# Northamptonshire Safeguarding Adults Board

## Safeguarding Adults Review

## SAR 051 – Adult D – Self-neglect

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## 1. Introduction

A Safeguarding Adult Review (SAR) referral was submitted to Northamptonshire Safeguarding Adults Board (NSAB) from Northamptonshire Police in late September 2023. The referral raised concerns regarding the person's self-neglect and mental health, and the possible failure of agencies to support. The referral was considered at the NSAB SAR Subgroup and the Chair and statutory partners agreed with the recommendation that the referral met the criteria for a Safeguarding Adult Review (SAR) under s44 (3) of the Care Act 2014.

*There were delays completing the report due to capacity within the NSAB Business Office and the SAR Subgroup.*

## 2. Safeguarding Adult Reviews (SAR) - Legal Context & Purpose

2.1 Section 44 of the Care Act 2014 requires Safeguarding Adult Boards to carry out safeguarding adult reviews involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if –

a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) Condition 1 or 2 is met

(2) Condition 1 is met if –

a) the adult has died and

b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse of neglect before the adult died)

(3) Condition 2 is met if

a) the adult is still alive and

b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs).

2.2 A SAR is a supportive multi-agency review process for partner agencies to look at agency contact and practice and identify lessons that can be learned from complex or serious adult safeguarding cases where an adult at risk has died or been seriously harmed, and abuse or neglect has been suspected. The review will not re-investigate or apportion blame, but aims to identify gaps in process and practice, including where agencies could have worked better together, and to recognise any good practice. Recommendations are made to change and improve practice and services.

2.3 The review process necessitates openness and critical analysis to allow an exploration of the decisions made and actions taken to identify any lessons to be learnt to improve practice from the circumstances, and to apply those lessons to future cases.

2.4 All agencies involved with Adult D were required to contribute to the review and a scoping of information from all known agencies involved was requested. Adult D was known to the following agencies/services:

DHU Healthcare NHS 111 Service, East Midlands Ambulance Service (EMAS), Langham Place Surgery, Northampton General Hospital (NGH), Northamptonshire Healthcare NHS Foundation Trust (NHFT) Mental Health Services including Berrywood Hospital, Campbell House, and St. Mary's Hospital, Northamptonshire Police, St. Andrews Healthcare (out of scoping period), West Northamptonshire Council (WNC) Adult Social Care (ASC), Approved Mental Health Professional (AMHP) Service, and the Safeguarding team.

2.5 A Multi-Agency Case Audit (MACA) was the agreed methodology used as the most proportionate way to approach the review. All agencies involved in the SAR provided an audit, not detailed chronologies, to enable the panel to review key aspects leading to the incident. The MACA was held on the 9th July 2024.

2.6 The agreed scope of the SAR was 1st December 2022 to 13th September 2023.

2.7 This report summarises the key findings from the review. The main key lines of enquiry in the audit were:

- Care co-ordination between in-patient mental health and community mental health services
- Robustness of Mental Health Act (MHA) Assessments
- Robustness of agency risk assessments
- Discharge from services
- Inter-agency communication
- Adult Risk Management (ARM)
- Barriers to engagement
- What consideration is given to closing cases where there is complex need.

## 3. Who is Adult D

3.1 Adult D is a white, north European female in her early forties. Adult D was married for 17 years, but separated in 2020.

3.2 Adult D has a history of self-harm and depression, and at the time of the incident, had a diagnosis of Emotionally Unstable Personality Disorder[1] - the diagnosis has since changed to Complex Personality Disorder. They are well-known to mental health and emergency services and had been a frequent attender at the hospital accident and emergency department. Adult D had been placed on Mental Health Act[2] (MHA) 1983, and Section 136[3] (s136) orders on a number of occasions, had been detained under Section 3[4] of the MHA, and had a number of informal admissions to mental health hospitals. There were a number of incidents of self-harm and threats of suicide that led to an incident on 13th September 2023, where Adult D suffered life changing injuries. There were a number of occasions where Adult D was unable to engage with services despite many attempts to support her.

3.3 We understand Adult D to be a very determined individual who has made a remarkable recovery physically following the incident in September 2023. She has been living independently since she was discharged from hospital, and had taken a lot of pride in decorating her flat. She actively participates in community group activities and therapeutic sessions, and enjoys cooking healthy meals for herself, walking and shopping. Adult D is very close to her family and enjoys spending time with them.

## 4. NSAB Contact with Adult D

The NSAB Business Manager made contact with Adult D's social worker to advise of the review, who in turn advised Adult D. The Business Manager also spoke briefly with Adult D as to the purpose of the review, but didn't discuss any wider issues due to their recovery and complex mental health issues.

A draft report was shared with Adult D via her social worker in November 2025.

At the time of writing this report, NHFT (various teams) and West Northants Council Adult Social Care, are actively supporting Adult D.

1 Emotionally unstable personality disorder (EUPD) is a psychiatric condition which can cause fluctuations in mood, and which affects how an individual interacts with and relates to others. Formerly known as borderline personality disorder (BPD), EUPD is part of a group of psychiatric conditions known as personality disorders – where someone's personality can interfere with their function, perceptions, behaviour and relationships with others.

2 Mental Health Act (MHA) 1983 is the main legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the MHA need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

3 Section 136 MHA – section 136 gives the police the power to remove a person from a public place when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

4 Section 3 MHA - is commonly known as treatment order, it allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met.

## 5. Chronology of events during the scoping period 1st December 2022 to 13th September 2023

5.1 From the information received as part of the Multi-agency Case Audit (MACA) the following interactions took place during the period of the review:

- Five safeguarding concerns were submitted to West Northamptonshire Council – 5th December 2022, 25th December 2022, 5th July 2023, 18th July 2023 (an unrelated historic issue), 3rd August 2023. One concern raised in September 2022 resulted in enquiries being made relating to Adult D absconding from Berrywood Hospital during a section 2 MHA order.
- Four requests for a Mental Health Act (MHA) Assessment were raised/undertaken.
- East Midlands Ambulance Service (EMAS) supported Adult D 13 times.
- Adult D attended Northampton General Hospital (NGH) on 15 occasions, and twice in one day at a Norfolk Hospital.
- Section 136 undertaken taken by Police taking Adult D to a place of safety, 14 times.

### Chronology

It is of note that the MACA audits submitted by the different agencies had contradictory information regarding events, dates and safeguarding referrals.

5.2 A chronology of events has been included in the SAR as we felt it was important to highlight the numerous interactions that took place leading up to the incident between 14th December 2022 and the 13th September 2023:

- 14th December 2022 and 15th December 2022 – Following discharge from Berrywood Hospital on 13th December 2022 (detained under Section 3 of the MHA), Adult D was brought to NGH by EMAS following an episode of self-harm and an overdose. She was referred to the Acute Liaison Mental Health Service (ALMHS) but left the hospital before a mental health assessment could be undertaken. She was recorded as a high-risk missing person by the police, was located at her home address and brought back to the hospital by the police. Adult D spoke with the Op Alloy Team over the phone as she hadn't been able to get in contact with her own Community Psychiatric Nurse (CPN). She agreed to return to hospital but advised that she would not be able to keep herself safe at home and did not believe Urgent Care & Assessment Team (UCAT) could support her. She agreed to an informal inpatient admission and ALMHS were to discuss a gatekeeping assessment with UCAT. A multi-disciplinary (MDT) meeting was held by mental health services in response to Adult D's presenting risks, and a plan was formulated. *There is nothing in the audit to suggest which agencies were present at the MDT or details of the agreed risk management plan.*
- 23rd December 2022 – Attended NGH following an overdose but left after being told that her bloods and electrocardiogram[5] (ECG) were fine.
- 25th December 2022 - Attended NGH following an overdose and admitted to Critical Care. *There was no information provided in the audits regarding plans to reduce risk of overdose.*

[5] An ECG (electrocardiogram) is a test that records the electrical activity of the heart, including the rate and rhythm. Visit the NHS website here for more information.

- 31st December 2022 – Adult D attended a planned appointment at the Personality Disorder Hub (PDH)[6] with her Community Psychiatric Nurse (CPN) for Dialectic Behavioural Therapy[7] (DBT). She disclosed that she was discharged with a month's supply of medication and that she had overdosed. An ambulance was called and Adult D was taken to NGH but she was not seen by ALMHS on admission as she had been declared to be medically fit by NGH.

- 1st January 2023 – Adult D was placed on Section 5 (2)[8] of the MHA at Berrywood Hospital, and then detained under Section 3 of the MHA on 4th January 2023. She was referred to the Eating Disorders Team due to poor diet intake by the ward staff, although found not to have an eating disorder.

- Between 8th January 2023 and 28th February 2023 – Whilst a patient at Berrywood Hospital, Adult D attended NGH on three occasions with chest pain, vomiting, and generally feeling unwell. Tests regarding chest pain were clear. On 17th February 2023, whilst still a patient at Berrywood Hospital, Adult D said ahead of her being discharged back to the community, that she wanted to stay in Berrywood as she didn't feel safe. *There is nothing in the audits about what measures were put in place to ease her safety concerns and no information relating to Section 117 planning.*

- 3rd March 2023 – Berrywood Hospital made contact with WNC's Adult Social Care Team to request their contribution to an Adult Risk Management (ARM) plan. WNC advised that Berrywood could instigate the ARM process to bring agencies together. *There was no explanation provided in the audits as to why Berrywood Hospital did not convene the ARM process.*

- Between 6th March 2023 and 16th April 2023 – Whilst a patient at Berrywood Hospital, Adult D attended NGH with chest pains on two occasions and with severe hydration. On the 16th April, she went to the toilet unaccompanied and absconded. The police located Adult D and advised that she was very upset and had been suffering from suicidal thoughts. *There was no information provided in the audits to suggest whether Adult D should have been accompanied to the toilet i.e. unsure whether there was a support plan in place to suggest this should happen and if so, why she was left unaccompanied.*

- 19th April 2023 – WNC Adult Social Care received a mental health form from Northamptonshire Police advising their concern regarding Adult D's discharge from Berrywood Hospital as they believed she was not well enough to be discharged, and that she may require a Care Act Assessment if she was to return to community living, and a robust support package was put in place.

- 25th April 2023 – Adult D was discharged from Berrywood Hospital to the care of the Urgent Care and Assessment Team (UCAT)[9]. Adult D had daily contact with UCAT to monitor her mental state and mood.

- 2nd May 2023 - Adult D had a fall after becoming dizzy and an ambulance was called by NHS 111 (Adult D reported to the report author that at that time, she hadn't been eating). EMAS attended and took her to NGH. Adult D reported that she waited a long time to be seen, so she did not wait for treatment in the Accident and Emergency Department. No overdose or self-harm was reported. On the same day, she contacted the Crisis Team as she was feeling suicidal following her discharge from Berrywood Hospital the previous week. *There was no information provided in the audits to suggest why ALMHS were not informed.*

- 3rd May 2023 – Adult D attended an appointment for Dialectical Behaviour Therapy (DBT). A further appointment with CMHT was scheduled later that same week.

[6] The Northamptonshire Personality Disorder Hub provides a countywide specialist service to promote understanding and hope regarding the treatability of personality disorder. The provide a Dialectical Behavioural Therapy one-year programme. Visit the NHFT website here for further information on the Northants Personality Disorder Hub.

[7] Dialectical Behaviour Therapy (DBT) is a type of therapy that helps individuals manage difficult emotions, improve relationships, and develop more healthy coping mechanisms. It's particularly effective for those with Borderline Personality Disorder (BPD), but it can also be beneficial for other conditions like depression, anxiety, and self-harm. Visit the Mind website via this link for further information.

[8] Section 5 (2) MHA - gives doctors the ability to detain someone in hospital for up to 72 hours, during which time you should receive an assessment that decides if further detention under the MHA is necessary.

[9] In Northamptonshire, the Urgent Care and Assessment Team (UCAT) works to make sure a responsive assessment is given by a multi-disciplinary team to service users regarding their mental health.

- 7th May 2023 – Police officers found Adult D in an emotionally distressed state. She had left her address during a home visit from the Crisis Team. She was detained under Section 136 of the MHA and taken to the Welland Centre at St. Mary's Hospital.
- 9th May 2023 – Police received a call from the Crisis Team who reported their concerns for Adult D's welfare (she had called mental health services stating she was unable to keep herself safe). Op Alloy[10] were contacted and Adult D was placed under Section 136 before being conveyed to St. Mary's Hospital.
- 18th May 2023 – Adult D's family telephone CMHT as she had not been in contact for two days. CMHT contacted UCAT who agreed to complete a supportive call. Sadly, no contact was made by UCAT, and this was escalated to the police for a welfare check. Again, no contact was made, and Adult D was reported missing. Police ANPR cameras sighted Adult D in the Norfolk area. Subsequently, contacts were made by Adult D to the Northamptonshire Integrated Response Hub (IRH)[11] to say she was feeling suicidal, but she ended the call.
- 19th May 2023 – The IRH was contacted by a Norfolk Hospital to advise that Adult D was an inpatient and awaiting blood results. Later the same day, Adult D was found by police trying to self-harm and was taken back to the hospital where she continued to self-harm. A MHA Assessment was convened and she was detained under Section 2[12] of the MHA and transferred to Berrywood Hospital in Northamptonshire.
- 3rd August 2023 – EMAS received a call from the Crisis Team due to Adult D's safety. Adult D did not want to attend NGH Accident & Emergency as this it would increase her depression. However, she was willing to go to Berrywood Hospital. Unfortunately, the crew were unable to transport to Berrywood as they were informed they were at capacity. The ambulance crew felt the patient was left at home in a high-risk situation that may result in further self-harm. A care concern was sent to her GP and Adult Social Care regarding reports of self-harm attempts. *The Safeguarding concern was closed following duty enquiries. Having checked with the Adult Safeguarding Team's Service Manager at West Northamptonshire Council, they are unable to confirm why the enquiry was closed as the transition to the new data management system, Liquid Logic doesn't have the complete workflow from the previous system, Eclipse. However, the notes show a lot of activity between mental health professionals at the time.*
- 4th September 2023 - Adult D contacted the WNC's Community Team to discuss being placed in supported accommodation. A strengths-based approach was taken and the social worker felt that Adult D needed a Care Act Assessment. Adult Social Care acknowledged this by allocating Adult D for a full Care Act Assessment on 4th September. It is noted that the assessment wasn't undertaken before the incident on 13th September 2023.
- 10th September 2023 – Adult D was reported missing after calling the IRH but was subsequently found by police in an extremely distressed state. She was detained under Section 136 of the MHA and transferred to St Mary's Hospital as a place of safety. The Emergency Duty Team advised Adult D that they were unable to undertake a MHA Assessment due to an urgent community assessment taking priority, and that the assessment would take place the following day. Adult D became distressed when told. *We acknowledge that this event occurred on a Sunday and therefore the service was not a full working week provision.*
- 11th September 2023 – A Mental Health Assessment (MHA) was undertaken, and an informal admission was agreed. It was noted that Adult D was flat and in low mood (evidence of recent self-harm). Unfortunately, a bed was not available and Adult D remained in the Section 136 suite overnight.
- 12th September 2023 – Adult D remained in the Section 136 suite but became distressed and requested to leave. A discussion between the Consultant Psychiatrist, Ward Manager and Registered Nurse agreed Adult D was not detainable and there was no indication to re-assess following assessment the previous day,

[10] Op Alloy is a mental health triage and police liaison service within the NHFT crisis pathway. The pathway incorporates the Acute Liaison Teams at the general hospitals, Crisis Cafes, the Integrated Mental Health Hub and Police custody.

[11] Northamptonshire Healthcare Foundation Trust (NHFT) provide a 24 hour, 7 days a week telephone support service to provide mental health support via the mental health charity, Mind. The mental health number 0800 448 0828 connects callers to trained professionals who provide local support or signposting, whether this is via the NHS, the voluntary and community sector, or advice over the phone.

[12] Section 2 MHA – under section 2, a stay in hospital can be up to 28 days. A doctor should discharge from section 2 if criteria for detention is no longer appropriate. Hospital staff cannot extend a section 2.

despite her distress. The Community Mental Health Team[13] (CMHT) was contacted but declined to attend the meeting due no availability. There were no grounds to detain and Adult D was supported with a taxi back home.

- On the same day, 12th September 2023 - Op Alloy[14] noted an incoming call from the police reporting an adult in distress. Adult D was detained under Section 136 and taken back to St. Mary's Hospital where a MHA Assessment concluded that Adult D was not acutely unwell and therefore not detainable, however, she was at risk of death by misadventure. The assessing doctor was to contact CMHT regarding a potential medication change.
- 13th September 2023 - CMHT attempted to contact Adult D but there was no response and a message was left. Later the same day, police attended an incident following a call to emergency services. It was confirmed that Adult D had self-harmed and may have suffered life threatening injuries. She was transferred to Coventry and Warwick Hospital.

## 6. Key lines of enquiry findings, missed opportunities and good practice

This section explores the findings from the Multi-Agency Case Audit (MACA) audits and discussion held in July 2024 including the suggested key lines of enquiry, missed opportunities and good practice.

### 6.1 Care co-ordination between in-patient mental health and community mental health services

a. Whilst detained under Section 136 at St. Mary's Hospital, on 12th September 2023, an informal admission was offered but refused by Adult D (she was assessed as not detainable). Unfortunately, support via UCAT was not offered instead.

b. There was a lack of availability for a member of CMHT to attend the MHA assessment on 12th September 2023 at St. Mary's Hospital.

c. In December 2022, Adult D informed the police that she was unable to make contact with her CPN. It is noted that the hours for CMHT are 09:00 to -17:00 Monday to Friday and there is no expectation that staff would answer or respond to an urgent call the same day, evenings or weekends, or when on annual leave. Outside the standard working hours, the IRH is available and is managed by mental health professionals.

*Risk may have been mitigated risk in the short term if CMHT had attended the MHA assessment on the 12th September, and support from UCAT had been offered and a personalised safety plan was put in place on her return home. The assessing doctor was to contact CMHT regarding medication for Adult D and to discuss her low expectation of support from the service. Sadly, it doesn't appear that CMHT were contacted.*

### 6.2 Robustness and timeliness of Mental Health Act 2005 Assessments, Care Act Assessments and Risk Assessments

a. The Approved Mental Health Professional (AMHP) service was involved with two MHA Assessments for Adult D just days before the incident. The first assessment was requested on Sunday 10th September 2023, but due to an urgent community assessment taking priority, this didn't take place until the following day, 11th September 2023. Following the MHA Assessment, Adult D agreed to an informal admission, but a bed wasn't available. She remained in the Section 136 suite but became distressed due to the delay. Following a professionals' discussion she was then deemed not detainable and

[13] NHFT provides the Community Mental Health Team (CMHT) service which includes local assessment, monitoring, support and treatment for a full range of mental health conditions. CMHT is for people with mental health needs which cannot be met by NHS Talking Therapies, the GP or the voluntary and community sector (VCS). Please see the link to the Community Mental Health Team NHFT website here.

[14] The service known as Op Alloy is the police street triage care providing a frontline police offer and a mental health professional. The service is in place to ensure that all service users with mental health issues are supported during a challenging crisis period. The specialist mental health skills are provided by NHFT and provides assessment, treatment and pathway support at initial point of contact.

provided with a taxi to get home. It is unclear from the NHFT audit what risk assessment took place to mitigate risk. *Did the lack of a psychiatric bed in or out of county put Adult D at increased risk?*

b. Robust community care and safety planning under Section 117 of the MHA[15] does not appear to have been considered or offered to Adult D.

c. The Mental Capacity Act 2005 should have been considered, and robust risk assessments undertaken where there was doubt that Adult D had the capacity to make a particular decision before being discharged.

e. The AMHP Service suggested advance decision planning may have identified what would have supported Adult D more effectively at times of crisis.

*The use of the Mental Capacity Act and assessment is a recurring theme for NSAB as evidenced in previous multi-agency case audits. As such, a multi-agency learning event was held in November 2024 with over 100 colleagues attending.*

*Robust safety planning should have been put in place to reduce the risk of re-admission for individuals with enduring mental health disorders such as Adult D.*

### 6.3 Discharge from services

a. When Adult D was transferred from one CMHT worker to another, it appears that inadequate handover was put in place to ensure consistent support. A multi-agency discussion prior to hospital discharge may have been beneficial to provide additional support for Adult D when back in the community.

b. Adult D had lengthy hospital admissions to mental health units both formally and informally under Section 2 or 3 of the MHA, with EMAS attending to Adult D repeatedly shortly after discharge.

c. A discharge letter dated 26th August 2023 was sent from St Mary's Hospital following Adult D's discharge from the service, but this wasn't processed on the GP surgery system until 4th September. There was no detail regarding the reason for admission to enable the surgery to risk assess, although Adult D remained under the care of CMHT.

d. On 12th September 2023, the assessing team at St. Mary's Hospital were in agreement about discharging Adult D back home as there was no evidence of distress by Adult D at the time, or that she would harm herself. However, Adult D was not as confident about how other agencies would support her and the Doctor stated he would request this. It is unclear whether this request was communicated.

*Good, robust communication and information sharing with other agencies is key when someone has complex needs.*

*Adult D would visit the same place when in crisis. Panel members felt it would be helpful if information such as details of the IRH or Samaritans were posted at common 'high risk hot spots.' This approach may help to alleviate adult distress at the point of crisis.*

### 6.4 Inter-agency communication and Adult Risk Management (ARM)

a. There was often a lack of information sharing, professional curiosity and consideration of multi-agency meetings from those working with and in contact with Adult D. This was particularly important in respect of Adult D not being in a position to engage with services before the case was closed.

[15] Section 117 of the MHA entitles an adult to free aftercare to support their mental health needs when discharged from hospital. Section 117 aftercare - Under the Mental Health Act 1983

b. Adult D was supported by CMHT regarding her medication, although it appears she was not taking medication. If there had been more robust multi-agency support in place there may not have been a need for the second MHA Assessment on the 12th September 2023.

c. On 2nd May 2023, despite reporting to the Crisis Team that she felt suicidal following discharge from Berrywood Hospital the previous week, and being taken to NGH Accident & Emergency following a fall, EMAS do not appear to have informed ALMHS of an overdose or self-harm on arrival. *There was no information provided in the audits to suggest why ALMHS were not informed.*

d. Agencies appeared to take a reactive response regarding support for Adult D and there was an over-reliance on mental health services.

e. From the information provided, no multi-agency discussion or ARM was held for Adult D during the 9-month period of this review, despite Berrywood Hospital requesting information from WNC Adult Social Care regarding an ARM on 3rd March 2023. There were a number of instances where Adult D had put themselves at risk of serious harm and were deemed to have capacity to make decisions, yet no multi-agency meeting or ARM occurred.

f. At the MHA Assessment on 12th September 2023, Adult D advised that she was experiencing stress due to finances and poor sleep, and a medication plan was made to support with this. No medical recommendations were made. *There is nothing in the audits to suggest Adult D received any support regarding her finances.*

*For adults experiencing enduring poor mental health, it may be beneficial to request a multi-disciplinary meeting when discharging from services to ensure all relevant parties are aware of the circumstance. This would capture strengths and positive factors to support agencies to provide a more preventative rather than reactive approach in an attempt to keep people safer.*

### 6.5 Barriers to engagement

a. A second MHA Assessment was arranged for 12th September 2023, following Adult D being found by the police. Adult D advised that they had not waited at the place of safety for an informal admission on 11th September 2023 as hospital admission didn't help – this was a joint decision between her and the Doctor.

*As a psychiatric bed was not available (responsibility of NHFT and Northamptonshire Integrated Care Board (ICB)), this proved very distressing for Adult D. Although it's difficult to know, had a bed been available, it might have prevented the incident from occurring on 13th September 2023.*

#### 6.5.1 Other findings of note

a. EMAS noted that it can be confusing to ambulance crews when they are trying to locate appropriate support for mental health crisis when the patient does not wish to attend hospital accident & emergency, and there are no available mental health beds.

b. Evidence was provided by the AMHP Service, EMAS, NHFT and NGH that mental capacity had been considered. The same could not be said of the GP Surgery or WNC ASC from the information provided and discussed.

c. A general Making Safeguarding Personal (MSP) approach for Adult D's wishes are evidenced in agency audits. More specifically, Adult Social Care staff spoke with Adult D about her views and desired outcomes; one of which was wanting supported accommodation and there was an agreement to complete a Care Act Assessment.

d. There was some confusion about when the use of Section 136 powers could be used by Northamptonshire Police. *See recommendation 6.*

e. It is noted in the NHFT audit that a shortage of mental health in-patient beds is a national issue.

f. NHFT confirmed a concise investigation had been completed following the incident on 13th September. Two recommendations are noted:

i. Clear process for on-going community care and safety planning following a MHA assessment and in the context of continued needs and risk to self – deadline 31.10.24.

ii. Development of CMHT change of keyworker guidance that would consider the transitions in care – deadline 12.07.24.

g. When discharged from Berrywood Hospital to the care of the UCAT in April 2023, daily contact with UCAT was put in place to monitor mental state, mood, and risks. The risk plan included:

- UCAT to complete a joint review with CMHT at NGH.
- To be reviewed for potential Crisis House.
- Encouragement with diet and fluids.
- Monitor low blood pressure and low potassium levels.

### 6.6 Good Practice

There are examples of good practice for this case from a number of agencies:

7.2.1 A referral to the Acute Liaison Mental Health Service (ALMHS) was made by NGH on 13th December 2022. Contact was made with the police when Adult D absconded, and they were safely returned to the hospital. A Doctor encouraged her to stay overnight at NGH for her safety until a bed became available for an informal mental health admission, which she did.

7.2.2 There were attempts by the GP to provide Adult D with support from a Social Prescribing Link Worker (SPLW).

7.2.3 The WNC Community Teams were receiving notifications regarding agency interactions with Adult D. These indicated the risk to Adult D's mental health and her ability to regulate her desire to self-harm. Actions were taken under the MHA as required and documented decision making by the AMHP and Doctors in line with legislation. In each case there is a detailed plan of support based on mental health services.

7.2.4 Good communication was in place between the police and mental health services, as well as cross-border liaison between forces when Adult D had been located out of county.

7.2.5 NGH made contact with the police when Adult D absconded from the hospital and she was safely returned following a welfare check.

7.2.6 The GP surgery saw Adult D in person following her discharge from inpatient services allowing for a more detailed review of her presentation. Also, Healthcare Assistant appointments were held with the same team member to ensure continuity of care. In addition, the Social Prescribing Link Worker liaised with other services involved in Adult D's care before discharging.

### 7.3 Missed Opportunities

The MACA panel felt that there were a number of missed opportunities:

7.3.1 From an EMAS perspective, there were concerns about a lack of robust discharge planning/safe discharge following a number of admissions at mental health hospitals, as they often attended calls for Adult D very soon after she had been discharged.

7.3.2 The GP practice advised that an initial assessment was undertaken by the Social Prescribing Link Worker (SPLW) on 1st June 2023, but Adult D was discharged on 15th June due to their non-engagement following two failed attempts at making contact. They felt that Adult D may not have been in a position to engage with the worker at the time. The MACA panel felt that there was a lack of professional curiosity in exploring the reasons why Adult D was unable to engage at that time.

7.3.3 A discharge letter dated 26th August 2023 was sent from St Mary's Hospital following Adult D's discharge from the service, but this wasn't processed on the GP practice computer system until 4th September 2023. There was no detail in the discharge letter regarding the reason for admission to enable the surgery to adequately risk assess, and Adult D therefore remained under the care of the CMHT. At the MACA, the GP advised that it usually takes a few days for a discharge letter to be received from acute/mental health hospitals and that the length of time depends on the day/time the individual is discharged, and the method the letter is sent i.e. by post or via SystmOne[16]. Not all GPs use SystmOne, so it is more likely that letters are sent via the postal service and then input on the system.

7.3.4 Officers from Northamptonshire Police issued Adult Public Protection Notices[17] (PPNs) and mental health referrals noting that they felt they had exhausted all avenues with the resources available to them at the time. A multi-agency meeting should have been called at this point to discuss a strategy and safety planning.

7.3.5 Following a call from Adult D on 4th September 2023, a MHA Assessment was undertaken on 11th September 2023, and Adult D returned home with a plan in place. However, a Care Act Assessment was not undertaken as suggested.

7.3.6 The lack of available adult mental health inpatient beds had an adverse impact on Adult D receiving appropriate, timely support. Despite being in a state of crisis, on a number of occasions Adult D was discharged only to be found in a state of crisis self-harming or attempting to end her life.

7.3.7 Given the challenges and risks associated with Adult D, WNC Adult Social Care had advised CMHT about the consideration of an ARM and noted on their audit that they were unclear as to why this didn't happen. It is unclear why CMHT did not instigate a multi-agency discussion or an ARM.

## 7.4 Agency learning and what has changed since the incident

7.4.1 There were a number of recurring themes in this SAR that have appeared in other Northamptonshire SARs – see narrative in italics. Note learning from SAR 019 Jonathan published in March 2021.

**a. Multi-agency discussion / Adult Risk Management (ARM)**

Despite the number of incidents where multiple agencies were involved with Adult D, there was no evidence of multi-agency discussion or an ARM being called. There still appears to be a lack of awareness as to who can raise an ARM at Berrywood Hospital, NHFT CMHT, and Northamptonshire Police - See 3rd March 2023 entry above. Further education should be provided by these agencies to ensure there is a multi-agency approach to supporting adults at high risk of harm.

*This remains a point of concern for NSAB as any agency can raise an ARM. NSAB has provided many opportunities for training and has raised awareness of the ARM process to the partnership since 2019. A detailed toolkit including guidance and meeting minute templates are provided on the NSAB website (includes a short information video). The ARM process has been reviewed since the incident, and the paperwork updated/simplified following feedback from colleagues. The ARM process was relaunched in January 2025.*

*There are numerous recorded training sessions available on the NSAB website, together with agency dedicated training. WNC have delivered monthly ARM training, and colleagues are willing to provide this to other agencies.*

*For further information, please visit the NSAB website pages via these links – policies and procedures and weeks of learning recordings.*

[16] SystmOne is a secure patient information recording system used in the NHS staff.

[17] A police Public Protection Notice (PPN) is an information sharing document that records safeguarding concerns about an adult or a child. PPNs are shared with partner agencies including local authorities to inform a multi-agency response.

**b. Professional Curiosity - Information Sharing**

There was a general lack of information sharing and professional curiosity from those working with, and in contact with Adult D, particularly when she was being discharged from hospitals.

**c. Professional Curiosity - Case Closures**

There are a number of instances where colleagues did not appear to use their professional curiosity to understand why Adult D was not in a position to engage with their service before the case was closed. *Should non-engagement be a warning sign to agencies when adults disengage from services*?

**7.4.2 What has changed since the incident and the MACA in August 2024:**

a. NHFT & Local Authorities - Weekly meetings are now in place at NHFT to discuss individuals who are medically fit for discharge, and what community support may be needed.

b. WNC are working with a large number of females with complex needs similar to that for Adult D. NSAB held a meeting with blue light services in 2024 which was a helpful exercise to identify support for some of the most 'frequent attenders' to agencies such as Adult Social Care & Safeguarding, EMAS, Northamptonshire Police and Hospital Accident & Emergency. There was an appetite to hold these meetings quarterly.

c. NGH have added a new slide to the hospital safeguarding training regarding the importance of Adult Risk Management (ARM) process.

d. When being discharged from the social prescribing service, the GP practice sends a text to the patient with follow-up information should they wish to engage in the future. This allows the patient to text or call rather than waiting to be re-referred by a professional.

e. NHFT undertook a concise investigation with two recommendations: 1. For there to be a clear process for ongoing community care and safety planning following a MHA Assessment, and 2. Develop guidance for CMHT worker transition in care.

f. WNC - All safeguarding referrals go into a central point for initial triage which provides an opportunity for more scrutiny.

g. Right Care, Right Person was implemented in Northamptonshire in July 2023. It is understood that this new process does not make a difference to how the Police respond to incidents similar to that for Adult D as they continue to attend all incidents where there is a risk to life.

h. Local agencies provided assurance that they have implemented the following changes:

**Northamptonshire Fire and Rescue Service has:**

- Embedded the Self-neglect toolkit since it was thoroughly reviewed in 2023.
- Ensured the use of the Adult Risk Management toolkit when appropriate.

**Northamptonshire Healthcare NHS Foundation Trust (NHFT):**

- Mental health services have undergone a transformation process. This includes many activities and changes, for example, carers and families have support in place via 'carers principles,' and additional staff training is available for various subjects.
- NHFT now hold 6-weekly Complex Mental Health Case Panel meetings.
- The Integrated Response Hub is advertised via the internal and external NHFT internet pages.
- The NHFT Recovery College[18] is available for all patients alongside leaflets, posters and campaigns.
- The creation of policies for hard to engage patients include:

[18] The Recovery College NHFT offers a range of different courses to help support adults understand their health conditions and aid their recovery.

- Did Not Attend Policy for Adult Mental Health.
- Was Not Brought, Did Not Attend, Disengagement (children and families).
- Gender Identity Services Managing DNA.

- There is a robust patient engagement service and feedback system to improve care for the most vulnerable adults.
- Self-neglect and Adult Risk Management (ARM) processes are a key feature in training.
- ARM processes are measured and reported to the Trust wide safeguarding group.

**Northamptonshire Police has:**

- Reinforced the need to consider self-neglect as a specific vulnerability to all front line officers and staff, this message was supported with the organisation wide publication of the bite-size NSAB Vlog for Self-neglect and other material.
- Promoted and enforced the use of professional curiosity within investigative and safeguarding process.
- Implemented structural change embedding a dedicated team within the police Multi Agency Safeguarding Hub team who are responsible for the assessment and onward sharing of Public Protection Notices (PPN's) completed by officers/staff. This function includes:
  - Performance scrutiny and additional missed risk, such as repeat incidents etc.
  - Administration and facilitating Adult Risk Management (ARM) process and actions.
- Implementation of the Adult Safeguarding Working Group in force. This is chaired by the head of PVP and to ensure Chief Officer strategic governance it will report into the force Vulnerability Board, chaired by Assistant Chief Constable Emma James. The meetings will have senior leader attendees from police and internal partners providing scrutiny and delivery at a force level. The meeting agenda will include:
  - Safeguarding Adult Reviews (SAR's)
    - Individual action plan and thematic learning
    - National and local learning events
  - Mental Health
    - S136/135
    - Suicide Prevention
  - Adult PPN's
    - Quality assurance / volume / efficiency
    - Adult Risk Management (ARM)
    - Individual case escalation / thematic review
    - Process performance and monitoring

**West Northamptonshire Council Adult Social Care has:**

- Undertaken a review of the Adult Risk Management (ARM) process internally and reinforced with colleagues the importance of undertaking multi-agency and / or ARM meetings.
- The Lead Principal Social Work was a key member of the team in place to review the ARM process across the partnership which resulted in the guidance and paperwork being revised. In conjunction with the revised guidance, they led on a number of re-launch briefing sessions in January 2025.
- Reviewed and refreshed the Non-engagement Protocol. The protocol was updated in July 2025. The ARM toolkit can be found here on the NSAB website.
- The NSAB Principles of Engagement resource was shared in staff bulletins and with staff teams. The information sheet can be found here on the NSAB website.

## 8. Local and Second National Safeguarding Adult Review Analysis 2024 – Self-neglect

8.1 In Northamptonshire, of the 34 SAR referrals received in the last two years (1st April 2023 – 31st March 2025), 21 (61%), referenced elements of self-neglect. This is in line with the findings in the national SAR analysis:

- 60% of the cases reviewed as part of the 2nd National SAR Analysis found self-neglect to be the highest abuse type. 46% of the SARs reviewed related to individuals with substance dependency, 13% featured homelessness and 72% of individuals were reported to have mental ill health.
- 72% of the SARs reviewed identified that inter-agency case co-ordination and working together remain the greatest challenge. The identification of risk/management of risk feature in 82% of the SARs reviewed, and in 56% of cases, it was found that there was poor recognition of the abuse or neglect.
- Many of the SARs reviewed identified issues with how agencies failed to engage with individuals and how professionals failed to understand a person's history with a view to overcoming barriers. There was a failure to identify repeated patterns of engagement followed by disengagement, and a lack of professional curiosity to explore what might be happening 'beneath the surface.' There was also a focus upon what was presented rather than what was not. In terms of safeguarding and missed opportunities, the 2nd National SAR Analysis found that alcohol dependency, neglect of health care and self-harm were not recognised as forms of self-neglect that warranted a safeguarding referral.

## 9. Analysis

9.1 It is very clear that Adult D was experiencing sustained mental health issues resulting in repeated contact with many different services, and that all agencies involved had concerns about her safety. Adult D suffered significant harm on the 13th September 2023, and it is concerning that despite intensive involvement from services regarding her care, there was increasing regularity over a fairly short period of time that failed to prevent the persistent self-harm. In fact, just two days prior, Adult D had telephoned the IRH as she had thoughts of suicide using the same approach undertaken on the 13th September.

9.2 Whilst services supported Adult D when she was in crisis, there appears to have been a lack of a multi-agency approach, and there was no mention of the Adult Risk Management (ARM) process being instigated, only discussed (it should be appreciated that at times, Adult D may not have had the mental capacity to make specific decisions, therefore the ARM would not be appropriate). There appears to have been an over-reliance on the local authority commencing an ARM when Berrywood Hospital could have done so on 3rd March 2023. Colleagues are reminded that all agencies can call an ARM and it is not the responsibility of the local authorities to do so. Agencies should refer to the ARM Toolkit on the NSAB website here for further guidance and awareness raising within their organisation.

9.3 It appears that agencies were reactive, not necessarily proactive. For multi-agency practice to work effectively, it's important to have honest, open communication and a willingness to understand the challenges that other partners face. Multi-agency discussion and the sharing of information may have helped to put preventative measures in place to help keep Adult D safe. An example of which is when Adult D gave consent to informal hospital admission but there were no beds available. It is unclear whether hospitals outside the county were considered based on the risk Adult D posed to herself.

9.4 The local Integrated Care Board and local authorities have a statutory duty under Section 117 of the MHA to provide after-care services for patients who have been detained in hospital under Sections 3, 37 (whether or not with restriction under Section 41), 47 or 48 of the MHA 1983, until they are jointly satisfied that this is no longer necessary. The Care Programme Approach (CPA) Policy & Practice Guidance clearly outlines the Section 117 requirement. However, it is unclear whether this was put into place for Adult D on the numerous times she was discharged from hospital under Section 3 of the MHA. NHFT confirmed there was one entry on SystmOne from 2020 (outside of scope), and the MHA Legislation Team had no information regarding Adult D's eligibility.

9.5 There was a need to understand what was beneficial to Adult D to support her when in mental health crisis. Would an increase in planning have made a difference for her? There is no mention of Adult D's family members being involved in decision-making or involvement in discharge planning.

9.6 Adult D had stated that she had little confidence in support from community mental health services. Therefore, is there a need for improved community mental health for patients like Adult D to prevent acute hospital admissions?

9.7 Regarding off-site hospital visits, an appropriate level of supervision must be in place and consideration of a support plan or risk assessment should be put in place (refer to the chronology entry for 14th & 15th December 2022 above).

## 10. Recommendations

The following recommendations are unique to this case, and some have been suggested from agencies contributing to the SAR and MACA process.

1. NHFT to confirm that the two recommendations in the concise investigation have been completed and provide evidence that changes have been embedded in practice (see 6.5.1 f above).
2. NHFT should develop more robust guidance for where an informal admission is agreed but there are no psychiatric beds available. If the adult decides that they do not want to be admitted yet they remain at high risk of self-harm, consideration must be given to who should be part of the multi-disciplinary discharge review meeting including the involvement of family/friends/advocate.
3. NHFT should request that mental health hospitals include the reasons for admission, safeguarding concerns and recommendations for mitigation in all discharge letters to GPs, and that a telephone call is made to the surgery where there are additional concerns.
4. NHFT should review their approach to discharge in respect of robust community mental health support being in place for patients to prevent acute hospital admissions (Adult D was frequently discharged from Berrywood and St. Mary's Hospitals with EMAS attending and relaying the patient to acute hospitals, often within a few days of discharge).
5. NHFT should provide assurance of the guidance in place regarding the level of supervision required for off-site hospital appointments for patients who are detained under section 3 of the Mental Health Act, and confirm the need for a support plan or risk assessment in place in this regard. If this is not in place, then guidance should be provided within 6 months of the publication of this report.
6. Northamptonshire Police should confirm they have clear guidance in place for their officers regarding the use of Section 136 police powers and whether this can be used when undertaken the previous day. If this is not in place, guidance should be developed immediately.
7. All agencies should work together to ensure risk management plans are readily available and reviewed and shared with relevant professionals.
8. All agencies should implement regular multi-agency complex case meetings to discuss risk management plans and any additional support needed for individuals with complex needs who are subject to regular safeguarding concern referrals or ARM.
9. Northamptonshire Integrated Care Board (NICB) and the local authorities should review the process for Section 117 discharge planning to ensure a multi-disciplinary team approach is in place and is embedded in practice.
10. NSAB to request the Suicide Prevention Group develops posters providing key information and contact details at suicide 'high risk hot spots.'

**Useful links to NSAB policies, procedures, and guidance below:**

Adult Risk Management (ARM) Toolkit

Bite sized learning videos – Professional curiosity and self-neglect

Professional curiosity practitioner guide

Self-neglect guidance

**Northamptonshire Safeguarding Adults Board**

**One Angel Square, Northampton, NN1 1ED**

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**Appendix**

1. On Wednesday 26th November 2025, and at the final stage of report approval, the report authors were made aware from Adult D's father that complaints had been raised with Northamptonshire Healthcare NHS Foundation Trust (NHFT), and he was surprised that there was no reference to them in the report. In this regard, the NSAB Business Manager contacted colleagues at NHFT to gain further information.

2. There were four complaints made: one by Adult D and three by her father. *Please note that the scope of the review was 1st December 2022 to 13th September 2023.*

    1. 5th August 2020 (out of scope of the report) – communication issues regarding ward visits during the pandemic, what steps were taken/put in place preventing visits to Bay Ward, risks to long-term patients being unable to see relatives, no printed information regarding how to make a complaint. An investigation was undertaken and a letter sent from Angela Hillery, Chief Executive dated 11th September 2020.

    2. 14th August 2023 – issues regarding medication/medication review, support when feeling overwhelmed, overnight staffing issues, and the actions taken when Adult D was reported missing. An investigation was undertaken and a letter sent from David Maher, Managing Director dated 9th September 2023.

    3. 11th January 2024 (out of scope of the report) – concerns raised with PALS - communication issues regarding transport arrangements.

    4. 4th October 2024 (out of scope of the report) – concerns raised with PALS - communication issues regarding invitations to support Adult D during ward rounds.

3. Following information received from NHFT, the NSAB Business Manager spoke with Adult D's father on the telephone on Thursday 27th November 2025. She explained that the SAR panel were unaware of the complaints made, hence no reference being made in the report. Adult D's father was happy for an appendix to be added to the report, and was grateful to NSAB for undertaking the review, and for the support given to his daughter when sharing the report.

4. Adult D's father raised concerns that there appeared to be no robust process in NHFT's Community Mental Health Team (CMHT) at Berrywood Hospital regarding an ARM (Adult Risk Management) being convened. However, he advised that NHFT were good at involving families. He did not wish for NSAB to seek any further information regarding the complaints and concerns raised.

5. *NHFT responded to the comment at point 4. above and advised, "that at the time of this incident (period under review) our teams had not completed their Level 3 Safeguarding Adults training which was then picked up in the CQC (Care Quality Commission) inspection of our adults of working age wards and Psychiatric Intensive Care Units (PICUs). We identified that our Community Mental Health Teams (CMHTs) had also not completed the training, so all staff had their Level 2 Safeguarding Adults training, not Level 3. This has now been addressed. In essence we (NHFT) had a training and knowledge gap and not a lack of robust process."*

6. Subsequently, Adult D's father raised additional points of clarification in relation to the NHFT Concise Investigation, reference W146147 and the SAR report and those points are detailed below:

    a. Concise Investigation W146147 - Adult D's father advised that "the family were extremely unhappy with the report outcome and its management."

    *It should be noted that a copy of the NHFT Concise Investigation report was not shared with NSAB as part of the SAR review so they were unable to respond to specific points without subsequent input from colleagues at NHFT.*

b. Safeguarding Concern raised on 17th July 2023 – Whilst an inpatient at Berrywood Hospital, Adult D made disclosures to staff about historic events. Details of this were not highlighted in the SAR report.

   Information provided to NSAB as part of the scoping/MACA confirm that there was a safeguarding referral but Adult D did not want action to be taken. Support was put in place by the Police and NHFT and West Northamptonshire Council Adult Social Care closed the case. Further information received from NHFT evidences that NHFT undertook a risk assessment and staff held 1-1s with Adult D. When she was discharged from the ward, support was provided from UCAT and CMHT.

   *Due to the sensitive nature of the concerns raised, a decision was made by the authors not to include in the SAR report.*

c. Discrepancy in the timeline and events on the 10th September 2023

   Events on the 10th September 2023 were noted in the SAR report but not in the NHFT Concise Investigation. NHFT subsequently confirmed that on the 10th September 2023 at 10:12am, the police contacted the Integrated Response Hub (IRH) for advice as they were concerned about Adult D's presentation and asked if it was ok to place her on a Section 136. IRH advised that if there was risk to her safety and she was not engaging, then yes. NHFT notes suggest that Adult D was admitted to the place of safety early afternoon of 10th September 2023. It would appear the Mental Health Act Assessment (MHAA) was due to be on the evening of 10th September but was re-scheduled to the following day (11th September). Adult D became distressed and tried to leave and ended up in seclusion (while awaiting MHAA).

d. Concise Investigation and Associated Factors – Uncertainty around Adult D's community care and the request for a change in key worker.

   The SAR report makes reference to changes in workers as referenced in 6.3.a Discharge from services, and the Concise Investigation recommendation in 6.5.1 and other findings of note in 7.4.2 e.

   NHFT have confirmed that this point is noted in the CMHT standard operating procedure and there is an expectation to make sure they consider the supportive arrangements during the transition – it states – *"Where a service user requests a change of keyworker due to a breakdown in the relationship, consideration should be given to transitional arrangements and supporting the individual in the period between keyworkers."*

   CMHT has also carried out work on ensuring patients are not allocated to staff while they are on leave and the expectation that appointments are pre-planned in advance. *The keyworker must ensure that the service user's 'My Recovery Plan' is reviewed regularly, based on clinical need but at least annually, and that the service user and carer (where appropriate) have a copy. Where a service user requests a change of keyworker due to a breakdown in the relationship, consideration should be given to transitional arrangements and supporting the individual in the period between keyworkers.*

   In relation to changes in community care and key workers, NSAB will seek assurance from NHFT regarding the three recommendations in the SAR report:

   1. NHFT to confirm that the two recommendations in the concise investigation have been completed and provide evidence that changes have been embedded in practice (see 6.5.1 f above).

   2. NHFT should develop more robust guidance for where an informal admission is agreed but there are no psychiatric beds available. If the adult decides that they do not want to be admitted yet they remain at high risk of self-harm, consideration must be given to who should be part of the multi-disciplinary discharge review meeting including the involvement of family/friends/advocate.

4. NHFT should review their approach to discharge in respect of robust community mental health support being in place for patients to prevent acute hospital admissions (Adult D was frequently discharged from Berrywood and St. Mary's Hospitals with EMAS attending and relaying the patient to acute hospitals, often within a few days of discharge).