Safeguarding Adults Review Extension: Final Report

Note: Damien is a pseudonym used for the purposes of this Report.

Published: 31 March 2021

Reviewer: Dr Susan M Benbow, MB, ChB, MSc, FRCPsych, PhD, GMC 2382872
Director of Older Mind Matters Ltd, Visiting Professor, University of Chester, Psychiatrist and Systemic Psychotherapist

Contents

Appendices

1 Introduction

1.1 Somerset Safeguarding Adults Board (SAB) initiated this Safeguarding Adult Review (SAR) extension in June 2018. It followed the death of a man aged 33 (referred to here by the pseudonym Damien) with a long history of contact with mental health services. Damien had been given diagnoses of mild learning disability, Asperger's Syndrome, and Attention Deficit Hyperactivity Disorder, and was known to use substances including alcohol, legal ('legal highs') and illegal drugs. He had come into contact with police and mental health services on a number of occasions. It was known that his vulnerability was exploited by others, who stole from him, misused his home for their own purposes, and probably encouraged his use of substances.

1.2 Damien's ethnicity was white British and he was heterosexual.

1.3 Damien was found suspended by his belt in supported accommodation 14 days after leaving a mental health inpatient unit. He subsequently died in hospital.

1.4 The aim of a SAR is to promote learning and improvement action in order to prevent future incidents involving death or serious harm. The Care Act 2014[1] states the following:

(1) An 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.

[1] See http://www.legislation.gov.uk/ukpga/2014/23/section/44

(4) An 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).

1.5 This Report builds on and extends work previously undertaken in a Safeguarding Adult Review, summarised in a Practice Briefing dated December 2016[2], and includes a review of detailed information collected for HM Coroner. The Independent Reviewer draws overall conclusions and recommendations from analysis of information provided.

1.6 Contributors to this extension review and Report include the following:

- Damien's Family
- The organisations involved in the original SAR
- Information from the Coroner's inquest
- NHS Somerset Clinical Commissioning Group
- Somerset's Safeguarding Adults Board

1.7 This Review seeks to capture as much learning as possible for the agencies involved in providing Damien with care and support, both as individual agencies and how they worked together:

- Tracscare[3] (now accomplish)
- Avon & Somerset Constabulary
- The Care Quality Commission (as the regulator of the service)
- The National Probation Service
- Rethink
- Somerset County Council
- Somerset Partnership NHS Foundation Trust[4] (now Somerset NHS Foundation Trust)
- South Western Ambulance Service NHS Foundation Trust

1.8 ***The Reviewer and all those involved in this extension Review would like to acknowledge how distressing the events that led to this SAR have been for the family and to send our sincere condolences. We would also like to thank all those who have contributed in any way to the review process for their time, patience, commitment and cooperation.***

[2] See https://ssab.safeguardingsomerset.org.uk/about-us/publications/learning-from-serious-cases/

[3] In February 2018 Tracscare rebranded as accomplish, however the organisational names at the time of the events described within this report have been used.

[4] On 01/04/2020 Somerset Partnership NHS Foundation Trust merged with Taunton & Somerset NHS Foundation Trust to form the Somerset NHS Foundation Trust, however the organisational names at the time of the events described within this report have been used.

2 Circumstances that led to a Safeguarding Adult Review extension being undertaken

2.1 On 29 June 2015 Damien was found suspended by his belt in supported accommodation. Emergency care was administered, appropriate emergency services were called, and he was taken to hospital where he subsequently died.

2.2 Prior to that Damien had been an inpatient in a mental health unit from 17 February 2015, initially detained on Section 2 of the Mental Health Act, but with informal status from 18 March 2015.

2.3 His placement prior to admission was reviewed as he was at risk of eviction and an alternative placement was sought.

2.4 On 15 June 2015 he left the ward and moved into supported accommodation.

2.5 He ran into the road in front of a car on 22 June 2015. Further incidents of attempted self-harm took place on:

- 25 June 2015: "jumped" in front of a car
- 25 June 2015: cut head superficially with knife from kitchen
- 27 June 2015: tried to "grab" bleach from cupboard
- 28 June 2015: asked for plastic bag to put over head

2.6 He also expressed suicidal ideas at times.

2.7 A Safeguarding Adults Review (SAR) took place and a Practice Briefing was published in December 2016. The full Safeguarding Adults Review was not published at the time following feedback from Damien's family.

2.8 Further information emerged during Her Majesty's Coroner's investigation and Somerset's Safeguarding Adults Board decided to commission a SAR extension to take account of this additional information and the perspectives of the family. This extension therefore replaces the original, unpublished, Safeguarding Adults Review, containing as it does information that has emerged since it was completed.

2.9 Expressions of interest were sought for the role of Independent Reviewer for the SAR extension and an Independent Reviewer was appointed in December 2018.

2.10 The detailed timescale covered by the extension review was agreed as 1 April 2014 to 3 July 2015 but with attention to relevant prior information.

2.11 The terms of reference for the extension SAR are set out in Appendix 2.

3 Process of the Safeguarding Adult Review Extension

3.1 Contextual information

3.1.1 This Review builds on and extends the Safeguarding Adults Review previously undertaken (under the pseudonym of 'Damien'), completed in March 2017).

3.1.2 Documentation relating to the previous SAR made available to this extension is set out in Appendix 3.

3.1.3 New information emerged during the inquest process that concluded on 9 March 2018 and an extension SAR was commissioned in order to take account of this and of the perspective of Damien's family.

3.2 Information provided to the Reviewer

3.2.1 Information provided to the reviewer is listed in Appendix 3.

3.3 Independent Reviewer

3.3.1 The Independent Reviewer and Author of this report is by professional background a psychiatrist and systemic psychotherapist. She has broad clinical and multi-agency experience in the North West and West Midlands.

3.3.2 In 2013 she became a visiting professor of Mental Health and Ageing at the University of Chester.

3.3.3 She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past.

3.3.4 She has no connections or ties of a personal or professional nature with the family, with Somerset, or with any agency participating in this review.

3.4 Timescale

3.4.2 The timescale for the Review was set as 1 April 2014 to 3 July 2015.

3.5 Family Involvement

3.5.1 The section headed Background under Section 4, Facts of the individual case, incorporates information contributed by family member/s on the telephone and electronically.

3.6 Process of developing this Report

3.6.1 The Report has evolved through an iterative process involving the family and the Somerset Safeguarding Adults Board in questions and information gathering, discussions, and feedback

4 Facts of the individual case

4.1 Context

Damien was on a psychiatric ward from 17 February 2015 until his transfer to supported accommodation (Placement 3) on 15 June 2015.

On 29 June 2015 he was found suspended by his belt in the supported accommodation. Emergency care was administered, appropriate emergency services were called, and he was taken to hospital where he subsequently died on 3 July 2015.

A summary timeline sets out key events below and a more detailed edited chronology is included at the end of this Report as Appendix 2.

4.2 Summary timeline

Date	Event
1 April 2014	Start of timeline
12 April 2014	Presented at Mother's home in agitated state and subsequently admitted to mental health ward on Section 2 of the Mental Health Act. Diagnosis – drug induced psychosis.
12 May 2014	Discharged to Placement 2, supported accommodation
14 May 2014	Burglary at Damien's supported accommodation flat – believed by Police to have used Damien's key to gain access.
28 August 2014	Mental Health Act assessment at Police Station after arrest for breach of the peace – detained on Section 2 of the Mental Health Act and admitted to mental health bed. Diagnosis – mental and behavioural disorders due to use of other stimulants including caffeine.
25 September 2014	Section 2 expired – remained as an informal patient. Assessed as "having capacity" in relation to offending behaviour.
29 September 2014	Discharged to Placement 2.
22 October 2014	Spending money on drugs for self and 2 others. Concerns that he's being taken advantage of but willing to hand money over.
13 November 2014	Theft of Damien's medication reported to Police and Somerset Partnership Safeguarding team.
30 November 2014	Threatening behaviour towards Crisis Resolution/ Home Treatment Team (CRHTT) – tenancy placed at risk.
2 December 2014	Change of care coordinator

3 December 2014	Safeguarding referral to Somerset Partnership by Adult Social Care (ASC) in respect of alleged theft of medication from Damien.
31 December 2014	Arrested for Breach of the Peace – no charges brought. Referred to MAPPA.
22 January 2015	Professionals meeting to share risk information in relation to a threat by Damien to rape female friend.
9 February 2015	Emergency Social Care Panel requested, placement breaking down due to incident of Damien breaking and entering.
17 February 2015	Mental Health Act assessment at Housing scheme. Placement 2 broken down. Damien having sexual/ violent thoughts. Drugs and alcohol noted as contributory. Admitted to mental health unit under Section 2. Discussions about possible placements start soon after admission.
5 March 2015	Panel suggested possible placement at Crewkerne.
16 or 18 March 2015	Becomes informal patient. It appears that Section was discharged on 16 March and due to expire on 18 March.
1 April 2015	Visited possible placement in Crewkerne with care coordinator.
17 April 2015	Damien met with a worker from a possible respite placement
7 May 2015	Somerset Partnership's Mental Health and Social Care Panel turned down placement at Crewkerne. In a letter to Damien's Care coordinator detailing the decision the Panel Chair said there were concerns regarding risk due to other residents residing there, that Damien's primary need was his mental health, and that the provider's expertise lay with supporting people with learning disabilities
14 May 2015	Referral to the provider of what became Placement 3, a Somerset residential home described as for 'forensic' mental health
15 May 2015	Assessed on ward for possible placement in Bristol.
19 May 2015	Discharge planning meeting (note: still 2 possible placements at that stage). "Ward staff to speak to (Damien) regarding his preferred placement option once he has viewed them both".
21 May 2015	Visited both Bristol placement and Placement 3 – Damien preferred Placement 3.
2 June 2015	Damien accuses another patient of stealing his wallet on ward. Police called.
4 June 2015	Panel agreed Placement 3.
15 June 2015	Moved from ward to Placement 3.

22 June 2015	Police brought Damien back into the home. Had attempted to jump in front of a car on a busy main road.
25 June 2015	Police phoned Home to ask if Damien had jumped in front of a car that morning and he told staff that he did.
25 June 2015	Damien superficially cut his head with a knife from the kitchen.
25 June 2015	Somerset Partnership records note that a message was received that Damien had run in front of traffic and was vocalizing suicidal thoughts. Also states GP requesting admission. Details passed to CRHTT who assessed and recorded "contact with (Damien) daily till 30/6" but the contact after this was telephone contact with staff rather than from visits to Placement 3.
27 June 2015	Handover note states that Damien tried to grab bleach from a locked cupboard. This information was not passed to the CRHTT.
28 June 2015	Noted on handover sheet that Damien asked for plastic bag to put over his head. This information was not passed to the CRHTT.
29 June 2015	Damien found hanging, suspended by his belt.
3 July 2015	Died in hospital.

4.3 Background

Note: This section *starts by summarising information about Damien's background, mainly extracted from a variety of documents, and then moves on to try to capture Damien as a person. It includes information kindly shared by his family.*

4.3.1 Summary taken from various documents and from detailed information supplied by Damien's family

Damien was born in Essex following a normal pregnancy at 36 weeks and was in special care for jaundice for nearly a week. He was the younger of two children, having an older sister. He was very ill at 8 months and had surgery. There were difficulties with feeding and sleeping, delayed toileting, delayed walking and delayed speech: he started talking at around the age of 4.

At the age of 11 he was statemented with learning difficulties, including dyslexia (his family recall his IQ being assessed as being quite high), and was then excluded from mainstream schooling in Essex: another school in the area could not be found. Therefore, he moved to an Emotional Behavioural Difficulties (EBD) school in Somerset.

Damien's parents separated in 1990 and he lived with his mother initially. He then had foster carers in Somerset from 1992-1996. He moved to the EBD

school in 1993. The carers were boundaried and kept him occupied in a small family home but he moved when they separated in 1996.

He then had a foster placement in Somerset from 1996-2001. His family feel that this was less successful as he had more freedom. After leaving school, he attended a further education college in Bridgwater, but a combination of the bus travel and his "behaviour" led to a breakdown in the college placement: he was expelled after a serious incident. At around this time, Damien was diagnosed with Aspergers Syndrome and he began to mix with a group of people who used illegal substances. His behaviour further deteriorated, so that his carers couldn't cope. After an incident when he pushed the male foster carer down the stairs, the placement became unsuitable.

From 2001 to 2009 he lived in a Residential Home (Placement 1) that is described as specialising "in providing an excellent service for people with Autism, Aspergers, Learning Disabilities & Mental Health Issues." Whilst in this placement, in Devon, Damien achieved a great deal and attended a local college specialising in horticulture daily. In addition, he held down a voluntary placement in a garden centre. Damien's family consider this a relatively stable period where his behaviours and risks were well-managed by a consistent staff group that knew him and his complicated needs well. He responded to daily support, boundaries and lots of things to occupy him.

In 2009 Damien was brought back into Somerset to live in supported accommodation in Placement 2, a new 24-hour supported housing service for people with Asperger syndrome. His family were of the impression that there was some pressure on adult social care to bring him back into county and independent living. Concerns were raised at the time that this transition should be well-planned, and the family report that it was. The family think that the OT Assessment referred to in the Coroner's Court was undertaken around this time to inform the move. This first time in Placement 2 worked fairly well. Night staff were in place and Damien was occupied, including with gardening and delivering charity bags.

In 2011 Damien moved to his own flat just over a mile away, where he lived until 2013. He was living in an area housing other vulnerable people including those with alcohol and substance misuse problems. His family describe how he soon became a target for grooming and funding their habits. He was often threatened. He had little support from services over this time. In independent living his use of substances increased, and his self-care and mental health deteriorated. He was the victim of assaults, robberies and exploitation. He spent large sums of money inappropriately. His 'friends' and a drug dealer were thought by family to be stealing from him leading to periods of not eating and angry outbursts. Later evidence (autumn 2013) emerged that he was using legal highs. In 2013 his family asked the Somerset Aspergers Team to undertake a mental capacity assessment

around finances. As a result, appointeeship was arranged through the local authority (Somerset County Council). His family felt that his vulnerability and inability to cope practically and financially meant that independent living did not work.

He returned to supported accommodation at Placement 2 in 2013 and remained there until 2015, but this time there was no night staffing in place. He was plagued by "grooming friends" at night and now had serious mental health issues. He had various visits to the police station with his sister acting as Appropriate Adult. In February 2014 Damien was attacked and robbed at his home, and in March 2014 he reported his money had been taken. After an admission under Section 2 of the Mental Health Act in April 2014 he returned to a higher level of support at the supported housing service (Placement 2). He continued to struggle with self-care and exploitation with noise and use of legal highs continuing, and this culminated in another admission under Section 2 of the Mental Health Act in August 2014. He was discharged back to Placement 2 but mixed with people who took his belongings and disrupted his room and he returned to using legal highs. His medicine cabinet was raided twice within a month: Safeguarding Adults were involved, and Damien entered into a new regime of collecting daily medications from the local pharmacy. The organisation running the accommodation expressed concern about his anger, that he might hurt someone, noise and disruption from his flat (but other people were believed to be using it), use of alcohol and substances, and threats of sexual assault. Damien was regarded as vulnerable to exploitation and it is recorded that he had been persuaded by so-called 'friends' to buy drugs and give money to others to buy drugs. Again, this period culminated in an admission (his final admission) to hospital under Section 2 of the Mental Health Act in February 2015.

His last placement was Placement 3 which was a Somerset residential care home described as suitable for forensic mental health and his family were told the staff could handle complex needs. The family say that he was unwell and depressed when he moved there, and that there was nothing to occupy him and no-one to connect with socially. His mother was of the view that he was not stable enough to make a major transition at the time he moved. There was no work with the family around the move. He lived at Placement 3 for 2 weeks.

4.3.2 Developmental disorders

In a detailed assessment, a forensic psychologist notes that Damien was diagnosed with two developmental disorders, namely Aspergers and ADHD and that these left him with difficulties in the following areas:

- Impulsivity

- poor planning and problem solving
- social interactions
- obsessive traits
- identity diffusion
- disinhibition and emotional dysregulation in response to stress
- vulnerability to misinterpreting the intentions of others

4.3.3 Damien the person

This section has been informed by Damien's family, and the Reviewer would like to thank them for their openness in doing so.

When well Damien was "high-functioning" and sociable, with a good sense of humour. He was independent in activities of daily living, but needed prompting for personal care etc. Without MAPPA and the complex risk presentation around the use of legal highs/ alcohol and the impact etc, his sister feels he would have done well in a supported living set up, with no need for residential care. His mother couldn't understand why a package of low-level social enabling couldn't have been commissioned when he lived "independently" in the community as part of a preventative approach.

He was a kind and generous person, who was able to see beyond material things and was generous in both time and money. For example, he would give a stranger his last pound – and his sister witnessed this. He demonstrated real empathy for other vulnerable people, particularly street homeless. He was also a brave person: he would go into battle for others he felt were struggling and often piped up about rights for friends living with him at Placement 2.

He had lots of abilities/ strengths. He was normally comical and chatty. He wanted to have friends and a normal life (but this probably made him susceptible to people who took advantage of him.) He was creative and enjoyed collecting DVDs/ movie memorabilia, including making models from favourite films. A real area of strength was his ability with computers, setting up electrical - sound systems/ TV etc. In fact, the home TV still has his special 'Heath Damienson' set-up that none of the family can work out to amend when the channels go down! A good sense of humour, with an ability to let things go and not become cross at those that had slighted him. A caveat here is the period of mate crime at one address that ended up in all sorts of skirmishes and fights with those that had financially abused him and charges for grievous bodily harm without intent. Over this period his sister regularly acted as his Appropriate Adult, and she highlighted this as good practice from the police.

Damien had a voluntary job collecting charity bags from residential houses, he didn't hold this down for long and did not enjoy the experience. His mother consistently raised concerns that he should be encouraged into work

to give him a sense of purpose, but no other opportunity was identified. Eventually, after a period of time, he began to see spending time with 'risky adults' (drug users/ people with significant criminal convictions) as a preferable way to spend his time.

5 Damien's family's description of areas of concern

The themes below are taken from conversations with Damien's sister and from documents supplied by her to the Reviewer. They are written as understood by the Reviewer but include some direct quotations. They are not in order of importance and are not discrete themes, and many overlap and interlink.

5.1 Discharge processes

There are a number of themes that Damien's family have identified in the process of Damien's discharge, which they feel illustrates difficulties in communication and lack of family involvement. These are:

Delayed discharge: The family felt that Damien's discharge was delayed largely because of difficulty in identifying a suitable placement. They observe that delay in discharge had an adverse effect on his mental health and emotional well-being. They suggest that delay in finding suitable accommodation for Damien was related to a lack of provision for high-function autistic people, part of a national picture, and note that his case was not aided by the long forensic/ offending history accrued by the time of the last Section 2 detention under the MHA 1983. In addition, they feel that staff were slow to respond to his distress at being on the ward for so long, and that panel processes took a very long time. The family saw this clearly at the time as a delayed discharge, with the issue of holding powers versus his voluntary patient status being a further concern for MAPPA: he was not compelled to stay in hospital if he didn't want to.

Damien's family also make reference to a statement by the responsible Clinician at the time of the final Section 2 detention period that Damien required a 'more structured placement' and that he was too vulnerable, at that point, to be living independently the community. They note that the Mental Health Act Code of Practice sums up what should happen well, in saying (bold added by the Reviewer):

> *20.28* ***People with autism should be detained for as short a period as possible.*** *Many people with autism who have been detained will require, and be entitled to, after-care (chapter 33).* ***Discharge planning for people with autism should begin when the person is admitted*** *and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge. This will require assessment by a practitioner with*

expertise in autism, as set out by the statutory adult autism guidance. Mental Health Act 1983: Code of Practice, Page 211.[5]

Identification of an appropriate placement for Damien: The family ask what the process was for identifying a placement appropriate for Damien's needs: and how was the placement checked regarding suitability and safety? They also suggest that delay in finding an appropriate placement for him was linked to the lack of provision for people with high-functioning autism and that this is part of a national picture.

Delay in obtaining funding approval: The family ask is it reasonable that a funding panel was booked in March 2015, but funding was only finally agreed in June 2015?

Discharge planning process: Damien's nearest relative (his mother) said that she was not invited to attend a discharge planning meeting, although she had been invited on two previous occasions when Damien was discharged following formal admission under Section 2 of the Mental Health Act. What was the process for planning Damien's transition from the ward to his new placement?

Lack of clarity regarding discharge: The family ask if Damien was discharged from the restrictions in the Mental Health Act when he moved to his final placement or not? In the SIRI report Damien's Responsible Clinician says that he had not been discharged and the family believe that it is likely that Damien was on leave from the ward, but this was not communicated to Somerset Partnership's Community Mental Health Team (CMHT), who clearly thought he had been discharged. Indeed, a discharge letter is on file. While someone can be discharged from hospital, but still subject to the Mental Health Act, there appears to be a lack of clarity both within Somerset Partnership and with Damien's family with regard to whether he was or not.

Lack of assessment of Damien's mental capacity around housing decisions: The family understood that Damien was presumed to have mental capacity to make decisions with respect to housing but would question this. They felt that he lacked understanding as to why he could not return to his previous address at Placement 2 and why he had been admitted to hospital under the Mental Health Act. When they talked to him about inappropriate risky behaviours, they report that Damien laughed inappropriately (a response they had previously observed when he did not understand or was embarrassed) and did not answer questions, but persisted in saying that he wanted to return to Placement 2. They felt that he did not appear to be able to understand or retain the information he was given.

[5] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Lack of medication review: Damien's mother said that she had made repeated attempts to get his medication reviewed, and felt that this was without success: including on the morning of 29 June 2015, hours before Damien took the final step that ended his life.

5.2 Risk assessment and risk management

In their written document on Key issues the family say:

> *"'Risk' is subjective and situational, inter-dependent upon the individual's needs/vulnerabilities and the context/situation in which they are living. Family view that (Damien) both a perpetrator and a victim: inter-connected ideas that people can be both defined as an 'adult at risk of harm' as well as pose risk to others."*

And:

> *"(Damien) was a complex young man, presenting with a myriad of vulnerabilities and risks, exacerbated by certain triggers/scenarios."*

Damien's mother stated a concern that she was not involved in risk planning/ risk management meetings despite the fact that she cared for him most weekends, and the family is not aware of any attempts made by any involved professional to talk through risks/ triggers in relation to change/ move/ transition.

5.3 Safeguarding and vulnerability

The family feel with during the period 2013 to 2015, Damien's anxiety, and inability to handle stress came to the fore, and presented as aggressive and anti-social behaviours. Whilst recognizing Damien's right to make decisions that might seem to them or others to be "unwise", they felt that:

> "*many of these frustration behaviours stemmed partly from the substantial amount of time he spent with Class A drug users and 'risky' adults involved with criminality who financially exploited him. These associates stole (Damien)'s belongings, including emptying his flat of electrical goods (TV/ HI FI) whilst he was in (a psychiatric) Ward detained under the first Section 2 (April 2014)."*
>
> Damien was "*'self-neglecting' during this period: no money for food (family shopping and filling fridge/freezer for (him) regularly), (he was) regularly sitting in the dark as no money to pay for electricity key and so on. Real evidence that (he) was not coping in the community.*"
>
> "*At* times*, (Damien) unwittingly described to (his sister) coercive or controlling behaviours on the part of at least one associate."*
>
> "*a* propensity *to 'self-neglect' (poor self-care, lack of money to pay for basic needs, such as food, electricity). (Damien) would regularly pawn his belongings to fund himself and others. Multiple Wonga loans."*

"evidence *of physical abuse ((Damien) seen with a black eye, bruises or missing teeth)."*

"evidence *of financial abuse (savings disappearing at an alarming rate; theft of electrical equipment)."*

"*theft of* controlled *medication."*

They feel that statutory services, and later Damien's final placement, were slow to identify and respond to safeguarding concerns.

5.4 Involvement of family/partnership working with family

Communication: From their perspective, Damien's family described a lack of communication regarding who the lead professional was (the assumption was that it was the social worker). They felt that when events started to go wrong there was no sense of leadership, of taking control of concerns/events as they unfolded. They believe that the social worker had no real 'voice' and they cite comments suggesting other involved professionals may share this view. They observe that professionals should not make presumptions about what people know or do not know about service delivery, about how services operate or how they joint-work in conjunction with each other, and that they regard it as good practice for professionals to introduce themselves to family when allocated a lead role, perhaps in a telephone call.

They also felt that their experience of communication from CMHT was poor, and that their telephone calls largely went unreturned. They go on to describe that their experience was one of "communication breakdown", and the family deemed it necessary to engage a solicitor from April 2015 onwards in order that a more formal approach could be taken towards negotiation. Damien signed the letter to engage the solicitor and had capacity around this decision (witnessed by his sister). They saw the solicitor's role as to negotiate with Somerset Partnership NHS Foundation Trust in matters pertaining to:

- Identifying an appropriate residential setting for Damien
- Focused care and support planning, including meaningful social activities
- Acknowledged confirmation of family input on a continuous basis

Overall family report that they were not aware of key decisions made by statutory services in respect of Damien's care and support.

Lack* of *partnership working with the family: The family felt there was a lack of partnership working with the family, despite the fact that his mother and sister were both closely involved with him and Damien had given consent to information sharing. They describe working in partnership with the NHS as feeling to them "laboured, defensive and (it) inevitably forced a legal response". They highlight the support of inquest, and the real and vital need for greater clarity, openness, honesty and transparency with families

when things go wrong. They are aware that "being able to have this level of scrutiny was frankly dependent on (Damien's sister's) awareness, training and position as a social worker: but what would happen in a family without access to that knowledge and awareness of how services operate. They note that a positive outcome of the original SAR was the appointment of a lead nurse for liaising with families following an incident, "akin to a Family Liaison Officer in the police force".

Damien's mother said that she was not involved in risk planning/ risk management meetings despite the fact that she cared for him most weekends. The family comment that the ward cared for Damien excellently, and worked well with his mother to manage him. Towards the end of his stay on the ward, his family had to regularly take him back there because he did not feel safe or did not feel that he could cope in the family home.

5.5 Lack of holistic assessment

Damien's mother and sister were closely involved in his life. His mother cared for him most weekends. His sister was, at that time, a distance away, working to finish her Masters degree and on a statutory adult social work placement, whilst at the same time trying to support both Damien and their mother: she describes a "stream of despairing phone calls from (the) Ward expressing suicidal ideation".

5.6 MAPPA

Damien's mother thinks that he did not understand or know what MAPPA was about. She was not told either. Damien's sister was present at meeting when it was first discussed and was able to tell Damien and family the implications. His sister thinks the MAPPA referral and status was probably necessary, given the offending history, risk to others etc, but would comment that it is an interventionist approach and individuals and families should be clearly told the implications of being subject to MAPPA. It should not rely on a family member having knowledge of services.

5.7 Medication regime

Damien's mother made repeated attempts to get his medication reviewed, without success. The family had concerns about his medication regime. He had been on an anti-depressant drug for approximately the previous 10 years, but this was stopped prior to him leaving the ward in 2015. He was also prescribed lorazepam and they were concerned about this because of his substance use. Damien's mother had concerns around the potential addictive effects of lorazepam, knowing that he had displayed addictive traits around the legal highs/ alcohol etc: the family describe that there was no discussion with the social worker around how to manage Damien's anxiety, given that anxiety is a core feature of a person presenting on the autistic spectrum and that anxiety had been a prominent feature for Damien. His

mother was also concerned about the lorazepam in view of the fact that Damien was actively expressing suicidal ideas. Another concern for the family was the absence of creative risk assessing around how to manage anxiety when Damien was 'placed' in a so-called dry house, with no access to his previous coping strategies, namely legal highs and alcohol.

6 Analysis

The timescale for this Review was set as 1 April 2014 to 3 July 2015 but the papers shared with the Reviewer provided contextual information prior to that timeline. Many of the themes identified run across the whole of the timescale of the Review so they are presented as a thematic analysis.

This section provides the analysis of events; incorporating the family's views as described above

6.1 Reviewer's thematic analysis

6.1.1 Difficulty in finding appropriate living accommodation

Over the years Damien lived in a variety of different settings and his accommodation history demonstrates the difficulty of finding an appropriate place for him to live.

Damien's accommodation history (kindly provided by his family and with comments from his family about how well the placements worked, minor edits by Reviewer)

- **Foster carers in Somerset 1992-1996**
  The family felt that this small family home worked well. It was boundaried and Damien was kept occupied, but the couple separated.
- **Foster carers in Somerset 1996-2001**
  The family felt that this didn't work so well. They believe that Damien had too much freedom, and mixed with the wrong crowd at his local college: it led to him being expelled following a serious incident, so the placement was not suitable for him anymore.
- **Placement 1 in Devon, 2001-2009, a residential placement**
  The family's view is that this worked extremely well. Damien responded to daily support, boundaries, and lots to keep him occupied. He also attended a college daily. They understood him and his complicated needs.
- **Placement 2 supported living in Somerset 2009-2011**
  Worked fairly well first time. There was lots for Damien to do - gardening, delivery of charity bags, and night staff in situ.
- **Living independently in the community in Somerset 2011-2013**
  The family describe this as 'disastrous' as he was in a housing area with other vulnerable people, alcoholic dependency and drug addicts. Damien

soon became a target for grooming and funding their drug habits. He was often being threatened. At this time, he had little support from any services at all. He was sectioned. Independent living did not work due to his vulnerability and not being able to cope financially or practically.

- **Placement 2 in Somerset 2013-2015 (back to supported living after section lapsed)**
  The family believe that the placement did not work this time round, as no night staff in situ. He was plagued again by the "grooming friends" at night. He now had serious mental health issues. He was sectioned twice under the Mental Health Act during this time along with various visits to the police station. His sister acted as Appropriate Adult. The view of Damien's family is that learning from Damien's return to Placement 2 is that professionals involved should have considered what worked well when he was previously placed there, and the environment itself, and how it interfaced with his vulnerabilities.
- **Placement 3 Somerset residential home described as for 'forensic' mental health May 2015 (only resided there for 2 weeks).**
  Damien's family felt that this was sold to them as a placement that could handle complex needs. However, he was unwell when he was placed there, and this was exacerbated by a reported lack of anything for him to do all day or anyone for him to connect with socially at the home. He was very unwell and depressed (antidepressants still not indicated). His mother was of the view that Damien was not stable enough to make such a big transition at that time. Damien had high functioning autism and his needs were often misunderstood. He also needed to be stimulated and to mix with like-minded adults: Damien's family strongly expressed that this was the wrong placement, at the wrong time, and that these problems were made worse by no work taking place with his family who knew him best.

Damien's family kindly commented on how well the different placements worked and why they thought that was. Placement 1 (Crediton) is described as specialising "in providing an excellent service for people with Autism, Aspergers, Learning Disabilities & Mental Health Issues." Placement 2 was a new 24-hour supported housing service for people with Asperger syndrome at the time that Damien first moved there and what worked well should have informed his future placements.

The accommodation history demonstrates that Damien responded well to clear boundaries, supervision and daytime occupation/ activities: this fits with the specialist assessments (for more detail see *Specialist assessments,* page 25).

6.1.2 Placements considered during Damien's time on the ward

During his time on the ward Damien was shown a placement in Somerset, one in Bristol and Placement 3. A further potential placement was considered but there are no details in relation to its exploration. According to his family, the placement in Somerset was sold to Damien as a destination with the expectation that funding was a 'paper exercise': they feel that expectations were not managed, and in fact it was set up to fail. Below are details relating to these potential placements extracted from the various documents supplied.

A letter to the Care Coordinator suggested a placement with a service in Crewkerne on 5 March 2015, and he was assessed on the ward on 26 March 2015. The service in Crewkerne later offered a placement which Damien visited on 1 April 2015. However, the Panel turned down this placement: a letter dated 7 May 2015 from the Chair of the Mental Health/ Social Care Panel to Damien's Care Coordinator said that:

> *"The Panel were not confident in the provider's ability to manage clients such as (Damien) whose dominant need is mental health, as the company's expertise lies with clients with a learning disability. It is possible (his) behaviour could put other vulnerable service users at risk … the Panel agrees that he himself is very vulnerable to the actions of others".*

There was a delay in securing funding and the funding panel decided the placement was not suitable due to Damien's risk factors and contextual risk factors (in particular other residents).

The Panel (in the same letter) recommended that the Care Coordinator refer Damien to a service in Bristol for assessment, saying:

> *"The Panel has confidence in this provider to manage challenging clients who present with a high-risk profile. The Panel does acknowledge there may be concerns for (Damien) to live in a city as it may be easier for him to access street drugs and alcohol…"*

Staff from a Respite Service visited Damien on 17 April 2015. In the progress notes this service is referred to as a possible respite placement while placement with the service in Crewkerne is finalised and secured. It appears that the respite placement was rejected by the ward, as it was felt that it would destabilise him and that several moves would be unlikely to benefit him in view of the diagnosis of Asperger's.

On 14 May 2015 Damien was referred to what became Placement 3 (Burnham-on-Sea). It is described now as "a residential transitional service, supporting people with complex Mental Health needs." He visited on 21 May 2015 (the same day that he visited another possible place to live) and it is

recorded that Damien preferred placement 3 over the alternative possible place.

The service in Bristol assessed Damien on the ward on 15 May 2015 and Damien visited 21 May 2015. The service in Bristol is described online now as "a specialist provider of supported living and outreach services for adults within the South West." This placement was rejected as unsuitable for several reasons: increased potential access to substances; out of county/ lack of continuity of care; distance from family. Damien also expressed a preference for Placement 3 after visiting both the Bristol service and Placement 3.

The family comment that they believe that delay in finding suitable accommodation for Damien was related to the lack of provision for high-functioning autistic people, and is part of a national picture. They feel that his case was not aided by the long forensic/ offending history he had accrued by the time of the last Section 2 under the MHA 1983. In addition, they comment that the social worker was slow to respond to Damien's distress at being on ward for so long, and that panel processes took a very long time. His family saw this clearly at the time as a delayed discharge, with the issue of holding powers versus his voluntary patient status for MAPPA being an additional concern.

Thus, the delay and difficulty in finding an appropriate place for Damien to live during his last admission to hospital sits in a context of several different types of accommodation over the years, some of which were more successful than others, and from which learning could have been drawn to inform future placements. One major difficulty, however, is finding an appropriate placement at an appropriate time for the individual concerned. There are potential complications if someone's hospital stay is extended due to failure to find an appropriate place for them to live, but equally there are consequences if someone is discharged to a placement that cannot meet their needs.

There are also questions about how a placement is assessed as equipped to meet a potential resident's needs. What checks are carried out before using a new or previously untried placement?

6.1.3 Mental capacity assessments

In the papers, there is evidence of (at least) three formal capacity assessments:

- ***2013:*** In 2013, his family asked the Bridgwater Aspergers Team to undertake a mental capacity assessment around finances. As a result, an appointeeship was arranged through the local authority.
- ***28 August 2014****:* Damien had an admission to hospital and in the discharge letter there is reference to capacity assessments, in that he "had capacity in relation to aforementioned decisions". Later there is

reference to capacity in relation to breaching other people's boundaries and "sexually inappropriate conduct", also that "his behaviour escalates following legal high use for which again he has capacity, though at times this is suggestible."

- ***25 September 2014:*** After the Section 2 expired, Damien remained on the ward and a capacity assessment was in recorded in the notes to the effect that he was assessed as having capacity "re offending behaviour".
- ***26 February 2015:*** Damien's care coordinator documented: "request from MAPPA to get a clearer idea of (Damien's) capacity around criminality".

The Mental Capacity Act (2005) Code of Practice[6] refers to the two-stage assessment of capacity, namely:

> *Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)*
>
> *If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?* (page 41, Code of Practice)

It sets out four questions to consider when assessing mental capacity:

1. *Does the person* have *a general understanding of what decision they need to make and why they need to make it?*
2. *Does the person have a general understanding of the likely consequences of making, or not making, this decision?*
3. *Is the person able to understand, retain, use and weigh up the information relevant to this decision?*
4. *Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?* (page 41, Code of Practice)

The starting assumption is that an adult has capacity, unless there are reasons to suspect otherwise. Damien would have been understood as having "an impairment of the mind or brain", but would he have been able to understand the likely consequences of decisions he was called on to make in respect of his offending behaviour, breaching other people's boundaries, and, importantly, in respect of deciding where to live? Would he have been able to understand a tenancy agreement and its expectations on him? From the information available there is no capacity assessment recorded in respect

[6] See Mental Capacity Act 2005 Code of Practice at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

of Damien making decisions about his future living arrangements and this is an issue that his family has also highlighted, noting that they were aware that he lacked understanding as to why he could not return to his previous address at Placement 2 and why he had been admitted to hospital under the Mental Health Act. This view is disputed by Somerset Partnership which states that this was not reflected in conversations staff recorded with him during this time, referring to records indicating that staff had a number of conversations with Damien regarding placement decisions and they did not have reason to question his capacity in relation to placement decisions.

Damien's family also said that, when they talked to him about inappropriate risky behaviours, they report that Damien laughed inappropriately (a response they had previously observed when he did not understand or was embarrassed) and did not answer questions, but persisted in saying that he wanted to return to Placement 2. They felt that he did not appear to be able to understand or retain the information he was given. Another factor to consider in relation to capacity assessments is that Damien was "*highly vulnerable to exploitation or influence by people who tell him they are friends*" (quoted from the Forensic Psychologist specialist assessment).

The Home Office definition of coercive behaviour, taken from Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework[7] (December 2015, and therefore published after Damien's death, but included for contextual purposes), is as follows:

> *Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.*

The document this definition is taken from refers to intimate or family relationships, but evidence suggests that Damien's "friends" were exploiting him and taken advantage of him in ways that fit with the concept of coercive behaviour.

Another way of understanding how Damien's "friends" may potentially have influenced him is by exerting undue influence, which is defined in a legal dictionary[8] as follows:

> *Virtually any act of persuasion that over-comes the free will and judgment of another, including exhortations, importunings, insinuations, flattery, trickery, and deception, may amount to undue influence.*

[7] See Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

[8] See https://legal-dictionary.thefreedictionary.com/undue+influence

The Home Office document Criminal Exploitation of children and vulnerable adults: County Lines guidance (2018, and therefore published after Damien's death, but included for contextual purposes) defines child criminal exploitation as follows:

> *an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual.*

But the document goes on to say that it:

> *can affect any vulnerable adult over the age of 18 years*

and

> *is typified by some form of power imbalance in favour of those perpetrating the exploitation. Whilst age may be the most obvious, this power imbalance can also be due to a range of other factors including gender, cognitive ability, physical strength, status, and access to economic or other resources.*

The Care Act statutory guidance of 2018[9] states that safeguarding duties apply to an adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs)*
- *is experiencing, or at risk of, abuse or neglect*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect*

Damien could have been regarded as exploited by his "friends" financially, psychologically and possibly in terms of criminal activities – indeed the forensic psychology assessment referred to below includes reference to people who tell Damien they are friends and exploit him (see 6.2.3 below, Specialist assessments). Although the document above focuses on children in relation to county lines, the concept of exploitation would describe the situation Damien was in (see 6.2.5 below, Safeguarding, vulnerability and exploitation). The difficulty is that (as the Home Office documents state) the activity may appear to be consensual and this is where the Mental Capacity Act 2005 might provide a structure in terms of capacity assessment for professionals to assess how far an individual is able to make decisions about the activities they are becoming involved in. It is interesting to note that the MHA CoP (page 214) states that one of the risks relating to people with learning disabilities or autism is "*incorrect assumptions that a tendency to*

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

acquiesce is the same as informed consent". There are references to Damien's mental capacity in relation to "criminality"/ "offending behaviour" being considered in September 2014 and February 2015 (see above for more detail) but how far was the possibility of exploitation by others considered?

6.1.4 Specialist assessments and holistic assessment

Contact with services took place over a number of years and during that time a variety of assessments took place. Some of them are pertinent to the events that led to this SAR and pertinent to the discharge planning process.

Specialist OT assessment dated 21/11/2006

This very detailed assessment by a Specialist OT gives the following information:

"requires a definitive structured routine and pattern of his daily life"

Damien is described to her as "articulate and insightful"

Also "can come across as more able than he is"

"any changes in (Damien's) life need to be based on carefully planned and accurate consideration of the very high anxiety levels (Damien) experiences in relation to any differences or changes that occur in his life".

Forensic Psychology assessment early 2015

A forensic psychologist was involved in assessing Damien at the request of MAPPA in early 2015 and in summarising risk information to inform future accommodation providers and to look at factors potentially exacerbating and mitigating risks.

He described Damien's case as "complex in terms of the interaction between his pervasive development disorder (Asperger's syndrome), mental health (predominantly anxiety and ADHD) and risk. (…) early assessment of (Damien) was he was at risk to himself through vulnerability and being exploited. There was also a risk to self through consumption of legal highs." He goes on to comment on there being historically little evidence of risk to self through deliberate self-harm or suicide, but that he was regarded as presenting a violence risk to others following a serious assault, and that there were concerns relating to the potential for sexual assault and possession of indecent images. He also notes that Damien "has a tendency to become overly familiar and to struggle with boundaries. This leaves him highly vulnerable to exploitation or influence by people who tell him they are friends". Furthermore, he notes that Placement 2 "represents a chaotic environment with an anti-social peer group that regularly influences and exploits (Damien)."

Holistic assessment

This is a term that is used for a comprehensive assessment and it comes from:

the notion that the physical, mental, social, and spiritual aspects of a person's life must be viewed as an integrated whole. This leads to a broader concept of patient/client care in which emotional and social needs are dealt with as well as physical needs.[10]

Damien's family felt that he was not understood 'holistically' and in particular that his strengths and vulnerabilities were not recognised and addressed in his care plan, although they may have been understood by individual members of staff. A holistic assessment does not exclude (and indeed should draw on) the specialist assessments referred to above.

6.1.5 Discharge/ transfer of care processes

The specialist assessments above make a number of important points relevant to discharge planning:

- Damien's needs were complex
- He could come across as more able than he was
- Change was likely to increase Damien's anxiety
- Discharge needed to be carefully planned
- Meaningful structured daily activities were likely to be protective
- The role of "ongoing assertive monitoring" (forensic psychology assessment)

The NICE guideline Transition between inpatient mental health settings and community or care home settings[11] states:

Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, if necessary. This may include: …

- *people on the autistic spectrum* (page 14)

Other points of note are:

*ensure that (discharge) is collaborative, person-centred and **suitably paced**, so the person does not feel their discharge is sudden or premature.* (page 23, bold added)

references to *phased leave*

and from the literature we know that:

[10] See https://medical-dictionary.thefreedictionary.com/holistic

[11] See https://www.nice.org.uk/guidance/ng53/evidence/full-guideline-pdf-2606951917

the first week and first month post discharge following psychiatric hospitalisation are periods of extraordinary suicide risk[12].

This is why the Royal College of Psychiatrists toolkit[13] recommends early follow up after discharge (within 2-3 days), that a care plan should be in place at the point of discharge, and personalised risk management.

One of the puzzling issues is that, as stated in the Somerset Partnership NHS Foundation Trust (Somerset Partnership) Incident Investigation, it is not clear whether Damien was still an in-patient, on extended leave or formally discharged from in-patient care and/ or still subject to the MHA when transferred to Placement 3. Whatever his status, however, guidance is that a care plan should have been in place and monitoring arrangements should have been clear to, and agreed by, all concerned.

6.1.6 Safeguarding, vulnerability and exploitation

There is documented evidence that Damien was the victim of assaults, robberies and exploitation, including financial exploitation, often involving people whom he perceived to be "friends" but who others felt did not have his best interests at heart, starting from around the time that he started to go to College (see comments above about mental capacity and undue influence). His kindness and generosity and his eagerness to have friends and a 'normal' life may have contributed to his vulnerability.

The Mental Health Act Code of Practice states that:

> *People with learning disabilities experience disproportionate harassment, 'hate crime' and 'mate crime', and they are disproportionately the victims of violence. These are all factors that may make aggressive behaviour sometimes a learned protective behaviour rather than a sign of a mental disorder*. (page 209)

While Damien had a learning difficulty rather than disability these factors and their impact on the behaviours he exhibited should still have been recognised.

The Royal College of Psychiatrists 2014 document[14] "Good practice in the management of autism (including Asperger syndrome) in adults" has a section on offending behaviour which is relevant to Damien and one pertinent point is included below:

---

[12] Chung D, Hadzi-Pavlovic D, Wang M, et al. Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. BMJ Open2019;9:e023883. doi:10.1136/bmjopen-2018-02

[13] https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/safer-services_a-toolkit-for-specialist-mental-health-services_updated-nov-2018.pdf?sfvrsn=f6620787_2

[14] See https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr191.pdf?sfvrsn=4cd65cde_2&sfvrsn=4cd65cde_2

> *A naive misinterpretation of social relationships may leave an individual open to being drawn into illicit relationships as well as to intimidation and exploitation. Limited emotional knowledge can hinder the development of a mature understanding of adult situations and relationships so that, for example, feelings of social attraction or friendship are misinterpreted as the stronger emotion of love.* (page 21)

The list below of safeguarding contacts is not exhaustive and is drawn from various sources. It demonstrates that there were repeated safeguarding concerns in connection with Damien.

- ***21 March 2014:*** A police incident report was received by Somerset County Council – Damien's bank card was missing and cash had been withdrawn from his account. The information was forwarded to with Somerset Partnership.
- ***14 November 2014:*** Somerset County Council received a Police referral concerning alleged theft of medication from Damien's medicine cabinet. Information was forwarded to Somerset Partnership in line with the prevailing local arrangements at the time. It should be noted, in relation to both this and subsequent safeguarding referrals, this was prior to the enactment of the Care Act (2014). The Care Act was introduced on 1 April 2015, not long before Damien's death, so the majority of his care (including all of the safeguarding referrals below) took place pre-Care Act. It also took place during a period when Somerset Partnership was operating as a Health and Social Care Trust, with functions delegated to it that are now performed by the local authority. In addition, prior to the Care Act lines of responsibility and the nature of those responsibilities were not clear-cut: the relevant guidance at that time was No Secrets.[15]
- ***26 November 2014:*** Contact to Somerset County Council from Placement 2 reporting the incident on 13 November concerning a "friend" of Damien who was thought to have previously taken money from him and may have broken into the medicine cabinet. This was forwarded by email to Somerset Partnership.
- ***2 December 2014:*** Contact to Somerset County Council from care provider chasing a safeguarding referral
- ***3 December 2014:*** –Somerset County Council forwarded the referral to Somerset Partnership.

[15] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf

- ***8 January 2015:*** Somerset Partnership – Damien's care coordinator sought advice from Somerset Partnership Safeguarding and liaised with probation.
- ***9 January 2015***: Somerset Partnership – Damien's care coordinator updated Somerset Partnership Safeguarding. Advice to be offered to Rethink to follow their own safeguarding procedures and provide care and risk management planning.
- ***15 January 2015:*** Contact again with Somerset County Council from the organisation running Placement 2 to advise about an incident giving rise to concern for the safety of a professional working with Damien – recorded as information only.
- ***22 January 2015:*** Somerset Partnership– Damien's care coordinator liaised with Somerset Partnership Safeguarding.

6.1.7 Contact with Police, experience of crime and criminal justice system

The list of contacts with police/ experiences of crime is unlikely to be exhaustive and is extracted from a variety of sources. It demonstrates that Damien was a victim of crime and was himself involved in criminal behaviour, mostly the documents record that he was intoxicated at the time.

- ***23 December 2013:*** arrested for a public order offence/ hate crime against a disabled neighbour (verbal aggression).
- ***14 February 2014:*** Damien was attacked and robbed at home.
- ***10 March 2014:*** Damien was arrested for an aggressive act (details unknown).
- ***21 March 2014:*** Damien's bank card was reported missing and cash withdrawn from his account.
- ***23 April 2014:*** Damien reported his money had been taken.
- ***14 May 2014:*** there was a burglary at Damien's flat – the unknown offender was believed by Police to have used Damien's key to gain access.
- ***28 August 2014:*** arrested for breach of the peace – this led to his admission to hospital under the Mental Health Act.
- ***20 October 2014:*** Damien's medicine cabinet was raided.
- ***13 November 2014:*** Damien's medicine cabinet was raided again.
- ***30 November 2014:*** Police called after Damien threatened to run in front of a vehicle – thought to be intoxicated with legal highs. Three possibly under-age teenagers were also found to be in his room, although this does not have any relevance to this report.
- ***31 December 2014:*** Damien was arrested for breach of the peace after taking alcohol and cannabis.
- ***January 2015:*** Concerns at his accommodation that Damien posed a risk of sexual assault to a named female friend.

- ***7 February 2015:*** Damien broke into a neighbour's property after taking alcohol and legal highs.

6.1.8 Communication between agencies and family

The issue of communication with families was identified in the original SAR report and the Learning Lessons Practice Briefing Note 'Damien' Case Review, March 2017 suggested the following actions in order that "good communication leads to better coordinated care and better experiences":

- *Identify a named practitioner who will ensure that the person's family members, parents or carers receive support and timely information*
- *Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information. Good practice would be to gain consent to share information with appropriate family members early to avoid delay or complications later on*
- *Take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge.*

For further information about communication with the family and between professionals from the family's perspective see Involvement of family/ partnership working with family page 6.

Some families will not include family members who have experience of how health and social care systems work and it is important that communication between agencies and families does not rely on family members with high levels of awareness and knowledge, but instead aims to equip and support families with the awareness and knowledge that they need to navigate the system.

6.1.9 Risk assessment

The forensic psychology risk assessment (summary dated 26 May 2015) refers to two main concerns, namely violence towards others and the potential for sexual assault, but also notes concerns about deliberate self-harm/ suicide and Damien's vulnerability/ possible exploitation by others.

After Damien's transfer to Placement 3, incidents of self-harm took place that were not shared with mental health staff and therefore were not taken account of in risk assessment. As a result, mental health staff were unaware of the nature of the incidents and the fact that they were continuing to take place.

The Crisis Resolution Home Treatment Team (CRHTT) assessed Damien on 25 June at Placement 3 and his long-term and acute risk of suicide was rated as low. His risk of accidental self-harm/ neglect was assessed as low in the long-term and significant acutely. The plan at that stage was to contact staff or Damien daily over the next four days. However, as the Reviewer understands it, the CRHTT contacted staff by phone rather than in person, and was not

informed of ongoing incidents so that their assessment of risk and of the need for further support or re-admission could not take account of what was happening. It may also be more difficult in telephone assessment to critically analyse information being shared and the overall situation. It also involves the risk that it may be a different member of placement staff being spoken to by the CRHTT on different occasions, and that they might be expressing how Damien was presenting at that moment in time rather than over the period since the last call. It also appears that placement staff were not aware of what information should be passed on to the CRHTT in order to assist in their assessment of risk.

We know that risk is dynamic: it fluctuates over time. It is regarded as best practice[16] that:

> *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time and a recognition that each service user requires a consistent and individualised approach.* (p 28)

And

> *A risk management plan is only as good as the time and effort put into communicating its finding to others.* (p 32)

In addition, we know that the highest risk of suicide after discharge from a mental health unit is within the first 2 weeks; that the annual number of suicides under CRHTTs is increasing; and that almost 40% of those who die whilst under the care of a CRHTT do so within the first week.[17]

Another publication from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[18] looks at the risk assessment and management prior to suicide and:

> *has found evidence of a 'low risk paradox'. Specifically we found the immediate risk of suicide at the final service contact was judged by*

[16] From Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services: see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

[17] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland, Wales. October 2018. University of Manchester, see https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-69-Mental-Health-CORP-annual-report-v0.4.pdf

[18] The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: University of Manchester, 2018, see https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf

clinicians to be low or not present for the majority of patients who died by suicide.

One of the clinical messages from this study is that families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk.

Adults who have the capacity to decide who should be involved in their care have the right to decide whether family/friends should be involved in their care decisions, and whether information should be shared. When people have complex needs, it is helpful to encourage people to agree to involve family involvement and give people a range of options, which could include families participating in meetings (but perhaps with only certain information being shared), or professionals seeking views from family members without sharing any information about the person. If family members are concerned about the wellbeing of their loved one, professionals can listen to the family member and consider the information they have provided in planning, but do not have to share information with the family member should an adult with capacity to decide about information sharing ask them not to. However, Damien's family were not invited to risk planning meetings leading up to placement three, despite having been invited to, and attend, risk planning meeting on the Ward prior to his two previous discharges. Damien's behaviour following his move to placement 3 might have appeared impulsive and perhaps chaotic but he:

- Twice jumped/ ran in front of cars
- Cut his head with a knife
- Voiced suicidal thoughts
- Tried to grab bleach
- Asked for a plastic bag to go over his head

In the context of his known high anxiety levels and difficulties in dealing with change, these impulsive perhaps chaotic acts might have been regarded as indicating an increased risk. Unfortunately, not all incidents were made known to the CRHTT, and the CRHTT had no experience of the level of mental health expertise that might be expected of the service provider where Damien was placed on leaving the ward: after their initial assessment of Damien on 25 June they relied on telephone assessments rather than seeing him and the staff face to face.

There may have also been differing understandings of what was meant by 1:1 care. NICE uses the following definition of continuous observation (which refers to a 1:1 nurse):

usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated

one-to-one nurse, with immediate access to other members of staff if needed.[19]

Having read the placement records (the reviewer believes, but cannot be certain) it appears that the term 1:1 was used when a member of staff spent time with Damien, rather than being used to indicate the level of observation being employed over time.

Events post transfer of care raise a number of questions including the following:

- How do practitioners decide when to visit people and when to assess them via another person, when to see them face to face versus when to rely on telephone assessment?
- When would practitioners consider an option for someone who knows the person to see them and make an assessment?
- How do practitioners ensure that staff of other establishments are aware of what information needs to be shared and is regarded as relevant to an individual's mental health assessment and treatment?
- How might practitioners be clear of the limitations of information shared with them (e.g. in terms of staff not being on duty/ not having a handover, or not being aware of what is important)?
- How might practitioners 'calibrate' the level of expertise to be expected from staff of other establishments?
- How might mental health practitioners assess risk in a collaborative way with other relevant persons (especially family)?
- How often should risk assessment be reviewed?
- Have mental health practitioners ensured that they understand the level of observation being employed by placement providers for someone with mental health needs?

6.1.10 MAPPA

The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements[20] ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

[19]NICE Guideline NG10, see https://www.nice.org.uk/guidance/ng10/chapter/recommendations#_Ref398644986

[20] See https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=7134100

Individuals and families should be clearly told the implications of being subject to MAPPA: it should not rely on a family member having knowledge of services.

6.1.11 Mental health issues, use of alcohol and substances

Damien was known to Child and Adolescent Mental Health Services from around the age of 16 and was in contact with learning disability services from around 2000. He was given ICD 10 diagnoses more recently: Aspergers syndrome, Attention Deficit Hyperactivity Disorder and mental and behavioural disorder due to the use of other stimulants including caffeine, harmful use of legal highs. He was also treated for low mood and anxiety. Damien was treated with Sertraline and his mother raised the question on 6 May (progress notes) of whether stopping it might have affected Damien's mood. The record notes that it would be discussed with the doctor.

6.2 Examples of good practice

6.2.1 Family involvement and the Police

His sister regularly acted as Damien's Appropriate Adult, and she highlighted this as good practice from the police.

6.2.2 Ward staff involvement with the family

The family comment that the ward staff cared for Damien excellently and worked well with his mother to manage him.

6.2.3 **Practice** Briefing

The practice briefing published in March 2017 highlighted a range of key considerations for practice that remain valid in addition to this extension to the original SAR.

7 Conclusions

7.1 Lessons Learned

The terms of reference of the extension SAR asked: What are the main issues (lessons) identified for the way in which organisations work to safeguard and promote the welfare of high-risk individuals? These are discussed below.

7.1.1 Finding appropriate accommodation

It may be difficult to identify appropriate accommodation for people with complex needs.

So, how can practitioners and families be assured that a provider can provide the required level of care for someone, particularly in circumstances when the practitioners involved in arranging the placements may not have had previous experience of or contact with the provider being considered? Some of the pertinent questions here are:

- Who decides (or how is a decision made) that a placement is able to provide appropriate care?
- What checks can be carried out to assess suitability and what information is available to guide practitioners involved in the process? For example, perhaps with CQC (including reading inspection reports) or with commissioners. How might practitioners assess the suitability of possible new placements?
- What is regarded as good practice in identifying and securing a placement?
- Who should visit possible placements?

Once a placement has been identified the discharge process should not be unnecessarily delayed by the process of securing funding. The pathways for securing funding should be clearly understood and timely. It should also be shared with all those who are relevant including the service user and their family (where the service user agrees or if in the service user's best interests if they are unable to make a decision about family involvement).

With regard to the involvement of the service user in the process of identifying appropriate accommodation, it will be important to determine the lawful basis on which the person will live there in order that their right to liberty is upheld. Is this with the person's consent? Is the person required to reside in a certain setting because of lawful requirements under the Mental Health Act? If not, and if there is doubt that the person has the capacity to consent to the living arrangements, it will therefore be necessary to formally assess that person's mental capacity to make decisions when there are signs that their decisional capacity might be impaired and, if the individual is assessed as lacking the capacity to make decisions about their placement, to implement a best interests decision-making process.

7.1.2 Discharge/ transfer of care processes

When the care of people with complex needs is transferred to a placement outside hospital the following need to be considered:

- Ongoing monitoring/ follow up: who by and when
- The daily activities that the individual needs and the help that the individual needs in respect of these daily activities
- The pace of discharge and whether a phased discharge would be appropriate to this individual's needs
- Where the individual has agreed to family involvement, or if they lack capacity to make a decision about family involvement and it has been decided that family involvement is in their best interests, how the family (and who in the family) will be included in the process of transferring care

7.1.3 Mental capacity assessments

Service users with complex needs and/ or subject to coercion and exploitation may not have the capacity to make some major decisions and it may be advisable where there is doubt or conflicting information regarding mental capacity in relation to a particular decision to carry out and document a mental capacity assessment. Should assessment find that a person does not have capacity in relation to a particular decision, this does not mean that the person's wishes and preferences will not be respected, as they should be taken account of in best interests decisions.

7.1.4 Risk assessment and risk management processes

The risk assessment process in Damien's case after his care was transferred did not take account of incidents that were happening in the placement. These incidents were not communicated to the relevant mental health practitioners.

A contributory factor in this lack of communication may have been that some assessments took place over the telephone.

7.1.5 Keeping high-risk services users safe from exploitation

Damien's vulnerability to coercion and exploitation was recognised as a risk but there was no plan to safeguard him.

7.1.6 Partnership working, communication with/ involvement of family and holistic assessment

Damien's family identified a lack of communication with them and were not involved in key decisions, particularly key decisions relating to transfer of care and risk assessment/ risk management.

They identified a lack of holistic assessment, in particular that Damien's strengths and vulnerability to exploitation were not addressed, and that care plans did not capture Damien as an individual.

A learning point for all professionals is to encourage discussions with people with complex needs about who they would like to be involved, and to what extent.

8 Recommendations

8.1.1 Single Agency Recommendations

Single agency recommendations were derived from the Somerset Partnership Incident Investigation and are acknowledged, but not included here.

8.1.2 Multi-agency Recommendations

Please note that while organisation names at the time of the events described have been used throughout this Report the current names of the organisation(s) to which each recommendation applies as at the date of publication have been used in this section.

Recommendations addressing finding appropriate accommodation

Recommendation 1

Written guidance is produced, or where already available reviewed, by Somerset County Council and Somerset NHS Somerset Foundation Trust for use by all staff tasked with finding appropriate accommodation for people with complex needs. This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case

This guidance should address issues including, but not limited to:

- Which organisation has the lead where there is multi-agency involvement
- Who should contribute to a decision about the suitability of a potential placement
- What information is available and should be sought in order to assess a placement's suitability to meet an individual's needs (this may differ for established accommodation and newly opened accommodation)
- What constitutes good practice in respect of finding appropriate accommodation
- How the individual and, where applicable and appropriate, those who are important to them, should be involved in the process.

This guidance should be completed and signed off within 3 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting following this.

Recommendation 2:

That decision-making processes for commissioning services for individual adults are reviewed by Somerset County Council, and Somerset NHS Foundation Trust to ensure that they produce timely decisions, and that the process is shared with the person themselves and, where applicable and appropriate, those who are important to them.

The review of pathways should be completed within 3 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting

following this. If applicable, the progress on any action plan emerging from the review of pathways should be monitored by the Somerset Safeguarding Adults Board's Executive subgroup and the confirmation provided to the Board when it has been completed.

This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case.

Recommendation 3:

That the Somerset Safeguarding Adults Board seeks assurance from Mendip District Council, Sedgemoor District Council, Somerset West and Taunton District Council, South Somerset District Council, and Somerset County Council that there is a shared commitment to joint action across local government, health, social care and housing sectors in Somerset to support the needs of adults with autism; and that through the Improving Health and Care Through the Home in Somerset (Memorandum of Understanding) and associated delivery they will:

- Use data, evidence, and user / lived experience (the client voice) to identify the homelessness challenges across the county.
- Focus on preventative interventions.
- Focus on person-centred / strength-based interventions.
- Ensure multi-agency operational forums are in place to help resolve complex cases and safeguarding concerns.
- Identify and coordinate across all partners the effective use of funding.
- And that where they can demonstrate that any gaps that require regional or national action to be addressed have been appropriately escalated.

The SSAB should write to the five Councils seeking this assurance within 28 days of the publication of this review, with the Councils asked to respond in writing within a further 28 days

Recommendation addressing the discharge/ transfer of care process

Recommendation 4:

Written guidance is produced by Somerset County Council and Somerset Foundation Trust that details the required content of care plans in circumstances when the care of an adult with complex needs is transferred to another setting (including where the commissioner is employed by another organisation that has a delegated role), including but not limited to:

- Details of who is following this individual up
- Details of when this person will be seen

- Information about how the family will be involved (where the individual has agreed to family involvement, or if they lack capacity to make a decision about family involvement and it has been decided that family involvement is in their best interests)
- If the family is not involved, then the care plan should include that information and state why the family is not involved – active family involvement should be promoted
- Details of the key person that family or others should contact if they have concerns
- Information about whether a phased discharge has been considered and would be appropriate, and details of any planned phased discharge
- Details of any arrangements in place for daily activities that the individual needs and the help that the individual needs in respect of these daily activities

This guidance should be completed and signed off within 3 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting following this.

Compliance should be checked through auditing processes and evidence that these checks are being undertaken, and analysis of their findings, should be reported to Somerset Safeguarding Adults Board's Quality Assurance Subgroup after 6 months.

This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case.

Recommendation addressing Mental capacity assessments

Recommendation 5:

That all organisations involved in providing care and support to Damien ensure that Mental Capacity Act training of their staff addresses the influence of coercion and exploitation on people with complex needs, and that quality monitoring processes are used to test that it is being addressed in practice.

Organisations involved in this SAR should be able to evidence to the Somerset Safeguarding Adults Board's Learning and Development Subgroup how any training they provide or commission addresses coercion and exploitation of adults within 6 months of the publication of this Review, and that they have appropriate arrangements in place to monitor the quality of this. Once received the Subgroup should determine the frequency of further monitoring, if required.

Recommendations addressing risk assessment and risk management

Recommendation 6:

All organisations involved in the care of Damien should review their risk assessment processes, considering the following areas in particular:

- Ensuring that a lead agency and lead practitioner is identified and communicated to all involved
- When to see people face to face, and when to assess them remotely referencing when the latter approach should be reconsidered
- Ensure that other professionals and organisations are aware of what information needs to be shared and is regarded as relevant to an individual's mental health assessment and treatment
- How to be clear of the limitations of information relevant to risk, for example information that has been shared by persons who may have limited involvement in an individual's care and/or support
- Who should contribute to risk assessments
- How a collaborative approach can be taken to risk assessment
- How risk assessments should take account of environmental risks
- How risk assessments should be shared and with whom
- How often should risk assessments and risk management plans be reviewed
- What should trigger an unscheduled review of a risk assessment and risk management plan

The review of risk assessment processes should be completed within 3 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting following this. If applicable, the progress on any action plan emerging from the review should be monitored by the Somerset Safeguarding Adults Board's Executive subgroup and the confirmation provided to the Board when it has been completed.

This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case.

Recommendation 7:

All organisations involved in the care of Damien should review the training that their staff undertake in respect of risk assessment and management to ensure that it addresses the issues identified in this SAR, including, but not limited to:

- The involvement of the individual, their family and others who are important to them in the development of risk management plans

- The need for a holistic approach to risk management that recognises that the individual may pose a risk to themselves as well as others; or be as, if not more, vulnerable to abuse and/or neglect by others as others may be to them
- The impact of changes to an individual's care and/or support arrangements on their existing coping strategies
- The risks resulting from an incorrect assumption that a tendency to acquiesce is the same as informed consent
- Understanding of the application of Mental Capacity Act (2005)
- Follow-up after discharge, including the monitoring of any incidents, and consideration as to how they impact on existing risk management plans, approaches and responses
- The impact of the assessment method (in person, by telephone etc.) on the assessor's ability to undertake an effective assessment with a thorough understanding of risk, and when a decision not to assess in person should be reconsidered
- Recognition of the capacity for the individual's risk level to change over time, and that each person requires a consistent and individualised approach.
- That risk management plans require communication to all involved in order to be effective, and are only as good as the time and effort put into communicating their finding to others.
- The specific risks associated with exploitation and 'Mate Crime'

Organisations involved in providing care and support to Damien should be able to evidence to the Somerset Safeguarding Adults Board's Learning and Development Subgroup that this review has been completed within 3 months of the publication of this Review. If applicable, the progress on any action plan emerging from the review should be monitored by the Learning and Development Subgroup and confirmation provided to the Board when it has been completed.

Recommendation 8:

The Somerset Safeguarding Adults Board should write to the Safer Somerset Partnership to ask it to review how information is brought together and shared in order to inform risk management, in particular in relation to the role of MAPPA where an adult is experiencing mental ill-health, and to implement any changes identified as a result.

The review should be completed within 6 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting following this. If applicable, the progress on any action plan emerging from the review should be monitored by the Somerset Safeguarding Adults Board's

Executive subgroup and the confirmation provided to the Board when it has been completed.

Recommendations addressing communication with and involvement of family and holistic assessment

Recommendation 9:

Somerset County Council and Somerset NHS Foundation Trust – should reinforce the requirement that, where adults with complex needs have given consent to involve family in their care or where they lack the capacity to decide about family involvement, but it is considered in their best interests to involve family them, that:

- There should be easily accessible routes for family to make contact with the organisation(s), and where applicable the named team or professional, involved in the individuals care and/or support
- Family should be involved in the discharge process
- Family should be involved in the risk assessment and risk management process
- The provision of information above should be documented and shared

Communications activities to reinforce this should have taken place within 3 months of the publication of this Review, and confirmation provided to the Somerset Safeguarding Adults Board that this has happened at its next meeting following this.

Compliance should then be checked through auditing processes and evidence that these checks are being undertaken, and analysis of their findings, should be reported to Somerset Safeguarding Adults Board's Quality Assurance Subgroup after 6 months.

Recommendation 10:

That the Somerset Safeguarding Adults Board seeks assurance that organisations are able to demonstrate that assessments are holistic.

Compliance should be checked through organisational auditing processes, and evidence that these checks are being undertaken should be requested by, and reported to, the Somerset Safeguarding Adults Board's Quality Assurance Subgroup. If applicable, the progress on any organisational action plans emerging from the audit process should be monitored by the Somerset Safeguarding Adults Board's Executive Subgroup and the confirmation provided to the Board by the organisation concerned when it has been completed.

APPENDIX 1: Glossary of acronyms

ADHD	Attention deficit hyperactivity disorder
ASC	Adult social care
CJA	Criminal Justice Act
CMHT	Community mental health team
CoP	Code of Practice
CQC	Care Quality Commission
CRHTT	Crisis resolution home treatment team
EBD	Emotional and behavioural difficulties
GP	General practitioner
ICD	International Classification of Diseases
MAPPA	Multi-agency public protection arrangements
MHA	Mental Health Act 1983
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NHS	National Health Service
OT	Occupational therapist
RCPsych	Royal College of Psychiatrists
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SIRI	Serious incident requiring investigation

APPENDIX 2: Terms of reference for the SAR extension

These Terms of Reference describe the scope of work for an independent reviewer who will be commissioned by the Somerset Safeguarding Adults Board (SSAB) to explore the events leading up to Damien's death on 3rd July 2015.

The review will build on and extend the Safeguarding Adults Review previously undertaken (under the pseudonym of 'Damien' completed in December 2016) considering new information that emerged during the inquest process that concluded on 09/03/2018 and the perspective of Damien's family.

The SAR will not seek to re-investigate or apportion blame. Its **primary function is to draw together the critical learning and consider what the relevant agencies and individuals involved in the case might have done differently that *could have prevented* harm**. This is so that lessons can be learned from the case and those *lessons applied to future* cases to prevent similar harm occurring again.

Scope

The SAR will seek to consider and address the following:

- What is the perspective of Damien's family on the events leading up to Damien's death and what learning do they feel should be identified
- Work previously undertaken alongside information from Damien's family, evidence given at the inquest and the outcomes of a learning event to establish areas where the existing SAR and the learning/recommendations it contains should be extended and strengthened within the following themes:
    - Understanding of the person: How well was Damien understood as an individual with his own needs and aspirations. To what extent was this recorded/communicated?
    - Actions Taken: How well did action taken accord with assessments or decisions made? How well were key decisions/assessments understood?
    - Appropriate Services: How appropriate were the services offered or provided? Were relevant enquiries made in light of assessments undertaken?
    - Risk Assessment: How effectively was risk assessed and managed? How well were variances in risk managed, understood and communicated?
    - Good Practice: Is there any good practice to highlight?
    - Key Issues: What were the key issues in communication, information sharing, risk management or service delivery that impacted on this case?
    - Lessons and Learning: What are the main issues (lessons) identified for the way in which organisations work to safeguard and promote the welfare of high-risk individuals?

The aim of the review is to draw together critical learning which identifies any systemic issues, learns lessons for the future and identifies any necessary action.

This will include a learning event involving key organisations and, should they wish to attend, Damien's family.

It is recommended the review cover the period 01/04/2014 to 03/07/2015.

It is recommended the review commence in the autumn of 2018 and conclude within a three- month timeframe.

The review should extend and expand on the existing SAR and use it to produce a revised overview report, summarising the key issues, identifying the findings and proposing a set of recommendations. It should include:

- An executive summary for publication
- A brief outline of the case, including information about Damien as a person
- An analysis of the key themes arising
- A list of agreed findings of fact
- A set of recommendations for action.

The Lead Reviewer will be required to formally present their findings to the Somerset Safeguarding Adults Board once completed, and to support a future Learning Event as part of their work with the partnership.

Lead Reviewer

To be identified

Agency Participants

The Review process should be informed by both Damien's family and practitioners who had been directly involved in the case, and supported by local key managers and officers who can provide operational and strategic knowledge. The organisations that have been identified with an involvement are:

Involved Agencies
Accomplish Group (formerly Transrace)
Avon & Somerset Constabulary
Care Quality Commission (as the regulator of the service)
National Probation Service
NHS Somerset Clinical Commissioning Group
Rethink
Safeguarding Adults Board representative
Somerset County Council
Somerset Partnership NHS Foundation Trust
South Western Ambulance Service Trust .

In undertaking reviews, Somerset's Safeguarding Adults Board expects that:

- There is a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice

- The approach taken to reviews will be proportionate according to the scale and level of the complexity of the issues being examined
- Reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals will be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Adults at risk will be involved in a SAR about their experience; if they have any significant difficulty in being involved, an independent advocate will be commissioned to support them to be involved as possible throughout the process
- Families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

Out of scope

- A critique of the previous Review.
- Repetition of work previously undertaken as it is our expectation that the Independent Reviewer will expand on, rather than repeat, work that formed part of the original Review. However, it is acknowledged that the conclusions drawn, and subsequent recommendations, may differ.

APPENDIX 3: Documentation made available to the extension SAR reviewer

Original SAR documents

- PowerPoint presentation, A Serious Case Review, dated September 2016
- Report of original SAR dated December 2016 together with Appendix 1 and Appendix 2
- File called Family response to SAR
- Letter to Damien's mother and sister from SSAB Independent Chair dated 9 December 2016
- Practice briefing Note dated March 2017
- Chronologies

Files from the Inquest

Index (updated)

- **Additional docs.pdf**
  - Witness statements, Crisis Plans & Other info
  - Risk information, Risk screening
- **FILE 1**
  - Witness statements (including family), notes for Coroner,
  - Post-mortem report, Placement Panel papers, 1st Medical Report.
- **FILE 2**
  - Somerset Partnership progress notes covering MH contacts
- **FILE 3 Part 1**
  - Somerset Partnership documents continued:
    - Copies of MH documents including Discharge Summaries
    - Section papers, and copy letters
- **FILE 3 Part 2**
  - Information about Highbridge Court
  - Copies of assessment, staffing & training information
  - Copies of drug chart and risk assessments
- **FILE 3 Part 3**
  - Transrace forms related to Recovery Star &
  - Care plans, incident forms, daily record sheets.
- **FILE 3 Part 4**
  - Transrace papers including Handover forms,
  - Meeting record forms, observation forms
- **FILE 4 Part 1**
  - Hospital records related to final incident.

- **FILE 4 Part 2**
  - Copies of GP records
- **FILE 5 Part 1**
  - Transrace Procedures
  - Somerset Partnership Procedures

- **FILE 5 Part 2**
  - Somerset Partnership Procedures continued
- **FILE 5 Part 3**
  - Various including DOLS forms, Somerset Partnership
  - Incident Investigation, CQC Inspection Reports

Other information

- SIRI Report
- Family contact details

Files/ information from family

- Regulation 28 Report to Prevent Future Deaths
- Somerset Partnership's Response to Regulation 28 Report dated 17 July 2018
- Family response to SAR: A document starting with the heading What were the key issues, in communication, information sharing or service delivery that you feel impacted on this case?
- Links to two press releases on the INQUEST website[21]: the links are https://www.inquest.org.uk/robin-richards-opening
  And
  https://www.inquest.org.uk/coroner-to-raise-concerns-on-lack-of-care-provision-for-people-with-aspergers-as-inquest-concludes-on-the-death-of-robin-richards
  A document in response to questions arising, including about accommodation history

[21] See https://www.inquest.org.uk/about-us for information about INQUEST which describes itself as a charity "*providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians*".

APPENDIX 4: Collated Chronology

YEAR	MONTH	DATE	AGENCY	NATURE OF CONTACT OR SIGNIFICANT EVENT
2002			ASC	Referred to Minehead CMHT
2011	February	11	ASC	Referred to Bridgwater CMHT by Minehead as Damien had relocated to Bridgwater from Minehead area.
2013	May	4	ASC	Emergency Duty Team contact from Police re: Damien fighting in street. EDT worker offered advice but did not see Damien.
2014			ASC	Mental Health Act assessment at Musgrove A&E. Damien admitted to PICU under Section 2 with probable drug induced psychosis.
2014	Feb	14	File 1	Attacked and robbed at home.
2014	March	10	Police	Damien has attended victim's home, and banged on the door shouting through the letter box saying he was going to beat up and kill him.
2014	March	10	ASC	Request for Appropriate Adult as due to attend court. Described as having Asperger syndrome and depression.
2014	March	21	ASC	Contact - alleged theft notified to Somerset Partnership - recorded on AIS
2014	March	24	File 1	Reported that money had been taken.
2014	March	25	Police	Suspect approached the victim Damien who was sitting outside a shop. He kicked over Damien's backpack and took a packet of tobacco.
2014	April	9	NPS	Damien received a 12-month Community Order for threatening behaviour and public order offence. This order had requirements for him to be supervised for 12 months and see an alcohol counsellor. This order was managed by the CRC's until 12 January 2015.
2014	April	12	SWAST	Damien's mother called 111 service at 08:02. He was 'ranting' and threatening violence. She confirmed he had a previously diagnosed Mental Health problem, Asperger's, Autism, ADHD and 'drug problems'. Call advisor unable to complete the assessment. Police dispatched to Minehead address

2014	April	12	SWAST	Call to 999 at 08:39. Police on scene. Damien agitated with extreme paranoia, repeating himself, not making sense. Mother on scene confirmed previous aggressive outbursts and violence. Does not live with mother, just turned up in an agitated state
2014	April	15	ASC	Contact - ambulance service contact for information. Damien conveyed to hospital. CMHT informed.
2014	April	12		Admitted to Hospital from address Placement 2 after presenting at A&E by ambulance – detained on Section 2 MHA – diagnosis recorded as drug induced psychosis
2014	May	12		Discharged to Placement 2 supported accommodation on sertraline, risperidone, methyl phenolate and cetirizine. Discharge summary states "had taken amphetamines".
2014	May	14	Police	Victim of burglary in dwelling. Unknown offenders have gained entry to victim's flat. No damage caused. Believed they have used the victim's key to gain access.
2014	July	3	Somerset Partnership	Open referrals to the following Mental Health services; Out Patients (OP) Asperger's Team Bridgwater Community Mental Health Team (CMHT) Forensic team Home visit on this date to Supported Housing. Notes state Damien was calm and appointment was positive
2014	July	27	Somerset Partnership	Risk screen
2014	August	14	Somerset Partnership	Reports from Placement 2 state Damien is volatile and agitated. Home visit, Damien unpredictable and under the influence of legal highs. Crisis Resolution and Home Treatment (CR/HT) team number given to staff
2014	August	26	Somerset	Damien did not attend appointment with Asperger's team

			Partnership	
2014	August	28	Somerset Partnership	CMHT duty call from Placement 2. Reports of Damien drug and alcohol use, threats to kill his friends and mother. Advised to contact police
2014	August	28	Somerset Partnership	Damien did not attend appointment with forensic team. No further appointment offered until further discussion
2014	August	28	ASC	MHA assessment at Police station following arrest for breach of peace. Damien appeared psychotic when arrested for fighting near home. Detained under s.2. Admitted PICU
2014	August	28	Somerset Partnership	Approved Mental Health Professional (AMHP) Somerset Coast Team Duty call from custody nurse following Damien arrest for breach of the peace at Placement 2 requesting a Mental Health Act (MHA) assessment. Damien detained under Section 2 MHA and transferred to Ward.
2014	August	28		Admitted to Hospital Site from Placement 2. Diagnosis given as mental and behavioural disorders due to use of other stimulants including caffeine. Reference in discharge letter to a capacity assessment and that he "had capacity in relation to aforementioned decisions". Later refers to capacity in relation to breaching other people's boundaries and "sexually inappropriate conduct". Also notes that "his behaviour escalates following legal high use for which again he has capacity, though at times this is suggestible." Reference to "his vulnerability in terms of financial organization."
2014	August	29	Somerset Partnership	Risk screen Transferred to Ward 2 Damien states he does not want to go back to his supported accommodation with "Rethink" as he does not believe they are providing enough support for his needs
2014	September	4	Somerset Partnership	Liaison with probation regarding discharge planning. Risk screen
2014	September	4	Somerset Partnership	Damien reported to Dr that he had a legal and illegal version of a movie containing necrophilia and paedophilia. Police have possession of his computer and DVDs. Damien reports he wants to move to Taunton

2014	September	12	Somerset Partnership	Care coordinator confirms Damien can return to Placement 2. Awaiting stability in accommodation due to other residents. Risk screen
2014	September	14	Somerset Partnership	Risk screen Notes state: The family believe that Damien's needs would best be suited towards placing him within a community setting …they described Damien's situation at Placement 2 as being more individually based.
2014	September	19	Somerset Partnership	Confirmation that forensic team will see Damien in community Risk screen
2014	September	20	Somerset Partnership	Notes state Damien was looking forward to returning to "my home" Risk screen
2014	September	25	Somerset Partnership	Section 2 expired, Damien remains informal, discharge planning includes returning to Placement 2. Risk screen Damien states he does not want to go back to his supported accommodation with "Rethink" as he does not believe they are providing enough support for his needs. Damien assessed as having capacity re offending behaviour. Capacity assessment recorded in notes.
2014	September	29	Police	Staff are concerned over his behaviour when watching news reports on a missing girl he stands and shouts at the television and is visibly aroused by what is reported. His behaviour is inappropriate. Damien suffers with Asperger's.
2014	September	29	Somerset Partnership	Discharged from Ward Risk screen
2014	September	29		Discharged to Placement 2
2014	October	1	Police	Damien has been spending his benefit money on drugs for himself and 2 other males. There are concerns that Damien is being taken advantage of, however he is willing to hand his money over.
2014	October	17	Somerset Partnership	Telephone call from Probation who were not made aware of discharge

2014	October	21	Somerset Partnership	Appointment with Dr forensic team, discussed risks, engaged well
2014	November	3	Somerset Partnership	Appointment with Dr forensic team- assessed as high risk of committing an offence. Comment: Care planning robust No risk screen update, assessment remains low risk for everything other than generic risk to children
2014	November	13	Somerset Partnership	Medication theft reported to police. Comment that medication management in supported housing setting problematic
2014	November	14	ASC	Contact - ASC safeguarding contact and hazard - alleged theft of medication from Damien- forwarded to Somerset Partnership Safeguarding Team for action
2014	November	26	ASC	Contact - information provided by care provider about alleged offences against Damien
2014	November	30	Somerset Partnership	Rethink report further police intervention due to threatening behaviour to CR/HT Team Risk screen updated. Comment: Rethink place tenancy at risk. Violence to others and suicide- significant risk acute, low suicide risk long term.
2014	December	2	ASC	Contact from care provider chasing a safeguarding referral
2014	December	2	Somerset Partnership	Damien does not attend final forensic team appointment. Care coordinator transfer Comment: Police confirm no evidence or charges to be bought re film or child images
2014	December	3	ASC	Safeguarding referral forwarded to Somerset Partnership by ASC duty worker
2014	December	19	Somerset Partnership	Rethink advise they are concerned re Damien behaviour
2014	December	31	Somerset Partnership	Police arrest Damien for breach of the peace Assessed by Court Assessment and Advice Service (CAAS)

				Mental health assessed as poor however robust support in place. Comment: No charges were bought No risk update
2014	December	31		Referred to MAPPA
2015	January	2		Letter from consultant psychiatrist states that Placement 2 finding Damien agitated, unpredictable and difficult to manage at times – described as a long-term problem related to his developmental disorder and aggravated at times by misuse of substances.
2015	January	7	Somerset Partnership	Placement 2 report Damien has threatened to rape a female friend. Comment: Female aware of risk
2015	January	8	Somerset Partnership	Care coordinator seeks advice from Somerset Partnership Safeguarding and liaises with probation
2015	January	9	Somerset Partnership	Care coordinator and Probation liaising and updating risk management planning. Care coordinator updating safeguarding Advice to be offered to Rethink to follow their own safeguarding procedures and provide care and risk management planning.
2015	January	12	NPS	CRC approached NPS to take Damien's case due to an escalation in his assessed risk of serious harm. Info received from forensic team evidencing risk. NPS take on case - allocated to Probation Officer
2015	January	12	Somerset Partnership	Report from Care coordinator offering advice and opinion
2015	January	13	Somerset Partnership	Care coordinator completes MAPPA referral Multi-disciplinary/professionals meeting arranged.
2015	January	15	ASC	Contact - information from Rethink. Being dealt with by Rethink
2015	January	22	NPS	Professionals Meeting at CMHT to share risk information. TAU on potential victim's address. Phone contact with Damien. NPS to refer into MAPPA L2. Police IRIS team to take Damien as a case.
2015	January	22	Somerset	Multi-disciplinary professionals meeting.

			Partnership	Probation will complete MAPPA referral. Care coordinator liaises with Somerset Partnership safeguarding.
2015	January	23	Police	Probation has received information from MHT that during assessment, Damien has disclosed having thoughts/urges to rape. He has named a potential victim.
2015	January	27	NPS	Telephone call from accommodation provider - inappropriate contact with female staff
2015	January	27	NPS	Damien reported to Probation Officer as required. MAPPA L2 referral submitted.
2015	January	29	Somerset Partnership	Probation confirm liaison with Police IRIS team and Treat As Urgent (TAU) marker on address
2015	February	3 &10	NPS	Damien reported to alcohol counsellor as required. Advice sought by probation officer from specialist colleague to address sexual behaviour.
2015	February	9	Somerset Partnership	Emergency Social Care Panel requested, placement breaking down due to incident of breaking and entering. Comment: Eviction process third and final warning from Rethink.
2015	February	11	NPS	Damien kept next Probation appt. Information that he broke into the flat of another resident. No police action. Presented in an angry and agitated state. Professionals Meeting called by probation for following day due to increasing risk and MAPPA L2 meeting date not until later in the month.
2015	February	12	NPS	Professionals Meeting - Probation, CMHT, Placement 2, Police. Placement 2 evicted Damien this date - against decision made by professionals meeting.
2015	February	17	ASC	MHA at Housing scheme. Placement broken down. Damien having sexual/violent thoughts. Drugs and alcohol noted as contributory. Admitted under s.2. Comment: Discharge back to previous address 16/05/15. Admission was voluntary after 16/03/15.
2015	February	17	NPS	Confirmation that Damien has been sectioned to Ward
2015	February	17	Somerset Partnership	Mental Health Act assessment Damien detained on Section 2 and transferred to ward. Risk updated

2015	February	18	Somerset Partnership	Damien states he wishes to go to a care home in Devon Risk updated
2015	February	24	Somerset Partnership	Forensic team recommend a specialist placement of legal supervision/ conditions. Comment: No risk updated.
2015	February	25	NPS	Heard at MAPPA Level 2. MAPPA L2 reviews 11 March, 22 April, 27 May and 22 July 2015.
2015	February	25	Somerset Partnership	MAPPA recommendations include placement issues to be clarified via Placement Support Team /Social Care Panel. Comment: Risk updated
2015	February	27	Somerset Partnership	Two placements identified by Asperger's Team- to liaise with Placement Support Team/ Social Care Panel Risk updated
2015	March	2	Somerset Partnership	Vacancies discussed with supported housing service in Crewkerne
2015	March	4	Somerset Partnership	Mother states a named placement will meet Damien needs Social Care Panel letter recommends referral to service in Crewkerne
2015	March	6	Somerset Partnership	Transferred to ward Risk updated to low excepting children
2015	March	10	MPH	Outpatient Appointment Anaesthetics in pre-operative assessment clinic: Planned surgery - attended. History of ADHD, Asperger's Syndrome, Dyslexia, Dyspraxia, Depression and OCD Assessment result - fit to proceed with surgery. Planned as a day case.
2015	March	11	Somerset Partnership	MAPPA recommendations include assessment to be completed by service in Crewkerne
2015	March	16		Discharged from Section 2 by Responsible Clinician.
2015	March	17	Somerset Partnership	Placement options discussed with Damien, he would like to visit as soon as possible Risk screen

2015	March	18	Somerset Partnership	Section 2 expires Damien is informal patient Risk screen
2015	March	19	Somerset Partnership	Probation input preparing to terminate
2015	March	26	Somerset Partnership	Service in Crewkerne commences assessment Risk screen
2015	March	26	Somerset Partnership	Damien distressed 'begging' to return to Placement 2, which reportedly informed they had been advised he shouldn't return. Placement 2 and Ward informed of his mental state. Comment: Damien stated he may as well be dead and kill himself. Risk updated, suicide low risk
2015	March	27	Somerset Partnership	Damien returned to Placement 2 distressed, placement 2 staff contacted ward unhappy not to have been informed he was returning concerned re MAPPA arrangements. Damien returned to ward independently. Comments: Confusion on ward re Damien whereabouts. MAPPA recommendations did not cover leave from ward, this is a clinical decision. Informal, own tenancy no issues following risk assessment with returning home. No risk assessment available
2015`	March	27	Somerset Partnership	Damien contacts Mother distressed, anxious re placement arrangements. Comment: Agreement made to visit potential placement.
2015	March	31	Somerset Partnership	Damien reportedly excited and nervous about visiting placement. Advocacy services contact care coordinator for update on placement. Comment: Ward will contact care coordinator to make visiting arrangements. Confirmation from care coordinator that at least two contacts have been made with service in Crewkerne, however await feedback from assessment

2015	April	5	Somerset Partnership	Contact from Police IRIS team to Ward- information shared
2015	April	5	Somerset Partnership	Damien sister and mother raise concerns regarding his mental health, reassurance given. Damien reports he feels out of control and is stressed about the upcoming move and an operation he is having
2015	April	7	Somerset Partnership	Care coordinator and Advocate communicate re move. Damien anxious, considering self discharge. Comment: Confirmation of contact made with service in Crewkerne on a further two occasions by care coordinator Assessed low risk.
2015	April	7	Somerset Partnership	Service in Crewkerne confirms admin for placement is in process and they can offer day services in meantime Mother states a return to Placement 2 however short would not be advantageous at this point. Comment: Care coordinator to seek advice re way forward from Placement Support Team/ Social Care Panel representatives.
2015	April	9	Somerset Partnership	Ward Round Damien reports increasing anxiety and discusses death/suicide 'impression anxiety due to uncertainty regarding transfer'. Comment: Assessed low risk suicide in risk screening
2015	April	14	Somerset Partnership	Discussion regarding increase in Damien anxiety due to uncertainty regarding placement arrangements. Comment: Assessed low risk suicide in risk screening.

2015	April	15	Somerset Partnership	Care coordinator to discuss respite placement with specialist residential home whilst awaiting input from placement support/TR to liaise with service in Crewkerne. Comment: Reports suggest placement or Social Care Panel delaying move?
2015	April	16	Somerset Partnership	Care coordinator meeting with Respite service manager to arrange an assessment for Damien for respite placement. Comment: Unclear why there is a delay with service in Crewkerne
2015	April	17	Somerset Partnership	Assessed by proposed provider of the respite placement, invited to visit in next couple of days. Damien anxious regarding a move to proposed respite service. Comment: Low risk suicide screening
2015	April	22	Somerset Partnership	MAPPA recommendations include to arrange a discharge planning meeting
2015	April	22	Somerset Partnership	Referral opened to Placement Support team
2015	April	23	Somerset Partnership	Damien anxious re discharge arrangement, informed no decisions made. Comment: Unclear where delay in decisions are. Low risk suicide screening.
2015	April	24	Somerset Partnership	Care coordinator discusses move. Comment: Confirms no further decisions have been made re move on
2015	April	28	Somerset Partnership	Damien nervous about impending operation, doesn't comply with nil by mouth, reports no further pain. Operation cancelled. Comment: Risk screen updated

2015	April	30	Somerset Partnership	Contact made with Mother who is upset at length of time to arrange move on. Comment: Email sent requesting update
2015	April	30	Somerset Partnership	Ward contact service in Crewkerne they confirm they are waiting for confirmation of funding. Comment: Reports suggest funding has not been agreed
2015	April	30	Somerset Partnership	Contact continues Damien remains disgruntled, anxious - related to move on.
2015	May	1	Somerset Partnership	Family liaison referral made for Mum
2015	May	1	Somerset Partnership	Ward Round 'Damien presenting as disconcerted and distressed wanting to know what is happening with his placement, hasn't heard from care coordinator, wants to discharge himself to a bed and breakfast informed that the funding for the placement has not come through yet and we are not aware where the plan for a placement for Damien stands at present…. have reiterated my concerns around the delay and lack of input or information relating to his placement may have on his mental health. He is informal and at present asymptomatic and hence should he wish to discharge himself I do not see any grounds for detention. Comment: Ward and Damien await funding decision. Senior managers to be contacted regarding the delay in discharge and funding and the impact on Damien's health. Damien informed that the previously proposed respite placement is not an option. Damien informal asymptomatic.

				Risk screen updated suicide low risk.
2015	May	1	Somerset Partnership	Reported that Social Care Panel are reviewing the costings for placement on Thursday 7th May, if they are not satisfied with the costing then they will liaise with service in Crewkerne Comment: Delay in funding agreement for another week, Damien not informed due to concerns re his mental health Service in Crewkerne have given the vacancy to a respite client for 1 month. Family and professionals meeting delayed to await panel outcomes.
2015	May	1	Somerset Partnership	Damien continuing to consider discharging his self, worried but no suicidal ideation
2015	May	2	Somerset Partnership	Damien low in mood, discussing necrophilia
2015	May	6	Somerset Partnership	Carers assessment booked with Mum, Damien distressed re move, informed about Social Care Panel meeting
2015	May	7	Somerset Partnership	Social Care Panel meeting, care coordinator informed by Panel that there are concerns regarding risk due to other residents residing there. Service in Crewkerne deemed not a suitable placement. Care coordinator recommended to refer to a service in Bristol. Social Care Panel letter states, service in Crewkerne specialise in learning disabilities, other service users could be put at risk. (Letter to care coordinator states that Damien's dominant need is "mental health".) Comment: Social Care Panel do not agree funding for placement, another placement recommendation is made by Panel
2015	May	8	Somerset Partnership	Mother informed of outcome of panel, she is concerned about a city based placement.

2015	May	8	Somerset Partnership	Mum engaged in family liaison meeting, extremely unhappy with placement arrangements
2015	May	8	Somerset Partnership	Safeguarding advice offered following disclosure that Damien got in to bed with Mum on weekend leave. MAPPA concerned regarding alternative placement. Comment: MAPPA raised concern re: alternative placement, out of county, further from family and Somerset resources.
2015	May	9	Somerset Partnership	Crisis Resolution and Home Treatment Team offer contact during home leave. Home leave described as stressful…..over valued thoughts - of suicide and comparisons to celebrities that have ended their lives, worry anxiety and frustrations over his own future and placement, delayed discharge from ward however further expanding to society's social and economic issues. Mum angry and frustrated re placement, Damien denied suicidal thoughts to professionals, Mum contradicted this.
2015	May	11	Somerset Partnership	Damien reports he is having suicidal thoughts of jumping in front of a car. 8/10 in strength. Comment: Does not know outcome of panel, prediction that outcome of this will be increase in negativity and risk of self-harm or becoming aggressive. Risk screen low suicide.
2015	May	12	Somerset Partnership	Damien asking other patients how to kill himself, upset. Assessment arranged for service in Bristol, Damien declines placement due to location, acknowledges he still has a tenancy at Placement 2 Comment: Trigger recorded as placement falling through. Still has tenancy at Placement 2. Risk screen low suicide.

2015	May	13	Somerset Partnership	Request to senior managers to review placement funding issues via CMHT. Ward also advised to do this. Mum advised to make official complaint. Care coordinator acknowledged to be doing everything he can.
2015	May	13	Somerset Partnership	Damien visited by lawyer from MIND to pursue a complaint about Trust and Social Care panel. Head office informed due to historic concerns about individual who visited from MIND. Damien consenting. Comment: Concerns raised re: advocate supporting complaint from mum about Trust and Panel by Somerset Partnership HQ.
2015	May	14	Somerset Partnership	Email to CMHT management and ward management, safeguarding and Asperger's team sent by care coordinator. Summarising recent events and requesting advice due to the deterioration in Damien mental health and difficulties managing the case and supporting Damien's recovery. Says he is "increasingly discussing his thoughts of suicide". Comment: Concerns for Damien raised and shared by care coordinator.
2015	May	14	Somerset Partnership	Alternative placement suggested - permission given to arrange an assessment. Safeguarding raise concerns that Placement 2 is still an option and high-risk alternative as tenancy is still held, advised family considers making a complaint. Somerset Community Care Matters ask for information to pursue complaint request referred to Somerset Partnership Head Office Comment: 4th placement recommended by Social Care Panel representatives. MAPPA representatives remain concerned re risk management planning due to accommodation issues.

				Complaints referred to Somerset Partnership HQ due to concerns regarding individual family and advocate advised to make a formal complaint.
2015	May	14	Somerset Partnership	Damien frustrated and unsure, advised he has had suicidal feelings whilst on ward.
2015	May	14 or 15	Somerset Partnership	Service in Bristol assesses Damien, advise he visits the placement.
2015	May	19	Somerset Partnership	Discharge planning meeting. (Family not present.) HRC-20 risk assessment updated
2015	May	20	Somerset Partnership	Damien visited both placement options, prefers Placement 3
2015	May	22	Somerset Partnership	Placement funding agreed for Placement 3 dependent on costings. Comment: Funding agreed outside of Social Care Panel
2015	May	28	Somerset Partnership	Notice on tenancy given to Placement 2 by Damien, awaiting news on placement. Costings sent to Social Care Panel.
2015	May	29	Somerset Partnership	Documentation re: care planning and risk assessment provided during meeting with manager Placement 3
2015	May	30	Somerset Partnership	Damien spoke excitedly about placement. Described as happy, rather quiet, settled. Comment: Damien reassured 'funding is going along nicely'
2015	June	1	Somerset Partnership	Email - funding decision is awaited from the Local Authority. Damien fed up, bored and lonely. Comment: Funding issues continue. Suicide screening remains significant risk.
2015	June	2	Somerset Partnership	Damien accuses another patient of stealing his wallet. Police called and given CCTV footage. Damien informed there is a social care panel presentation arranged 4 June 2015. Damien described as restless.

				Comment: Social Care Panel arranged to confirm funding. Continuing Health Care documentation completed.
2015	June	4	Somerset Partnership	CCTV for alleged theft inconclusive. Comment: No further action.
2015	June	4		Mental Health/ Social Care Panel meeting at community hospital – informed by care coordinator that specialist residential home placement (for people with a mental health condition and forensic background) offered.
2015	June	4	Somerset Partnership	Documents provided to Social Care Panel for review and forwarding to LA who will offer a decision by the end of the week. Mum informed. Comment: Awaiting funding decision from Local Authority.
2015	June	5	Somerset Partnership	Funding confirmed. Damien described as quiet, notes state he was found in another patient's bed. Contact made with Police IRIS team. Comment: No further action taken.
2015	June	9	Somerset Partnership	Discharge meeting, mood stable, bright, excited. Date arranged for discharge. Stated the world is a frightening place. Comment: Suicide risk screened as low.
2015	June	15	Somerset Partnership	Transferred to placement 3. Mood bright.
2015	June			Moved to live at Home Placement 3 – a 9 bedded property of self-contained flatlets each with a kitchen/ living area and ensuite bathroom. Communal lounge and

				kitchen. Private garden area. Registered with CQC as a Care Home service without nursing. Note that the assessment dated 18 May 2015 states "able to make decisions".
2015	June	16	Somerset Partnership	Damien described as settled after phone contact with manager and Police IRIS team.
2015	June	16	Witness statement	Sister visited him on second day in placement – but he declined to see her.
2015	June	22		Incident form Placement 3: 5.30pm police brought Damien back into the home. Had attempted to jump in front of a car on a busy main road. Context was described as he had moved belongings in the previous day and some boxes were damaged, He was anxious and low after this, and told agency staff member that he felt suicidal. "Staff offered 1:1 support throughout the day."
2015	June	23	Somerset Partnership	Home visit, care plan and risk updated and produced for Damien and care home. Damien described as settled and better, had been overwhelmed and suicidal the night before. Police were called as he had run out in front of a car. Comment: To be reviewed in a week. Suicide risk screened as low.
2015	June	24		Discharge date in discharge letter. Elsewhere discharge date given as 23 June. Discharged on methyl phenidate, lorazepam, haloperidol and procyclidine. Diagnosis given as mental and behavioural disorders due to use of other stimulants including caffeine, also noted legal highs, Aspergers and ADHD.
2015	June	25		Incident form Placement 3: 7.15-7.30am Police phoned Home to ask if Damien had jumped in front of a car that morning and he told staff that he did. Owner didn't want to press charges. Police to visit. Marked on form as a safeguarding incident.
2015	June	25	Somerset Partnership	Placement 3 report being concerned about Damien 3 x running out in front of care since start of placement. CRHTT asked to assess Damien

2015	June	25	Progress notes	Damien has superficially cut his head with a knife from the kitchen.
2015	June	26	Somerset Partnership	CRHTT assessment. Placement 3 struggling to cope with risky behaviour. Damien stressed, upset, contradictory re: risk. Risk management plan formulated.
2015	June	26	Witness statement	Last contact with sister in telephone call.
2015	June	27	Somerset Partnership	No further incidents, reports are Damien positive Comment: T/C to CRHTT from Placement 3 staff
2015	June	27	Handover note 8.3	States that Damien tried to grab bleach from a locked cupboard.
2015	June	28	Somerset Partnership	Damien reports to be settled Comment: T/C with Placement 3
2015	June	28	Handover sheet	Noted on handover sheet that Damien asked for plastic bag to put over his head. Bags moved.
2015	June	29	Somerset Partnership	Placement 3 report Damien settled, advice given. Comment: No face to face contact in 4 contacts, discharged from CRHTT
2015	June	29	Witness statemen	Sister offered job more locally. Mother visited approx. 0930 to 1200.
2015	June	29	Police	On 29 June, Damien found hanging and later died on 3 July.
2015	June	30	ASC	Contact - care provider reports further suicide attempt on 29 June - admitted to General Hospital
2015	June	30	ASC	Information from General Hospital – Damien currently in ICU. Prognosis described as poor.
2015	June	30	Somerset Partnership	Contact from Placement 3 Damien attempted suicide by hanging, found unconscious transferred to General Hospital.

				Comment: Risk updated suicide risk high. Risk information updated.
2015	July	1	ASC	DoLS application received from General Hospital
2015	July	3	ASC	Died in ICU in General Hospital - notified by Hospital safeguarding lead. Also reported by care home manager.
2015	July	7	Somerset Partnership	Time of death 09:20am Comment: Suspect error - should be 3 July
2015	July	15	Police	ASC has received information that Damien has been attempting suicide since arriving at the home in June.
2015	July	24	ASC	Safeguarding meeting scheduled to consider potential safeguarding adults review.
2018	March	09	Jury verdict	Narrative conclusion *"At about 1950 on 29 June 2015 Damien was found suspended by his belt on the staircase at Highbridge Court. Emergency care was administered and he was taken to Weston General Hospital where he died at 0920 on 03 July 2015. Damien deliberately chose to suspend himself by a belt and on balance, at that that time, he intended that the outcome be fatal. We conclude that issues contributing to Damien's death included communication, training, information sharing, discharge planning, care planning and risk assessment"*