Safeguarding Circle

Safeguarding Adults

Review

“Phillip”

Overview Report

June 2022

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1. Introduction

1.1 City and Hackney Safeguarding Adult Board (CHSAB) have commissioned this Safeguarding Adult Review (SAR) after "Phillip" was found dead in late 2021, having taken his own life.

1.2 Phillip's children were known to children's social care as 'children in need' in 2021 as Phillip's wife had disclosed that he had been emotionally and physically abusive and was misusing alcohol. The social worker supported his wife to evict Phillip from the family home. The following week, a family member contacted the children's social worker, complaining about the children being left in Phillip's care previously, raising safeguarding concerns including historic offences. Phillip attempted suicide the same day and was admitted to Royal London Hospital.

1.3 Two days later, Phillip was transferred to the East London Foundation Trust where he was admitted informally for treatment of his mental health. He reported feeling low following the breakdown of the relationship with his family, but expressed his intention to rebuild this. Having assessed that Phillip's presentation had improved, and during a period where there were enormous pressures on mental health beds, Phillip was granted leave from the ward and placed in B&B accommodation on the basis he would return ward daily to engage with support. He was referred to the homelessness team and other support services, but he became inconsistent in maintaining contact with professionals. In late 2021, Phillip attended the police station to disclose serious historic offences, having initially reported this to the children's social worker. The police gave Phillip the opportunity to obtain legal advice before being formally interviewed. Phillip was found deceased in his room 4 days later.

1.4 The authors wish to thank Phillip's wife for contributing to the review and express their sincere condolences to all members of his family for their loss.

1.5 This report is an anonymised version of the original report, with details removed that are not relevant to the findings or recommendations to maintain the confidentiality of Phillip's family.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Phillip from harm.

Themes

2.3. The CHSAB prioritised the following themes for illumination through the SAR:

- How effectively was risk communicated and managed, in particular:

    - How effective was the multi-agency response in recognising and responding to prevent an escalation of Phillip's mental health and risk of self-harm?
    - Was information regarding risk posed by and to Phillip appropriately shared and used to effectively manage risk?
    - Whether the victim/perpetrator paradigm had an impact on the level of care provided to Phillip or masked the level of risk to him
- How did local availability of resources impact on care planning, hospital discharge and safeguarding, including consideration of the impact of the Covid-19 pandemic?
- To what extent, if any, was a Think Family approach adopted for Phillip and his family?

Methodology

2.4. The CHSAB commissioned independent reviewers to conduct a SAR using a modified version of the Social Care Institute for Excellence SAR In Rapid Time methodology. This was to enable learning to be turned around more quickly than usual through a SAR (an initial set-up meeting took place on 21 February 2022 and the report was approved by the CHSAB on 28 June 2022), but with a more detailed report that would typically be produced for a SAR in Rapid Time.

2.5. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies. Although this review has been carried out as a safeguarding adult review, the involvement of Hackney's Children and Families Service with Phillip's children, overlapping safeguarding issues within the family and examination of the Think Family approach within the review has resulted in learning being identified for children's safeguarding partners.

2.6. The following agencies provided documentation to support the SAR:

- London Borough of Hackney Children and Families
- London Borough of Hackney Adult Social Care
- London Borough of Hackney Benefits and Housing Needs
- Metropolitan Police Service
- Royal London Hospital
- Homerton University Hospital Foundation Trust
- East London Foundation Trust
- Latimer Health Centre
- London Ambulance Service
- Turning Point
- Routes to Roots
- Domestic Abuse Intervention Service

2.7. Multi-agency learning events took place, both with front-line practitioners who worked with Phillip and the leaders who oversaw the services involved in supporting them.

Involvement of Phillip's family

2.8. Members of Phillip's family were invited to participate in the review. The reviewers are grateful to Phillip's wife for taking time to discuss her experiences. She has illuminated the report with a picture of who Phillip was and spoke about the importance of practitioners managing risks faced by adults experiencing a mental health crisis and communicating effectively with family members. Children and Families and Child and Adolescent Health Services are continuing to provide support to Phillip's younger children.

2.9. The reviewers and CHSAB partners remain committed to supporting the family's involvement and will invite their comments on this report before publication.

3. Pen Picture of Phillip

3.1. Phillip was a middle-aged White British man. Phillip had adult children from previous relationships and younger children with his second wife. Phillip's wife reported that he could be generous and charming, but became angry when he was drinking and had been secretive about his past. His drinking had become heavier during lockdown, as the stress of the number of people living in a small flat had created a 'pressure cooker' situation. He drank daily from the time he woke up, and his emotionally abusive, controlling and manipulative behaviour was impacting on his entire family. Phillip had no formal mental health diagnosis and professionals assessing his mental health gained a clinical impression of someone who had experienced an acute adjustment reaction, with alcohol dependence and narcissistic traits. After Phillip's death, letters to some family members were found dated from approximately 3 weeks prior to his death, explaining that he had experienced abuse as a child and acknowledging harm he had caused to others.

4. Analysis of Agencies' Actions

Involvement with Children's Services

4.1. In 2021, child protection concerns began to emerge, initially as a consequence of police being called to an alcohol-fuelled argument between Phillip and his wife. Police referred this to Children and Families and although a risk assessment was not completed, officer carried out a 5 year history check on Phillip's criminal record which resulted in a 'standard' risk rating. During a period when she was staying away from the family home, Phillip's wife disclosed that she was experiencing abuse and that the children were also experiencing emotional harm. During this period, the children remained in Phillip's care while an assessment of their needs was carried out by the social worker, one of the first cases allocated to this ASYE (first year qualified).

4.2. Phillip's wife reported to the reviewers that she and the children were well supported by Children and Families, mental health, domestic violence services and the children's schools during this period, with clear and effective safety planning taking place. She was clear to the social worker at this time that she did not consider that there was any immediate risk to the children in their father's care, despite her reports of emotional abuse and concern that the children would be left to fend for themselves in respect of their basic needs, given their ages. Although consideration may have been given to a higher level of home visits during this period, it is not unreasonable that a more interventionist safeguarding plan was not imposed, in light of the limited disclosures made at that point and having regard to the requirement for any interference with a right to private and family life (Article 8 ECHR[1]) to be necessary, proportionate and in the child's best interest. Additionally, practitioners and senior leaders involved also recognised this initial assessment of risk may have been impacted by the fact that, in October 2020, Hackney Council was the target of a serious cyber-attack which resulted in officers being unable to access children and adults' files for several months, including those relating to Phillip's family. Urgent ICT work was undertaken to restore all records, prioritising current child protection files initially, then over the course of several months, restoring historic files. This meant that historic information about Phillip's older children would not have been available to the social worker assessing his younger children during the period of their assessment.

4.3. To mitigate this risk while the files were inaccessible, partner agencies were proactive in providing relevant documentation held in respect of current children's cases. The Metropolitan Police made additional resource available to support the Council in obtaining such documents from their files, which showed excellent partnership working. In the event of a future

[1] Human Rights Act 1998 and Article 8, European Convention on Human Rights

system-wide ICT failure, police should also consider whether it is feasible to provide police national computer checks going back further than 5 years when safeguarding allegations are made in respect of children or adults with care and support needs in the area, to attempt to identify any historic safeguarding concerns that may otherwise be unavailable to inform risk assessment. This response would be supported by the Data Protection Act 2018 and GDPR, which provide a framework to ensure that personal information is shared and stored appropriately, and require that data should be retained as long as it is relevant, necessary and proportionate to retain it.

4.4. When Phillip's wife returned to the family home, she was resolute in evicting Phillip to protect her children and began the process of obtaining an injunction against him with the support of the social worker. The children then made further disclosures to their social worker about emotional harm. When the social worker spoke to Phillip about his wife and children's allegations, he minimised this, and refused a referral to the Better Man programme for male perpetrators of domestic abuse.

4.5. The following week, a family member contacted the Hackney's Multi-Agency Safeguarding Hub, advising that she wished to complain about the children being left in her father's care. The children's social worker returned her call, and she disclosed that Phillip had assaulted her the previous week after leaving the family home, although she had not reported this to the police. She complained that he had been looking after his children alone while his wife out of the home, as she considered that his history of offences was well known within the family and community. She disclosed emotional abuse she had experienced as a child that was consistent with the allegations made by Phillip's younger children.

4.6. The social worker's line manager was on long-term leave due to travel restrictions caused by the pandemic, so he acted appropriately by seeking advice from a more senior manager, who advised the social worker to treat the contact as a complaint against his practice rather than as part of the child protection process, which would mean that a manager would investigate and respond to the complaint. Consequently, at that time a strategy meeting was not convened, nor was information passed to the police (although this occurred at a later date as set out below). Although immediate safeguarding measures were already in place as Phillip had already been excluded from the family home and was not having contact with the children, these allegations should have resulted in a strategic multi-agency approach to investigating the allegations, sharing information and assessing risk.

4.7. The manager involved reports that she attempted unsuccessfully to speak to Phillip's family member to obtain more information about the allegations, however, the only contact details held was a landline which was not answered and this attempted phone call was not recorded on the children's files. When spoken to by the reviewers, the family member reported that she was never contacted by either police or social care after the initial conversation with the social worker and was understandably distressed by this. She had been courageous in coming forward about her experiences to protect Phillip's children and when she received no response, felt that she had not been believed. For the avoidance of doubt, there was clear evidence in the steps that social worker took to safety plan for the children and discussions he had with other professionals that he believed and acted on her disclosures. The reviewers notified senior managers in both Children and Families and the Metropolitan Police of her distress about having received no further contact in respect of her allegations. Both agencies are reviewing the actions taken at the time.

4.8. On the day these allegations were made against him, Phillip was taken to hospital, having been found in a park after an attempt to take his own life. It appears that the timing was coincidental to the allegations raised by his family member, as Phillip was found in the park before the social worker had the opportunity to respond to their message. The fact that Phillip was hospitalised may also have overtaken the response to the safeguarding concerns raised

by the family member in respect of the children. The social worker's focus was primarily on the impact of their father's suicide attempt on the children and he took appropriate steps to support them.

4.9. However again, this incident taking place in such close proximity to the allegations of the family member should have triggered the manager to recommend a strategy meeting. This would ensure that the team around the children could clearly plan how to provide them with multi-agency support and that the social worker was adequately supported by the professional network in his assessment and management of the resulting risks. This would have also facilitated a strategic approach to raising the allegations made by the family member with Phillip, likely in consultation with his treating clinicians.

4.10. It is likely that the impact of the pandemic on staffing levels, in particular, the inability of the line manager to return to the UK for an extended period, placed considerable pressure on the management team during a period when many staff members would have pre-booked annual leave after months of lockdowns and disruptions. It must also have been extremely stressful for the social worker, who was newly qualified, to be dealing with a case that was sharply escalating in complexity and risk without the support of his direct line manager. Even in the most accommodating team environment, a junior member of staff may be more reluctant to frequently approach a senior manager, who is themselves extremely busy.

Systems finding

4.11. Record keeping by Children and Families was incomplete with respect to actions in response to a complaint which referred to allegations of abuse and managers did not identify the serious safeguarding concerns within the complaint or give appropriate advice to convene a multi-agency strategy meeting. Although immediate risks were mitigated, this had the potential to impact on long-term safety planning for the children. Good practice needs to be embedded in accessible procedures, to support effective supervision during periods of service disruption.

Recommendation 1: *Hackney Children and Families should review their complaints procedure to provide a mechanism to ensure that safeguarding concerns are captured as formal safeguarding referrals when incorporated within complaints, and strengthen their case recording to ensure that all complaints, together with any onward referrals, actions and responses, are recorded on the subject's files.*

Mental Health admission and step-down

4.12. Following Phillip's attempt on his life, London Ambulance Service made a referral to Hackney's Adult Safeguarding team and Phillip received emergency physical and psychiatric treatment at Royal London Hospital (RLH), who made referrals to the Hackney's Adult Safeguarding and Benefits and Housing Needs ('Housing Needs') teams, Children and Families as well as to substance misuse services. Both the London Ambulance Service and RLH demonstrated good practice in making the appropriate referrals. Detailed assessments were carried out by RLH and the quality of their handover to East London Foundation Trust ('ELFT') was reported to be very good by the receiving clinicians.

4.13. Three days later, Phillip transferred to the Joshua Ward of ELFT's City and Hackney Centre for Mental Health ('the Ward') as a voluntary in-patient, initially under one-to-one supervision with 15-minute checks as he was assessed as being at high risk of a further suicide attempt at the point of transfer. He cited the breakdown of his relationship and separation from his children as the trigger for his self-harm. Although he expressed to staff his belief that he had been a victim of events, his clinician got a sense that this was an edited version of events. Demonstrating good professional curiosity, the clinician carried out checks and found the records of his wife's disclosures of domestic abuse and that Children and Families were

involved with his children. In accordance with good practice, a referral was made to Children and Families, as well as Turning Point and Housing Needs. Phillip was very clear that his suicide attempt had been a 'moment of madness', that he posed no risk to himself in the future and that his primary focus was to re-establish his relationship with his family. Consequently, clinicians assessed his risk of further self-harm as lower and he was stepped down from one-to-one to general supervision.

4.14. The following week, the children's social worker contacted the Ward, and discussed both the allegations made by Phillip's wife and younger children and the allegations made by Phillip's family member. It appears that because the social worker referred to his discussion with Phillip about the first set of allegations, staff on the Ward believed that the social worker had already spoken to Phillip about his family member's allegations prior to his suicide attempt. Clinicians took a decision not to confront Phillip about this directly as they believed it was being addressed by Children and Families and did not see this as their role.

4.15. Around this time Phillip started to complain about remaining on the Ward, reporting that the disturbances caused by other patients, many of whom were acutely mentally ill, were increasing his stress and making him feel isolated. It is unclear whether he was offered access to an Independent Mental Health Advocate, as he was not compulsorily detained and in any event, One participant in the review shared their experience of being unable to get through to any of the contact details for IMHAs during their own hospital admission, which may indicate that this service is under-resourced. Practitioners reported that Phillip could be quite critical and controlling of staff, particularly younger female members of staff, who informally reported feeling slightly uncomfortable around him. Because this was not a clinical observation, this was not recorded in his notes or shared with partner agencies. Phillip did not show symptoms of being physically dependant on alcohol and when he had day leave from the Ward, there was no sign he took the opportunity to drink. Phillip was very clear that he wanted to leave the Ward and as a voluntary patient who was assessed as having mental capacity, Ward staff would not have had any legal power to stop him unless his condition deteriorated to a point that detention under section 2 of the Mental Health Act 1983 was warranted. Although they could not have stopped him leaving in any event, clinicians took a decision ten days after his admission that Phillip should be given day leave and accommodated by the Trust, so he could return daily to the Ward for treatment and support. This meant that he remained formally admitted to the Ward and under the care of its clinicians, and normal hospital discharge procedures did not take place. The hospital's ward manager also made a referral to Hackney Council's Housing Needs Team for temporary accommodation in line with their duty to refer.[2]

4.16. During this period, the Ward – and acute mental health services nationally – were facing overwhelming pressures from bed and staffing shortages. Staff on the Ward commented that the week that Phillip was admitted was, at that stage, the most pressure they could ever recall on beds with a large number acutely unwell patients resulting in chaotic and stressful working conditions (although they noted that subsequently this level of demand has occurred with increasing frequency). This was due in part to the pressures caused by the Covid-19 pandemic, but staff were clear in their belief that this was predominantly as a consequence of the impact of a decade of the Government's national austerity measures. Although enquiries were made, the mental health bed numbers for ELFT specifically were not available. However, since 2010, the number of mental health beds in NHS hospitals nationally has been cut by 25%[3], albeit there has been an increase in funding of community services during this time. This systematic under-funding of acute mental health beds nationally for over a decade meant that when the pandemic hit, hospitals had no capacity to respond to the surge in demand; an issue further impacted by high levels of staff sickness or self-isolation requirements given existing recruitment challenges.

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[2] Section 213B Housing Act 1996

[3] Number of NHS mental health beds down by 25% since 2010, analysis shows | Mental health | The Guardian

4.17. Consequently, daily triage meetings took place with senior managers to manage incoming patients and identify which patients could be moved out of the ward. Although ELFT had previously had a 'step-down' facility in Hackney for mental health patients ready for hospital discharge but who required further therapeutic support before they could return home, this was closed in or around 2011. Staff reported that no alternative provision existed, which meant that they had no choice other than to allow patients on leave to return home, or where patients were homeless, place them in Bed and Breakfast accommodation in the local area.

4.18. NICE guidelines[4] state that suicidal concerns need to be responded to, not with a risk assessment that distinguishes based on method and a statement of intent, but a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This should then facilitate development of a care plan to prevent the escalation of self-harm and risk management plan to include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail. GPs need to be an integral part of the inter-professional risk holding network.

4.19. Although clinicians were clear that the decision to place Phillip on leave was based on the fact he was a voluntary patient who did not want to remain on the Ward, was engaging with treatment, denied that he was a risk to himself and was hopeful about his future plans to rebuild his relationships, they acknowledged that the pressure on beds and resources meant that higher risk patients had to be prioritised for beds on the Ward. However, despite this pressure, they did not discharge Phillip to the streets, placing him in B&B accommodation funded as part of the hospital discharge pathway with support from Ward staff, while a referral to Housing Needs was progressed.

4.20. At the time Phillip was given leave, 9 other patients on the Ward were also on leave in B&B accommodation in at least three different locations. Given that Joshua Ward only has 19 beds, effectively this meant that staff were being required to run a 'virtual ward' with 50% more patients than they were resourced or staffed for to provide care. ELFT had a list of alternative accommodation that patients could access, but this was on the basis of the availability of places, rather than the level of need or risk to the patient.

4.21. Because these patients had not yet been formally discharged from the Ward, a number of referrals for community-based support that would ordinarily be automatically triggered were not activated when Phillip was granted leave, namely:

4.21.1. Notification of discharge was not sent to Phillip's GP, who only became aware that he had been admitted to a mental health ward when he later presented to her surgery, which had the potential to pose a risk if duplicate or incompatible medication was prescribed (as she would not be aware of any prescriptions given by the hospital without specifically enquiring) and meant that she was not involved in developing a suicide risk management plan.

4.21.2. The hospital discharge duty under Schedule 3 of the Care Act 2014 did not take effect, so consideration was not given to whether a referral should be made to Adult Social Care for an assessment of Phillip's care and support needs.

4.21.3. Phillip was not referred to community mental health services, as he remained under the care of clinicians on the Ward.

4.21.4. Additionally, the children's social worker had requested that he be notified when Phillip was discharged from hospital to facilitate safety planning for the children, however, this notification was not given for several days after he was granted leave.

4.22. At the time of Phillip's leave, the Community Mental Health Team (CMHT) was in the process of transitioning to a new structure, with North and South Recovery teams providing care to

[4] NICE Clinical Guidance CG113: Self-harm in the over-8s: long term management 2011

patients who are subject to the Care Planning Approach (CPA), a Home Treatment team for immediate post hospital discharge care and eight neighbourhood teams to provide primary care to patients with a lower level of need. Staff from both the Ward and Housing Needs services commented that there had been some challenges during this transition and that communication with staff from the neighbourhood teams could be very difficult, with a perception that responses could lack urgency. A particular concern was the risk of patients 'falling through the gaps', as although Discharge to Assess pathways for patients with physical health needs are very clear, mental health pathways were less clear because patients could rapidly fluctuate in their presentation. However, practitioners involved in this review also acknowledged that community-based services were facing similar challenges in respect of staff sickness due to the pandemic. There was general consensus from practitioners and leaders that stronger relationships and communication between neighbourhood teams and the Ward may have enabled Ward staff to rely on community practitioners to support them in managing their patients on 'virtual wards' within the community and providing outreach services during this period of crisis.

4.23. Despite the existing pressures on the physical Ward, staff endeavoured to maintain contact with all patients within B&B accommodation through Ward visits and telephone calls, regularly arranging taxis for staff to carry out outreach visits if any welfare concerns arose. Because this arrangement had only recently become necessary, accommodation was arranged in an ad hoc manner by the Ward manager, without a formal system in place to coordinate the placements or monitor that regular contact was made with patients. The Ward manager has subsequently introduced a system that provides oversight of these placements and reports that this has been effective, together with more robust supervision from senior managers and oversight by directors in the Trust but at the time, this situation must have been incredibly stressful for staff. Their efforts can only be described as heroic.

4.24. It was clear from discussions with the reviewers that frontline staff believe this level of bed pressure and triaging has now become normalised, even now that pandemic pressures have eased, and it is unclear the extent to which these 'virtual wards' may be masking recognition of the inherent risks such a situation gives rise to for patients to leaders in the CCG, North East London Health and Care Partnership, Health and Wellbeing Board or Safeguarding Adults Board. It is essential that a clear strategic approach is taken across the safeguarding partnership to safely manage patients, commission appropriate, specialist step-down provision and provide wrap-around support to help people during periods of crisis.

4.25. ELFT currently commissions Tower Hamlets Crisis House through specialist housing provider Look Ahead, which offers short-term accommodation to people experiencing mental health crisis. This alternative to acute hospital admission provides accommodation, care and support to those who are too unwell to be treated at home. This accommodation is only available to Tower Hamlets residents, but a similar type of short-term accommodation within Hackney may have been suitable for Phillip's needs. This may be something that Adult Social Care Commissioners wish to consider further as part of its current review of Housing Related Support accommodation provision in the borough, which incorporates mental health, single homelessness and rough sleeping. The aim of the review is to support future commissioning and service development through an analysis of how the supported living system meets the needs of Hackney residents and commissioning priorities for the future.

4.26. Hackney Council and the CCG obtained funding through the Care and Social Care Ministry's Out of Hospital Rough Sleeper Fund to launch a new 6-bed unit provided by Peabody Homes, with support staff onsite 12 hours daily, specifically designed to provide short-term step-down accommodation for homeless mental health patients for up to 6 weeks while their longer-term accommodation needs are assessed. This project went live in January 2022 and will go a long way to bridge the gap between hospital admission and a return to the community for rough sleepers. In Phillip's circumstances, where clinicians had not yet assessed that he was ready

for discharge from hospital, very clear and coordinated mental health support would need to wrap around the placement to meet his needs and, in any event, this may not have been suitable for his needs as it targets long-term multiple exclusion homelessness. However, this project reflects a collaborative and collegiate culture across the partnership that values an integrated approach towards prevention of care needs developing and sharing expertise in accordance with national best practice.[5]

4.27. Hackney Council and ELFT have introduced a Joint Housing Protocol which supports early information sharing and agreeing a shared plan with the individual and services involved, with the intention of preventing temporary accommodation placements from failing, keep the individual safe and prevent a further deterioration in health while long-term accommodation options are progressed. A monthly Homeless, Health and Housing Multidisciplinary Team meeting monitors progress and provides senior oversight of this joint working approach to ensure that individuals with complex needs are able to access the support they need from a range of agencies and departments. This includes monitoring the welfare of anyone who has been identified as presenting a risk to others, or at risk of suicide. This is supported by a bespoke escalation guidance.

Systems finding

4.28. Chronic underfunding of the NHS has resulted in a national shortage of mental health beds which meant there was little resilience in ELFT's system for the additional pressure of the Covid-19 pandemic. This placed pressure on Ward staff to triage patients according to their assessed risk and place them on leave from the Ward in mainstream Bed and Breakfast accommodation, when they were clinically unready for discharge. Despite the valiant efforts of staff to ameliorate this risk, this was unsafe. There is a clear need for specialist placements or, in the interim, greater flexibility from commissioners locally to use powers under National Health Service Act 2006[6], Mental Health Act 1983 and Care Act 2014 to provide accommodation based, trauma-informed holistic support to avoid over-reliance on accommodation provided via Housing Act 1996 duties.

Recommendation 2*: ELFT (and other Health partners where appropriate) should formalise the procedures for authorising, monitoring and supporting mental health patients who are granted leave during a hospital admission, whether pursuant to section 17 of the Mental Health Act 1983 or voluntary patients. Where people are on leave in 'virtual' wards offsite, the serious incident reporting framework that governs NHS hospital admissions should apply and the CHSAB should be provided with findings from such reviews.*

Recommendation 3: *Hackney Council should broaden its commissioning strategy and coordinate with the CCG/ICS to allow for more bespoke commissioned placements to target the needs of individuals. The current Housing Related Support Review should consider joint commissioning with Health to ensure that there is a seamless spectrum of provision from individuals with pure social care needs to those with continuing healthcare needs or on leave from mental health wards.*

Recommendation 4: *In any cases where individuals who are at significant risk of harm are placed temporarily in accommodation which is unsuitable for their vulnerabilities or mental health needs, a multi-agency strategy meeting should be promptly convened by the lead agency and the resulting safeguarding plan kept under review to ensure that any risks are identified and mitigated.*

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[5] Adult Safeguarding and Homelessness: a briefing on positive practice; ADASS and the Local Government Association.

[6] Consistent with the obligations set out in National Framework for Continuing Healthcare

Accommodation needs

4.29. Temporary accommodation for families and particularly vulnerable single people within Hackney comprises around 800 units of hostel accommodation, mostly self-contained with the majority owned and run by the Council. Temporary accommodation for single homeless people with complex and multiple needs or people who rough sleep is provided by three hostels run by private providers in the borough. When these properties are full, the Council has a number of managing agents who provide the Temporary Accommodation team with properties that are available to be used as emergency and temporary accommodation.

4.30. Efforts are made to allocate properties that best meet the needs of the household, where possible, but 40% of residents who approach the Housing Needs team have a support need and nearly 20% have multiple and complex needs. The type of properties, as well as the location and size of the properties available change daily and many of these properties share facilities. The demand for temporary and settled housing across the borough exceeds the supply of housing stock available as there are currently over 8500 households on Hackney's Housing Register, with over 3000 of these in temporary accommodation and over 1000 of these households placed outside the borough, including Kent, Hertfordshire and Essex. This shortage of local placement poses a particular risk when patients are granted leave or discharged from acute mental health wards into the community, as local community mental health teams do not support people placed out of borough, and the need to refer to other CMHTs risks a more disjointed service.

4.31. Phillip had initially approached Hackney's Housing Needs service for accommodation the day before his suicide attempt, but he did not reply when they subsequently telephoned him. Staff at both RLH and the Ward then made timely referrals to Housing to support Phillip in obtaining accommodation, while he remained in hospital. Communication between the Ward and homelessness services (both Housing Needs and Routes to Roots) at this time was reported to be extremely effective in general and this collaborative approach has continued to grow. Housing Needs had a dedicated liaison officer who worked with mental health wards to secure accommodation for people with mental health needs at the point of hospital discharge. Housing Needs also have two social workers embedded in their team, including one from a mental health background, whose primary role is to liaise with services and upskill staff in terms of understanding the needs of service users. These links have been further strengthened as one of the former social workers from that team was recently appointed as the senior discharge practitioner on Homerton Hospital's mental health wards, although Housing Needs staff commented that their relationship with community mental health services was less well established and communication could be more difficult. Housing Needs referral forms have been redesigned in consultation with mental health professionals to ensure the right information is captured without adding to the workloads of busy clinicians. The innovative and aspirational approach of leadership within Housing Needs very clearly cascaded to its staff and the reviewers were extremely impressed by the initiative and commitment shown. All Housing Needs staff have received trauma informed care training, mental health first aid and awareness training and training sessions with the Samaritans in addition to the normal safeguarding training available. Many staff members have a lived experience of homelessness and have worked for the Third Sector.

4.32. A specialist Third Sector housing service, Routes to Roots (R2R), is commissioned by Homerton Hospital, Hackney Council and Providence Row Charity to support vulnerable people with significant physical or mental health needs to prevent them from being discharged back into a cycle of homelessness or risk at the end of their hospital treatment. R2R provide advice and support to improve people's housing, financial and health situations and their long-term prospects for recovery. Phillip was referred to this service and staff were proactive in attempting to contact him, offering empathetic, trauma-informed support, meeting with him 4

days after he was granted leave, to support him to obtain the necessary paperwork for his housing application.

4.33. Housing Needs staff reported that referrals from the Ward were consistently of a high quality with risks assessments provided for all patients. It is unfortunate that in Phillip's case, the risk assessment was missing and there was a sense that because information sharing was usually so effective, staff on both sides assumed the relevant documentation had been attached. The children's social worker had raised the recent allegations raised by his family in respect of Phillip posing a risk to women and children these allegations with Ward staff during his conversation with them before Phillip was discharged. Ward staff identified that these allegations would limit the type of accommodation that Phillip could be placed in, although it appears they were uncertain whether this could be shared with Housing Needs. Had the risk assessment been attached, this should have included issues such as the allegations of abuse. Housing staff would then not have placed him in accommodation with shared facilities with women and children, and the only accommodation that would have been available would have been in one of the three single male hostels in the area, which were described as being of a relatively poor standard.

4.34. A week after he was granted leave, the Ward notified the children's social worker that Phillip had been placed on leave in B&B accommodation in Hackney, with a plan to discharge him into mainstream housing. The social worker advised Ward staff that Phillip would need to be placed away from the area of the family home as his wife was seeking an injunction. Again, it does not appear that this information was shared with Housing Needs. The Ward's records did not state which agency would take the lead on notifying Housing Needs of these risks, and it may be that this resulted in some miscommunication.

4.35. Consequently, Phillip was placed in one of the better maintained B&Bs with shared facilities with families, close to the hospital so that he could continue to access support for his mental health. This presented a clear risk to the other residents, and while this may well have been a one-off human error in an otherwise effective system, leaders may wish to consider whether any other checks or procedures need to be implemented to reduce the risk of this recurring. However, this error resulted in Phillip living in more suitable, local, council-run accommodation and meant that the views and responses of Housing Needs staff to his needs were not tainted by any potential prejudice arising from his offending behaviour. Housing Needs staff reported that their perception of Phillip was of a very vulnerable older man who had recently attempted suicide and were very proactive in their efforts to support him.

Systems finding

4.36. Communication between mental health wards and housing in respect of hospital discharge processes is generally robust and referrals are proactively progressed, although some refinement of procedures may help to reduce the risk of occasional oversights during periods of pressure. Effective collaboration between frontline staff and senior leaders has created efficiencies in practice and identified innovative solutions.

Recommendation 5: *Partner agencies should consider opportunities to expand on the good practice identified in respect of the close partnership working between homelessness services and ward staff during hospital discharge, in particular to strengthen an integrated approach between housing and the community mental health teams.*

Mental health support in the community and missing episode

4.37. Phillip moved to a B&B provided by the Ward, on the basis that he would be monitored and attend the Ward during the day. During a ward round review by a psychiatrist 4 days later, Phillip reported feeling lonely and rejected by his move into the community, but was verbally assured and subsequently stated that he had largely stopped using alcohol or cannabis and was looking forward to seeing his children. Although he initially responded to telephone calls

and/or attended the Ward most days, and he presented as being in good spirits, though at times frustrated by his housing situation. Routes to Roots supported him in approaching Housing Needs to ensure that accommodation was available for him once the funding for B&B accommodation provided by the Ward ended and he had an appointment with Housing Needs on the following week. When Phillip spoke to Ward staff two days later, he said he was feeling cheerful and would contact then if he felt down.

4.38. However, from this point Phillip's engagement with the Ward and the homelessness services became inconsistent and ward staff were unable to contact him by telephone on several occasions. Concerns escalated when Phillip checked out of the B&B funded by the Ward but he did not turn up at the temporary accommodation that had been provided for him by the Council's Housing Needs team. Housing Needs and R2R officers showed good practice by contacting Joshua Ward the next day, who tried to contact staff at the B&B who confirmed he had checked out and it became apparent that no one had been able to contact him. Ward staff and the Housing Needs officer collectively agreed that a missing report should be made to the police by calling 101.

4.39. Although a CAD number was given, the police did not record this as a missing report as in their view, Phillip was a voluntary patient who had checked out of his B&B accommodation by choice. This decision was unsuccessfully challenged at the time by both the Ward manager and Housing Needs officer. Given the concerns of all agencies for Phillip's welfare, a decision was taken by the Ward manager to escalate the police decision not to record the missing episode, although he was uncertain of the appropriate route to take this forward and Phillip made contact with Housing Needs before this could be progressed.

4.40. Ward and Housing Needs staff stated that this was a common experience when attempting to report patients with a mental illness missing and expressed their frustration. When explored with senior police officers, they explained that it was necessary to triage referrals, even those made by mental health professionals, as the Basic Command Unit could receive 10-20 such referrals each day and officers would otherwise be unable to carry out their primary duties in respect of investigating and preventing crime. In all cases, officers should reasonably question what steps have been taken by the referring agencies to locate the missing person beyond calling their mobile, such as calling emergency contacts or carrying out a welfare check to last known addresses. When contacting the police, practitioners should be clear about what the expected outcome is in the event the individual is located beyond merely locating them. In Phillip's case, he was not detained under the Mental Health Act 1983 and there was no indication that at the last point of contact he had been presenting so unwell that the police might be required to use powers under s136 of the Act to take him to a place of safety. The missing report was graded by the receiving officer before being considered by a supervising officer, so there was senior oversight of the decision-making process.

4.41. Operation Resolute is a pan-London strategic approach by the Metropolitan Police to understanding localised problems regarding the risk of harm to vulnerable people during a missing episode. This encompasses three strands, the Philomena Protocol (for young people missing from care) the Herbert Protocol (for people suffering dementia) and the Affinity Protocol, relevant in this case. The Affinity Protocol is a pan-London protocol developed in partnership between the Metropolitan Police, NHS trusts and hospitals to achieve a clearer mutual understanding of each other's responsibilities and ensure a sustainable joint responsibility in respect to people missing from mental health services. The Protocol seeks to address reoccurring missing episodes, problematic volume and reporting approaches through effective partnership working and problem solving. This will ensure that police resources are available to provide an urgent response in cases that are assessed as high risk. Operation Resolute has been rolled out in Hackney and although a presentation was given to senior ELFT nurses which was positively received, practitioners who participated in the review were not aware of the protocol.

4.42. Both police and mental health services commented that it would be helpful to have a single email address (rather than an address for an individual staff member) to facilitate direct contact with the other service when problems arose. This would ensure that all staff would have a clear method of making contact without relying on individual relationship and would assist when staff moved on or took leave. Police noted that in circumstances where any agency or individual sought to challenge decision not to record a missing episode, further contact could be made with 101 to raise a complaint about the decision.

4.43. After 5 days, Phillip made contact with Housing Needs. When Ward staff spoke to him, he said that he had been staying with a friend and lost track of time. A family member was noted to be supporting him to sort out his accommodation during this period.

Systems finding

4.44. The reduction in the number of mental health beds nationally and pressures on community mental health resources are increasingly pushing demand for managing mental health support onto the police through missing person referrals. It is essential that practitioners across the safeguarding partnership have a shared understanding of appropriate circumstances to make a missing person report to the police, to manage demand on police resources and manage practitioners' expectations of the police response, so that proportionate risk management plans can be implemented by the agency/s best placed to action these.

Recommendation 6: *The Safeguarding Adult Board and safeguarding partners to consider how to raise the profile of missing episodes as a safeguarding issue across the wider partnership and how to embed understanding of the Affinity Protocol amongst frontline staff, to support effective discussions with police about people with mental health conditions who cannot be contacted, and promote sustainable joint responsibility for managing risk.*

Response to criminal confession

4.45. The 'victim/perpetrator paradigm' explores the simplistic narrative that portrays victims and perpetrators as separate, distinct and mutually exclusive.[7] In the context of this review, this considers whether the perception of an individual as a being a perpetrator, or posing a risk to others, impacts on the manner in which the professionals involved in supporting them respond to safeguarding concerns, because they struggle to recognise that a perpetrator may also be at risk of harm themselves.

4.46. The day after he was located, Phillip contacted his children's social worker and admitted to offences against children in the 1970/80s. The social worker told Phillip to report this to the police, sought advice from his manager and followed up with the police to ensure that Phillip had attended the station.

4.47. At the station, Phillip told the officer at the front desk that, during the 1970/80s he had committed offences against children, providing sufficient detail to enable their identification. The officer acted appropriately by seeking instructions from the specialist Child Abuse Investigation Team, who advised that Phillip should be given an opportunity to obtain legal advice before a formal interview was carried out in a planned way. Phillip was therefore not arrested or detained. He told officers about his recent suicide attempt and that he was currently homeless. The officer was proactive in making contact with the Housing Needs team to ensure that accommodation was made available for Phillip that night, which was excellent practice and showing that the officer had given careful thought to Phillip's presenting needs and his duty of care.

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[7] Borer TA (2003) A Taxonomy of Victims and Perpetrators: Human Rights and Reconciliation in South Africa. Human Rights Quarterly 25(4): 1088-1116.

4.48. During the reviewers' discussions with senior police officers, they described that the front desk of a police station is typically extremely busy, often with a queue of people waiting to speak to an officer. It is not uncommon for people to come to the station to make a confession and it would be unusual to arrest them contemporaneously unless there was evidence of an urgent risk to the public or an individual, or there was a flight risk. Interviews are generally carried out in a planned way, unless time sensitive and it is good practice to ensure the person has obtained legal representation in advance, to minimise the chance that a confession will subsequently be deemed inadmissible.

4.49. It is also very common for people attending the police station to have a history of mental illness and it would be impractical, and potentially a breach of rights under Article 8 ECHR, to make a referral to mental health services for each person, unless their presentation gave cause for concern. Had Phillip been presenting as mentally unwell, the officer would likely have detained him under s136 of the Mental Health Act 1983 and taken him to hospital for assessment. If a decision is taken to interview the individual immediately, a Voluntary Attendance Assessment is completed, which is designed to identify whether the person has any mental health, capacity, learning disability or other impairment such as being under the influence of a substance, which may indicate that it would not be appropriate to interview them, or that an Appropriate Adult is required to facilitate the interview. This also requires officers to consider whether there is any suicide risk and how this will be mitigated. However, because a decision was taken not to interview Phillip on that day, this assessment was not completed. Senior officers explained that frontline staff are trained to use the Vulnerability Assessment Framework during every interaction with a suspect or victim, to informally evaluate the individual's presentation and establish whether a Merlin report should be made to Adult Safeguarding, who would then triage it and only send it on to mental health services if they assessed this as appropriate. However, having discussed the reflections of other professionals in respect of Phillip's presentation during this period, the senior officer thought it unlikely that this would trigger a referral. Given that Phillip had disclosed his recent suicide attempt, it would have been good practice for the officer to record how he presented on the day so that it was clear why a Merlin was not triggered, although perhaps a reasonable assumption can be made that this was not recorded because Phillip's behaviour did not cause concern.

4.50. Two days later, a strategy meeting was convened between Children and Families, the police and the health visitor. Phillip's treating mental health team was not invited to the meeting as this was approached very much from the perspective of safeguarding the children and progressing the criminal investigation. Clinicians on Joshua Ward said that it would be unusual for them to be invited to a strategy meeting for children and that they did not consider attendance to be in their remit (although it is noted that Ward records of a Ward Round meeting during Phillip's admission record a plan for a child safeguarding referral to be made due to the discrepancy between the allegations of abuse against Phillip and his account, demonstrating staff members' understanding of their safeguarding duties towards children[8]). This presents as a missed opportunity to share vital information in respect of Phillip's presentation, 'soft' intelligence such as the discomfort expressed by staff members about Phillip's interactions with them and the risk he might pose to others. Equally importantly, it was a missed opportunity to share information about the likely increased risk to Phillip, given the likely consequences for him (criminally and socially) of his disclosure, which could have provided mental health staff with an opportunity to provide him with additional support. His treating clinician was clear that had he been aware of Phillip's disclosure, he would have asked him to attend the Ward for his mental state to be assessed.

[8] Section 11 Children Act 2011

4.51. During the strategy meeting, the social worker informed police about the allegations made by Phillip's family member on the day of his first suicide attempt. Although her allegations that Phillip had abused a child in the past were discussed in terms of confirming the likelihood that Phillip's disclosures were true, no clear actions were recorded in respect of how the allegation that Phillip had recently assaulted his family member would be taken forward. During the review process, senior police noted that this was a significant learning point, that where another professional relayed a criminal allegation to police officers, for officers to record a clear decision about how this would be actioned; whether the complainant would be interviewed by police or the person reporting the allegation (here the social worker) would be asked to complete a third-party report. It is important that practitioners across the partnership understand that discussing a third-party allegation of a crime with police officers does not automatically trigger a criminal investigation; a formal report must be made.

4.52. Police carried out a welfare visit to Phillip's youngest children that day. The children's social worker then also visited the family, to speak to the children, offer support and discuss safety planning with Phillip's wife.

4.53. There was little evidence during the course of the review that the victim/perpetrator paradigm had a significant impact on the support that was provided to Phillip by the agencies who had responsibilities in respect of his welfare. Housing Needs and R2R staff were unaware of the allegations against Phillip and were very careful in their efforts to support him as they perceived him to be very vulnerable. The police officer who met with Phillip was conscientious in his duty of care in ensuring he had a safe place to stay that night. Mental Health staff on the Ward were open to reflect on whether the information they were aware of in respect of the allegations against Phillip, together with his discomforting interactions with staff had impacted on their perceptions of him. However, there was no evidence that this had any impact on their care of him in practice and again, they were not aware that Phillip had confessed to these offences.

4.54. The children's social worker was very honest that his priority was the safety and wellbeing of the children and reflected that at that point he had only perceived Phillip as a risk to the children, rather than considering the risks to Phillip himself. He suggested that a multi-agency meeting to manage the risks following Phillip's suicide attempt would have better supported him to consider these risks holistically. He noted with real insight, that in hindsight Phillip's suicide risk was in itself a risk to the children, who have experienced loss, grief and psychological harm as a consequence of their father's death.

Systems finding

4.55. Although frontline practitioners and police officers' focus was understandably the protection of the children in the family and investigation of the reported historical offences against children, a combination of the missed opportunities to share information and a fragmented approach to risk analysis prevented agencies from taking a holistic approach to managing the complex risks in this case, to Phillip as well as his family.

> ***Recommendation 7:*** *The Safeguarding Children Partnership and members of the Safeguarding Adult Board should explore how to ensure that their respective policies and training programmes incorporate wider consider of a Think Family approach, supporting all practitioners to identify risks to both adults and children.*

> ***Recommendation 8:*** *The Safeguarding Children Partnership and members of the Safeguarding Adult Board should consider whether introducing a multi-agency suicide risk management strategy meeting involving agencies supporting both the individual at risk of suicide and relevant agencies involved with family members would better support broader approach to managing suicide risk and potential impact on the wider family.*

Recommendation 9: *Children and Families should ensure that its procedures for convening multi-agency strategy meetings reflect that practitioners should routinely invite the mental health and other adult professionals supporting the parents and, following the meetings, ensure effective information sharing on risk and risk mitigation actions. Commitment from mental health partners should be given to attend such meetings when invited, or if staffing pressures do not allow this, to provide a report to support decision making.*

Recommendation 10: *Police and partner agencies should ensure that frontline practitioners understand how third-party criminal allegations should be reported and that decision making around how investigations will be carried out is clearly recorded. This could be incorporated in existing safeguarding training.*

Conclusion

4.56. Given the tragic outcome of this case, it is tempting to apply hindsight bias and conclude that because Phillip had made one suicide attempt and later went on to complete suicide, that it had been predictable that he would do so. However, international studies[9] have found that 93% of people who have been admitted to hospital following a suicide attempt will not go on to take their lives at a later point and in light of his clear statements that he would not self-harm again and was making future-oriented plans, clinical judgements (that Phillip's risk of a further suicide attempt was relatively low) were reasonable. Although he had written a series of letters to family members in the weeks that lead up to his death, which could be taken as suicide notes, he did not disclose this to professionals. Four days prior to his suicide, Phillip wrote a letter to his GP, noting that he wanted to continue to be registered with her surgery if he was moved to another CCG area by Housing, again, indicating that he was making future plans. Following his death, it was established that he had discussed methods to take his life with another resident of his hostel, but this was not disclosed to professionals at that time. There were no clinical signs for professionals that his mental health was deteriorating.

4.57. The practitioners who worked directly with Phillip were very upset about his death and admirably open to self-reflection in respect of their practice. They welcomed the opportunity to contribute to the professional understanding of this case and to improve systems for the future. It is unclear whether anything could have been done by agencies to prevent Phillip's death, given his apparent careful planning and misdirection of professionals, but increased resources at a national level for mental health in-patients when they leave hospital in particular, may have ensured that the support Phillip needed was available.

[9] Owens D, Horrocks J, and House A. Fatal and non-fatal repetition of self-harm: systematic review. British Journal of Psychiatry. 2002;181:193-199

5. Recommendations Emerging from this Review

Recommendation 1: Hackney Children and Families should review their complaints procedure to provide a mechanism to ensure that safeguarding concerns are captured as formal safeguarding referrals when incorporated within complaints, and strengthen their case recording to ensure that all complaints, together with any onward referrals, actions and responses, are recorded on the subject's files.

Recommendation 2: ELFT (and other Health partners where appropriate) should formalise the procedures for authorising, monitoring and supporting mental health patients who are granted leave during a hospital admission, whether pursuant to section 17 of the Mental Health Act 1983 or voluntary patients. Where people are on leave in 'virtual' wards offsite, the serious incident reporting framework that governs NHS hospital admissions should apply and the CHSAB should be provided with findings from such reviews.

Recommendation 3: Hackney Council should broaden its commissioning strategy and coordinate with the CCG/ICS to allow for more bespoke commissioned placements to target the needs of individuals. The current Housing Related Support Review should consider joint commissioning with Health to ensure that there is a seamless spectrum of provision from individuals with pure social care needs to those with continuing healthcare needs or on leave from mental health wards.

Recommendation 4: In any cases where individuals who are at significant safeguarding risk are placed temporarily in accommodation which is unsuitable for their vulnerabilities or mental health needs, a multi-agency strategy meeting should be promptly convened by the lead agency and the resulting safeguarding plan kept under review to ensure that any risks are identified and mitigated.

Recommendation 5: Partner agencies should consider opportunities to expand on the good practice identified in respect of the close partnership working between homelessness services and ward staff during hospital discharge, in particular to strengthen an integrated approach between housing and the community mental health teams.

Recommendation 6: The Safeguarding Adult Board and safeguarding partners to consider how to raise the profile of missing episodes as a safeguarding issue across the wider partnership and how to embed understanding of the Affinity Protocol amongst frontline staff, to support effective discussions with police about people with mental health conditions who cannot be contacted, and promote sustainable joint responsibility for managing risk.

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Recommendation 10: Police and partner agencies should ensure that frontline practitioners understand how third-party criminal allegations should be reported and that decision making around how investigations will be carried out is clearly recorded. This could be incorporated in existing safeguarding training.

6. Glossary

ADASS	Association of Directors of Adult Social Services
CAD	Computer Aided Dispatch (crime reference number)
CCG	Clinical Commissioning Group
CHSAB	City and Hackney Safeguarding Adults Board
CMHT	Community Mental Health Team
ECHR	European Convention on Human Rights
ELFT	East London Foundation Trust
GDPR	General Data Protection Regulation
ICS	Integrated Care System
NICE	National Institute for Health and Care Excellence
R2R	Routes to Roots, housing charity
RLH	Royal London Hospital
SAR	Safeguarding Adult Review
The Ward	Joshua Ward, ELFT