Bexley Safeguarding Adults Board

Helping adults to live a life free from abuse or neglect

Adult Safeguarding Review

SAR N

May 2020

Independent Reviewer

Deborah Stuart-Angus

Acknowledgement of Thanks and Candour

In very difficult circumstances and in acknowledgement of an exceedingly tragic incident, involving this young person, the Panel and myself, want to thank the agencies and family, who have taken part in this process and give credit to all, for the candour that has been expressed.

Privacy and Confidentiality

The subject of this Safeguarding Adult Review has been referred to as "N" in agreement with N's family. The Safeguarding Adult Review Panel is aware that this form of address may be somewhat upsetting to some friends and loved ones, however, the Panel is also concerned about the subject and their family's right to confidentiality and privacy. Referring to this Safeguarding Adult Review as 'N' provides some measure of protection in this regard. In this version of the Overview report, names of staff have been removed but names of organisations have been stated for ease of reading. Please note this factor, if considering publication or circulation, as a redacted version of this report also exists and had been supplied to BSAB.

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1.DUTY, DECISION & CONTRIBUTORS

On the 29th August 2018, the former Independent Chair of Bexley Safeguarding Adults Board (BSAB) notified partners that a SAR recommendation was received on August 6th, regarding a 19-year-old person, in receipt of care and support services. Between August 2018 and May 2019, BSAB started to conduct a SAR and at a later date Deborah Stuart-Angus was appointed as the Independent Reviewer. BSAB met its duty under section 44 of The Care Act, by undertaking this Review, as lawful criteria were met; there was reasonable cause for concern about how BSAB members had worked together to safeguard N, and the BSAB, knew or suspected that death resulted from abuse or neglect. From this Review, lessons learned have been identified, which will be applied to the management of future cases, for improvement and prevention, and no blame will be attached to any individual or agency. All recommendations and the action plan will be monitored through the BSAB and the SAR Panel. Contributors have been:

- N's Family
- Trust A: Hospital 1
- Trust B: Hospital 1
- Trust C: Hospital 2
- Trust D: Hospital 3 (Ward A) and Hospital 4 (Ward B)
- Trust E: Hospital 5
- Mental Health Charity
- The General Practitioner
- Housing Services
- Adult Social Care
- Children's Social Care
- Local College
- The Police
- The Urgent Care Centre (based at Trust C, Hospital 3)
- Clinical Commissioning Group
- CQC

N's partner (Partner A) did not take part in the Review, although contacted, no engagement followed.

2. TERMS OF REFERENCE & METHODOLOGY

The Independent Chair of the SAR Panel oversaw the Review process and was simultaneously commissioned as Independent Reviewer. The review covers the period from July 2016 up to the conclusion of the adult safeguarding enquiry in 2018. Internal Management Reports (IMRs) and various documentation was submitted to the Review, including a Root Cause Analysis from Trust D. Additional information was requested from Care Quality Commission, Trust E, The Urgent Care Centre and The Police. IMRs include: a chronology; analyses of service provided; highlight of good or poor practice; resourcing, workload, supervision, training and experience of staff. They also identify lessons learned, challenges and opportunities, making recommendations for improvement, along with any issues relevant to equality, culture and or faith.

Specifically to this case, IMR's have also focused on post incident response; the section 42 Safeguarding Enquiry; deficits in risk assessment, care, recording, and ward handover; support provided to N between November 2017 and March 2018 (when N was discharged and subsequently admitted to Hospital Trust D); N's housing situation at the time of admission to Trust D; referral oversight, medication management and engagement; advice regarding risks that N was facing; GP awareness/community mental health team or home treatment team awareness levels; and any known research that may contribute to learning.

In the spirit of Making Safeguarding Personal, family members were identified and N's Mother fully participated with the SAR at various meetings and by sharing information. Differences and discrepancies were noted by N's Mother in the first draft of the Overview Report between information

supplied by Trust D to the SAR, compared to some evidence supplied to, and given at the Article 2 Coroner's Inquest for N. Consequently, it was agreed that the SAR Chair, would approach the HM Coroner for clarity, and consequently the Coroner's Office availed all (23) evidence recordings from the Inquest. It should be noted that this process extended the timeline of the SAR by several months, which was unfortunate, but unavoidable within the circumstances described and the family supported the approach.

A full Overview Report exists which outlines system and case findings; thematic analyses, key learning and priorities for change, to ensure improved adult safeguarding in future.

3. Circumstances

By July 2016 N had become 18, had nine sisters and three brother (siblings and half-siblings). N was very close to a sister and both lived at home, with their Mother, and other siblings. One sibling had experienced enduring mental health problems, and Children's Services had been involved. N had experienced several close bereavements, including deaths of a grandparent; a half-brother and an aunt. N experienced a difficult time at school and was bullied. N was a bright, intelligent young person, with a warm and gentle, personality. N gained 7 GCSEs; studied a Nursing course; aimed to go to University and worked at various jobs whilst studying. N moved to a second College and left, owing to heightened feelings of anxiety.

During April 2017, N visited the GP, feeling very low and tearful, referring to feelings of grief following 3 family deaths, all having occurred in 2013. However, it is not evident what the clinical outcome was, or if any referrals were made. During September N returned to the GP, describing visual hallucinations, fear of crowds, grief and the concerns regarding the sibling with mental health issues. The GP noted that N's depression score and anxiety had increased, yet the phobia score had decreased. N was referred to the Improving Access to Psychological Therapies Programme (IAPT) at Mental Health Charity, with a 4-week review.

N engaged initially, with an IAPT telephone assessment, provided family and personal history, and advised that sometimes N found it difficult to be mixed race. N referred to an attempted overdose in 2016, following a family argument, and not seeking medical help. There is no other reference to this found during the time of the review.

N advised having a same sex partner, as a protective factor. N referred to having thoughts to end life but did not describe an active plan. IAPT informed the GP. N was asked to attend a Cognitive Behavioural Therapy Group which was not available till November and was given crisis contact information. N saw an IAPT Therapist mid-October, and told them N would be better off dead. The GP was contacted again, and the Therapist noted that N's depression and anxiety scores were both very high, with a 5/10 score for suicidal intention. A plan was made for N to attend a 'Step 3' Therapy Group. 2 days later, N attempted to overdose with tablets and alcohol, and was taken by ambulance to Trust A Trust, Hospital 1 by the partner. N reported wanting to feel numb, but did not lose consciousness and was then admitted to Trust B, also in Hospital 1 for psychiatric assessment. N was assessed as medium risk to self, was referred to the community mental health team at Trust D; and to the GP, and discharged the next morning.

The referral was accepted by the Home Treatment Team, at Trust D, on the 21st October for short term intervention, with a plan to provide intensive community support and GP contact. On the 23rd N was risk assessed as being in 'Red Zone' but it is not clear how the assessment was made, later that day N was assessed at moderate risk, with no suicidal thoughts. It is not clear why the assessment outcome was changed. The following day (24th) N reported feeling better. The next day (25th) a multidisciplinary team meeting decided that N should have Promethazine (for poor sleep) and that a referral to the Day Treatment Team (for managing intense emotions) should be made.

The following day (26th) N reported: feeling sad and suicidal, with impulsive thoughts of self-harm and hurting others; low mood; poor sleep; poor appetite, and feeling 'overwhelmed' (with coursework and having left home 5 weeks earlier following a family argument). N reported occasional cannabis use

and having taken an overdose a few days earlier, following an argument with the partner. N advised feeling uncomfortable, now living at the partner's father's house, who was seemingly unaware of their single sex relationship. N was assessed as having low to moderate risk; diagnosed as having a reaction to stress with anxiety and depressive symptoms; referred to IAPT's Cognitive Behavioural Therapy Group and prescribed 20mg of Citalopram and Promethazine. Access to independent accommodation was also discussed, along with the possibility of a referral to a Day Treatment Team, with access to a psychologist.

On the 28th N was contacted by the Team to offer home support and a follow up appointment. By the 30th N seemed brighter, however N refused the referral to the Day Treatment Team, on the grounds of the open referral to IAPT/Mental Health Charity - which a nurse seemed to believe that N was engaging with. The Nurse arranged a support plan, medication and N's imminent discharge was discussed. N reported returning to work and college, but seemingly it would appear N had not returned. On the 31st a record stated that N was already engaged with IAPT/ Mental Health Charity.

By the 1st, of November, N did not respond a call from the team, so a visit was set for the next day, to the Partner's address. However, a man at the door advised that N did not live there. Successful contact was later made with N's partner and N called the Team back. N reported feeling low at times but 'coping', and had no suicidal ideation. N was referred to IAPT/ Mental Health Charity and again offered the Day Treatment Referral, to attend a group for managing intense emotions, which N again declined. N was given information about CRUSE; the Urgent Advice Line; and a care and crisis plan and agreed to collect medication and to meet on 3rd to discuss discharge.

On the 6th, N's risk level was moved to 'green zone' and N reported moving permanently into Partner A's flat (which was actually Partner A's father's flat). N seemed happier; was not arguing with Mother; reported reduced working hours; feeling better; eating well; sleeping well; taking medication and with no thoughts of harm to self or others. N's final diagnosis was reaction to stress and Adjustment Disorder and a discharge date was set for the 7th. N thanked everyone for helping. Seemingly, the impression gained by the team, was that N would manage better with the Partner, but the issues in the relationship had not been explored, and it was a missed opportunity. N was given crisis contacts and discharged to the GP. Records say a follow up appointment was in the team diary, but it is not clear if this happened. N had taken Citalopram at that point, for 11 days.

On the 9th November, N failed to attend IAPT but did see the GP on the 10th, who continued the prescription. N advised about being discharged and received a sick note, until the 30th. N attended a GP Review on the 22nd, and assessed as not well enough to return to work, with another appointment given for the 27th.

IAPT referred N back to the GP on 11thof January 2018, due to non- attendance, and N by then, had separated from Partner A, albeit they still apparently played a part in each other's daily lives. No further clinical records exist for N from that point until March 2018.

On the 21st February N made a housing application to the local council. On the 8th March N followed this up, gave accommodation history, and referred to issues at home. N was advised to look into a private shared rental. It is not clear if N understood how to claim housing benefit, or how to go about this, or if felt able to. N's mother felt N could afford a privately rented flat, and consequently no soultion was found regarding N's housing situation. It would appear that this was a missed opportunity as N had care and support needs and Care Act responsibilities, could have afforded Housing to work with Adult Social Care, regarding N's needs, and perhaps considered Supported Housing as an option.

On 14th March N was prescribed Fluoxetine and another Mental Health Charity/IAPT referral was made and an appointment confirmed for the 22nd.

On the 18th N's sister contacted Trust D's Home Treatment Team with concerns about N having a low mood and that N had self-harmed the previous week. She was advised to take N to A&E for a Mental Health Act Assessment. The next day, (19th) N attended A&E at Hospital 2, at Trust C with the sister, to whom N referred as next of kin (previously N had the partner as next of kin). The sister advised that N had nowhere to live and had overdosed about 6 weeks ago (if this was the case there are no records

of the alleged overdose). N also advised that six weeks ago they were admitted to Trust B following an overdose. It would appear Trust C Hospital staff believed that N had been discharged from Trust A, Hospital 1, 6weeks earlier, but records show that the admission and discharge, was actually in October 2017, which was nearly 5 months earlier. Trust C, Hospital 2 also noted that N was '*not aware of the crisis plan or support available in the community*' after being discharged, yet records demonstrate that N had been made aware.

N was referred to the Inpatient Psychiatric Liaison Team, at Trust D, reported feeling suicidal; wanting to jump off a building or overdose to end their life. Trust D's records refer to N presenting with strong suicidal thoughts; on-going mood problems with multiple triggers; poor social support; very low mood; using excessive alcohol and occasional cannabis; having 'severe financial difficulties'; experiencing stress in the relationship with partner and with no particular protective factor, apart from N's sister. N was offered admission as an informal crisis patient, which N accepted, and N was transferred and admitted to Ward A, Trust D.

(Various references made by various staff seemed to presume N was unemployed, which has concerned the family, who advise that N was working full time prior to admission and on March 21st Ward A issued N with a 14-day work place sick certificate. It would appear that this 'mis-information' travelled with N, through ward transfer).

On the 20th, a Duty Doctor assessed N as having active suicidal thoughts and plans, and high risk level, which was not recorded Later that afternoon a different doctor recorded N's risk to self as low to moderate, stating N had suicidal ideation but no active plan or intent. Later, the same day, a nurse recorded that N had no active plan for suicide, because N had apparently said there was no suitable place on the ward in which to kill themselves. On the 21st during a ward handover, a doctor recorded that N wanted to hang themselves with a blanket. This was not recorded in N's notes and there was no discussion regarding bed linen being a potential risk. N later told staff about wanting to jump out of a window and that N felt unable to guarantee their safety. In the evening, a different doctor, recorded N's risk to self as high, and this was not recorded in the risk assessment on RIO.

N wanted to move to be nearer family, which was agreed, with a transfer arranged to Ward B, Hospital 4, Trust D. There was a delay which frustrated N, who wanted a medical review the next day, and N agreed to stay on the ward. N was seen the next day (22nd) in a ward round, and it was noted N felt there was no purpose to their life and was trying to find a way to kill themselves on the ward.

After the ward round, N wanted to leave. Staff believed N's risk level had increased. N was detained under section 5(2) of the Mental Health Act and, the next day detained under section 2 (23rd). Simultaneously the level of observations for N was changed from Level 2 to 'general observations'. Family advised that N was not allowed leave, other than 15 minute trips to the ward garden, due to serious safety concerns. From the 22nd to 27th there was no evidence on RIO of a review of the risk assessment for N.

On the 25th, N subsequently transferred to Ward B, Trust D, alone, by ambulance on the 25th with no written record of a handover of care between nursing staff. N had a verbal risk assessment from a nurse on admission to Ward B, who felt that N was safe enough to keep most belongings, which included track suit bottoms, with what was believed to be, a stitched in waist cord, and a bag with a shoulder strap. N's phone charger was removed. On the 26th, a ward round was planned and N and sister were due to attend. N's family advise that scheduling was changed and N's slot was cancelled. N became very agitated and N punched a wall and a plastic leaflet holder, sustaining a hand injury, which was not reported on the incident reporting system. The ward round concluded that N had active suicidal thoughts of wanting to die and had a plan to run onto a rail track. The Consultant agreed pre-assessed, s17 supervised leave, for an hour a day, with family or friends, and if N returned, an hour of unsupervised leave could be granted. N's sister and Mother did not understand this decision, given that on Ward A, leave was not granted. N was prescribed Venlafaxine, commencing the next day, with augmentation being considered as an option. That evening in a telephone call with Mother, N advised that the hand injury was causing pain. Following examination N was advised to go to the Urgent Care

Centre (on the same hospital site) for an X-Ray (26th). N attended, accompanied but when N got there, did not wish to wait.

On the morning of the 27th there was a particularly busy ward environment. N was to return to the Urgent Care Centre and was signed out of the ward at 10.30am. Records state N was seen on the ward at 10.30am and 10.46am. (The SAR is advised that the timings of observations may not be absolute as one member of staff did not have a watch, and there seems to be some fluidity regarding times and records). N was booked in at the Centre at 10.41am, therefore ward observation records cannot be relied on. N was not triaged (as it had been carried out the day before) and a consultation was held at 10.43am.

The family advise that at 11.15am N spoke to their Partner by phone and advised N had been to the Urgent Care Centre alone, and now going back to Ward B. At 11.41 am, N was called to be seen, at the Urgent Care Centre, but had already left and the case was closed at 11.48 am. It is unclear at what time N arrived back on Ward B, because N was not signed back in.

Observations were not completed by staff between 11am and 12pm on 27 March 2018, and one staff member seemed unaware that they had been allocated these observations, albeit they were timetabled on the shift coordination sheet in line with Trust D's Policy. According to the Coroner's Inquest information, N had asked staff for a bandage at some point between 11am and 11.30pm, which was not recorded. Information from Trust D, regarding sightings of N, advised that staff last saw N alive at approximately 11.35am, and Trust D's investigation advised that various sightings of N were not recorded.

(The family advised that the Inquest received a statement from a member of the ward staff referring stating that N was searched on the morning of 27th when N returned to the ward at 11.30 am, reporting '*no contraband was found*'. However, the same person gave a supplementary statement, advising that an error was made, as N had been signed back onto ward on the 26th as opposed to the 27th).

Trust D have advised that it would have been normal practice for a returning patient to be signed back in and checked for 'contraband'. It would appear that N was not searched on their return, and the receiving nurse was about to escort another patient to a different hospital by ambulance.

At 11.50am, 11.55am and 12.10pm, N's Mother called N, but the call was not responded to. Trust D reports that at 12pm, a healthcare assistant was carrying out hourly and Level 2 intermittent observations and went to N's room. The healthcare assistant reported to the Inquest that they went to get N for lunch. When the assistant was asked in evidence, if they knew what time this was, the response was that they did not, because the assistant was not wearing a watch, however they recalled it was not long after lunch had been called at 12pm. The assistant got no response from knocking on N's door, and was unable to open it.

A Charge Nurse from Trust D, Ward B, advised the Coroner that he became aware of a situation at approximately 12.10pm as his emergency alarm was activated. He left his office to attend the scene, taking approximately 2 minutes to reach N's room. On arrival the Charge Nurse noted staff were gathered outside. The door was opened in his presence. The family advise that witness evidence stated that it took approximately 7 minutes for the door to be opened. When the door was opened the anti-barricade latch was used and N was found unresponsive on the floor with a ligature around the neck. N's mother was told by a member of ward staff that N had been seen on the ward seven minutes, prior to being found.

N was given CPR and an ambulance was called (Trust D does not have an Accident & Emergency service in house). N was administered an incorrect dose of adrenalin, however it was enough to provoke spontaneous circulation. It is not clear if N was breathing independently. When the ambulance arrived, it had a broken tailgate, and another ambulance was arranged, subsequently N was transferred to Hospital 5 at Trust E and placed under 'assisted coma.'

At 13.15 N's Mother received a call from Ward B's Consultant to say that N had been found in the bedroom at 12.10pm with a belt around their neck and that N had to be resuscitated, but was breathing alone and was being taken to Hospital 5 by ambulance. N's family maintain this was incorrect, believing at that point, that N was in cardiac arrest.

Police were called at 16.39 hours to attend Ward B, leaving a 4-hour delay in contact. The police report states that N returned to the the unit and was last seen at approximately 11.00 hours, which differs to Trust D's report which stated N was last seen at 11.35. It was reported to Police that N was discovered at 12:15hrs. A Police Merlin Report was made. On the evening of the 27th a police officer attended Hospital 5's Intensive Care Unit to see N, and was told that a black holdall strap was used as a ligature and advised there were no suspicious circumstances. He spoke to N's Mother advising he had seen and sealed N's room, and after examination of the room door, at Ward B, and believed the ligature was placed through the door, by the hinges, and held in place by a buckle. N's Mother was advised by the Ward B Manager that the ligature was a cord from a tracksuit. At this point N's Mother had been advised that a bag strap; a belt; shoelaces and a tracksuit cord had been used as 'the' ligature.

There are contradictory views and statements regarding the type of ligature used and it is of extreme importance to the family that this point is made clear, and that the confusion regarding this, and the lack of accurate records, has added significantly to their anxiety. It was not clear from records or evidence submitted to the Coroner's Court, whether the ligature was a white cord or a black bag strap, however the Coroner's Pathologist (non-forensic) advised the Article 2 Hearing that injury marks were conducive with the ligature that he had seen, which was a 1cm white fabric belt.

An EEG conducted at Hospital 5, indicated moderate to significant hypoxic brain injury. N sadly died on 29th March 2018. The cause of death was hypoxic brain injury; asphyxia and suspension by the neck, confirmed by the Coroner's Inquest, which delivered a Narrative Verdict on N's death, contributed to by neglect. Trust E raised a safeguarding concern, because the incident had taken place whilst N was sectioned under the Mental Health Act. This was passed on to Adult Social Care for consideration of a Section 42 Adult Safeguarding Enquiry, under the Care Act 2014. N's possessions were returned to N's Mother, and Trust D did not preserve the incident scene, as their protocol did not require this.

On March 28th police received information from a member of staff from Ward B who wanted to report organisational malpractice and abuse of patients on Ward B by the Consultant Psychiatrist and other individuals. The whistle-blower believed many patients were not given proper treatment or help, which lead to self-harm and attempted suicide. The individual was advised to contact the Care Quality Commission to report malpractice, following a consultation by the Officer from CID, who took the information. Police were unable to advise if this information was followed up or if a complaint was made to the Care Quality Commission.

Adult Social Care commenced a section 42 Safeguarding Adult Enquiry having received a MASH referral on April 27th from Police, and Trust E's referral on the 28th. A Director from Trust D confirmed that given the seriousness of the incident, a Board Level enquiry was considered and the concern was escalated to both CQC; Commissioners and Patient Safety Lead. CQC have responded to this SAR and advised that during their Inspection (21st November 2018 to 11th January 2019), the core service rating of Trust D remained 'Good' and CQC found examples of outstanding practice in acute wards for adults of working age and in psychiatric intensive care units.

On the April 12th the Adult Social Care Safeguarding Adults Team called Hospital 5, for an update regarding N, and were informed that N had died the week before. On the 22nd N's Mother formally requested the Trust to account for N's whereabouts from 11.30am to 12.10pm on the 27th of March.

4. ANALYSES

4.1 Hard to Engage Service Users

IAPT, General Practitioner and the CCG

N's GP made several referrals to IAPT/ Mental Health Charity, and N found it difficult to engage. Given N's depression and labile mood, personal motivation may have been very difficult to sustain. It is likely that N would have benefited from assertive community support, if it had been available. The Primary Care Plus Pathway Specialist Mental Health Liaison Service did not appear to have featured in N's care and seemingly, they could have helped. When N's GP recognised N's did not engage with IAPT, exploration and discussion about a referral to community mental health services would have been useful, however given N's wish not to be referred to that service, the GP respected this.

4.2 Clinical Assessment and Administration of Medication

General Practitioner and the CCG

When N failed to fully engage with IAPT, the same issues that had been causing N high levels of anxiety, in 2016, were reported again from April 2017 onwards and N scored highly on depression scales. Anti-depressant medication could possibly have been considered earlier, and was subsequently prescribed by the Trust D's Home Treatment Team. in October 2017.

Trust D, CCG, CQC and BSAB

A duty of candour was honoured by a doctor, from Trust D, when an incorrect dosage of adrenaline was administered during N's resuscitation, post incident. However, it would appear, that albeit the dose was incorrect, it was enough to provoke N's spontaneous circulation.

4.3 Professional Curiosity

Trust D, the Home Treatment Team and GP

In various encounters with services, N referred to only 'occasional' cannabis use. N's family are of the view that N was receiving large amounts of cannabis from a Partner - which remains unsubstantiated. N was drug tested by the Home Treatment Team (HTT) and when N's belongings were returned to N's Mother, post incident, a small plastic bag appeared to contain remnants of cannabis. No further drug tests took place and there was professional acceptance with regard to what N told staff.

On the 28th October, N was contacted by a nurse from the HTT, who was aware that a referral to IAPT had been made and records show that the nurse believed N was engaging with IAPT. However, due to policy, no contact was made with IAPT to establish if this was correct, nor did the HTT seem aware that N had not engaged well with IAPT in the past, and yet attendance at IAPT was a major contributing factor to N's discharge plan.

A missed opportunity occurred when a worker from the HTT visited the partner's father's address to be told N was not resident there. It is not evident that anyone asked N why the visitor would receive such a response and if this had been explored, it may have provided access into gaining insight into N's accommodation issues; issues for N having a same sex partner; the dynamics of that relationship and the couple's alleged shared abuse of illicit substances.

6.4 Discharge Decision Making

Home Treatment Team, Trust D

Clinical judgements agreed that N was safe to be discharged on the 7th November, following acceptance by the Team on the 20th October. This would appear to be a very short period of time to have considered N's stability, given that there were ongoing issues with the relationship with the Partner A; a history of impulsive behaviours; two overdoses in a year; changing moods and having taken antidepressant medication for 12 days. Trust D were not aware that N subsequently did not engage with IAPT as it is not Trust policy to provide follow up.

6.5 Carer Recognition

Trust A , Trust B, Trust D and the CCG

N had on several occasions referred to partner A, as a protective factor and as next of kin, prior to this N lived with their Mother, and at no point would it seem evident that either party were offered a Carer's Assessment and nor was a referral to Adult Social Care made. Had this have happened, more insight into the complexities of both relationships may have been able to be accessed and appropriate

support could have been made available to all concerned. In addition, if Partner A was experiencing the alleged mental health problems, then N may also have been a carer for Partner A - and vice versa.

6.6 Equality and Cultural Issues

All Services

N commented that '*it was sometimes difficult to be mixed race'* to some services. This was evidently not explored, nor were any other issues explored regarding N's experience of a same sex relationship particularly in relation to (according to N's Mother), the fact that Partner A's family culture apparently found same sex relationships unacceptable. However, it is recognised that N did not engage well with some services, and declined an offer of a referral to the Day Treatment Service, thus limiting N's therapeutic options.

6.7 Accommodation and Care and Support Needs

6.7.1 Housing Services

In Spring 2018, N explained to the Council about being homeless. It is not evident that Housing Services understood or knew that N was experiencing mental illness, and consequently, possibly not cognisant of Care Act duties to work with Adult Social Care if a person over 18, has Care and Support needs. The s179 duty (Housing Act 1996) to provide advisory services, was deployed, but it is not clear if the service took into regard the N's particular needs in respect of s179(2)(f) – '*persons suffering from a mental illness or impairment'*, and s179(2)(g) – *'any other group that the authority identifies as being at particular risk of homelessness in the district*'.

6.7.2 Housing Services, Trust D, GP and the CCG

N had an entitlement under the Care Act 2014 to have an assessment of need, and to be consequently considered for help in relation to accessing to housing. The emphasis in the Act is on *'meeting needs'* to improve the *'well-being'* of adults in need care of care support (because of physical or mental impairment or illness). It is not evident that any organisation or provider ensured that this duty was carried out - and it should have been.

6.8 Risk Management

In January 2018, N separated from their Partner. It could be argued that N's risk had now heightened, given N cited Partner A as a protective factor. The Review recognises that the relationship itself possibly, could also have exposed N to risk because, if Partner A had experienced mental ill health, there could have been the added issue of the mutual impact on both young people, each trying to deal with their own mental health issues, and potentially substance abuse.

6.8.2 Trust D

The Trust have recognised that issues were apparent with regard to risk assessments for N, and that they were not carried out in accordance with Trust Policy. It is not clear why this was the case on Ward B. On Ward A, risk status was recorded in Progress Notes. This is an internal matter for The Trust, and in relation to prevention, it brings concerns, about quality assurance and deployment of Trust Policy. It is important to state that these issues were wider than recording and process issues, as they also involved a wide range of difference of clinical opinion, regarding risk for a potentially suicidal patient.

Between March 20th and 21st, 2018, 5 different clinical judgements were made regarding N's mental state, which brings into question Trust D's decision making processes for suicidal patients and associated risk. It is understood that Trust D will be implementing a Performance Management System, but it is not clear if this will strengthen clinical decision making and a bring about a uniform approach to assessing risk, when different and busy staff, are working different shifts, and consistency is in itself, placed at risk.

Another example exists in the vast difference in clinical opinion, in relation to N as a suicidal patient, when on March 23rd, N was a patient on Ward A, who had been placed on a Section 2 of the Mental Health Act and leave was not to be given and post transfer to Ward B, a leave agreement was drawn up. This agreement was made on the same day as N started a new antidepressant and that it was recorded that N was acutely suicidal, and that risk of self-harm, and or suicide, was high.

It is also not clear why on the 27th, the ward did not call the Urgent Care Centre to obtain N's results, which would have reduced risk to N.

In turn the Trust D's investigation established that Ward B staff did not read N's RIO notes made on Ward A, and therefore, were not aware of a) the level of N's risk b) the reason why N was detained under the Mental Health Act and c) the comments N had made on Ward A about wanting to take their own life, which is an internal matter for Trust D, in relation to supervision, policy, procedure, quality assurance and individual staff performance and management.

6.9 Systems and Processes

6.9.1 Trust D

a) Care Planning

The Trust investigation established that there was no written care plan on Ward A or B for N, and that care planning was not carried out according to Trust D policy. On Ward, this happened because the Primary Nurse allocated to N, was absent from work. On Ward B, N was a new patient and on '72 hour assessment'. This remains a Trust internal matter, however it raises the question of how allocation to absent staff will be prevented in future and consideration needs to be given to assurance from quality checking systems.

b) Patients Leaving and Entering a Ward, whilst detained under the Mental Health Act 1983.

Trust D advised that it would have been normal practice for a returning patient to be signed back in to the Ward, and recognised this system failure, as N was not signed back in to Ward B. It would appear N was also not searched on their return, on the 27th March 2018. The Trust investigation established this was because the receiving nurse was about to leave with another patient to go to A&E in an ambulance, and the ward had a very busy environment. However patient safety was compromised.

Regarding N's property, the Trust investigation could not establish how N's property was given back, when leaving Ward A. On admission to Ward B, the receiving staff member talked to N and believed N felt safe enough to keep the property. The staff member wanted to work on a 'trust' basis with N and the Coroner's Hearing was advised that the staff member would conclude the same again in the same circumstances. Trust D's Search Policy states that when patients return from leave they are advised to '*declare and hand in any prohibited item or item of concern'*. However, handing an item in or declaring ownership of an item, totally relies on a person's motivation to do so, if the person wants to keep or conceal the item, and so the policy is flawed, if it is not supported by a 'search and remove' methodology.

c) Observations

Trust D have acknowledged that observation and its management lacked robustness, and it is not clear why, when N was detained under section 5(2) of the Mental Health Act on Ward A and declaring suicidal thoughts, that observations were later changed from Level 2 to 'general observations'.

The Trust have acknowledged that observations on Ward B, were not completed between 11am-12pm on 27 March 2018, despite allocation, and that policy was not followed, which is to be addressed via the Trust's Human Resource Procedures, and the issue warrants concern with regard to systems assurance.

It is not clear why a Wad B record exists that states N was seen on the corridor on the 27th at 10.46am when an Urgent Care Centre record, states that N was booked in at 10.41am or why observations were not conducted between 11am-12pm. N was found to be unresponsive at approximately 12. 05pm. The Trust investigation was concerned about both issues which are being addressed by their Disciplinary Procedure.

d) Transfers

When N was transferred from Ward A to Ward B, it happened at the weekend, apparently owing to more staff being on duty, yet N was transferred alone by ambulance with two paramedics, which could have increased N's level of risk. It is not clear from Trust D's investigations why this happened.

e) Handovers

Trust D have acknowledged that there was no written record of a handover or a telephone handover between staff from Ward A to Ward B on March 25th and that this meant that Ward B was not fully aware of N's level of risk. The SAR is assured that this has been dealt with by instigating a new handover policy, covering internal and external handovers. However, despite the value of policy it is only useful if it is deployed at the front line and professional curiosity regarding a patient, subject to an internal ward transfer, is of great importance and value.

f) Care Programme Approach (CPA)

The Review has received no information that would advise that N was considered as part of The Care Programme Approach. It is accepted that as a new patient to Ward B, CPA consideration may have been premature, but it is worth noting that the 2008 Practice Guidance: *Refocusing the Care Programme Approach*, sets out key groups of people whose needs should be fully explored, examined, understood and addressed when deciding if support under revised CPA arrangements is required. The Guidance states: '*the default position for individuals from these groups would normally be under (new) CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records'.* [1] The groups referred to include a dual diagnosis with substance misuse; a history of self-harm and people with unsettled accommodation. In this case N's mental health profile fitted these criteria. If N had been assessed for CPA, a framework would have existed for a range of multi-agency beneficial circumstances, to be considered in relation to risk and care and support management, however as stated this may have been premature.

6.11 Recording

6.11.1 Trust D and Police

There are numerous examples of recording issues and, where records, were not placed on appropriate systems, which has been acknowledged by the Trust and a police report states that on the 27th March, N returned to the unit and was last seen at approximately 11.00 am, which differs from a verbal Trust report saying N was last seen at 11.35 am, which was not recorded. Accurate recording is vital to good quality mental health care, as is accurate sharing of information with partners.

6.12 Working Together

6.12.1 Trust D

There were delays caused in the final production of the SAR because the Independent Reviewer had to apply to HM Coroner's Office for access to information, given that there were discrepancies and differences in information shared from the Trust, compared to evidence given at Court, and The Trust seemed unable to share further information. There is a lawful duty under s45 of the Care Act 2014 to comply with a SAR with regard to accurate and timely information sharing, and to demonstrate the duty to co-operate. This issue caused significant delay to reaching a final draft, and moreover caused the family further stress in waiting for the report to be completed.

6.12.2 GP, Trust D, Trust E and Adult Social Care

No medical history was shared with IAPT regarding N when the GP made the second referral, which does not enable good multi-agency working and information sharing regarding high risk cases. In relation to Trust D, N's room on Ward B, had been tidied up before Police arrived and it may have benefited police and the Coroner to have preserved the site of the incident. It is not clear why it took Ward B staff 4 hours to contact the police, post incident.

Adult Social Care commenced a s42 Adult Safeguarding Enquiry into events at Trust D on 28th March and were aware that the Trust held an internal enquiry. They recognise that the Safeguarding Team should have retained oversight and Trust E did not inform the Adult Social Care Safeguarding Team that N had passed away. Mutual liaison is of extreme importance when managing safeguarding and sensitive information. The Safeguarding Team have stated they had minimal involvement, and the

[1] Refocusing the Care Programme Approach Practice Guidance, Department of Health, 2008

Review was advised by the Team, that there are weaknesses in the multi-agency safeguarding process, where a Root Cause Analysis forms, replaces or contributes to a s42 safeguarding enquiry.

6.12.3 GP and IAPT

IAPT have pointed out that as a primary mental health service provider, they treat the symptoms of mild to moderate anxiety and depression by talking therapies, such as CBT and counselling. When they receive a referral from a GP, they expect an initial 'step 1 assessment' to have been completed, along with interventions or tests that may have been necessary. IAPT state they do not have control over this and are not necessarily privy to the information, which can cause delay to patients when the information then has to be requested.

6.12.4 Trust D and the Police

Trust D staff and police, cannot be clear what N used as a ligature, and following the Coroner's Inquest, it remains unclear. It has also been reported that some evidence was lost. This has not helped N's Mother, in her search for the facts surrounding N's attempted suicide and subsequent death, whilst in the care of Trust D.

Police were not made aware of N's attempted suicide on the 27th by Ward B until 16:32hrs, which is over 4 hours after it had taken place. On police arrival, staff who had dealt with the incident had gone home. The scene had not been secured, nor had any possible evidence, impacting on evidence contamination. The delay in reporting to police; the impact on evidence and witness's having left the scene, had potentially serious consequences for the ability of police to fully and accurately investigate the incident.

This report cannot emphasise enough the extreme importance of: the preservation of evidence; competent responses to potential crime scene management (including the management of potential witnesses); accurate recording and staff debriefing, in the circumstances outlined herein and in relation to any future incidents. However, Trust D have advised that a protocol to secure the scene would not apply in the circumstances described, which warrants review.

6.12.5 All Services

There were many missed opportunities for all services to have made either a request to Adult Social Care for a Care and Support Needs Assessment, and or, to make a Safeguarding Adult Referral, particularly after N declared homelessness; was suicidal; had mental health problems; was unable to sustain a home; was unable to attend college; was isolated at times and was using drugs and alcohol. N was thus at risk of abuse, exploitation and self-neglect.

6.13 Follow up

6.13.1 Trust D Home Treatment Team (HTT)

It is not evident to the Review, that any support was provided to N between November 2017 (when N was discharged from the HTT) and March 2018, when N was admitted to Ward A. N would have benefitted from follow up, however, Trust D advised the Review that National Guidance sets the policy of the HTT, and patient follow up is not part of discharge protocol.

6.13.2 Urgent Care Team

The Urgent Care Team Team have already acknowledged that following N's X-ray, the team did not contact Ward B to advise N had left without waiting for the results. However, N was accompanied by a member of staff from Ward B and the team had assumed that the staff member would have made others aware. On the 27th N failed to wait a second time, and this time was unaccompanied, and this was also not shared with Ward B . The Review is assured that Policy about attendance of on-site mental health patients has been reviewed.

6.14 Family Support

6.14.1 Children's Social Care

Children's Social Care have advised that family support could have been improved, and it is unclear why N was not considered individually, as part of their original assessment process. Children's Social Care have advised that it would be reasonable to assume that as N was living in a household where

there was serious and enduring mental illness, this would have had a significant impact on N, despite the diligent responses of N's Mother, who was noted as a caring, responsive parent. The team stated that a lack of family support was also impacted on, by:

- historical information regarding N's family being part of a 2015 system change to a new electronic system, where some data was lost in the process and paper/handwritten files had to be uploaded. Handwritten records were not searchable, and frequently not legible and new staff may not have known how to access historical data
- assessments being focused on N's sibling, and consideration not given to the impact of one child's mental ill health, on other family members including N
- a family history of trauma which impacted on the children and N's Mother
- limited information and consideration of the support network around the family where N's Mother was the sole carer for then, 7 children, and that additional support, and a break may well have helped the family. (N's Mother however, believes that Children's Social Care could not have done anything more to help her, given very difficult circumstances she was facing.

6.14.2 Trust D

Following N's passing, an offer of support was offered to N's Mother but it was not clear if this was followed up or if it involved support to N's siblings. The Independent Reviewer has followed this up with Trust D and N's Mother, and support has now been put into place and N's Mother will consider next steps accordingly, in relation to support for N's siblings.

6.15 Access to Health Services

6.15.1 Trust A

Trust A has advised that there is daily attendance from patients presenting with low mood, suicidal ideation and overdose; that a triage system is in place along with medical examination and a referral system for Psychiatric Liaison or Children's and Adolescent Mental Health Services. However, Psychiatric Liaison do not provide a twenty-four-hour service and patients who attend in the early hours of the morning have to wait till 9am for assessment (albeit an out of hours' service is deployed by the Crisis Team). The Review has noted that this can impact on patients who arrive, who may have urgent mental health issues.

7. GOOD PRACTICE

N was appropriately triaged by Trust A, and a history was taken. A medical assessment took place and various investigations and tests were undertaken and appropriate referral was made to the Psychiatric Liaison Team. Medical interventions were timely. At Trust B, staff were aware of N's risk of self-harm and a plan for care was made, which considered N's safety, physical health and accommodation issues. At Trust C an appropriate mental health referral was made from A&E, which resulted in an admission. N's GP made appropriate referrals, carried out appropriate assessments and N was listened to and their wishes respected and taken into account. At Trust D, The Home Treatment Team wrote to N's GP to a) provide an update on N's care plan b) request an Encounter Report c) request for repeat prescription information, to ensure consistent and safe treatment d) request that medication was not prescribed without consultation with the Team's Consultant Psychiatrist. At IAPT, N was risk assessed and staff sought supervision, after the telephone assessment on 26th September 2017. IAPT informed N's GP about their concerns of risk and safety and crisis information was shared with N during assessments. Follow up from IAPT was systematic.

At Trust D, N's wishes for care and treatment were documented on Ward A, and belongings that posed a risk were removed. Subsequently, a root cause analysis has taken place and an Action Plan is in place. At the Urgent Care Centre, appropriate action was taken in regard to N's hand injury and good records were kept. Police, units were appropriately dispatched to the scene of the incident and a full initial investigation was completed as far as it could be. A Police Inspector, Sergeant and CID attended, and actions were logged on a crime report. In accordance with safeguarding procedure, a Merlin report was created with relevant details, and sent to the MASH. Trust E,raised a safeguarding adults concern

with the local authority and a meeting was held with N's Mother, sister, and partner, post incident. There was also appropriate involvement of the Chaplaincy Service.

RECOMMENDATIONS

The following recommendations have already been made:

Trust A advise that they should record actions relating to professional curiosity appropriately, and review their interview questions if a person has taken an intentional overdose, or they present with suicidal ideation. They also advise that patient notes are audited to review the recording of professional curiosity**.**

Trust C have recommended that there will be more focus on adults at risk due to their mental health issues and deteriorating mental health, and that adult safeguarding training will reflect this need.

Trust D have conducted a Root Cause analysis and made recommendations about updating care planning; transfer policy; internal handovers; recording and updates of risk assessments; supervision; patients attending on site services; staff rostering and their observation and search policies. An action plan will be monitored and a regular number of cases will be audited.

Children's Social Care recommended that: staff will be familiarised with how to access historical records to inform assessments; that senior managerial expectations will be established regarding assessments of all children in a family/household when a referral is related to a particular sibling who has particular needs (with regard to the impact on others and the impact of inter-relational issues); that guidance on family network meetings will be re-shared to ensure families have additional support, outside of professional help; that the Signs of Safety practice model will be embedded, and that additional vigilance would be offered to help N's Mother and the youngest sibling.

Urgent Care Centre recommended that communication between healthcare professionals will be made to ensure patient follow up, particularly if a patient does not wait for results of a clinical assessment, and that signposting to appropriate help/support will be made, where necessary. They have also advised that policy regarding mental health in-patients attending the Centre should state that they are accompanied, which will be audited and outcomes shared with the on-site mental health service providers, and with the Trust D's Provider Group Meeting.

This Safeguarding Adult Review recommends the following:

Recommendation 1
a) BSAB should commission training for multi-agency partners on lessons learned from this review and b)training should be carried out by the relevant agencies (in accordance to appropriate professional knowledge levels in staff teams) on suicide prevention, which takes into account contextual safeguarding issues (e.g. the impact of illicit drug and alcohol use; mental ill health; potential and actual homelessness; equality issues; same sex relationships, ethnicity and possible cultural expectations).

Recommendation 2
BSAB receive from Trust D, assurance and evidence that a)a review of risk assessment policy and procedure has been carried out b) they have completed delivery of the Serious Incident Action Plan demonstrating how learning has been deployed and what systems have been reviewed c) ward systems reflect the inclusion of CPA decision making, where appropriate d) CPA decision makers are trained on its implementation e) when a suicide occurs, that a system is in place which ensures families are contacted about potential support and are provided with appropriate signposting within primary care services f) the search policy for mental health service units is amended to include i)the removal of items which pose risk to mental health patients ii) formal and systematically assessed risk which is recorded, where any return or ownership of property exists iii) that the policy does not rely on a patient's motivation to 'hand

in' contraband items g) a policy exists that recommends time frames for staff to contact police post an attempted or actual suicide, and or following, or during either any suspected criminal or where a an attempted alleged suicide has taken place h) joint work is conducted with police colleagues to establish good practice in view of the management of actual or potential crime scenes and shared expectations if a patient on site, and is involved in non-fatal or fatal self-harm i) clear escalation processes are put into place for raising critical or serious incidents j) support mechanisms are in place for mental health patients in relation to actual or potential homelessness j) quality assurance systems and processes exist that demonstrate an improvement journey for inpatient mental health care and suicidal patients and changes and recommendations are fed into a revision of The Suicide Prevention Strategy, as soon as is reasonably possible k) that all policies appertaining to patient care and harm reduction, over emphasize the importance of accurate reporting and recording l) that recorded facts are triangulated, where possible, by quality assurance systems m) that The Trust's Harm Reduction Policy is reviewed to consider all aspects of this case in relation to potential and creative ligature risk n) that staff debriefing after such an incident as described herein, take place and are accurately recorded and that this forms part of policy in relation to harm reduction.

Recommendation 3

BSAB develop a) Complex Case Guidance for staff when they are working with people who experience both illicit drug use and or alcohol abuse, mental health issues, potential self-neglect and homelessness and b)a Board Working Group to focus on the ongoing development, production and on-going review of all safeguarding adult policies, procedures and guidance for multi-agency staff c) a multi-agency risk assessment framework.

Recommendation 4

BSAB seek assurance that the Children's Social Care, Urgent Care Centre and Trust's A, C and D, complete their action plans; that learning is deployed and systems have been reviewed.

Recommendation 5

BSAB seeks assurance from all relevant agencies in this review, that agencies are confident that statutory duties are being deployed and met under the Care Act, in relation to a) making appropriate safeguarding referrals b) offering assessment of Carer's needs c) referring service users to Adult Social Care for Care and Support Needs Assessments d) the consideration of supported accommodation, in cases where service users experience mental ill health and potential homelessness and e) that all parties involved in a SAR have a legal obligation under s45 of the Care Act 2014, to supply information on request from a Safeguarding Adults Board, if that party is likely to have information relevant to the Board's functions, and therefore such a request places that person under a duty to disclose. In this case it could be argued that that duty was not met, and this is a matter going forward for both the Trust, its commissioners, CQC and the BSAB.

Recommendation 6

In relation to the local Suicide Prevention Strategy, BSAB partners are asked to demonstrate their activity. This is to be part of an annual Board quality assurance audit and supported by a standing board agenda item which ensures that member's feedback is regularly shared regarding the strengthening of strategic and operational collaboration for suicide prevention, and that this is aligned and collaborates with The Crisis Care Mental Health Concordat requirements.

Recommendation 7

BSAB seek assurance from the CCG and Public Health that a) with regard to the embedding of risk management processes and systems in commissioned mental health services and primary care services, that the recommendations from HQIP[2]'s research outcomes on *The Assessment*

[2] The Health Quality Improvement Programme Research Paper: The Assessment of Clinical Risk in Mental Health Services – National Confidential Inquiry into Suicide and Safety in Mental Health 2018

of Clinical Risk in Mental Health Services: National Confidential Inquiry into Suicide and Safety in Mental Health, 2018' are fully adopted where appropriate and b) Public Health keep the BSAB advised regarding the outcomes of their current work focusing on a range of activities in reaching and working with hard to engage service users and regularly update BSAB on associated local and national intelligence.

Recommendation 8
BSAB inform CQC of issues appertaining to this Review, where regulated services have been involved.

Recommendation 9
BSAB seek assurance and evidence from Housing Services that a) when people with mental ill health are assessed for housing that all legal and regulatory requirements are applied to that assessment and that the assessment and registration process considers if the person has a mental health issue b) that the need for 9(a) is raised at national level in the Housing arena in relation to current template forms and guidance c) that officers are trained in mental health awareness d) that when a young person presents as homeless with care and support needs, that statutory duties under the Care Act and or Children Act, are applied by joint working with either Adult or Children's Social Care, via making relevant referrals and seeking relevant and supportive advice and d) that as a consequence of 9(c) supported housing maybe considered.

Recommendation 10
BSAB seeks assurance from the CCG that a) providers are enabled to maximise intervention outcomes by receiving appropriate information from GP referral processes b) demonstrates how GPs are encouraged to consider the wider impact on families where mental health problems and young carer's exist and clearly sets out the expectations for relevant actions.

Appendices

Appendix 1 - Documents, Websites and Bibliography

Bexley System Wide Prevention Strategy; The National Suicide Prevention Strategy; Suicide Prevention Strategy Trust D; BSAB Safeguarding Adult Policy and Procedures; Borough Locality Team Overview – Primary Care Plus Pathway, October 2016, Trust D; The Care Act 2014; The Mental Health Concordat 2019; The Mental Health Act 1983; Mental Health and New Models of Care : Lessons from the Vanguards, May 2017, Kings Fund; Quality Improvement in Mental Health, July 2017, Kings Fund; The Mental Health Strategy for England, 2011 ; The National Suicide Prevention Strategy, updated 2017 and 4th Report 2019; The Cross Government Suicide Prevention Work Plan, January 2019; Health Select Committee Report, 2017 - Inquiry into Suicide Prevention; Self-harm and Suicide Prevention Competency Frameworks, Health Education England, October 2018; Health Quality Improvement Programme Research Paper- A Confidential Enquiry into Suicide Prevention 2018

Websites Viewed or Cited:
Mental Health Charity; Trust D; The Local Authority; NHS Health Education England; Health Quality Improvement Programme; SCIE; Department of Health and Social Care; CQC Trust D Inspection Reports 2016 and 2017

2. About The Author

Deborah Stuart-Angus - BSc(Hons), CQSW, Cert.Ed., Dip.App. SS
A senior executive, background in social care and mental health, having lead strategic safeguarding, learning and organisational development across the public sector, health, charities, and a local authority trading company. Produced National Domestic and Sexual Violence Service Standards for the The Home Office, and (former) Office of Deputy Prime Minister. Lead Safeguarding Consultant to Local Government Association; Social Care Institute of Excellence and member of National

Safeguarding Adult Chair's Executive. Managed high levels of acute county and city risk. Designed systems, practice and performance improvement strategies; led high profile local and national investigations, involving children and adults. Held executive directorships at Laser Learning; Assess ForCare and NED at Social Care Association. Previous Public Trustee, Judge at the National Training Awards; Department of Health Quality Assessor and former member of their Performance Action Team. Published author on preventing abuse and delivering care principles in practice; an adept trainer and a public speaker. Awarded specialist commissions, including training the Metropolitan Police Murder Squad; and conducting various safeguarding business reviews for care and health partnerships; supported housing, and safeguarding adult boards.

SAR and Chair Experience

Overseen 40 Safeguarding Adult Reviews, focusing on self-neglect; mental health, suicide, hospital and residential care, domestic violence and drug and alcohol abuse. In 2015, appointed as Independent Chair for Kent and Medway Safeguarding Adults Board. In 2018, appointed as Independent Chair for Surrey Safeguarding Adult's Board Review, concerning elderly residential care and mental health. Later that year appointed as Hertfordshire's Independent Reviewer for a Partnership Case Review, where two young people receiving mental health support, took their own lives. In 2019 appointed as Independent Chair and Reviewer for Bexley Adult Safeguarding Board's Safeguarding Adult Review in relation to a young person, subject to a section of the 1983 Mental Health Act, who took their own life. Later that year conducted SCIE's Safeguarding Adult Review into a Supported Housing Association. Later appointed as Independent Chair of the Essex Care and Health Partnership Safeguarding Adults Board. In 2020 appointed as Independent Chair of Southampton Safeguarding Adults Board, and later that year, appointed as as Stockport's (Greater Manchester's) Independent Chair and Reviewer of their Safeguarding Adult Review, involving an adult who took their own life.