**Case Study** March 2020

**Contract: Cheshire and Merseyside Amparo**

**Referral Information:**

Client A was referred by the Coroner's office following the death of their partner who had died while an in-patient of the mental health team.

**Assessment Tools/Focus identified:**

Initial contact took place within 24 hours of receiving the referral, and a first visit was offered within 7 days. The face-to-face meeting took place at the beneficiary's home, with all initial paperwork completed. This included a full needs assessment, the production of a support plan, a safety plan (which was left with the beneficiary in case of emergencies) and the first Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) was completed. It was also suggested that perhaps they should make an appointment with their GP and, if they had difficulty getting this, to let the Suicide Liaison Worker (SLW) know and they would try for them.

The support that the client had was discussed and they said that their parents lived round the corner and that a friend was staying with them, as was their daughter (no relation to the deceased). There is the added pressure on the client that, as they were not married, there was no will. The client was given information re the CAB, the house was in both their names but the deceased's son is their official next of kin. Before leaving, it was arranged that the SLW would phone the day before the funeral to see how client A was feeling and it was also re-iterated that they could ring at anytime before then if they had any questions or needed to talk. They were given a card and told if the deceased's son needed support they could also phone.

**Communication:**

The SLW kept in touch with client A by phone and text until they had to send a police statement. A text was received asking if the SLW could phone the client to go through the statement and answer any questions about the inquest. It was arranged that the SLW would make a visit to go through the statement. At this visit, the client said they were having difficulty coping, as they were having to wait for the deceased's son to start probate and they didn't want to push them as they were struggling. The SLW suggested the client should arrange to see their GP, but they said they didn't want to as they felt they would "end up on pills". They were frightened this would take them down the same road as the deceased. They had been to a SOBS meeting and found this helpful and had tried counselling, but felt this wasn't for them. The SLW suggested it might be too early for the counselling and perhaps they might feel differently later on. The client was going back to work as they felt this would help them trying to get back to normal. The client was informed that they could request information from the coroner as an interested party and given the address to write to.

**Communication:**

On one of the SLW's later phone calls the client was really struggling and was not coping well, working all hours and could not stay at home so was staying with their parents round the corner. The SLW asked if they had made an appointment with the GP, which they hadn't, so it was suggested they make one first thing in the morning and that the SLW would text and call to see if they had done this. After the call, the SLW contacted their team leader and explained what had happened and that they were worried about the client. It was agreed by both that the SLW would contact the GP first thing the next day and explain their concerns, which they did. Although the GP didn't get back to the SLW, they phoned the client and arranged an appointment. When the SLW contacted the client, they thanked them, saying they had been to see the GP and were having regular appointments to monitor their medication.

**Communication:**

The SLW continued to remain in contact by phone and text and arranged another appointment for a pre-inquest meeting.

**Final Session:**

A pre-inquest meeting was held where the client's parents attended with them. It was noted that the client was so much better and their parents thanked the SLW for all the help they had given their child. At the meeting, the SLW went through who would be at the inquest and how the room would be set out and the questions the coroner has to answer. The client had been asked to attend and they had been informed that a legal team would be there to represent the hospital. The SLW explained that the press could also be there and that they could only report on what is said and nothing more. The client had been informed that it would be a full day inquest. The SLW arranged to meet them at the inquest and support them on the day.

**Where any risk/incident reports completed?**

On one phone call the client had said they where not coping, the SLW had made sure they were safe and not on their own, informed the team leader and phoned the client's GP, who contacted the client and saw them straight away.

| **Outcomes** | Fully Achieved | y | Partially Achieved | | Not Achieved | |
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The case study above indicates that **the client fully achieved** the outcomes following referral and therapeutic intervention. Through regular contact and knowing the client, Amparo has been able to give the support needed, i.e.: SOBS, GP and Citizens Advice. Also, through our knowledge of the inquest proceedings, the SLW was able to prepare them and support them through this very difficult time.

| Evidence of Best Practice | Lessons Learned | Skills sharing |
|---|---|---|

By getting to know the client, the SLW was able to tell when they were struggling and they felt confident to tell them that, so they were able to access the GP to get the help needed.

Both the client and their family thanked the SLW so much for all the help and support they have been given and were happy to fill in an Amparo questionnaire about the service, which was sent out to the client.