marys Hospital by ambulance with Police presence and restraint. A Mental Health Act Assessment was carried out when Adult K 'appeared distracted and inattentive but was euthymic (stable) in mood, her speech was normal in tone and volume with no reported formal thought disorders or perceptual abnormalities. She stated that she had consumed three bottles of wine before her attendance'. Some background information about Adult K had been obtained: she had been recently discharged from psychiatric services in Bristol, was on the waiting list for Adult ADHD services and had recently been referred to Bristol Drug Services after a court appearance for an assault charge. The outcome of the assessment was that she did not meet the criteria for detention. She left hospital at 14.30 with a plan for her to register with a GP and seek help from Rethink Mental Health Services in Bristol.

3.5.7 On 22 August 2022 at 15:42, the Single Point of Access (SPA) for the Central and Northwest London NHS Foundation Trust (Mental Health) received a call from a police officer requesting a Health Based Place of Safety (HBPoS) for Adult K, detained on a Section 136 after she had been seen jumping onto a ledge and had been restrained before she could jump off a bridge. No HBPoS was available so Adult K was taken to St Mary's Emergency Department at 16:20 by ambulance accompanied by police. She was agitated, unpredictable and tried to run out of the ED, being restrained by police several times. She was medically fit for assessment and was referred for a MHAA, scheduled for 23:15. At 19:18 Adult K became very agitated and was banging her head on the wall and sedation was given. She went outside several times for fresh air escorted by police officers. Two of these breaks, 22:00 and 22:45 were recorded on Cerner (the hospital system.)

3.5.8 The MHAA was completed with the outcome of a Section 2 application, pending availability of a suitable bed. Adult K 'was suffering from a mental disorder of a nature and degree which required detention as she was at risk of serious self-harm and had made two attempts to end her life within the previous 24 hours. She did not want to be admitted and could not guarantee her safety if discharged'. Adult K lacked capacity because she was unable to weigh up risks to herself if she were to remain in the community.

3.5.9 There were no mental health beds available in Bristol, so Adult K remained in ED with care by 2 RMNs. The Police left at 14.30. At 15.20 Adult K asked to go out for fresh air and to vape. The decision was made by the Registered Mental Nurse (RMN) that she would be escorted outside with 2 RMNs and a 2 Security Officers. Adult K left her belongings, including her phone, in her cubicle. The area available for outside breaks is through external doors to the ambulance bay, which has two exits to street level, via an ambulance ramp, and a pedestrian

ramp, both of which are easily accessible from the ED exit and ambulance bay. There is a covered walkway leading to the adjoining building, which is used to move between the two. When Adult K and her escorts reached this, the Security Officer swiped the access control and Adult K pushed the door and ran through, out into the ambulance bay and down the ramp. The Security Officer chased after Adult K, but she was lost to view. They did not continue to pursue her due to safety risks in the traffic. The Security Officer informed the police. At 20.16 a call was received from the Police advising that Adult K had been found deceased at Victoria train station at 19:00. British Transport Police (BTP) confirmed that Adult K had been found deceased next to a live rail just outside Victoria Station

4. Analysis by Theme

The information available about the events prior to Adult K's death will be considered under the following themes, covering lines of enquiry set out in the Terms of Reference. The themes are:

- 4.1 Multi-Agency Interventions and Assessments in South Gloucestershire.
- 4.2 Multi-Agency Interventions and Assessments in London.
- 4.3 Factors Impacting on Adult K
- 4.4 Impact on Staff
- 4.5 Organisational systems – Safeguarding, Risk Assessments

Theme One: Multi-Agency Interventions and Assessments in South Gloucestershire.

4.1.1 Emergency Interventions. There was an extremely high number of emergency interventions. It is important to understand more about these interventions to explore whether any alternative approaches were available or could be developed in future. The timeline provides the key information with more analysis below.

4.1.2 Avon and Somerset Police (See 3.5.3) Officers liaised with a mental health professional prior to detention on Section 136 on only two occasions. On a further 2 occasions there was no opportunity due to the imminent danger Adult K had put herself in. Officers were unable to get a response from the MH crisis team on one occasion and on another, were advised to return her to hospital due to concerns of an overdose. When liaison took place, section 136 was generally not used.

4.1.3 Mental Health Act Assessments. Six Mental Health Act 1983 Assessments (MHAA) were carried out on behalf of South Gloucestershire Council (on 7.8.22, 3.9.22, 21.9.22, 30.9.22, 10.10.22 and 18.10.22). On each occasion, Adult K was detained under Section 136 by the Police who took the decision that she was 'suffering from a mental disorder and to be in immediate need of care or control'. (This permits the individual to be held in a place of safety usually for 24 hours, to be examined by a registered medical practitioner and interviewed by an Approved Mental Health Professional (AMHP). A MHAA determines whether further assessment and treatment are required on a compulsory basis under Section 2. These took place in ED or at the Bristol HBPoS operated by AWP at Southmead Hospital. (This provides an appropriate environment for people with mental health concerns). Adult K's presentation at each assessment did not give grounds to consider further detention or admission to hospital on a voluntary basis.

4.1.4 Mental capacity and mental health are closely linked, and it is part of the AMHP's role to assess whether an individual has capacity under the Mental Capacity Act 2005. Adult K was assessed as having capacity in relation to her need for care and treatment on each occasion. The AMHPs commented that Adult K was 'engaged fully' in each assessment She 'expressed very clear insight into her difficulties' and was 'future focused, not psychotic and not detainable'.

4.1.5 Plans in place to manage responses.

Professionals shared information over incidents at the time, for example the police contacted mental health professionals when Section 136 was used. Plans were also put in place by individual organisations to manage responses to Adult K to promote consistency of approach by different professionals. These included:

4.1.6 High Impact User Personal Support Plan. Adult K attended ED in Bristol Hospitals on at least 8 occasions due to mental health crises. She was referred to the High Impact User Team

at NBT Southmead and UBHW Bristol Royal Infirmary in November 2021, prior to the Review Period. This is a multi-disciplinary team based in ED to support patients who frequently attend more than 3 times a month. A Personal Support Plan was put in place for Adult K to support her to utilise ED appropriately and to access her other support networks e.g., mental health and drug and alcohol services. Multi-disciplinary Reviews of the Plan were held on 3 occasions from November 2021 until 1 July 2022, and then twice during the Review Period. The High Impact User Team also attended a multi-disciplinary meeting called by other organisations to facilitate a consistent approach e.g., a meeting called by Adult K's Care Co-ordinator from AWP on 28 August 2022.

4.1.7 This Plan highlighted the potential risks of harm to Adult K from her behaviour, including intoxication from drugs and alcohol and overdoses, jumping from heights, and getting on train tracks. It identifies the difficulty in providing a consistent response between organisations and the possibility of potentially damaging, overly restrictive reactions to her. The Plan suggests assessment of mental capacity, blood tests for drug levels, treating her in a visible area and maintaining a positive professional approach, giving her time to express herself. There is also guidance on referrals to other services, e.g., liaison psychiatry or alcohol specialist nurse, and how to facilitate safe discharge.

4.1.8 Police Mental Health Tactical Plan. The aim of this is to ensure a consistent approach with local partners to someone with complex mental health needs. The Plans are uploaded to RiO (the IT system used by AWP) for their staff to access and to Somerset NHS Foundation Trust's clinical system. Internally to the Police, the Plan is placed on the person's local record (Niche) and on their Police National Computer record. This should enable a Police Officer in any location to identify that a plan exists if a records check is made. Police Officers attending the Practitioner Workshop made the point that checking records and reading plans was not always possible in an emergency. For Adult K, the plan suggested avoiding prosecution for trespass on railway property.

4.1.9 High Intensity User Plan (SWASfT). There were 28 emergency calls to SWASfT during this period. Adult K was a High Frequency caller (the national definition being an adult with 5 or more incidents relating to individual episodes of care within one calendar month or 12 or more incidents relating to individual episodes of care, within a 3 consecutive month period). These criteria were met on 30th June 2022 and continued. The SWASfT Frequent Caller Team reviewed Adult K's activity to ensure responses to her were supported with information provided through the High Impact User (HIU) meetings at the Royal United Hospital (RUH). This team liaised with the RUH HIU as well as later with the North Bristol Trust (NBT) HIU meetings, following Adult K's move to Bristol. The supportive approach reflected on the Computer Aided Dispatch system (3.5.2) is noted as good practice.

4.1.10 Treatment Plans. These are longer term, structured plans with specific treatment goals. They include:

4.1.11 Structured Clinical Management Pathway (AWP) Adult K was open to South Bristol Recovery Team from September 2021 to 12th September 2022. Her mental health treatment was delivered jointly by her Recovery Team Care Co-ordinator and the Bristol North Somerset and South Gloucestershire Personality Disorder Pathway Service Senior Practitioner. This included multi-disciplinary team discussions and attendance by Adult K at several therapeutic appointments. There is evidence of many telephone calls from Adult K, often in distress, with liaison by other services as they supported her through many crises. This included a psychiatric ward admission in Bristol after being placed on Section 2 of the MHA in London hospital on 15 August 2022 although she was discharged 3 days later.

4.1.12 Adult K was discharged from the South Bristol Recovery Team on the 12th of September 2022. Multiple reasons are given for this, including moving out of the catchment area and a view that other challenges in Adult K's life made it difficult for her to focus on her mental health, e.g., homelessness. She was not actively engaged, and it was stated that she should be discharged from secondary mental health services with encouragement to seek re-referral via her GP if necessary.

4.1.13 Structured psychosocial group work programme (Developing Health and Independence – Drug and alcohol service) Adult K was referred by Bristol Drugs Project (BDP) Mental Health Learning Disability Link worker on 6 July 2022. Adult K presented with high

alcohol usage, a Severity of Alcohol Dependency Questionnaire score of 46, (range is 0-60) debt, housing and Mental Health needs. Adult K had ongoing contact with Bristol Drugs Project Mental Health and Learning Disability Link Worker but limited contact with the DHI service. Despite the series of incidents and serious concerns, Adult K's case was not escalated, the worker believing other professionals were managing the situation. In October Adult K attended group work on 'Preparation for Change'. Her last contact was on 20 October, just 3 days before she died.

4.1.14 Findings

Adult K was the subject of many crisis interventions and treatment plans before and during the Review Period with a significant amount of time and effort invested by the organisations involved in delivering these services, including multi-disciplinary meetings and consultations, sharing information, and recording into the various systems. There is evidence of some effective communication between organisations regarding Adult K's crises, but also some gaps. These were usually managed well, often in challenging circumstances. Responses were supported by plans which took account of Adult K's vulnerabilities and were shared between organisations in South Gloucestershire.

4.1.15 Concerns have been expressed by AMPHs during this Review about access to risk assessments in the AWP RIO system. In carrying out a MHAA, an AMHP needs swift access to the risk assessment. The current format of the system does not facilitate 'a quick and useful summary of the key risk issues' and there is a need to go through several sections of the system to find the required information. AMHP's do not have access to the High Impact User Personal Support Plan. Key risk issues should be available easily on the system with links to the details.

4.1.16. Working with dual diagnosis, substance misuse and mental health problems, requires close liaison between DHI and AWP professionals to ensure that care pathways utilise the expertise of each service. For Adult K's situation, this included ADHD services. Professionals made some efforts to work together, but they were working within separate organisational systems which do not lend themselves well to collaborative working. It would have been helpful to formulate a risk assessment which took all factors into account and supported Adult K. Dual and triple diagnosis are common, and a service tailored to meet individual needs could be much more effective than forcing them to fit in with existing services and teams with rigid boundaries. There were incidents known to Adult K's DHI worker which were not escalated to consider appropriate action.

4.1.17 It is not clear why Adult K's care was not transferred to a Recovery Team within her catchment area, particularly as it was known that she was not registered with a GP at the time, which would have presented a barrier to re-referral. Adult K wished to remain open to mental health services, and it does not seem that full consideration was given to the impact this ending may have had on her. Adult K had told other mental health professionals that the mental health team was all she had. Following Adult K's discharge from the Recovery Team, there was an increase in the frequency of her being detained under Section 136 to eight times in just under three months. The case closure also undermined the hospital Personal Support Plan and SWASfT support as the mental health service was not available to Adult K. Mental Health services are under great pressure and need to move patients through the system appropriately. Different options for ongoing support should be explored pending discharge when the individual is distressed and at risk, particularly when their lifestyle makes it difficult for them to follow standard processes.

4.1.18 Hospitals in the South Gloucestershire/ Bristol area shared information between themselves. There is no national database between hospitals, but relevant information would be shared if a request was made by another hospital, provided they knew where the individual had come from.

4.1.19 The Plans put in place for Adult K by each organisation were informative and were shared between some partners. However, each organisation produced its own plan, there was not a single plan which brought together all the key facts and risks. Some areas (23 out of 52 NHS Trusts) have adopted the Serenity Integrated Mentoring (SIM)[2], a system provided by a private company designed to reducing emergency service usage, including police, ambulance,

[2] Serenity Integrated Mentoring: Suicide Attempt? Do Not Pass Go (mentalhealthathome.org)

and A&E by High Intensity Users. This includes the assignation of a police "mentor" to meet with the individual regularly with a plan to provide support and establish boundaries, working closely with other professionals involved, and 'flagging' in relevant systems so that a consistent and co-ordinated approach is provided. This system has not been adopted in South Gloucestershire although elements of such a system are in place such as the High Intensity User Plan and High Impact User plan. It may be possible to combine these plans and approaches if SIM is not the preferred model.

4.1.20 Summary of findings for Theme One

- There was good communication between professionals at the time of incidents enabling them to be managed effectively to keep Adult K safe.
- There were some gaps in communication. E.G. AWP did not inform SWASfT, UHBW and NBT that they were closing Adult K's case.
- When Police liaised with mental health professionals, section 136 was generally not used.
- Responses were informed by plans which took account of Adult K's specific needs and vulnerabilities.
- Key risk issues about an individual are not available easily on the RIO system.
- DHI and AWP did not always work together. Dual and triple diagnosis are common, and a service tailored to meet individual needs may be more effective than fitting them into existing services and teams with rigid boundaries.
- DHI did not escalate known incidents involving Adult K to consider appropriate action. (See Safeguarding Adults)
- Adult K found it difficult to access services due to her lifestyle, lack of engagement and difficulty in following standard processes e.g., GP, ADHD, and mental health. Options should be explored pending discharge or transfer between services the individual is distressed and at risk of harm.
- Organisations each developed their own Plan for managing responses to Adult K.

Theme Two: Multi-Agency Emergency Interventions and Assessments in London.

4.2.1 Most of this information was taken from the ICH which has undertaken a Serious Incident Investigation Report. (3.5.6)

4.2.2 Findings. St Marys ED is a very busy environment, near Paddington Station. It is situated on the first floor, with no windows and artificial lighting, described by staff as noisy and 'a challenging environment for mental health patients. Registered Mental Health Nurses (RMN) are present. The HBPoS was unavailable at the time. Adult K spent 23 hours in ED due to various delays. Mental health patients in ED are often taken outside for breaks to manage stress.

4.2.3 It is not known whether Adult K planned to abscond or whether she saw her chance and took it on impulse. ICH has examined the decision making and planning for outdoor breaks.

4.2.4 Adult K had been escorted outside several times by the two Police Officers accompanying her whist on Section 136 for fresh air breaks and to vape but this is not generally discussed or documented.

4.2.5 The RMNs felt that Adult K 'was much calmer and co-operative' than she had been earlier in her admission. She had been escorted outside several times by police with no concerns that they were aware of. She was facing a long journey to Bristol in a secure ambulance; she was being affected by the challenging behaviour of another patient and she was asking to go outside to vape. The decision was made to take Adult K outside without discussion with the Nurse in Charge. It was assumed that outdoor breaks had already been agreed as Adult K had been out so often already with the police. In the absence of a formal process for risk assessing and decision making, the decision made by the RMN is reasonable in the circumstances. However, 'a formal tool or process in place for risk assessment, decision making or planning on taking patients outside' would have been useful.

4.2.6 The Serious Incident Investigation found that a choice of nicotine replacement was not readily available in the ED or considered for Adult K. Nicotine patches were available but there were no nicotine inhalators which are sometimes preferred by patients. It states that: 'Nicotine replacement should be an early consideration for patients who smoke or vape as even if they

may go outside for breaks, this may reduce the frequency and relieve agitation in between breaks.'

4.2.7 The Mental Health Act Assessment was delayed by 6 hours (from 17.46 until 23.55) due to the unavailability of a doctor qualified under Section 12 of the MHA and of an AMHPs approved by the Local Authority. This is a long time to be held in an ED and puts strain on both individual and staff. Professionals with these specialist qualifications are in short supply. Adult K had been assessed under Section 136 earlier that day but was not detained.

4.2.8 The Central and Northwest London NHS Foundation Trust (which operates the psychiatric liaison services at St Marys Hospital), and the Bristol Crisis Team (bed management) were unable to locate a mental health bed for Adult K following her detention under Section 2. On this occasion, at 2.55, Bristol responded to say they had located a bed, but this turned out to be an error at 5.55) No beds were available in Bristol (nor in London) until 11.54. At this point, after a wait of 12 hours, Section 2 papers were finalised, and transport booked for Bristol at 14.47. There is a national shortage of mental health beds.

4.2.9 When no local mental health beds are available, an 'Extra Contractual Referral' to a private mental health bed can be authorised by a manager. The Bristol Crisis Team sought to do this but needed management approval which was not available. This resulted in a longer stay for Adult K.

4.2.10 The Root Cause of the incident was 'overarching lack of mental health beds which resulted in Adult K's long length of stay in ED, which is not set up for the optimal care and safety of mental health patients.' Several delays occurred in assessment and location of mental health bed with the result that Adult K was in ED for 23 hours. This is a reportable breach of a stay in ED above 12 hours. The shortage of mental health beds and ensuing delays puts a great burden on both individual and the professionals with responsibility for looking after them.

4.2.11 Communications between Bristol and London. Police shared information between areas about incidents involving Adult K on 21 and 22 August 2022. Police officers can check the national computer records in any location to access whether plans are in place for individual, although this is not always possible in an emergency.

4.2.12 Hospitals in the South Gloucestershire/ Bristol area share information between themselves. There is no national database between hospitals, although relevant information would be shared if a request was made by another hospital if the patient gave consent for this. It would have been useful for St Marys ED to know that Adult K was a 'high intensity user', particularly her history of absconding. The difficulty in accessing a brief and concise risk history on RIO has already been highlighted.

4.2.13 Lack of information can have a direct impact on patient outcomes. For example, it had been possible to avoid the use of Section 2 in South Gloucestershire as better access to her history enabled local AMHPs to use alternatives. London AMPHs had minimal information and few options available for Adult K expressing suicidal ideation. It is noted that her admissions under Section 2 were very brief, one was 2 days and the second just 9 hours.

4.2.14 Summary of Findings Theme Two

- Adult K was detained twice in London under Section 2 whereas this was not the case in South Gloucestershire where more information was available to use local alternatives to detention.
- The lack of an available Health Based Place of Safety for Adult K contributed to the sequence of events prior to her death.
- The shortage of available mental health hospital beds created the delay in transferring Adult K from ED to an appropriate setting.
- A formal process for decision making and documentation of each break and whether there were any issues or not would facilitate an ongoing risk profile which could be used for further decisions on breaks.
- 'Nicotine replacement' was not considered for Adult K and was not available.
- The shortage of mental health beds and ensuing delays puts a great burden on both individual and the professionals with responsibility for looking after them until one is located.

- The shortage of doctors approved under Section 12 of the MHA and of AMHPs created delays.
- Difficulties in South Gloucestershire authorising an Extra Contractual Referral out of hours contributed to the delay in finding a bed for Adult K in a mental health unit.
- Information sharing between South Gloucestershire and London organisations could have been more effective if easy access to a risk summary was available.
- A national database of AMHP Services, Crisis Teams and Emergency Department contact details would facilitate information for out of area patients being shared.

Theme Three: Factors Impacting on Adult K

4.3 Adult K was living through a very unsettled and troubled period of her life which caused her to take huge risks with her safety and well-being. This Review considers the causes of this and whether appropriate responses and services were available to meet her needs.

4.3.1 Diagnoses

Several diagnoses of mental health disorders are recorded on the RIO system used by AWP and shared by partner organisations as appropriate. These include:

- F102, Mental and behavioural disorders due to use of alcohol/dependence syndrome,
- F191 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances/harmful use
- F603 Emotionally unstable personality disorder (EUPD)

4.3.2 EUPD (or Borderline Personality Disorder BPD) is defined on the NHS Website as a disorder of mood and how a person interacts with others. The individual 'will differ significantly from an average person in terms of how he or she thinks, perceives, feels, or relates to others.' The symptoms range from mild to severe, usually emerge in adolescence and persist into adulthood. They include emotional instability, disturbed patterns of thinking or perception – cognitive distortions or perceptual distortions, impulsive behaviour and intense but unstable relationships with others.

4.3.3 The causes are unclear but may result from a combination of genetic and environmental factors. Most people with EUPD will have experienced some kind of trauma or neglect as children. Many also have another mental health condition or behavioural problem, including misuse of alcohol and drugs, generalised anxiety disorder, depression, self-harm, and suicide attempts.

4.3.4. Diagnosis is important for mental health treatment plans, but some diagnoses can carry perceived stigma. Adult K was unhappy with her diagnosis of EUPD, stating on 6 and 19 July 2022 that she thought people did not believe her or take her seriously due to her diagnosis. This is not uncommon. Mental Health Charity 'Mind'[3] states that EUPD is a complex diagnosis, not always well understood, giving rise to a negative opinions and misconceptions. It is sometimes considered untreatable and that it makes people 'difficult' to help. One person with the disorder is quoted as saying that EUPD 'is a label which acts as a disadvantage in life. It knocks my confidence'. Adult K was reassured that this was not the case by the Response Line and her Care Co-ordinator. It was clearly distressing to live with a diagnosis which may not be taken seriously by some.

4.3.5 Adult K was also diagnosed with ADHD (3.3). Without ADHD medication, Adult K found herself unable to study or work, attributing this to her restlessness and lack of concentration. She called her GP twice in September 2021(3.4.6) requesting to restart medication but after a long process, exacerbated by Adult K's lack of engagement, and overcoming various obstacles , it was felt that her alcohol and drug consumption was not compatible with ADHD treatment in May 2022. The requirement to be re-referred into ADHD services by a GP presented an obstacle to Adult K being re-assessed for ADHD medication between February- May 2022.

4.3.6 Self-harm and Suicidal intent. It is not known if Adult K intended to take her own life on the railway tracks or whether she was taking risks with her safety as she had done so many times in the past. Adult K's risk-taking behaviour was always in a public place where it was

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[3] What is borderline personality disorder (BPD)? - Mind

likely someone would intervene to prevent her taking the final step. This was mentioned by an AMHP, stating that she was 'fearful that at some point Adult K would end her life by misadventure due to her impulsivity'.

4.3.7 Allegation of rape. A report that Adult K was raped by a health worker was made in February 2022 by a third party. There had been 4 rapes over a period of about 3 months. Contact not made with Adult K until end of April 2022 Adult K confirmed on 24/05/2022 that she wanted to pursue a complaint and was referred at this time for an Independent Domestic Violence Advisor. (IDVA). It was considered that she had capacity and could make her own choice about pursuing the allegation of rape.

4.3.8 The suspect knew Adult K had made a complaint and contacted her via Facebook in May calling her a liar, saying that no one would believe her allegation and that he was looking forward to seeing her in court. Adult K reported this, and she blocked him.

4.3.9 Adult K was anxious about the police interview regarding the allegation and called the AWP response line. However, she went ahead, recording an "Achieving Best Evidence' interview with Police on 31/08/2022. She provided detail about the allegations which would have been critical for prosecution. The suspect was arrested on 18/10/2022, and an interview arranged for him on 23/10/2022, of which Adult K was notified by email on 20/10/2022. The interview went ahead as planned between 17:45 – 19:15 on 23/10/2022. Adult K was notified by email at 20:59 on 23/10/2022 about the outcome of the interview, that the suspect was released under investigation.

4.3.10 Adult K travelled to London on 20th or 21st October. She would not have received the email about the outcome of the interview as she left St Mary's Hospital at 15.20, without her mobile phone or bag, and the email informing her of this was not sent until 20.59. Sadly, Adult K had died by this time. The rape investigation is ongoing with officers planning to go to the CPS imminently.

4.3.11 Adult K was referred to Safe Link, on 30/05/22 by The Bridge, a sexual abuse service, who also completed an adult safeguarding referral. Safe Link attempted to contact Adult K by email as requested, but the case was eventually closed after there was no response to multiple attempts at contact. A further referral was received after Adult K's video interview on 31/08/22. An email was sent to Adult K to introduce ISVA service but there was response and referral closed on 20/09/22. SafeLink kept the police informed, but they did not liaise with Adult K's care coordinator as they did not have a name.

4.3.12 Adult K received emotional support from her Care Coordinator, who liaised with the Police Engagement Officer who had sporadic contact with Adult K directly but liaised with Adult K's mother.

4.3.13 Prosecution for assault. Adult K was arrested for assault on a nurse in ED and for a public order offence after an incident at Southmead on 30/09/2022. She was taken to custody and later charged with the offences. She also assaulted a paramedic during this incident, but the paramedic did not support a prosecution. She pleaded guilty at court on 18/10/2022 and was remorseful for her behaviour. At the time of her death the court outcome had not been passed. Adult K had committed other offences during this period in trespassing on railway lines, but police had not thought it was in Adult K's best interests to prosecute for these.

4.3.14 Victim of crime Adult K reported being a victim of crime to the Police on three other occasions with allegations of having her drink spiked, theft of her laptop and date rape. Regarding the report of having her drink spiked, officers found abusive messages on her phone and recorded this as a crime against Adult K. The alleged perpetrators of the drink spiking and date rape were both arrested but later released and no further action taken, as Adult K was not able/willing to provide any details after the initial allegations despite concerted effort by officers. There was insufficient evidence to consider a victimless prosecution. Adult K did not provide any further information about the theft of her laptop, so officers were unable to pursue it and the case was filed. These offences show Adult K's vulnerability and difficulties in keeping herself safe from harm.

4.3.15 Death of friend. Little is known about this, but Adult K told emergency services in London that her ex-boyfriend had died a few days before she travelled to London.

4.3.16 Findings

Adult K was at high risk of exploitation and abuse due to her mental health and substance misuse, exacerbated by insecure housing and her chaotic lifestyle. She may have been more distressed than usual when she went to London on 21 October 2022. The culmination of the Police investigation into the rape allegations and suspect's interview date, her prosecution for assault, being a victim of crime and the death of her friend would all have had a significant impact on Adult K's fragile mental health.

4.3.17 The investigation process for the alleged rape was lengthy with delays in contacting Adult K after the allegation was reported (from February to April 2022), interviewing Adult K (31/08/2022) and in arresting and interviewing the suspect (18/10/2022 and 23/10/2022). Some of this was caused by Adult K's lack of engagement in the process. Police tried to connect her to SafeLink for support. AWP records show Adult K's mother's concerns about delay in the Police investigations. She felt the alleged perpetrator was responsible for her death, as the day he was released after his interview was the day, she completed suicide. Adult K would not have known this outcome but was anxious about it.

4.3.18 SafeLink made many attempts to contact Adult K but noted that they could have liaised with Adult K's care coordinator to try a joint face to face meeting to engage Adult K with the service. This would have needed Adult K's consent, which she declined previously. All opportunities for working together with 'individuals who are 'difficult to engage' should be taken and for organisations to facilitate this by including all relevant information in their referrals to each other.

4.3.19 Adult K was not registered with a GP from 25 August 2022 as she did not re-register after moving address. Retaining a patient living outside a GP's catchment area can increase risk to the patient as services cannot be provided and may prevent registration elsewhere. As Adult K had capacity, it was her responsibility to register with another practice. She had support and guidance from her initial GP to do this. She did not have access to mental health services from 12 September 2022 as her case was closed to AWP.

4.3.20 Adult K was issued an exclusion order by NBT Southmead on 5th October 2022. (Known as a red card by UHBW) Adult K was able to access emergency care at other local hospitals.

4.3.21 Adult K was allegedly sexually assaulted on more than one occasion by a health worker. As she had experienced sexual abuse as a child, this is likely to have had a very traumatic impact.

4.3.21 At the Kensington and Chelsea/ Westminster Safeguarding Adults Executive Board Learning Event, Dr Faye Nikopaschos, Clinical Psychologist, described research which showed the impact of Adverse Childhood Experiences (ACE)[4] on disorders of many types in adult life. The more ACEs experienced, the greater the impact is likely to be, with Adverse Community Environments (including poverty and poor housing) compounding it. The key message was that mental health difficulties are a response to trauma. It is more pertinent to ask, "What has happened to you?" rather than "What is wrong with you?". The use of Trauma Informed Approaches is promoted in the NHS 10 Year Plan.[5]

4.3.22 Professionals in South Gloucestershire understood the need to show sensitivity to Adult K's circumstances e.g., the SWASfT system notes and High Intensity User Personal Support Plan (4.1.9). However, there is little information recorded about traumatic events affecting Adult K. A more comprehensive, multi-agency Trauma Informed Approach would offer better responses for individuals in similar circumstances, based on the Three Phase Model, the phases being: stabilisation/ safety – education, coping, safety; talking about, processing, and coming to terms with past; taking up life again, moving forwards[6].

4.3.23 Adult K was unable to engage consistently with services. An AMHP summarised the situation as follows: 'There is no doubt that the nature of Adult K's presentation and her diagnoses made it challenging for services to assist her'. With her history 'it is completely understandable that Adult K's response is chaotic, counterproductive, and self-sabotaging responses, contrary to Adult K's desire to work through and resolve her life issues'. Furthermore: 'Without a consistent will on Adult K's part to make a difference in her life,

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[4] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation (eif.org.uk)
[5] NHS England » NHS Long Term Plan
[6] therecoverycollege.co.uk/the-hub/managing-my-mental-illness/books/62-the-three-phase-approach-by-carolyn-spring/file

services are at a major disadvantage when working with service users with substance dependence issues and with emotionally unstable personality disorder and their effectiveness in making constructive lasting change will be limited'.

4.3.24 Organisations shared information and conferred on plans to support Adult K and professionals complied with the policies and procedures expected of them. This kept Adult K safe from the consequences of her behaviour for a while by managing the crises. However, the system was fragmented and did not make a difference ultimately as Adult K died in a final crisis. A new vision is required which brings together the skills of a multi- agency team which can offer people like Adult K the 'wraparound' support they need.

4.3.25 Summary of Findings for Theme Three

- Adult K was unhappy with the diagnosis of EUPD and experienced it as stigmatising.
- Lack of concentration and restlessness caused by ADHD made it impossible for Adult K to study or work to support herself.
- The allegation of rape may have had a profound impact on Adult K, probably exacerbated by delays in the investigation process.
- Adult K did not engage with SafeLink despite numerous attempts to contact her. They reflect that they could have worked with her Care co-ordinator to achieve this.
- Adult K did not have a GP or Care Co-ordinator for the last month of her life.
- Trauma Informed Approaches could be utilised more comprehensively.
- Adult K's presentation and her diagnoses made it challenging for services to assist her.
- A new vision for a multi-agency service is required to provide effective services for people with complex mental health and substance misuse difficulties.

Theme Four Impact on staff

4.4 Adult K met many professionals, often in distressing circumstances. She could be out of control, upset, aggressive, and unpredictable, requiring restraint at times. Professionals may have come to see contacts with Adult K as the same event repeated over and over, with Adult K unable or unwilling to engage with the services offered to help her make a change. Continuing to 'hold the hope' for her would have been challenging.

4.4.1 At the Kensington and Chelsea/ Westminster Safeguarding Adults Executive Board Learning event, CNWT described how repeated involvement with individuals experiencing trauma can lead to 'compassion fatigue and burn out' with 'secondary or vicarious trauma' and 're-traumatising and triggering', with individual staff responding differently and adopting 'understandable protective strategies 'which can then become problems in themselves.

4.4.2 It is essential for organisations to recognise the impact on their staff and to put in place the right support to enable them to manage the traumatic events to which they are exposed. 'The Stabilisation Manual – Supporting Internal Safety' is a resource produced by CNWT containing an information pack plus 10 stabilisation skills workbooks to support with this.[7]

4.4.3 It is important to recognise unconscious bias. Kathy Oxtoby, (February 2020, British Medical Journal)[8] describes this as "what happens when our brains make snap judgments about people, places, and things based upon past experiences." Repeated exposure to Adult K's crises could result in judgements around how worthwhile an intervention might be. Adult K considered that her diagnosis of EUPD led to people not taking her seriously. Unconscious bias may affect decision making about how care proceeds. It may underlie the assumptions made that other people were dealing with the situation, and they did not need to act. (4.5.1, 4.5.3, 4.5.5) and AWP's case closure.

4.4.4 Summary of Findings for Theme Four

- Repeated exposure to traumatic events impacts on staff causing compassion fatigue and burn-out.
- There are resources available to provide appropriate support to enable staff to cope.
- There needs to be awareness that unconscious bias can affect decision making.

[7] 'The Stabilisation Manual – Supporting Internal Safety'- Central and North West London NHS Trust

[8] How Unconscious Bias can discriminate against patients and their care. Kathy Oxtoby 3/11/20

Theme Five Organisational Systems

4.5 Health and social care are complex organisations by necessity, managing large numbers of people in unique individual circumstances. Effective services rely on many systems working together and a problem with any one of them can cause the whole structure to collapse. In health and social care, systems include databases, policies, procedures, and operational practice. Effective systems depend on good communication between organisations. Safeguarding Adults is a multi-agency system. It can investigate concerns about adult abuse and co-ordinate appropriate planning to identify and mitigate risks. This system was not used in this case although there are some references to it.

4.5.1 Adult K presented as vulnerable to police. Avon & Somerset Police officers used a BRAG (blue, red, amber, green) tool on 11 occasions to assess Adult K's vulnerability and determine the response needed. These were all rated amber and were reviewed by the Lighthouse Safeguarding Unit (LSU), but no onward referrals were made to other agencies (including Adult Social Care). Each incident in isolation might not have warranted action but the frequency and nature of incidents should have prompted a referral for Adult Social Care to consider any wider care and support needs, particularly given Adult K's housing situation. An assumption was made that Adult K's care and support needs were being met by health services and that they would make onward referrals if necessary.

4.5.2 On 10th October 2022, when Adult K was in a Place of Safety, an AWP professional spoke to her about how substance misuse may mean she is putting herself in vulnerable situations. Adult K disclosed a situation in an unknown male's house where she thought she had been given her a substance without her consent. The AWP Safeguarding Team were not contacted following this and there is no reference to Adult K wishes after sharing this information, e.g., reporting this to the police or an Adult Safeguarding Referral to be made. Adult K was not offered information about support from specialist sexual abuse organisations.

4.5.3 The DHI Recovery Worker was aware of occasions when Adult K was at risk of harm. This included adult safeguarding, client dis-engagement, deterioration of Adult K's mental health and suicidal intent. The concerns were not escalated to their line manager, Safeguarding Lead, or any Team Leader. The recovery worker thought other professional were aware and dealing with it and that no action was necessary from her.

4.5.4 Adult K was seen by SWASfT ambulance crews 26 times during the Review Period and 3 Safeguarding Adults referrals were submitted. The incidents attended all identify Adult K as a vulnerable adult having needs of care and support and therefore, meeting criteria for safeguarding. Crew assessments were conducted effectively but the wider context of each incident indicated that a Safeguarding Adults referral may have been the correct management on all 26 incidents.

4.5.5 The GP received multiple notifications that Adult K was in crisis due to her mental health but had no direct contact with her. A Safeguarding Adult referral was not made for this reason. Her GP said that she "felt Adult K was being seen and dealt with by other agencies i.e., mental health, emergencies services and drug and alcohol services. We always contacted her when she asked for help but often, she didn't answer the phone to booked appointments. In retrospect, we could have tried harder to engage with her but at the time her case seemed complex, and I was falsely reassured that she was being looked after by mental health team. I think if I had had direct requests from mental health or A&E to contact Adult K as primary care was the best place to manager her, I would have been more proactive. Given her complexity I feel like I would have been looking to refer her on to specialist agencies and I doubt I would have managed her independently."

4.5.6 Southmead Hospital. Adult K's Emergency Department Personal Support Plan includes a recommendation that Safeguarding Adults referral is considered for Adult K if the situation at the time met the criteria, but this was not considered necessary.

4.5.7 The Bridge, a Sexual Assault Help Centre within UHBW, completed an adult safeguarding referral. It is not known what happened to it.

4.5.8 Findings. Safeguarding Adults referrals were not usually made by organisations having contact with Adult K. She presented as vulnerable due to her mental health and substance misuse, the frequent crises, her housing situation, and the number of times she was a victim of crime, particularly sexual abuse, and alleged rape. Adult K took serious risks with her life on

many occasions and was unable to keep herself safe. Several services were also closed to her. She met the three criteria for an enquiry under Section 42 of the Care Act 2014. She had needs for care and support; was experiencing and was at risk of abuse and, because of those needs was unable to protect herself against the abuse or the risk of it.

4.5.9 A National Analysis of Safeguarding Adults Reviews for 2017-2019[9] was carried out by Professor Michael Preston Shoot. He identified a failure to use Safeguarding Adults procedures in mental health cases. As in Adult K's case, the reasons for not doing so are not known but further exploration is needed with a view to improvement.

4.5.10 Organisational Information Systems. The Police is the only organisation to have a national system for sharing information between areas, the Police National Computer. This flags the existence of a Tactical Plan. It is often not realistic for officers involved in a crisis to access this, however. NHS Trusts and Local Authority Social Services all have their own information systems which may be shared locally in a limited way and with other organisations as appropriate if the person consents. Making requests for information can be difficult in situations where time is limited, especially out of hours. It is clearly not feasible to remove all limitations on access to each other's systems, but it should be possible to develop a risk assessment which could be shared easily in crisis situations, especially if the person is known to use services in other areas.

4.5.11 Summary of Findings for Theme Five

- Adult K met the criteria for referral to Safeguarding Adults but was not usually referred.
- It is not known what happened to the referral made by The Bridge.
- Safeguarding Adults concerns are not always identified in mental health situations**.**
- Different systems make information sharing across organisations in different areas difficult. It may be possible to improve accessibility of risk assessments.

5. Good Practice and Improvements to Practice since incident

5.1 NBT Southmead and UBHW Bristol Royal Infirmary. Development of the High Impact User Personal Support Plan in collaboration with AWP Care Co-ordinator, Police Tactical Plan and SWASfT High Intensity User Plan. These made consistent and helpful responses to Adult K's crises more possible.

5.2 The Bridge and SWASfT made Safeguarding Adults referrals for Adult K.

5.3 SafeLink made multiple attempts to engage with Adult K.

5.4 There was good liaison between professionals e.g., Care co-ordinator and GP, SafeLink and Police

5.5 All organisations participated fully in this SAR and produced thorough, reflective accounts of their involvement with Adult K.

6. Conclusions

Adult K comes across to this SAR as an engaging, articulate and educated young woman grappling with significant difficulties arising from ADHD and mental health conditions. Her misuse of alcohol and drugs exacerbated her impulsivity and prevented treatment, resulting in many episodes of self-harm and risk-taking behaviour. It made her vulnerable to exploitation and abuse by others. Adult K reached out to emergency services when she in crisis but did not engage consistently with services offering treatment and support.

6.1 Adult K was an alleged victim of rape and other sexual assaults and crimes and committed crimes herself, many of which resulted in police and court action in the weeks prior to her death. These events may have exacerbated her fragile mental health and resulted in increased risk taking and her travel to London. She did not have a GP or Care Co-ordinator at this time.

6.2 Adult K was held for 23 hours whilst in crisis in St Mary's Hospital Emergency Department on Section 136 and Section 2 due to unavailability of mental health services. To mitigate the stress caused by this, staff took her outside for breaks. This resulted in Adult K making her escape from the building and disappearing. It is not known if she planned this or took a chance

[9] Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

when she saw it. Tragically, Adult K was found deceased by the railway at a London station. It is not known if this was a suicide attempt or the tragic result of risk-taking behaviour.
6.3 This SAR shows that there are improvements to be made in the way in which organisations arrange and deliver services to people with dual and treble diagnosis. It highlights serious gaps in resources for people with mental health difficulties, especially whilst in crisis, which result in significant risks to their safety. Professionals had to work within systems which were under-resourced and with communications systems which did not facilitate information sharing in crises.

7. Multi-Agency Recommendations

7.1.1 Organisations followed policy and procedures in managing incidents and shared some plans for responding consistently. Dual and triple diagnosis are not unusual, and a service tailored to meet individual needs may be more effective than fitting them into existing services and teams with boundaries. The focus was on crisis management without a co-ordinated approach which placed Adult K at the centre. This resulted in an extremely high use of emergency services.

7.1.2 It is recommended that SGSAB seek assurance that the acute trusts (UHBW and NBT) review the High Impact User Group teams to ensure they are working with all organisations involved to share information, and that there is a Regular User protocol in place underpinned by training in the Trauma Informed Approach.

7.1.3 The shortage of Health Based Places of Safety, beds in Mental Health Units and availability of professionals approved under the MHA is having a serious impact on the availability of appropriate services for people in mental health crisis. It creates delays which result in individuals being detained for long periods in Emergency Departments which are unsuitable and unsafe. This SAR has shown that Adult K died after running away from an Emergency Department from detention under the Mental Health Act 2005, where she had been held for many hours awaiting transfer. These are national issues.

7.1.4 It is recommended that SGSAB seeks assurance that partners keep them informed of commissioning arrangements to review the availability of services to meet the needs of people with mental health problems in crisis in a timely way to reduce delays which distress individuals and put pressure on organisations which are not equipped to manage them.

7.1.5 It is recommended that SGSAB seeks assurance that escalation process for extra-contractual referrals operates out of hours to reduce the length of time patients wait in inappropriate settings.

7.1.6 It is recommended that SSSAB ensures that the findings of this SAR are used to highlight the fatal consequences of the lack of availability of HBPOS and mental health beds across England.

7.1.7 Organisations formulated their own risk assessments with some collaboration between them. In working with vulnerable individuals with complex needs who are at risk of harm or abuse, an accessible shared risk assessment and management plan is essential. Referrals between organisations should contain contact details of people involved. It has been shown that Safeguarding Adults was not used as means of protecting Adult K. It could provide an established process for multi-agency information sharing and planning.

7.1.8 It is recommended that SGSAB seek assurance that partners investigate why the Safeguarding Adults legal framework is not considered consistently in mental health situations when the criteria set out in the Care Act 2014 are met.

7.1.9 It is recommended that SGSAB seek assurance from partners that improvements are made to ensure that key risk information is saved in an easily accessible location and includes contact information for professionals involved.

7.1.10 Adult K was concerned that her diagnosis of EUPD resulted in negative perceptions of her. Professionals participating in this Review agree that the diagnosis is unhelpful and 'drains hope' and that the language used with individuals needs to be considered carefully.

7.1.11 It is recommended that SGSAB seek assurance that training is made available across all organisations to support professionals in understanding how people present with this type of behaviour and the far-reaching impact that a diagnosis of EUPD and can have on an individual. This should include training around conscious and unconscious bias in their practice when working with people with this diagnosis.

7.1.12 At the time of her death, Adult K had been closed to mental health services by AWP and was not registered with a GP[10]. Obstacles had also been experienced in accessing support with ADHD. Whilst these closures were due in part to Adult K moving area, it contributed to her inability to access appropriate support and increased her dependency on emergency services, which was not good use of resources.

7.1.13 It is recommended that SGSAB seeks assurance that partners ensure that, when people with complex mental health problems cases move area, the most appropriate option for maintaining services and for managing and sharing risks is put in place.

8. Individual Organisation Actions

The following Recommendations have been proposed by individual organisations in the South Gloucestershire Safeguarding Adults Partnership. Imperial College Healthcare NHS Trust include Recommendations in their Serious Incident Investigation Report.

8.1 Avon & Wiltshire Mental Health NHS Trust

- Supporting practitioner's understanding around the far-reaching impact a diagnosis of EUPD can have on individuals.
- Risk assessments and care plans that are regularly reviewed and fully acknowledge the risk history and how the current pathway and approach is/ isn't working.
- Improved triangulation of care with service user's family and friends
- Therapeutic discharge planning to fully acknowledge barriers that may impact on a service user's ability to re-access support from secondary mental health services.
- Appropriate safeguarding responses to disclosures of abuse
- Improved multiagency working between drug and alcohol services and AWP when working with service users who have a dual diagnosis.

8.2 Developing Health and Independence (DHI) Bristol (Drugs and Alcohol)

- Identifying staff that may be unaware or averse to identifying risk and / or safeguarding.
- Improvement in quality of case notes and identifying if escalation required.
- Communicate outcome of client death to the recovery worker and highlighting missed opportunities for escalation & safeguarding measures

8.3 SafeLink

- Liaison with care co-coordinator where it is known one is in place.

8.4 Avon and Somerset Police

- Evaluate data from the S136 panel meetings and implement learning.

[10] How to register with a GP surgery - NHS (www.nhs.uk)

- Amend MH procedural guidance to make clear the requirement to complete a BRAG for all incidents, particularly when detaining people under S136.
- Continue to raise awareness and knowledge of MH TAC plans, ensuring supervisors check their teams know about them and refer to them.
- Consider developing guidance or processes to ensure that, where appropriate, consideration is given to using the Criminal Justice System when people trespass on railway tracks.
- Consider reviewing practice for notifying Adult Social Care when people with MH vulnerabilities who may have care and support needs come into regular contact with the police.
- Consider reviewing its use of Adult at Risk forms.

8.5 South Gloucestershire Council (Approved Mental Health Professionals)

- A revised risk screen to facilitate speedy risk assessment and management.
- Ensure out of area teams have a clear summary of risk issues to facilitate their management and mitigation.

8.6 Primary Care/GP services

- GP to contact patients who have had recurrent ED attendances/SWAST call outs linked to mental health or substance misuse upon notification from the High Impact User Team. This needs to link for recommendation 7.1.2 that the High Impact User Team will alert the GP Practice to their involvement and discussion.
- A copy of the High Impact User Personal Support Plan should be saved in GP patient records regarding the agreed responsibility for the care of patients who have mental ill health and high levels of urgent care and 999 service contacts when patients are residing out of area. This includes the management of information shared by urgent care and 999 services.
- ICB Safeguarding Team to arrange and deliver a learning event to Primary Care (GP Practices) on the learning points from this review, involving colleagues from AWP and Drug and Alcohol Services.

8.7 South West Ambulance Foundation Trust

- Focus on Safeguarding Education
- Delivery of Level 3 safeguarding training to all clinical staff

9. Appendix One

Date	Incident summary and significant actions	
03/07/2022	Bristol Response Line. Call from Adult K reporting panic attack induced by weed.	AWP
04/07/2022	Recovery Team. Structured Clinical Management. Stabilisation Stage 2 Session 4 including CPA review. Not feeling able to engage.	AWP
05/07/2022	Adult K threatening suicide on train tracks. Taken home after consult with MH team.	Police
05/07/2022	Response Line. Call from Police to say Adult K on trainline expressing suicidal ideation. South Bristol Response Team: Adult K called to say anxious about court case, solicitor lack of contact, work, and money.	AWP
06/07/2022	Call between Adult K and Care Co-ordinator. Concern re admission to ED and diagnosis of EUPD Adult K referred to DHI structured psychosocial group work programme by Bristol Drugs Project (BDP) Mental Health Learning Disability Link worker. High alcohol usage, debt, housing, and mental health needs	AWP DHI

07/07/2022	Bristol Drug project called Ambulance after Adult K drank one bottle of wine, 4 cans and one bag of cocaine and was talking about ending her life in specific terms. Adult K called Recovery Team, angry at being discharged from them and that they weren't helping her	AWP
13/07/2022	Police called as Adult K by bridge having taken overdose. Ambulance called.	Police
14/07/2022	Section 136 after trying to access train tracks and taken overdose. Taken to Place of Safety, assessed, and discharged. Persistent low mood and alcohol misuse – encouraged to engage with Drug and alcohol Service.	AWP
15/07/2022	Public Order: Adult K drunk, refusing ambulance. Arrested, taken to RUH and de arrested for medical intervention to take primacy.	Police
16/07/2022	Adult K called 999 for ambulance as suicidal, self-harming with knife and overdose.	AWP
16/07/2022	Reported overdose. Officers attended and left for ambulance to deal.	Police
18/07/2022	Recovery Team Session 5 . Adult K concerned that other professionals do not take her seriously due to EUPD diagnosis.	AWP
19/07/2022	BaNES IS Adult K attended after overdose of prescribed ADHD medication. Intervention declined.	AWP
19/07/2022	Adult K absconded from RUH after presenting with overdose. Returned prior to police attendance. Homeless as cannot stay with father due to anti-social behaviour.	Police
24/07/2022	Adult K reported missing after drinking and self-harming. Located soon after, no further action.	Police
26/07/2022	Request from BRI for help due to Adult K being confrontational in ambulance. No dispatch.	Police
27/07/2022	Paramedics attended fathers address, but Adult K denied calling and was alone. Safeguarding alert raised as homeless from Friday. Adult K called Care Co-ordinator and said she was taken to ED x3 yesterday. Discussed use of emergency services- plan to reduce.	AWP
29/07/2022	Report from MH practitioner to report Adult K had been verbally abusive and threatened to kill herself. Officers located Adult K and agreed ambulance to deal. Response Line: Adult K expressing desire to jump off bridge/take tablets or cut herself. Dissatisfied with support offered. Adult K found lying at the bottom of DHI outside stairs intoxicated, ambulance was called and attended to Adult K	AWP DHI
31/07/2023	Adult K attended ED via ambulance – deliberate self-poisoning. Left hospital but deemed to lack capacity and returned by Police	North Bristol NHS Trust (Southmead)
31/07/2022	Adult K absconded from SMH after overdose. Located and left with hospital to deal.	Police
01/08/2023	Missing/suicidal – Adult K left SMH after presenting with overdose, saying she was going to jump of a bridge. Located and returned to SMH. Recovery Team Stage 2 Session 7	Police AWP UHBT

	In August 2022 a warning letter was sent to Adult K for unacceptable aggressive behaviour towards staff	
01/08/2023	Adult K attended ED via ambulance – deliberate self-poisoning. Refusing treatment and not communicating with staff. Left hospital and brought back by Police as unsure re her capacity.	North Bristol NHS Trust (Southmead)
02/08/2022	Southmead Hospital reported Adult K attended with overdose but left prior to being assessed/treated. Located at home address. MH team confirmed she could safely be left there	Police
03/08/2022	Concern for welfare – report of being suicidal and having taken overdose. Found with black market Valium – which was confiscated and destroyed. Ambulance left to deal.	Police
04/08/2022	Suicidal threats from Adult K – dialled 999- wanting to jump off bridge. Located near Southmead with ambulance service who were left to deal. Admitted to Southmead with adverse drug reaction, poss ketamine	Police DHI
04/08/2023	Adult K attended ED via ambulance – deliberate self-poisoning. Assessed as having capacity. She left and returned. Security involved as she refused to leave.	North Bristol NHS Trust Southmead
04/08/2022	Call from Adult K who was outside BRI threatening suicide. Hospital staff dealt prior to police attendance.	Police
06/08/2022	Adult K found drunk in bar and reported having drink spiked. Taken to RUH. Abusive messages found on her phone. Male arrested for spiking drink but no evidence on stop & search. Adult K refused to provide information and declined to act regarding messages.	Police
07/08/2022	Suicide threat – detained under S136 and later released. Adult K attended ED via ambulance – deliberate self-poisoning at 10.30 and 4.30. SBART Duty: Adult K contacted in distress. Said been to ED but sent home. MHA assessment done and discharged home.	Police Southmead AWP AMHP
08/08/2022	Adult K called to say she was at a random house and had taken drugs. Officers attended and confirmed she was safe and could be left there. Stage 2 Session 8 planned but DNA. Contact made...Adult K wanted to make formal complaint about her treatment and support.	Police AWP
09/08/2023	Adult K self-presented at ED. Mental health assessment completed but Adult K left before treatment.	Southmead
14/08/2022	Suicide threat from Adult K at a train station. Liaison with BTP and facilitated contact with MH crisis team.	Police
15/08/2022	Ambulance responded to call and found suicide note and Adult K missing. Located in London – Met police left to deal. 136 Met police. Section 2. Transferred to home area. Admitted Cherry Ward , Bristol	Police Met Police
15/08/2022	Admitted after overdose. Plan for voluntary admission but Adult K left before bed located.	Chelsea and Westminster Hospital
16/08/2022	Adult K returned and was detained under Section 2 and transferred to mental health unit in Bristol.	Chelsea and Westminster Hospital

18/08/2022	Informed Adult K had been discharged home from Cherry Ward.	AWP
21/08/2022	Report of overdose – passed to ambulance to deal. Adult K attended ED via ambulance – deliberate self-poisoning. Left before assessment	Police Southmead
22/08/2022	Suicidal threat – jumping in front of cars. MH Triage advice given. Taken to BRI for assessment by ambulance but later discharged. **Professionals meeting held: Personality Disorder service, BRI High Impact User Team, RUH Liaison Psych, SWAST and Police**	Police UHBW AWP
26/08/2022	Overdose and third-party report of her being assaulted. Adult K refused to provide details of alleged assault. Taken to hospital by ambulance.	Police
27/08/2022	Threat to jump of a bridge – extensive tour of area, not located.	Police
30/08/2022	Response: Adult K called re her police interview tomorrow regarding allegations against HCA on **Silver Birch** .	AWP
02/09/2022	Threat to travel to London to jump off a bridge, then wandered into road and collapsed. Detained under S136 and later released.	Police
03/09/2022	Adult K attended ED via ambulance – deliberate self-poisoning/crack cocaine and alcohol. CT scan normal. Signposted to Bristol Drugs Project.	Southmead
03/09/2022	MHA assessment. Discharged home.	AMHP
05/09/2022-06/09/2022	Adult K reported her laptop was stolen by flat mate and she'd been date raped but later refused to provide details of either allegation. Male arrested, denied offence and was later released with no further action.	Police
06/09/2022	Report of Adult K going missing. Located in London and detained under S136 by Met police. Taken to Chelsea and Westminster Hospital. Section 2 in place - transferred to Bristol psychiatric ward.	Met Police St Marys Hospital
09/09/2022	Adult K tried to climb out of window. Taken by police to BRI ED but later discharged.	UHBW-BRI
12/09/2022	South Bristol Recovery: CPA discharge meeting Unmet needs as not engaging and alcohol misuse. First Stage of Structured Care useful but Adult K no longer engaging. Moved out of area	AWP
20/09/2022	Ambulance report that Adult K had self-harmed and locked herself in bathroom. Officers attended and later left ambulance to deal. Later absconded from hospital but returned on own accord.	Police
20/09/2022	Adult K found on train tracks by network rail. Detained under S136 and later released.	Police
21/09/2022	MHA assessment . Discharged home.	AMHP
24/08/2022	Response: Adult K called to say intoxicated with alcohol plus weed and cocaine. Hopes to start rehab in 6-8 months.	AWP
25/09/2022	Report that Adult K detained in Worcester after being prevented from jumping under train.	AWP
29/09/2022	Report that Adult K is suicidal from her drug/alcohol worker. Detained under S136 and later released.	Police
30/09/2022	Concern for welfare – left door open. No action.	Police

30/09/2022	Public order offence and assault of staff at SMH. Arrested and charged. Pleaded guilty on 18/10/2022. (Died before court outcome).	Police
30/09/2022	Adult K attended ED via ambulance – intoxicated and unconscious. Left after assessment but before treatment. Assault on staff member so security and police involved. Exclusion order for 12 months given.	Southmead
30/09/2022	MH Act assessment. Discharged home.	AMHP
09/10/2022 October	Adult K threatening suicide on rail tracks - detained under S136 and later released. Began to attend Preparation for change group. Given food vouchers and discussed residential rehab options	Police DHI
10/10/2022	Absconded from BRI and found running into traffic - detained under S136. MH Act assessment. Discharged home.	Police AMHP
11/10/2022	Admitted at 23.00 in distressed state on Section 136.Letter sent to GP.	UHBW
17/10/2022	Report of Adult K running in front of cars - detained under S136 and later released. High Impact User Team tried to contact Adult K unsuccessfully. Personal Support Plan posted to her.	Police UHBW
18/10 /2022	Court Hearing. Supported by **Assessment and Support in Court and Custody Team.** MH Act assessment. Discharged home	AWP AMPH
20/10/2022	Last group attendance	DHI
20/10/2022	Report that Adult K was going to go to railway tracks. Located at home after extensive search.	Police
21-22/10/2022	Found by canal threatening to take own life. Taken to St Marys Hospital by ambulance with Police presence and restraint.	Met police
21/10/2022	Adult K brought in at 22.48 on trolley by ambulance with restraint by Police. Reported taking cocaine and alcohol. Agitated and risk to self so detained under 136. Given sedation.	St Marys Hospital
22/10/2022	Declared fit for MHAA at 6.47 on 22 Oct. Assessment carried out at 13.30. Appeared distracted and inattentive but stable with no thought disorders etc. Not detainable under Section 2 so discharged at 14.30 with plan to register with GP an seek help from Rethink in Bristol. At 15.42 Detained on 136 about to jump off bridge. No HBPoS available so admitted to ED by ambulance with Police. Very agitated so sedated. MHAA at 23.55 with recommendation for Section 2.Lacked capacity as unable to weigh up risks to self in community. Held on ED with Police as no HBPoS. Taken for several breaks for fresh air. No MH beds in Bristol.	St Marys Hospital
23/10/2022	11.54 Bristol MH bed available. Section 2 papers completed, and secure transport booked. 14.30 Police left ED. 15.20 Adult K asked to go outside to vape and was taken by 2 RMNs and 2 Security Officers. As Security Officer	St Marys Hospital

	swiped access control, Adult K pushed the door and ran off out of sight. 20.16 police called to say Adult K had been found deceased next to a live rail at Victoria Station.	
23/10/2022	Report from Met Police re Adult K's death.	Met police

Addendum:

BNSSG ICB requested changes to the wording of single agency recommendations at 8.6 and this was agreed at the South Gloucestershire Safeguarding Adults Board on 7th December 2023.

- Further to recommendation 7.1.2, the High Impact User Team will alert the GP Practice to their involvement and discussions had, which will enable the GP to contact patients who have had recurrent ED attendances/SWAST call outs linked to mental health or substance misuse.
- A copy of the High Impact User Personal Support Plan should be saved in GP patient records regarding the agreed responsibility for the care of patients who have mental ill health and high levels of urgent care and 999 service contacts in order that this information can be highlighted and shared with other agencies including other GP Practices should the patient move area at the earliest opportunity. This includes the management of information shared by urgent care and 999 services.