BEXLEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Mrs BA
January 2019

Bexley Safeguarding Adults Board
Bexley Civic Offices
Watling Street
Bexleyheath
Kent
DA6 7AT

Contents

1. Introduction

1.1. Why this case was chosen to be reviewed

1) Bexley Safeguarding Adults Board agreed that the circumstances of Mrs BA's death from suicide met the criteria for a statutory Safeguarding Adults Review under the Care Act 2014. Mrs BA had been receiving secondary mental health services, for over ten years, since first becoming unwell in 2006. Mrs BA had three children, two of whom who lived at home with her and her husband, they had been the subject of input from Children's Services until shortly before her death. Bexley Safeguarding Adults Board agreed with Bexley Safeguarding Children's Board that a Safeguarding Adults Review was appropriate to seek to learn lessons as to how Mrs BA took her own life whilst services were involved with her and her family. This case is unusual for a SAR, in that no abuse or neglect was identified prior to her death.

1.2. Family composition

2) A Family household at the start of the period under review June 2014 -

Mrs BA	42 (at time of death)
Mr YO	44 (husband)
Children	
TO Girl	11 (In Nigeria, under care of maternal grandmother)
AA Boy	6 (in Bexley, under care of father)
FO Girl	4 (in Bexley, under care of father)

Black Nigerian Heritage and 2 younger children lived together with parents in a privately rented house in Bexley.

1.3. Timeframe and Scope

3) The SAR focussed on multi-disciplinary work with Mrs BA and the family from January 2014 to the time of death in September 2017. Although during the SAR, learning was also identified from agencies involvement with Mrs BA prior to this time.

4) The focus of the review was services provided to Mrs BA in relation to recognition and treatment of her mental health needs, care for her children and immigration status. Mrs BA's case was complex, as it came to the attention of both Mental Health and Children's Services through concern about the neglect of her children and the child protection process, this also involved immigration agencies which do not usually work in the field of adult mental health.

5) The Review Team looked at information in relation to Mrs BA, her children and the work undertaken to protect them but has not analysed or appraised that work in detail, except where its focus was relevant to Mrs BA, her health and its impact on both her role as a parent or on Mr YO.

1.4. Organisational learning and improvement

6) The purpose of Safeguarding Adults Reviews is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

7) Bexley Safeguarding Adult Board (in consultation with Bexley Safeguarding Children Board) identified that the Safeguarding Adults Review of this case held the potential to shed light on areas of practice, including addressing the following questions:

- How immigration statuses and the Human Rights Act interact/impact on the Care Act 2014?
- What were the safeguarding policies and procedures in place during the review for each agency and were they followed?
- What feedback does the husband have and how this information could impact services?

1.5. Methodology

8) The Department of Health Care and support statutory guidance – published to support the operation of The Care Act 2014, states[1]:

> '14.163 Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
>
> '14.167 The following principles should be applied by SABs and their partner organisations to all reviews:
>
> there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
>
> the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
>
> reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
>
> professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
>
> families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

9) 14.168 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

1.6. Reviewing expertise and independence

10) The SAR has been led by two people independent of the case under review and of the organisations whose actions are being reviewed - Mick Haggar and Maria Gonzalez-Merello. Neither has any previous involvement with this case, or any previous or current direct employment by Bexley Council or partner agencies.

11) Mick Haggar is a registered social worker and experienced reviewer. He was supported by Maria Gonzalez-Merello, who is a Barrister and gave independent expert advice as to the immigration process and submissions by Mrs BA's solicitor on her behalf to the Home Office. The SAR

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

incorporated some aspects of the SCIE Learning Together methodology combined with a more traditional model for SARs, involving each agency submitting Independent Management Reports, outlining each agencies involvement in the case. The IMRs were used to inform a combined and integrated chronology of all agencies contact with Mrs BA and her family.

1.7. Methodological comment and limitations

12) The Review Team was provided with the integrated chronology of all agency involvement with Mrs BA and her family by the following agencies:

London Borough of Bexley No Recourse to Public Funds Team (NRPF Team)
London borough of Bexley Housing Services
London Borough of Bexley Legal Services
Royal Borough of Greenwich Children's Services
London Borough of Bexley Children's Services
London Borough of Bromley Health Care (Health visitors)
GP Practice
Oxleas NHS Foundation Trust (Mental Health & Health Visiting Services)
The Home Office, Immigration Services

13) Many original case documents were provided by Adult Social Care, Housing and Children's Social Care, Oxleas NHS Foundation Trust, the Home Office and the family's solicitors. The solicitors' applications and Home Office responses were further reviewed by Maria, giving her expertise opinion of this process to inform the review.

14) It was a challenge that the Review did not start until nine months after Mrs BA's death and it took time to obtain the various agency chronologies, copies of original documents and case records. Individual conversations were also held with Mr. YO and several key professionals (the manager of the NRPF Team, 2 Oxleas staff; her care coordinator in ICMP before Mrs BA's death and community social inclusion worker ADAPT, also the Head of Safeguarding Adults for Oxleas NHS Foundation Trust; and the Practice Review & Learning Manager of the Bexley Children's Safeguarding Board). The Review Team held two Meetings, to consider the Integrated Chronology and subsequently to explore potential learning from 9 Key Practice Episodes identified from within the Chronology.

1.8. Participation of professionals

15) A Review Team of senior managers was appointed to assist the Review. They are listed in Appendix 3. There were some gaps in attendance at some of the Review Team Meetings and inconsistencies in Review Team Membership. At the outset it was agreed to seek as much information as possible, with further details requested of each agencies involvement upon receipt of the initial Individual Management Reports.

1.9. Perspectives of the parents and children

16) Mr YO was advised of the Review and invited to participate by meeting the Lead Reviewer and Manager of the Bexley Safeguarding Adults Board. Two meetings were held with Mr. YO and he was keen to be involved with the Review and learning from the death of his wife.

Below is a summary of the key points and his views from these conversations;

17) Mr YO felt that Mrs BA's immigration process was initially badly handled by his first solicitor but that the second solicitors were much better, and he gave consent for their correspondence to be released for consideration during this review. He also viewed the decision by the NMC not to allow Mrs BA to practice as a nurse in the UK was unfair and unhelpful. Mrs BA was offered a place on a short course to help her return to work, but as she had no work visa at this time she was unable to enrol on the course. She was stuck at home and unable to regain her profession even after many years of mental stability. He was very upset that both BA and YO were accused of fraud by Bexley Council when an overpayment was made to them in error. He felt that this was communicated and handled badly.

18) Mr YO valued the support offered to Mrs BA at times by the Mental Health Service, especially her support worker and was disappointed when this service was lost. He commented that when Mrs BA started to become unwell he always alerted mental health services, but there was often a delay in admitting her to hospital, which usually occurred after a crisis. He felt that earlier intervention could have avoided these crises happening in the first place. He also commented that when BA was admitted to hospital she was usually discharged home too soon, whilst she was still unwell. This happened on several occasions and led to her subsequent readmission, again after a crisis occurred. He was particularly upset that when Mrs BA was in a crisis and he tried to call the 24hr emergency line he was unable to get through. At one point he remained on the phone for an hour, waiting for the call to be picked up, but it never was.

19) YO stated that Mrs BA was also very guarded about her mental health problems and due to the stigma sought to keep it both from members of her community/church and to conceal the extent of her symptoms from most mental health professionals. He felt he had a good understanding of her condition but was not always listened to by professionals. The children's Health Visitor was very good, and she worked with the family well, as did their local GP Practice.

2. Timeline of Agencies' Involvement and Key Practice Episodes

2.1. Introduction

20) Following submission of all agencies chronologies, this section includes brief information beginning with Mrs BA first becoming known to services in Bexley and Greenwich. Key periods of the timeline were identified after the first SAR Meeting and analysed for subsequent learning in the second meeting. These refer to significant interventions and events during the timeline, which the author felt had a bearing on both the individual case and gave an opportunity to explore wider learning about the systems in Bexley. These are called Key Practice Episodes (KPEs),

The 9 Key Practice Episodes within this section are summarised below, (full details in Appendix 1) these are analysed in more detail, in the next section of the report.

21) Mrs BA was born in Nigeria in 1975 and entered the UK in 2004, on a student visa, in order to train and register as a nurse. This was supported by her father, who was resident and UK citizen. She was successful in gaining her accreditation with the NMC after doing a nursing adaptation course and was granted leave to remain until December 2010, with a work visa, on the basis that she worked as a nurse. She worked in a Nursing Home for the elderly in Brixton. She worked long hours in this post, partly due to covering for staffing absence at the home.

22) In March 2006, Mrs BA had a mental health episode; she had been behaving strangely at work and was found in a confused state near her workplace. She was admitted to a psychiatric hospital (Queen Mary's Hospital, Woodlands Unit) and detained under Section 2 MHA'83. She remained in hospital for 4 months. She was diagnosed with Paranoid Schizophrenia and discharged home to the care of her partner, YA. The couple returned to Nigeria and married in March 2007 and returned to the UK in May 2007. The SAR Review has analysed significant periods of agency involvement with BA and her family after this time.

2.2 Summary of Key Practice Episodes (KPE) and Appraisal of Practice

Below is a table containing a summary of events and an overview of the appraisal of practice within each KPE, these appraisals and associated recommendations are explored in more detail in the next sections of the report. There is also a summary of the independent legal review of the case, with more details set out in the next section.

KPE (Dates)	**Summary and Appraisal of Practice for Each KPE** **(Links with Findings and Recommendations)**
KPE1 (15/05/07-11/04/08)	• Poor Transfer of Care between Bexley & Greenwich Children's Services when YO moved area after TO placed in foster care by Bexley. • Lack of coordination between Mental Health (both community and hospital services) and Children's Services to keep Mrs BA and TO together. • Inappropriate refusal for Mother & Baby Unit admission. • Use of unqualified and inexperienced staff for a complex case by both boroughs may have contributed to poor practice. • Lack of support for Mrs BA, no legal advice offered and decisions about removal of daughter rather than help to keep the family together. ***(Finding 1)***
KPE2 (16/03/12-04/08/14)	• Pre-birth conferences were not held prior to the children being born, possibly due to staffing pressures with Children's Services.

	• Good leadership from Children's Services and multi agency work from Mental Health was effective in maintaining the family unit and Mrs BA's mental health. • The Home Office refused all Mrs BA's solicitor's applications to permit the family to remain in the UK, but at this time it did not lead to any relapse in her mental health. • Mrs BA continued to seek permission to return to work, which was being monitored by the NMC, despite her being stable for the past 6 years.
KPE3 (17/01/15-21/07/15)	• Domestic abuse was alleged but not investigated by Children's, Adults or Mental Health Services, in line with Safeguarding procedures. • There was a 4-month delay in Children's services response, via a telephone call, which determined no risk and led to a decision to close the case, as the situation was deemed to be low risk. ***(Finding 2)***
KPE4 (07/07/16-23/08/16)	• Reorganisation of Oxleas Mental Health Services led to the loss of Mrs BA's long-term support worker. • Reorganisation of Support to Families in Bexley, with the establishment of the NRPF Team, led to an overpayment of subsistence payments to Mrs BA and her family, which were not identified for over 12 months. • Both these changes adversely affected Mrs BA's support network and caused her additional stress.
KPE5 (09/11/16-09/01/17)	• Several stress factors (immigration status and applications all being refused, hearing scheduled at NMC for her fitness to practice, threatened with eviction, as NRPF team stopped paying rent) were present at this time, which precipitated an acute relapse in Mrs BA's mental health, after many years of stability. • Police were needed at her address to convey her to hospital and return her x2 when she was deemed AWOL from section. • A lack of available female inpatient beds led to Mrs BA initially not being re-admitted when she went AWOL on the first occasion and subsequently being transferred out to a private PICU, as no intensive care female beds are commissioned from the Trust. • A further lack of available local beds led to Mrs BA being then discharged directly home from the PICU, with insufficient transfer to local services, whilst she was still unwell.
KPE6 (13/02/17-23/05/17)	• Following a "poor handover and a premature discharge" (as reported by YO) from the private PICU, Mrs BA was sent directly home, whilst still mentally unwell, leading to risks to both BA and potentially to her children. • A plan by the HTT to monitor medication in the community led to delay in her reassessment and readmission to hospital, due to a delay getting a warrant, until a crisis event where Mrs BA locked her husband out of the house, waving a knife through the letterbox and leading to police attendance and ultimately breaking down her front door and arresting her. This would have been frightening for both Mrs BA and her 2 young children. • Children's Services responded to a safeguarding referral by assessing risks as low, but this was closed prior to Mrs BA being discharge home from this admission, therefore without a full understanding of the family situation. • Children Services closed the referral without the involvement of the ICMP Team, who had raised the referral, which was not good practice. • The financial and immigration stress factors were not addressed during this

	period, thereby exposing Mrs BA and her family to on-going risks of further mental ill health. • There was better coordination between private PICU and local psychiatric services, including authorised discharge with compliance with medication through a Community Treatment Order. ***(Finding 3)***
KPE7 (06/06/17-27/06/17)	• A debt recovery letter was sent without explanation, which was threatening legal action and unrealistic to expect repayment, given that the family were destitute. Increased pressure and stress on Mrs BA at a time when she was mentally fragile. • Home Office had advised that Mrs BA's only option to remain in the UK was to seek asylum, which showed some good practice by the Removals Preparation team. But she was never supported to consider this. Due to her poor mental health it is unclear whether she was able to make such an application. • Mrs BA's depot medication was reduced, at her request due to side affects, but given increased pressures on her this may have increased the risk of further psychotic breakdowns. ***(Findings 4 & 6)***
KPE8 (14/07/17-18/08/17)	• The communication of the Home Office's final decision regarding Mrs BA's application to remain in the UK was poorly managed. • There was a significant deterioration in Mrs BA's mood following this and she expressed suicidal ideas, including hearing voices with specific plans as to how to end her life. • Mrs BA was felt to be in crisis by her Care Coordinator and was seen by the HTT, who felt an admission would be of benefit, but once again there were no local beds in the Woodlands Unit and Mrs BA was advised to present at A&E but refused to go. • This was not pursued, and Mrs BA was given sleeping pills prior to being discharged back to ICMP team after a brief period of assessment by the HTT • This case clearly highlights how crises are defined within HTT and ICMP teams, and how risks of suicide assessed and managed in the community.
KPE9 (01/09/17-10/09/17)	• The 10 days prior to Mrs BA's suicide included a decision by her mental health team to stop her depot medication, at her request due to her reporting side effects and to increase her oral medication. • The potential increase in risks of suicide following the above change to treatment were not monitored, or managed by ICMP, or the HTT. • Mrs BA was not seen again by mental health services after this reduction in treatment to review her mental state and the associated risks to her welfare. • Her husband reported difficulties contacting mental health crisis services when Mrs BA deteriorated in the days prior to her suicide and he tried to call for help. • The risk of suicide was not immediately communicated by MPS to the BTP as tragically she had died prior to a report being taken by MPS. Mrs BA took a train to Victoria station, where she went to the Victoria Line underground platform and shortly afterwards jumped in front of an oncoming tube, resulting in her death, due to multiple injuries. ***(Finding 5)***

Legal review	• That the unstable nature of Mrs BA's mental health could have been better presented to the FTT, with an up to date psychiatric report in 2016. The report submitted was 2 years old, at which time her mental health was stable, prior to her relapse later in 2016. • The realistic likelihood of Mrs BA being actually able to access sufficient mental health care should she return to Nigeria and the impact on her health were this unavailable could have assisted the FTT to consider the Human rights submission at this time, given reference to relevant case law, (Bensaid v UK [2001] 33 EHRR). • If Mrs BA's first child (TO) was not removed from the UK and placed with her maternal grandmother to be raised in Nigeria then Mrs BA and her family may have been granted leave to remain in the UK, as TO would have spent at least the first 7 years of her life in the UK. • Although appropriate submissions were made by Mrs BA's representative during this period an application for asylum should have been made, as grounds were present for this (FGM) and the Home Office encouraged consideration of this when refusing all other grounds for her to remain in the UK. • The refusal to allow any of Mrs BA's submissions may have been a significant contributory factor to her becoming suicidal.

2.3. In what ways does this case provide a useful window on our systems?

23) Whilst all cases are different there are some important features of this case, which may be seen to highlight some more common practice issues.

BA was a woman with complex, severe and enduring mental health problems. She was also a mother who had needs for support in this role and her children were deemed at times to be at risk and in need of additional services. Her husband was her primary carer and an important source of both support to the family and a key point of contact about the nature and degree of her mental health problems, which she sought to conceal from services especially at times of relapse. There were concerns about domestic abuse within this relationship at times, which were not robustly addressed by Adults or Children's' services. Her immigration status and applications for leave to remain in the UK had a direct impact on both her need for and entitlement to public funds and specialist help. Her mental health problems and the relationship between this and her risk of suicide highlighted the need for coordination between all the agencies seeking to assess and manage this risk. Analysis of these aspects of her circumstances can give valuable insight for services seeking to assist people in future.

3. Appraisal of Practice

3.1 Structure of the report

24) This section contains priority findings that have emerged from the SAR. The findings explain why professional practice was not more effective in protecting Mrs BA in this case.

25) Each finding also lays out the reasons identified by the review team that indicate that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

26) First, an overview is provided of an appraisal of what happened in this case. This clarifies the view of the Review Team about how timely and effective the help that was given to Mrs BA and her family was, including where practice was below expected standards.

3.2 Appraisal of professional practice in this case: a synopsis

Agency actions throughout the review period were analysed in line with the 9 key practice episodes (KPEs).

3.3 Appraisal of KPE 1, (15/05/07-11/04/08)

27) In May 2007, at the time of the birth of TO, she was with her mother (Mrs BA) in the Special Care Baby Unit of Queen Elizabeth Hospital, where she stayed for 3 months. In August TO was ready to be discharged but due to Mrs BA's reported bizarre and chaotic behaviour on this ward she was removed by the police and admitted informally to Woodlands Unit where she was then detained (under S2 MHA '83) in the Psychiatric hospital ward. TO was then placed in Foster Care by Bexley Children's Services, according to records this was due to the wishes of her father (YO), however on interview for this SAR this was not YO's recollection-as he felt pressured into this decision, although he did agree at the time as a short-term measure whilst Mrs BA was in hospital and because he was busy working shifts, so he could not care for TO by himself.

28) An appropriate plan was made to transfer both Mrs BA and TO to the South London and Maudsley NHS Foundation Trust (SLAM) special Mother & Baby Unit at the Bethlem Royal hospital, but this was refused by the hospital due to TO be a MRSA carrier. This however should not have prevented the placement and a complaint was lodged by Public Health with the Medical Director of the Bethlem Royal Hospital. The outcome of this is not known, but as a carrier of MRSA this ought not to have been a barrier to admission to the Mother & Baby Unit. This is significant as it could have enabled BA and TO to bond. It could have given time for Mrs BA to receive appropriate mental health support to recover and care for her baby herself. Mrs BA did get leave from hospital to visit her daughter at the foster carer's in September 07 but appeared to struggle to care for and bond with TO, which may have been because she was still suffering from the affects of her recent psychotic episode.

29) Also, at this time YO moved to Greenwich and there was a 2-month period where case responsibility was handed over, but not picked up by Greenwich Children's Services. This was a critical time for the family and the welfare of Mrs BA and her chance to bond with her baby, the delay was detrimental to both mother and baby. The reason for this delay is not clear for the review, but a factor is clearly related to the handover of the duty of care between the 2 local authorities. There was a LAC (Looked After Children) review at which care was taken over by Greenwich, in November 2007.

30) Also, at this time BA was readmitted and then detained again under MHA '83 in a mental health unit, due to a further relapse whereby she was expressing suicidal thoughts, she threatened to drink bleach. During this time a Greenwich Children's Services Student SW undertook work with the family resulting in a decision that TO should not be returned from foster care to the care of her mother/father. Adoption was considered but an alternative plan was made for TO to be cared for in Nigeria by her maternal grandmother. Despite her paternal grandfather being in London this was thought to be better for her. The reason for this decision is unclear.

31) As outlined above whilst these plans were made Mrs BA was still mentally unwell and her ability to take capacitated and informed decisions about the care of her daughter did not seem to have been taken into account. Also, her legal rights to have a parenting assessment and advice/representation for this decision do not appear to have been upheld. There was no pre-birth assessment done of TO's needs, which would have helped with plans for BA to have been supported in her role as a mother. The Mother and Baby unit was refused inappropriately due to TO carrying MRSA, this was against the advice from the Infection Control Nurse.

32) As Greenwich Children's Services were unable to submit their assessment records as part of this review further analysis of work at this time was not possible. However, it appears that the decision to remove TO from her parents and return her to Nigeria was not in line with best practice to keep the family together where possible. Also, the apparent lack of any legal advice offered to Mrs BA or YO when plans were made for TO to be taken to Nigeria was also not good practice. YO certainly felt pressured to agree to this plan (he said it was either this or TO would be put up for adoption). Given Mrs BA's mental health at this time her right to independent legal advice being breached and her ability to engage meaningfully in this process certainly call into question the quality of practice by Children's Services at this time. Also, YO stated he had to work and so could not look after TO. At this time the option of financial support was not explored to enable him to be supported to care for his daughter.

33) The initial case work by Bexley Children's Services was undertaken by a Social Work Assistant and as a clearly complex case this would appear to have been challenging and may have been inappropriate. When Greenwich eventually took over the case it was allocated to a student SW and again this seems inappropriate given the complex issues of mental health, immigration and NRPF for the family. The conduct of Greenwich Children Services has been questioned by YO (child's father) and formed part of a subsequent correspondence between Solicitors representing the family's immigration appeals status. It appears significant that this may have not be good, or even lawful practice and certainly had a detrimental affect on both parents and their subsequent immigration claim to remain in the UK. This may have been avoided through better coordination between Bexley and Greenwich Children's Services, Mental Health Services and the child's family.

3.3 Appraisal of KPE 2 (16/03/12-04/08/14)

34) After a prolonged period of stability for Mrs BA, in terms of her mental health, she gave birth to her 2nd child (AA, 16/03/12) and 3rd child (FO, 12/02/14). By this time, she had returned to live within Bexley and concerns about the children's welfare were again the responsibility of Bexley Children's Services, having been identified by the Mental Health Team, due to the possible impact of pregnancy on Mrs BA's mental health and the subsequent risks to her children. In these situations, it would be expected that Pre-birth conferences would take place to consider these risks, but these did not take place for either child, until after their birth. During this time there was high turnover of staff in the Children's department and consequently high use of agency staff. Bexley Children Services were rated as inadequate by Ofsted following an inspection in 2012 and although better following reorganisation, still required improvement in 2014[2].

35) In this case a Bexley Child Protection Plan under the category of neglect was agreed in March 2012, whereby YO was given financial support (£900 per month rent and £600 subsistence) to remain at home as AA's primary carer. Also, Mrs BA's visa had expired, and applications were made by her solicitor for Leave to Remain under Article 8 Human Rights Act. This was refused in September 2013 but a further application for discretionary leave was made in October 2013. This was also refused and a request for a Judicial Review was then submitted in January 2014.

36) The plan to support YO was extended in June 2012 and the Bexley Child Protection Plan was ended but support continued as AA was considered a Child in Need in March 2013, as Health Visitors saw the baby and he was doing well. Continued financial support was offered by Bexley Children's Services and the case was kept open, due to the on-going immigration issues and NRPF. During this

[2] https://files.api.ofsted.gov.uk/v1/file/50004266

time Mrs BA ‘s mental health was stable on oral medication (Quetiapine) and she was seen twice-weekly and had frequent telephone contact for mental health support. There were concerns that her pregnancy and birth of her first child increased the risk of postnatal depression/psychosis. Mrs BA was attending college to enable her to retrain and she planned to return to nursing. She attended a meeting with NMC and was placed on a supervision order for 18 months to enable her to return to work, due to her previous episode of mental illness.

37) Following the birth of her third child in February 2014 a “pre-birth assessment” was completed in March 2014, with a plan to continue support arrangements as before. There was some evidence of good practice at this time, whereby Child Protection Meetings, professionals meetings, PLO (Public Law Outline) meetings and Children in Need meetings aimed to coordinate Children’s and Mental Health services to support Mrs BA and her family network, including child-minding services. It was noted that pre-birth assessments did not take place before the birth of each child, possibly due to staffing issues within Bexley Children’s Services at the time.

38) The pressure of the repeated applications for leave to remain, which were all refused by the Home Office during this period was noted and the possible implications of this stress on Mrs BA’s mental health increased the risk of her suffering further mental health relapses. An appeal was lodged with the first tier of the immigration tribunal in August 2014. Shortly prior to this the family were served with a notice (IS.151A) by Immigration Services that they were deemed to be illegally in the UK and were liable to be removed. Throughout this time Mrs BA was given on-going support by her allocated social inclusion worker from the Mental Health Recovery Team, with whom she had a good rapport.

3.3 Appraisal of KPE 3 (17/01/15-21/07/15)

39) This period starts with an alleged incident of domestic abuse, following a call to police from a neighbour, of Mrs BA screaming and being dragged inside by YO. Police attended and Mrs BA alleged YO had punched her, YO stated Mrs BA had threatened him with a knife. YO was arrested and accused of assaulting Mrs BA, despite there being no sign of injury. He was bailed upon conditions that he did not return to the home address. The police notified Bexley Council, using a Merlin report, which was sent to the Domestic Abuse & MARAC Coordinator. This was subsequently passed onto Bexley Children’s Services, due to the possible risks to the 2 children, however there are no records of any visit or assessment by Children’s Services in response to this incident. There was not clear compliance with Think Families, nor any referral for an Independent Domestic Violence Advocate (IDVA) for Mrs BA. There are also no records of any communication with Mental Health Services for their involvement, which meant no Bexley Safeguarding Adults Referral was made. No CAADA DASH Risk Assessment was done and no referral was made to the MARAC, although the threshold may have been met in this case.

40) No Safeguarding Adults, or Children investigation appears to have taken place following this alert being raised, which is a clear gap in practice. The reason for a lack of identification for a safeguarding referral or investigation was identified from a review of agencies records, which suggests a lack of both sufficient process and awareness of local authority responsibilities in both Children’s and Adults Services. The criminal case was adjourned and ultimately dismissed at Court, but the facts of the matter remained unclear, due to the lack of any further investigation. This incident may have reflected a sign of Mrs BA’s deteriorating mental state, but this does not seem to have been assessed at this time.

41) There are brief records of a risk assessment in May 2015 by Bexley Children’s Services, which was undertaken via a telephone assessment, 4 months after the above domestic abuse referral, where YO stated there was no violence between the couple. It was unclear whether Mrs BA was spoken to at this time. The case was then closed to Children’s Services in June 2015, despite concerns about this from Mrs BA’s mental health worker about possible risks to the children. This was not good practice and a clear opportunity was missed for a thorough and timely response by services to the alleged domestic abuse referral, the reasons for which are unclear, due to the lack of recording about decision making at this time.

42) It does reflect a lack of consideration of potential risks to both Mrs BA and her children, from either YO, or if a false allegation was made, due to Mrs BA's deteriorating mental health. The response to the allegation of domestic abuse by Bexley Children's Services was to close the case but other options do not appear to have been explored as to how joint safeguarding responsibilities might have been undertaken by Children's and Adult or Mental Health Services. Mental Health Services recorded that they were not happy that Children's Services were withdrawing from the case and opportunities were subsequently lost for a joint needs assessment in addition to exploration of any potential safeguarding implications.

3.4. Appraisal of KPE 4 (07/07/16-23/08/16)

43) In the period between KPE3 and 4 Oxleas had reconfigured Mental Health Services, away from geographical teams, to specialist teams along diagnostic criteria and Mrs BA's case was transferred to ICMP (Intensive Case Management in Psychosis Team). Her long-term social inclusion worker was moved to another team (ADAPT) and was instructed to cease involvement with Mrs BA, which she did for a time before working with her again. Her CPN, who was also her Care Coordinator, left and this also required a full handover of her care to a new CPN in the ICMP Team.

44) Following an MDT Review, the ICMP team then planned to close Mrs BA's case to the team entirely, as part of a step-down plan which began with her transfer from enhanced to standard CPA in January 2016 due to her long period of stability. Mrs BA formally complained about this decision, despite this the Team Manager initially deciding to still close her case and discharge her to the care of her GP. This was explained to Mrs BA on a home visit, where she was extremely angry. Following her formal complaint being heard and subsequently upheld by Oxleas Mrs BA's case was never closed. She continued to see her newly allocated CPN from the ICMP team, as her previous CPN had left the Trust in 2015.

45) The combination of the stress of her immigration claims being refused and the potential prospect of losing Mental Health Services and the way this was communicated to Mrs BA and her GP preceded a subsequent deterioration in her mental state.

46) Another relevant factor identified between KPE3 and 4 was the No Recourse to Public Funds Team being set up by Bexley in September 2015, which was under the Housing Department, but had Social Workers seconded from Bexley Children's Services. It also had workers embedded in the team from the Home Office. Mrs BA's case was taken over by them in and they took over responsibility for Financial Support under the previous subsistence arrangements that had been set up through Children's Services. The Housing Dept. thereafter paid the financial support however Children's Services did not cease their payments to the family, which continued for some months, until September 2016 leading to a significant overpayment by Bexley Council. The reason for this mistake was unclear although appears to have been a combination of Human error and poor systems for Financial Accountability between different Departments of the Council with inadequate transfers and checks in place. This becomes significant as the family are blamed for not noticing this error and are subsequently accused of Fraud. YO's view was that prior to this overpayment he was told that the family had been under paid and he thought the extra money was an entitlement, rather than an error.

3.5. Appraisal of KPE 5 (09/11/16-09/01/17)

47) In the month prior to this period all Mrs BA's immigration appeals rights had become exhausted with the Home Office and her case was referred to the Removals Team to plan for her possible removal from the UK. Another known stress factor was identified at this time, which was a Fitness to Practice hearing with the NMC scheduled for 14/11/16. This would look into whether she could return to practice as a nurse. This was highly significant, as it could then have affected her right to remain in the UK. Also, the NRPF Team had stopped paying her rent and the family were being threatened with eviction from their home.

48) Mrs BA stopped taking her oral medication and her mental state significantly deteriorated, leading to bizarre and chaotic behaviour, destroying possessions and putting her children at risk. She was

admitted to hospital (under Section 4 MHA ’83). YO reported she had been unwell for some time prior to this admission and due to the severity of her relapse her worker from ICMP referred the family to Bexley Children’s Services over concern on the impact and safety of her 2 young children. It appears that this referral was initially received by the Children’s Worker in the NRPF Team but was then transferred to Children’s Services for a full assessment, as the NRPF team remit did not include assessing Child Protection Concerns. It was at this point that the overpayment of subsistence was noted by the Children’s Social Worker.

49) The request for assessment from children’s services was not followed up for some time but the case was allocated, and the family circumstances were assessed whilst Mrs BA was detained in hospital. As YO was caring for the 2 children well, there were no risks identified to the welfare of the children and the case was closed in January 2017.

50) Mrs BA’s mental state led to a crisis admission. Mrs BA was given home leave but when she did not return as expected the police were called to the home by YO; once located they took her to A&E, but there were no available beds on the ward and Mrs BA refused to wait for a bed to be found, she then left A&E on her own; eventually returning home. She was then conveyed by the police to the ward; due to the acute level of her mental ill health at this time she was then detained (under S3 MHA ’83) and transferred to a Private PICU (Psychiatric Intensive Care Unit) in Roehampton, following an assault on ward staff. This was due to Oxleas Mental Health NHS Foundation Trust having no female only PICU ward.

51) The access to a private PICU unit out of the local area may have been significant at the point that she was then deemed to be no longer in need of PICU and as no adult acute female beds were available in the local services at the Woodlands Unit. She was discharged directly from the PICU to her home. Ideally, she would have “stepped down” to a female acute ward locally prior to being absolutely discharged from psychiatric inpatient services. Her Care coordinator attended a pre-discharge meeting and accompanied her home. In YO’s opinion the “premature” discharge from hospital was a repeated issue, with Mrs BA still appearing to be mentally unwell when she was discharged from the above PICU unit. When she returned home her husband immediately raised concerns with her Community Mental Health Services, as she seemed to be still unwell and acting oddly. She did not allow her husband to supervise her medication and he felt she was non-compliant.

3.6 Appraisal of KPE 6. (13/02/17-23/05/17)

52) Following her discharge Mrs BA’s mental health continued to be a concern for her husband, due to her behaviour at home. She was assessed by Mental Health Services and transferred to the HTT (Home Treatment Team), who attempted to supervise her medication in the community. However, 5 days later, there was an incident where she locked YO out and threatened him. Police broke into her house and removed her to hospital for assessment. She was then assessed and detained (under S4 MHA ’83) again, within weeks of her discharge from the PICU. This was then changed (to S2, then S3 of MHA ’83) before she was once more transferred back to the same private PICU. It appeared that the transfer to local services in January 2017 may have been related to this repeat admission. In YO’s view Mrs BA was able to mask her symptoms and had not been fully ready for discharge from hospital. It also appeared that if she was in fact still unwell and not taking medication she could have been readmitted, although she was assessed twice by clinicians she was not readmitted until the crisis and incident involving the police breaking into the family house and arresting her. This is significant when considering the usual good practice model of avoiding the use of inpatient beds whenever possible, as a least restrictive measure and to manage mental health in the community. There may be learning here about the adverse consequence of this practice in some cases, where delays in admission and early discharge lead to the subsequent escalation of risk and crisis in community.

53) The RPT (Removals Preparation Team) at the Home Office advised Mrs BA’s solicitor she could seek to make an asylum claim, on the basis of Female Genital Mutilation (FGM). However, Mrs BA was

currently too unwell to make this decision and was still detained in a mental health unit. The RPT then participated by phone in a professionals meeting at the end of February 2017, where this advice was repeated, as all her other applications were refused, and she had no further basis for an appeal. A request was made for her CPA Care Coordinator to tell Mrs BA this, but this was not felt to be appropriate by them, so they passed this onto her solicitor. The management of decisions regarding communication with BA in this meeting did not appear to be clear, or well led. The concerns about FGM although shared in this meeting, do not seem to have been followed up by any agency. There is a duty to report FGM for under 16s under the national scheme and this now falls under the Safeguarding Policy as a concern of abuse which wasn't identified or followed up.

54) The referral for assessment of the risks to the children following Mrs BA's mental health relapse was followed up through visits to the family, whilst Mrs BA was detained in hospital, but as YO did not want to engage with support the case was closed. However, good practice would have been to continue the assessment once Mrs BA was discharged back home after her hospital admission. This would have enabled a more thorough assessment of the potential risks to the family when they were all together, rather than just when YO was in sole care of his 2 young children. The potential risks to the children when Mrs BA was unwell were not assessed prior to the case being closed and therefore did not include coordination with Community Mental Health Services.

55) In March 2017 Children Services undertook another assessment with YO, but the case was again closed without seeing the children, as he did not wish to engage at the time. He stated he only needed financial assistance, due to non-payment of rent and arrears. As Mrs BA remained in hospital the risk to the children was recorded as low, but this was done without seeing either the children or Mrs BA, either individually or together. This was especially concerning as when BA had become unwell she had been paranoid, threatening, violent and locked her husband out of the house, whilst she was inside with the 2 young children. This information was known and included on her discharge report from hospital to the GP but was not taken into account by Children's Services.

56) During this time there was clearly another severe mental health crisis, which coincided with the Home Office informing Mrs BA that all appeals had been exhausted and she was advised to return to Nigeria. There was communication between Mental Health, NRPF Team and the Home Office about how to take this forward but was left to her solicitor to address following the professionals meeting. It was unclear how the risks were to be managed or the impact of this on her mental health and behaviour. It was also unclear how the current social circumstances (including debt) and immigration status were ever addressed in relation to the on-going affect on her mental health and the associated risks of a further episode.

57) Mrs BA was transferred back to Woodlands Unit (24/04/17) from the private PICU prior to her subsequent discharge back to the community, initially on leave (11/05/17). As part of her planned discharge from hospital she was assessed and placed on a CTO (Community Treatment Order) on 23/05/17. This was good practice; to manage her previous poor compliance with medication and her CPA Care Coordinator was involved in this discharge planning decision.

3.7 Appraisal of KPE 7 (06/06/17-27/06/17)

58) During this period Mrs BA had been discharged from hospital, whilst remaining subject to the CTO, the conditions of which were for to remain compliant with medication and to be in touch with her CPA Care Coordinator from the ICMP Team.

59) Also, a further invoice was sent to Mrs BA by Bexley Council, demanding repayment of the £10,800 overpayment that they had made in error, following the previous mistaken double subsistence payments. The invoice stated that the money had been falsely claimed by Mrs BA/YO-rather than paid in error due to a system failure by the Council.

60) As Mrs BA and the family had no other source of income it was clearly not realistic to expect them to repay this debt in this instance and it caused a considerable increase in stress for both Mrs BA and YO. The accompanying letter also identified that Mrs BA had committed fraud by accepting this money, despite the NRPF Team having previously told YO they had been underpaid. This had led to YO accepting the extra money in good faith rather than questioning whether it was a mistake at the time by Bexley Council. Sending this letter out directly to the family was not good practice, as the basis for the overpayment was not explained to them directly at this time. The letter was threatening in tone and unrealistic given the lack of income for the family to ever repay this money.

61) The Home Office advised Mrs BA had run out of appeals options and subsequently advised her solicitor that she could make an asylum claim on the basis of FGM. It was unclear whether this was ever discussed directly with Mrs BA, upon her release from hospital or whether she was mentally well enough and competent to decide regarding such an application. Her solicitor never further pursued this, and the Home Office did not receive a request for asylum, after advising of this option. This led to further removals action being considered and letters to Mrs BA, advising that she was now liable to be removed. The Home Office did follow up with further requests for information about Children's Safeguarding Issues and details of Mrs BA's CTO mental health plan, in order for them to consider as part of the Human Rights application. But as there were no Child Safeguarding issues identified by Children's services, no updates were sent to them.

62) Whilst Mental Health Services knew these social pressures, the possible impact on Mrs BA and potential increased risk for further psychotic episodes did not appear to have been considered. At a CPA in 20/06/17 her depot medication (Clopixol) was reduced at Mrs BA's request, due to the unpleasant side effects of this treatment. There was a plan to increase her oral medication (Quetiapine) to compensate for this reduction in her depot.

63) The continued pressures of a financial debt to the local authority, the lack of options for remaining in the UK and the potential impact on Mrs BA's mental health did not appear to be taken into account when her antipsychotic treatment was reduced. Both these factors potentially increased the risk of a further relapse in her mental health, despite being discussed at a multi professionals meeting. This was a judgement about her care, based on the information available about her health at the time. To not reduce medication, as she appeared to be doing well may have been seen as an unjust restraint, which demonstrated the difficulty of managing mental health in the context of social circumstances and the wider stress factors at that time for Mrs BA.

3.8 Appraisal of KPE 8 (14/07/17-18/08/17)

64) This period begins with the reduction of depot medication as above, being confirmed at a CPA meeting. Shortly after this Mrs BA's solicitor and her CPN received the letter confirming the final refusal decision of her immigration process from the Home Office. Mrs BA was phoned by her CPN, to ask how she was after the news. However, as she had not been told, her CPN informed her of this decision over the phone and her CPN then saw her at home days later. She was given her reduced depot and reported feeling very suicidal after receiving this news. She was advised to contact her solicitor about this by her CPN. YO was very concerned and her CPN referred BA to the HTT (Home Treatment Team) for daily support. Given YO's key role as main carer of Mrs BA this news should also have been shared with him in a planned, direct way, rather than over the phone to Mrs BA, whereby he was not aware of this news at the time.

65) The HTT did visit over the weekend and Mrs BA was offered an admission but there were no local beds at Woodlands Unit available, although other options could have been explored. Mrs BA reported feeling better and agreed to call if she needed help, so she was discharged back to her ICMP team

on the Monday. There was limited involvement from the HTT over the weekend and the risks to Mrs BA were not thoroughly explored prior to discharging her from the service. The same day this decision was made a Health Visitor attended the house and saw YO with the children. YO informed the Health Visitor that Mrs BA had been hearing voices telling her to jump in front of a train. There was no evidence that the HTT had also been informed of this, but it could have formed an important part of the assessment of risk. The Health Visitor did not inform the GP, nor Mrs BA's Care Coordinator of this information, about Mrs BA's suicidal psychotic experiences, which was a clear gap in practice. However, 2 weeks later she did record a number of unsuccessful attempts to telephone the Care Coordinator-despite, but no actual contact was ever made. It was unclear why e-mail communication was not attempted to communicate this.

66) The following week YO reported to the Care Coordinator that Mrs BA was still talking about suicide (she talked about jumping into the Thames) and he was advised to lock the doors to stop her gong out. Her Care Coordinator referred Mrs BA again to the HTT. This referral did not include the reports from YO that Mrs BA was hearing voices at this time telling her to jump in front of a train. Her Care Coordinator did discuss a hospital admission with the bed manager. However, as there were still no beds available at Woodlands Unit, the bed manager advised that she go to A&E. This may have been the only option but did not appear realistic to expect Mrs BA to go to A&E herself as she was hearing voices, was depressed and lacked insight into her mental health episode. She was not deemed as "sectionable" at this time, so was offered HTT instead.

67) She was then seen at home again by the HTT, the team doctor prescribed sleeping pills and assessed her risk of suicide as low moderate, based on Mrs BA talking about the impact of this on her children. There were no records of this visit exploring whether Mrs BA had been or was still hearing voices. The HTT had telephone contact over the next 2 days, which is usual practice, and recorded that Mrs BA said she felt OK and had no psychosis. Given the risks and history making this assessment over the phone of a patient who had a history of denying and masking her symptoms was possibly not best practice, although it is common practice in HTT. Mrs BA then called the mental health crisis line and was visited again by HTT, at which she continued to report low mood and poor sleep. Her suicide risk was then judged to be moderate and her case was closed to the HTT, as she was deemed to be no longer in crisis. The basis for this judgement was not clear, again given Mrs BA's reluctance to engage and share information about her mental health. YO should have been more involved in this period as he was a consistent and reliable source of collateral information. The assessment of suicide risk was a statement and not based on any structured assessment or consideration of the available information. Mrs BA requested a further reduction in her medication as she was still reporting unpleasant side affects from her depot.

3.9 Appraisal of KPE 9 (01/09/17-10/09/17)

68) Following a further deterioration in Mrs BA's mental health she was seen at home by her Care Coordinator who agreed to discuss Mrs BA's request to stop her depot medication with the MDT and then to increase her oral medication (from 200mg to 300 mg Quetiapine) to compensate for this. The team Dr agreed it and her Care Coordinator did collect the increased prescription for her Quetiapine. This plan was within normal prescribing guidelines for moving from depot to oral medication.

69) On the 01/09/17 there was a home visit from her Care Coordinator. Further unsuccessful attempts were made on 04/09/17 by the Health Visitor to speak to Mrs BA's Care Coordinator and so the information about potential risks given the report of her hearing voices telling her to end her life was not communicated to the ICMP team. Also concerns from a visit by a nursery nurse were also not passed onto either the Health Visitor or the ICMP team. The Health Visitor did then discuss her concerns in supervision, but this did not lead to any escalation of the risks with the Care Coordinator in the ICMP team, following further unsuccessful attempts to communicate these by telephone.

70) YO reported that he had attempted to contact the mental health crisis line repeatedly over the weekend of her death but had been unable to get a response, due to the number not being answered.

Mental Health Services had no record of a call and the reason for this is not known, although it was reported to the reviewer that other patients had also reported similar issues in accessing the crisis line. This was anecdotal evidence but was not corroborated through Trust Datix reports, so the veracity of these comments was not proven. The police did record her as a missing person, as her whereabouts were unknown but before they were able to take the report she had already taken her own life. No communication was made of her intention to commit suicide to the BTP (British Transport Police) suicide prevention team, which coincidentally is based at Victoria Station. Although no one clearly knew that Mrs BA intended to go to Victoria, and she had previously also indicated that should would 'jump in the water at London Bridge', her previous statements of hearing voices telling her to jump in front of a train could have been reported and consideration could have been given at an earlier stage to have developed a suicide prevention plan with BTP. If it had been the team at Victoria station do have system to look for patients thought to be at risk of suicide. On the day of her death YO did report to local police that Mrs BA had left the family home and had gone missing. The Crisis Line does now have a voicemail option and is staffed by a CPN 24 hours a day.[3]

3.10. Independent Legal advice and review of BA's immigration applications.

71) As part of this review the involvement of the Home Office Immigration Services and applications on Mrs BA's behalf by her solicitors for leave to remain in the UK were considered by an independent Barrister, whose summary report is included in full below;

72) "I am instructed by The London Borough of Bexley's Legal Department on behalf of Bexley Safeguarding Adults Board who are conducting a Safeguarding Adult Review (SAR) under the Care Act 2014 in relation to Mrs. BA who took her own life on the 10th September 2017.

73) I am asked to review and comment on the immigration process including the conduct/communication of the Home Office with local services and the submissions made by Ms. BA's solicitors since she arrived in the United Kingdom on 04 December 2004 as a student nurse.

The brief history of the Immigration applications made by BA is as follows:

74) When Mrs BA's work visa expired, she applied on 23 March 2012 for Indefinite Leave to Remain for the whole family, which was refused on 20 September 2013 with no right of appeal.

75) On 22 July 2014 a further "Human Rights" (Articles 3 and 8) application was submitted, which was refused on 29 July 2014 with a right of appeal.

On 18 August 2014 an appeal was lodged at the First Tier of the Immigration and Asylum Tribunal.

On 1 October 2015 BA's appeal was finally heard, but on 12 November 2015 the appeal was dismissed.

On 27 October 2016 further submissions regarding family/private life were made, which were finally rejected on 18 July 2017.

Mrs BA was informed of this on 19 July 2017.

[3] http://oxleas.nhs.uk/advice-and-guidance/how-to-get-help/how-to-get-help-bexley/

76) The circumstances in which an applicant can make applications for leave to remain in the UK after an initial application has been refused are governed by Rule 353 of the Immigration Rules, which provides as follows:

77) When a human rights or protection claim has been refused or withdrawn or treated as withdrawn under paragraph 333C of these Rules and any appeal relating to that claim is no longer pending, the decision maker will consider any further submissions and, if rejected, will then determine whether they amount to a fresh claim. The submissions will amount to a fresh claim if they are significantly different from the material that has previously been considered. The submissions will only be significantly different if the content:

(i) had not already been considered; and

(ii) taken together with the previously considered material, created a realistic prospect of success, notwithstanding its rejection. This paragraph does not apply to claims made overseas.

353A. Consideration of further submissions shall be subject to the procedures set out in these Rules. An applicant who has made further submissions shall not be removed before the Secretary of State has considered the submissions under paragraph 353 or otherwise.

78) Thus, the subsequent applications that Mrs BA made were due to the deterioration of her mental health and the continuation of her family and private life in the UK with her husband and children.

79) Mrs BA started to suffer from mental health difficulties in March 2006. In January 2007 she was diagnosed with acute polymorphic psychosis. Further in 2008 Mrs BA was diagnosed with Paranoid Schizophrenia, the precise date of which is unknown. Mrs BA's immigration status was precarious, and she had submitted different unsuccessful applications for leave to remain in the UK.

80) Her first child, TO was born on the 15th May 2007. At the time of the birth Mrs BA suffered from mental health issues, her fitness to practice as a nurse was impaired and consequently she was suspended from her employment. She was admitted under S.2 & S.3 of the Mental Health Act 1983 on 07 August 2007 and November 2007. TO was initially put into foster care pursuant to S.20 of the Children Act. Ultimately, it was decided by the Local Authorities of Greenwich and Bexley to relocate the daughter to Nigeria on the 11th April 2008 to be looked after by the maternal grandmother. Mrs BA travelled to Nigeria with her daughter and returned to the UK on the 12th July 2008, since that time to the point of her death she had not seen her daughter. Mrs BA unfortunately died by suicide on the 10/09/17.

81) It has been argued by Universe Solicitors acting on behalf of Mrs BA that she did not have capacity and could not have understood whatever reason given to her for her daughter's relocation. I do not have sufficient factual information before me to comment on this point. One would assume that those involved at the time in the decision had followed the adequate protocols however, it is noted that there are outstanding legal challenges regarding the lawfulness of the removal of TO from the U.K.

82) The First Tier Tribunal (FTT) in a written determination dated November 2015 stated inter alia that the decision to remove the appellant and her dependents would not breach the UK's obligations under the Human Rights Act. In particular the FTT found at paragraph 64 of the determination that the appellants children would not be at risk of significant harm in Nigeria.

83) In respect of a breach of Article 3, the FTT rely on the case of N v United Kingdom 2008 (ECHR 4533) to dismiss the Appellants claim. It is noteworthy that at Paragraph 37 (e) of the FTT decision the Judge notes that the Appellants condition is stable.

84) The Upper Tribunal in a determination dated 27/09/16 specifically refers to paragraph 53 of the FTT decision when refusing permission to appeal. It is noteworthy that the report referred to is 2 years old, it would have assisted the Tribunal if an up to date report would have been provided. *(1)*

85) I note that the FTT gave no consideration to the case of Bensaid v UK [2001] 33 EHRR which provides as follows:

> *The difficulties in obtaining medication and the stresses inherent in returning to this part of Algeria, where there is violence and active terrorism, are alleged to endanger seriously his health. Deterioration in the applicant's already existing mental illness could involve relapse into hallucinations and psychotic delusions involving self-harm and harm to others, as well as restrictions in social functioning (e.g. withdrawal and lack of motivation). The Court considers that the suffering associated with such a relapse could, in principle, fall within the scope of Article 3.*

86) Although Mrs BA was diagnosed as having suicidal ideation on the 3rd November 2007, it is unclear if the Tribunal or courts were provided with such evidence throughout the appeals process. (2)

87) The issue of whether Mrs BA's prospects of succeeding in her appeal would have differed if her eldest child had been living with her in the UK. The answer to this question in short is in the affirmative for the following reasons. (3)

Paragraph EX1 of Appendix FM of the Immigration rules provides as follows:

EX.1. This paragraph applies if
1. (i) the applicant has a genuine and subsisting parental relationship with a child who-
(aa) is under the age of 18 years, or was under the age of 18 years when the applicant was first granted leave on the basis that this paragraph applied;
(bb) is in the UK;
(cc) is a British Citizen or has lived in the UK continuously for at least the 7 years immediately preceding the date of application; and

(ii) taking into account their best interests as a primary consideration, it would not be reasonable to expect the child to leave the UK;

88) More recently the courts have commented that powerful reasons are required to remove a child who has been in the UK for 7 years or more -MT and ET (child's best interests; ex tempore pilot) Nigeria [2018] UKUT 88(IAC). I accept that the aforesaid post dates the decision in the matter before me, however, it reveals the powerful nature of the above exception.

89) It is my opinion that Mrs BA's solicitors pursued her interests with vigour and determination as is evidenced by the various representations that they made on her behalf. It would have been advisable for a claim for asylum to have been lodged in 2017, alternatively it is unknown if Mrs BA or her husband gave such instructions to their solicitor at an earlier date. In which case the asylum claim should have been lodged forthwith.

90) The conduct of the Home Office in making repeated decision refusing Mrs BA's applications is not unusual and was within the range of decisions that were lawfully open to them based on the evidence. The Home Office was aware of Mrs BA's mental health diagnosis and medical history and in my opinion, they acted in line with safeguarding guidance.

91) It is submitted that there was a combination of different factors that triggered the death of Mrs BA. All of these factors need to be examined as a whole. A significant stressor was in my opinion the financial worries that Mrs BA and her family encountered on 28 February 2017 due to a demand of £10,800 from Bexley Council for an alleged rent overpayment.

92) In conclusion, it is difficult to infer that the most recent refusal letter issued by the Home Office on the 18th July 2017 was the trigger for Mrs BA to commit suicide for two reasons. Firstly, there had been several refusals in this matter and secondly the most recent refusal provides for Mrs BA to lodge a claim for asylum via her husband. (See letter dated 22nd February 2017). Such a claim for asylum would have inevitably taken many months to resolve.

93) Thus, I disagree with the Root Cause Analysis Report dated 04/12/17 in which they conclude that the major trigger appears to be the refusal although the evidence indicates that Mrs BA became actively suicidal after the 18th July 2017, therefore it is likely that this was a contributory factor.
(Maria González-Merello Barrister Holborn Chambers)

4. Findings

4.1 Summary of Findings Following Appraisal of Practice

1. Concerns regarding a new mother's poor mental health and potential risks to her new born child should be carefully considered with all viable options explored to keep the family together. Where alternative arrangements are made, due to assessed risks to the child, a parent's rights to independent legal advice must be upheld and the child's father included in any parenting assessments.

2. Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would be responsible for the S42 Enquiry.

3. Lack of availability of local psychiatric inpatient services due to patient flow can be associated with problems caring for people in mental health crisis both in the community and in hospital, with increased risks to them and their families. This puts pressure on local community mental health services to try to manage admissions when there is a clinical need and on the inpatient services to discharge people too quickly. The use of out of area private psychiatric hospitals may ultimately adversely affect the handover of care when patients are discharged back to local community mental health services.

4. The immigration status of people being deemed unable to remain lawfully in the UK with No Recourse to Public Funds requires complex decisions including appeals to the Home Office. For people who in addition also have mental health problems, this process can be difficult and stressful, with an increased risk to both their mental health and subsequently their safety.

5. The assessment and management of the risk of suicide for people with mental health problems in community mental health services needs to include a structured model incorporating social and psychological stress factors, enabling information sharing by all health and social care professionals, involving families where appropriate. This should include a pathway to access to emergency hospital admissions where people are identified as both experiences mental illness and at high risk of suicide following this assessment.

6. The use of a standardised and corporate debt recovery process, including automated letters threatening legal action, is not always appropriate. Sending letters to residents with serious mental health problems may cause them harm, including potentially increasing the risk of suicide amongst this group. Interdepartmental systems need to take account of the vulnerability of residents prior to formal debt recovery processes being implemented.

4.2 Findings and recommendations in detail

Finding 1

Concerns regarding a new mother's poor mental health and potential risks to her new born child should be carefully considered with all viable options explored to keep the family together. Where alternative arrangements are made, due to assessed risks to the child, a parent's rights to independent legal advice must be upheld and the child's father included in any parenting assessments.

How did the issue manifest in this case?

Mrs BA's first child TO was removed from the UK, as Mrs BA was deemed to be unable to bond with her child (who had been placed in foster care whilst she was detained in a mental health unit) and YO had to work-so he could not look after her either. Mrs BA & YO were then led to believe that TO would

be adopted if she did not agree to her being looked after by her mother. No formal adoption proceedings were taken, and no clear risk assessment done to justify removing TO. Mrs BA was mentally unwell throughout this time, so may not have been able to fully participate in decision making and had no access to legal advice during this process.

How do we know it is an underlying issue and not something unique to this case?

94) The decisions by Children's Services about a mother's ability to safely be a parent is often taken as the key in decisions about a child's safety, whereas the father's ability to be supported as the main carer can be overlooked in parenting assessments.

95) Page and colleagues (2008, p89) in their review of UK services for fathers undertaken on behalf of the Department of Children, Schools and Families, found that: *'traditional' views of fathers remained prevalent among the workforce. This was seen to have led some staff to hold negative attitudes towards males as less able or willing carers of young children.*

96) Furthermore, insufficient understanding of these issues within Children's Services may impair the quality of the parenting assessment of parents with mental health problems.

97) "Different professional groups may not share the right information because they work to different criteria for information-sharing, use a different language and lack sufficient understanding of each others' roles. This means they may not understand what information is important for other agencies to have and so do not ask the right questions or pass the information on. Adult mental health staff are concerned that children's social care staff may make important decisions based on limited information such as a mental health diagnosis or may over- or under react because they do not have a good understanding of mental health problems."[4] (Parental mental health and child welfare: A guide for adult and children's health and social care services).

How prevalent and widespread is the issue?

98) There is limited local data to back up this finding in Bexley although in 2014, an Inquiry by the Equal Opportunities Committee took extensive evidence, revealing the failure of services to keep pace with changing societal expectations of fathers. It called for the Government and all agencies to take greater steps to actively include fathers in their policies and practices, recognising 'that 'parent' is often taken to mean 'mother'' (Scottish Parliament, 2014, p9).

99) Also, the issue of Children's services assessments of mothers with mental health problems who are deemed unable to safely look after young children based on the diagnosis alone (as identified above), or the mothers' abilities when still unwell could clearly impact on the outcome of such assessments.

Why does it matter? What are the implications for the reliability of the multi-agency adult, or child protection system?

100) Children's services need to undertake thorough and informed assessments of both parents' abilities to care for their children. Where one parent has a mental health problem then detailed involvement as to the nature, degree and prognosis of this condition must be included to avoid discrimination on the rights and abilities of both parents, whether mothers or fathers. Also, where parents are subsequently assessed to be unable to care for their children legal advice needs to be provided if lawful applications are made for the child's removal.

[4] https://www.scie.org.uk/publications/guides/guide30/assessment.asp

FINDING 1. RECOMMENDATONS FOR THE BOARD TO CONSIDER
1. The protocol for undertaking joint risk and parenting assessments, including timely pre-birth assessments with Mental Health and Children's Services, should be reviewed and updated, where there are safeguarding concerns for children with parents who have mental health problems. **2. Ensure that mothers who have psychosis during or immediately after birth have access to adequate specialist mother and baby inpatient services.** **3. Ensure adequate training on Mental Health Awareness for Children's Social Workers to enable an understanding of the impact of serious mental illness for parents and how to escalate concerns.**

Finding 2

Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would also be responsible for the S42 Enquiry.

How did the issue manifest in this case?

100) A Merlin report was sent in to Domestic Abuse and MARAC coordinator after police were called to the address of BA and YO was arrested. However, this was not immediately responded to and the subsequent response was delayed and inadequate. The Risks to children in the house and to BA were never investigated thoroughly be Children's or Adults Services. The only recorded response by Children's Services was telephone call 4 months after the referral. There was no CAADA-DASH Risk assessment completed for BA and no referral to the MARAC made.

How do we know it is an underlying issue and not something unique to this case?

101)The difficulties of working across Adult and Children's Services for Safeguarding responsibilities in cases of domestic abuse are well known anecdotally but were not supported by local data during this review. However, the Adult services have a clear responsibility to involve Children's Services and now under the Care Act 2014, this duty would similarly apply to Children's Services notifying Adults Services of a Safeguarding Concern.

102)"Where adult safeguarding and domestic abuse are being addressed, and children are involved or present as family members, professionals have a duty to refer to children's services, using local protocols and procedures, even if the adult victim chooses not to, or is not able to, accept help for themselves.

Exposure to domestic abuse is always abusive to children although the impact on them may vary. Section 120 of the Adoption and Children Act 2002 clarifies the definition of significant harm outlines in the Children Act 1989:

> 'Any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence. Where there are opportunities for joint assessment and joint working across both services these should always be considered. Parents who are

victims of domestic abuse and also receiving support themselves from adult social services, as well as their children, may benefit from this approach."[5]

How prevalent and widespread is the issue?

103)There were no local statistics on safeguarding adult's referrals for domestic abuse in Bexley but national research from the Mental Health Foundation 2016 highlights the following;

104)The relationship between domestic violence and mental health is both ways, with research suggesting that women experiencing abuse are at a greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse. In a 2009 UK study, lifetime prevalence of domestic violence among women with mental health problems was found to range between 30% and 60%[6]

Why does it matter? What are the implications for the reliability of the multi-agency adult and child protection systems?

105)Domestic abuse often involves adults who are both parents and may have mental health difficulties, which can exacerbate the risks and impact of domestic abuse within such households. Improved practice and joint work for safeguarding adults and children in these circumstances can be crucial to improve outcomes and demonstrate statutory services have met their legal duty of care. If Merlin reports are received about domestic abuse, there needs to be a clear process to share information across Children's & Adults Services in the first instance and then for some joint work to undertake enquiries as to the nature and degree of risk.

FINDING 2. RECOMMENDATIONS FOR THE BOARD TO CONSIDER
1. Undertake research and audit of safeguarding responses to domestic abuse across both Adults and Children's services. **2. Ensure joint Safeguarding Enquiries (Between Adults and Children's Services) are undertaken in coordination with the police for families where mental health and domestic abuse concerns are raised, irrespective of whether they are raised first with only one agency initially.** **3. Consider setting up an integrated MASH (Multi Agency Safeguarding Hub) Service, to triage referrals to either Adults or Children's Safeguarding (or both, working together).**

[5] **Adult safeguarding and domestic abuse** A guide to support practitioners and managers (https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf)

[6] Devries, K.M., Mak, J.Y.B., Loraine, J., Child, J.C., Falder, G., Petzold, M. ... & Astbury, J.(2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLOS Med, 10*, e1001439.

Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew- Davies, R., & Feder, G. (2009). Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine, 40*(6), 881–893.

Finding 3.

Lack of availability of local psychiatric inpatient services, due to patient flow can be associated with problems caring for people in mental health crisis both in the community and in hospital, with increased risks to them and their families. This puts pressure on local community mental health services to try to manage admissions when there is a clinical need and on the inpatient services to discharge people too quickly. The use of out of area private psychiatric hospitals may ultimately adversely affect the handover of care when patients are discharged back to local community mental health services.

How did the issue manifest in this case?

106)At several points during the last 2 years of her life Mrs BA suffered from mental health relapses, when she became paranoid and threatening to her husband, also scaring and potentially putting herself and her children at risk. She was known to lack insight at these times and required admission/treatment under the Mental Health Act. However, her mental health was managed in the community as a least restrictive option. Although this option is good practice it may have delayed Mrs BA receiving treatment in a mental health unit. There was a lack of local available beds on her preferred ward although whether this affected decisions about her admission, or not, was not proven. At some points when still unwell she went on leave, did not return and was AWOL. This is an accepted practice and part of the care plan for patients who are detained, but not discharged.

107)When subsequently conveyed by police back to hospital there was no bed for her to be admitted into. She was too unwell to be safely cared for in acute services and needed a higher level of safe care (PICU). As Oxleas has no female PICU ward at these times Mrs BA had to be transferred to Roehampton, which was a long way from her home and family. When deemed no longer in need of PICU she was discharged directly home, rather than to a local Oxleas female ward, again as no beds were available. All of these factors clearly adversely affected the quality of mental health services that Mrs BA received, when she most needed them.

How do we know it is an underlying issue and not something unique to this case?

108)It is now recognised that mental health services have been under significant pressure following an increased demand for services whilst there has been and decrease of central government funding. In the most recent CQC Report into the national picture of mental health services, they highlighted waiting times as a key area of concern;

109)“Access and waiting times: a number of people have difficulty in accessing the service that is best equipped to meet their needs. Sometimes our inspectors identify this unmet need directly on inspection: for example, long waiting times in a community child and adolescent mental health service, a mental health crisis team that did not provide 24- hour cover, or patients’ discharge being delayed because of the unavailability of a community care package. It was harder for inspectors to gauge other instances of unmet need – for example, how many people had been admitted to a distant independent hospital because a bed was not available locally. Also, we could not always attribute responsibility for this unmet need to the providers that we regulate. These difficulties with access to local services were sometimes due to decisions of commissioners, rather than providers. “[7]

110)However, improvements were found locally when CQC re-inspected Oxleas in 2017 with a rating of good now given across all 5 domains of inspection criteria. Of particular relevance to this finding is the following;

> “In February/March 2017 we inspected one core service rated as inadequate and one rated as requires improvement for responsive and found that improvements had been made. We have changed the rating of responsive for acute wards for adults of working age and psychiatric

[7] The State of Care in Mental Health Services 2014-2017 CQC (20170720_stateofmh_report.pdf)

intensive care units from inadequate to good. This is because the service had addressed bed occupancy levels of over 100% on the acute wards for working age adults. During the current inspection, we found that the trust had contracted for an additional 12 beds in a neighbouring NHS trust. When patients went on overnight leave, their bed remained available for them for the next 24 hours. Patients were no longer required to sleep on sofas or other wards due to a lack of available beds." [8]

How prevalent and widespread is the issue?

A briefing paper (Mental Health under Pressure) published by the Kings Fund identified the following:

111) Between 2011 and 2014 there was a 7 per cent reduction in the number of inpatient beds.

The lack of available beds is leading to high numbers of out-of-area placements for inpatients. Out-of-area placements are costly, have a detrimental impact on the experience of patients and are associated with an increased risk of suicide.

An FOI request by Community Care found that use of out-of-area beds rose by almost a quarter in 2014/15.

A survey conducted by The Commission on Acute Adult Psychiatric Care found that 91 per cent of responding wards were operating above recommended levels of bed occupancy.

The UCL Core Study of crisis resolution and home treatment found that among the 75 teams surveyed, there was no single area of performance that could be rated as 'good'. Performance was poorest in responding quickly to referrals and offering frequent visits. [9]

Why does it matter? What are the implications for the reliability of the multi-agency adult & child protection systems?

112) Relapses in serious mental health problems may require the use of the Mental Health Act for formal assessment and treatment in a hospital setting. Mental Health Services quite rightly seek to support people through times of ill health/crisis at home rather than in hospital, where possible. However, this review identified that there was at some points a lack of available local inpatient beds. This is relevant to decisions about managing mental health issues in the community and indirectly could have led to delays in admissions, rapid discharge from hospital, the use of leave and out of area placements. The implications of this are that judgements of the need for an inpatient bed whilst based solely on clinical need, are not taken in isolation of availability of local resources. Potentially this puts additional responsibility for managing these times of high risk and instability on patients' carers and can lead to the increased use of emergency services (police, A&E Units) when the crisis becomes unmanageable in the community.

[8] Oxleas NHS Foundation Trust Quality Report 02/05/2017

[9] mental-health-under-pressure-nov15_0.pdf

FINDING 3. RECOMMENDATIONS FOR THE BOARD TO CONSIDER
1. Undertake an updated audit of the patient flow both into and out of placements for women in need of hospital admission to both PICU and acute services, within and outside the local area, within the South London Partnership. **2. Review of commissioning arrangements in light of above to consider including local services for women needing PICU admission.** **3. Consider the impact of inpatient services availability on judgements made by community mental health services on needs for patients requiring admission, specifically whether Mental Health Act assessment staff (AMHPs and Consultant Psychiatrists) perceive that this affects admissions where there is a clinical need, based on risk.**

Finding 4.

The immigration status of people being deemed unable to remain lawfully in the UK with No recourse to Public Funds requires complex decisions including appeals to the Home Office. For people who in addition also have mental health problems, this process can be difficult and stressful, with an increased risk to both their mental health and subsequently their safety.

How did the issue manifest in this case?

113) Mrs BA's legal representative made a series of appeals under Human Rights grounds (article 3 & 8) to the Home Office, when she became unable to work, due to her mental health problems. As her permission to remain in the UK was directly related to her employment as a nurse, when she was deemed unable to work by the NMC, this permission was withdrawn. Despite the best efforts of her solicitors all her appeals were refused by the Home Office, culminating in a decision that she had to leave the UK, unless she made a claim for asylum, based partly on the FGM risks in her country of origin. At this time, her mental health had relapsed, and she may have been unable to give instruction to her solicitors to make and asylum application. No asylum application was made.

114) Also, the way the final decision was communicated was thought to have had a direct negative impact on her mental health, partly due to the stress of this decision and having it communicated to her by a telephone call from her Care Coordinator. She became psychotic after this time, including hearing voices telling her end it all and to jump in front of a train. The decision that she had to leave the UK and she had exhausted all her rights to appeal this decision was therefore a factor in Mrs BA becoming mentally unwell. Furthermore, her relapsing mental illness impaired her ability to make decisions and to give instructions to make an asylum application. Therefore, her immigration status had a negative impact on her mental health and her subsequent deteriorating mental health then also had a negative impact on her ability to address her immigration status. The emotional support offered to her by local mental health services and the financial support by the NRPF Team may not have sufficiently addressed the relationship between her immigration applications and her mental health. This was not sufficiently addressed by the Home Office in their communication with Mrs BA and her local services.

How do we know it is an underlying issue and not something unique to this case?

Again, there unfortunately there was no local data on Oxleas services for people with mental health problems, who are also making applications in relation to the immigration status. However, anecdotal evidence gathered during this review identified this as an issue by Oxleas Mental Health staff with an increasing and significant proportion of their client group. Staff reported a gap in knowledge of patients' legal rights and the appeals process, where this becomes apparent during their involvement.

How prevalent and widespread is the issue?

115) On a national level this has also been identified as a significant issue in the cross government strategy for improving outcomes in mental health (No Health without Mental Health);

116)**"**Improving outcomes for black and minority ethnic people with mental health problems the rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

6.21 Tackling the inequalities for BME communities has been a central focus for a number of years. However, the outcomes have in some ways been disappointing.

6.22 *Race Equality Action Plan: A five-year review* looks back at the work of the delivering Race Equality in Mental health care programme and describes some of the key challenges, successes and learning. It provides a strong base from which commissioners and service providers can make improvements. These will rely on:

Local collection and monitoring of information on ethnicity and culture; better use of these data to inform commissioning and provision in health and social care; a focus on outcomes that work for individuals and communities; monitoring and evaluating effectiveness of service delivery, especially around equality needs; and

Establishing mechanisms that allow local user groups to engage with providers and commissioners, and that empower and support them so that they can engage effectively.

6.23 This will be underpinned by the new statutory responsibilities of the NHS commissioning Board and GP consortia. In addition, department of health research and analytical staff will continue to make best use of research in developing effective approaches for reducing race inequality in mental health.'[10]

Why does it matter? What are the implications for the reliability of the multi-agency adult & child protection systems?

117) An improved understanding of the complex needs for people with mental health problems and immigration issues, could assist with the provision of appropriate services, which are sensitive to these needs. Currently there are gaps in the awareness of complex Immigration Legal processes by mental health practitioners. This may impair the ability of local services to meet the above outcomes for improved equality in mental health services for this group. Also, the NRPF Team had limited recognition of the mental health needs of families they were supporting and joint work between these services was not well coordinated in this case.

FINDING 4. RECOMMENDATIONS FOR THE BOARD TO CONSIDER
1. Joint Training Programme for Mental Health Professionals and NRPF Team on the Immigration and Appeals Process. **2. Consideration of specific support, advocacy and advice for people with mentally health problems, who are making immigration claims.**

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdfhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

3. Review current arrangements to improve joint working and responsibility for delivering support, including communication to this group between NRPF Team and Mental Health Services.

Finding 5.

The assessment and management of the risk of suicide for people with mental health problems in community mental health services needs to include a structured model incorporating social and psychological stress factors, enabling information sharing by all health and social care professionals, involving families where appropriate. This should include a pathway to access to emergency hospital admissions where people are identified as both experiences mental illness and at high risk of suicide following this assessment.

How did the issue manifest in this case?

118)Mrs BA disclosed to her husband hearing voices telling her to end her life by jumping in front of a train some 4 weeks before she took her own life. This information was shared by YO with a Health Visitor and a Nursery Nurse when they visited the property. However, they were unable to directly pass this information on to Mrs BA's Care Coordinator, partly due to problems with information sharing between Primary Care and Mental Health Services. Her Care Coordinator, who recommended an admission, knew the risk of suicide but no local beds in Woodlands Unit were available. Mrs BA did not want to be admitted elsewhere and this lead to a referral to the HTT (Home Treatment Team) as an alternative to admission. This service then discharged her back to ICMP team after a week, as they assessed her risk of suicide as variously low, or moderate saw her at home.

119) Also, the stress of a final immigration decision was communicated to Mrs BA, via a telephone call. Mrs BA's antipsychotic medication was also then reduced at her request and changed to oral medication. She was not followed up in the week after this by mental health services to review its impact on her psychosis and the on-going risks of suicide. When YO felt that her risk of suicide had increased he tried unsuccessfully to contact a crisis line to share his concerns over the weekend. Mrs BA then left her home and died by jumping in front of a train, before being seen again by any mental health services. She had been reported missing to local police but her intention to take her own life in this manner was not known to the Suicide Prevention Team, based at Victoria Station.

How do we know it is an underlying issue and not something unique to this case?

The assessment of risk of suicide in mental health services is a complex process and hard to determine. The use of Risk Tools is common across the UK in mental health services but does not necessarily give reliable indication of prediction of suicide.

A recent national study of the assessment of risk in mental health trusts (by the Health Quality Improvement Partnership) has made some relevant findings and recommendations, which are set out below.

"Characteristics of clinical risk tools -

120) We collected data from all NHS mental health services in the UK. There was little consistency in the use of risk tools, although greater consistency within Wales and Northern Ireland. Tools varied widely in format, content, and the extent to which they had been adapted for local use.

121) For around 40% of tools there was no accompanying local guidance and fewer than one in five suggested liaising with primary care when assessing the patient. Most tools sought to predict future behaviour, and scores on the tool also determined management decisions. This is contrary to national guidance for self- harm assessment.

Views on clinical risk assessment

122) Clinicians reported that tools were sometimes useful (for example to act as a prompt or measure of change) and could be helpful as part of a wider process of formulation where different risks were considered together to determine the patient's management plan. Others suggested that the tools could provide false reassurance. Clinicians reported issues around lack of training in risk assessment processes, risk management, and practical issues around user friendliness and accessibility of information.

123) Patients and their carers highlighted that tools must take account of fluctuating risk. **They also emphasised the need for carer involvement, and clarity about what to do in a crisis.** Potential drawbacks of tools included inconsistency in their use or making the assessment process impersonal.

Clinical messages:

a. Risk assessment tools should not be seen as a way of predicting future suicidal behaviour. This is consistent with the NICE self-harm guidelines.

b. Risk is not a number, and risk assessment is not a checklist. Tools if they are used (for example as a prompt or a measure of change) need to be simple, accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.

c. There is a growing consensus that risk tools and scales have little place on their own in the prevention of suicide. **This study suggests ways in which clinical risk assessment processes might be improved; by placing the emphasis on clinical judgement and building relationships, and by gathering good information on (i) the current situation, (ii) history of risk, and (iii) social factors to inform a collaboratively- developed management plan.**

d. Risk assessment processes need to be consistent across mental health services, and staff should be trained in how to assess, formulate, and manage risk. On- going supervision should be available to support consistency of approach.

e. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed where possible. Communication with primary care may also be may also be helpful.

f. The management of risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely."

How prevalent and widespread is the issue?

124) Death by suicide is relatively rare, especially for females in London, when compared with other areas, with the latest figures available set out below;

125) The region with the lowest rate of suicide was London (7.7 per 100,000). The rate in London in 2017 was significantly lower than the rate for the whole of England (9.2 deaths per 100,000). The 2017 suicide rate for females in the UK was 4.9 per 100,000 population (1,439 deaths).[11]

126) "Many people who die by suicide are patients with mental illness and over a quarter are in touch with specialist services. In 2015, there were 1,538 deaths by suicide in individuals who had been in contact with mental health services in the previous 12 months. Many had factors associated with high risk of suicide (e.g. self- harm, substance misuse, economic problems) but the majority (88%) were judged to be at low or no immediate risk of suicide by clinicians at their final service contact[12].

Why does it matter? What are the implications for the reliability of the multi-agency safeguarding system?

127) The key recommendations for improvement of risk assessments outlined above, identify the need for good information sharing, relationship building, consideration of social factors and the involvement of families in the risk assessment. As part of this a better understanding of the impact of social factors on individuals with mental health problems and how this relates to an increased risk of suicide could inform clinical decisions on risk and the need for appropriate interventions. Improvements in the assessment of risk may enable better access to emergency support and safety planning at times of crisis for people with mental health problems.

FINDING 5. RECOMMENDATIONS FOR THE BOARD TO CONSIDER
1. Review of the local suicide prevention strategy signed up to by all partner agencies in Bexley, to ensure consideration of the following: • **Improve systems for information sharing between primary health care, social care and specialist mental health care where risks of suicide are identified** • **Review current pathway to inform good risk assessments for suicide prevention and management of this risk. Ensure families and patients have input into dynamic, clinical risk assessments** • **Identify those agencies in need of Suicide First Aid training and consider a training strategy** • **Ensure Mental Health Crisis Line is accessible and available 24 hours a day** **2. Consider links between local agencies and BTP Suicide Prevention Team, where adults are reported missing and have stated an intention to act on suicidal thoughts by jumping in front of a train.**

Finding 6.

The use of a standardised and corporate debt recovery process, including automated letters threatening legal action, is not always appropriate. Sending letters to residents with serious mental health problems may cause them harm, including potentially

11 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

12 The assessment of clinical risk in mental health services (https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf)

increasing the risk of suicide amongst this group. Interdepartmental systems need to take account of the vulnerability of residents prior to formal debt recovery processes being implemented.

How did the issue manifest in this case?

128) In March 2017 Mrs BA received a letter from Bexley Council, which stated that she had fraudulently obtained £10,800 from Bexley Council, by falsely claiming via a Pre-Payment Card, whilst also receiving payment by BACS. The accompanying letter stated that she had 10 days to pay, or the case would be referred to court for debt recovery. At the time this letter was sent to Mrs BA, she was detained in a mental health unit under S3 MHA 83. Her husband opened the letter and was very angry about this. He had been unaware that the money paid by Bexley was an overpayment, due to an error with payments continued by Children's Services through BACS after financial support was taken over by the NRPF team in October 2015. This had continued for a year until the error was noted in October 2016, which precipitated the council's attempt to reclaim the money, despite Mrs BA and YO being destitute and relying on Council subsistence was they had No Recourse to Public Funds. This was followed up with a further letter and invoice in June 2017, as no repayment had been made. At this time Mrs BA probably did not have capacity to manage her financial affairs and this communication was not informed by an understanding of her personal circumstances.

129) This put a huge amount of stress on both Mrs BA and YO, in addition to the immigration claim being refused YO identified this as a contributory factor in Mrs BA's feelings of hopelessness and desperation. Her admission to hospital escalated to require her transfer to PICU services after the first letter and her mood was low even after her discharge home from hospital, requiring a further formal admission and CTO upon discharge.

How do we know it is an underlying issue and not something unique to this case?

130) There was no data available to the review on how frequently debt recovery letters are sent to residents in Bexley with serious mental health problems, although anecdotal evidence raised by the Review Team identified this as a broader issue for patients who are struggling with debts. In relation to dual payments made in error once the NRPF Team took over subsistence payments for families supported by Children's Services, no other cases had come to light, so this particular source of debt may have been unique to the case.

How prevalent and widespread is the issue?

131) A recent article in the Guardian Society (Aggressive debt collectors raise risk of suicide. 03 December 2018) identified this as an area of widespread concern and summarised some relevant research into the links between debt and suicide.

> "More than 100,000 people a year in England who are mired in heavy debt try to end their lives, new research has revealed.

132) Intimidating and threatening letters sent by debt collectors, bailiffs and councils raise the risk of suicide by adding to people's feelings of despair, the study found. The findings have prompted calls from mental health experts for an urgent overhaul of the tactics banks; utility companies, credit card companies and others use to pursue people struggling to repay money they owe.

133) One in 14 adults are in problem debt, meaning they have fallen very behind on paying bills or credit agreements or have been cut off by a gas, electric or water supplier in the past year. They are three times more likely than the general population to have thought about ending their life, according to research undertaken by the National Centre for Social Research (Nat Cen), Britain's largest independent social research body. Nat Cen analysed detailed NHS data about adults' mental health undertaken for the Money and Mental Health Policy Institute. It found that 13% of people in problem debt – about 420,000 a year – think about suicide and 4% of them – more than 100,000 people – try to end their life.

134) Martin Lewis, the personal finance expert who set up and chairs the institute, said letters to debtors, who can receive several a day, are so ruinous to mental health that they are pushing people to consider suicide. He urged ministers to amend the Consumer Credit Act 1974, which obliges those seeking to recover debts to use an array of formal language, which many find terrifying.

> "The fact a law set decades ago doesn't just allow companies to use intimidating language when collecting debt, but near forces them to do so, causes tragedy," Lewis said. "The last thing those struggling with debts need is a bunch of near thuggish letters dropping through the letterbox, in a language you can't understand, threatening you with court action.
>
> "And with such a tight link between mental health and debt crisis, we know that many of the people receiving these letters are extremely vulnerable. These letters are destroying lives."
>
> Samaritans, Mind and the Royal College of Psychiatrists are among those backing the institute's campaign, which aims to persuade the government to change the legislation, so such letters are much less threatening to those receiving them.

135) The institute's report points out that the feelings often displayed by people who are thinking about suicide mirror the psychological responses of many people who end up in serious debt.

Nat Cen's findings, based on its analysis of a huge NHS dataset called the adult psychiatric morbidity survey, also found that:

- *People with multiple debts are five times more likely to have tried to kill themselves than those with one debt.
- Almost a quarter (23%) of those who made a suicide attempt last year were in problem debt.
- The "double stigma" around debt and suicide means many of those who are struggling do not tell anyone how they are feeling or seek help."

Why does it matter? What are the implications for the reliability of the multi-agency safeguarding system?

136) The vulnerability of residents supported by Bexley Council and Oxleas Mental Health Trust does not appear to be taken into account when decisions are taken at a corporate level by financial services to seek recovery of debt. This may exacerbate residents' vulnerability and in some cases increase the risk of suicide to these vulnerable residents. Decisions to instigate debt recovery processes need to be improved and person centred, by being informed by multi agency information about the potential risk of this action.

FINDING 6. RECOMMENDATIONS FOR THE BOARD TO CONSIDER

1. A review of the current corporate systems for instigating formal action to recover debts to Bexley Council accrued by residents, especially where these are due to errors made by the Councils own systems and processes.

2. Information sharing protocol between Adult/Mental Health services and Financial Services to ensure standardised letters are not sent out to vulnerable residents, prior to a discussion with the appropriate Care Services.

3. Consideration of the risks to residents' mental health by receiving formal demands for debt recovery to be included in decision-making processes as part of the above protocol.

4. Development of Person Centred approaches to seek recovery of debts for the most vulnerable residents in Bexley.

APPENDICES

Appendix 1 –
Details of Key Practice Episodes and Summary of Full Timeline subject to review

KPE 1, (15/05/07-11/04/08)

137) Her first Child, a daughter, TO, was born prematurely at 27 weeks. She was taken to the Special Care Baby Unit, where she stayed for the next 3 months. BA became mentally unwell and whilst still in hospital was admitted initially informally for treatment of her mental health to the Woodlands Mental Health Unit, she was subsequently detained under Section 2 MHA (83). There was a plan to admit BA and her daughter to a psychiatric mother and baby unit in another trust, but this did not happen as TO had been found to be a carrier of MRSA. TO was removed from BA under Section 20 Children's Act 89 and then initially placed in foster care by Bexley Children's Services. There was 2 months drift in the role of Children Services, between Bexley and Greenwich, to resolve case responsibility, as her husband had moved to Greenwich borough.

138) In November 2007 Mrs BA had a further mental health episode and another hospital admission under section, as she was not sleeping and expressed suicidal thoughts. She was worried about her employment and feared the possibility of losing her daughter to adoption. During this time plans for her daughter to be looked after by family members were explored. Mrs BA was discharged after a period of home leave in February 2008. TO was subsequently taken back to Nigeria by her parents in April 2008, after Mrs BA had been discharged from the mental health unit. This was for her to be looked after by Mrs BA's mother in Nigeria. TO has remained in Nigeria and has not seen her parents since this time.

(2008-2012)

139) Mrs BA returned to Bexley in July 2008. She was dismissed from her job at the nursing home and referred to the NMC, who suspended her nursing pin number. She has been unable to work as a nurse since. Mrs BA was supported by community mental health services in Bexley and complied with oral medication treatment. Her mental health remained stable for next 7 years. However, as she was now deemed unable to work, her right to remain in the UK was then stopped by the Home Office.

140) Mrs BA then made an application to remain in the UK, under Article 8 of the Human Rights Act in December 2010, which was refused by the Home Office in January 2011. Mrs BA had an appeal against this decision heard in June 2011, which was dismissed and her appeals rights became exhausted in August 2011. Mrs BA then became pregnant with her second child and midwives referred her to Bexley Children' services, due to concerns about her mental health and her first child being looked after in Nigeria. Children Services planned to review her case in November 2011, for a pre-birth conference. This did not happen and after further referrals her case was allocated for assessment in February 2012. Housing subsistence payments commenced at this time, as the family had No recourse to Public Funds, due to the immigration status.

KPE 2 (16/03/12-04/08/14)

141) Second Child, AA, (16/03/12) and Third Child, FO, (12/02/14) were born during this time. Family move to a new house to Bexley Heath and a child in need meeting was held, to consider child protection concerns related to Mrs BA's mental health and any potential risks to AA. Financial assistance was provided under Section 17 Children's Act, whist the immigration process was addressed, and support offered to the family. Right to remain was refused with no right to appeal. AA's father (YA) was financially supported to stay home for 3 months to be AA's primary parent-as Mrs BA was thought to be at high risk of a possible mental health relapse. This was extended to 6 months and meetings were held with mental health services, who visited regularly to monitor and support Mrs BA during this time. AA was subject to a Child Protection Plan from his birth until this was rescinded in

November 2012, at a conference where things were felt to be going well. He remained on a child in need plan.

142) Mrs BA's solicitor made a further Article 8 submission to the Home Office (23/03/12), based on both her medical condition and family rights, as her work visa had expired by this time. This was refused by the Home Office (20/09/13), with no right to appeal. In January 2014, her solicitor made a further application, this time for a Judicial Review of the above decision. In December 2013, Children's Services received a further referral, as Mrs BA was pregnant with her third child. This ought to have been allocated for a pre-birth conference, however the assessment did not commence until 19/02/14, a week after her third child (FO) was born.

(2014-2015)

143) In May 2014 Mrs BA agreed to with draw her Judicial Review, as the Home Office agreed to reconsider her case. A Child in Need meeting was held in June 2014, where no concerns were identified and her CPN continued to visit Mrs BA at home, she was deemed to be stable at this point. In July 2014 her solicitor submitted another Human Rights application, which was again refused. On 18 August 2014 an appeal was lodged at the FTT (First Tier of the Immigration and Asylum Tribunal).

KPE 3 (17/01/15-21/07/15)

144) In January 2015 the police were called to Mrs BA's address by a neighbour and Mrs BA alleged that her husband had grabbed her, punched her in the face and hit her with a broom. YO denied the offence, but was arrested and charged with common assault. The police also made a referral (Merlin) to Children's Services, as the children were present at this time. The referral was reviewed by the Domestic Violence Coordinator who informed the NRPF team about the incident. This communication included further details of Mrs BA screaming, being pulled back into the house by her husband and stating she screamed as she thought she would be harmed with a knife. No CAADA-DASH risk assessment was done at this time and no safety plan developed. The case went to court in March 2015, and was adjourned, then subsequently dismissed by the Judge in April 2015. The details of this incident are unclear, as other notes indicated that Mrs BA threw a brick at her husband's car and came at him with a knife, which he then took off her and hid under a bed at the home.

145) In May 2015 the Child and Family assessment was updated after the above referral following the alleged domestic violence incident, The response to the allegation of domestic abuse by Children's Services was to close the case as there was no risk identified to the children. Mental Health Services did not follow this up with any formal, or informal safeguarding enquiry for Mrs BA despite extensive involvement and meetings with Childrens Services at this time. In June 2015 at a Child in need meeting the case was formally closed to Children's services, as Children were deemed to be no longer in need, as care provided well by father.

(2015-2016)

146) In September 2015 Oxleas Mental Health Services reconfigured and new teams were set up, to work with people according to the nature of their mental health condition, rather than purely on geographical area. The Intensive Case Management for Psychosis (ICMP) team took over Mrs BA's mental health management as the appropriate team to manage her condition.

147) Despite Children's services closing the case, they continued to pay financial support. The No Recourse to Public Funds Team also paid financial support from October 2015. The family reported that the NRPF team told them they had been underpaid and so when the payments increased they had thought this was an entitlement, rather than a duplicate payment. This was not picked up by Bexley systems for some months, leading to an overpayment accruing of £10,800.On 1 October 2015 Mrs BA's

appeal was finally heard, but on 12 November 2015 the appeal was dismissed.

KPE 4 (07/07/16-23/08/16)

148) Mrs BA's appeal rights become exhausted with all applications refused. As her mental health had been stable for many years, there was a plan by the ICMP Team Manager to discharge Mrs BA from specialist mental health services back to the care of her GP. Her regular support worker was instructed by her manager in supervision to stop working with her. The plan to discharge to the GP was challenged by Mrs BA, who raised a formal complaint with Oxleas Trust, despite this the Team Manager initially upheld the decision but this plan was later reversed following Mrs BA's complaint being upheld by the Trust.

(2016-2017)

149) In October 2016, due to her appeals rights having then been exhausted and her subsequent Judicial Review being refused (10/10/16) her case was referred to the Returns Preparation Team at the Home Office to consider removal action against Mrs BA and her family. Mrs BA's solicitor then made further representations to the Home Office, about her mental health issues, safety in Nigeria and for the first time the issue of FGM was raised by her solicitor.
A review of Medical records did identify FGM was included in the diagnosis for Mrs BA, but there does not appear to have been any action taken about this, which should have included a safeguarding adults referral as this is included as a category of abuse in revised London Safeguarding Adults Procedures and also a safeguarding children referral for her daughter who could also been at risk.

KPE 5 (09/11/16-09/01/17)

150) Mrs BA stopped taking her medication and her mental health deteriorated. She called the police and claimed her neighbours were trying to drill into her house. She was detained under S4 following an incident at home. It became apparent the she was having a mental health episode. YO return home and informed officers that she had refused to take her medication. The Police officers raised a Merlin for safeguarding though Mental Health and Adult Social Care, although no record of this was found on the Mental Health system. YO phoned for an ambulance as Mrs BA had picked up a knife, was behaving oddly and had frightened her son. Mrs BA had come to police notice again since the report was reviewed and taken to Queen Mary's Hospital, Woodlands Unit, where she was detained.

151) Mrs BA had been refusing to return to hospital after a period of 5 days home leave (24/11/16), she was then alerted as AWOL by the ward and the police brought Mrs BA to A&E Assaulted staff in A&E, police called did not arrest her as they felt she was in a place of safety. No beds were now available on Lesney Ward (where she technically still an in-patient) and while staff were looking for an alternative bed Mrs BA would not wait in A&E. Mrs BA then left A&E and made her way home, her husband then called police to attend her address. A bed was made available and she was brought back to the ward, Mrs BA was very agitated, screaming and then assaulted staff. Her care was transferred to S3 MHA ('83) and due to her presentation she was transferred to a Private female only Psychiatric Intensive Care Unit (PICU) in Roehampton (04/12/16).

152) She was discharged from this PICU unit (06/01/17), as she was no longer in need of intensive services, she was due to be returned to Woodlands, but as there were no beds available she was discharged directly home. Her Care Coordinator accompanied her home and it became apparent that she had succeeded in masking her symptoms, but remained unwell. Her husband phoned the NRPF

Team to report Mrs BA was aggressive, shouting and he found it hard to cope with her. She was discharged with oral medication but was not allowing her husband to monitor this.

153) Her case was referred back to C&F by her support worker at the ICMP Mental Health Team due to the above deterioration in her mental state (she was challenging, verbally aggressive, paranoid restless and not sleeping) and her case also remained open to NRPF team. However, the NRPF Team policy was such that they did not hold case responsibility for child protection concerns. An assessment was made by Children's Social Worker (17/01/17), which concluded that the children were well cared for by their father and the case was then closed to Children's Services, so the family were being dealt with by the NRPF Team and the ICMP Mental Health Team. The risks of domestic abuse were not addressed at this time. During the next month Mrs BA's husband continued to raise his concerns about Mrs BA's mental health. Also, the Home Office requested up to date information about Mrs BA's mental health and recent hospital admission, to enable them to make another decision on her further Human Rights application, based on any change in her circumstances.

KPE 6 (13/02/17-23/05/17)

154) On the 13/02/17 there was deterioration in Mrs BA's mental state. She attended A&E brought by LAS due to issues at home (she had been showering in the dark and brushing her teeth excessively) she was assessed by MHLT not found to need admission, but was referred for follow up by the Home Treatment Team (HTT) 15/02/17. Mrs BA was seen at home by HTT and their impression was that she appears to not have been taking medication, she did not agree to an informal admission and the plan was to supervise medication.

155) On the 18/02/17 Mrs BA's husband called the ICMP worker, as he was scared for the safety of himself and children. He was advised to call police, which he then did on the 20/02/18 when her returned home from taking his child to school to find himself locked out of the house, by Mrs BA and his youngest child was inside. The youngest child was advised to call police. Police gained entry to the property by breaking door after Mrs BA had waved a knife at them through the letterbox. HTT contacted arranged an emergency MHA assessment. Mrs BA was then placed under section 4 and then section 2 MHA and admitted to Woodlands unit, required IM sedation as she spat at staff on arrival at Millbrook Ward.

156) Mrs BA was assessed and placed on S3 of the MHA and transferred once more to Huntercombe Hospital female PICU ward. Whilst on the ward she threw water over the head of a fellow patient who had slapped her. Police were called but took NFA.

157) The Home Office wrote to Mrs BA's solicitor asking whether she wished to make an asylum claim on the basis of FGM. The following day her solicitor wrote to Greenwich Children's Service with a notice of intention to commence proceedings against them for the way her first child was removed. Her GP review at this time identified these issues as stresses that continue to affect her mental health.

158) In March 2017 Children Services undertook an assessment with YO, but the case was again closed without seeing the children, as he did not wish to engage at the time. As Mrs BA remained in hospital the risk to the children was recorded as low. Mrs BA was transferred back to Woodlands on 25/04/17 and then given home leave on 28/04/17. She was then placed on a Community Treatment Order (CTO) on 23/05/17. This order required her to take prescribed medication (at the time this was both depot Clopixol injections and oral Quetiapine) and to be in regular contact with her CPN.

KPE 7 (06/06/17-27/06/17)

159) The Bexley Council Fraud Team had sent an invoice to the family for £10,800 for the overpayment of subsistence allowance. Mrs BA had been advised by the Home Office to seek asylum but had taken no action over this and information was requested by the Home Office about both her CTO and Children Services Assessments, to check any change in circumstances. These were subsequently sent to the Home Office who stated that they also wanted to check whether there were any safeguarding issues.

KPE 8 (14/07/17-18/08/17)

160) A CPA was held on the 14/07/17 at which her depot was reduced due to her side affects to Clopixol depot 100mg IM, every 2 weeks and oral 200mg Quetiapine. On the 18/07/17 the Home Office decision on her Human Rights representations was made and sent to her legal representative to serve and explain to her, with the option of making an asylum claim was also advised. This would usually be done in person at an immigration-reporting centre, but due to her recent admission Mrs BA was not attending meetings at the centre.

161) The Care Coordinator was informed by e-mail that the decision had been made. The refusal letter dealt with all the representations made including her medical issues and the safeguarding of her children. She then phoned to ask Mrs BA how she was after receiving this news that her immigration decision had been reached. However, as Mrs BA had not been told before her Care Coordinator then told her this news by phone. On the 21/07/17 the care coordinator made a home visit, at which Mrs BA reported feeling very suicidal following the above news from the home office, YO felt that the HTT would be helpful over the weekend, a referral was made and her depot administered. She was then seen by the HTT on 23/07/17, where YO reported being on suicide watch for the past 2 days as Mrs BA was trying to kill herself.

162) Mrs BA was offered an admission to hospital but would only agree to go to Woodlands Unit, nowhere else. However, there were no available beds on the unit at this time. The HTT plan following this visit was to transfer care back to care coordinator at meeting with Mrs BA on Monday 24 July 2017, where she reported feeling better and did not want daily visits. However, when a health visitor attended the same day YO reported that Mrs BA had told him she had heard voices that had told her that; “it would be better to end it all and that she could throw herself in front of a train”.

163) YO stated that he felt he could not leave her alone at all and had managed to stop her going out. He felt angry that the news of immigration had been given over the phone by the CC, as this precipitated her current crisis. The Health visitor did not share this information with the mental health services at this time.

164) On 07/08/17 YO phoned the Care Coordinator (CC) to report that the weekend did not go well and that he felt Mrs BA needed to go back into hospital. CC agreed to undertake a home visit that day at which YO reported that Mrs BA was again talking about jumping in the water at London Bridge. He was advised to lock the doors and the CC contacted HTT and spoke to bed management, there were still no beds at Woodlands, so Mrs BA was advised to attend A&E, this plan was agreed with her consultant. At home visit with Mrs BA by her CC she did not agree to an informal admission as no bed at woodlands but agreed to be seen by the HTT again.

165) Mrs BA reported negative thoughts, which were recorded as follows; "I will do it, I am going to do it" then said "I am ok, I am fine" Her risk to self was then judged to be- Moderate/High with her Risk to suicide deemed to be - Moderate

166) On 08/08/17 she was again referred to the HTT due to the above deterioration in mental state, and suicidal thoughts following rejection by Home office for leave to remain in this country. Mrs BA had voiced that following this news she felt suicidal and had thoughts of ending her life by jumping under a train. She was recorded as presenting with acute distress but no psychosis.

167) She was then seen on 09/08/17 by HTT Dr at home, support from YO was noted and her suicide risk was now judged to be low to moderate, as she was able to discuss the impact this would have on her children. Issues were identified with sleep so Zopiclone was prescribed and delivered to her. Mrs BA wanted to stop her depot, HTT Dr to hand over to ICMP to discuss this request. She was phoned by the HTT over the next 2 days and reported feeling OK.

168) On 13/08/17 Mrs BA called the mental health urgent advice line saying she felt a dip in her mental state when YO left home to attend church. She was visited at home by HTT and confirmed this and also her continued low mood and sleep issues. Suicide risk was then judged to be moderate, she was provided with Zopiclone to help her sleep and the HTT plan was to close her case and to return to ICMP.

169) On the 14/08/17 at a HTT MDT meeting; progress noted on her case and Mrs BA was deemed to be no longer in crisis so her case was to be returned to ICMP team, care co-ordinator informed of plan by phone. There was also a plan to review depot medication at Mrs BA's request-due to side effects. The CC undertook a home visit and administered Mrs BA's depot. A week later unsuccessful attempts were made by the Health Visitor to contact the CC, about her concerns following her visit in July 2017. On the 29/08/17 YO again telephoned her CC to report his concerns that Mrs BA was not sleeping and there was a plan to then reduce her depot medication, due to the side affects of this.

KPE 9 (01/09/17-10/09/17)

170) On the 01/09/17 there was a Home visit from care co-ordinator. The depot medication was stopped altogether on Mrs BA and YO's request due to the distressing side effects and following discussion with Registrar, this was not felt to be contravening the terms of her CTO (which required medication compliance). Her Care co-ordinator collected an increase in the dose of her Quetiapine (from 200mg to 300mg oral) from chemist for Mrs BA. This had previously been a therapeutic dose for her and this change was communicated to her GP, for her prescriptions to be changed. Further unsuccessful attempts were made on 04/09/17 by the Health Visitor to speak to Mrs BA's CC about her concerns.

171) On 05/09/17 A Nursery nurse made a home visit in response to a referral about toileting her youngest child and saw Mrs BA at home, as YO had taken their older child out to an appointment. The nursery nurse had tried to contact Mrs BA's Care Coordinator but had not been able to speak to them. She was concerned about Mrs BA, who appeared to be vacant. YO arrived home and Mrs BA went into another room. YO reported that he had attempted to contact the mental health crisis line repeatedly over the weekend of her death but had been unable to get a response, due to the number not being answered. Mental Health services had no record of a call. The Crisis Line was previously diverted to the trust switchboard. The current Crisis Line service is now 24 hours and is staffed by a team, although at the time there was no voicemail option available to leave a message.

172) On the 10/09/17 Mrs BA left the family home in the morning, saying she was going to the shops, but did not return. YO reported her missing to the police at 11.07 on Sunday 10.9.18. Mrs BA was last seen at 10.00 on Sunday 10.9.18. Mrs BA then took a train to Victoria Station and proceeded to the underground. Following a subsequent investigation Mrs BA can be seen on the station CCTV and was tracked on her journey through the station up until she jumped in from of the train at 11.36.21

173) The officers on the Scene treated this as a Non-Suspicious Fatality at the time and the Control Room Inspector as reported by the Coroners Enquiry Co-Ordinator B-Fatality Investigation Unit.

Appendix 2 –
Glossary and References

[1] Care Act Statutory Guidance (Department of Health) 2015
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

2. London Borough of Bexley Inspection of services for children in need of help and protection, Inspection date: 11 March 2014 – 2 April 2014 https://files.api.ofsted.gov.uk/v1/file/50004266

3. Emergency help contact details for current service users in Bexley (Oxleas NHS Foundation Mental Health Trust 2018 http://oxleas.nhs.uk/advice-and-guidance/how-to-get-help/how-to-get-help-bexley/

4.Parental mental health and child welfare: A guide for adult and children's health and social care services.(https://www.scie.org.uk/publications/guides/guide30/assessment.asp)

5. Adult safeguarding and domestic abuse. A guide to support practitioners and managers(https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf)

6. Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLOS Med, 10*, e1001439. Devries, K.M., Mak, J.Y.B., Loraine, J., Child, J.C., Falder, G., Petzold, M. ... & Astbury, J.(2013).

7. Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine, 40*(6), 881–893. Howard, L.M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew- Davies, R., & Feder, G. (2009).

8.The State of Care in Mental Health Services 2014-2017 CQC (20170720_stateofmh_report.pdf)

9. Oxleas NHS Foundation Trust Quality Report 02/05/2017 CQC (https://www.cqc.org.uk/sites/default/files/new_reports/AAAG3852.pdf)

10. Kings Fund Briefing mental-health-under-pressure-nov15_0.pdf (https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf)

11._ No Health without Mental Health Department of Health https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

12. Suicides in the UK (Office for National Statistics 2017) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations

13.The assessment of clinical risk in mental health services (https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf)

14. Guardian Society 03 December 2018 (Aggressive debt collectors raise risk of suicide.

Appendix 3 -
Participants in the Review

Review Team (in no particular order):

1. Dawn Henry - NRPF Team Leader, NRPF Team LBB
2. Margaret Anderson – Head of Social Care & Principal Social Worker – Bexley Care Oxleas NHS Foundation Trust
3. Malcolm Bainsfair - Head of Safeguarding Adults, Safeguarding Adults LBB
4. Stacy Washington - Head of Safeguarding Adults & Prevent Oxleas NHS Foundation Trust
5. Julie English – Safeguarding Adults Lead -Home Office –
6. Dian Stanley – Returns Preparation Immigration Enforcement-Home Office
7. Karen Upton – Named GP for safeguarding Children Bexley, Clinical Lead for Adult/Children's Bexley CCG, Champion for asthma, autism and learning difficulties
8. Amanda Gillard – BSCB Practice Learning and Review Manager, LBB,
9. Kevin Murphy – Head of Housing, LBB
10. Jim Charles – St Peter's Church, Family Liaison
11. Chris Dalton – CPN Oxleas
12. Marilyn Severin – Community Social Inclusion Recovery Worker, Oxleas
13. Anita Eader- BSAB Practice Review & Learning Manager, LBB
14. Alexandra Gregory – BSAB Coordinator, LBB
15. Harmeet Archer –Detective Inspector, MPS
16. Detective Superintendent Jim Foley Safeguarding lead, SE BCU (Lewisham, Greenwich and Bexley)
17. Charmaine Parkinson – Service Manager for Child Protection Chairs and Independent Reviewing Officers, Professional Standards & Quality Assurance, LBB

Individual Conversations were held with the following Practitioners (in no particular order):

18. Dawn Henry – NRPF Team Leader, NRPF Team LBB
19. Deborah Simpson – DVSM, LBB
20. Stacy Washington - Head of Safeguarding Adults & Prevent
21. Oxleas NHS Foundation Trust
22. Chris Dalton – CPN Oxleas Mental Health Foundation NHS Trust
23. Marilyn Severin – Community Social Inclusion Recovery Worker, Oxleas NHS Foundation Trust
24. YO - Husband
25. Amanda Gillard – BSCB Practice Learning and Review Manager, LBB
26. Helen Smith – Deputy Director, Oxleas NHS Foundation Trust
27. Jane Wells – Director of Nursing, Oxleas NHS Foundation Trust

Other Key Practitioners that contributed to the Review (in no particular order):

28. Tom Brown – Service Director, Bexley Care, LBB
29. Sharon Frieslaar – Royal Borough of Greenwich
30. Simon Pearce – Director, Health & Adult Services, Royal Borough of Greenwich
31. Lorraine Thomas – Named Nurse Safeguarding Children, Bromley Healthcare
32. GP Practice at Westwood Surgery
33. Alan Taylor – Head of Safeguarding, London Ambulance Service
34. Laura Jones – Legal Services, LBB
35. Maria Gonzalez-Merello - Barrister

~~~~~~~~~~~~~~~~~~

Mick Haggar
Independent Consultant/Lead Reviewer
March 2019
~~~~~~~~~~~~~~~~~~

Executive Summary SAR – Mrs BA

This Safeguarding Adult Review was carried out so that the agencies involved in providing services to Mrs BA could learn lessons and improve practice. Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight. The overall aim is to improve services because of that learning.

Bexley Safeguarding Adults Board agreed that the circumstances of Mrs BA's death from suicide met the criteria for a statutory Safeguarding Adults Review under the Care Act 2014. Mrs BA had been receiving secondary mental health services, for over ten years, since first becoming unwell in 2006. Mrs BA had three children, two of whom who lived at home with her and her husband, they had been the subject of input from Children's Services until shortly before her death. Bexley Safeguarding Adults Board involved Bexley Safeguarding Children Board and key partners from Children's Services so that a Safeguarding Adults Review would seek to learn lessons as to how Mrs BA took her own life whilst services were involved with her and her family.

This SAR has been externally reviewed at the request of the Independent Chair, Annie Callanan, in January 2018. The Independent Reviewer has clearly identified areas of learning and practice improvement. It is important to remember the purpose of a SAR is not to proportion fault to an agency or individual, but to seek learning and assurances on how service development that the potential have to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.

The BSAB has a good working relationship with all its key partners and we will use the integrity of the independent scrutineer and have signed off this report as statutory partners to address all the recommendations and findings therein. We seek assurances as outlined in our Action Plan to ensure agencies working in Bexley continue to focus on improving services to adults at risk in Bexley.

In closing, it is essential that at the centre of this work is, of course, a 42-year-old woman who had been in receipt of services in Bexley at the time of her death. We must retain her and her life in our sights and I know the agencies working across the services have done so. I also want to extend sincere condolences to Mrs BA's family and friends, who have suffered significant loss.

Michael Boyce, Acting/Vice Chair, Bexley Safeguarding Adults Board,
Deputy Managing Director, Bexley CCG

Stuart Rowbotham, Director Adult Social Care, London Borough of Bexley

James Foley, Detective Superintendent – SE BCU, London Metropolitan Police Service

Signed off date: 8th March 2019

Bexley Safeguarding Adults Board

SAR- MRS BA Statutory Action Plan

CONTEXT: This is the BSAB Statutory Action Plan following the SAR-Mrs BA Safeguarding Adult Review. The Findings are that of the Independent Reviewer, which were signed off by the statutory partners on 15/03/2019; Updated Actions on 15/07/2019. The BSAB Recommendations and Actions can be amended or updated at any SAR Sub Group Meeting or by any of the SAB Statutory Partners at any time with the approval of the full Board.

FINDING 1: Concerns regarding a new mother's poor mental health and potential risks to her new born child should be carefully considered with all viable options explored to keep the family together. Where alternative arrangements are made, due to assessed risks to the child, a parent's rights to independent legal advice must be upheld and the child's father included in any parenting assessments.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
1. For those working with Mental Health Services to continue working in partnership to ensure Finding 1 is satisfied. To achieve this the BSAB recommends that services consider using a protocol for undertaking joint risk and parenting assessments, including timely pre-birth assessments with Mental Health and Children's Services, and where there are safeguarding concerns for children with parents who have mental health problems.	BSAB Chair to raise awareness across the partnership of this Finding and ask agencies to consider where appropriate the recommendations. The BSAB will need to seek assurances from partners that they have embedded learning from this Finding.	BSAB Chair	By 1st October 2019	28th January 2020 SAR Sub Group
2. For those working with Mental Health Services to continue making referrals as appropriate for more specialised care; including, mothers who have psychosis during or immediately after birth, have access to adequate specialist mother and baby inpatient services.	BSAB Chair to raise awareness across the partnership of this Finding and ask agencies to consider where appropriate the recommendations. The BSAB will need to seek assurances from partners that they have embedded learning from this Finding.	BSAB Chair	By 1st October 2019	28th January 2020 SAR Sub Group
3. Those working in frontline services to have a basic awareness of Mental Health Services to enable an understanding of the impact of serious mental illness for parents and how to escalate concerns.	BSAB Chair to raise awareness across the partnership of this Finding and ask agencies to consider where appropriate the recommendations.	BSAB Chair	By 1st October 2019	28th January 2020 SAR Sub Group

	The BSAB will need to seek assurances from partners that they have embedded learning from this Finding.			

FINDING 2: Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would be responsible for the S42 Enquiry.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
4. Undertake research and audit of safeguarding responses to and from domestic abuse across both Adults and Children's services to ensure LA oversight.	BSAB to arrange joint project with CSPB regarding domestic abuse/violence.	BSAB partner, Domestic Abuse Sexual Violence Manager	1st October 2019	29th October 2019 SAR Sub Group Meeting
5. To continue practicing, 'Think Family' when safeguarding concerns are raised across all service areas; regardless of first point of contact to ensure this finding can be satisfied.	BSAB to arrange joint project with CSPB regarding domestic abuse/violence.	BSAB partner, Domestic Abuse Sexual Violence Manager	1st October 2019	29th October 2019 SAR Sub Group
6. The Local Partnerships to consider setting up an integrated MASH (Multi Agency Safeguarding Hub) Service, to triage referrals to either Adults or Children's Safeguarding (or both, working together).	BSAB Chair to raise awareness across the partnership of this Finding and ask agencies to consider where appropriate the recommendations. The BSAB will need to seek assurances from partners that they have embedded learning from this Finding.	BSAB Chair	1st October 2019	28th January 2020 SAR Sub Group

FINDING 3: Lack of availability of local psychiatric inpatient services due to patient flow can be associated with problems caring for people in mental health crisis both in the community and in hospital, with increased risks to them and their families. This puts pressure on local community mental health services to try to manage admissions when there is a clinical need and on the inpatient services to discharge people too quickly. The use of out of area private psychiatric hospitals may ultimately adversely affect the handover of care when patients are discharged back to local community mental health services.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
7. Undertake an updated audit of the patient flow both into and out of placements for women in need of hospital admission to both PICU and acute services, within and outside the local area, within the South London Partnership.	CCG will complete a mapping exercise on what data is currently available and what could become available as a report back to the BSAB.	BSAB partner, CCG	15th January 2020	28th January 2020 SAR Sub Group
8. Review of commissioning arrangements considering above to consider including local services for women needing PICU admission.	CCG to consider this within its SE London Arrangements and update the BSAB on services commissioned.	BSAB partner, CCG	15th January 2020	28th January 2020 SAR Sub Group
9. Consider the impact of inpatient services availability on judgements made by community mental health services on needs for patients requiring admission, specifically whether staff perceive that this affects admissions where there is a clinical need based on risk.	CCG to give assurance to BSAB about acute bed availability and incidents of serious incident or readmission occurring less than one month following discharge from hospital.	BSAB partner, CCG	15th January 2020	28th January 2020 SAR Sub Group

FINDING 4: The immigration status of people being deemed unable to remain lawfully in the UK with No Recourse to Public Funds requires complex decisions including appeals to the Home Office. For people who in addition also have mental health problems, this process can be difficult and stressful, with an increased risk to both their mental health and subsequently their safety.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
10. There should be a Joint Training Programme for Mental Health Professionals and No Recourse to Public Funds Team on the Immigration and Appeals Process to help support and navigate the system with their clients.	BSAB to support MH and NRPF Teams to have immigration and appeals process training and to ensure that details of Immigration SOCS are available on the BSAB website.	BSAB Bexley MH and NRPF Team	1st October 2019	29th October 2019 SAR Sub Group
11. Those working across the partnership to consider specific support, advocacy and advice for people with mental health problems, who are making immigration claims and understanding the impact on the whole family.	Partners to assure the BSAB that there is enough provision and report back to BSAB.	Partnership	January 2020	January 2020 SAR Sub Group Meeting

FINDING 5: The assessment and management of the risk of suicide for people with mental health problems in community mental health services needs to include a structured model incorporating social and psychological stress factors, enabling information sharing by all health and social care professionals, involving families where appropriate. This should include a pathway to access to emergency hospital admissions where people are identified as both experiences mental illness and at high risk of suicide following this assessment.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
12. Review of the local suicide prevention strategy signed up to by all partner agencies in Bexley, to ensure consideration of the following: • Improve systems for information sharing between primary health care, social care and specialist mental health care where risks of suicide are identified • Review current pathway to inform good risk assessments for suicide prevention and management of this risk. Ensure families and patients have input into dynamic, clinical risk assessments.	BSAB to organise an update and presentation at June 2019 Board meeting on the Bexley Suicide Prevention Strategy	BSAB partner, Public Health	13th June 2019	23rd July 2019 SAR Sub Group
13. To work closely with partners to identify those agencies in need of Suicide First Aid training and consider a training strategy.	Public Health to map out agencies and scope for offering Suicide 1st Training across the partnership and feedback to BSAB for assurance.	Bexley Public Health	13th June 2019	23rd July 2019 SAR Sub Group
14. Consider making stronger links between local agencies and BTP Suicide Prevention Team, where adults are reported missing and have stated an intention to act on suicidal thoughts by jumping in front of a train.	BSAB to share this information across Bexley partners and make links with BTP and share information across partnership and invite to BSAB Full Board Meeting to present their services.	BSAB Practice Review & Learning Manager	1st April 2019	13th June 2019 Full Board

FINDING 6: The use of a standardised and corporate debt recovery process, including automated letters threatening legal action, is not always appropriate. Sending letters to residents with serious mental health problems may cause them harm, including potentially increasing the risk of suicide amongst this group. Interdepartmental systems need to take account of the vulnerability of residents prior to formal debt recovery processes being implemented.

Recommendations	BSAB Actions	For whom	By when	BSAB Review Date
15. A review of the current corporate systems for instigating formal action to recover debts to Bexley Council accrued by residents, especially where these are due to errors made by the Councils own systems and processes.	BSAB Chair to request that the Chief Executive of LBB provide assurance that debt recovery processes have been reviewed, and that clear processes are in place to ensure a proportionate approach for adults at risk.	BSAB Chair	1st October 2019	October SAR Sub Group
16. Information sharing protocol between Adult/Mental Health services and Financial Services to ensure standardised letters are not sent out to vulnerable residents, prior to a discussion with the appropriate Care Services.	BSAB Chair to request that the Chief Executive of LBB provide assurance that debt recovery processes have been reviewed, and that clear processes are in place to ensure a proportionate approach for adults at risk.	BSAB Chair	1st October 2019	October SAR Sub Group
17. Consideration of the risks to residents' mental health by receiving formal demands for debt recovery to be included in decision-making processes as part of the above protocol.	BSAB Chair to request that the Chief Executive of LBB provide assurance that debt recovery processes have been reviewed, and that clear processes are in place to ensure a proportionate approach for adults at risk.	BSAB Chair	1st October 2019	October SAR Sub Group
18. Development of Person-Centred approaches to seek recovery of debts for the most vulnerable residents in Bexley.	BSAB Chair to request that the Chief Executive of LBB provide assurance that debt recovery processes have been reviewed, and that clear processes are in place to ensure a proportionate approach for adults at risk.	BSAB Chair	1st October 2019	October SAR Sub Group