BSAB Executive Summary - Safeguarding Adults Review Paul March 2020

Key Factors in the Review: Mental Ill Health, Trauma History, Cultural Considerations, Domestic Abuse and Suicide

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Acknowledgements

The BSAB thanks all agencies participating in the review through the provision of information and reports, and to the participants who attended the learning event. All have approached involvement in the review with an openness to reflection that has contributed powerfully to the quality of overall learning that emerges from the SAR process.

The BSAB thanks Deb Barnett, for being the Independent Reviewer and Chair of the SAR process to gather the learning and make recommendations for the partnership in Bexley. The BSAB has signed-off the full report for the board executive but have agreed this Executive Summary to be used for purposes of publication, learning and embedding with practitioners.

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1. Introduction of this Review – why did BSAB review this case?

On the 8th November 2018 the Chair of the Safeguarding Adults Board wrote to partner agencies accepting the need for a Safeguarding Adults Review regarding Paul. The initial information described Paul as a fifty-five-year-old male patient who doused himself in petrol and threatened to set fire to himself and later died of suicide by hanging.

2. Paul: The Person -

Early Life:

Paul was from a large Irish family in Bexley. The Review found that the Irish Community Services in the Borough identify the specific cultural needs and barriers which easily prevent people from this community accessing support. Irish Community Services state that*, 'The Irish community also has one of the highest rates of mental health issues, often linked to alcohol or drug misuse, but also linked to issues of historical sexual abuse, the traditional roles of men and women, religion and social stigma'*.

Nothing is mentioned of the cultural context of Paul's life about how this might have impacted upon him. Within his local area there are support services for those who have experienced trauma and services should explore the impact of culture, background and discrimination and not make assumptions. For Paul the potential for this to have affected his life was not explored.

Paul never knew his father; his step father was physically abusive and would beat Paul severely with a belt. Paul had 3 male and 4 female siblings. His eldest brother took his own life in 1979 by setting alight to himself. Paul's other brother had severe mental health problems (Bi-Polar Disorder) and the remaining brother (Details unknown) died around 2017.

Paul attended catholic schools and then a 'Special School' after being expelled from four schools. On one occasion, Paul was expelled for accidentally stabbing a dinner lady. Paul left school at 16 years old with no qualifications. Paul was later diagnosed with dyslexia and was considered illiterate.

Paul's working life:

Work life for Paul consisted mainly of manual labour:

- Aged 16 – 18 he worked as a labourer
- Aged 18-20 he worked as a road sweeper
- Latterly Paul worked for Thames Water as a labourer until 2009 when he was made redundant.

Paul had worked for Thames Water for twenty-five years and his redundancy led to severe financial problems and the repossession of the family home.

3. Paul's Health and Wellbeing:

Paul registered with his GP Practice in 1991. The medical history for Paul included:

- Type 2 Diabetes (since 2006),

- Chronic renal failure (kidneys),
- Long standing alcohol misuse,
- Alcoholic cirrhosis of the liver,
- Peripheral neuropathy (Damage to peripheral nerves, often causes weakness, numbness and pain in hands and feet – affects mobility and can cause confusion)
- Depression,
- Hyperlipidaemia (High Cholesterol),
- Ischaemic heart disease – heart attack in 2008,
- Laparoscopic gastric bypass (2012) for obesity
- Cholecystectomy (2013) (Removal of the gall bladder)
- Delirium (2012)
- Sciatica (2009)
- Adjustment Disorder (2009)

Paul smoked and began excessively using alcohol, stating that it made him feel relaxed. Paul used cannabis and occasionally other drugs, however, there is no identification of problematic drug use. Alcohol appears to have been Paul's main problem substance.

Paul had been known to local mental health services since 2009. He had a diagnosis of Mental and Behavioural Disorders thought to be due to alcohol consumption and not necessarily due to the symptomology of trauma for early-midlife experiences. Early and midlife trauma does not appear to have been considered as no supporting information was submitted for this Review.

In 2009, Paul was diagnosed with an Adjustment Disorder following redundancy. Adjustment Disorders are considered to be reactive to life events and should be diagnosed as a short-lived experience following a significant event. It is the Independent Reviewers opinion that had full understanding of Paul's life and experiences been gathered a clearer picture of the long-term impact of trauma may have emerged.

In 2010, Paul told his GP that his brother X was very demanding of him. Paul identified that his brother had a diagnosis of Bipolar/Manic disorder. Paul said that his other two brothers were not interested in providing support for Paul or his brother. GP records also confirm that Paul's son from a previous marriage was under local Psychiatric services with a query of Schizophrenia and a diagnosis of Prolonged Depression Reaction. Fluoxetine, Risperidone and Mirtazapine were prescribed.

In 2012, Paul was diagnosed with Delirium following surgery and was detained under Section 2 of the Mental Health Act for assessment. It may have been beneficial during these assessments to consider the historical traumatic events and how this might have affected Paul.

In January 2015, Paul admitted to feeling suicidal to one of the GPs and was advised to be seen in A&E where he was seen and given advice by the Mental Health Liaison Team. On 2nd February, Paul was admitted to a mental health unit. Paul was later discharged on 20th February 2015 with a diagnosis of Adjustment Disorder and harmful

use of alcohol. Paul was detoxed within hospital. Prior to his detox the antidepressants previously prescribed had become ineffectual due to the extent of alcohol consumption. Following detox Paul was told that he could resume use of his anti-depressants.

On the 17th April 2015, Paul was advised by his GP to engage with alcohol services and began trial of anti-depressants again. On the 25th April 2015, Paul was admitted to hospital again after been found by Police intoxicated having flashbacks of his younger 5-year-old daughter suffering (she unfortunately died due to cerebral palsy at the age of 5). Paul said that he "could not go on like this" and wanted to hang himself. He remained stable, denying any self-harming thoughts on the wards, received psychotherapy, was referred for additional therapy and discharged on the 28th April 2015.

On the 26th June 2015, Paul was assessed at length by Mental Health services. Paul was arrested for trying to assault his wife (2nd occasion) whilst intoxicated and was seen by the Court Diversion Service. Paul identified that he was staying with his brother during probation. Paul reported to have a poor recollection of the events. His wife was keen for him to live with them again and wrote a letter of support for him to the Courts. There was little consideration relating to potential coercive and controlling behaviour or support for victims.

4. Traumatic incidents:

Paul had a long history of traumatic incidents and on more than one occasion referred to long term reactions to the death of his daughter as a trigger for his response.

Traumatic events include but are not exclusive to:

Early Life:	**Adult Life:**
• Physical abuse – stepfather • Possible discriminatory abuse and bullying at school • Exclusion • Mother working a number of jobs • Absent father • Inability to read • Sent to secure school • Paul and siblings had a history of trauma	• Elder brother killed himself (1979) • Made redundant after 25 yrs. in same employment (January 201) • Car stolen (2012) • House repossessed and family rent it (2009 - 2011) • Detained under the Mental Health Act, psychotic episode (January 2013) • Paul- Severely overweight, diabetic, depressed, has arthritis, sciatica and suffers anxiety / chest pains. Eventually peripheral neuropathy, high blood pressure and prolapsed disc (January 2013, March 2013 surgery) • Death of daughter aged 5, reported flashbacks of her suffering (April 2015) • Cautioned assault wife (May 2015) and daughter (2006 & October 2017) • Victim of burglary • Personal Independence Payment declined

	• Caring for daughter – cystic fibrosis • Caring for wife's brother – unclear what care and support needs • Unclear whether wife has care and support needs herself • Brother has severe MH problems and dies (2017) • Brother sexually abusive with daughter (April 2017) • Brother died (May 2017) • Constant pain in foot reported (2016 – 2018)

Paul's attempts at death by suicide escalated and presented a similar pattern to his brother's death. Some of the following indicators present were:

- There was evidence that Paul had the equipment (Petrol, lighter, rope)
- Increased alcohol consumption
- Family tension and marital tensions
- Detention (MHA)
- Detention (Custody – Domestic Abuse)
- Suggestion that Paul felt unloved by his family
- Increased caring responsibilities
- Loss of work and financial status
- A history that has involved abuse
- A family history of mental ill health and death by suicide

5. Paul's Family/Home Life:

Paul lived with his wife for about 35 years and they raised four children together. Paul's eldest son was born within a previous relationship and was diagnosed with Schizophrenia. The couple's first child (A girl) had an early diagnosis of Cerebral Palsy and died at the age of five. Another daughter lives at home. Paul's daughter suffers from Cystic Fibrosis. Paul's other son (X) lives at home and is unemployed.

Paul was carer for his brother who was diagnosed with Bi-Polar disorder and who Paul found challenging to support. Paul also cared for his eldest son and daughter. Paul was also a paid carer for his brother in law.

During the last years of his life, Paul seemed to become more aggressive with family members and this was exacerbated by alcohol consumption. When under the influence of alcohol Paul would engage in risky behaviours or suicidal attempts. The chronology identifies a number of occasions where Paul assaulted his wife. She described being *'afraid'* of her husband. The Oxleas IMR author describes Paul as, *'moving between being a very caring person to a different character altogether when under the influence of alcohol*.'

During a Domestic Abuse Sexual Harm (DASH) Risk Assessment, (DASH – assessing the level of risk in domestic abuse situations), regarding Paul's daughter as victim and Paul as perpetrator, the daughter identified to Police that that the only physical incident of domestic abuse with her father had been in 2006. Paul slapped her around the head for telling him he could not go to see her grandmother in hospital drunk.

The daughter said, '*that the police were called, and her father was arrested, but she dropped the charges. Since the domestic abuse incident, the daughter reported that her father felt guilty and kept asking her for forgiveness. The daughter said that her father poured petrol on himself twice in June 2017 and then again in August and asked her to set him alight. Client said that this caused her and the rest of the family great distress and being in the environment where her father is constantly abusive towards her mother, contributes to making her unwell.'*

The daughter identified that her mom and her brother were isolated as friends and family no longer came to visit because of her dad's alcohol misuse. When the family were invited out, they hid it from her father as he made them feel guilty for going. The daughter said that her father was first addicted to food and then got a gastric bypass after which he became alcohol dependent due to depression. She said that 6 years ago their house was repossessed, and her father became depressed and things got worse from there.

The DASH risk assessment identified – '*Significant concerns: There is a risk of serious harm and death to client, her mother and adult brother due to father's alcohol abuse. Two recent incidents in June 2017 and August 2017 where father has poured petrol on himself and asked client to set him alight. There are high levels of emotional abuse and risk of escalation of physical incidents*.

6. Key Agency Records/Analysis:

A. <u>Mental Health Records/Analysis:</u>

Adjustment disorder and serious depression are identified within the GP notes and within the mental health summary of involvement with Paul. All agencies identify that Paul was illiterate and struggled to read letters, whilst some identified dyslexia as being diagnosed.

Between 2009 and 2011, Paul was supported by Mental Health Services to retain his home, to address financial matters, referred for social inclusion activities, employment support and medical reviews. A referral was also made to the Podiatry Service due to pain in his feet. Paul's feet were checked, and his nails cut on a regular basis up until his death. There appears to be some good multi-agency working and social work support during this period of time. The Social Worker visits regularly and the Care Programme Approach is reduced from enhanced level to standard.

Following a domestic abuse incident involving intervention by the Police Paul and his wife are referred for family therapy. This is in response to his wife expressing her wish to remain in the relationship with Paul. Paul's wife cancels the sessions.

There appears to be some very appropriate, responsive and preventative measures taken by mental health services consistent with the best approaches available at the time. There is evidence of creative multi-agency response, reconnecting Paul with family and community.

The referral for Paul and his wife to family therapy following domestic abuse does not appear to be a well-informed decision. If a similar situation arose today, services might be expected to recognise this as potential victim blaming that could exacerbate the abuse by colluding with the perpetrator that both parties are to blame. Our understanding of domestic abuse has increased dramatically over the past few years and the introduction of S76 of the Serious Crime Act (2015) relating to coercive and controlling behaviours has made a significant difference to perspectives of abuse.

On the 12th December 2012 Paul was admitted to hospital for bypass surgery and was thought to be suffering from delirium following the operation. The possibility of Cannabis use is identified. The surgical ward considered the use of the Mental Capacity Act 2005, but did not use this legislation on this occasion. The following day Paul is assessed by a medic as he had been up and showered 34 times during the night, was reported to be excessively cleaning his room and was displaying disinhibited behaviours (Walking naked). Paul was diagnosed with delirium and transferred to a mental health ward. Paul was detained under Section 2 of the Mental Health Act for assessment. He was displaying highly sexually disinhibited behaviours. One to one specialist nursing was provided on the ward.

On the 21st December 2012 Paul was discharged. The delirium was assessed as being resolved and there was no patient follow up. Records state that Paul was called and written to over the Christmas period, however, there was no response over this period of time. We now know that Paul was struggling to cope with the death of a friend.

The staff on the ward detected Delirium and provided a quick and supportive response to Paul. This indicated good practice in responding to symptoms that supported his recovery process. Today we might begin to see nursing and medical staff begin screening and identify markers for increased likelihood of Delirium prior to procedures and weigh these risks within decision making. We might also see some follow up to provide reassurance that Paul was safe and well.

On the 30th January 2015, Paul was arrested for being drunk in charge if a motor vehicle at 10.30pm the previous night. Paul informed Police that he was intending to hang himself and stated that the rope was in the boot of the car. Paul agreed to an informal admission to hospital under Police bail. There was a crisis plan established for discharge on the 20th February 2015 with follow up support.

By April 2015, an appointment is arranged for Paul, to see a psychologist and care were reviewed on the 17th April 2015. Medication and increased alcohol consumption were discussed. On the 23rd April 2015, Paul was admitted to hospital by ambulance with suicidal ideation and alcohol consumption. An informal admission to a mental health ward took place, however, Paul discharged himself on the 28th April 2015.

On the 28th April 2015, Paul attended a group session (Psychology) where he was encouraged to explore ways of resisting urges to drink and to manage rumination relating to loss. Later the same day Paul discharged himself from hospital.

On the 7th May 2015, Paul meets with the Psychologist and Paul and his wife agree to spend more time together.

On the 27th May 2015, Paul is arrested for the assault of his wife and is advised not to have contact with his wife who was the victim.

There are two episodes of attempted death by suicide with the equipment or means present within a four-month time scale, early 2015.

By this time, Paul has been expressing some distress and inability to cope with his caring responsibilities, loss of family members and friends. The group support regarding alcohol consumption was a popular referral method at this time. The process of supporting Paul to manage rumination relating to loss was also common during this period of time. Psychological intervention is good practice but should be trauma informed.

Paul's wife advised that he had been violent and hit her when drunk and that she followed the family counselling service advice to call the Police. Paul admitted to threatening to pour petrol through the letter box and 'Burn them all.' Paul was discharged from mental health services due to nonattendance on the 17th July 2015.

The information suggests that contact was sent via letter, however, Paul could not read. Paul was encouraged to engage with alcohol services as low mood and suicidal thoughts were determined to be linked to alcohol use.

The GP refers Paul for Primary Care Plus (PCP), which is, '*a service for people experiencing mental health problems who need extra support to help them recover. This support may be provided by their GP, a primary care mental health nurse or a charity sector provider such as MIND.'*

There are three occasions that services were arranged with PCP for Paul to attend and due to a lack of engagement the referral was closed. On the last occasion PCP closed the case because Paul had been admitted to hospital.

Paul was residing with his brother during the period of time following his assault on his wife. It is not clear how information about appointments was communicated or where communications were going to. Paul was unable to read; his wife was a victim of Paul's assault and they were instructed not to have contact. Paul's brother had severe mental health problems. It would be a period of increased anxiety and stress and unless face to face contact was actively sought it is unlikely that Paul would be in a position to respond. Paul regularly attended podiatry appointments and this may have offered an opportunity that could have been utilised to make contact with him and make future contact arrangements.

On the 7th June 2017, Paul was detained under S136 of the Mental Health Act. Paul was of low mood and suicidal. The recent death of his brother and being declined for the Personal Independence Payment (PIP) were cited as stress factors (Information and / or a response was requested from the DWP but no response was supplied). Paul

had doused himself in petrol and was threatening to set himself alight using a lighter. He was playing with the lighting mechanism as if to light it. Paul had made comments to his family that he wanted to end his life. The Approved Mental Health Professional (AMHP) noted that there were allegations that Paul's brother had sent his daughter inappropriate texts of a sexual nature. Paul agreed to a voluntary admission and a week later requested discharge from hospital.

A follow up care plan was agreed and included:

- A referral to MIND
- Sessions for Wellness and Recovery Crisis Planning

A follow up visit on the 6th September 2017, Paul had been drinking alcohol and was observed using threatening language towards his wife. The relationship was described as strained. Paul's wife had allowed him to return to their home address.

On the 10th November 2017, mental health nursing records of a home visit note:
'The purpose of this visit was to assess Paul's mental capacity in relation to his decision of not accepting support from alcohol services as per care plan.

Mental Capacity Assessment: To assess his understanding of the risk of addressing his alcohol abuse and the impact this has on his mental health.

Explanation given to Paul and his wife…Paul's understanding of the consequences of refusing to engage with alcohol services as per his care plan. Paul asked why he had to explain himself as it is his choice to decline. We explained to him that we needed to ensure he understood the impact that his alcohol use has on his mental health and the consequences of not receiving treatment for this. Paul agreed… although said that he did not see why this needs to be done as it is his choice. We explained…he is being presented at the High-Risk Panel following last incident involving the police.

We did not identify any current impairment or disturbance of the functioning of the Paul's mind, which would impact on his ability to make a specific decision and this was confirmed by his wife. Paul was not under the influence of alcohol during this assessment. Paul was able to understand the reason why alcohol services were offered to him and the reason why he is declining to engage. He explained that he disagrees that alcohol is having a negative effect on his mental health and feels that if he wants to drink it's his choice to do so. He said that he does not wish to engage in group work or one to one as he does not want to discuss his issues with anyone as it is private to him.'

The Mental Capacity Assessment demonstrates good practice in evidencing the words said by Paul that led the practitioners to believe that he had capacity to make the decision himself. Respect for personal autonomy is recognised and determined to be good evidence of person-centred ethical practice at the time. The impact of trauma on the executive functioning of a person's brain and the potential impact of this in decision making has only recently come to the forefront of safeguarding discussion. We might now expect a more trauma informed consideration of capacity. It is not clear whether the practitioner was reassured that Paul and his family were safe and well.

Paul was referred to the MIND Recovery project on 28th June 2017 by his allocated Community Psychiatric Nurse for community-based activities, benefits advice and voluntary work/ training support. It is not recorded whether he contacted the Recovery College. The Recovery College offers a personal journey toward living as well as possible support. It aims to empower people to become experts in their own recovery. There are a range of services including 1:1 support, psychotherapy, peer mentoring, debt and welfare rights advice. The recovery college also offers advice and support for family members.

Paul was able to access support provided by the, 'Lived Experience Practitioners'. The aim of this service is for people who have experienced their own mental health problems and who can draw upon their lived experience of mental health challenges and their personal recovery journey, to develop empathic relationships and support recovery of others.

Paul was able to access talking therapies via MIND This Psychological Therapies Programme is known locally as, Improving Access to Psychological Therapies (IAPT). Interventions include trauma informed approaches offering some of the most contemporary responses to mental ill health including:

- Cognitive Behavioural Therapy (CBT)
- Counselling
- Mindfulness
- Guided self-help
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Group and individual therapy

Paul was also seen by the Community Mental Health Team and the Occupational Therapist offered sessions to develop a wellness and recovery plan. He was supported to address his heavy alcohol, use however declined offers to assist him to access support from local alcohol services.

There is evidence of a whole family approach and that Mental Health Services tried to explore the family dynamics. Reports identify, '*During a home visit Paul's wife explained that they all get on well as a family unit but that her husband's misuse of alcohol often leads to arguments and the children will often try and defend her, thereby escalating things further*'.

Paul's wife talked about the domestic abuse incident and expressed feeling guilty that Paul was sent to prison. Paul continued to blame her for this. The records identify that the Social Worker assessed the wife's capacity to recognise domestic abuse -

'*Paul's wife explained that domestic violence includes abusive language, shouting and hitting. She stated that her husband last hit her years ago and she is confident that he will not do so again. Should he however do, she was emphatic that she will leave him for good. In terms of the threats that he has made to her and the children, she stated that he is "all talk" and she does not feel that he will anything. She alluded to the fact that she does find his behaviour threatening sometimes but she does not feel that he*

will actually harm her, given the fact that they have been together since they were both young.'

Risks relating to Paul being threatening with knives was discussed with Paul's wife and there is evidence that the Social Worker is considering the extent of risk. Paul's wife explained that she tries to keep him away from accessing knives whenever he is under the influence of alcohol.

Records state,

'*Paul's wife was made aware of the fact that there is a general concern for her welfare and the welfare of the family, in view of the issues that have been reported to us. Paul's wife laughed about it and explained that she is not that worried and if she became worried, she would seek support.*

I explained to her that part of my role is to undertake a capacity assessment with her and the conclusion from the discussion we have today is that she has capacity to make decision in relation to the safeguarding concerns. She was able to understand and retain the information. She understood that this was safeguarding concern in relation to domestic violence. She retained the information, used and weight the information and communicated the outcome which is that she is able to control her current home environment and does not require support.

Paul's wife was offered support with domestic violence services but she declined. She was encouraged to investigate structured day activity for herself and the children, in view of the fact that there are four adults in the house without any structure to their day. She stated that her son is looking for employment and she will also consider part-time work to give her time away from the home.

The conclusion of the meeting is that Paul's wife has capacity in relation to her experiences of domestic violence'.

The services available to Paul were an example of good practice which should be shared. This is a good example of empowering Paul to manage and control his own mental ill health and in preventing further deterioration. Protective factors were established through direct contact with services and capacity assessments being conducted. The methods used in assessing capacity for Paul's alcohol use and his wife's understanding of domestic abuse and services available are evidenced and balanced with sensitive and proportionate recording. ***These examples of good practice should be recognised and shared as good practice examples.***

On the 6th September 2017, nursing notes identify that Paul and his wife were visited by the nurse and Paul's wife recounted a recent incident when an engineer came to change their gas metre to a smart metre requested by her. An argument about the installation of the meter ensued. The Police were called, and Paul expressed feeling unhappy at home, not feeling loved and that his wife watches him all the time. Paul's wife expressed her dislike of Paul's alcohol consumption. Records note the tension present in the relationship and that family therapy discontinued because they were arguing most of the time. The nurse planned to make contact later that day but gained

no response. An appointment letter was sent out. Telephone contact was eventually made with Paul's wife.

There are some good examples of the exploration of key risk factors and the impact of domestic abuse on Paul's wife. Letters sent to Paul were inaccessible as a method of communication requiring an autonomous response. Paul was unable to read and in such circumstances Paul's literacy might have been better considered. Consideration of a Multi-Agency Risk Assessment Conference (MARAC) referral or referral to the High-Risk Panel was not considered. The risk to others residing with Paul and his wife and others who were being provided care by Paul were not considered. These matters have been identified previously.

On the 17th September 2017, a home treatment assessment was conducted by a Mental Health Social Worker. Records indicate,
'*Paul was drinking large amount of alcohol (approximately 3x 2L bottles of cider) on Friday evening. He then had an argument with his wife at home and said to her he had 'had enough' and went to the garden and soaked the wooden shed in petrol and sat inside shouting threatening to set his lighter off. His neighbour called the police who took him to hospital.*

Paul was seen by psychiatry liaison but was still under the influence of alcohol, he became sober afterward and expressed feeling very remorseful for his actions. He denied any suicidal ideation and said that he had no plans to harm himself. He was aware drinking alcohol always makes him feel suicidal but when he is sober, he does not have any thoughts like this. Paul denied any low mood, anhedonia - feelings of guilt/ worthlessness/ hopelessness.

Paul takes Zopiclone for sleep; there has been no change to his appetite. Paul denies any delusions or hallucinations of any type. However, he states when he is drunk, he sometimes hears voices telling him what to do. He had a similar episode of self-harm attempt in June where he threatened to set fire to himself whilst intoxicated. He then completed an inpatient Detox Program. Paul was alcohol free for 6 weeks but began steadily drinking more over the next 4 weeks. Paul to present at services the following day.'

The assessment concluded that Paul's self-care was reasonably good, he reported his mood to be good 8/10, his speech was fluent and coherent, he denied negative thoughts, concentration was good as was his energy. Paul reported poor motivation at times. There were no reported feelings of aggression. Paul was happy to take his medication. Paul was assessed to have capacity to make decisions about identified care and support and did not require a Mental Health Act Assessment. No safeguarding concerns were identified. Further services have been developed to support with mental health crisis:

Crisis Line – The Crisis Line has now replaced the Urgent Advice Line. The Crisis Line is the contact point for people in crisis requiring support from Mental Health services. The Crisis Line is operated by mental health practitioners in order to support

those experiencing crisis associated with a mental health condition to access mental health services urgently without the need to access the emergency service at A+E.

The Crisis Line service aims to support service users, carers, family/friends who are experiencing mental health crisis. The intervention of a mental health practitioner over the phone may support them and assist in managing the risks. The team offer 24-hour response.

Crisis Café - The Crisis Café is open from 6pm to 10pm daily - The Crisis Café is a safe and friendly place that you can come to if you are experiencing severe emotional or psychological distress. It is a place to access mental health support and advice from mental health and wellbeing workers. It is open outside of usual mental health service hours.

This represents the development toward some innovative and creative responses that aim to reduce stigma, reduce social isolation and to provide accessible, timely support that are now available to people in crisis.

On the 20th September 2017 nursing reports identify further domestic abuse concerns for Paul's wife. A court injunction was offered by Police to Paul's wife which she declined. Paul's wife reported feeling unable to cope with the emotional abuse when Paul is intoxicated. The nurse reinforced the need to connect with MIND services, carers support and a carers assessment. Women's Aid contact number was also given to her.

After several missed telephone calls a nurse visits Paul and his wife on the 4th October 2017 on a welfare visit.

The report states,
'*Paul's wife identified that Paul had been placed on high risk after contact with the Police the previous Monday.*

Paul's wife expressed her frustration that Paul is not engaging with services. She reported how he arranged to see the nurse at their surgery for his diabetic check and an appointment with his GP for medication review, but he refused to attend on the day.

Paul informed us that he did not want any help from the mental health team either and he also did not intend to attend the pier project stating, "I will sort things myself I don't need any help from anyone".

He presented as angry and it appeared that his anger is directed towards his wife. He also reported that he was told by the Home Treatment Team (HTT) that they will increase his citalopram medication, but this did not happen. The wife reminded him that this was because he did not attend any medical review as he was drinking.

Paul was dismissive of any offer of support and made it very clear that he did not want any Community Mental Health Team (CMHT) intervention and with this he excused himself and went in his garden. Paul's wife reported that Paul did not like her

independently going out and about and that he felt unhappy that she is being offered support as his carer. Paul's capacity to make decisions regarding the care and treatment offered was identified. There is evidence of a thorough risk assessment'.

Additional Nursing notes on the 10th November identify,
'*We completed the assessment; Paul and his wife began arguing when his wife pointed out that he should be engaging with relevant support services as he needs help with his drinking. Paul became very loud and again said " I can drink if I want to, it's you that needs help (referring to his wife) as you never listen to me and keep having a go at me". This argument escalated and he called his daughter and son to support the argument. His daughter supported his wife stating that she agrees with her mother. Paul's son did not respond to his father's request to join.*

Paul went on to say that he would like to move out due to the difficult relationship with his wife and that he will be better off on his own. As we were leaving his wife stated that Paul argues all the time and recently, he threatened her with a knife and also cut up their bed. At this point Paul said, " don't tell them that as this will get me in trouble". She did not ring the police as she does not want Paul arrested and sent to prison. His wife and daughter reported that Paul is often abusive towards them and she has in the past rung Women's Aid but did not pursue the support. Advised her to contact them again if she believes they could provide support to her. Also advised them to ring the police if they feel threatened by Paul's behaviour in future'.

Notes identify that Paul continued to refuse mental health services support and that he was to be referred to the High-Risk panel. There is nothing to indicate whether detention under the Mental Health Act was considered. During this panel meeting Paul was identified as high risk. The plan identifies:

- Disclosure interview with Paul's wife to be arranged.
- Referral to safeguarding adult for his wife to be made.
- To contact link person for his daughter Rebecca's care team with her consent.
- To update risk assessment to reflect recent event.
- Risk panel review in January.

B. <u>Emergency Response Records/Analysis:</u>

On the 9th September 2016, Paul was taken to accident and emergency after consuming approximately two litres of cider, pouring petrol on himself and he was planning to set himself on fire. Paul expressed that he had thoughts of hanging himself and jumping off a bridge in the past.

Paul is deemed fit for discharge and is seen regularly by community services following discharge. Four days after hospital discharge Paul is found by his wife drunk in an alleyway. Alcohol services had discharged him for non-engagement within the context of continued excessive alcohol use. A referral was made to the high-risk panel. Early October the Police were called because Paul was refusing to leave a petrol station and was said to have been drinking and to be disruptive. Paul declined support from

mental health services. A National Inter-Agency Liaison Officer (NILO) was used to coordinate emergency service response.

This time period demonstrates Paul to be disengaging with services, increasing alcohol consumption, making moves to find resources to kill himself with and on several occasions required Police, ambulance service, or fire service interventions. Paul is also becoming more aggressive and threatening with family members and particularly his wife. This should have flagged a concern about a vulnerable person at that address and a safeguarding adult referral should have been made. Vulnerable people include Paul, his daughter, eldest son and his wife as a victim of domestic abuse. The fire service later recognises the need for a safeguarding response and make a referral. Police and ambulance services did not make referrals. It is not clear whether this was because of coordination conducted by the NILO.

C. Substance Misuse Services Information from Records/Analysis:

A nurse from the substance misuse team identified,
'*Home Visit for purpose of Mental Capacity Assessment. To assess his understanding of the risk of addressing his alcohol abuse and the impact this has on his mental health*.' And notes state, '*No mental capacity issues found. Wife stated that Paul argued all the time and recently he threatened her with a knife and cut up their bed. She did not ring the police as she does not want Paul arrested and sent to prison Wife and daughter reported that Paul was often abusive towards them and she has in the past rung Women's Aid but did not pursue the support. Advised to contact them again if she believed they could provide support to her. Also advised to ring the police if they feel threatened by Paul's behaviour in future. Paul's wife also informed that although Paul claimed that he is not able to read he was noticed by the family to be using the TV guide and subtitle to watch TV programmes.'*

The following day the Multi-Agency Risk Assessment Conference (MARAC) meeting is attended by a representative from the safeguarding team. A strategy meeting is to be arranged regarding Paul's wife. Mental Health Service notes identify that Paul's daughter was informed that she did not meet the criteria for safeguarding.

On the 6th December 2017, a social worker visited Paul's wife and the note states,
'*Wife demonstrated full mental capacity in relation to her experience of domestic abuse and declined services in relation to this'. The Root Cause Analysis states that, Wife was deemed to have capacity to make decisions in relation to safeguarding concerns. She was offered domestic abuse services but declined'*.

The nurse does not appear to be conducting a capacity assessment. There seems to be little focus on whether Paul can understand, weigh up, or communicate a decision about access to services (Substance Misuse Services). It appears that the nurse has asked about his functional abilities and has based her decision on presenting factors such as domestic abuse and Paul's wife's interpretation of his reading ability.

The nurse has correctly assessed that Paul's wife is eligible for safeguarding adult support and has made a referral. The risk assessment is updated, and the risk panel

informed. Support in respect of Paul's daughter is also considered. This is good practice.

The safeguarding team (Not Mental Health Team) determined that Paul's daughter was not eligible for safeguarding. This is incorrect, as Paul's daughter is both a carer, and someone who has care and support needs, add the domestic abuse and the co-dependency issues she would meet the statutory eligibility criteria for safeguarding.

The Social Worker does not appear to have recorded a capacity assessment regarding Paul's wife's ability to decide about access to domestic abuse services. Perhaps it is because there is no indication of how she would meet the diagnostic element of the assessment and therefore it would be assumed that she had capacity unless the impact of domestic abuse prevented her from making decisions. The potential for coercive and controlling behaviours is not considered and ruled out/in relation to decision making.

If safeguarding and domestic abuse services are fully explained to the person in respect of 'Making Safeguarding Personal' stating:

- What would make you feel safe and well?
- What would you want to happen?
- How can we support you to achieve this? What do you not want to happen?
- What potential things do you have to consider?
- Who would support you through this?

Why would a person refuse to get this type of support? Paul's wife had expressed that she was afraid of Paul being imprisoned. There are other family members and complex co-dependency dynamics and therefore safeguarding measures could have been considered.

D. <u>Other Key Mental Health Information/Analysis:</u>

Between January and March 2018, Paul and his wife had disengaged with services. Matters were referred to the high-risk panel. On the 11th April 2018 the Social Worker visited and identified that Paul and his wife reported to be fine. Paul had stopped drinking and had been coping well. The social work report for December 2018 records that Paul was getting drunk over the Christmas period and that police found him trying to cross a busy road. They had taken him home.

Paul was recorded as a carer to his wife's brother daily and that he was not abusive towards family. Paul's wife did not engage with carers support and the Root Cause Analysis identifies, '*Paul's wife felt she and her family were safe. Paul and his wife both declined further community support and were happy for Paul to be discharged. Plan was to update high risk panel and agree discharge from ADAPT as care plan had been completed*'.

The high-risk panel agreed to close Paul to ADAPT services on the 29th May 2018.

The Serious Incident records identify that there was no up to date care and support plan with the last care and support plan dated October 2017, with no evidence of a review. Neither is there a copy of the wellness and recovery plan identified in recording. Risk assessment, risk management and identification of triggers were not present. There were no clear needs, outcomes, goals identified. The Serious Incident panel felt that the care plan could have been applied to any number of individuals as it was very general.

Increasing disengagement, increasing use of emergency services, increased aggression and domestic abuse, increased alcohol consumption, increased suicidal ideation and actual attempts to kill himself in addition to a trauma history, multiple bereavements, financial loss, loss of status (Work), stress of multiple care roles and Paul's word / actions should have alerted services to the increased likelihood of suicide.

The Social Worker identified that the plan to mitigate these risks was to refer him to the High-Risk panel. This is not a plan to mitigate risk, it is a plan to assess risk. The High-Risk Panel made the final decision to discharge Paul from their care and there was no medical review prior to discharge.

On the 10th January 2018, the risk assessment identifies, 'No change' however, this was noted as a period when Paul had not been coping following the death of his friend. It cannot be said that services were reassured that all parties are safe and well.

The Social Work report does not identify whether Paul is a paid or unpaid carer for his brother in law and there is nothing identified in relation to making enquiries ensuring his safety and wellbeing.

The Social Worker identified that, 'When it was deemed that Paul had capacity to decline input and that his problems were alcohol related, rather than mental health, he was discharged'.

Moving forward the development of mental health services to consider the root cause of a person's alcohol problems (eg. What happened to you?) and the fundamental trauma, loss or bereavement experiences that fuel the alcohol consumption to blot out the associated emotions, will need to be assessed and regarded as an aspect of mental ill health. This will support the prevention of escalating need for physical and mental health services by those who have experienced Adverse Childhood Experiences or trauma and turn to substances, self-harm, self-neglect in an effort to manage emotions and experiences.

The IMR report from Mental Health Services states,
'This case was not safeguarding but wishes for his care and treatment were documented.' There are multiple safeguarding concerns here regarding Paul and his wellbeing, his wife and her role as carer, his daughter as a carer and cared for, his son as a carer and cared for, Brother in law dependent upon Paul for care provision, brother of Paul supported by Paul, domestic abuse and co-dependency. Today all

parties would be considered in a clear safeguarding plan, coordinated by an identified agency, considering parties mentioned above.

The impact of Paul's actions on his wife and children are never addressed, because carers assessments were not considered and because safeguarding concerns were not directed to the correct local authority and acted upon. Mental Health Services report that the whole family now receive mental health service intervention as a result of escalating mental ill health.

E. Agency plans/actions since Paul's death:

All staff within both Adult Social Care and Mental Health Services now receive specialist training on all aspects of adult safeguarding which includes eligibility as set out in the Care Act and statutory guidance. Regular audit processes are in place to review consideration and application of the criteria. A series of workshops are being planned in response to the recent ADASS guidance regarding decisions to carry out safeguarding enquiries.

There are new Adult Social Care Pathways being developed to ensure that there is a single point of contact that will enable improved recognition and early intervention responses to non-eligible needs, in addition to eligible needs. A strengths-based approach is intended. The difficulties of a strength-based approach were discussed by panel members. Where finance and resources are scarce, and practitioners want to achieve budgets that reflect the needs of the individuals, the focus becomes risk centric. The difficulties of moving from this long-term deficit-based approach to an approach that focusses on what a person can do is recognised as being both supportive to the person and their family, however, is a large cultural change in practice.

A single system to record is being investigated and likely to be that utilised within wider Adult Social Care (Liquid Logic). This will enable more extensive analysis and review of both activity but also nature of referral and consideration of wider information/risk factors known across Adult Social Care and other departments such as Children's Social Care.

Mental Health Services and Adult Social Care are going to ensure that there is an additional focus on carers needs and safeguarding carers within existing training. Opportunities will also be explored in joint learning events.

F. London Fire Brigade Records/Analysis:

On the 7th June 2017, two fire appliances were sent to Paul's home address. Two officers monitored remotely a group manager and a National Interagency Liaison Officer (NILO). The NILO role is to liaise with other emergency services as part of an emergency response (Civil Contingencies Act 2004).

Paul was doused in petrol and was threatening to set himself alight. Police were in attendance.

The NILO identified that the Police had removed Paul from the property and that he was in the care of Local Authority services. The NILO supported the crew to respond in accordance with S1 of the Civil Contingencies Act 2004 providing assessment, planning and advice. (S1 identifies the duty to assess, plan and advise.) It was determined that the fire service was no longer required and their intervention ceased. The fire service had been ready to respond to prevent serious incident.

A similar incident occurred in September when Paul was described to have doused himself in petrol in the shed in the rear garden. Paul was said to be threatening to set alight to himself and the premises. The same resources were deployed by the ambulance service but again the Police intervened this time taking Paul into Police custody.

A follow up safety visit, the following day, was conducted by the fire service officers who met with Paul's wife. It was identified that there was one person who had care and support needs within the property, however, no outstanding risks were identified, or safeguarding concerns raised. Two days later the fire service reflected upon this decision and decided that due to multiple attendances at the home address and the nature of the incidents a referral was appropriate.

The safeguarding referral was sent to the wrong local authority but was confirmed to have been passed on to the appropriate local authority area. The local authority report that the referral was not received.

There is good evidence-based practice identified here with the use of the NILO in advising and assessing to prevent risk. The responses were consistent with applicable legislation.

The lesson learned here was that if there were a number of emergency service call outs to a particular address within a certain time period then a safeguarding referral should be made. The fire and rescue service demonstrated that this lesson had been learned and was being put into practice. Emergency services cover multiple local authority areas and local authority boundaries can be confusing. An easy method of identification might be useful.

***'My intention is that the three stations in this borough collaborate closely with our partner agencies and borough council to maximise the safety of all those who live, work and visit this area'*.**
Peter Curtin, Borough Commander for Bexley, London Fire Brigade

The collaborative working expressed by the Borough Commander was evident in practice with Paul and his family. The fire service also considered domestic abuse and made a referral for Paul's daughter under alternative support to ensure that she was not identified to the perpetrator Paul. Victim support made a referral to MARAC.

G. London Metropolitan Police Service Records/Analysis:

On the 22nd May 2015 Police were called to Paul's home address by Paul's son. Paul demanded that his wife give him some money, he subsequently bought and drank a bottle of wine, she then believed he stashed further alcohol in the back garden because he became further intoxicated throughout the day. Paul's son saw him urinating on their back step, he then went into the kitchen demanding his dinner, which he had already eaten. Paul's wife confronted him and told him to go to bed, but he became verbally aggressive and followed her into the front room. He then punched her on the side of her face with his fist while she sat on their sofa. As his wife walked out of the room he punched or slapped her on her back resulting in her being pushed forward. Paul's son then came downstairs and witnessed Paul threaten to stab his mother, he called Police. As Paul was leaving, he threatened to burn down the house.

On the 11th January 2016, Paul was arrested for common assault on his son. Paul had punched his son in the face following an argument about Paul's alcohol consumption. Paul identified that he had lost a close friend who had passed away on Christmas day and that this was making him feel down.

On the 8th September 2017, at 20.57 hours the Police were called to Paul's home address. Paul's wife stated that her husband was in the garden and had poured petrol all over the summer house and himself. Paul's wife stated that this was not the first time that this had happened and that she wanted him to be taken to get his mental health assessed. She said that his mental health had become worse since he lost his brother who had set himself on fire causing his own death.

As Police approached the summer house, they could smell a strong smell of petrol and a large 10L opened petrol container was in the middle of the summer house. Paul became aggressive with Police and abusive. Police tried to engage with Paul, but he took the lighter in his hand. Police stayed 10 feet way and state that he was repetitive and not listening when Police were trying to answer his questions. The Police report Paul to be having a mental health crisis, seeming very irritated, paranoid and was constantly looking everywhere. Police felt that he may have been seeing more than two people. After about ten minutes of shouting at Police Paul locked himself in the summer house and sat on the sofa to watch the TV. Petrol could be seen all over the floor, furniture and on his trainers and lower jeans.

Paul's wife informed the Police that Paul had returned home drunk and had gone to his bedroom and cut the bed in two with a saw. Paul then told his wife that he was going to go outside and burn himself alive. Paul would not discuss why he was feeling suicidal. A spare key was used to gain access to the summer house and Paul was detained and searched to remove anything of danger from him. Paul was very verbally and physically abusive leading Police to detain him until he calmed down. Paul did not like the hand cuffs and repeatedly asked for them to be removed. Eventually Paul calmed down and began to engage with Police whilst sitting on the floor. Whilst being walked to the ambulance Paul tried to head butt one of the officers and threatening over and over again to knock police out. Paul was extremely violent towards Police and took some time to calm down.

Police report that Paul was eventually taken to hospital and seen by a psychiatric nurse to assess his mental health. The nurse determined that he was no immediate danger to himself or other and that he could be referred to the crisis team and returned home.

Police note,
'*There is serious concern for Paul as this appears to be a reoccurring incident and could potentially turn into a major incident. Paul is clearly suffering mental health issues and not getting the support he needs and this is clearly being aggravated by drinking*.'

On the 3rd October 2017 at 5am Police were called to attend a garage where a drunk man was reportedly refusing to leave. Paul had been at the petrol station for six hours.

Police were called to Paul's home address on the 11th June 2018 at 22.29 hours by Paul's Son. Paul's son informed the Police that his father Paul was being abusive and aggressive towards his mother and him. Paul had damaged his wife's iPad. Prior to Police arriving Paul had left the family home with his house and car keys.

The same day officers found Paul on a major road near to his home address. Paul admitted that he had been having a tough time of it lately, saying that he was still struggling with the death of his child ten years ago. Paul told his wife and officers that he had been having suicidal thoughts and was really struggling with life in general.

It feels intrusive to record in such detail in a public report the issues identified above. It is difficult to get a full picture of the distress, agitation and desperation of Paul and his difficulty with trauma, loss and how alcohol affected his ability to control these emotions, without understanding how he responded in times of crisis.

It is also important to get a clear picture of the levels of distress the family must have been experiencing during this period of time.

Police could have also presented a referral to the local authority ensuring that Paul and his family were safeguarded.

H. <u>Community Safety – Crisis Intervention Team:</u>

The Crisis Intervention Team were based in Housing during the period of this review. The team accepted referrals for domestic abuse regardless of level of risk. Prior to 2018 the MARAC accepted referrals for cases of domestic abuse where referrers considered the risk to be medium and high. A risk assessment process was not used, neither was the Safe Lives (Then CAADA) DASH risk assessment. Paul's daughter was referred from victim support in October 2017 after disclosing that there was physical, verbal, mental and emotional abuse directed at her and her mother. Paul's daughter identified one physical incident in 2007 directed at her. Paul's daughter identified that Paul was known to mental health services, but they could not assess him as he is always drunk.

On initial referral form from Victim Support:

- Daughter regularly mediates between mother and father.
- Daughter states that her father always used the fact that he was arrested against her mother and makes them all feel guilty for calling the police
- Daughter states that father poured petrol on himself twice in 2017 and then again in August
- Tension in family and distress being in environment where father is constantly abusive
- Daughter states that family and friends no longer come to visit due to father's alcohol abuse

Daughter was referred to MARAC however the risks to wife, son and wider family were not considered.

Some key themes regarding MARAC are:

- Lack of a clear picture of the person, carers and family members on the initial victim support referral, the referrer identified that Paul's wife was also being abused. The MARAC did not explore this and only focussed on Paul's daughter, when a whole family approach should have been considered. There is also a son X within the family, who is not mentioned at MARAC. There was no link in MARAC that Paul's wife had previously been referred to services but had not engaged. The care provision to Paul's brother in law was not considered.
- Lack of consistent risk assessment processes - No DASH risk assessment is recorded and therefore any actions that were raised at MARAC would not have been as part of a risk management plan. Identifying the risks would have informed a safety plan for family members.
- Lack of appropriate advocacy. Whilst the IDVA has made 3 attempts to contact the victim, there is no thought to speaking to multi agency partners to try and facilitate a conversation with the victim.

A review of the MARAC process took place in 2017/18. Quality assurance processes now ensure that only high-risk cases are referred to MARAC. A restructure of whole practice relating to MARAC and the community intervention team took place. The community intervention team has now been dissolved and the Independent Domestic Violence Assessors were transferred to new provider in April 2019. A review of domestic abuse support services and pathways has been completed in 2018 and a new provider for all domestic abuse services was commissioned in 2019. The aim is to ensure that domestic abuse services have a joined-up approach to support and information sharing. The new approaches will be reviewed through contract management for the commissioned service. MARAC now have a MARAC steering group which identifies practice and audits cases to ensure that effective safety planning is put in place. This is good practice that demonstrates a move toward safeguarding individuals through MARAC using the principles of safeguarding and holding agencies to account for their subsequent actions and responses.

With the recognition of Domestic Abuse within the Care Act and within the eligibility criteria for safeguarding adults there is scope to bridge the gaps in domestic abuse responses from preventative to protective measures and to ensure that safeguarding individuals is a multi-agency process considering all parties who may be affected by

abuse or neglect. MARAC and SAB processes are now working more closely to ensure that support is provided in respect of the victims. Access to trauma informed services, psychological or counselling intervention is something to be considered for all parties including the perpetrator but never the same service and never together.

Risk assessment in familial domestic abuse can be significantly different to that of intimate partner relationships. This review process highlights a combination of both familial and intimate domestic abuse with complex dynamics involving a wider family network.

Any safeguarding, including Domestic Abuse, response should consider:

- The risk to others
- Whether there are any potential crimes - identify what has been ruled out and why
- Are there any public interest concerns?
- Is there risk of repeated or escalating abuse?
- Perpetrator history and risk
- Cultural or religious issues
- Has coercive and controlling behaviour been considered and how does this impact on the victim / family decision making?
- What is the impact of mental ill health and / or substance misuse on the victim / family?
- What does the person / persons want to do and what outcomes do they expect?
- Does the person have capacity and are they free to make autonomous decisions about each of these things that they have identified as desired outcomes?
- Do any / all family members have access to advocacy where required?
- Has a multi-agency response been considered?
- Has a whole family approach been considered?
- Have trauma informed responses been used and assessed in relation to all family members and perpetrator and those affected been signposted or supported to access appropriate services to maintain physical and mental wellbeing?
- Is recording defensible in manner stating what the decision was based upon
- Have all persons with caring responsibilities to meet an identified need, been assessed as capable of meeting those needs within the context of the domestic abuse, own care and support needs, ability and understanding of how to meet the need?

Partner agencies felt that domestic abuse was identified throughout the review period, but risk planning was not as good as it could be. DASH training is available to any professional needing to access this training. Domestic abuse services have also developed a new website.

I. Hospital NHS Foundation Trust Records/Analysis:

On the 24th July 2008, Paul attended the Emergency Department with chest tightness and left arm pain. It was recognised that he had a stressful day. Paul reported that he had been in Court regarding housing difficulties. Paul stated he lived with his wife and his brother who had bipolar disease. His daughter, aged 16 at the time, has Cystic Fibrosis. It was recorded that patient had financial worries.

He was seen on the 30th of July 2008 in the Cardiac catheterisation unit where a history was taken but personal difficulties were not discussed.

On 31st July 2012 on assessment for weight reduction surgery the Upper GI & Laparoscopic specialist documented Paul's mental health history stating, '*Patient had a breakdown when he lost his job and house*'. It was noted that he was discharged from the care of psychiatry six months prior.

On the 18th January 2013, Paul was seen in the department of minimal access surgery regarding post Roux-en-Y Gastric Bypass surgery. He disclosed that two weeks post operatively he was diagnosed with acute cholecystitis and during this admission had a psychotic episode and was sectioned in a psychiatric hospital for 20 days.

On the 30th of January 2013, he was seen again by the doctor, no record of concerns disclosed, were discussed.

On the 1st March 2013, Paul was admitted for elective surgery for Laparoscopic cholecystectomy and laparoscopic Common Bile Duct (CBD) Exploration. He was discharged on the 2nd March 2013. His notes acknowledge a history of depression "mental breakdown" and previous inpatient admission for 20 days in a psychiatric hospital.

On the 6th of March 2015 Paul was discharged back to the care of the GP from the minimal access surgery team. He was reportedly pleased with his weight loss of 140kg down to 98kg.

On the 17th of November 2016, Paul was seen by the Orthopaedic consultant and his Psychiatric history were noted. He was referred to the diabetic foot clinic. but no psychiatric history was relayed in the referral letter.

The most significant contact was on the 7th of June 2017 where Paul attended the Emergency Department, following a suicide attempt, under S136 of the MHA. He was not admitted and was medically cleared, discharged to the care of the S136. A letter recording cause of attendance was shared with the GP on the 8th of June 2017. It was stated that Paul had been feeling very depressed as his daughter has Cystic Fibrosis, and his brother who was abusive to her had recently died. Paul poured petrol on himself but did not ignite the petrol.

Following this Paul's contact was limited to the diabetic foot clinic. He was also referred to the pain clinic however he did not attend on in May 2018.

Documentation did not reflect Paul's wellbeing at the time of visits:

- No one considered his history of psychological trauma and how this might affect engagement and decision making.
- No one considered asking how things were going at home. This may have provided a much greater understanding of the complex dynamics between Paul's physical and psychological health, and his responses, behaviourally (Aggressive,

agitated, distressed, suicidal), Psychologically (Mental ill health, delirium and trauma) and physically (The development of physical health conditions and his wellbeing following surgery).

- The preventative measures for the future are lost in the response to presenting conditions.
- The hospital needs to be reassured that the person and others involved are safe and well. Wellbeing covers both physical and psychological wellbeing. If not reassured then agencies should be contacted for reassurance and/or advice and guidance sought from the Local Authority.

J. Primary Care GP Records/Analysis:

GP information reflects the complex medical history of Paul. On the 24th April, Paul admitted to his GP that he was having flashbacks of his younger daughters suffering leading up to her death and he stated that he could not go on like this and that he wanted to hang himself. In December 2015 was referred back by GP to Mental Health Services again for depression and background of alcohol intake and family strain.

In December 2015, Paul's wife wrote a letter saying that if Paul is removed from the family home it would be detrimental to his health. Paul's wife showed a letter from February 2016 from Mental Health services saying that he is not eligible for housing (as social services said) and not responding to letters so discharged. A lack of response to telephone calls and letters meant that referrals were made by the GP to mental health services, however, due to a lack of attendance Paul was discharged on a number of occasions.

In June 2017, Paul informed the GP that he had tried to kill himself and then during a second attempt four days later he was admitted to hospital. Paul said that thoughts of his daughter stopped him from killing himself. Paul admitted that heavy drinking makes him more impulsive and more vulnerable.

The GP notes identify that Paul attended a mental health assessment on the 6th September 2017 with his wife. An argument ensued resulting in both parties leaving half way through the assessment. Two days later Paul again tried to kill himself using petrol in the summer house at their home address.

The GP notes:

- All Mental Health assessments were performed by both GP and specialist services. Reviews included capacity assessment.
- Patient had also insight and had accepted plans. Letters from Mental Health 2nd December 2017 mentions Paul's inability to read – dependency on wife.
- Mentions stresses like loss of daughter at 5, daughter chronic illness, loss of job since 2009. Alcohol.
- Mention of Dyslexia on file but reviews have been face to face.
- **Paul was repeatedly referred to:**
    - Specialist Mental Health Services
    - Alcohol Services
    - Gastroenterology

- MIND/counselling services.
- He was followed up at GP practice for his conditions.
- He was referred to A & E when appropriate in a crisis situation.
- Wife has been referred to carer's support.
- He underwent Court Diversion Service.

The GP was responsive to Paul's physical health needs and recognised the impact of pain on his physical and mental wellbeing. Appointments were facilitated to meet Paul's literacy needs and his capacity to consent to treatment was considered with each treatment offered. No concerns were identified. A wider family approach is considered in offering Paul's wife carers support (Although use of statutory carers assessment might have been more appropriate any carers service should have been able to redirect when eligibility criteria for statutory assessment is met).

Triggers for suicidal ideation and plans were also considered and recorded building a picture of the trauma and stress Paul had in his life at the time of attending and also some brief recognition of post trauma as a result of the loss of his daughter. Being trauma aware and understanding the impact of trauma, assessment for trauma responses and gathering a trauma history may have been considered, although there was limited information available during this time period. Being trauma informed today may lead to potential therapeutic and treatment interventions to prevent escalating mental and physical health concerns.

K. Adult Social Care Records/Analysis:

Adult services identify that a safeguarding referral was received on the 12th September 2017. No further contact or outcomes for the review process to consider are identified.

S.75 Agreement:

Section 75 agreements are made between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s; the S.75 agreement in Bexley includes the Mental Health Services commissioned by the CCG. This would therefore include mental health teams, support workers, and qualified social workers in the integrated teams across MH Services. The expectation under this agreement is that the MH Integrated Service provider would lead on the health & social care matters for their cases including safeguarding concerns.

There is no indication of which agency / who made the referral or any overview of the circumstances. The referral was passed to the Mental Health Team to action or forward to the GP. There appears to be a single agency response to a very complex family dynamic requiring significant multi-agency assessment and intervention to prevent or delay the need for services, promote wellbeing and protect from abuse or neglect. A separate referral to the Local Authority was made by Paul's daughter for support. The daughter was a child (Aged 16) during these events, but due to the IT systems and common practice at the time, children and adult services do not appear to have communicated about the domestic abuse issues, needs for care and support of the daughter as a young adult and in preparation for her future, or the role of the daughter as a young carer at risk of abuse / neglect.

The lack of oversight guidance and reassurance that all parties are safe and well is a common theme throughout this review process. The impact of trauma and loss on decision making, the impact of coercive and controlling behaviours on a person's ability to make autonomous decisions and a lack of safeguarding leadership all mean that safeguarding ping pongs between Social Worker case work and high-risk assessment. The holistic assessment and comprehensive care and support plan was not clear and there is no clarity about safeguarding plans and interventions for Paul wider than his clinical mental health needs. Paul's family and caring responsibilities are not consistently considered and there is limited defensible decision making.

Where existing arrangements were not maintaining wellbeing and safety, the Local Authority should have had oversight of the safeguarding of Paul and his family and should have been reassured that each individual was safe and well. The concluding comments and tools offer some opportunity for the Local Authority to consider in their response to safeguarding adults and in particular safeguarding where there are complex family dynamics.

8. Review Conclusion:

This review has highlighted some excellent multi-agency practice in relation to Paul and his family. It is commendable that the options available to Paul were ahead of the time and did consider contemporary responses to trauma in a manner that reflected good clinical practice.

There are some key themes to conclude with:

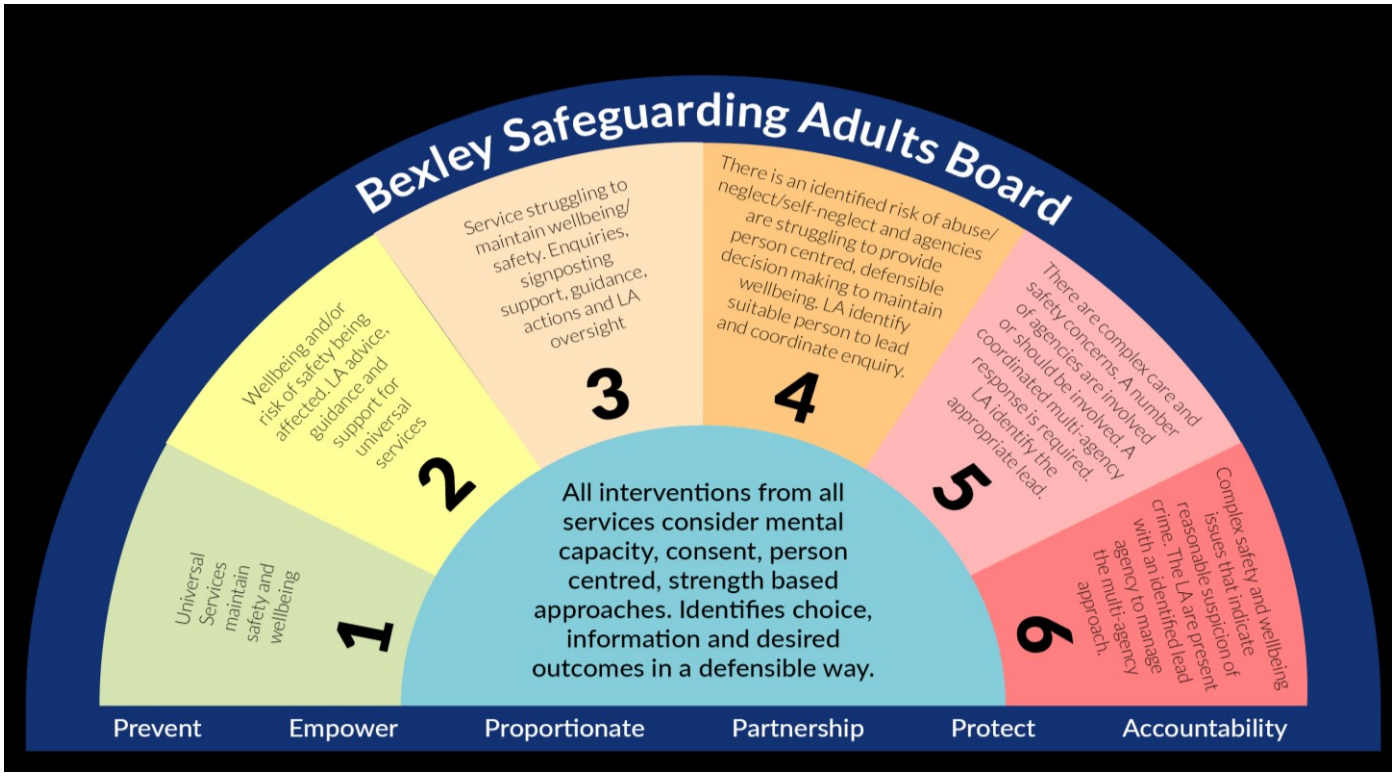
- **Safeguarding Adults Eligibility Criteria:**

Not all agencies were aware of what 'needs for care and support' means and some were applying the two-part eligibility criteria for Social Services. Safeguarding falls within the wellbeing principles and therefore you do not need to have Local Authority or Health related eligibility, anyone can seek safeguarding and wellbeing advice, guidance and support. The Care Act also explicitly identifies the need to safeguard carers.

Reports provided for this review refer to Paul's daughter as not meeting the threshold for safeguarding. There should be no thresholds for maintaining a person's safety and wellbeing. The person should define their own thresholds and if they are seeking support and guidance then we should be supporting them to maintain their own safety and wellbeing and preventing the need for services in the future.

Instead of thresholds being applied the focus should be upon agencies being held accountable for supporting a person (Within their family and community) to remain safe and well, providing defensible decision making, or in seeking support regarding these matters. The approach advocated within the Care Act is not risk centric, it is person centred. The emphasis is placed upon preventing abuse or neglect and maintaining wellbeing.

- **The Safeguarding Continuum (see diagram below):**



- **The severity of risk and the severity of need should not be barriers to safeguarding:**

The pre-Care Act, Adult Protection response is still being used with a focus being upon the severity of risk to the person and the severity of their care and support needs. Care and support are commissioned and provided until abuse is identified and then this is referred to the safeguarding MASH, triage or Team. The focus of the safeguarding response becomes risk and the level of risk with procedures being invoked or not.

This is not what is reflected in the Care Act description of safeguarding. If I am an elderly person who requires feeding and my care provider does not feed me, then I have needs for care and support and as a result of those care and support needs, I cannot protect myself from neglect. The appropriate provision of care and support safeguards a person from abuse or neglect. If the care provider cannot achieve this, then the manager, or senior person must safeguard, providing additional advice or by seeking further support. If the person is making capacitated but unwise decisions, then this must be recorded by the appropriate agency. Defensible decision making (What policies procedures, legislation, research, models, methods or theories were used, what did the person do or say (Including background) that made you think this was the right course of action, (What was ruled out and why, how is this a proportionate and least intrusive response?)

If the manager has not intervened or supported the action with defensible decision making, then they should seek further advice from the Local Authority who can sign post, get other agencies involved in support and / or reassess to ensure that the commissioned service is the right service to meet need. If the person remains at risk of abuse or neglect and these responses are not achieving the persons description of safe and well, or what safe and well is considered to be in the persons best interests

(Assessed as lacking capacity) then the Local Authority should cause further enquiries to take place and to identify what care and support agencies are providing, what capacity and consent issues are involved, what legislation applies to the situation and who should be communicating with whom. Advocacy and support, information and guidance are to be offered.

If the above situation fails and concerns for the persons (Or families) wellbeing and safety increase, then a multi-agency meeting with a lead person is required. The lead person is the person who has the skills relative to the area of concern. For example, if the issue is about feeding then a dietician or speech and language therapist may be most appropriate to lead the enquiry. The person should not have any vested interest in the outcome and should be independent from the service provided to the person / family). Police intervention should be considered.

If the above fails then the Local Authority has overall responsibility for information, advice and support, therefore they should be informed of the failure of services to keep the person / family safe and well. They should be informed about the barriers to defensible decision making. The Local Authority should hold the multi-agency meeting, coordinate the process, seek all appropriate assessments to be conducted in a defensible manner, provide the basis for appropriate communications and information sharing. In some cases, it may still be identified that there is a more suitable agency to lead the enquiry. The purpose of health and social care involvement is to make the person feel safe and well and to put things in place to ensure that they continue to feel safe and well. Criminal enquiries are the remit of the Police and should be handed over to the Police at the point of 'Reasonable Suspicion of a Crime.' The Local Authority should determine what lessons are to be learned from this and seek to address those lessons, preventing the escalation of safeguarding concerns and ensuring that agency record in a defensible manner in similar situations in the future.

- **The Most Appropriate Agency to Lead the Enquiry:**

In this case the safeguarding of Paul was handed over to Mental Health Services to lead the enquiry process. Safeguarding enquiries are different to enhanced care management and should seek to establish and rule in / out hypothesis, coordinate multi-agency responses and actions. Oversight, guidance and outcomes are shared with the Local Authority to ensure that actions are managed in a timely and defensible manner. The transfer of safeguarding responses to Mental Health Services following a referral will now be supported with oversight and guidance required of the Local Authority and the Local Authority will be reassured by the safeguarding outcomes meeting the needs of the persons involved.

9. Reviewer Recommendations:

Potential Learning:	Recommendations:	Outcomes:
Mediation services may be used where both parties independently express an autonomous wish to remain together. The impact of coercive and controlling behaviours on decision making to be considered. Agencies should not refer couples to family, marriage guidance or couples counselling where there are issues of domestic abuse without considering this risk.	Familial domestic abuse examples to be explored within safeguarding training to ensure that all agencies can recognise familial abuse.	Multi-Agency Audits identify practitioners utilising domestic abuse care and support recognising all persons affected and provide reassurance of safety and wellbeing and / or defensible decision making.
Moving forward a full history of traumatic events impacting on a person's mental wellbeing should be taken into consideration. Trauma informed approaches represent good clinical practice and would improve understanding of a person's mental health history. Follow up care and support to be arranged	A full history of traumatic events impacting upon a persons' mental ill health should form part of the assessment. Trauma informed approaches should be used and follow up care and support arranged.	Delirium is better understood in context with trauma history and mental health history.
Safeguarding is an aspect of every intervention and the practitioner must be reassured of the safety and wellbeing of parties involved. If there is not reassurance, then a clear and lawful rationale should be provided for the actions taken. If neither can be provided, then reassurance of appropriate support should be sought from others and / or advice and guidance from the Local Authority provided.	Mental Health Services to recognise the importance of the Local Authority role in providing advice, guidance and oversight to safeguarding interventions.	The continuum of safeguarding response begins with reassurance that care and support plans for the person and the whole family are maintaining safety and wellbeing. If this is not achieved the rationale

		should be clear. Further advice and guidance must be sought.
Good clinical practice would ensure that the full history of adverse childhood experiences (Mum not being around due to work commitments, abusive step father, difficulties at school, belonging to a minority group that was targeted for abuse during this period of time in this area, father not being present in family's life, family mental ill health). Traumatic events in Paul's life would be explored (As previously identified) and the accumulative impact of these events on Paul recognised in relation to the escalation of attempts at death by suicide. Emergency services recognised some of these indicators, however, the tools currently in use did not provide a good enough risk assessment process.	The development of a suicide risk assessment process/training for emergency services to be recognised within crisis planning. Suggested template for consideration. The safety and wellbeing of each party should have been considered. If plans in place were not maintaining safety and wellbeing of either party further advice and guidance should be sought and / or a defensible rationale provided.	Risk assessment and reassurance of safety and wellbeing as well as a defensible rationale for decision making along with building stronger relationships is required.
The accessibility of services to be considered in relation to literacy and / or the impact of trauma on decision making. Sending letters to someone who cannot read them or respond to them means that some of the most vulnerable people will be denied access to services. This is not the first time that this matter has been identified in a local Safeguarding Adults Review, it should be highlighted as National Learning.	All assessment processes to consider the accessibility of services in relation to literacy and trauma informed approaches. If audits suggest that letters are routinely sent to those who are displaying signs of trauma, unable to read or incapable of accessing the service for some other reason then, an equality impact assessment covering accessibility to services should be conducted as a multi-agency event.	Access to services is an aspect of reasonable adjustment under the Equality Act 2010. All agencies should be reassured that they have supported equitable access to services.

A wide variety of practitioners would benefit by these proportionate and sensitive capacity assessments being shared as examples of good practice. A full and detailed explanation is not always required for every situation, enough evidence to provide a rationale is a more proportionate response. It would be useful to look at this and then consider the impact of trauma on a person's executive functioning. If found to lack capacity the ethics involved in best interest decision making can be complex as to remove power and control from someone who has suffered from trauma, loss and a lack of power and control may not be the best way forward.	Capacity assessment recording to be shared as examples of good practice across all agencies. Although Bexley are working hard on capacity across the partnership, some examples of proportionate assessment where a full report is not required would be helpful for everyday use.	
It is recognised that when someone suffers from traumatic incidents there can be sensory things that continue to trigger distress (Somatic markers similar to Post Traumatic Stress). When suffering trauma, the area of the brain affected is the executive functioning that governs chronology, date and time, self-care, impulse control, risk assessment and future planning. This would most often affect a person's ability to weigh up information which is required to deem someone as having mental capacity to make that decision. Panel members recognised the importance of this form of assessment in understanding whether a person can make decisions. This form of assessment is difficult to achieve, as the person can describe a course of action and / or a rationale, however, they may struggle to employ the actions, or to have insight into their own abilities. Panel members identified the current local and national struggle to get all agencies to conduct simplistic capacity assessments and that this may be too much to expect. This is a repeat theme in Safeguarding Adult Reviews conducted in the case of self-neglect, self-harm / suicidal ideation, hoarding, homelessness, abuse or neglect. Panel members discussing the understanding of executive function in assessing capacity recognised that even if the person were to be found by the assessor as lacking capacity to make these decisions, it is rare that it would be in that persons best interests to force a course of action that would remove further power and control away from the individual displaying symptoms of trauma. Nevertheless, the rationale in some cases is more defensible and evidence based. It is worth noting that a person who lacks capacity to make a decision is not making an informed choice and therefore the best interest decision is required but must be proportionate and balanced.	Panel members and Board members to reflect upon who would be expected to conduct such complex capacity assessments (Understand the impact of executive functioning on a person's ability to make a decision).	

This is an example of practice that reflects 'Making Safeguarding Personal', the wellbeing agenda, the principles of safeguarding adults and the whole family approach. It is helpful for practitioners to be able to identify practice that reflects current legislation and contemporary safeguarding initiatives. Sharing this example of good practice across partner agencies ensures that all practitioners know what to strive within practice and recording. Sharing the DA risk plan with services involved would have been considered very good practice. The GP, MIND, CMHT and Nurses involved with Paul were not made aware of these risk assessments and plans, a more coordinated approach across safeguarding would have been beneficial.	To share good practice examples in a manner that is accessible to all practitioners. (See recommendations about safeguarding, information sharing and Local Authority overview of outcomes).	
The factors used in assessing risk are very helpful and could be shared more widely to ensure consistent risk assessment. The development of mental health community services is very creative and may exemplify good proactive development of the consideration of other SABs	The ability of people to access these services to be shared across all agencies as good practice examples. Mental Health Services have an array of useful resources that may not always be known to other agencies.	**Consideration:** Access to information can be difficult for people in a crisis. The development of QR codes that all practitioners can share to provide information to these using services may be a simple and cost-effective way to address this matter. This need not be constrained to mental health service resources. The MAAPP QR Code resources key ring is an example of this simple and cheap methodology.
There is recognition and early response identified to this episode of domestic abuse by Mental Health Services which is good practice. At this point hypothesis may have been useful to explore for safeguarding purposes: • Neglect • Self-neglect • Domestic Abuse (Whole family) A coordinated multi agency response for safeguarding purposes would have been valuable. The coordination of support and services, recognition of the history of trauma and the impact on the	Multi-agency safeguarding responses with a lead agency identified and oversight, guidance provided by the Local Authority in safeguarding situations. Oversight does not require the Local Authority to chair or lead enquiry processes, rather to be reassured	

whole family, capacity assessments and applicable legislation discussed to ensure a lead agency in safeguarding responses would have provided a clear picture of the complexities involved.	that steps have been taken to maintain safety and wellbeing as defined by the individuals themselves or provide a defensible and lawful rationale. The Care and Support Statutory guidance identify, *14.77 An enquiry is the action taken or instigated by the local authority in response to a concern that abuse, or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views, wishes, and any immediate action has taken and the reasons for those actions.* *14.78 The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult. If the local authority decides*	

	that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.	
Carers and anyone who has any care and support needs are eligible for safeguarding. Safeguarding measures are to consider the whole family.	The safeguarding of carers (Family members providing care and support) to be identified in all safeguarding training. Safeguarding considers the whole family and wellbeing principles are applied. Training should provide examples in practice. At each stage the Local Authority should be providing oversight and guidance.	
Recordkeeping when providing health and social care to individual should include the methods used to help the person clearly understand the question being asked, so that they can make an informed decision in an appropriate and proportionate way (MCA, 2005).	SAB to consider what proportionate responses are expected	
Coercive and controlling behaviours are the impact on autonomous decision making to be considered.	The potential impact of coercive and controlling behaviours affecting a person's ability to make autonomous decisions should be explored in all safeguarding interventions that involve domestic abuse, including familial domestic abuse. Training	

	and briefing regarding decision making and autonomous to be provided in the most accessible format across all agencies.	
Further analysis is required to understand indicative budgetary systems currently focussed up on the allocation of funds based upon the extent of need and risk with little indication of preventative measures or the promotion of strengths to prevent or delay the need for services in the future. The interface between carers services and support and the services and support required by the person poses systemic difficulties in applying a mathematical approach. A person may have a lot of needs and risks that are addressed by care provision by a family member. However, to achieve this the family member may require several services and support. Conversely a person may have limited needs but little support and without complex rehabilitation and therapeutic intervention their physical and mental health may deteriorate.	Support to be provided to Adult Social Care practitioners to ensure that they can recognise that strengths-based approaches will not limit access to services.	
New Adult Social Care front of house systems and approaches are being developed. Assessment and care and support planning across the whole family is required. The need for a safeguarding enquiry suggests that something is not going well, and a revision, review or reassessment of needs may be required. Where family members are providing support to meet an identified need or to maintain wellbeing then they should eb informed about the responsibility to identity to services is they are struggling to meet the identified need. All identified needs including those met by family care providers should be identified on care and support plans.	For the SAB annual report to identify the impact that the change of process has had in creating improved preventative measures and strength-based approaches. The review of referral pathways including adult safeguarding to include an audit of improved and more consistent decision making and identification of the person leading the safeguarding enquiry. To ensure that all mental health and ASC staff recognise the importance of up to date care and support planning that supports family care providers, but also holds them accountable for	

	meeting needs or reporting concerns.	
The complexities of familial domestic abuse and risk factors to be explored in all safeguarding cases involving family members.	For domestic abuse services and ASC to monitor recognition and response of familial domestic abuse and risk assessment management.	
GPs to consider that adverse childhood experiences and other traumatic events experienced through the life of the person, along with any neurodevelopmental differences (autism, dyslexia etc) will affect the way that patients may present and interact with them or any other member of the primary care team, when they attend or contact the surgery. They may also affect their ability to access care. It is important to take such factors into account, as has been highlighted by this IMR in someone who has mental health and drug and alcohol abuse problems but will be relevant in other situations as well. This should be considered when notes are summarised, in order that relevant information is accessible to clinicians who see the patient. It is important that account should be taken as to whether there is any third-party information in such a note, or if there is any other information which might be harmful if read by the patient themselves. In which case this should not be accessible to anyone requesting on line access to their full notes, or in other circumstances where the notes may be requested for purposes such as insurance etc. It is important to be aware of the potential for changes in status and availability of information which may occur when a patient's notes are transferred from one practice to another and Nationally this does need to be addressed. Ref: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/managing-and-protecting-personal-information		

Article 15 of the General Data Protection Regulation gives patients the right to access their personal information, although exemptions apply in certain circumstances. Most exemptions are contained in the Data Protection Act 2018. For example, an exemption applies if providing subject access to information about an individual's physical or mental health or condition would be likely to cause serious harm to them or to another person's physical or mental health or condition. You also do not have to supply a patient with information about another person or that identifies another person as the source of the information, unless that other person consents or it is reasonable in the circumstances to supply the information without their consent. See the Information Commissioner's Office technical guidance, dealing with subject access requests involving other people's information (Information Commissioner's Office, 2014).		
The S.75 agreement requires greater clarity across the system and the SAB needs to understand the complexities and challenges to the partners involved. The Care Act requires all agencies to escalate concerns where they are not managing the safety and wellbeing of persons.	For the SAB to understand the S.75 agreement as a critical issue particularly regarding clarity and oversight around health & social care safeguarding concerns as it lacks at the moment coherency across the agencies. The Care Act requires agencies to be reassured of the safety and wellbeing of a person / family and to seek advice, support, guidance and oversight from the Local Authority. The question is where all agencies reassured of safety and wellbeing and if not, what actions would be taken moving into the future.	
	For the SAB to support partners to understand 'Think Family Approach' so that measures in	

	place are effective and robust to give the LA oversight it requires.	

End of Executive Summary – BSAB Action Plan to be created and published.