



# ROCHDALE BOROUGH SAFEGUARDING ADULTS BOARD

## SAFEGUARDING ADULT REVIEW CONCERNING

'Lian'

OVERVIEW REPORT

May 2020

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### Appendix A            Care Act 2014 Criteria for Safeguarding Adult Reviews

<b>Version Control Table</b>			
Version	Date	Author	Reason
0.1	20191021	PJC	Initial draft for panel meeting 20191119
0.2	20191126	PJC	Feedback from meeting 20191119
0.3	20191213	PJC	Feedback from meeting 20191211
0.4	20200128	MK	Final amendments following RBSAB meeting 20200123

0.5	20200513	DH	Additions following contact with family
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## 1. INTRODUCTION

1.1 The main people referred to in this report are:

Lian<sup>1</sup> Subject of the SAR

Mother of Lian

Sister of Lian

Brother of Lian

1.2 This review is about Lian. At the time of her death she was living in supported accommodation. Children's Services were involved with her and she transitioned to Adult Care. The panel heard that Lian suffered adverse childhood experiences and had been the victim of sexual exploitation. She had a chaotic history that included behaviour which put her at risk of serious harm. This included self-harm, overdoses of various substances [including proprietary, prescribed and illicit drugs], attempts to commit suicide and excessive consumption of alcohol.

1.3 In her 20's Lian was detained in hospital under the provisions of S3 of the Mental Health Act 1983<sup>2</sup>. Over the next 12 months she moved, first as an inpatient to a local Psychiatric Intensive Care Unit and then to a specialist residential placement in another local authority.

1.4 Lian made the decision to leave the placement in another local authority and returned to the family home. Because of issues at home, Lian was asked to leave and moved to temporary supported accommodation. There is frequent reference in her history to her having a diagnosis of Emotionally Unstable Personality Disorder. A cognitive assessment of her eighteen months before her death concluded she had a learning disability although only on the cusp<sup>3</sup>.

1.5 As Lian did not meet the threshold for a learning disability and did not meet the criteria under the Mental Health Act for statutory intervention, her case was considered by the local authority Adult Care Forum. It was determined

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<sup>1</sup> This is a pseudonym chosen to protect her identity.

<sup>2</sup> The Act makes provision for a patient to be admitted to a hospital and detained there for a specified period for treatment. The grounds for this detention is that the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and it is necessary for the health or safety of the patient or for the protection of other persons that they receive treatment and it cannot be provided unless they are detained under this section. An application for admission for treatment must be made in a written recommendations by two registered medical practitioners.

<sup>3</sup> This assessment identified that Lian scored 71; the threshold for learning disability is 70.

that Lian's care should be transferred from Adult Care Complex Needs Service and Community Learning Disabilities [henceforth referred to as CLD] to the Community Mental Health Team provided by the local NHS Foundation Trust [henceforth referred to as CMHT]. Lian also continued to maintain contact with a social worker from the council's Adult Care and Support [henceforth referred to as ACS]. Professionals from both agencies continued to have contact with Lian and she was last seen by a member of CMHT one week before her death.

- 1.6 In late 2018, North West Ambulance Service received a call to attend an address [henceforth referred to as Address 3]. Lian was found deceased in a chair and pronounced dead. Greater Manchester Police [GMP] investigated the death.
- 1.7 The police investigation did not disclose any evidence of crime and Her Majesty's Coroner was informed of Lian's death and authorised a post mortem which established the cause of death as:
  - 1a) Combined drugs toxicity [pregabalin<sup>4</sup>, methadone; cocaine and heroin].At the time of writing, an inquest into the death of Lian has not yet taken place.
- 1.8 This report sets out the findings of a discretionary Safeguarding Adult Review [SAR] that was undertaken following the death of Lian. The time frame of the review was limited as it was recognised that that services have changed significantly, as a result of lessons learned, since Lian's childhood experiences. The review identified some learning points for the future care of vulnerable adults such as Lian and makes a number of recommendations for partner agencies of the local Safeguarding Adults Board.

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<sup>4</sup> Pregabalin is a medication used to treat epilepsy, neuropathic pain, fibromyalgia, restless leg syndrome, and generalized anxiety disorder. It is a Class C controlled substance. Methadone, cocaine and heroin are all class A drugs within the meaning of the Misuse of Drugs Act 1972. The police established that Lian had been prescribed this drug.

## **2. ESTABLISHING THE ADULT SAFEGUARDING REVIEW**

### **2.1 Decision Making**

- 2.1.1 The Care Act 2014<sup>5</sup> gave new responsibilities to local authorities and Safeguarding Adult Boards [SAB]. Section 44 of that Act<sup>6</sup> requires SAB's to arrange for a review of a case when certain criteria are met. These criteria appear in Appendix A.
- 2.1.2 ACS were made aware on 16 October 2018 of the death of Lian by another service user who informed a member of staff of comments made on social media. Contact was made by ACS with GMP who confirmed that Lian had died and that HM Coroner had been informed. At a pre-inquest hearing HM Coroner was concerned about Lian's high level of vulnerability and apparent lack of support and that a referral had not been made to SAB for a screening review of the case.
- 2.1.3 As a result of these concerns the local SAB [Safeguarding Adults Review Screening Panel] met in early 2019. They reviewed information supplied by the agencies that cared for, and supported Lian and concluded that the grounds for a statutory SAR had not been met. Nonetheless they recognised there may be some learning for the future and instead recommended to the chair of SAB that a discretionary Safeguarding Adult Review [SAR] should be undertaken in respect of Lian. The Chair of SAB agreed and arrangements were made to appoint an independent chair.

### **2.2 Safeguarding Adult Review Panel**

- 2.2.1 David Hunter was appointed as the Independent Chair. He is an independent practitioner who has chaired and written previous adult and child serious case reviews, domestic homicide reviews and multi-agency public protection arrangement reviews. He has never been employed by any of the agencies involved with this SAR and was judged to have the necessary experience and skills. He was supported in the task by Paul Cheeseman who wrote this report. He is also an independent practitioner and brings the same experience.
- 2.2.2 Panel members' non-availability meant that the first of three SAR panel meetings were held in October 2019. The panel was supplied with a chronology of contacts and identified some key lines of enquiry. Following the first meeting a draft overview report was presented and discussed by panel members at the second meeting. Here panel members identified some

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<sup>5</sup> Enacted 1st April 2015

<sup>6</sup> The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

key learning and recommendations. These were refined and developed and a final draft of the report was presented to the SAB in January 2020.

- 2.2.3 Attendance at the meetings was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings significant additional work was undertaken via e-mail and telephone. The chair and author extend their thanks to all contributors for their quick turnaround on queries.

## **2.3 Panel Membership**

- 2.2.3 The panel comprised of representatives from agencies involved in the care of Lian.

## **2.4 Agencies Submitting Information to the Review**

- 2.4.1 Agencies provided chronologies and other written material to the review panel. Agencies included the local Advocacy Service, hospitals, CCG, substance misuse services, MH services, police, support living provider, ambulance service and services within the local authority.
- 2.4.2 The review panel are grateful to the following who agreed to meet with the SAR chair and Author and discuss their involvement in the case.
- The social worker primarily responsible for the care of Lian [henceforth known as SW1]
  - The former team manager for SW1 [henceforth known as TM1]

## **2.5 Notifications and Involvement of Families**

- 2.5.1 The Chair of the SAR wrote to Lian's mother informing her of the SAR in respect of her daughter and invited her to meet with him and contribute to the review. That letter was helpfully delivered by a health professional. Lian's mother did not contact the review but wanted a number of points passing on. These appear at paragraph 2.10.

## **2.6 Purpose of a Safeguarding Adult Review**

- 2.6.1 Section 44 (5) of the Care Act 2014 specifies:
- Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to—
- (a) Identifying the lessons to be learnt from the adult's case, and
- (b) Applying those lessons to future cases.
- 2.6.2 RBSAB added the following<sup>7</sup>:

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<sup>7</sup> Safeguarding Adult Reviews: <https://www.rbsab.org/professionals/safeguarding-adult-reviews/>

'The purpose of an SAR is to 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. It is a review of multi-agency working not an investigation of an individual's actions and its purpose is to identify learning, 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 Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.

It is important that the Adult and/or their family are engaged throughout the process, and that their voices are paramount'.

2.6.3 The SAR was undertaken from that perspective.

## **2.7 Key Lines of Enquiry**

2.7.1 An analysis of the screening papers by the SAR panel identified the following Key Lines of Enquiry. The analysis of these lines will be addressed in Section 5 of the report.

- Assurance around current practice for Children who disclose sexual abuse;
- A reflection on the last 18 months using guidance from the Care Act.

## **2.8 Period under Review**

2.8.1 January 2017 to October 2018

## **2.9 Other Processes**

2.9.1 GMP attended at Address 3 following the discovery of Lian. Police officers completed an investigation and submitted a report to HM Coroner. The police investigation did not disclose any evidence of crime.

2.9.2 HM Coroner has opened and adjourned an inquest into the death of Adult Female 1 until such time as this SAR is completed. The SAR panel are not aware of any other reviews that are taking place in respect of Lian.

## **2.10 Family's Concerns**

2.10.1 The following points came to the review from Lian's mother via a health professional.

- Mum felt judged by services thinking she had negative intentions towards her children when all she wanted was what was best for them.
- Mum felt she was not involved or contributed to any of Lian's care or treatment plan.

- Mum felt she and the family were not supported or offered mental health support for themselves.
  - Mum feels her son is experiencing depressive thoughts because of this.
  - Mum feels the local authority took Lian away from her.
  - Mum does not trust the local authority and was sceptical that the review was being undertaken by the local authority.
- 2.10.2 In March 2020 the review chair met with Lian's sister. Also present was a representative from the Safeguarding Adult's Board and a representative from the local NHS Foundation Trust to support Lian's sister.
- 2.10.3 The purpose of the meeting was to share the findings of the review with Lian's sister. The chair offered condolences and disclosed all the findings of the review. A copy of the report will be provided to sister once the Safeguarding Adult Board has had further liaison with HM Coroner. The chair explained that 'Lian' was a pseudonym which the sister acknowledged was appropriate.
- 2.10.4 Lian's sister wanted to know what time Lian died and the chair provided the detail of Lian's last 24 hours including the time of death. The sister felt the accommodation Lian was living in after she left their mother's house in 2018 was unsuitable in that it was, small, cramped and added to her isolation given its location within the overall property. The sister added that Lian asked for her medication to be altered because it appear not to be working. The sister believed that request was not listened to.
- 2.10.5 The Safeguarding Adult Board made contact with Lian's brother. The review's chair had a brief exchange of e-mails with the brother which included sending him a copy of the case presentation the chair made to the Safeguarding Adult Board. The brother did not respond to further e-mails from the chair and therefore at the time of writing [13 May 2020] it is not believed that the family has seen a copy of the report into Lian's death.
- 2.10.6 It is believed that the review report is likely to form part of HM Coroner's inquest bundle and therefore the family will receive a copy through that route. However, if at any time before the inquest the family would like see the report and be briefed, Rochdale Safeguarding Adult Board will arrange it.



### **3. BACKGROUND**

#### **Events Pre-Dating the Review Period**

- 3.2 Lian was raised and educated in the Rochdale area and was known to agencies from childhood due to known adverse childhood experiences. She had a history of encephalitis at age six months. Concerns about her mental well-being were first recorded when she was about 8 years of age. She was referred to a Clinical Psychologist after displaying aggressive behaviour and attachment difficulties.
- 3.3 Children's Social Care [CSC] records show that Lian had a history of low-level self-harm. She was felt to have significant learning needs. It was difficult to ask her questions or to understand her responses which were largely confused and mixed up. She was felt to be a vulnerable young person who required intervention. CSC records show intermittent involvement over a period of five years.
- 3.4 From aged 11 years of age onwards Lian had extensive contact with the Healthy Young Minds Service [HYMS] [then known as Child and Adolescent Mental Health Service [CAMHS]]. It was at this age, that the first reference appeared about Lian taking an overdose which she took as a response to bullying.
- 3.5 Lian, in her early teens, reported that she was sexually assaulted by a stranger and later made an allegation that she had been historically sexually abused. Following investigations no further action was taken regarding the allegations made.
- 3.6 Throughout her adolescent years Lian continued to self-harm, take overdoses and make references to feeling suicidal or intending to take her own life. There are also references to Lian suffering from auditory hallucinations. There are extensive records that Lian engaged with a range of health agencies who responded to both the immediate concerns relating to overdoses and self-harm, and also Lian's longer-term mental health issues. These included, amongst others, her GP, Healthy Young Minds and the Learning Disabilities Team. Interventions included Cognitive Behavioural Therapy [CBT] and she was also prescribed medication.
- 3.7 During adolescence Lian's mood, and consequently her contact with services, appeared to fluctuate from time to time with reported improvements then being followed by a rapid deterioration. A counsellor who engaged with Lian in her teens was concerned she was a vulnerable young person.
- 3.8 A detailed description of each of the episodes of crisis is beyond the scope of this background. However, by way of illustration, during one year, Lian made over 40 presentations to the local Accident and Emergency

Department. 12 of these related to overdoses, two related to self-harm and four related to suicidal thoughts. Other attendances related to medical concerns such as abdominal pain.

- 3.9 On each of the occasions Lian attended with overdoses or suicidal ideation she was seen by a member of the Mental Health Liaison Service discharge team [MHLS] for assessment and treatment. Their records provide some insight into the cause of Lian's behaviour. There appears to be a consistent pattern of her hitting crisis point causing her to self-harm, overdose or threaten to jump off buildings or bridges in order to end her life.
- 3.10 The conclusion of the assessments by MHLS was that Lian did not intend to take her own life. A Consultant Psychiatrist concluded that Lian did not have a mental disorder and instead that she had developed 'maladaptive coping strategies due to having experienced abuse'.
- 3.11 In her early 20's, Lian attended hospital with suicidal feelings. She was admitted to a hospital ward during which she deliberately self-harmed with boiling water.

## **4. SIGNIFICANT EVENTS DURING THE REVIEW PERIOD**

### **4.1 Detention under S3 Mental Health Act**

- 4.1.1 Lian's admission to hospital in late 2016 allowed clinicians to assess whether she was suitable for a placement at a specialist residential therapy service in another area. While in hospital in early 2017 Lian's admission was made compulsory under the S3 of the Mental Health Act [see footnote 2].
- 4.1.2 During her detention in hospital, Lian's behaviour was disruptive and she presented risks to herself and others. For example, she took an overdose of Clozapine<sup>8</sup> after taking this medication from a trolley; she assaulted staff kicking a member of staff in the face; she was found smoking cannabis and she deliberately started a fire in her room. The assaults upon staff and the deliberate fire were reported to, and investigated by, GMP.
- 4.1.3 While detained in hospital SW1 engaged with Lian. SW1 had extensive contact with Lian throughout the following eighteen months up until Lian's death. SW1 had a number of discussions with clinicians in an effort to obtain funding for Lian's to a specialist residential service.

### **4.2 Transfer to Psychiatric Intensive Care Unit [PICU] February 2017**

- 4.2.1 The initial plan for Lian was to transfer her to a specialist residential therapy service in another area. This was changed as it was felt that her behaviour was at such a level that she required intensive nursing input. As a consequence, in order to reduce the risk to herself and staff, it was decided to transfer her to a PICU.
- 4.2.2 Lian's stay lasted two months. During this time her behaviour fluctuated and there were a significant number of incidents throughout her stay.
- 4.2.3 Although compulsorily detained, S17 of the Mental Health Act allows for patients to be granted 'leave' for specified periods after which they are required to return to hospital. Lian's behaviour, while still challenging, improved sufficiently for her to be granted a number of short periods of leave under S17 during early 2017. The panel was told that Lian was always accompanied by a member of staff during these short absences of leave.
- 4.2.4 In early 2017, the young people's drug and alcohol service made a referral for Lian to the substance misuse service in another area, where Lian was a patient. While the information was received by the substance misuse service, there was then a delay of about 10 weeks before the referral was actioned [see paragraph 4.3.6].
- 4.2.5 Later the same month Lian made a disclosure as she suspected there was an attempt to force her into marriage. Staff at the PICU submitted a

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<sup>8</sup> Clozapine is an atypical antipsychotic medication. It is mainly used for schizophrenia.

safeguarding alert to ACS. They responded and drafted a forced marriage protection order<sup>9</sup> pending another review of Lian's mental capacity.

- 4.2.6 Progress was being made towards Lian's transfer to a specialist residential therapy service. Her mental health had improved and her behaviour had settled so that she was considered appropriate for transfer under the terms of a Community Treatment Order [CTO]<sup>10</sup>.

### **4.3 Transfer to specialist residential therapy service April 2017**

- 4.3.1 Within two days of transfer Lian climbed over a fence and was reported as a missing person to the local police. She returned to the hospital of her own accord, intoxicated with superficial self-harm injuries. Several other incidents followed.

- 4.3.2 While in Accident and Emergency Lian underwent an Acute Liaison Psychiatric [ALP] assessment. A risk assessment was conducted and documented as follows;

- Low apparent risk of suicide;
- Significant risk of deliberate self-harm;
- Low apparent risk of accidental self-harm;
- Significant risk of abuse/exploitation by others;
- Low apparent risk of violence /harm to others.

Lian was advised to obtain a copy of 'Hurt Yourself Less' workbook available on the internet and work with staff to identify a plan of action when feeling wants to self-harm.

- 4.3.3 Lian's mother visited her whilst at the specialist residential service. While the visit was described as 'pleasant', after her mother left, Lian showed a member of staff an aircraft boarding pass in her name for a flight. Later the same day Lian absconded from the hospital and was found on a motorway bridge. The police attended, closed the motorway, and returned Lian to the care of the residential service.
- 4.3.4 A couple of days later, Lian attended Accident and Emergency saying she had taken an overdose. Although she was prescribed the drug, it was

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<sup>9</sup> The Forced Marriage (Civil Protection) Act 2007 assists victims of forced marriage, or those threatened with forced marriage, by providing civil remedies. A Forced Marriage Protection Order is unique to each case and contains legally binding conditions and directions that change the behaviour of a person or persons trying to force someone into marriage. The aim of the order is to protect the person who has been, or is being, forced into marriage.

<sup>10</sup> A responsible clinician can arrange for a person who has been detained in hospital under the Mental Health Act to be subject to a CTO. This means they will have supervised treatment when they leave hospital. Conditions can be applied to the CTO which the patient must follow. They are intended to protect the patient from harming themselves or other people. They can include where the patient live or where they will get treatment. A care coordinator helps the patient manage the CTO. Breaking the CTO can result in a return to hospital for up to 72 hours.

unclear how she had obtained a quantity sufficient for an overdose. She left the hospital before seeing a doctor.

- 4.3.5 Police officers visited the residential service after staff disclosed concerns about the boarding card. Lian was reluctant to speak to the police. After they left she smashed an ornament, telling staff she had stored medication in there from when she had been at the PICU and said she had taken them all. While being escorted to the bathroom Lian absconded from staff shouting to them that she 'had a car waiting for her'. She later spoke to staff by telephone and told them she did not want to be there and was going on holiday with her mother. The police were notified and measures put in place to prevent her travelling abroad. Later that day the police found her near to the residential service and she was returned to staff.
- 4.3.6 As a result of the referral made by the young people's drug and alcohol service [see paragraph 4.2.6] in June 2017 Lian was sent an appointment letter to attend an assessment at the substance misuse service. This team provides specialist assessment and interventions for individuals with alcohol and/or drug problems who have additional complex needs. Lian did not attend this appointment and there was no further contact between her and this service.
- 4.3.7 Following these events [when Lian left the residential service] there are seven recorded occasions when she took an overdose.
- 4.3.8 An analysis of each of these would be repetitive, however one of the events is noteworthy as it was by far the most serious in terms of the threat to Lian's life. In July 2017 staff at the residential service carried out a routine check of Lian's room. She was found unresponsive, and staff started cardio-pulmonary resuscitation on her as she had stopped breathing. Lian was taken by ambulance to accident and emergency. She was intubated and treated with anti-biotics in the event her condition might have been encephalitis.
- 4.3.9 A head scan disclosed no abnormalities, her blood results were not abnormal and when she recovered she denied having taken alcohol, drugs or having had suicidal intent. However, during a group therapy session, Lian disclosed that she had visited her mother's house stolen her anti-depressants and taken a large overdose which had resulted in her admission to hospital. A safeguarding referral was submitted by the hospital to ACS.
- 4.3.10 In mid-2017, ACS obtained a Deprivation of Liberty Safeguard [DOLS]<sup>11</sup> in respect of Lian. The frequency of incidents involving Lian reduced following

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<sup>11</sup> The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person them of their liberty, in order to provide a particular care plan. It is the role of Adult Social Care to arrange for assessments to ensure the deprivation of liberty is in the person's best interests.

the application of DOLS although there were still some events which put either her or staff at risk. This included a report to the police force that she had assaulted staff and a few days later she swallowed chlorine cleaning tablets and absconded from hospital while being treated.

- 4.3.11 Lian was missing for 4 days before returning of her own accord to the residential service. She would not tell the police where she had been other than to say she had engaged in sexual activity in return for drugs.
- 4.3.12 In late 2017 several multi-disciplinary team meetings [MDT] were held to review Lian's placement and to discuss what course of action to take when her placement ended in 2018. It was reported at an MDT that Lian was making progress and, while there had still been some incidents, these had reduced in frequency. In an MDT meeting held it was felt that;
- 'Lian is able to understand the risk associated with the behaviours that Lian has expressed previously such as engaging in sexual acts, taking drugs and alcohol'
- 4.3.13 The meeting heard that the residential service recommended Lian should remain with them for a further 6 months. However, the commissioners of the service jointly felt this was outside the agreed 12-month programme and that there was no evidence to support an extension. It was agreed that, while Lian was stable, another cognitive assessment would be conducted. While incidents involving Lian did not stop, there was a marked reduction in the number and frequency from the end of 2017 until April 2018.
- 4.3.14 In April 2018 the residential service made an application to extend the DOLS for Lian. This was considered by ACS. At that time there had been no reported incidents of Lian being restrained or prevented from leaving the property since December 2017. Although the residential service felt her capacity could fluctuate and she had the potential to become aggressive to staff. It was reported that Lian had capacity;
- 'in regards to longer term accommodation and in regards to her care and support'
- The DOLS application was not approved and ceased in April 2018.
- 4.3.15 Lian remained at the residential service while MDT discussions continued as to her future placement and treatment. The reduction in incidents involving Lian continued.
- 4.3.16 A clinician from the residential service conducted a learning disability assessment. At this time Lian was assessed as having capacity. The clinician concluded that the learning disability assessment supported the previous diagnosis of mild learning disability. Her full-scale IQ score of 71 was slightly higher than previously, although this could be accounted for by improved environment, improved mental health and practice effects. The clinician felt Lian would continue to need residential support and may need to be managed in a residential setting under the Deprivation of Liberty Safeguards

[DOLS]. He felt she should remain at the residential service. However, Lian had decided to return to local area.

- 4.3.17 An MDT in May 2018 considered these findings. The learning disability team felt that the score placed Lian on the cusp of learning disability [the boundary for learning disability is 70] and consequently, when she came back to the local area, she should be discharged from their care.
- 4.3.18 The agreement for the placement was for twelve months and no further funding would be approved by the commissioners of the placement. The MDT heard that a new supported living placement had been identified in the local area and that the Community Mental Health Team [CMHT] there had accepted responsibility for the care of Lian who would be allocated to an advanced practitioner [henceforth referred to as AP1].
- 4.3.19 One week after the MDT Lian was involved in a serious incident when she was struck by a car. While Lian initially told hospital staff she had misjudged the speed of the car while crossing the road, she later said it was her intention to end her life. She suffered no fractures although she had severe bruising.
- 4.3.20 The following day Lian was taken to the accident and emergency department having told staff she had injected crack cocaine and had taken 6 tablets of an unknown substance. Blood tests disclosed no abnormality and she was discharged back to the residential placement.
- 4.3.21 During conversations with SW1 on the telephone Lian said that she did not want to move to the placement in the local area as it was too close to a park used by street drinkers and she 'did not want to go back to her old behaviour'.
- 4.3.22 In May 2018 Lian's case was considered by professionals in the local area. It was agreed ACS would not be responsible for her care and instead her case would be the responsibility of the CMHT. This was subject to a proviso that there would be a period of joint working between ACS and CMHT once Lian returned to the local area.
- 4.3.23 The following day, the residential placement contacted ACS with concerns that Lian was distressed and clearly did not want to return to the local area. She had absconded from the residential placement the previous day, stayed out all night and on her return was unable to engage with staff. There was concern that Lian was extremely vulnerable and at significant risk of taking her own life. However, she had capacity, the DOLS restrictions had ended and consequently there was no legal framework to assist in supporting her. SW1 advised that she had cancelled Lian's placement in the supported accommodation and would look for accommodation more suitable for her.
- 4.3.24 In June 2018 Lian's placement at the residential service broke down and ended. She subsequently returned to the family home.

#### **4.4 Lian returns to live in Rochdale June 2018**

- 4.4.1 The day after leaving the residential placement Lian spoke with SW1 and discussed her mental health. She said that she did not feel it had deteriorated. She wanted to move back to the local area and finding somewhere to live was taking too long. Lian said she would live temporarily at the family home until ACS could find her somewhere to live.
- 4.4.2 Because Lian reported using alcohol, unknown tablets and spice a referral was made by the young people's drug and alcohol service to the commissioned provider for drugs and alcohol services. The commissioned provider acknowledge that they received this referral. The referrer informed that they had been working with Lian and now she needed to be transferred to the adult drug and alcohol team. The referrer stated Lian had learning difficulties and went to the park, drank and used drugs with whoever was there. She usually only did this when things were 'going on for her'. She had recently used heroin for the first time via injection and drank, used spice and used cocaine. It was stated that this had been going on for many years but seemed to be escalating. The referral stated that Lian wasn't able to gauge volumes due to her learning difficulties.
- 4.4.3 The following day, police officers attended the home address and conducted a welfare check following a concern for welfare. Later the same day Lian contacted police reporting domestic issues. Police attended and completed a DASH risk assessment and a Public Protection investigation document. This incident was reviewed and it was documented that there were 19 other PPI's linked to incidents at the family home. GMP did not make any referrals to partner agencies as it was documented that Lian did not support this and no consent was obtained.
- 4.4.4 In the following days Lian visited SW1 on two occasions. On the first of these she reported issues at home. She was told the process of finding her accommodation had started although it would take some time to complete. On the second visit Lian said she was now interested in the supported accommodation she had previously declined.
- 4.4.5 Later that month, Lian presented herself to staff at the residential service saying she felt suicidal and wanted to remain in that area. The residential service staff contacted ACS documenting what happened and repeating the concerns Lian had expressed to them. They were advised that Lian was being supported by services, that she would not be returning to the residential service and if she was suicidal then emergency services needed to be called.
- 4.4.6 After visiting the supported accommodation she had been offered, Lian told ACS that she did not want a place there and wanted her own flat in the community. Later that night Lian rang GMP saying she felt suicidal and that she was afraid of going home. Lian told police she was staying at a friend's address and Lian provided the details of the friend and the address.
- 4.4.7 Lian's friend spoke to the police and told them Lian was distressed and had been drinking and was OK to stay there if she wanted to. Lian then recalled



GMP and advised she was walking to the friends address and could be seen there. The police did not visit Lian and the log was delayed until the following morning as she was felt to be in a place of safety and not at risk overnight.

- 4.4.8 The following day Lian was found collapsed, an ambulance was called. Her friend was present and she told the police officers Lian had been with her overnight, had been drinking during the evening and that morning she had witnessed Lian take a large quantity of tablets. Her friend said she had advised Lian she needed to go to hospital and while walking there she collapsed.
- 4.4.9 Found in Lian's bag were several packets of tablets. She was admitted to the intensive care unit of a local hospital. Here a nurse submitted a safeguarding referral which went to ACS. When she was admitted to hospital Lian was seen by the MHLS team. They recorded that she had taken an excessive and intentional overdose of an unknown quantity of her mother's medication. She did not meet the criteria for detention under the Mental Health Act.
- 4.4.10 The same day SW1 liaised with agencies to try and resolve the accommodation issue for Lian. A temporary placement was found in emergency accommodation [address 2]. A plan was recorded on the ACS system.
- 4.4.11 Lian moved to supported accommodation [address 2]. The following day she attended an appointment with SW1 and a member of CMHT staff. She explained that she took an overdose following an argument with her mother, although she had no suicidal intent. She said she found being in accommodation helpful. A full assessment and risk history were obtained and a management plan formulated.
- 4.4.12 In July 2018, Lian's care was formally transferred to the Community Mental Health Team [CMHT]. On the same day she was seen by a consultant psychologist at a local hospital [henceforth known as DR1]. She was accompanied by SW1. DR1 considered her history and she told him that she was hearing 'good and bad' voices. She said she self-harmed and had on-going suicidal thoughts. Lian was provided with contact numbers for CMHT should she feel she needed to speak to a member of staff.
- 4.4.13 Lian attended at the commissioned provider for drugs and alcohol services and spoke to a support worker about accessing the service. She was offered an appointment for assessment. Lian did not attend this appointment.
- 4.4.14 Between that meeting and her death, Lian continued to have regular contact with both SW1 and AP1 as well as other members of staff from CMHT and Adult Care. Some of these were 'face to face' contacts and others were by telephone.
- 4.4.15 Many of the telephone calls and contacts related to routine daily matters such as Lian needing money, a bus pass and a telephone. During this period it appears that Lian was much more stable than at any period before. After

the event when she was found collapsed, there is no record that Lian was treated for a deliberate or accidental overdose.

- 4.4.16 During this period it appears that Lian's mood fluctuated, sometimes daily, and she sometimes gave conflicting comments about her condition. For example she met with a duty social worker from Adult Care and appeared to be fine. The same day she visited CMHT saying that she felt overwhelmed and needed support.
- 4.4.17 At the start of this period Lian made a number of disclosures that she misused alcohol and drugs. She told staff she had been drinking with friends and admitted using cocaine although she denied injecting heroin. Two days later Lian was involved in an incident which was attended by police officers. She was part of a group who were reported to be extremely intoxicated.
- 4.4.18 However, towards the end of this period Lian's use of alcohol and drugs appeared to have reduced and there were no further reports of Lian being involved in street drinking incidents. She told AP1 in September that, while she continued to use cocaine, cannabis and alcohol occasionally with friends, she had not injected heroin for a few weeks. She also told AP1 she had stopped taking her prescribed medication as she felt it did not work and she felt good without it.
- 4.4.19 In September, Lian sent a text message to a member of staff at the residential service stating she was doing well, abstaining from drugs and was keeping herself safe.
- 4.4.20 The same day she met with AP1 and a support worker [henceforth known as SUP1] who had been appointed to work with Lian and to involve her in daily activities, groups, college or voluntary work and future plans. Lian told them that she had some suicidal thoughts at the weekend. She said she was able to rationalize this: her past behaviour would have been to attempt suicide or self-harm yet on this occasion she was able to distance herself and use alternative coping mechanisms. Lian denied any suicidal ideation, her mental health appeared settled, she was happy, smiling and engaging well in planning for activities in the future.
- 4.4.21 The commissioned provider for drugs and alcohol services were not aware of any other agencies being engaged with Lian. Because there had been no further contact between Lian and the commissioned provider, the service sent a letter to Lian requesting that she contact the service within the next 2 weeks if she still wanted to access support. The letter included contact details for the service including telephone number, email address and details of the Wellbeing Cloud that could be used to re-refer herself in the future. The commissioned provider received no response to this letter
- 4.4.22 Lian's last contact with a professional was when she had a planned meeting with AP1 shortly before her death. By this time Lian had secured a tenancy on a flat, although she had not yet moved from address 2. She told AP1 that she was fine and she had been out socialising with friends. She re-assured

AP1 that her mood was positive and she had no thoughts of self-harm. AP1 made another appointment to meet with Lian.

#### **4.5 Circumstances of Lian's death**

- 4.5.1 On the night prior to her death, Lian visited an address in Rochdale [address 3] which was occupied by two individuals who were described as friends. They spent that evening drinking alcohol and using cannabis. They fell asleep awaking the morning after.
- 4.5.2 They visited a shop to buy food returned home and went to sleep again. In the late afternoon, the two individuals left the house to visit the shop. They tried to rouse Lian, however she did not wake properly and was said to be snoring and speaking incoherently. When they returned to address 3 they found her unresponsive in the chair where they left her. They called for an ambulance and attempted CPR. Sadly that was not successful and the ambulance crew pronounced Lian dead.
- 4.5.3 Police officers attended and undertook an investigation. The overnight bag Lian had brought with her contained no evidence of drugs or drug use. One of the individuals was prescribed methadone and the police officers found both bottles prescribed the day before full and unused. One of the individuals was interviewed by police officers and denied supplying or administering drugs to Lian. The Detective Inspector in charge of the investigation, having reviewed all the material available, had no reason to suspect third party involvement or any other suspicious circumstances surrounding Lian's death. GMP made a report to HM Coroner. The cause of her death is described earlier in paragraph 1.7.

## **5. ANALYSIS AGAINST THE KEY LINES OF ENQUIRY**

### **5.1 Introduction**

5.1.1 A SAR should seek to understand the following<sup>12</sup>;

- a) What happened?;
- b) Any errors or problematic practice and/or what could have been done differently;
- c) Why those errors or problematic practice occurred and/or why things weren't done differently;
- d) Which of those explanations are unique to this case and context, and what can be extrapolated for future cases so become findings;
- e) What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases.

5.1.2 Section 4 of this report has already considered point 'a' above ['what happened']. This section of the report seeks to understand points 'b' to 'e' above by analysing the material within the two terms of reference set by the RBSAB screening panel. Commentary is made using the material gathered during the SAR, including the family's views, and the panel's debates.

### **5.2 TERM ONE**

#### **Assurance around current practice for Children who disclose sexual abuse.**

5.2.1 The panel received a letter of reassurance from the Assistant Director of Children's Social Care for Rochdale which sets out how current practice, knowledge and understanding of intra-familial sexual abuse [IFSA] has improved since the events involving Lian occurred. The letter included the revised Intra-Familial Sexual Abuse Strategy [July 2018] and the minutes of the Excellence in Practice Meeting [July 2018] at which the strategy was ratified.

### **5.3 TERM TWO**

#### **A reflection on the last 18 months using guidance from the Care Act.**

5.3.1 The review panel felt it would be helpful to structure their reflections into the following six key questions that are pertinent to the care and treatment of Lian.

### **5.4 Question One**

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<sup>12</sup> Safeguarding Adults Reviews: <https://www.scie.org.uk/safeguarding/adults/reviews/care-act>

**To what extent did Lian have needs for care and support? Did agencies understand, assess and document those needs appropriately and in accordance with the principles in the Care Act and local policies?**

- 5.4.1 Care and Support Statutory Guidance [issued 2018 and henceforth referred to as 'The Guidance']<sup>13</sup> sets out how Local Authorities and other agencies should fulfil their obligations to The Care Act 2014. In short, Local Authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as 'the wellbeing principle' because it is a guiding principle that puts wellbeing at the heart of care and support. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person.
- 5.4.2 'Wellbeing' is a broad concept, and it is described as relating to the following areas in particular:
- Personal dignity (including treatment of the individual with respect);
  - Physical and mental health and emotional wellbeing;
  - Protection from abuse and neglect;
  - Control by the individual over day-to-day life (including over care and support provided and the way it is provided);
  - Participation in work, education, training or recreation;
  - Social and economic wellbeing;
  - Domestic, family and personal;
  - Suitability of living accommodation;
  - The individual's contribution to society.
- 5.4.3 Because of her complex needs, Lian was open to a number of services both as a child and then as an adult. Lian received counselling and as she approached adulthood she underwent episodes of crisis, often involving overdoses or suicidal thoughts and actions, she received regular care and support from Accident and Emergency and the MHLS team.
- 5.4.4 The responsibility for formally assessing wellbeing rests with the Local Authority [in this case Rochdale Borough Council [RBC]] in their role as providers of care and support under the Care Act 2014. RBC were asked to provide the review panel with copies of all care act assessments, any care plans and any Mental Capacity Act [MCA] Assessments conducted during the period of this review.
- 5.4.5 The FACE assessment and the two Care Act assessments contained a detailed analysis of Lian's circumstances, her capabilities to care for herself and her health conditions. A detailed analysis of each of them is beyond the scope of this report. While there are some gaps and omissions in relation to the assessment and management of risk [considered further in section 5.7]

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<sup>13</sup> <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

they appear to have been carefully completed. Furthermore it is clear that Lian's views have been sought and she has contributed to their completion.

- 5.4.6 The result of the care act assessments-that Lian had needs for care and support-appear to the panel to have been appropriate decisions. The review panel considered that, taking account of all the issues, events and risks that Lian was exposed to at that time in her life they are balanced and accurate assessments. They appear to have been made in line with the requirements of the Care Act and local policies.

## 5.5 Question Two

### **To what extent did agencies understand the reasons for Lian's behaviour and her 'maladaptive coping strategies'? Did agencies recognise the impact of her childhood experiences?**

- 5.5.1 Lian's history and contact with agencies is well documented both as a child and an adult. As set out earlier in the report there were concerns within the family home related to the complex relationship between Lian and members of her household.
- 5.5.2 The documentation and chronologies the review panel have seen contain extensive reference to Lian's behaviour. While her behaviour appears at first sight to be unpredictable, it is clear that agencies soon identified a pattern to it. This seemed to coincide with events in her life such as disputes with individuals.
- 5.5.3 There are many references when Lian was seen by professionals as to the possible reasons for this behaviour. Some of the comments come from Lian and some are assessments made by professionals. Here are some examples;
- 'I wanted a good relationship...it did not work in the past [Lian]
  - 'Her maladaptive patterns worsened after a visit' [Dr]
  - 'Happy with place...Threatening to self-harm when needs not met' [Ward round review]
  - Absconded and thoughts of injuring herself after being denied unsupported leave to visit a relative in hospital [professionals note]
  - Lian's behaviour becomes increased the more restrictions are applied [From an MDT meeting]
  - Hit out at a member of staff after they tried to remove a piece of plastic she had concealed in order to self-harm [Note from residential service]
- 5.5.4 There is much evidence in the chronology [from residential service] of both individual and group dialectical behaviour sessions [DBT]<sup>14</sup> to address the pattern of poor behaviour by Lian. There was a gap between her discharge and her care becoming the responsibility of CMHT. However, when CMHT

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<sup>14</sup> DBT is a talking treatment based on cognitive behavioural therapy adapted to help people who experience emotions very intensely. It is mainly used to treat problems associated with borderline personality disorder.

assumed responsibility there is evidence she engaged well and was able to demonstrate insight into her behaviour.

- 5.5.5 CMHT report that Lian recognised that the relationship she had with her mother was rather difficult and could trigger thoughts of self-harm and suicide. Although the period of care she had with CMHT was brief, Lian appeared to improve in mood, was keen to work with CMHT and had plans for the future.
- 5.5.6 It appears that agencies did understand the things that drove Lian's behaviour and worked hard to put measures in place that reduced episodes such as overdose and suicidal events. However, the panel has seen very little documentation that relates to Lian's childhood experiences particularly those that relate to sexual abuse. It is therefore not possible to say what, if any work, was done by agencies to deal with the trauma of those events during Lian's formative years.
- 5.5.7 Whatever the circumstances were, it seems clear from the many references that Lian made to them, that her childhood experiences impacted significantly upon the way that she coped as an adult. The review panel recognises that contemporary practice would now mean children that are victims of abuse receive some sort of counselling or therapeutic input at a very early stage of their victimisation so as to mitigate the impact upon their mental and physical health. Unfortunately, it does not appear that was available to Lian as a child. Whether it would have helped mitigate the behaviours that Lian went on to display is a question the panel cannot answer with any certainty.

## **5.6 Question Three**

### **Was the way in which agencies planned and delivered care and support appropriate and proportionate to the needs of Lian?**

- 5.6.1 In addition to the general principle of promoting wellbeing, there are a number of other key principles and standards which local authorities must have regard to when carrying out the same activities or functions<sup>15</sup>;
- a) The importance of beginning with the assumption that the individual is best placed to judge the individual's wellbeing;
  - b) The individual's views, wishes, feelings and beliefs;
  - c) The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
  - d) The need to ensure that decisions are made having regard to all the individual's circumstances;
  - e) The importance of the individual participating as fully as possible;

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<sup>15</sup> <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutor>

f) The importance of achieving a balance between the individual's wellbeing and that of any friends or relatives who are involved in caring for the individual;

g) The need to protect people from abuse and neglect;

h) The need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

5.6.2 Lian presented with complex and multiple needs. For reasons associated with her childhood experiences her behaviour on occasions was extremely disruptive and presented professionals with significant challenges. The review panel consider that, with some exceptions, the overall level of care that Lian received from individual agencies and practitioners was reasonable and acceptable. Some practitioners worked very hard to support Lian. The panel felt the exceptions related to multi-agency working particularly when Lian returned to Rochdale.

5.6.3 Lian's care and the responses to her behaviour required significant amounts of agencies resources including primary and secondary health care, social care and policing. Some of the things she did put her own life at risk and potentially other people who had to deal with her, such as when she climbed on high buildings and motorway bridges. Throughout the history of her care during this review period, staff from those agencies appeared to have dealt with her patiently and professionally showing high levels of patience care and compassion.

5.6.4 The review panel believe the decision to treat Lian in a PICU and then when her condition had improved to transfer her to the residential service was appropriate. It was clear that it was necessary to do this in order to ensure that her needs for care and support were met and to prepare her for some type of independent living.

5.6.5 The panel believe the decisions to compulsorily detain her under the Mental Health Act and then to restrict her liberty using the DOLS procedures were both appropriate and necessary to protect Lian and the public. In line with the principles of the Care Act 2014, to ensure that any restriction on the individual's rights or freedom of action is kept to the minimum necessary. They appear to have been regularly reviewed and were only in place for the amount of time necessary to protect her and the public.

5.6.6 The panel understand there were some procedural issue in relation to the Community Treatment Order when Lian was transferred between the PICU and residential service. The panel do not believe these impacted upon Lian's care when she returned to Rochdale nor on the risks she presented to herself as they were not proximate in time.

5.6.7 The panel have considered the transfer of care when Lian left the residential service and returned to live in the community in Rochdale. The panel understand that professionals at the residential service felt Lian should have



remained there for a further period of time. However, by this time her behaviour had improved and stabilised and she had been assessed as having mental capacity.

- 5.6.8 The panel recognise the learning disability assessment conducted in 2018 was felt by the MDT to be only marginal, in that Lian was one point above the threshold, and that IQ like mental capacity can fluctuate. Critically the joint funding that had been agreed to pay for 12-month programme had ended. Professionals appear to have carefully considered all the issues. The panel recognise that decisions such as this are challenging and that the stark reality of health and social care in the UK is that budgets are cash limited and that resources are finite.
- 5.6.9 The ACS team felt Lian's needs would be better met by the CMHT mental health team because of her needs such as an Emotional Unstable Personality Disorder and her chaotic and challenging behaviors. CMHT accepted Lian's case on the understanding there would be joint working for a period post discharge into the community, to ensure consistency of care. On balance, and considering all the different factors at that time, the review panel feel that was an appropriate planned decision.
- 5.6.10 It is at this point that the management of Lian's care appears to weaken. The most significant issue in this case is the way in which ACS assessed the risks that Lian faced and posed to others and how they planned to manage that risk. These issues are considered in more detail in section 5.7.
- 5.6.11 The other issue at the time Lian was returned to the community was the absence of joint working between ACS and CMHT. This meant that Lian spent almost one month without a community mental health risk assessment and plan. However, she did have input from a CMHT worker who met with Lian. The panel understands this issue of the transfer of care was raised with the management team at the time and the process for this meeting has since been reviewed to ensure cases are handed over in a more collaborative manner.
- 5.6.12 The other significant issue that occurred at this time was in relation to Lian's referral to the substance misuse provider. While a referral was made by the young people's drug and alcohol service it appears that did not result in Lian being contacted by the substance misuse provider.
- 5.6.13 The commissioned substance misuse provider have undertaken a detailed review of this case. Their review found that when the referral was made to them relatively scant information was supplied. Limited information was recorded as to Lian's learning disability and no risk assessment was completed. At this time the contact point was only recording information

supplied by the referrer<sup>16</sup>. There is no indication in their records whether an appointment for assessment was given to the referrer to pass to Lian.

- 5.6.14 At the time Lian attended the substance misuse provider she was offered an appointment for a week later. Lian did not attend that appointment. The review panel have not been able to establish why that was. The service did not take any action in relation to the missed appointment, such as trying to contact Lian or contacting the referrer to inform them she did not attend. It was over a month later that a letter was sent to her inviting Lian to contact the service or her referral would be closed.
- 5.6.15 Had there been communication or dialogue between the commissioned provider, ACS and CMHT then this risk would have been identified and may have led to a plan being formulated between the agencies. The review panel feel that this represented a missed opportunity to engage with Lian and to address her substance misuse which was a significant risk she faced. Again, the commissioned provider have identified learning points and made recommendations arising from this case to improve the way cases like this are handled.

## 5.7 Question Four

**Did agencies recognise, assess and document the risks that Lian presented to herself and others? Were the measures they took to remove or reduce any risk appropriate, proportionate and in accordance with safeguarding policy, practice and her rights? Did Lian recognise the risks that she took and how well equipped was she to manage them?**

- 5.7.1 The review found there were a significant number of references to the risks that Lian faced and the risks she presented to others. During the period under review there are nearly 130 references to 'risk' within the chronologies supplied to the review team and 20 references to either 'risk assessment' or to 'risk management plans'. A detailed analysis of each of these references is beyond the scope of this review.
- 5.7.2 The level of risk that Lian faced or presented varied depending upon many factors, which included issues such as her mood, her personal and family relationships and the place she was detained at or living in. This review therefore looks at risk from two different perspectives;
- **Period one:** Residency at PICU and specialist residential therapy service.
  - **Period two:** Transition from residential service to Rochdale until the date of her death.

### Period One

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<sup>16</sup> It is important to note that at this stage in the service implementation, the contact center was only taking brief referral details and passing the information to the service to arrange the appointments.

- 5.7.3 It appears the risks Lian faced and presented during this period were generally well documented by the agencies involved. Whilst at the PICU Lian was involved in a number of incidents that placed her or others at increased risk of harm. These incidents included concealing weapons, attempts at self-harm, verbal and physical assaults upon staff and other patients. The review found these were well documented within the chronology supplied by Cygnet and there was an appropriate response to them. For example searching Lian and using approved restraint when verbal de-escalation did not work.
- 5.7.4 Lian continued to present risks to herself and others when she was transferred from PICU to the residential service. The review has been supplied with an extensive amount of documentation from the residential service relating to the risks that Lian faced and presented and the plans for managing them. Appendix C is an example of one such risk assessment.
- 5.7.5 As well as risk assessments, the residential service also supplied a number of 'outcome support plans' for Lian relating to issues affecting Lian [i.e. Finance]. Where there is a link between a risk and an outcome plan this is included in the risk assessment. Each risk assessment includes a risk level grading after intervention. The review felt that the risk assessments and plans produced were of good quality and presented an appropriate response to the risks presented.
- 5.7.6 In addition to risk assessments conducted by the residential service during period one, the local NHS Foundation Trust also undertook risk assessments in relation to Lian.
- 5.7.7 The risk assessment carried out by the NHS Foundation Trust in June 2018 is significant, as it represents the last risk assessment conducted by any agency before Lian left the residential service and returned to live in Rochdale.

### **Period Two**

- 5.7.8 Several multi-disciplinary team [MDT] meetings were held in the months prior to May 2018 to consider what course of action to take when Lian's placement at the residential service ended. These meetings considered the risks associated with the behaviours expressed by Lian. The MDT meeting in December 2017 concluded that Lian was able to understand the risk associated with her behaviour. The same meeting noted that a protection plan was required prior to Lian's discharge. There is no indication of who would take responsibility for preparing that protection plan.
- 5.7.9 An MDT held in April 2018 again documented the necessity of having a protection plan when Lian returned to Rochdale. However there was no specific action as to who would complete that plan. An assessment undertaken by Rochdale ACS in June 2018 contains a number of references to Lian's vulnerabilities and the risks she faced. The assessment contains a section titled 'Details of your need-making safe use of your home'. Here is an abstract from that section;

'Lian requires daily support to check on her safety. Lian has engaged in activities that pose a risk to her, such as meeting strangers and agreeing to perform sexual acts in return for financial gain, drugs/alcohol.

Lian has previously socialised with others that abuse substances-Lian reported that she feels accepted by these groups of people as they do not judge her'

- 5.7.10 The review panel asked ACS to establish if a risk assessment had been completed following this assessment. They told the panel they could find no record of such a risk assessment. A support plan for Lian was completed the same day. Page 3 of the plan contains the following section;

<b>Factors and Risks</b>
<b>Special Factors</b>
None
<b>Risks to the Service User</b>
None
<b>Risks from the Service User</b>
None
<b>Other Risks</b>
None
<b>Allergies</b>
None

- 5.7.11 It is not known why the section above records no risks when within the document there are so many references to the risks Lian faced. The following examples have been abstracted from the document.

' Lian is extremely vulnerable and at risk of sexual exploitation evidenced by the number of allegations she had made against men in the Rochdale area who she has met in the community. Lian is also at risk of being easily influenced by others....'

There is also a reference to the risk of Lian performing sexual acts in return for money and drugs. The following appears immediately next to this section:

'Lian will require daily visits to check on her well-being following her return to Rochdale Borough as she will be moving into a less restrictive environment....'

While there are several references to the need for daily support there is no narrative as to who will provide this support.

- 5.7.12 In May, a meeting agreed the transfer of Lian's care at the end of her funded placement at the residential placement to Rochdale. The agreement reached at the meeting was that Lian's case would be jointly worked by ACS and the NHS Foundation Trust Community Mental Health Team [CMHT] for a period of time post her discharge into the community. While there was

discussion within the meeting about Lian's vulnerabilities the review panel have seen no evidence that a risk assessment was presented at that meeting or that the meeting raised an action for a risk assessment to be completed.

- 5.7.13 Shortly after returning to Rochdale Lian disclosed alcohol and drugs misuse during a visit to the young people's drug and alcohol service [see paragraph 4.4.2]. The disclosure that Lian had used heroin intravenously for the first time, that her drug misuse was escalating and that she was not able to judge volumes represented a significant increase in the risks she faced.
- 5.7.14 The response to that disclosure was to make a referral to the commissioned substance misuse service<sup>17</sup>. While that was appropriate, there is no indication that any other action was taken in relation to this disclosure such as an exploration of why Lian had escalated to using heroin, or where and how she had acquired this and other substances. There is no evidence that a risk assessment was completed in response to this new information or that there was any liaison between ACS and other agencies such as CMHT and the commissioned provider to ensure Lian accessed substance misuse services.
- 5.7.15 The next significant escalation in risk was when Lian was found collapsed in the street [see paragraph 4.4.8-4.4.10]. This resulted in the involvement of the police and Lian was admitted to hospital. This incident appears to have occurred when Lian deliberately took an overdose in response to events at home. On this occasion GMP undertook a risk assessment. They did not make any referrals as Lian was taken to hospital.
- 5.7.16 At the hospital a thorough assessment was completed by the MHLS team which identified Lian had not intended to take her own life and was deemed medically fit to be discharged back into the community. However, because the cause of this overdose related to home circumstances Lian was placed in emergency accommodation to avert the possibility of this risk continuing. The review felt the response to this incident and the removal of the risk factor [living at home] was appropriate and achieved commendably swiftly.
- 5.7.17 In July 2018 CMHT formally assumed responsibility for the care of Lian and she was placed on the Care Programme Approach [CPA]<sup>18</sup>. On that day a full assessment and risk history was obtained [see paragraph 4.4.12]. Lian told CMHT that since she moved back to Rochdale, she had been using substances once again. She had acquired tablets off the street including spice, injected heroin and potentially smoked crack cocaine. She said she got these from people that she didn't know although she denied having sex in exchange for drugs which she had a history of engaging in previously.
- 5.7.18 CMHT provided the review with a copy of a community mental health risk assessment undertaken on Lian, this is dated at the start of July 2018. The

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<sup>17</sup> The commissioned substance misuse service were informed about Lian's learning difficulties although they were not told that Lian was in engagement with ACS or CMHT.

<sup>18</sup> A package of care for people with mental health needs.

assessment is very comprehensive and clearly sets out the presenting risks as follows;

- Risk of self-harm/suicide;
- Risks of harm to others;
- Vulnerability/Exploitation

5.7.19 The following is extracted from the Vulnerability/Exploitation section;

'[sic] Lian is continuing to misuse drugs/alcohol but less so due to financial constraints. She strongly [the word denies is missing] using sex to get drugs or being forced into sex with others for drugs currently. However, she states that people do give her drugs cheaply or for free, which nevertheless will possibly put her into a vulnerable situation. She recognises that her drug use does make her vulnerable and also puts her at risk of losing her accommodation. She wants help to stop this'

5.7.20 The risk assessment contains a section headed 'Formulating the Risk'. Within this section each of the 'Presenting Risks' is set out, beneath which are listed a number of 'Factors Reducing the Risk'. The following is an extract from that section;

### **High Risk of self-harm with suicidal thoughts**

#### FACTORS REDUCING THE RISK

Support with strategies to regulate emotional distress

Discussions with psychology to assist with formulation/discuss referral to psychology/DBT work

Building up therapeutic relationship

Lian engaging with substance misuse services/abstinence

Professional support

Psychological interventions to assist with Lian identifying triggers to thoughts

Concordance with medication

### **Moderate risk of harm to others**

#### FACTORS REDUCING THE RISK

Ability to regulate emotions

Professional support

Abstinence from substances

### **High risk of vulnerability/Exploitation**

#### FACTORS REDUCING THE RISK

Ongoing education of the impact of substance misuse on decisions in daily life

Structured activity/social inclusion

Support in the community/professional input to monitor/assist managing risk

Regular capacity assessments

- 5.7.21 Following this section is a 'Risk Management Plan' the following is extracted from that plan;

<b>Risk Management Plan</b>
<b>Based on the historical and presenting risks what actions are going to be taken to minimise the risks? Please include information about who will be involved.</b>
Lian is willing to engage with therapeutic and CMHT to work on identifying triggers and strategies to reduce impulsive actions. Care coordinator to build up therapeutic relationship
<b>Please identify any risks that will be difficult to manage/minimise and provide an explanation why this is the case</b>
Lian impulsively acts on thoughts to end her life/self-harm usually in response to variable stressors in life such as disagreements. She also uses substances regularly increasing this impulsivity.
<b>Do the risks identified indicate the need for a CPA plus screening meeting?</b> <b>NO</b>
<b>My Safety Plan</b>
<b>What I'm going to do to manage my safety and the safety of others</b>
Lian will contact services if feels distressed or struggling with thoughts
<b>How other people will know I'm unwell</b>
Becoming verbally and physically aggressive Feeling not listened to

- 5.7.22 CMHT have conducted a Concise Investigation review into Lian's death and provided the panel with a copy of it. CMHT report that the main concern around the time of Lian's death was her use of substances. Particularly as she was not concerned about how or who she obtained these from. CMHT say they offered support on numerous occasions to Lian to seek help with her substance misuse and she turned this down on every occasion.
- 5.7.23 While accepting that support was offered to Lian, the review panel have not found any evidence that there was engagement between CMHT and the commissioned provider for alcohol and substance misuse in Rochdale. It is not clear whether CMHT staff knew that two referrals had been made concerning Lian [one by the young people's drug and alcohol service and one by Lian personally]. The fact that Lian had visited the commissioned provider for substance misuse tends to suggest that she had some motivation to engage with that service. It was a potential opportunity to address her significantly high risk of self-harm identified within the CMHT risk management plan.
- 5.7.24 One of the conclusions reached by CMHT in their review concerns a lack of exploration of Lian's capacity to understand information and risks; particularly in terms of her drug use. Lian consented to others injecting drugs into her. However, she had a low IQ and had only recently been

discharged from a Learning Disability Service. CMHT believe that should have given cause for concern and the need to further explore risks and formalise a risk management meeting with all professionals. They further believe a full capacity assessment should have been completed and screening for an MRM [Multi-Agency Risk Management]<sup>19</sup> may have been considered. However CMHT acknowledge that, as Lian was engaging with services, she would not have met the criteria for MRM.

- 5.7.25 It appears to the review panel that Lian presented with a range of complex issues and associated risks both to herself and others. It appears these risks were well known to those who worked with Lian and there is evidence that agencies shared information and regularly discussed these risks.
- 5.7.26 The weakness the panel has identified is an inconsistent approach by some agencies towards the assessment of those risks and the formulation of plans to remove or reduce the risks. Risk assessment and planning while Lian was in Heathcotes appears to have been particularly robust. However, the panel accepts that Lian's treatment at the residential service in another area had a higher level of confinement and monitoring whereas when discharged and deemed to have capacity, the same level of monitoring was not possible.
- 5.7.27 Risk assessment and planning became much weaker when arrangements began for Lian to leave that placement and return to the local area. For example, despite the significant risks of self-harm and self-neglect that are documented in the Care Act Assessment and Support Plan prepared by ACS, there is no evidence of a protection plan being formulated. That is despite two MDT meeting recognising one was needed.
- 5.7.28 There was a gap of one month between the discharge of Lian from her placement to ACS and her handover of care to CMHT during which there appeared to be no robust plan to address Lian's risks of self-harm and self-neglect. That was a period when risk was likely to rise as she returned to an environment which she recognised herself was one where she was likely to start associating with substance misusers.
- 5.7.29 The review panel acknowledge that the referral of Lian to the commissioned provider for substance misuse in June 2018 was an appropriate step in response to her disclosures about drug misuse. Unfortunately, the lack of a follow up to this referral by ACS or the commissioned provider, meant there was a missed opportunity to address risk.
- 5.7.30 The handover of care from ACS to CMHT was delayed [this has been considered earlier within section 5.6]. When the handover occurred CMHT immediately undertook an assessment which the panel feels comprehensively documents the risks that Lian faced. The assessment concludes that Lian was at high risk of both self-harm and

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<sup>19</sup> MRM is a protocol that provides professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services.



vulnerability/exploitation. Substance misuse and/or abstinence from substances is identified within that assessment as factors that reduce those risks.

- 5.7.31 The panel acknowledge that CMHT staff acted correctly by offering Lian help for substance misuse and that she declined that help. The panel also recognise that those who have mental capacity have choices and sometimes make unwise decisions. However, in response to Lian declining help, the panel feel more could have been done to explore her continued misuse of substances. The panel acknowledge that CMHT developed an initial plan for managing Lian's risks. However, when Lian declined help for substance misuse, there was an opportunity to revisit this risk management plan and consider other approaches and actions; such as for example engaging with the commissioned provider for substance misuse.

### **Question Five**

#### **5.8 Is there any evidence that Lian suffered neglect, including self-neglect? If so did agencies recognise and respond appropriately to that neglect?**

- 5.8.1 Before considering this question the review panel felt it was important to establish what is meant by self-neglect. The following paragraphs taken from Rochdale Borough Safeguarding Adult Board [RBSAB] policy<sup>20</sup> help illuminate the issue;

'An individual may be considered as self-neglecting and therefore maybe at risk of harm where they are:

- Either unable, or unwilling to provide adequate care for themselves;
- Not engaging with a network of appropriate support;
- Unable to or unwilling to obtain necessary care to meet their needs;
- Following a mental capacity assessment is unable to make reasonable, informed or mentally capacitated decisions due to mental disorder (including hoarding behaviours), illness or an acquired brain injury;
- Unable to protect themselves adequately against potential exploitation or abuse;
- Refusing essential appropriate support without which their health and safety needs cannot be met and the individual lacks the insight to recognise this'.

- 5.8.2 'Self-neglect is a safeguarding issue when the person who self neglects has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect (including self-neglect) and as a result of those care and support needs is

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<sup>20</sup> <https://www.rbsab.org/professionals/neglect-and-self-neglect/>

unable to protect themselves from either the risk of, or the experience of abuse or neglect'<sup>21</sup>.

- 5.8.3 The panel is in no doubt that Lian's behaviours meant she was someone who was at significant risk of self-neglect both throughout the period of this review and before. The nature of that self-neglect is extensively documented by professionals who had responsibility for her care and in agencies risk assessments, care act assessments and care plans. The most significant risks Lian faced related to self-harm, both accidental and deliberate, and her risk of vulnerability and exploitation.
- 5.8.4 Lian had significant and multiple needs and the panel recognise that her care presented professionals with great challenges. As set out already within this report, the panel feel that on most occasions, agencies recognised and understood these risks and responded appropriately to either remove or reduce them. The opportunities to remove or reduce the risk of self-harm were greater when Lian was detained in hospital under the provisions of the Mental Health Act/or DOLS. This was because agencies had much greater opportunity to control both her movements and the environment she was in. As will be clear from this report, even with those measures in place, Lian was still able to engage in behaviour that led her to suffer self-harm.
- 5.8.5 When Lian returned to live in the local area, she was assessed as having mental capacity. That meant there were few if any opportunities to control where Lian went, what she did and who she associated with. The review panel considered whether there were any other legal approaches that might have helped regulate Lian's behaviour. The panel were told about 'inherent jurisdiction'<sup>22</sup>. The Chair and Author discussed this doctrine with TM1 who had experience of other cases in which it had been used. It was her view that Lian's behaviour fell well short of the threshold the High Court would expect to be met and therefore an application for inherent jurisdiction was unrealistic in his case.
- 5.8.6 At one-point Lian self-referred to the commissioned provider for substance misuse which may have indicated a willingness to seek help. The panel felt that Lian's behaviour had a reckless element in relation to prescribed and non-prescribed overdosing and these risks were not raised with her by professionals. While Lian appeared to have some insight, her learning

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<sup>21</sup> Opcit: 'Seven minute briefing in self-neglect'

<sup>22</sup> Before the implementation of the MCA, the means for the High Court to intervene in the life of a mentally incapacitated adult was founded upon the Court's inherent jurisdiction. The inherent jurisdiction is a doctrine of the English common law that a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal.

The regulations of the MCA have replaced the inherent jurisdiction of the High Court in the case of mentally incapacitated people. However, the High Court has gradually extended the use of the inherent jurisdiction to the group of vulnerable adults – adults who possess capacity but still require protection for certain reasons.

<https://autonomy.essex.ac.uk/resources/vulnerable-adults-and-the-inherent-jurisdiction-of-the-high-court/>

difficulties meant she may well not have seen the consequences of her actions. However, while the review panel recognise there was weakness in some of the risk planning during this period, they also recognise that any plan [no matter how robust] relied significantly upon Lian being prepared to engage and cooperate with agencies.

- 5.8.7 While there is evidence that Lian was engaging with professionals in some areas, that did not include addressing her substance misuse. Lian also continued to be unable to protect herself adequately against potential exploitation as she continued to associate with substances misusers, obtain and take controlled substances and allowed others to inject her. All of which contributed to her self-neglect.

### **Question Six**

#### **5.9 Did the death of Lian result from neglect or self-neglect? Could her death have been predicted? Could her death have been prevented?**

- 5.9.1 The review panel conclude Lian was at significant risk of self-neglect at the time of her death. Throughout the period covered by this review, there were numerous occasions when Lian self-harmed by deliberately or inadvertently taking overdoses of both prescribed and illegal substances. Some of these occurred during so called "recreational" use. Lian had been admitted to hospital on numerous occasions for treatment as a consequence of consuming these substances.
- 5.9.2 On two occasions she was admitted to hospital in a very serious condition. On the first occasion she was resident at the residential service [see paragraph 4.3.8] and had stopped breathing when found by staff and was admitted to the intensive care unit. On the second occasion [see paragraph 4.4.9] she was again admitted to intensive care. While Lian told professionals she understood the risks of substance misuse [see paragraph 4.3.12] and had capacity, the panel feel given her low IQ, it is highly doubtful she truly understood. In addition, Lian could not judge quantities well.
- 5.9.3 The review panel do not know whether Lian took a deliberate overdose of substances with the intent to take her life on the day she died. That will be a matter for HM Coroner to consider. Neither do they know whether she accidentally took an overdose of substances as part of some 'recreational' pattern of behaviour.
- 5.9.4 The review panel have tried to avoid hindsight bias in this case. However, the risk of self-harm and vulnerability/exploitation that Lian faced when she died was significant [as documented in the most recent risk assessments]. It was also connected to the misuse of substances. The panel therefore feel it was predictable that at some time Lian would come to harm as a result of substance misuse and that harm might be fatal.
- 5.9.5 The review panel have found there were weaknesses in the assessment of risk and the plans for managing risk when Lian returned to Rochdale.

However, they also recognise that any plan for managing risk while Lian was living in the community relied significantly upon the contribution and cooperation of Lian. Although Lian had a mental disorder, she was also assessed as having capacity and agencies had no means of restricting Lian's liberty.

- 5.9.6 Consequently no plan for managing the risks while she was living in the community, no matter how robust, would have provided a guarantee that Lian would not come to harm. While recognising there is some learning from this case about the assessment and management of risk, the review panel do not feel that any agency or professional could have prevented the death of Lian.

## 6. LEARNING POINTS

- 6.1 The SAR panel identified the following lessons. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

<b>Lesson 1 [Panel recommendation 1]</b>
<b>Narrative</b>
When Lian returned to live in Rochdale she was vulnerable and at risk for a number of reasons set out in this report. While her vulnerability was recognised within the narrative of assessments undertaken by both ACS and CMHT teams, the evidence of evaluating risks were weak or absent and therefore there was no evidence indicating if intervention was achieving positive outcomes or reducing risk.
<b>Lesson</b>
The identification of risk and the development and review of risk management plans when information changes ensure individuals receive the appropriate services, help and support that ensure the risks they face or present to others are reduced or removed.

<b>Lesson 2 [Panel recommendation 3 &amp; 5 ]</b>
<b>Narrative</b>
When Lian returned to live in Rochdale assessments undertaken by a number of agencies documented that she was vulnerable because she misused substances. The young people's drug and alcohol service made one referral to the commissioned provider for substance misuse and Lian self-referred. Neither of these referrals resulted in Lian being assessed and treated for her substance misuse. Professionals in ACS and CMHT knew that Lian was chaotic and impulsive and it was therefore possible she would not keep appointments with the commissioned provider. Within the local area there is a transitions strategy for children moving into adult services. However, that strategy does not acknowledge the increased risk for anyone, at any age, moving between services. For Lian, there was a missed opportunity for an MDT at this stage.
<b>Lesson</b>
When professionals support service users who are known to be chaotic, impulsive and at risk from substance misuse robust plans need to be in place to ensure they are referred as soon as possible to substance misuse providers. It would always be helpful to consider an MDT in circumstances such as this when developing those plans. Professionals supporting plans for someone like Lian also need to have a good understanding of the techniques for working with someone who has a personality disorder.

### Lesson 3 [Panel recommendation 4]

#### Narrative

When Lian was resident in the specialist residential service, a number of multi-disciplinary meetings [MDT] were held to consider her treatment and care. When Lian returned to Rochdale she was not considered eligible for the MRM process. Consequently no multi-agency meetings were held and it appears that agencies tended to operate in silos. For example, the commissioned provider for substance misuse [to which Lian was referred], did not know that she was under the care of ACS/CMHT. In turn neither of those agencies knew that Lian was not engaging with the commissioned provider. Nor were Greater Manchester Police, who had significant contact with Lian, consulted and involved in the planning to manage her risks.

#### Lesson

The fact that there was no requirement for an MRM should not preclude any agency asking a service user for consent to share information [and if granted] then requesting a multiagency meeting for those service users that require multi-agency support. Multi-agency meetings help facilitate the sharing of information and the development and resourcing of plans to manage the risks they present.

### Lesson 4 [Panel recommendation 5]

#### Narrative

When Lian was the subject of MDT meetings her vulnerabilities appear to have been understood and documented. While Lian had named workers supporting her the SAR panel felt the MDT process appeared to lack rigour in that requests for individual agencies/professionals to undertake actions were not tracked between meetings and there was little accountability for actions. For example the MDT in December 2017 identified the need to develop a protection plan for Lian and the SAR has not been able to identify if this was ever completed.

#### Lesson

MDT meetings and multi-agency meetings should have a robust process in place that ensures when a need for action is identified, it is documented. That any action identified is allocated to a named professional for completion. That there is a process in place for tracking those actions so as to ensure they are completed and/or professionals held accountable for their progress. This ensures that important actions are not overlooked or forgotten.

## Lesson 5 [Panel recommendation 6]

### Narrative

Lian's family lived in the local area. Lian also had friends in the local area. The panel recognise that Lian had a problematic relationship with her family, and that professionals also found them hard to engage. The panel also recognise some of her friends had vulnerabilities that included substance misuse and it may not have been easy for professionals to engage with this group either. The SAR panel heard that Lian trusted some of these people because they did not judge her. There is no evidence that consideration was given to try and engage either family or friends as potential protective factors when planning Lian's care.

### Lesson

While they may be difficult to engage, family and friends often hold significant information and may be able to alert agencies when the risk of harm rises. Even though they may be difficult to engage professionals should still consider using friends and family as potential protective factors when planning for the care and support of service users. This may help professionals understand how service users gravitate towards people who put them at increased risk and how agencies can deal with the negative influence of such people.

## Lesson 6 [Panel recommendation 5]

### Narrative

The need for a cognitive assessment for Lian was identified at an MDT in December 2017. This was not carried out until May 2018 and the SAR panel was told that when it was completed by a doctor from the specialist residential service, the report produced was a learning disability assessment rather than a cognitive assessment. The assessment identified that she had a mild learning disability although professionals in Rochdale felt the numerical score did not support that diagnosis. Lian was therefore assessed by agencies in Rochdale as no longer having a learning disability. That affected her entitlement to care and support when a Care Act Assessment was completed and this meant eligibility for services was low.

### Lesson

It is important professionals understand terminology and the difference between the types of assessments and the services that are available. When planning the care and support of service users such as Lian it is important that professionals have access to timely and accurate assessments. It is important that actions are set at MDT meetings that specify exactly which type of assessment is required and when they are needed are these are given to named professionals to complete. When considering someone such as Lian, whose abilities may fluctuate above or

below a threshold for diagnosis, it is important to recognise how such fluctuation can impact upon their access to care and support resources. In such cases it may be prudent to ensure assessments are repeated at predetermined intervals and that they form part of the risk management plan.



## **7. NOTABLE GOOD PRACTICE**

- 7.1 While the panel identified many areas of acceptable practice they did not recognise any notable good practice.

## **8. CONCLUSIONS**

- 8.1 Lian was a person with recognised needs for care and support that went back to her childhood which was troubled and unstable. She was someone who was vulnerable to sexual exploitation and she told professionals that as a child she had been the victim of such activity. This thread ran through her life to adulthood and may be one of the reasons for her low self-esteem and erratic behaviour. Contemporary policy and service now ensures children with those experiences receive a very different response. Had they been available then, those services might have helped Lian cope better with her experiences.
- 8.2 Throughout her adolescent and early adult years Lian self-harmed, took overdoses and behaved in an erratic and impulsive way. Lian received significant levels of support from many agencies in Rochdale and her needs for care and support were correctly identified and addressed. When Lian's behaviour began to reach levels at which her risks could not be managed in the community she was quite properly detained under the Mental Health Act.
- 8.3 It is clear professionals both in the PICU and specialist residential area in another local authority recognised these risks and worked hard to mitigate them and protect Lian from herself. While the level of risk assessment and planning in the specialist residential service was good, it never completely removed the risks that Lian presented to herself. By the time her placement ended, she was more stable and had mental capacity. However, she was still 'on the cusp' of having a learning difficulty. Ultimately, it was Lian who wished to return to Rochdale.
- 8.4 Lian's risks were well documented and understood by agencies in Rochdale and there was a joint plan for ACS and CMHT to manage her needs before her care transferred to CMHT. During this transition period there was a gap during which there appeared to be no robust plans to address Lian's risks of self-harm and self-neglect. Particularly as returning to Rochdale meant she was likely to start associating with substance misusers. While Lian was correctly referred to the commissioned provider for substance misuse, that referral was not followed up. Another opportunity to engage Lian in reducing her risks of substance misuse was lost when she self-referred to that service but did not keep her appointment.
- 8.5 Agencies in Rochdale maintained contact with Lian and continued to put effort into providing her support [for example with housing needs]. However, Lian remained very vulnerable and at risk because of substance misuse. Any plan to manage Lian in the community relied significantly on her being prepared to engage. While Lian may have led professionals to believe she had some insight, her learning difficulties meant she may well not have seen the consequences of her misuse of substances.
- 8.6 It was therefore predictable that at some time Lian would come to harm as a result of substance misuse and that harm might be fatal. However, because she was living within the community in an environment that was very

difficult for agencies to control, no risk planning no matter how robust could have prevented her death in the circumstances in which it occurred.

- 8.7 The review panel recognise that dealing with service users with personality disorders and erratic behaviours will always remain challenging. Although they could not prevent Lian's death, professionals had clearly built a good relationship with her. Despite the challenges Lian presented them with they have been affected by her death and describe Lian as someone who had 'great potential'. While the lessons learned from this case can never provide a guarantee that future deaths such as this can be prevented, the panel believe they will help agencies take steps that help towards reducing that risk.

## 9. RECOMMENDATIONS

9.1 The SAR panel identified the following recommendations. The SAR panel has not repeated any lessons or recommendations that have been separately identified by individual agencies and which are embedded within their action plans. These action plans are monitored by the RBSAB Business Unit through the Safeguarding Adult Review Sub-Group.

1. That RBSAB ask partner agencies to demonstrate that staff are trained (or training is planned) and processes are in place for the identification of risk when dealing with vulnerable adults and the development of plans draws on expertise on personality disorders in their construction of plans to manage those risks
2. That commissioned substance misuse providers ensure that when appointments for substance misuse services are not kept, then the referrer to the service is notified.
3. That RBSAB ensures partner agencies are updated on the changes that have been made to the MRM process<sup>[1]</sup>, the risk assessment model and action-planning model within it. This will ensure the process for allocating, tracking the completion of actions in all multi-risk management meetings is effective, and professionals tasked with actions are accountable for doing so.
4. That RBSAB provides guidance to professionals that requires them, in appropriate cases, to consider engaging family and friends as protective factors when developing plans for the care and support of service users and formulating risk management plans.
5. That RBSAB to cascade the learning from this SAR to partner agencies and professionals through the development of a seven- minute briefing. Partner agencies should disseminate the learning from this SAR within their own organisations.

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<sup>[1]</sup> <https://www.rbsab.org/UserFiles/Docs/MRM%20protocol%20-%20v17%20Finalised.pdf>

**SAFEGUARDING ADULT REVIEW CRITERIA**

**1. Section 44 Care Act 2014**

Safeguarding adults' reviews

- (1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
  - (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
  - (b) condition 1 or 2 is met.
- (2) Condition 1 is met if—
  - (a) the adult has died, and
  - (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
- (3) Condition 2 is met if—
  - (a) the adult is still alive, and
  - (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
- (4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

End V0.5 Rochdale Lian SAR 20200513