Suicide case: Patient A

Risk management
Patient A was being treated in the community and became acutely manic. The home treatment team could not engage her in the community, where she lived alone. A decision was made to detain her under mental health legislation. On the day of admission, she was given unescorted leave to retrieve clothes from home. Patient A was later found to have died by taking an overdose at home.

Comment: The clinical team clearly recognised the risk of suicide by detaining this patient. However, the decision to grant Patient A unescorted leave did not reflect this. Whilst risk is not always foreseeable, clinical decisions should be defensible.

Suicide case: Patient B

History taking and risk formulation
An acutely psychotic male patient, with a history of substance abuse, criminal history and violence against his partner, was seen by the crisis team in the community. Since Patient B lived alone, the risk of violence was considered low and no attempt was made to assess his risk of suicide. Patient B went missing from home in the early hours of the morning, and was found drowned in the local reservoir.

Comment: Risk factors associated with suicide and serious violence often overlap. Clinicians should remain alert to these factors.

Homicide case: Patient C

Management of personality disorder and substance misuse
Patient C was well known to the A&E liaison/crisis team. He had a history of polysubstance misuse, self harm and overdose of medications. Patient C had a chaotic lifestyle and had a history of low level violence. Following a break up with his partner, Patient C started attending A&E with increased frequency. The clinical team did not reconsider his treatment options and Patient C was discharged with information leaflets for the local voluntary services. Three days after his latest presentation, Patient C was arrested for killing his partner.

Comment: Patients with personality disorder repeatedly present in crisis. Given the risk associated with these patients, clinicians should be vigilant for warning signs such as life events, and be prepared to adjust management plans.

Homicide case: Patient D

Communication
A forensic psychiatric opinion was requested regarding an acutely psychotic young male patient, with a history of violence. The psychiatrist assessed Patient D urgently, and thought that he would benefit from clozapine as an in-patient. However, the letter did not reach the clinical team for more than 2 weeks. The patient was discharged under the care of the crisis team. He was arrested for killing his neighbour shortly after discharge.

Comment: Communication failure has often been identified as contributing to serious incidents. Clinicians should consider communicating their findings verbally, where risk may be high.
Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study, June 2013

DEVELOPED BY: The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

COMMISSIONED BY: The Healthcare Quality Improvement Partnership (HQIP) on behalf of the funding bodies of the Department of Health; Department of Health, Social Services and Public Safety Northern Ireland; NHS Scotland; NHS Wales and the Channel Islands of Jersey and Guernsey to undertake the Mental Health Clinical Outcome Review Programme

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