Camden Safeguarding Adults Partnership Board

"Safeguarding is everybody's business"

A Safeguarding Adults Review in respect of "Judith"

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Executive Summary

This Safeguarding Adults Review (SAR) was commissioned by Camden Safeguarding Adults Partnership Board in July 2020 following a referral by the Metropolitan Police after they were requested to make a welfare visit to Judith in November 2019. They entered Judith's flat and discovered her to be deceased at home, from natural causes. This SAR considers the care and support received by Judith, with a focus on the 12 months leading up to the time of her death.

Judith was a 65-year-old white woman of Jewish heritage who had been a resident in the London Borough of Camden for over 20 years. Judith had experienced mental health problems of varying degrees from early adulthood and was well known to a range of statutory and voluntary mental health services. Judith's mental health problems were assessed, and she was given different diagnoses and treatment, including for both a mood disorder and a personality disorder. At times of crisis she required in-patient care, often coming to the attention of the police and being subsequently assessed for admissions under the Mental Health Act '83. She also had type 2 diabetes, which was generally well controlled through medication. Judith lived alone in council accommodation, but she struggled to cope with this both in terms of practical tasks and social isolation, particularly when she was unwell.

Judith made frequent use of telephone support and often called emergency services, including the police when she was in distress, which were reported to Adult Social Care using the Merlin system. Following assessment by a range of various specialist mental health services, all of whom found her ineligible for their care, she was accepted as the first client of the Serenity Integrated Mentoring Team (SIM Team) in 2018. This is a small service with staff from both mental health services and the police, whose remit is to offer intensive ongoing support with the aim of reducing contact with emergency services through better coordination and they offered Judith care throughout 2019.

During this time intervention was Care Coordinated by the SIM team, with frequent home visits, telephone support and as well as liaison with relevant agencies that Judith had contact with, to promote a more joined up approach. This included Emergency departments of local hospitals that she attended and mental health inpatient wards where she was admitted for assessment and treatment on 4 occasions in 12 months. Judith's admissions were initiated by concerns of both self-neglect as well as her feeling suicidal and appearing to be psychotic, they were usually brief with the view that longer periods in hospital were not appropriate or beneficial for her. She used a Women's Crisis House as an interim measure prior to returning home from hospital.

Judith's Care Coordinator from the SIM team worked with the Housing Department to facilitate a move to supported accommodation for her, however due to resource issues with identifying suitable 24 hour supported this process was not completed. She was helped to move to temporary accommodation without relinquishing her tenancy using discretionary power to re-house her. This was partly due to issues with neighbours and Judith's flat became a source of stress for her, often becoming cluttered and dirty especially when her mental health deteriorated. Although ambivalent about a move she had accepted this, but sadly died prior to this being completed.

Judith died from a rare condition leading to her blood Ph levels dropping due to an increase in ketones, which are often found associated with a high blood sugar level, due to poorly controlled diabetes. However, in Judith's case her blood sugar levels were normal, and the toxic level of ketones found were not due to this. The cause was undetermined at both her Post-mortem and at a subsequent Inquest. It was possible that her chronic self-neglect contributed to this, but other reasons were not ruled out (e.g., dehydration, side-effect of medication etc). Given these possible but not confirmed causes it was not reasonable to predict the risks to her life from her self-neglect.

This SAR used a hybrid methodology involving agencies submitting chronologies of their contacts with Judith from their individual records and a series of conversations with the workers from the following agencies.

GP (Junction Medical Practice, Tufnell Park)

Camden & Islington NHS Foundation Trust

Camden Council Housing Department

Whittington Health NHS Trust

Metropolitan Police (Central North area)

University College London Hospitals

The main issues that were identified from this process are 7 key findings, which used analysis of Judith's care according to the SAR Terms of Reference. These illustrate a number of practice issues with potential wider implications. Several recommendations are then made in relation to each individual finding, these are summarised below under each finding and can be found in full along with a suggested action plan to address them in the final sections of the full report.

1. The management of adults with both a personality disorder and mood disorder require the development of an integrated person-centred pathway for crisis services considering hospital admission to respond rapidly to increased risks to self-harm and self-neglect, especially where adults live alone.

   Recommendations address the dilemmas arising from the usual practice of delaying or avoiding hospital admissions and how this can give rise to an escalation in risk taking behaviour when adults seek hospital admission.

2. Self-neglect amongst adult mental health service users may tend be dealt with using traditional approaches, such as CPA/Care Coordination, which while it can lead to individual good practice but does not follow the Multi-agency Self-Neglect toolkit and so may miss some opportunities to work together to assess and manage the risks of self-neglect.

   Recommendations identify the need to consider a range of approaches to coordinate work with adults who self-neglect, under the Safeguarding and Needs Assessment/Care Support Planning duties, as set out in the Care Act 2014.

3. Where an adult frequently makes use of hospital admissions at periods of crisis, the model of minimising the time spent in hospital can lead to a pattern of repeated relapses and readmissions, where they are discharged back to the same environment.

   Recommendations consider the appropriateness of admissions under either Section 2 or Section 3 of the Mental Health Act '83 and the need to delay discharges until appropriate Housing and aftercare is set up in the community, with consideration of a CTO, or a Guardianship order.

4. The current model of mental health services in Camden and Islington Mental Health Trust being aligned according to diagnostic criteria can lead to multiple re-assessments and rejections of adults who have complex, or multiple diagnosis-serving to exclude people based on subjective interpretations of eligibility criteria.

   Recommendations address the need for specialist Mental Health Services to work together when assessing complex adults, including joint assessments to identify the best option without the need for the adult to have several assessments by individual teams.

5. Police use of S136 in Camden has improved since the time of this SAR, with better systems for information sharing with Care Coordinators/ The SIM Team where it is used frequently, oversight and training by the Police Mental Health Team and through the development of a specialist S136 suit with Highgate Mental Health Centre.
   The SIM Team was noted to be an example of good practice facilitating improvements in multi-agency partnership work and this model was recommended for wider adoption in other local authority areas.

6. Where adults have both mental health and physical health problems there can be problems with the effective management of long-term physical health conditions, due to a lack of timely information sharing and subsequent monitoring of poor physical health in the community.

   Recommendations suggest several ways for improvements to be made in coordination between Primary Care and Secondary Mental Health Services. Both in the discussion and review of adults who self-neglect with negative consequences for increased risks to their physical health and overall wellbeing.

7. Where the MASH Team receive notifications via the police Merlin system, these should be triaged by the MASH team to identify and recommend action required to respond to these concerns, prior to a decision for forwarding them onwards to a Mental Health Service, where the adult is known to be under the care of Mental Health Services.

   A final recommendation to audit a sample of Merlin reports in order to assess these for consideration for statutory Safeguarding duties (under S42 of the Care Act 2014) by either Adult Social Care or Mental Health Services.

1. Introduction

1.1 This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the Camden Safeguarding Adults Partnership Board (CSAPB), relating to the death of an adult in 2019 (referred to as Judith throughout this report to preserve her anonymity).

1.2 The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Camden in the future.

1.3 The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews.

The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014, states[1]:

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

1.4 Why was this case chosen to be reviewed?

Initially the case was raised with the Camden Safeguarding Adults Partnership Board (CSAPB) as a potential case for review in November 2019 by the Police, following their discovery of her deceased in her flat, showing signs of self-neglect and self-harm. Judith had been well known to a number of agencies, including the Police, Camden and Islington Mental Health NHS Trust, Camden Housing Department and a number of local acute hospitals. The SAR request was initially raised to explore whether these agencies had missed opportunities to support Judith, prior to her death.

Judith cause of death was not suspicious, as it was found to be of the following natural causes, recorded by the Coroner on 20/11/19 as Acute cardio-respiratory failure[2] (build-up of fluid in the lungs), Severe euglycaemic ketoacidosis[3] (build-up of ketones in the blood), Diabetes mellitus type 2[4]. (a condition that causes elevated blood sugar levels, if untreated) Chronic obstructive pulmonary disease[5], (COPD, is the name for a group of lung conditions that cause

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

[2] https://www.healthline.com/health/acute-respiratory-failure

[3] https://bmcnephrol.biomedcentral.com/articles/10.1186/s12882-020-01930-6

[4] https://www.nhs.uk/conditions/type-2-diabetes/

[5] https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

breathing difficulties, often found in smokers), Systemic hypertension[6], (high blood pressure in the systemic arteries), Mental health disorder. There was no evidence that Judith's death was caused by a deliberate act of suicide but due to the above range of poorly managed long term health conditions, which were possibly indirectly related to Judith's mental disorder and associated periods of self-neglect.

An inquest into the death of Judith was heard on 27th March 2021. The conclusion of the Coroner as to the death was that it was due to natural causes. She was found deceased in her own residence, unclear cause of ketoacidosis but insufficient evidence of self-neglect to include in conclusion.

1.41 Brief Summary of Judith

Judith was a single white woman, aged 65 at the time of her death who lived alone in temporary council accommodation, a flat in Kentish Town. Judith's cultural background and faith was Jewish. Her parents were deceased when she was a young adult and she had one brother, who she was not in regular contact with. Her history revealed early life difficulties, whilst she was still at university. She had issues with her parents and felt she had to work twice as hard as her brother who she perceived to be the favourite child. She had a relationship at a young age with a man, who rode a motorbike and subsequently emigrated to Australia. She was never able to completely let go of this relationship, when becoming unwell she would report hearing his motorbike and was often pre-occupied with thoughts about him. She ruminated extensively about this relationship and would often be unable to focus on the present situation.

She had been diagnosed with a range of mental health conditions (mixed anxiety and depressive disorder, Schizo-affective disorder[7], personality disorder) and was well known to both community and in-patient mental health services, having a number of hospital admissions, usually detained under the Mental Health Act '83. She was known to struggle coping at times with the impact of her mental health problems and was a frequent caller to emergency services, (the police, ambulance, mental health crisis services). As a result of these issues, in the final year of her life her care was managed through a small specialist team Serenity Integrated Mentoring, (SIM Team) with staff working jointly from both the police and mental health services.

She was quite frail, neglecting both her self-care and her home environment a lot of the time. She often was seen to be dishevelled, with matted hair, ingrained dirt in her hands and feet, and pre-occupied with stopping smoking (she was a heavy smoker). She was also highly intelligent and able to reflect at times on her behaviour and compulsion to sabotage attempts by professionals to help her.

She had resided in the same flat for 20 years and had long standing difficulties with her neighbours. Her flat was poorly maintained due to her chronic self-neglect and would often be

[6] http://www.pted.org/?id=syshypertension1

[7] https://www.rcpsych.ac.uk/mental-health/problems-disorders/schizoaffective-disorder

subject to blitz cleans after hospital admissions, but improvements were never sustained for long, she would revert back to living in clutter, having poor hygiene and this was thought to be an indication of her sabotaging improvements. At times of returning to her flat from either hospital or a Crisis House admission it was a struggle to get her to accept help with cleaning, tidying up.

1.5 Timeframe, Terms of Reference, Methodology and Scope

The SAR was initially commissioned in July 2020, with a draft Terms of Reference agreed in August, which was subsequently amended in September 2020, at which point it was agreed that the SAR should focus on the time period from November 2018 to November 2019 (date of death).

The methodology for this SAR was through a collation of Individual Agency Chronologies submitted by relevant agencies working with Judith. The Independent Author then collated a combined merged chronology from all the individual agency submissions, which was extensive at over 400 pages of records. The combined chronology was then broken down to several distinct phases of contact called Key Practice Episodes (KPE). The involvement of services during each KPE was then appraised and underlying factors affecting decisions and actions were then explored to explain the practice in this case and potential wider implications. In order to explore some additional factors and context to the work in the case a series of telephone conversations were held with representatives from key agencies, in December 2020 and January 2021.

1.5.1 Terms of Reference

The SAR (and by extension all contributors) will consider and reflect on whether the care provided by all organisations and professional was consistent with expected standards and in line with primary legislation, statutory guidance and codes of practice.

- The impact of both Judith's mental and physical health (diabetes) conditions on her vulnerability, risks and needs, including the management of her chronic and complex conditions.
- The systems in place to respond to self-neglect during the period subject to review.
- The effectiveness of in-patient and community mental health services, including housing-based services (e.g. Crisis houses), which were provided to manage the impact of Judith's conditions on her health and wellbeing.
- The quality of services delivered in response to periods of acute crisis as well as the long-term difficulties experienced by Judith.
- The circumstances and events leading to the Judith's death.
- The response of any key safeguarding mechanisms including the Multi-Agency Safeguarding Hub, where concerns were reported to the agency for safeguarding enquiries to be undertaken.

1.6 Agencies that had involvement in the review:

- GP (Junction Medical Practice, Tufnell Park)
- Camden & Islington NHS Foundation Trust
- Camden Council Housing Department
- Whittington Health NHS Trust
- Metropolitan Police (Central North area)
- University College London Hospitals

1.7 Methodological comment and limitations

The SAR was delayed due to the pandemic, nationwide lockdown and subsequent impact on all services involved with this case. Meetings were held online for the review and conversations undertaken remotely for all professionals involved with the case. There were no Individual Management Reports requested for this case, although conversations with agency representatives were helpful in providing additional context to the chronologies submitted.

1.8 Reviewing expertise and independence

An Independent Consultancy undertook the SAR and appointed an Independent Lead Reviewer. All relevant documentation was then shared with and scrutinised by the Independent Lead Reviewer, to compile the Independent Overview Report. Mick Haggar is the author of this Overview Report, which has been completed on the basis of submissions of Individual Agency Documents, conversations with individuals and Chronologies (outlined above).

1.9 Structure of the Report, Acronyms and terminology explained

Section 2 of the report considers what happened in the period subject to review, this is sub-divided into a series of periods of the chronology, called Key Practice episodes. The practice of individual and multi-agency systems are discussed for their significance and appraised after each Key Practice Episode.

Section 3 then analyses the practice found against each of the Terms of Reference for the SAR (see 1.5). Then 7 Findings with associated recommendations for the CSAPB following this review are set out briefly below and in full with reference to aspects of the case in Section 4 and an Action Plan to address these recommendations is in Section 5.

In Appendix 1 a section listing any abbreviations used to support readers who are not familiar with these. In Appendix 2 language and terminology of medical, including mental health, and safeguarding work are explained and referenced. Appendix 3 gives a summary of the issues identified for each period of the review, which are set out in the detail in Section 2 of the Report. References are also made to key documents in footnotes throughout the report.

1.10 Involvement of family members

The input and opinions of family members of the deceased is an important aspect of the SAR process, both to inform them of the review, and to include them to take account of their first-hand experience of services provided to them/their relative. Judith's brother discussed his views on the care provided to Judith. A summary of his input is set out here.

Judith grew up in Croydon in a stable household with loving parents. She began to experience mental health problems aged 16-17. She left home to go to University in Norwich but dropped out as she was unable to cope with the course. She had a boyfriend at school and subsequently in her early 20s she moved in with a much older man who had alcohol problems. She lost contact with her family for about 10 years after this, during which time she changed her surname by deed poll, to her father's original birth name in order to re-connect with her Jewish identity. Roughly 20 years ago Judith re-established sporadic contact with her brother which over the next few years developed into regular phone calls once or twice a month and regular visits every couple of months. About two years before her death, the phone calls increased the more she became distressed and often late at night. Her brother's visits then became less frequent at her request.

Her brother became more involved with her care and persuaded Judith to let him visit her GP to discuss her care, at which point he felt no-one had taken ownership of responsibility for her. He would also be contacted as her Nearest Relative when she was assessed under the Mental Health Act and had regular communication with her Care Coordinator (CC) from mental health services, who he felt was very caring and close to her for her final 2 years. He would attempt to visit her while she was in hospital, but sometimes she refused to see him and ward staff would report to him she had capacity for these decisions, but he was not sure this was always the case. After she left hospital her brother felt that she would have benefited from some legal requirement to require ongoing compliance with aftercare, as she would not let her CC into the flat when he visited to check on her.

He felt she had good care in hospital and was well looked after during her admissions, but community follow up was difficult, due to her periodic rejection of this. She had no relationships with friends and struggled to cope with loneliness and a lack of structure when she went home, if she had been moved to staffed or supported accommodation then this would have been much better for her. He was aware of the attempts to do this, but this did not happen partly due to resource availability but also due to Judith's ambivalence to accept she needed to move from her flat. She had multiple contacts with lots of professionals and her brother felt overall she received a good level and standard of care from Camden services, although despite this they could not prevent her from self-neglect or sabotaging plans made with her.

Her brother was invited and planned to attend the Inquest into Judith's death, which was held in March 2020. He did receive papers and a recording of proceedings and hoped something could come out of this in terms of preventing

future deaths, although nothing was recommended following this. He hopes that some things may change as a result of the SAR process.

2. Summary of Case and significance of Key Practice Episodes

The section below sets out a brief summary of the multi-agency chronology of services involvement with Judith. The author collated this chronology from the individual agency chronologies and other reports submitted on each case by the agencies participating in this review. As outlined above, the integrated chronology for the case was then divided into a number of Key Practice Episodes (KPEs), which are set out separately along with an appraisal and the significance of practice during each KPE. These are then analysed further for learning and recommendations in Section 3 of the report.

2.1 Brief Summary prior to the period subject to review (Pre-November 2018).

Judith's first moved to Camden in 1987 after fleeing an abusive relationship. She had a history of depression and anxiety since the age of 18, when she sought help after contemplating suicide. She had psychological difficulties that caused interpersonal problems. Periods of acute mental illness were triggered by situations which she felt were not within her control. Unable to work after 1980, she received income support and disability benefit.

In 1989 she spent a period in St Pancras Hospital due to an inability to cope and having thoughts of self-harm. She was discharged with a community support package and she did not come to attention of services again until 1997, when a further episode of depression was triggered by reported constant noise from her neighbour who was a drinking associate of her ex (abusive) partner. Judith fled the flat in crisis in March 1997, going to a Sanctuary and then she was admitted to St Pancras Hospital, when she left hospital she surrendered her tenancy and moved into mental health supported accommodation managed by St Mungo's in Stamford Hill. In 1999 she was considered well enough to live independently and took up a Camden tenancy in a flat where she remained until 2019.

She was prescribed Lithium to help stabilise her mood, but stopped taking this for a time in 2017, she had engaged with independent psychotherapy for 2 years from 2015 and also group therapy prior to this time. She attended a women' support group at a Jewish Day Service (JAMI, Jewish Association for the Mentally Ill[8]) and Occupational Therapy to help structure her day. She suffered from chronic fatigue and was further diagnosed with ME in 2017. She had two brief admissions to psychiatric hospital in 2017, following reports of feeling suicidal and was prescribed anti-depressant medication. Her diabetes was monitored via her GP surgery, with annual reviews and blood tests to monitor her medication.

In February 2018, she attended A&E requesting an admission to psychiatric hospital after an incident of noise and a confrontation with a neighbour, which she panicked about and reported feeling suicidal. She then phoned the police and ambulance from her flat, who attended but did not take her to hospital, contacting the Mental Health Crisis Service instead. She attended A&E again in April and was seen once more by the Crisis Service, subsequently being admitted to North Camden Crisis House for 2 weeks, as an alternative to psychiatric hospital admission. In May 2018, Police were called to her address by a concerned neighbour as Judith was heard to be screaming in her flat at night-time. Her neighbour also reported these issues to the Housing Department who shared information with Camden Social

[8] https://jamiuk.org/about-us/

Services and the Multi Agency Safeguarding Hub (MASH Team) where all new safeguarding referrals are assessed.

The Police also notified Camden Social Services of this by completing a Merlin form and this occurred again when Judith contacted Police later in the month. She subsequently attended Kentish Town Police Station the same day, showing signs of acute distress and paranoia. On this occasion Police detained her on S136 of the Mental Health Act '83 (MHA'83) and conveyed her to UCLH for assessment, where she was then subsequently discharged home. In June and July Judith again phoned police on 3 occasions, reported feeling suicidal and not taking her diabetes medication, on these occasions she was conveyed voluntarily to the Whittington Hospital, where she was seen and then sent home. At this time, she had an allocated worker from the Mental Health Reablement Team who advised police that Judith was "indulging in attention seeking behaviour" and advised that she had been referred to and was due to be assessed by the Personality Disorder Service.

Over 2 days in July Judith phoned police on 5 separate occasions, these were recorded as Hoax calls and police did not attend her address. Her neighbour again contacted Housing about noise, who visited the property which was in a severely bad state and Judith stated that she slammed doors, shouted and smashed items, due to hearing voices at this time.

This information was shared with Mental Health Services, who reported back that Judith was open to the Complex Depression Anxiety & Trauma Team (CDAT) and was due to have an assessment, she also made frequent further use of the Crisis Service for telephone support. She had been previously assessed by the Personality Disorder Service, who did not accept her as they felt that she either had depression with psychosis or possibly dementia. She was then referred by them to the Ageing and Mental Health service for assessment, who found no evidence of dementia and felt she had Personality and Mood Difficulties. They had then referred her to the CDAT service, while she was clearly not coping and showing signs of self-neglect.

In August 2018 her Housing Support Officer visited Judith at her flat, which was still in a filthy and neglected state, which was subsequently shared with the Mental Health Team (CDAT). It was at this point that Judith was referred to the Serenity Integrated Mentoring Team (SIM team), who took over responsibility for Care Coordination (CC) of her case and after 2 home visits recommended an assessment under the MHA'83.

Shortly after this the Police were called to a Premier Inn at 2 AM, where Judith was found to be wandering and incoherent, she was taken to the Whittington Hospital under S136. On this occasion Judith was admitted to the Sapphire ward at The Highgate Mental Health Centre, where she remained for a month before being briefly discharged back to her flat and then returning to hospital. She had another annual diabetic and medication review while in hospital, where she continued to be prescribed Metformin to manage her blood sugar levels.

Due to her problems coping with her tenancy and the issues with her neighbour, her Care Coordinator[9] (CC) at the SIM Team discussed the possibility of a move to supported accommodation with her Housing Officer (HO). The HO then explored this with the Housing Mental Health Liaison Officer, who explained the process for applying via the Vulnerability Panel. Subsequent discussion with Judith led to this plan being put on hold as she wanted

[9] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

to return to her flat and see whether she could cope. Her CC organised a blitz clean of her flat prior to her discharge from hospital in October 2018, however due to practical problems with her flat having no heating she spent 2 further weeks in the Crisis House before returning home in October.

2.1.1. Significance and Appraisal of Practice

From the above summary the difficulties experienced by Judith due to her complex mental health problems resulted in her repeatedly seeking help from emergency services directly through contacting the police, Mental Health Crisis Services and A&E. She also sought help indirectly through her behaviour, such as screaming at home during the night time or being found by police in a public place. She had a series of acute episodes of distress, possibly experiencing psychotic symptoms, including reporting hearing voices and being incoherent when seen. She was difficult to help at these times and despite several assessments was usually sent home after being brought to hospital, as the view was that she would not benefit from inpatient care, and/or was not detainable under the Mental Health Act. She made a number of threats suicide, which were thought to be attention seeking to get admitted, rather than serious risks to her life.

The practice during these periods of crisis was to follow the least restrictive option and offer her alternatives to hospital admission where possible. Whilst this was good practice on the part of mental health services, there were clearly repeated occasions where Judith escalated her behaviour to the point where admission to hospital was required. To an extent delaying admissions for Judith did leave her at risk when she was unable to contain/cope with distress. At these times she would present directly to crisis services or come to the attention of emergency services as a result of her behaviour.

She also had more chronic difficulties, mainly related to her self neglect, both in terms of her personal care and environment, living in chaotic circumstances with her flat reportedly filthy and damaged. In terms of her physical health, she clearly struggled to maintain a good and healthy lifestyle, reportedly not taking her diabetes medication, possibly either linked to the above threats of suicide when in crisis but also linked to her more long-standing inability to care for herself. She had reviews of her diabetes at her GP surgery. This is good practice to manage her physical health through her GP, but it was complicated by her chronic self-neglect and acute periods of crisis, when she would sabotage her health, including stopping her medication.

Although clearly complex and challenging to support through mainstream or specialist mental health services, Judith attended for a series of assessments during this time, however they all found her to be ineligible for the various mental health teams that saw her (Reablement, Personality Disorder, Old Age Psychiatry, CDAT).

It did appear that whilst she didn't fit neatly into the diagnostic categories for these specialist services, she did have aspects of all the relevant conditions, but each refused to take over responsibility for her care and suggested another service. This does give the impression that she was passed around to a number of specialist mental health teams and was rejected by each in turn, until the SIM team was formed and agreed to take over the Care Coordination of her case. The SIM team had been recently set up in August 2018 to work with people who frequently and inappropriately made use of emergency services and Judith was one of the first referrals to the service.

Her assessment by the various teams was standard practice but the themes arising from this period of her history did reveal a reluctance to accept her by any specialist team, due to different perspectives on what was her main diagnosis/issue. This may be a potential unintended consequence of the structure of how Mental Health Care is delivered in Camden and Islington, which is based on different teams' responsibility being based on different

diagnostic categories (Personality Disorder, Psychosis, Mood Disorders etc) and which is considered the primary diagnosis.

Analysis of this case and conversations with staff indicates that where adults have multiple different diagnoses, they may face multiple assessments and rejections from the services based on the eligibility assessments identifying various differing judgements on what was thought to be her primary diagnosis. With adults such as Judith that have been known to a number of teams, this is problematic from them to receive the most appropriate service. The SIM team took on her case, as a way of bridging this gap and accepted that she needed intensive support partly to manage her attempts to use emergency services when she felt unable to cope. The Team were more accepting of the complexity of her issues.

2.2 Key Practice Episode 1: (01/11/18- 18/02/19) SIM Team involvement, Housing problems with neighbour and move to temporary accommodation, following psychiatric hospital admission.

In November Judith's CC in the SIM team made contact with her brother, updating him on her discharge from hospital and the ongoing role of the SIM team to support her at home through regular 3x a week visits and rapport building. Judith attended her GP for a further medication review, no changes were made to her medication. She told her CC that her concordance with her medication was sporadic, she was not eating well enough to manage her diabetes and her difficulties with her neighbours were due to her shouting at night and this was troubling her. Neighbours had again raised complaints with the Housing Officer (HO) and Community Support Officer (CSO, a small team dealing with anti-social behaviour), who passed these onto the CC, requesting a meeting and housing needs review, due the impact her behaviour was having on other tenants. The CC liaised with the HO about applying for supported housing via the Housing Vulnerability Panel[10].

Case notes recorded at the time and subsequent discussion with her Care Coordinator indicated that Judith was disappointed to have been discharged by the Reablement Team and was clearly ambivalent about moving-at times stated either she did or did not want supported housing, via a referral to the Housing Vulnerability Panel. Despite this, her case was taken to the Panel late in November at which point her move was endorsed through a scheme called Pathways, where the tenant surrenders a tenancy and agrees to move to supported living. At a future time when they are assessed as ready to live independently, they are guaranteed sufficient points to bid for another suitable council tenancy. As there was a waiting list for supported housing, the option of a temporary move was also discussed, as an interim measure.

Judith then does not engage with a series of home visits from her CC and when Police are called to her address as she was seen acting strangely, they detain her under S136 and take her to the Whittington Hospital for assessment at the end of November. She was then assessed and found to have been self-harming and hearing voices. She was detained under Section 2 MHA'83 and admitted to Pearl Ward, where her CC visited her to inform her of the Housing options and Judith agreed to move to temporary housing. Subsequent Liaison between CC and HO, who identified 2 vacant suitable properties that Judith could visit and if she agreed a direct offer could be made to her, which was agreed in principle by the Housing Dept Head of Services (who can make a discretionary housing offer, in exceptional circumstances).

Judith remained in hospital for all of December and was taken to view a vacant flat by her CC in early January but refused this, she then visited the other property. She was noted to

[10] https://cindex.camden.gov.uk/kb5/camden/cd/service.page?id=7K8OXVpdkqU

be very anxious about a move and had psychological support from both inpatient psychology and her CC who maintained visits. She initially refused both offers and wanted to return to her old flat, but over the course of further meetings with her CC and ward psychologist changed her mind and agreed to move to the second offer. This was agreed with the HO and ward staff, who planned her discharge for mid-February to her new (temporary) accommodation. Immediately prior to this Judith's self-care, night-time shouting and threats of suicide returned with ward staff, thought to be related to her anxiety about being discharged. Despite liaison with Crisis Services the risks of discharge were then thought to be too high, so this was delayed from a Friday to the following Monday (18/02/18).

2.2.1. Significance and Appraisal of Practice

During this period Judith showed both long term problems of self-neglect and also further presentations to crisis services due to her shouting at night and visiting a neighbour-initiating police attending to her address. The decision of the police officers to arrest Judith under S136 at her flat indicated a lack of knowledge, or compliance with the police powers under S136 on this occasion, which was poor practice at the time (as S136 is not to be used to detain people at their own address, it is a police power to remove people from a public place and convey them to a place of safety for assessment).

There has been significant work done by the Camden Police Mental Health Team to improve officers' knowledge and use of S136, since this time. The Mental Health Team now do regular dissemination and training to other officers on the threshold, definitions, use of S136 in a case study etc. This is regularly sent out to officers and any new recruits also get training as part of their induction in the Central North area, which has the highest use of S136 in the Met (26% of all S136 in London).

These initiatives by the MH Team have improved police awareness of mental health issues and their working much more in partnership with MH Trust now than previously.

Judith then has quite a long period of hospital care, for 2 months which was much longer than most of her previous admissions. She did benefit from the inpatient care, her physical and mental state improved considerably as she clearly felt contained and supported while in hospital. As is often the case with hospital admissions, the discharge process was complicated, due to Judith's Housing situation (as her breakdown in mental health was related to her housing/relationships with neighbours).

However, this was resolved with use of discretionary offers to enable Judith to be accommodated nearby without having to go through the usual housing processes, which was good practice by the Housing Officer. She in fact did not have to give up her previous tenancy prior to moving to her new flat. This showed good evidence of multi-agency work between Housing and Mental Health Services, to consider Judith's needs for housing and support. Judith was required to relinquish her tenancy to be accepted onto the Pathways scheme, but discretionary measures were used so she could have an alternative temporary flat while further supported housing options were explored, which was also again an example of good person-centred practice by her Housing Officer.

2.3 Key Practice Episode 2: (19/02/19- 20/05/19) Ongoing support from SIM team at new address, with increased calls to Crisis Helplines, LAS, Police and A&E, another admission.

On the day of discharge Judith phoned the CSPA (the new Camden and Islington single point of access, crisis line) and Adult Social Services, which were deemed inappropriate for her and she was directed to call her CC at the SIM Team instead. Her flat had no heating at this point and an urgent request to resolve this was made by her HO and it was subsequently resolved. 3 days later she again phoned a duty social worker in the Personality Disorder Team twice, reporting she had stopped her medication as didn't think it helped her-she was encouraged to continue this, and her CC was informed. He visited her and she reported feeling better, but then contacted CSPA again 2 days later again several times, reporting distress and anxiety.

She then called LAS & Police in early March, reporting a plan to set fire to her flat which was recorded on a Merlin form and discussed with her CC, who visited her 2 days later and she had calmed down, reporting regret at contacting emergency services. She had run out of medication but was encouraged to pick up a repeat prescription from her pharmacy. She again used the CSPA service several times, for telephone support, which was deemed appropriate use on these occasions.

She had more contact with a new SIM Team worker and reported compliance with mindfulness based coping strategies, as well as calls to the Jewish Day Centre (JAMI) helpline for support. Following further calls to the Personality Disorder Service, she was again seen at home by SIM Team and was encouraged to buy food, attend to her self-care, she was thought to be coping better with this support. Her GP then called Judith to attend surgery to check lithium levels but reported she had been taken off lithium during her last hospital admission, which was confirmed in the discharge summary-so she was not seen.

Judith had ongoing support from the SIM Team and contacted the PD duty team, CSPA and the Samaritans (often about ruminations and regrets of smoking) several more times during late March and early April, but with a decreased frequency which was a positive sign for her. She continued to engage with regular SIM team home visits for therapy and support, her calls to the crisis services were shared with her CC. These calls increased in frequency in mid-April (8 calls in 4 days) and she also called out the LAS twice in 2 days, misinforming LAS paramedics that she was not getting help. LAS liaised with CC from SIM Team about these calls, which were thought to be due to anxiety related to her CC's annual leave, however they continued after his return. She had agreed with her CC to attend her GP for smoking cessation support but then changed her mind and was seen to have more bleeding from her face, due to her self-harm behaviour, which was a known sign of a relapse in her mental state.

In May the Police were called by a concerned member of the public, Judith was sitting on a wall, looking dishevelled, confused, wearing pyjamas and reported not eating or drinking all day, she was taken to the Whittington Hospital and the information was shared with Camden Social Services via another Merlin form. She was assessed but not admitted on this occasion, but she did not go home and represented at the Whittington the next morning, where she was seen by the Mental Health Liaison Psychiatrist again. She was noted to be thought disordered and reported feeling suicidal. Again, she was not admitted and returned once more the next day, having not been home.

Her CC attended A&E and met her there, at which point she said she liked it in A&E and felt safer there than at home, she refused to go home and wanted to be admitted to hospital. An alternative plan for her to go to the Crisis House was agreed with her CC, but there were no vacancies in the Camden service, so the Islington Crisis House was contacted and agreed to offer her a bed, but she did not stay there and returned to A&E.

After 4 days of this pattern of attending and refusing to leave A&E she was assessed as being thought disordered to the point of lacking capacity, not taking her medication (for mental health or diabetes), with the duty doctor recommending a Mental Health Act Assessment, following which she was admitted to Opal Ward under Section 2.

2.3.1. Significance and Appraisal of Practice

Following Judith's discharge to her new flat she coped well at first, but fairly rapidly returned to her previous behaviour of repeatedly calling Crisis and Emergency services, feeling unsafe and unable to cope at home on her own. The condition of her new flat rapidly began to resemble her previous flat and her behaviours of shouting/self-neglect continued. Her medication compliance also deteriorated periodically and despite intensive support from the SIM Team she escalated her use of services (both emergency and crisis services), to the point of once more deteriorating to such an extent that she was detained under Section 2 of the MHA'83.

Review of this period of work with Judith identified the following areas of good practice;

- There was good information sharing by emergency and crisis services with the SIM Team, as a single point of contact to try and coordinate individual services' responses and aimed to reduce her use of LAS inappropriately. However, this had limited success, especially out of office hours.

- There was a much more joined up approach by all agencies, which was supported by the role of the SIM Team.

- Police, Crisis Line, Personality Disorder Duty, LAS and Housing all liaised with the SIM team, which showed good use of this more joined up approach.

- The practice of sharing information with one service (SIM Team) showed how important this was in maintaining a consistent response to her presenting to various agencies as well as having an overview of deterioration.

However, this also showed how resourceful Judith was in managing to circumnavigate efforts to avoid admitting her, ultimately this culminated in her being admitted after 5 days of refusing to leave A&E. Whilst the practice of delaying/avoiding admission for her was in line with common practice, for Judith this led to further escalation of her behaviour, until she was finally successful in her goal of being re-admitted to hospital once more. This indicated that when Judith was not coping, she would persist in escalating behaviours until she was admitted and so delays in this outcome were ultimately counter productive. For example, there were several assessments at the Whittington which indicated that she was unwell but not in need of admission, although due to her persistence at presenting there she was finally admitted on the third occasion.

Finally, the decision to detain Judith using Section 2 of the MHA'83 illustrates the current practice of using Section 2 rather than Section 3 at the point of a Mental Health Act Assessment. There is always a judgement to be made by the AMHP[11] (Approved Mental Health Professional) about the most appropriate Section of the MHA'83 when considering admission or alternatives which might be less restrictive.

[11]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843539/AMHP_Workforce_Plan_Oct19__3_.pdf

Section 2 is intended for the assessment of people to inform a subsequent diagnosis of a mental disorder and if necessary treatment, it authorises an adult to be detained in hospital for up to 28 days. Section 3 is intended for the treatment of people who are known to services and have been diagnosed with a mental disorder, it authorises an adult to be detained in hospital for up to 6 months.

As Judith's diagnosis and treatment were well known, it may have been more appropriate to consider Section 3, rather than her repeated admission under Section 2. This would have also allowed consideration of discharge options for her to remain under some lawful powers to supervise her in the community, for example using a Community Treatment Order[12] (CTO).

This could have required Judith to comply with her medication and follow up by her CC after she left hospital, but as she was only ever admitted under Section 2 this was not an option for her. The implications of this being that outside of formal hospital admissions any subsequent work done with her was dependent on her consent, which at times she withheld. However, her brother felt that she needed the structure that such an order would permit to maintain her health outside of her crisis hospital admissions.

There is currently consultation on a Government White Paper, as part of a review of the Mental Health Act, following Professor Simon Wessely's Independent Review 2018[13].

In particular it recommends that;

- "Code of Practice should make it clear that Section 3, rather than a Section 2, should be used when a person has been already subject to Section 2 within the last twelve months" and that the Code "should be amended so that, where a person has been subject to detention under Section 3 within the last twelve months, an application for detention under Section 2 can only be made where there has been a material change in the person's circumstances."
- "Section 2 is used too often for patients who are well known to services, and who are not realistically in need of the full assessment required for someone who is not."

Guardianship was another option which could have been considered and this is relevant for anyone, whether they have been detained under the MHA or not. Guardianship allows the local authority to decide where the person resides, the person must allow access to their accommodation by services, and Judith could have been required to attend certain resources eg day hospital. The care package under Guardianship therefore could have required Judith to live at a certain place, allow her CC, perhaps a support worker to assist with housework etc., and Judith to go to a day centre. This option may have been more compliant with the 'least restrictive' principle of the MHA.

[12] https://www.mentalhealthlaw.co.uk/Community_Treatment_Order#Granting_a_CTO
[13] https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act

2.4. Key Practice Episode 3: (20/05/19-10/08/19) Admission to Opal Ward under S2, discharge home, referral to supported housing, deterioration and re-admission to Pearl Ward S2.

Notes upon Judith's admission to Opal ward identified a high risk of self-neglect and self-harm, that she had ran to a member of the public saying she felt unsafe and was perplexed then taken to A&E by police, she had not been taking her diabetes medication prior to this, but it was re-started on the ward. Her CC visited her, noted her deterioration and refusal to engage, over the following days she remained angry and agitated, expressing paranoid & suicidal thoughts. Her blood was tested for medication levels, but these revealed "no acute concerns", on admission. However, a few days later her HBA1c[14] was slightly elevated (indicator of high blood sugar levels), with a plan to then monitor and consider up titrating (increasing) her Diabetes medication. Her antipsychotic medication was changed to Quetiapine, which was thought to be better for her.

She continued to shout at night on the ward and was often given sedatives by the night staff to help her sleep. The plan agreed with her CC was a brief admission on this occasion, with a stay at a Crisis House prior to returning home. She was also seen to be overeating, thought to be as a way of self-harming, and possibly vomiting afterwards, she did not engage in ward activity and spent most of the time in her room. Her blood sugar remained high a week later, but her diabetes medication level was not changed. Her CC visited her and after 2 weeks was recommending discharge plans, initially to the Crisis House, but Judith did not want this.

She was then discharged home in June, having been referred to the Crisis Service (NCCRT, North Camden Crisis Resolution Team) for follow up support. She was visited in the days following her discharge both by her CC and a CPN from the NCCRT, who subsequently decided not to take on her care. Judith then began phoning the CSPA Crisis Line repeatedly again, with 8 calls recorded over the next 3 days, covering the same themes of depressive thoughts and inability to cope. This was thought to be a possible reaction to a sense of rejection by the NCCRT.

Her CC was on leave in July and a plan for Judith to get support from the Personality Disorder Service in office hours and CSPA out of hours was agreed, with Judith reporting her new medication was starting to work as she was feeling better. However, when visited by her CC again later in July she had once more deteriorated in her self-care, her flat was badly neglected and more wounds were visible on her face-she had not been taking her medication. Her brother agreed that Judith needed to move to supported accommodation and there was a plan to refer her. This was discussed with Judith, who was not keen but resigned to this, due to her deterioration her CC suggested a 2 week stay in a Crisis House to help her restart treatment, but this was refused. Her CC completed the supported housing referral, and this submitted to the Housing Dept Mental Health Pathways and reviewed by the Mental Health Referrals Coordinator (MHRC), who requested more information on her needs/risks.

[14] https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/hba1c

Her CC referred her to the Drayton House Women's Crisis House, in late July, but there were no vacancies and alternative options for other Crisis Houses were suggested, however these were also full. Home visits by the SIM Team noted further deterioration in self-care and limited engagement by Judith, both indicative of a relapse. Police were called to attend to Judith, following reports from the public that she was confused and following liaison with SIM Team they took her home and Social Services were notified via a Police Merlin form. SIM Team took her to the Crisis House for assessment, but she was unsure about staying there, so returned home.

Her Housing situation was explored with the Mental Health Referrals Coordinator (MHRC), in order for supported housing to be pursued through the Mental Health Pathway Judith would need to sign to relinquish her tenancy. Other options were also discussed; sheltered housing (her needs thought to be too high), or extra-care sheltered housing via Social Services (her needs were thought to be not high enough). Her new neighbours contacted the Housing Officer about Judith's behaviour; coming to their door, asking to be let in, screaming & shouting at night and behaving erratically.

CC attempted further home visits, but Judith was either not in/not answering the door and her CC negotiated a plan for an informal hospital admission. The Police entered her flat in August, for a welfare check but she was not home, having left her door open and her keys & phone inside and she was reported as a missing person. She attended A&E at UCLH after being found by a member of the public, who called an ambulance as she was looking dishevelled, confused and crying.

She reported having been wandering the streets for 10 days and did not want to return home, her blood sugars were high as she had not been taking her medication, she was again assessed under the MHA'83 and admitted to Pearl Ward in Highgate Mental Health Centre (under Section 2) on the 10th August 2019.

2.4.1. Significance and Appraisal of Practice

This period showed the difficulty of supporting Judith with a brief hospital admission to manage her chronic difficulties with coping living alone in independent housing. On admission there were significant concerns about her physical and mental health and there was some good practice with health checks and action taken to monitor her raised blood sugar levels, possibly due to poor compliance with medication in the period prior to her admission.

Her long-term self-neglect continued once she returned home and she relapsed quite quickly. Her compliance with medication was poor and her mental health deteriorated, despite intensive support from the SIM Team at home. This was recognised by her CC, who pursued alternative housing options via the Mental Health Housing Pathways for her to be considered for Supported Accommodation. However, this required Judith to relinquish her tenancy and she was advised to get independent legal advice about this first. She was too unwell during this period to do this and it delayed the process.

An alternative option to re-admission was also explored with a referral to the Crisis House, which was good practice, but again Judith was too unwell to agree to this and after a period of fully disengaging with support, she once more came to the attention of psychiatric services via a member of the public calling an ambulance to take her to

hospital. Upon assessment she was found to be significantly self-neglected, thought disordered and distressed, resulting in another formal admission to hospital. The events during this 3-month period followed a very similar pattern to the previous KPE, with a plan for a brief hospital admission of just over 2 weeks, leading to a fairly rapid relapse in Judith's health and another series of calls for help to a range of services after returning to her flat. Also, her pattern of self-neglect including neglecting her new home followed a familiar pattern of deterioration, as did the final outcome whereby she was re-admitted again, under Section 2 MHA'83.

2.5. Key Practice Episode 4: (10/08/19-19/09/19) Hospital admission, discharge to Crisis House and then back to her flat.

Judith was compliant with inpatient care and relieved to be back in hospital. When first admitted, she was thought to be experiencing visual hallucinations and said she did not want to return to her flat. She was restarted on her medication and her blood tests were done, she also had additional PRN (as required) sedation (Zopiclone and Lorazepam) to help her sleep and required a lot of reassurance from staff about her usual depressive thoughts and ruminations. Her CC liaised with her HO about the supported housing option, supplying proof of her ID and confirming she had refused to get legal advice, which had been delaying the application process. It was hoped supported housing could be arranged for when she was ready to leave. However, her ID was insufficient as photo ID/birth certificate was required to process her application.

When her medication was reviewed by the hospital pharmacy Judith confirmed she did not take her diabetic medication and her blood sugar levels were found to be slightly high. She settled on the ward gradually and needed lots of staff prompting reassurance to attend to her personal care. She was seen after 10 days by her CC, who planned for her to have another brief admission and be discharged to the Crisis House before going back to her flat, she was then re-referred to 2 Crisis Houses (Drayton Park and North Camden), but there was a 2 week wait. Her CC was then able to locate Judith's birth certificate at her old flat and this was supplied to Housing for her Pathways application, whereupon she was added to the waiting list for supported accommodation. Her legal status in hospital was then transferred to informal, as she was agreeing to stay and engage with an assessment by the Drayton Park Crisis House, which she went to visit with her CC. She was accepted and discharged there on 29/08/19.

She settled in the Crisis House, but on her first evening she screamed at night, waking other residents and continued to report feeling anxious/depressed. She did not want to take PRN to help her sleep but did have support from waking night staff to help with her negative ruminations and attended group therapy sessions in the daytime. She was thought to be in need of a more structured day and needed lots of staff 1-1 attention when returning to her heavy smoking, self-sabotaging, self-neglect and depressive thoughts. She had a meeting with her CC in early September about discharge home and the need to get her flat blitz cleaned first. She was encouraged to return and gradually start clearing up the rubbish in her flat and other practical tasks. She was visited again by the SIM Team and thought to have improved through the staff support being offered at the Crisis House. Her mental state then fluctuated

with an increase in negative thoughts & behaviours, possibly linked to anxiety over imminent plans for her discharge back to her flat, which were then postponed.

She was again visited by the SIM Team and supported with practical issues, such as ordering a new bed to facilitate her return home in mid-September. She was then seen at her flat and helped to begin tidying it up before being discharged from the Crisis House on the 19th September. Her housing referral was confirmed, and she was on the waiting list for supported accommodation options.

2.5.1. Significance and Appraisal of Practice

This period covered Judith's 3rd hospital admission in 9 months and her need for support to recover from her mental health relapse, where she improved over her 3 week stay to the point she was discharged to the Drayton Park Crisis House. She had been not taking her medication prior to the admission, which resulted in a familiar pattern of relapse, becoming more thought disordered and increasingly self-neglected. She once more came to the attention of mental health services via emergency admission but was thought again to require a brief admission to stabilise her mental and physical health. Following this a discharge plan for a period of support in the Crisis House was agreed with her and she continued to slowly settle with staff engagement at this service. This was good practice to reduce her time in hospital, while offering her some ongoing structure and support at this service, during her stay she was able to engage with the staff and improved during her 3 weeks there.

At the point of a planned discharge home, she showed some deterioration again, due to her anxiety at returning home and her discharge was delayed for a further week. She did engage with various practical tasks and was helped to improve her home environment before returning to her flat after her 3 weeks in the Crisis House. Although remaining anxious she did cope with the discharge plan and her health had improved after a period of medication compliance. Her blood sugar levels were slightly high when tested in hospital, but this was not assessed as being a significant health risk.

2.6. Key Practice Episode 5: (20/09/19-14/11/19) Brief period at home before presenting in crisis at police station and re-admitted to hospital for a further 10 days, then discharged home for a month prior to her death.

Judith was seen at her flat by the SIM Team and given encouragement to finish cleaning and tidying her flat. She was referred to a medium support housing service by her HO. She was seen again 2 weeks later, after missing an appointment and her flat was less tidy, especially her bedroom, she had been smoking heavily and had further signs of picking at her face again. She then presented at Kentish Town Police Station in early October, asking to see female officers and appearing distressed, with more cuts to her face. She was given a coffee and some support, a Merlin report of her visit was shared with Social Services and CSPA, as usual. She then returned to the police station later in the day, feeling suicidal and she claimed to be homeless-

following advice from Mental Health Services, she was detained under S136 (MHA'83).

She was then taken to UCLH for a mental health assessment, at which she reported hearing voices, had black feet, dirty and dishevelled clothes and cuts on her face from her self-harm. She had not been eating or taking her medication and her blood sugar levels were again found to be high. Crisis House options were explored as an alternative to admission, but due to lack of availability Judith was admitted, this time informally to Dunkley Ward in St Pancras Hospital on 07/10/19.

She was again seen by her CC from SIM Team and agreed to a brief admission for a few days and then to go back to the Crisis House at Drayton Park. She was then referred to another Crisis House (The Rivers) where she was taken for assessment but was thought to be too unwell and chaotic, so her referral was refused. She was thought by ward staff to sabotaging these Crisis House options, as she wanted to remain an inpatient, but this was considered to be not productive for her. She continued to express depressive and suicidal thoughts to nursing staff, although was thought to be at low risk and allowed to go out from the ward on leave. She was known to have raised blood sugar levels and advised to cut down on sugar but continued to have excessive amounts of sugar in her tea on the ward. At a subsequent ward round there was a plan to double the dose of her Metformin. She was then discharged home on the 16/10/19, after initially refusing to leave-with a plan to be supported initially by the Crisis Team and SIM Team.

Her referral to the Supported Housing, run by St Mungo's was rejected by them as the project was only staffed during the day and they felt Judith needed 24-hour staff support. She was seen briefly by her CC after 3 days and then again 7 days after her discharge, before he had further 2 weeks of annual leave. A neighbour contacted her HO again in early November to report further nocturnal noise of screaming from Judith and this was shared with her CC, her attempted to visit the next day, but could not get in to see Judith.

Housing looked for 24 hour supported accommodation, but there were no vacancies at this time. Her CC attempted 2 further unsuccessful home visits over the next 4 days, leading to contacts with A&E depts in case she had presented there and also reporting her to the police again as a missing person, requesting police make a welfare check. A further 2 visits were attempted again by her CC to see her over the next 2 days and on 14/11/19 police then forced entry to her flat, finding her deceased on the bathroom floor. The Homicide Assessment Team (HAT) were called to advise on whether the death was suspicious, but although she had wounds on her body these were thought to be self-inflicted. Her brother was contacted to notify him of her death, which was later confirmed to be of natural causes.

2.6.1. Significance and Appraisal of Practice

This period covers her 4th hospital admission in 12 months, which followed a familiar pattern to her previous deteriorations when at home, where she struggled to cope with her anxiety and exhibited more serious indicators of self-neglect after being discharged back to her flat from Drayton Park Crisis House. Although the plan remained to pursue supported living

options through the Housing Vulnerability pathway, due to a lack of suitable 24 hour staffed accommodation being available.

Her attendance at the police station led to a further crisis situation, culminating in Judith being detained under S136 by police who conveyed her to UCLH, where again she was subsequently assessed and admitted, (this time informally, rather than under S2) to a psychiatric ward, due to her non-compliance with medication and associated self-neglect. The attempts by the SIM Team to support her at home were not sufficient to prevent this rapid deterioration, where she was only in her flat for just over 2 weeks, before Judith was seeking crisis care through her presentation at the police station.

There was some good information sharing at this point where the police liaised with the SIM Team about Judith, following which the use of S136 was agreed to take her to a place of safety. This is in line with the S136 policy and was appropriate practice given the circumstances, as Judith had been self-harming, reported hearing voices and claimed to be homeless. The use of UCLH as a place of safety for a subsequent MHA assessment was also usual practice at the time, although since then a designated place of safety has been set up at Highgate Mental Health Centre, which has a specialist triage service and so A&E depts are no longer used, as long as there as sufficient space at the S136 suite.

When she was assessed at UCLH, she was noted to have black feet, badly soiled clothes, reported to have not been eating or taking her medication and was thought to be hearing voices, as well as expressing delusions about her CC being her boyfriend. Given her presentation and history it was expected practice to re-admit her, once any alternatives were explored. She could have gone back to the Crisis House, but none had any availability at the time, so the least restrictive option of an informal hospital admission was the outcome of her MHA Assessment. This was a change from her previous admissions, which had all been under Section 2 MHA'83.

Alternatives to admission, such as the various Crisis Houses were explored during her assessment, which would have been preferable-but due to a lack of resources were all full at the time. Due to the nature of these services, demand and availability vary and although it had only been just over 2 weeks since she had been discharged from Drayton Park it was not possible to keep her bed open there once, she had returned home. After being admitted to Dunkley Ward Judith did request going back to the Drayton Park Crisis House, however 2 other Crisis Houses (Islington CH and Rivers CH) were explored as there were still no vacancies at Drayton Park, but the alternatives did not accept her, as she was either too unwell, or she refused to engage.

After 10 days on the ward, she had not changed much, according to the inpatient notes and ward round discussions, she was still anxious and depressed, staying mainly in her room and requiring sedatives at night to help her sleep-but she was thought ready for discharge home. She was considered to not benefit from continued hospital admission, although had improved during her previous periods in hospital on other occasions during the year. She may have improved further if she had either had a longer admission, or a discharge to a Crisis House

instead of returning back to her flat. However, these were either not available in the case of Crisis Houses or not thought to be helpful, so she was discharged, despite her reluctance to leave the ward.

At the time this decision was standard practice and may reflect the pressure on in-patient services to minimise hospital admissions, however with hindsight it appears to have been a premature discharge, given her previous rapid relapses after hospital stays during the year and her reluctance to leave. There was communication with her CC and a discharge summary was sent to her GP, which was good practice.

Whilst this was happening her housing referral to supported living was refused by a medium support project, as her needs were thought to be too high following a review of the referral. The project felt she required 24 hr staff on site, which was not available at this service. After 2 weeks of Judith returning home, she was screaming at night (threats of suicide and to kill someone else) and her neighbour reported this to the Housing Officer, which indicated she was still not coping and in need of more support, especially at night-time. This was communicated to her CC who attempted to visit Judith, without success.

The HO also noted at this stage that Judith remained on the waiting list for supported accommodation and had been turned down for medium support. It was also recorded that there was a high demand for 24 hour supported housing and other referrals took priority, due to the person being in hospital. As Judith had left hospital she was deemed less of a priority, despite actually being at higher risk. This indicates that priority for supported housing might need to be looked at differently-in terms of current risk, due to lack of support, as opposed to as a solution to resolve inpatients' discharges.

Her CC made series of 4 unsuccessful home visits to Judith over the next 5 days and circulated her to both the hospitals and police as a missing person, prior to the police forcing entry to her flat and finding her deceased. This was considered to be usual practice and proportionate to her risk history, whereby she thought to be at risk of deterioration and associated self-neglect, but not at a high risk of self-harm or suicide, which could have indicated a more urgent welfare check. With the benefit of hindsight, a more rapid welfare check could have prevented her death, but this was not indicated at the time, based on the information available.

Her autopsy and subsequent inquest identified that she died due to Severe euglycaemic ketoacidosis, which means that her blood sugar levels were in the normal range, but her blood Ph had reached toxic levels, due to ketones in her blood stream. Therefore, the cause of this may not have been directly due to unmanaged diabetes, it could have been due to dehydration, poor diet, side-effects of her medication, or some other factor. As blood ketone levels are not routinely screened for during blood tests this would not have been picked up through the standard monitoring process, unless a specific urine test had been done, either during her hospital stay or through monitoring in the community via her GP. It is a rare condition and the fact it went undetected is not a sign of a failure in practice, as it would not be part of the usual management for diabetes. Furthermore, although the Coroner noted her self-neglect

this was not thought to have been significant enough to be a contributary factor to her death. Analysis of Practice against Terms of Reference.

3. Analysis of Practice against Terms of Reference

This section contains analysis of the practice found in this case which are set out against the agreed Terms of Reference for the SAR, below. These are taken from the information received and subsequent follow up discussions with key personal involved with the care of Judith during the period subject to review. Where relevant there is link to the subsequent overall findings and recommendations which are set out in the final section of the report.

3.1. The impact of both Judith's mental and physical health (diabetes) conditions on her vulnerability, risks and needs, including the management of her chronic and complex conditions.

Judith was known to have coped with mental health problems of varying degrees from an early age. Following a series of assessments at which she was not accepted by a number of mental health teams, she was one of the first clients of the SIM Team, whose remit was to reduce demands on emergency services. Although Judith was described as having insight and an awareness of her mental health problems, she was unable to contain her anxiety and continued to use crisis services throughout the period of the review.

Despite the good work done to support Judith with the impact of her poor mental health by the SIM team she became increasingly vulnerable and at risk of self-neglect during her final 2 years, requiring 4 admissions to mental health hospital wards during her last year of life. During the periods preceding each admission she was extremely vulnerable, to the point of coming to the attention of police, sometimes by wandering the street and requiring assessments under the MHA '83. Attempts to delay or avoid admission at these points often led to an escalation of her risky behaviour to

The reason for her deterioration during this period was not clear, although she clearly found the isolation of living alone at times too much to cope with. Judith's physical health condition (diabetes) had been monitored mainly through her GP, with annual blood checks. This was supplemented through additional reviews when she was admitted to hospital and although when in crisis, she was non-compliant with her medication and blood sugar levels were high, they were not dangerously so.

(See Finding 1)

3.2. The systems in place to respond to self-neglect during the period subject to review.

The system used to respond to Judith's self-neglect was through specialist mental health services support, mainly from the SIM Team Care Coordinator. Judith was known to self-neglect throughout the review period, but this was not raised as a safeguarding concern, under S42 of the Care Act 2014, which has included self-neglect as part of the eligibility criteria for a Safeguarding Enquiry.

There was no multi-agency meeting which would have been a possible response to try to mitigate the ongoing risks to Judith of her self-neglect. She was not referred to any service for ongoing social care support, despite the known inability to cope at home and also did not have an assessment of her care and support needs under S9 of the Care Act 2014.

As she was not referred to any day care, home care, or community support service it is not known what the response of Judith to this may have been, but conceivably ongoing regular practical support could have mitigated both some of her isolation/loneliness and her distress at her inability to stay on top of the lack of cleanliness and general disorder in her home environment. As this was an unmet need, which was not recorded this can be considered a gap in practice, the possible benefits of which were not explored during the work with her.

There is a self-neglect multi agency policy and procedure in Camden, but this was not used at the time of work done with Judith. This has been updated and a revised Multi Agency Toolkit version was published in 2020[15], which includes provision for a High-Risk Panel meeting. For similar future cases to Judith, this is to be followed, in order to fully explore the risks and strategies to manage these in future.

(See Finding 2)

3.3. The effectiveness of in-patient and community mental health services, including housing-based services (e.g., Crisis houses), which were provided to manage the impact of Judith's conditions on her health and wellbeing.

Judith received a lot of different acute mental health services during the review period, including a total of 5 inpatient admissions in total in 15 months.

1. Sapphire Ward under Section 2 after police detained her using S136 in September 18 and was discharged in November 18.
2. Pearl Ward in December 18 again after police detained her using S136 and was discharged in February 19.
3. 4 days in A&E at UCLH in May 19 before being admitted to Opal Ward under Section 2 and was discharged in June 19.
4. A&E at UCLH in August 19, where she was admitted to Pearl Ward again under Section 2 and discharged at the end of August 19 to Drayton Park Crisis House. She was discharged from the Crisis House in August 19.
5. admitted this time informally to Dunkley Ward for 10 days.
6. Altogether she spent over 5 months either in hospital, or a mental health crisis house during this period.

Whilst looking at each individual period of treatment she did benefit from the care and containment she received when looking at this period overall, this does not appear to be the most effective use of resources, as a cycle of relapse and readmission occurred quite regularly but was not addressed. Each episode followed the same pattern of relapse rapidly at home, culminating in either multiple calls to emergency services or the intervention of the police when Judith was unwell in a public place and then subject

[15] https://www.camden.gov.uk/documents/20142/0/2710.16+-+Multi-Agency+Self-Neglect+Toolkit+-+Final+Version+October+2020.pdf/5a0b1ae4-3c13-257a-4e19-2c6a59d2dcc1?t=1601479188472

to S136 to take her to hospital. The inpatient services dealt with her acute distress but there was often a view to discharge Judith rapidly usually back to the conditions she was in prior to her admission, except on one occasion when she went to the Crisis House Service.

Whilst it's difficult to clarify the pros/cons of decision making about the 5 admissions/discharges there was consensus during ward round discussions, involving Judith's CC, that these ought to be brief and that longer periods in hospital could even be counter therapeutic. From the above summary it can be seen following each admission Judith was only out of hospital for between 1-2 months before being re-assessed again and re-admitted, irrespective of the duration of her admissions.

In between these admissions, Judith was supported mainly through home visits by her CC at the SIM Team, as well as making use of the Crisis Line and Personality Disorder Duty Line. Prior to the SIM Team's involvement Judith had been assessed by a number of mental health teams but thought not to fit into the eligibility criteria of any. It was interesting to note that often her primary need was assessed differently by these teams, in order to explain why she wasn't appropriate for their services. For example, The Reablement Team said her needs were due to her Personality Disorder, whilst the Personality Disorder Team said her needs were due to Psychosis, or Dementia, The Ageing & Mental Health Team said she had no sign of dementia and her needs were due to Personality and Mood Disorders. Each team therefore interpreted her needs as more appropriately met by another service.

Her brother felt that no-one was taking responsibility for her and he requested a meeting with her GP to discuss this, clearly Judith had complex issues and had a number of diagnosis but her experience of repeatedly being assessed and refused a service shows the limitations of organising mental health services according to diagnostic criteria for patients like Judith, who don't neatly fit under any one diagnostic label. If the SIM Team had not been set up at this time and accepted her on the basis of her use of emergency services, it is not clear which service would have taken over responsibility for her.

It was noted that police liaised with the SIM Team when considering use of S136 and A&E also liaised with them when Judith presented there. Due to the model of the SIM Team which had a small case load they were able to work quite intensively with Judith and aimed to support her with coping strategies and a therapeutic model of intervention. They engaged successfully with her and she did value their input, but despite this she was clearly unable to manage for any length of time at home.

Her Housing needs were identified as a key issue and the SIM team worked well with colleagues from The Housing Department, to navigate the systems and facilitate a temporary move, whilst pursuing supported living for her. However, despite the best efforts of both services a suitable service was not found for her.

(See Finding 3 & 4)

3.4. The quality of services delivered in response to periods of acute crisis as well as the long-term difficulties experienced by Judith.

This aspect of the terms of reference to some extent duplicates the one above, so discussion is limited to the responses taken at the point of a decision to assess Judith under the Mental Health Act, by the police when using S136. There were several occasions where Judith came to the attention of the police, including community policing where she was found in a state of distress in a public place. Section 136 was used inappropriately on one occasion where she was detained after police were called to her address, in November '18. This has been recognised as an area for improvement by the Police Mental Health Team, who are now rolling out a training and awareness programme to ensure officers are aware of the threshold for correct use of S136. It has also been recognised that police in Camden use S136 more often than other areas, partly this is due to demographic issues in the borough.

Once police made the decision to use S136 in this case Judith was conveyed to A&E for a Mental Health Act Assessment, although there is now a dedicated S136 suit at Highgate for conveying all S136 for assessment, so now police very rarely use A&E (unless either this is full, or patient has physical health problems). The suite has 5 rooms (3 now in use due to CV19). Relationships are good with staff at this service and it generally works well.

As a place of safety, if patient needs taking to A&E this is now lawful to convey them to a new place of safety using the same S136. All the S136s used in the area are reviewed by the Mental Health Team, monitoring number, any patterns, repeat use for the same person etc. If more than 2 are for the same person there is a discussion with the relevant Care Coordinator for the patient to review and agree a multi-agency approach to be used, which is uploaded to the Crim Int system to inform officers who might encounter the person again. So the CC's details are available, and officers can discuss the individual circumstances of the case and get advice, although in a crisis the officers may have no option but to use S136 (risk to self, public etc).

The system used by police to notify Adult Social Care of their contacts with adults with mental health problems is by completion of police Merlin report, which is sent to the MASH Team. The response to this by ASC was not included in this SAR, but from police and mental health contributions to the SAR it was noted that there were 8 Merlin reports which forwarded to the relevant Mental Health Team by the MASH team. A Merlin report may lead to trigger a Safeguarding Concern being raised by the MASH Team, although there was no evidence that this was done for Judith. This separate police IT system for recording Merlin reports done by officers is due to be replaced by a single system (IIP) so all the current separate systems (CrimInt, Cris, Merlin, CAD) will be able to be all searched simultaneously.

(See Finding 5)

3.5. The circumstances and events leading to the Judith's death

As set out earlier in this report, (in section 2.6. & 2.6.1.) Judith died from a rare condition leading to her blood Ph levels dropping due to an increase in ketones, which are often found associated with a high blood sugar level, due to poorly controlled diabetes. However, in Judith's case her blood sugar levels were normal, and the toxic level of ketones found were not due to this. The cause was undetermined at her Post-mortem and subsequent Inquest. It

was possible that her chronic self-neglect contributed to this, but other reasons were not ruled out (e.g., dehydration, side-effect of medication etc). Given these possible but not confirmed causes it was not reasonable to predict the risks to her life from her self-neglect.

It was further not known how long exactly she had been deceased prior to her body being discovered after the police welfare visit, so the decision to visit on 4 occasions and her lack of response, prior to requesting the police force entry to her flat could not be identified as a gap in practice, given what was known at the time and specifically her history of previous non-engagement with either the planned or ad hoc visits from the SIM Team. Despite this there were some issues identified during this review which could support practice for ensuring adults with both mental health and physical health problems are well managed through better information sharing with Primary and Secondary Care services.

(see Finding 6)

3.6. The response of any key safeguarding mechanisms including the Multi-Agency Safeguarding Hub, where concerns were reported to the agency for safeguarding enquiries to be undertaken.

There were no Safeguarding processes undertaken in this case, in order to address the issues which Judith was well known to be experiencing, due to her ongoing self-neglect. As Adult Social Care had no direct involvement in this case, it appeared that any Merlin raised to the MASH by the police, was forwarded onto her CC in Mental Health Services, without any triage, or recommendation from the MASH Team. Furthermore, there did not appear to have been an assessment of Judith's needs under The Care Act 2014, neither under the Section 9 duties to assess any eligible needs for care and support, nor under Section 42 Safeguarding Adults Duties.

(see Finding 7)

4. Findings from the Review

This section contains the priority findings from this SAR, including references to key examples from the work done with Judith. Recommended actions in response to each Finding for service improvement are set out for consideration by Camden Safeguarding Adults Partnership Board in the next section of the report.

4.1.1. Finding 1

The management of adults with both a personality disorder and mood disorder require the development of an integrated person-centred pathway for crisis services considering hospital admission to respond rapidly to increased risks to self-harm and self-neglect, especially where adults live alone.

Example from the case

For each KPE analysed in the case, Judith began to breakdown at home in a way that became predictable, following a period of disengagement with community-based support, non-compliance with medication and use of crisis/emergency services, especially out of hours. The usual response to these were attempts to delay, or avoid use of compulsory powers, either preceding or at Mental Health Assessments, which always led to an escalation in her risk-taking behaviour and self-neglect in order to for her to secure access to hospital admissions. Delaying the use of formal hospital admission powers is usually considered best practice under the Mental Health Act, however this can be counter-productive, where an adult with a personality disorder is not coping and can lead to an increase in subsequent risk-taking behaviour by the adult to gain a hospital admission.

Recommendations for the Board to consider

- **Where there is a known consistent pattern of escalating behaviour to seek hospital admission by an adult with mental health problems the practice of seeking to delay, or prevent inpatient admissions needs to be carefully balanced against the impact of this decision on health and safety of the adult**
- **Consider more rapid use of in-patient mental health facilities as an appropriate response when an adult is presenting, or known to be in crisis, rather than always seeking to avoid admission through gatekeeping strategies.**

4.1.2. Finding 2

Self-neglect amongst adult mental health service users may tend be dealt with using traditional approaches, such as CPA/Care Coordination, which while it can lead to individual good practice but does not follow the Multi-agency Self-Neglect toolkit and so may miss some opportunities to work together to assess and manage the risks of self-neglect.

Example from the case

As set out above, although the SIM Team shared information and did some good, intensive work with Judith, this tended to be on a single agency basis and there were no multi-agency meetings to coordinate risk management, or contingency plans. Instead, the traditional model of community mental health work, alongside periods of formal hospital treatment were used, resulting in a cycle of re-lapse, self-neglect, decline and re-admission in revolving-door type manner. Whilst alternative housing was found on a temporary basis and supported housing was pursued the self-neglect issues were never suitably addressed either during or between hospital admissions.

Recommendations for the Board to consider

- **Work needs to be done in Mental Health Services, to recognise the need for and use of the multi-agency Self-Neglect Toolkit, where traditional approaches to the issue of self-neglect amongst service users is not effective.**
- **While the therapeutic model of engagement when working with adults with personality disorders can be effective over time, a more practical care & support plan would assist to meet needs for assistance when adults are unable to cope with independent living.**
- **A review/assessment of those adults with mental health problems' care and support needs should be undertaken in line with the requirements of the Care Act 2014.**
- **Where self-neglect is a chronic issue this should be addressed either through Section 42 safeguarding enquiries, Section 9 Assessments and/or in line with the Self-Neglect Toolkit.**

4.1.3. Finding 3

Where an adult frequently makes use of hospital admissions at periods of crisis, the model of minimising the time spent in hospital can lead to a pattern of repeated relapses and readmissions, where they are discharged back to the same environment.

Example from the case

Each admission and discharge did not lead to any sustained change, or improvement in Judith's health-resulting in the cycle as set out of repeated re-admissions. It appeared that there was some partnership work done between the community and hospital mental health services and clearly inpatient resources are a scarce resource, often under pressure. This can affect decisions to discharge patients as quickly as possible. However, if this is back to the same circumstances repeatedly resulting in regular re-admissions, it calls into question whether this is the most effective use of an inpatient service and whether either a longer admission, a discharge delayed until a placement is found, or a discharge under CTO where compliance with medication/aftercare is required might have been more constructive for Judith. Guardianship was also another possibility and would not have required hospital admission before being applicable.

Recommendations for the Board to consider

- **Where people are repeatedly admitted to hospital (3 or more times a year) the appropriateness of the decision to use of Section 2 for re-assessment needs to**

be reconsidered, as Section 3 (for longer treatment, or use of a CTO) might be more appropriate.

- **Frequent re-admissions at points of crisis at home, as above, may indicate a need to delay discharge until an alternative aftercare plan is set up, such as a step-down or supported housing service, which needs to be agreed with housing prior to the patient being discharged to their current address and also consider the use of** Guardianship (s7 of the MHA), as an option to facilitate access to the adult and compliance with a treatment plan.

4.1.4. Finding 4

The current model of mental health services in Camden and Islington Mental Health Trust being aligned according to diagnostic criteria can lead to multiple re-assessments and rejections of adults who have complex, or multiple diagnosis-serving to exclude people based on subjective interpretations of eligibility criteria.

Example from the case

As set out above Judith had numerous assessments by various mental health teams, each identifying another team as more appropriate than their own service. There was always a reason not to accept Judith into any specialist team, the reason varied depending on which team was assessing Judith-but each team found a reason to refuse and pass back her referral. The impact of these multiple assessments and refusals of service on Judith is not known, but her brother felt she they were "passing the buck" rather than anyone stepping up to take responsibility.

Recommendations for the Board to consider

- **The decision to exclude an adult with multiple diagnoses from any single specialist mental health service based on the view that another service is more appropriate ought to be taken only after the other service has been involved in the decision.**
- **Consideration of joint assessments for these clients by the various teams which may be appropriate along diagnostic lines, should be agreed to avoid multiple single team assessments/refusals to offer a service.**

4.1.5. Finding 5

Police use of S136 in Camden has improved since the time of this SAR, with better systems for information sharing with Care Coordinators/ The SIM Team where it is used frequently, oversight and training by the Police Mental Health Team and through the development of a specialist S136 suit with Highgate Mental Health Centre.

Example from the case

As set out above Police resources in Camden make frequent use of S136 compared to other boroughs, with practice improvements identified both through better oversight of S136 from the Police Mental Health Team and the development of a dedicated S136 suit at Highgate Mental Health Service.

Recommendations for the Board to consider

- **Dissemination of the SIM Team Model for high-risk clients to other areas, in order to improve both coordination of S136 work and the interface between the police and mental health services, for clients that are frequent callers to emergency services.**

Finding 6
Where adults have both mental health and physical health problems there can be problems with the effective management of long-term physical health conditions, due to a lack of timely information sharing and subsequent monitoring of poor physical health in the community.

Example from the case
Judith had a good relationship with her GP and attended the surgery to regular blood tests and medication reviews. However, once she began to disengage from her GP and did not attend appointments, there were difficulties with ensuring her diabetes was overseen at the surgery. This was done as part of the inpatient care she received whilst in hospital, but this was not always shared with her GP in an effective and timely manner subsequent to her contact with other health services. For example, her attendance at A&E was not always known by her GP and partly due to the large caseload following the re-configuration of Primary Care services liaison between Mental Health Services and her GP became ad hoc. There is a team as part of the GP federation called the SMI Team who undertake an annual review of patients, for Judith this was done virtually as she was an inpatient in a psychiatric ward at the time the review was due. Also, there are physical health specialist teams now located within Mental Health Teams, under the Psychosis service line. These are specialist nurses who seek to ensure patients physical health is part of an ongoing process of regular review. This service is not currently available within the Personality Disorder service line, as the SIM Team fall under the PD service line Judith did not have any ongoing community review of her physical health from the Mental Health Trust.

Recommendations for the Board to consider
- **Ensure that when patients are seen at A&E a timely and effective system is in place to notify the patients' GP of the outcomes of these contacts.**
- **Where complex patients are discussed at multi agency meetings at the GP services, that these are attended by the relevant Care Coordinator from Mental Health.**
- **Where patients with physical and mental health problems are reviewed via the GP specialist Team (SMI Team) for a review, that these are undertaken in person, rather than virtually through telephone contacts.**
- **The management of patients who self-neglect and are known to a GP should include the GP where any meetings are held as part of either a Safeguarding Enquiry or through the Self-Neglect process.**

- **That physical health teams are established within the Personality Disorder service line, to give an equivalent service to those patients in the Psychosis Service Line.**

Finding 7
Where the MASH Team receive notifications via the police Merlin system, these should be triaged by the MASH team to identify and recommend action required to respond to these concerns, prior to a decision for forwarding them onwards to a Mental Health Service, where the adult is known to be under the care of Mental Health Services.

Example from the case
There were a total of 13 Merlin reports sent by police officers to the MASH Team for Judith during the period subject to review in this SAR. These are graded by the police according to their assessment of risk in the case, in order to notify Adult Services of the contact by Police with the Adult. These ranged from police attendance at her address after contact from neighbours, direct contact by Judith to police in distress, to Judith being found by Police in a public place and being detained under S136. In all cases these were graded and sent to the MASH Team, although from a review of mental health chronology of contacts these were not always recorded on Mental Health Case notes. It is not known whether they were always sent onto Judith's Care Coordinator by the MASH Team. From a review of reports received they were all known about by the SIM Team, although this may be due to the presence of a police officer in the SIM Team, who has access to all Police information systems, rather than because the MASH Team had sent them on to C&I Mental Health Services.

Recommendations for the Board to consider

- **Audit of Police Merlin reports sent to MASH Team, to review decision making as to whether the Merlin ought to lead to a Safeguarding Concern being raised, whether in Adult Social Care, or Mental Health Services, for adults at risk through self-neglect.**

5. Recommended Action Plan Following the Review

For each of the Findings and associated recommendations for the CSAPB, a series of suggested actions, with an identified lead agency for each action are summarised in the table below.

Finding	Recommendations	Action Plan	Lead Agency
1.	Where there is a known consistent pattern of escalating behaviour to seek hospital admission by an adult with mental health problems the practice of seeking to delay, or prevent inpatient admissions needs to be carefully balanced against the impact of this decision on health and safety of the adult	Ensure that AMHP assessments and subsequent gatekeepers to inpatient admission, consider the likely impact of any alternatives to the admission, taking into account the previous history and likelihood of an adult escalating risk taking behaviour if they are not admitted following an assessment under the MHA '83.	Camden & Islington NHS Foundation Trust
	Consider more rapid use of in-patient mental health facilities as an appropriate response when an adult is presenting, or known to be in crisis, rather than always seeking to avoid admission through gatekeeping strategies.		
2.	Work needs to be done in Mental Health Services, to recognise the need for and use of the multi-agency Self-Neglect Toolkit, where traditional approaches to the issue of self-neglect amongst service users is not effective.	Disseminate the multi-agency Self Neglect toolkit to all Mental Health Team Managers and offer training on its use, where needed for practitioners	Camden & Islington NHS Foundation Trust/ Camden Adult Social Care Services
	While the therapeutic model of engagement when working with adults with personality disorders can be effective over time, a more practical care & support plan would assist to meet needs for assistance when adults are unable to cope with independent living.	Ensure that Care Act 2014 duties are met as follows; for the assessment of needs for Care & Support (Section 9) a suitable support plan is put in place to	Camden & Islington NHS Foundation Trust/ Camden Adult Social Care Services

		meet eligible needs (Section 25) this is subject to regular review (Section 27)	
	A review/assessment of those adults with mental health problems' care and support needs should be undertaken in line with the requirements of the Care Act 2014.		
	Where self-neglect is a chronic issue this should be addressed either through Section 42 safeguarding enquiries, Section 9 Assessments and/or in line with the Self-Neglect Toolkit.	Ensure all Team Managers are aware of the statutory framework for responding to chronic Self-Neglect for their service users	Camden & Islington NHS Foundation Trust/ Camden Adult Social Care Services
3.	Where people are repeatedly admitted to hospital (3 or more times a year) the appropriateness of the decision to use of Section 2 for re-assessment needs to be reconsidered, as Section 3 (for longer treatment, or use of a CTO) might be more appropriate.	Ensure AMHPs take account of relevant history of previous formal hospital admissions when considering an application for admission under either Section 2 or Section 3 of the MHA'83. Audit a sample of patients, to establish who have had more than 3 admissions under section 2 in a 12 month period	Camden & Islington NHS Foundation Trust
	Frequent re-admissions at points of crisis at home, as above, may indicate a need to delay discharge until an alternative aftercare plan is set up, such as a step-down or supported housing service, which needs to be agreed with housing prior to the patient being discharged to their current address and also consider the use of Guardianship (s7 of the MHA), as an option to facilitate access to the adult and compliance with a treatment plan.	When people are not coping in their accommodation and frequently admitted to hospital, discharge needs to be planned with the Housing Services to ensure they are provided with suitable accommodation before they leave hospital.	Camden & Islington NHS Foundation Trust and Camden Housing Services
4.	The decision to exclude an adult with multiple diagnoses from any single specialist mental health service based on the view that another service is more appropriate ought to be taken only after the	Where adults are known to have a number of differential diagnosis they have a suitable assessment done in partnership by all the appropriate	Camden & Islington NHS Foundation Trust

	other service has been involved in the decision.	services to determine the most appropriate service, without them having to multiple assessments and rejections by each individual team/service.	
	Consideration of joint assessments for these clients by the various teams which may be appropriate along diagnostic lines, should be agreed to avoid multiple single team assessments/refusals to offer a service.		
5.	Dissemination of the SIM Team Model for high-risk clients to other areas, in order to improve both coordination of S136 work and the interface between the police and mental health services, for clients that are frequent callers to emergency services.	The SIM Team Model to be recommended as good practice for frequent callers to emergency services across London.	CSAPB
6.	Ensure that when patients are seen at A&E a timely and effective system is in place to notify the patients' GP of the outcomes of these contacts.	A&E services to ensure that notifications are sent to the persons' GP, whether or not the patient is subsequently admitted to hospital.	Whittington Health NHS Trust University College London Hospitals Camden CCG
	Where complex patients are discussed at multi agency meetings at the GP services, that these are attended by the relevant Care Coordinator from Mental Health.	Ensure that Care Coordinators are involved as part of complex patient meetings held by their GP surgery.	Camden CCG Camden & Islington NHS Foundation Trust
	Where patients with physical and mental health problems are reviewed via the GP specialist Team (SMI Team) for a review, that these are undertaken	Ensure Primary Care Services actually see all Patients for their annual review by the SMI Team	Camden CCG

	in person, rather than virtually through telephone contacts.		
	The management of patients who self-neglect and are known to a GP should include the GP where any meetings are held as part of either a Safeguarding Enquiry or through the Self-Neglect process.	Ensure that GPs are included as key partners during either a Section 42 Enquiry into Self-Neglect or when using the Self-Neglect Toolkit	Camden CCG Camden Adult Care Services CSAPB
	That physical health teams are established within the Personality Disorder service line, to give an equivalent service to those patients in the Psychosis Service Line.	Include equivalent services are provided for the physical health needs of adults with mental health problems, irrespective of their diagnosis.	Camden CCG Camden & Islington NHS Foundation Trust
7.	Audit of Police Merlin reports sent to MASH Team, to review decision making as to whether the Merlin ought to lead to a Safeguarding Concern being raised, whether in Adult Social Care, or Mental Health Services, for adults at risk through self-neglect.	Undertake an independent audit of Merlin referrals sent to the Camden MASH Team, to look specifically at the triage and response to these referrals.	CSAPB

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Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
CSAPB	Camden Safeguarding Adults Partnership Board	The overarching purpose of the CSAPB is to help and safeguard adults with care and support needs by: • Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance; • Assuring itself that safeguarding practice is person-centred and outcome-focused; • Working collaboratively to prevent abuse and neglect where possible; • Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and • Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area. The Board meets four times a year and has an Independent Chair.
SAR	Safeguarding Adult Review	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. It is a statutory review, commissioned by CSAB, under Section 44 of the Care Act 2014.
KPE	Key Practice Episode	Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term ‘key practice episodes’ to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not

Abbreviation	Full Version	Explanation
		restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects. https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp
JAMI	Jewish Association for the Mentally Ill	Jami's vision is a Jewish community which accepts, acknowledges and understands mental illness. A community which is resilient and has the capacity and capability to be healthy. A community in which symptoms of mental illness are as recognisable as a heart attack and trigger an equally appropriate First Aid response. We work with individuals, communities and organisations to help prevent mental illness from developing, improve early intervention and promote wellbeing. https://jamiuk.org/about-us/
CC	Care Coordinator	A CPA care co-ordinator (usually a nurse, social worker or occupational therapist) will manage a patients' care plan and review it at least once a year. A care plan will say who the care co-ordinator is. https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
MAR	Medicine Administration Record (MAR) Charts	A MAR chart is a working document used to record administration of medicines. They are normally produced by the pharmacy on a monthly basis at the time of dispensing and are delivered with the medication. All medicines for a client should be listed on an individual MAR chart; items such as dressings with no medicinal content have no legal requirement for MAR records to be kept, but it is good practice to do so for the purpose of creating a clear audit trail. http://www.pharmacy-xpress.co.uk/manuals/training-handbook/9-medicine- administration-record-mar-charts

APPENDIX 2

Terminology	Explanation	Reference
Acute cardio-respiratory failure	Acute respiratory failure occurs when fluid builds up in the air sacs in your lungs. When that happens, your lungs can't release oxygen into your blood. In turn, your organs can't get enough oxygen-rich blood to function. You can also develop acute respiratory failure if your lungs can't remove carbon dioxide from your blood. Respiratory failure happens when the capillaries, or tiny blood vessels, surrounding your air sacs can't properly exchange carbon dioxide for oxygen. The condition can be acute or chronic. With acute respiratory failure, you experience immediate symptoms from not having enough oxygen in your body. In most cases, this failure may lead to death if it's not treated quickly.	https://www.healthline.com/health/acute-respiratory-failure
Severe euglycaemic ketoacidosis	Sodium-glucose co-transporter-2 (SGLT-2) inhibitors are a relatively novel class of oral medications for the treatment of Type 2 DM with a generally acceptable safety profile. However, these agents have been associated with rare events of a serious and potentially life-threatening complication named euglycemic diabetic ketoacidosis (euDKA). euDKA is not identical with the typical diabetic ketoacidosis, as it often presents with serious metabolic acidosis but only mild to moderate glucose and anion gap elevation	https://bmcnephrol.biomedcentral.com/articles/10.1186/s12882-020-01930-6
SGLT2 inhibitors	SGLT2 inhibitors are a type of oral medication used to treat type 2 diabetes. They're also called sodium-glucose co-transporter-2 inhibitors (SLGT2i) or gliflozins.	https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/treating-your-diabetes/tablets-and-medication/sglt2-inhibitors
Diabetic ketoacidosis	Diabetic ketoacidosis is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones. The condition develops when your body can't produce enough insulin. Insulin normally	https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-

	plays a key role in helping sugar (glucose) — a major source of energy for your muscles and other tissues — enter your cells. Without enough insulin, your body begins to break down fat as fuel. This process produces a build-up of acids in the bloodstream called ketones, eventually leading to diabetic ketoacidosis if untreated.	20371551
Diabetes mellitus type 2	• **Type 2 diabetes is a common condition** that causes the level of sugar (glucose) in the blood to become too high. • **It can cause symptoms like excessive thirst, needing to pee a lot and tiredness**. It can also increase your risk of getting serious problems with your eyes, heart and nerves. • **It's a lifelong condition that can affect your everyday life**. You may need to change your diet, take medicines and have regular check-ups. • **It's caused by problems with a chemical in the body (hormone) called insulin**. It's often linked to being overweight or inactive, or having a family history of type 2 diabetes.	https://www.nhs.uk/conditions/type-2-diabetes/
Chronic obstructive pulmonary disease	**Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.** It includes emphysema – damage to the air sacs in the lungs, chronic bronchitis – long-term inflammation of the airways COPD is a common condition that mainly affects middle-aged or older adults who smoke. Many people do not realize they have it. The breathing problems tend to get gradually worse over time and can limit your normal activities, although treatment can help keep the condition under control	https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/
Systemic Hypertension	Systemic Hypertension is high blood pressure in the systemic arteries – the vessels that carry blood from the heart to the body's tissues (other than the lungs). High systemic (or body) blood pressure is usually caused by the constriction	http://www.pted.org/?id=syshypertension1

	of the small arteries (arterioles). This increases the peripheral resistance to blood flow, which increases the heart's workload and raises arterial pressure.	
Schizo-affective disorder	This is a disorder of the mind that affects your thoughts and emotions and may affect your actions.You may experience episodes that are combinations of both 'psychotic' symptoms and 'bipolar disorder' symptoms. These symptoms are clearly present for most of the time over a period of at least two weeks.	https://www.rcpsych.ac.uk/mental-health/problems-disorders/schizoaffective-disorder
Metformin	Treatment of type 2 diabetes mellitus, particularly in overweight patients, when dietary management and exercise alone does not result in adequate glycaemic control. • In adults, Metformin tablets may be used as monotherapy or in combination with other oral anti-diabetic agents, or with insulin.	https://www.medicines.org.uk/emc/product/594/smpc#gref
HbA1c	HbA1c is what's known as glycated haemoglobin. This is something that's made when the glucose (sugar) in your body sticks to your red blood cells. Your body can't use the sugar properly, so more of it sticks to your blood cells and builds up in your blood. Red blood cells are active for around 2-3 months, which is why the reading is taken quarterly. A high HbA1c means you have too much sugar in your blood. This means you're more likely to develop diabetes complications, like serious problems with your eyes and feet.	https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/hba1c
PRN	PRN prescribing means giving you extra doses of your medication, in addition to your regular daily dose. 'PRN' stands for 'pro re nata', which means 'as the circumstances require' in Latin. So, it only happens in certain circumstances. You are most likely to be given a PRN dose if you are staying in hospital, either because: the medical staff think you need a bit more medication in some situations, or you've asked for a bit more medication in some situations.	https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/dosage/

Vulnerability Panel (Camden Council)	A multi-agency panel which scrutinises possession proceedings where there is vulnerability. It also advises on the management of complex cases and this may include recommendations for additional support, supported housing, sheltered housing or other transfers. All other options should have already been tried. Panel should be considered as a last resort.	https://cindex.camden.gov.uk/kb5/camden/cd/service.page?id=7K8OXVpdkgU
Section 136 Mental Health Act '83	Section 136 allows the police to take you to (or keep you at) a place of safety. They can do this without a warrant if: • you appear to have a mental disorder, AND • you are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to, AND • you are "in need of immediate care or control" (meaning the police think it is necessary to keep you or others safe). Before using section 136 the police must consult a registered medical practitioner, a registered nurse, or an AMHP, occupational therapist or paramedic.	https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/
Community Treatment Order (CTO)	A CTO is an option for s3 and unrestricted criminal patients (hospital order, transfer direction, or hospital direction). The criteria of which the RC must be satisfied are found in s17A (5): *(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment.* *(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment.* *© subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital.* *(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E (1) below to recall the patient to hospital; and* *© appropriate medical treatment is available for him.* An AMHP must certify in writing that he agrees the criteria are met and that it is appropriate to make the CTO (s17A (4)).	https://www.mentalhealthlaw.co.uk/Community_Treatment_Order#Granting_a_CTO

	The time periods for a CTO are the same as for detention under s3. It lasts initially for a maximum of six months but can be renewed for a further six months and thereafter can be renewed for 12-month periods (s17C, s20A (3)). There are two mandatory conditions (s17B (3)): *(a) a condition that the patient make himself available for examination under section 20A below; and* *(b) a condition that, if it is proposed to give a certificate under Part 4A of this Act in his case, he makes himself available for examination so as to enable the certificate to be given.* The first mandatory conditions relate to renewal of the CTO; the second to assessment for a SOAD certificate.	
Approved Mental Health Practitioner **(AMHP)**	AMHPs are approved or authorised by local authorities. Historically, the role has been undertaken by social workers (prior to the 2007 amendments, the role was known as the Approved Social Worker). Since 2007, mental health and learning disabilities nurses, occupational therapists and chartered psychologists have been able to train to be AMHPs, but currently social workers still occupy 95% of the AMHP role.	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843539/AMHP_Workforce_Plan_Oct19__3_.pdf

APPENDIX 3

KEY PRACTICE EPISODE	SUMMARY OF KEY ISSUES
Brief Summary of the case Prior to the period subject to review **(Pre-November 2018).**	• Delaying admissions for adults with complex mental health and personality problems can lead to an escalation in the adults' risky behaviour, in order to overcome barriers to hospital admission. • The long-term difficulties of adults who self-neglect requires both intensive input when the difficulties are at crisis level, but might not be addressed consistently between these crisis periods • There is a link between chronic self-neglect, mental health and physical health, which is challenging to assess especially with adults that don't engage. • Adults with a range of different diagnoses may get rejected by a series of specialist mental health teams, based on these diagnoses before being accepted by one team • The development of the SIM Team led to Judith being accepted on the basis of her behaviour and frequent use of emergency services when in Crisis, rather than her diagnoses.
Key Practice Episode 1: (01/11/18- 18/02/19) SIM Team involvement, Housing problems with neighbour and move to temporary accommodation, following psychiatric hospital admission.	• The housing needs of adults with mental health problems was addressed through the use of the Vulnerability Panel, which usually requires adults to agree to relinquish their tenancy, but in this case, discretion was shown to offer temporary housing, whilst supported housing options were explored • Use of Police Powers to remove adults from a public place under S136 MHA 83 had been used inappropriately at the time, but awareness of this has since been addressed through training and oversight on S136 by the Police Mental Health Team • There is now a specialist S136 suit for use by police to enable assessments to be undertaken in a safe place, under MHA
Key Practice Episode 2: (19/02/19- 20/05/19)	• During the 3 months following discharge to new accommodation JI's previous pattern of contacting agencies, especially out of hours, continued indicating a rapid relapse in her mental health and

Ongoing support from SIM team at new address, with increased calls to Crisis Helplines, LAS, Police and A&E, another admission.	a lack of ability to cope with her anxiety when living alone. • The SIM Team had a key role in coordinating the responses to JI's contacts with a range of agencies and tried a consistent approach to help her manage her anxiety, but with limited success • Delaying the decision to admit JI led to an escalation in her behaviours to seek admission • Alternatives to admission were explored but were not available due to resource constraints in the Crisis Houses • When the decision was taken to admit JI under the Mental Health Act '83, the decision was taken to use Section 2 again rather than Section 3, which limited options for supervised treatment when she was deemed ready to be discharged again.
Key Practice Episode 3: (20/05/19-10/08/19) Admission to Opal Ward under S2, discharge home, referral to supported housing, deterioration and re-admission to Pearl Ward S2.	• Ji was once more unable to sustain improvements in her mental and physical health, subsequent to her hospitalisation and discharge home • Her relapse and disengagement with informal support through the SIM Team in the Community resulted in her coming to the attention of emergency and crisis services. • Her housing move to a new tenancy followed a previous pattern whereby she once more neglected herself, treatment and her environment. • The agreed plan to secure supported housing options was delayed by her inability to engage with the Mental Health Pathways process, despite which she was accepted onto this scheme • Alternatives to admission by use of Crisis Houses were unsuccessful to lack of availability • Attempts to avoid admission led to her frequent re-presentation over 4 days at A&E, until she was once more detained under Section 2
Key Practice Episode 4: (10/08/19-19/09/19) Hospital admission, discharge to Crisis House and then back to her flat.	• On this occasion JI was discharged to a Crisis House rather than home, after another brief inpatient admission, where her mental and physical health had improved. • She benefited from the support on offer at the Crisis House and was helped to improve her home environment prior to returning home. • She was accepted for Supported Housing and options were explored but no suitable placement was found for her.
Key Practice	• On this occasion JI was unable to cope at home,

Episode 5: (20/09/19-14/11/19) Brief period at home before presenting in crisis at police station and re-admitted to hospital for a further 10 days, then discharged home for a month prior to her death.	after being discharged from the Crisis House, or following a brief hospital admission. • On both occasions she self-neglected and screamed at night-time, but the risks to her health and safety were not thought to be acute. • It was not clear that she had improved sufficiently during her brief hospital admission to cope in the community in independent housing, so possibly her discharge should have been delayed until either a Crisis House bed or a supported placement was available. But her risk to herself was not thought to be sufficient to keep her in hospital for longer. • Despite the attempts to re-house into supported accommodation, she was not deemed suitable for medium support and not a priority for the limited availability of higher support housing, as she was in the community, rather than taking up a hospital bed. • Her cause of death was from a rare condition, its cause was unknown, but was not directly attributable to her diabetes, given this the delay in SIM Team requests for the police forcing entry to her flat after she had not responded to home visits for 5 days was deemed a reasonable course of action in the circumstances.