Safeguarding Adult Review

"Carol"

Publication Date: 13 June 2017

The independent lead reviewer and all those who have been involved in the Serious Adults Review (SAR) extend their deepest condolences to Carol's family for their loss. Carol's murder had a significant impact upon those professionals who worked closely with her over many years and knew her well.

While this review seeks to capture as much learning as possible, it should be acknowledged at the outset that no professional or agency could have foreseen that Carol would be murdered in the manner that she was or predicted the actions of the young people. The murder of Carol was shocking to all in the professional community.

1. Introduction

1.1 This Safeguarding Adult Review (SAR) was initiated in 2015 by Teeswide Safeguarding Adults Board (TSAB) following the death of a 39-year-old woman, who for the purposes of this report will be called Carol. Carol was attacked and murdered in her home during the early hours of 8th to 9th December 2014. She was discovered dead at home by her landlord on the morning of 9th December 2014. Two teenage girls, aged 13 and 14, were arrested for Carol's murder.

Why was this case reviewed?

1.2 As a result of Carol's death, TSAB were required to consider if a SAR should be conducted. A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame but capture positive learning to improve systems and professional practice for the future.

1.3 In making a decision to initiate a SAR, TSAB complied with the Care Act 2014, the main provisions of which came into force in April 2015. Under the Care Act, Safeguarding Adults Boards (SABs) must initiate a SAR when an adult in its area with needs for care and support dies or suffers significant negative impact as a result of serious abuse or neglect (known or suspected), and where there is concern that partner agencies could have worked more effectively to protect the adult (The Care Act 2014, section 44).

1.4 Carol had been identified as having multiple care and support needs, and many agencies and professionals had had involvement with Carol going back some years.

1.5 This case was therefore chosen to be reviewed in that the death met the legal criteria. An independent lead reviewer was appointed by TSAB to facilitate and lead the review.

Timeframe

1.6 It was agreed for this review that it would be helpful to focus on a period from January 2012 to the date of Carol's death, 9th December 2014. Appraising the work of agencies further back in time is unlikely to achieve useful learning, given the inevitable changes in personnel, local arrangements, national guidance, regulations and legislation.

1.7 It is within this timeframe that particular attention has been paid, to understanding both Carol's needs, and the services and systems around her. That is not to say that earlier information is ignored or unable to provide context. It will be apparent in this report that for Carol the context of her past is important and she had a long history of health and social care needs.

1.8 The SAR was unable to commence immediately due to the ongoing criminal proceedings. The trial of the two girls did commence in 2015 but was then halted for legal reasons and resumed in February 2016. Both girls were convicted for murder on 7th April 2016 and each sentenced to 15 years' imprisonment.

1.9 Following the trial, it was possible to progress the SAR in a meaningful manner and access all the relevant documents and other relevant material for the review without the risk of prejudicing legal proceedings. Most importantly post trial, agencies and professionals were able to participate fully in the review. In the interim, agencies had been directed by TSAB to identify their internal organisational learning in readiness to be part of the SAR multi-agency review.

Methodology

1.10 The SAR has been conducted alongside two Serious Case Reviews (SCRs) pertaining to each of the girls convicted of Carol's murder. The SCRs have been conducted and led by a different independent lead reviewer. There has been cross referencing and an interface across the three reviews. There has also been oversight from a governance group for all three reviews.

1.11 There is no prescriptive methodology for a SAR, though it is now widely accepted that for multi-agency reviews, a system-based approach and methodology is desirable. For children's SCRs a systems approach is required. There are a number of system methodologies that can be deployed but for this review it was agreed it would be helpful for the same methodology to be used across all three reviews. To this end, 'Learning Together' methodology was selected. Details of the Learning Together model and the process of this review is in **Appendix 1**.

1.12 The review has therefore followed the process as set out in Appendix 1 and has interfaced with the two SCR's as the reviews have progressed. There has been quality assurance during the reviews from the Social Care Institute of Excellence (SCIE). SCIE developed the 'Learning Together' methodology.

1.13 It was also agreed by the governance group that the lead reviewers have access to mental health clinical expertise.

Independence and expertise

1.14 The lead reviewer, Deborah Jeremiah, is accredited in systems learning and the 'Learning Together' model and is an experienced independent investigator across Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. Deborah is a safeguarding lead and works nationally. Deborah has a health, legal and governance background and has also worked on high profile national public inquiries.

1.15 Medical expertise was facilitated by NHS England (NHSE) under Appendices 1 and 3 of the NHS Serious Incident Framework 2015. Under this Framework the North NHSE region had begun collaboratively to commission single investigations in joint cases which meet all of the statutory requirements of Mental Health Homicide investigations, Domestic Homicide Reviews, SCRs and SARs.

1.16 NHSE commissioned a consultancy specialising in mental health homicide reviews to input into the reviews. This included a mental health nurse with 26 years experience and a forensic consultant psychiatrist in adult mental health services who is also a medical director and an dual diagnosis expert.

Review Team

1.17 The lead reviewer was assisted by a review team as set out below:-

Job Title	Agency
Assistant Director of Adult Services	Hartlepool Borough Council
Head of Service-Safeguarding	Hartlepool Borough Council
Domestic Abuse Inspector	Cleveland Police
Head of Commissioning and Clinical Quality	Hartlepool Borough Council
Named Professional for Safeguarding Vulnerable Groups	North East Ambulance Service
Community Safety & Engagement Manager	Hartlepool Borough Council
Named Nurse (Adult Safeguarding)	North Tees and Hartlepool NHS Foundation Trust
Clinical Team Lead (Affective Disorder Team)	Hartlepool Borough Council
Head of Safeguarding Adults	Tees Esk and Wear Valley NHS Foundation Trust (TEWV)
Head of Housing	Hartlepool Borough Council
Head of Quality and Adult Safeguarding	NHS Hartlepool and Stockton on Tees Clinical Commissioning Group
Locality Manager Hartlepool Adult Mental Health Service	Tees Esk and Wear Valley NHS Foundation Trust
Head of Community Safety	Cleveland Fire Brigade
Consultant Psychiatrist / Medical Director	Niche Health & Social Care
Mental Health Nurse / Practitioner	Niche Health & Social Care

1.18 The review was also assisted by a case group of frontline professionals across all the relevant agencies who mainly had direct involvement with Carol. This also extended to professionals who were managing or supervising those professionals involvement and the foster carers. They provided data and sensitive critical reflections to the review to best understand the professional response to Carol at the time but also the current systems of work. This has not been an easy thing to do given the circumstances and the independent reviewers are genuinely grateful to them for their honesty and openness.

Summary of the case

1.19 This SAR involves a woman who lived in a ward which was classified in the top 10% of the most deprived in Hartlepool[1]. Carol's life was chaotic as a result of a long history of alcohol addiction and personality disorder. Carol was primarily under the care of an integrated mental health team. Carol was thought to have fluctuating mental capacity to make decisions. The various agencies and professionals involved with Carol understood and responded to her with differing perspectives and one of the features of this review is how that informed professional responses to safeguarding and risk assessment. Carol's complex condition and needs posed many challenges to those agencies and professionals who came into contact with her.

1.20 It is not possible in a report of this nature to detail each and every incident and contact Carol had with agencies as Carol had complex needs. For the period for which this review is focused (January 2012 to December 2014), Carol's contact with mental health and alcohol services, ambulance, hospital, and others was in excess of 1000 recorded direct contacts. Some professionals state this is a conservative number as some contacts were not formally recorded.

1.21 During the period under review there were 472 reported incidents to the police concerning Carol. Carol made 219 calls to the police, the rest were made by other people either concerned for Carol or about her behaviour.

1.22 By the time of her death there were also incidents relating to 175 offences, mostly while intoxicated. An Anti-Social Behaviour Order (ASBO) and a legal order was made on 16 July 2009 for a period of three years, meaning it was a criminal offence for Carol to buy alcohol or attempt to buy or obtain alcohol from a licensed premise. Such orders are rare.

[1] *IMD2015*

2. The Findings

2.1 This section contains five findings that have emerged from the review. Each finding also provides evidence identified by the Review Team that indicates that these are not simply quirks of the case.

2.2 The findings are therefore a reflection of the system at the time but also indicate that the system issues raised are not “one off” events but reflect a more widespread and prevalent observation. This has current implications for the relevant systems.

2.3 SARs should ‘provide a sound analysis of what happened, why and what action needs to be taken to prevent a recurrence’. The Care Act also requires that findings should be ‘of practical value to organisations and professionals’.

Appraisal of professional practice in this case: a synopsis

January to March 2012

2.4 The review period starts in January 2012. Carol had been living in Hartlepool for 6 years and was well known across the main agencies. Her health care was managed in the community by her GP and the Affective Disorder Team[2]. This team is part of an integrated community mental health team between Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and Hartlepool Borough Council (HBC). The Affective Disorder mental health team include nurses, psychologists, social workers and a Consultant Psychiatrist.

2.5 The integrated mental health team operates under the management structure of TEWV including on behalf of HBC under a partnership agreement. The Head of Service for Mental Health and Learning Disabilities for HBC is involved directly in operational & strategic decisions relating to the Hartlepool area. Two integrated community teams work within the boundaries of HBC to provide secondary care mental health care for people suffering with Psychosis and/or Affective Disorders.

2.6 Carol’s care was managed under the Care Programme Approach (CPA). The CPA is a framework under which mental health services assess, plan, co-ordinate and review the care of an individual with mental health problems or a range of related complex needs. Those receiving care under the CPA have a Care Coordinator (CCO). The CPA was an appropriate framework in which to manage Carol’s needs. The CCO appropriately involved alcohol service workers in the multi-disciplinary team meetings as well as those managing Carol’s finances. Carol had agreed to be under an appointeeship so the

[2] Affective disorders are a set of psychiatric diseases, also called mood disorders. The main types of affective disorders are depression, bipolar disorder, and anxiety disorder. Symptoms vary by individual, and can range from mild to severe.

Council could hold her money safely and she would collect this each week. This was an arrangement to prevent her spending her money immediately on alcohol but there was also an awareness that Carol was vulnerable to being financially exploited by others.

2.7 Carol had an experienced CCO. For practical reasons Carol's care was co-worked with another professional in the team (CW). Both the CCO and CW were supervised by an experienced Team Manager. All three professionals were experienced social workers in mental health services. All three were also Approved Mental Health Professionals.[3] The professionals state that they felt confident they had the experience and knowledge to manage Carol with her complex needs of a personality disorder, alcohol dependency and associated behaviours.

2.8 The CCO and CW knew Carol very well and had a good rapport with her. The professionals were able to provide continuity of care to Carol. This is good practice. They knew of Carol's history of a childhood mainly spent in care with little stability. Carol told professionals that her childhood, which was spent in a different town in the north east region, was unhappy and traumatic and the happiest and safest she had felt in her life was during the periods she had been in prison. Carol had started drinking as a child and by adulthood had a serious and enduring alcohol dependency which was very resistant to change. She had also been diagnosed with a personality disorder - primarily Emotionally Unstable Borderline Personality Disorder (EUPD). Carol was therefore considered to have a dual diagnosis.

2.9 Dual diagnosis is the term used to describe a condition of suffering from a mental illness and a drug or alcohol abuse problem. The one condition can complicate the other and it can be challenging for professionals to manage the complexity it brings to an individual. Either condition can vary in severity or fluctuate.

2.10 The care plan for Carol's dual diagnosis was led by the CCO and CW under the framework of the CPA. There were multi-disciplinary meetings with a Consultant Psychiatrist attending intermittently. Carol was not being prescribed any medication, having become non-compliant to taking medication in the past. Under the CPA, formal CPA meetings were also held at least every six months.

[3] This relates to Mental Health Act assessments. These professionals need to consider all the factors present to ensure that the least restrictive principles are applied. They need to ensure the person is aware of their rights, treated with respect and dignity and has access to an advocate.

2.11 Carol had some form of agency contact practically every day, often when intoxicated, and she was extremely well known to the local Police Community Support Officers (PCSOs) and other agencies such as the ambulance service. The ambulance service would collect her when she called them and take her on a regular basis to the A&E department. Carol also had a propensity to lie in the middle of the road and put herself at risk leaving police and other agencies with no choice but to intervene. The integrated mental health team generally had contact with Carol three times a week but also often received information from other agencies about her. They also received information from Carol's landlord. Carol's landlord stated to them that Carol needed 24 hour care and that she was a danger to herself. He was very involved trying to support Carol and saw her regularly. He gave the review a good insight into Carol's life.

2.12 There was initially also regular support from Support, Time & Recovery (STR) staff who visited several times per week, supporting Carol to collect her money, and purchase food and household items, in order to prevent her giving money to others. The STR service was discontinued in mid 2013 as a result of service changes. They had worked with Carol for five years and she had got to know and trust the STR staff.

2.13 Carol was recognised by the integrated mental health team and alcohol support workers as a having a personality disorder but the mental health experts assisting this review state it has been difficult to ascertain a clear and defined care pathway for this specific disorder aligned to the national guidance on managing this disorder.

2.14 Carol's personality disorder was complicated by her chronic alcohol dependency. It should be noted that at the time the integrated mental health team did not have immediate access to an addictions consultant. The last input from an addictions consultant for Carol had been in 2011. The mental health experts advising the review conclude that closer senior clinical oversight, and earlier input from a specialist for personality disorder in particular, would have been helpful to more thoroughly explore options of care. This could have included the feasibility of secure and non-secure specialist placements as well as possibly revisiting whether the Mental Health Act [4] could assist, with Carol being a detained in-patient or with a Community Treatment Order[5]. Carol had been detained under the Mental Health Act in 2011 but was discharged after she appealed to the Mental Health Review Tribunal.

[4] The Mental Health Act 1983 is the law which sets out when an individual be admitted, detained and treated in hospital without consent. It is also known as being 'sectioned'.

[5] A community treatment order (CTO) may be given if you have been in hospital under the Mental Health Act. A CTO means there is supervised treatment after leaving hospital. Conditions of the CTO must be followed.

2.15 The mental health experts state that the care plans for Carol should have been more specific, including being more goal oriented, and better focused on the evidence based approaches. There also should have been a focus on possible alcohol (and previous drug) related cognitive deficits, and Carol's physical health.[6]

2.16 The review found that there was a lack of multi-agency awareness and understanding around Carol's personality disorder. Across the agencies, there was a great deal of disparity of knowledge of Carol's personality disorder or whether she had mental illness at all. Some agencies were genuinely surprised to learn that Carol had a personality disorder and many professionals did not understand what that meant for their work with Carol or how this might need to influence how an individual may need to be managed.

2.17 The care pathway is further explored in **Finding 1.**

April to September 2012

2.18 In April 2012, the integrated mental health team sought a specialist placement for Carol. The CCO put forward a funding application and case to the Primary Care Trust (PCT) who they understood to be the funding commissioner for specialist placements for health at that time. The report to the funding commissioner pulled together a comprehensive and thoughtful appraisal of the rationale for a specialist placement as well as a cost benefit analysis of the comparative cost of Carol continuing to use services at an extraordinarily high level as opposed to the cost of a placement.

2.19 It was considered important that the placement be outside Hartlepool away from influences there. Carol agreed in principle to go to a placement and she worked with professionals to reduce her drinking to a level where she would be accepted for help. The time and effort that the integrated mental health professionals put in to research placements, who they contacted directly, should not be underestimated. This was driven forward by the frontline mental health professionals.

2.20 The report to the PCT in April 2012, included:

"Carol has a significant trauma history and is a particularly vulnerable individual. Her alcohol consumption seems to serve as a coping mechanism for her distress, yet increases her vulnerability to further exploitation and abuse … Carol's current social situation suggested she is at continued high risk of abuse and exploitation …

[6] *NICE guidance https://www.nice.org.uk/guidance/cg78*

It has been identified by all professionals currently involved with Carol that her safety and mental and physical well being cannot be maintained in the community setting and the only appropriate option is a period of structured, supported in patient care … Carol's cognitive capacity has been assessed as poor and this may be a consequence of both alcohol and poor diet … At present there is no Trust facilities that meet her current needs therefore a private placement has been identified …"

2.21 The integrated mental health team were unclear as to what process to follow to seek this placement. They had identified a placement outside Hartlepool but were not sure what had been commissioned previously by the PCT in any similar case and what was available outside the County that was NHS funded. The initial response from the PCT was that the integrated mental health team needed to look at alternative places to the one that they had suggested, as the PCT had identified one more appropriate. There was also some debate as to how it would be commissioned as it included two elements, i.e., personality disorder and alcohol addiction. The PCT suggested a placement in Bradford and the integrated mental health team helped Carol to be assessed there accordingly.

2.22 It was a challenge to work with the suggested provider in Bradford to agree to admit Carol but the professionals achieved this through hard work and a date to admit Carol was agreed for August 2012. However, a few days before Carol was due to be admitted, the commissioning manager at the PCT rang the CCO and advised that the placement would not be going ahead. It was advised that the PCT was no longer using Bradford and that a new facility in Durham should be looked at. However, this facility would not be open until 8th October 2012.

2.23 Even now, there is some confusion and differing recollections as to why the Bradford placement did not come to fruition, but whatever the reason this had a significant impact upon Carol.

2.24 When the commissioning manager advised that the placement would not be going ahead the integrated mental health team sought to challenge this and explained that since Carol had been informed that the treatment placement was put on hold, her behaviour had become more chaotic. The integrated mental health team maintained that *"Carol requires a specialist placement in an environment where she can learn the skills to cope with stress and help develop meaningful activities to improve her motivation and self-esteem."*

2.25 During the review, it became apparent that some PCT emails and audit trail on this issue might not be retrievable because of the changes that had taken place, with the PCT being disbanded and Clinical Commissioning Groups (CCG's) being created. However, the commissioning process around Carol was in any event confusing from both ends and this was ultimately to Carol's detriment.

2.26 The impact of this upon Carol and the implications for the commissioning system is explored in full in **Finding 2.**

October 2012 to May 2013

2.27 Carol was offered another specialist placement some months later but this was not sustainable as Carol did not comply with treatment. Professionals state Carol's motivation for the later placement was less than when she had prepared to go to Bradford. Given that she did not go to the placement in Bradford how she would have fared there cannot be known. Further, it must be acknowledged that the nature of her personality disorder was such that compliance with treatment was more difficult for Carol. As Carol was unable to fully commit and comply with the later placement she was discharged back into the community.

2.28 During this period when back in the community, Carol complained to the integrated mental health team and her landlord about young people pressing her to buy them alcohol and cigarettes. During this period, neighbours, Carol's landlord and PCSOs helped Carol clear her house of young people and adults she no longer wanted there, but they would not leave. Carol would be intoxicated most times this happened. Although a requirement, an anti-social behaviour referral was not passed to the anti-social behaviour team in community safety as Carol was not seen as a victim at that time. She had anti-social behaviour orders against her historically and she was thought to be making a choice (albeit an unwise one) to permit individuals into her home and associate with those of whom she complained about.

2.29 Carol was judged to have mental capacity to make decisions and choices unless she was in an intoxicated state. The integrated mental health team state they made mental capacity assessments of Carol, but more informally. Carol's mental capacity was complex and multifactorial but this was seen in more narrow terms at the time. There is very little recorded in the mental health records or elsewhere around Carol's mental capacity. Whether a person has mental capacity to make decisions is a key factor to how they will be managed and the law seeks to protect those who lack mental capacity as they are inherently more vulnerable.

2.30 It was known by the integrated mental health team that Carol's full scale IQ was initially tested in 2008. This concluded that her range of intellectual abilities was within the extremely low range. It was noted that this was likely to have a significant impact upon her daily activities and to increase her vulnerability. It was further noted she experienced significant memory problems which would get worse when she abused alcohol and during stressful situations.

2.31 Carol's cognitive functioning and memory were found to be impaired. The psychologist suggested her memory problems needed to be considered in terms of her clinical care; that she would be likely to struggle to remember day to day details and that complex messages might need to be broken down into manageable chunks of information. His view was that she would be likely to regain some memory function if she abstained from alcohol.

2.32 There are many incidents where Carol forgot things and this was largely put down to her intoxicated state. It was positive that the neuropsychology opinion concluded she did not have alcohol related brain damage as yet, but there were many incidences where she did not retain information.

2.33 Agencies describe Carol as presenting in different ways at different times. She had a certain way of communicating using nicknames for things and people. When more calm, she dressed and came across more softly and was thought to be a kind-hearted woman by most professionals who had contact with her. At other times she was distressed, anxious and would shave her hair and appear much less confident and be fearful of others to the extent that she would leave her home and stay with others or sleep rough. Carol could be hostile at times and had significant problems building relationships and trust with others. Some professionals described her as "feisty" and "able to look after herself". Carol was therefore seen differently by different agencies, eliciting very different responses. A good example of this is when Carol accidentally started a small fire in her kitchen. The fire service raised an internal safeguarding alert around this incident and also spoke to the integrated mental health team with concerns around Carol's safety and mental health, thereby seeing her as a vulnerable. However, when the police became aware of this they arrested Carol on a charge of Arson with Intent to Endanger Life.

2.34 Alcohol was a prominent factor and Carol drank to excess. There are many recorded entries where Carol had contact with agencies and was barely coherent, unable to control her behaviour and impulses and generally keep herself safe. At times she would ring the police or ambulance and then forget she had done so a short time afterward. Her landlord was of the view that she required continuous care and that she was unable to make safe decisions around who she wanted at her house. This was another indication for a formal and more contextual mental capacity assessment.

2.35 Professionals understandably considered it inappropriate to assess Carol's mental capacity when Carol was intoxicated, but even when sober there were indicators that Carol's mental capacity may have been impaired by other factors. This review has concluded that not all the factors affecting Carol's mental capacity were appreciated at the time and that the consideration of mental capacity assessments lacked formality.

2.36 The learning around assessing mental capacity and Carol's ability to make decisions is considered at **Finding 3**.

May to September 2013

2.37 During this period there were a number of concerning incidents which should have resulted in a full adult safeguarding investigation and a multi-agency strategy consideration within that framework.

2.38 In May 2013, Carol reported she had been a victim of a serious sexual assault by a male known to her. She was sober when making the allegation. The police investigated but there were inconsistencies in Carol's account and there was no corroborative evidence. The male concerned died from alcohol related illness soon afterward. This was not the first allegation of serious sexual assault that Carol had made. An earlier allegation in 2012 had also been made. Ascertaining information from Carol on that occasion was difficult as she was very intoxicated and her account changed, though she did maintain that she had been seriously sexually assaulted. There was no corroborative evidence and the police were unable to pursue this further. Carol was not offered serious sexual assault crisis support.

2.39 In August 2013, Carol was distressed stating she was afraid to go home but she would not elaborate why. She had a black eye from a physical assault upon her. This was explored with Carol with a view to hold those responsible for the assault but Carol gave contradictory information regarding the assault. She was confused and reluctant to give details for fear of reprisals. Carol told professionals certain people would "do her in". Sometimes Carol would let other drinkers into her home for company. However, in August 2013, it became apparent that Carol was sleeping on a beach at times to avoid being at home and having contact with others. She shared this with the integrated mental health team. Carol said there were adults who were harassing her, and also young people whom she called the "schoolies".

2.40 Also in August, two named adult females were using Carol's house without her consent to have paid sex. This information was passed to the Neighbourhood Policing Team (NPT) who noted the information and the PSCO's would monitor. The information was not passed to Community Safety team and there was no natural link up point. The integrated mental health team worked closely with the PCSOs and the PCSOs did inform the integrated mental health team of incidents.

2.41 A safeguarding alert was raised by the integrated mental health team to the Local Authority 'First Contact' team. 'First Contact' was the 'front door' of the adult safeguarding team and system in Hartlepool. The referral stated that Carol was sleeping rough; there was known intimidation from others and financial exploitation. There was discussion between the safeguarding and integrated mental health team and the integrated mental health team agreed to take matters forward. This did not result in a full multi-agency strategy meeting or discussion as would usually be the case. The safeguarding team's rationale was that as the integrated mental health team knew Carol best they would be better placed to manage the safeguarding referral. While

accepting that adult safeguarding can be done in partnership, this hindered the fullest multi-agency consideration, information sharing and safeguarding response.

2.42 In September 2013, Carol reported another serious sexual assault by a named male. A medical examination was arranged. The male was arrested and there was forensic evidence captured while the man was in custody. Arrangements were made for Carol to have an “Achieving Best Evidence” (ABE) interview. However, she failed to attend and was seen intoxicated, in the town, by patrolling officers.

2.43 Carol was later supported by a mental health professional for the police interview. The police said they could not progress matters due to Carol’s aggression and intoxication. The mental health professional explained Carol’s difficulties in emotional regulation and communication due to her personality disorder. Carol was distressed and said she would sort it out herself. From that point on no further steps were taken by the police because it was inferred that Carol did not want to take the allegation further and she was seen as unreliable in the information she gave. The police were not saying that they would not investigate but they needed Carol’s cooperation. A mental capacity assessment was not conducted as Carol was intoxicated. It would have been good practice for the police to have followed this up with Carol when she was sober and reassess what was appropriate in terms of the investigation.

2.44 Another safeguarding adult referral was made by the integrated mental health team. Carol’s CCO liaised with the ‘First Contact’ team and was advised no further action was required. The CCO informed TEWV’s safeguarding adult lead nurse who noted the outcome.

2.45 The integrated mental health team stayed closely in contact with Carol and they were viewed as the repository for information for all other agencies who would contact the CCO in the main to advise them of incidents, problems and contact points. The other agencies tended to do that rather than raise safeguarding alerts to ‘First Contact.’

2.46 Most incidents where Carol was harmed, harassed and unsafe from herself or others were not seen as requiring formal safeguarding referrals to the safeguarding team and subsequently there were very few referrals made over the period for this review. The PCSOs were very responsive and sought to support Carol as best they could within the restrictions of their powers and resource. The attentiveness and genuine concern of the two officers concerned is to be commended. That team had lost a mental health liaison officer and other support roles with changes to the service. The implications of those changes are still unfolding.

2.47 The review has found that amongst the professionals and agencies working with Carol there was not, nor is there currently, a common understanding of adult safeguarding thresholds (i.e. in what circumstances should safeguarding referrals be made) across the agencies. There is a thresholds criteria document but not all agencies or professionals are familiar with it. The review team also discussed the use of safeguarding escalation processes. It is good practice to use this when there may be differing professional or agency opinions on the risk to an individual. It allows professionals and agencies to challenge the safeguarding team/system if a decision of 'no further action' is considered inappropriate by a referring agency. Not all agencies or professionals did escalate or challenge in this way and currently some agencies are not familiar with this process, so do not currently challenge.

2.48 It should be noted that while the adult safeguarding system has changed, in that there is now a legislative framework within the Care Act, the forms of abuse have not changed greatly although there is now a much better national understanding of self neglect. The forms of abuse remain but are now better enshrined in law. These are:-

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.
- **sexual abuse,** including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting.
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

2.49 Carol's situation meets a number of the above categories. Carol's risk was not seen in these terms at the time. The formal multi-agency safeguarding system did not capture the whole information around her though elements of these risks were discussed at multi-disciplinary meetings within the integrated mental health team. Carol was seen as having mental capacity and making unwise life choices.

2.50 When alerts and referrals were made to the safeguarding team by the integrated mental health team the system was such that formal and full strategy meetings with all relevant agencies present sharing information did not occur within a formal safeguarding framework. The consequence was that risk was being managed at frontline service level, rather than by the lead agency managing the formal safeguarding process with full multi-agency information sharing and independent challenge and oversight. The accumulative impact of the incidents for Carol, which were at a high level, was not appreciated or managed effectively within the adult safeguarding system. Risk assessments were being made by the integrated mental health team but they lacked the multi-agency assessment, analysis and planning that a strong safeguarding system and process brings.

2.51 Carol was not considered in the context of self neglect by any agency but this was not as well recognised then under the main adult safeguarding guidance – 'No Secrets'. Self neglect has emerged, however, as a real indicator of risk under the Care Act. To this end TSAB have been undertaking positive work in this area.

2.52 As indicated, there were a number of key challenges to the adult safeguarding system at the salient time, some of which continue. This is considered further in the context of the adult safeguarding system in **Finding 4.**

October 2013 to 9 December 2014

2.53 Closely linked to the safeguarding consideration for Carol was what was happening in Carol's community.

2.54 Carol had moved into privately rented accommodation in a street which was known to be problematic in terms of criminal activity and anti-social behaviour. The population of the street tended to be transient with a high number of private landlords.

2.55 In January 2014, Carol told her CCO she was giving money to people to stay away from her house. She stated that people were calling around to her home on Monday, Wednesday and Friday lunchtimes when they knew she had collected her money, and that sometimes they would even wait for her outside the Civic Centre. Carol's money was managed under an appointeeship which meant that her money was held safely for her and she would go and collect this every week and be given a certain amount to live on. However despite this positive practical help, Carol continued to be financially exploited. The identity of the individuals is unknown. The information was passed onto the PCSOs to monitor the situation. This did not result in a safeguarding alert at the time, although there was ongoing financial exploitation. The adequate professional response was thought to be monitoring when it would have been appropriate to refer into the safeguarding system.

2.56 In April 2014, an unknown adult male and six unknown teenage males were found in Carol's house. A domestic violence report was submitted but this did not initiate any further actions, as considered low risk. This was an inadequate response and again should have been referred to the safeguarding team.

2.57 Young people (who it is believed were under 18s) continued to bother Carol intermittently. The difficulty was identifying the young people. Carol's willingness to share information about young people was influenced by a situation she had experienced when aged 18 when there was an altercation between her and a younger teenager below 18. This resulted in serious consequences for Carol and therefore she was reluctant to report young people. It is not known if the girls who murdered Carol were part of the group of young people who were at times in Carol's home.

2.58 Looking at what is recorded and what professionals knew at the time, the young people to whom Carol referred appeared to be males in the main. It is not known exactly who these young people were, or where they lived. They were called "schoolies" by Carol. A fellow resident in the street describe the group as teenagers, both male and female congregating outside the nearby off licence/shop and approaching adults to buy them alcohol and cigarettes. The resident also reported "youths banging on Carol's door to be let into her home at night". The neighbour did not call the police as she did not wish to become involved.

2.59 There was growing evidence in 2014 that Carol was being targeted by young people and adults. Carol complained of individuals coming into her home uninvited who would use the house to take drugs and she told professionals that people were having sex in her home. It is difficult to ascertain to what degree Carol was targeted but certain individuals would appear regularly and she described them as tormenting her.

2.60 Carol also reported items being stolen from her home. Her front windows were smashed numerous times. It cannot be ascertained by whom. Carol's front door was also damaged and in November 2014, unknown young people walked into her home and wrecked it, covering her with food, which caused her great distress. Carol took great pride in her home and keeping it clean and tidy and asked her CCO and landlord to help provide cleaning materials.

2.61 The street was identified as a Crime and Disorder "hot spot" in mid 2014 and the Community Safety Partnerships multi-agency Joint Action Group started to take very proactive steps to manage the street through a defined strategy. By this time, the Council had also installed CCTV at the end of the street. However the Partnerships Joint Action Group did not receive the full picture regarding front line intelligence around Carol. The community safety team had no formal link with frontline intelligence or the full picture around Carol. A formal mechanism to capture that and to feed that into a wider community safety strategy would have been helpful. Nevertheless, it was not until the

review that the community safety team had the fullest picture of Carol's experience and risk. This was the case around both adults and children who were associating with Carol and is in the context of wider community safety and joining that up with the adult and children safeguarding systems.

2.62 In the last six months before her death there was an increase in damage to Carol's property. The overview and accumulation of damage was only really known at the time by the landlord and the appointee. The landlord would deal with the problems at Carol's home in terms of repair himself. Carol's landlord, however, expressed concerns about Carol to her mental health team several times and he told the review that his persistent view was that Carol needed 24 hour care and that she could not look after herself and keep safe. The landlord did not raise a safeguarding alert as he thought the appropriate action to take was to report his concerns to Carol's mental health workers. He was aware of the wider problems in the street but as a private landlord was not engaged with community safety yet he held helpful information that would have been usefully shared with community safety personnel.

2.63 The complex nature of Carol's relationships with those who came to her home was sometimes predicated on mutual 'benefit' such as company as she was lonely but could also be viewed as exploitative. She would often give money to others to buy her alcohol, and would sell items of her belongings in return for this too.

2.64 Carol was still being supported by the integrated mental health team at this time and up until her death, although she had been informed of the multidisciplinary plan to discharge her from the integrated mental health and other services following input from a specialist in personality disorder, and a series of failed placements.

2.65 The link between Community Safety Partnership management and adults at risk is considered at **Finding 5.**

Involvement of Carol's family

2.66 Carol's family were not involved with her over the salient time and therefore they did not have contact with the integrated mental health team around Carol or her challenges at the time. However, in a SAR it is important to capture family views as far as possible.

2.67 Carol's mother declined the invitation to be involved in the review but Carol's niece and partner have helpfully contributed. For this, key principles for involving families were used to ensure a sensitive, structured and well prepared approach for initial contact, negotiation, information gathering and feedback.[7]

[7] Morris, K., Brandon, M. and Tudor, P. (2012*) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8*

2.68 Carol's death has raised a great deal of questions for her family. These centre on why Carol was not safe in her own home and what were the motivating factors for the girls to murder. Carol's niece and her partner have thought a great deal about Carol's situation and say they would like to see a change in the law which would:

"empower adult services, the police, and the Court to obtain and enforce prohibited steps orders against individuals who intrude upon, or take over a vulnerable person's home or possessions. In some cases the prohibited steps order should be issued on the spot by the attending officer once it is established that a particular resident or person may be vulnerable and in need of protection. Adult social workers should be able to obtain these orders easily. These orders should be treated at the same level of a non-molestation order obtained in cases of domestic violence and the sentences should be the same or similar with multi-agency referrals made and any necessary safeguarding measures put in place …"

2.69 They would like to see Carol's situation placed on the same footing as domestic abuse extending to a visitor in the same way as it would apply to a partner, as what happened to Carol, they feel, mirrors domestic violence cases and the impact upon the victim is as devastating. They say that the numbers of vulnerable adults whose homes are taken over and who suffer regular abuse are unknown, yet there is no law making this type of home invasion illegal. They consider that this type of law would benefit and protect vulnerable adults in similar situations nationally. Also, that the authorities should be able to act even if the vulnerable person feels they cannot make a complaint in the same way as domestic abuse can be pursued by the police without a formal complaint from the victim.

2.70 These are matters which will no doubt continue to be debated into the future with the appropriate authorities.

In what ways does this case provide a useful window on our systems?

2.71 This case raises some fundamental issues facing professionals when working with complex individuals with a dual diagnosis and high level of need who present with significant risk in the community. The case reflects the ethical dilemmas around mental capacity, care pathways, commissioning for complex need and the challenges in understanding an individual in the context of their community and adult safeguarding.

Tools

2.72 To identify the findings, the review team has used the SCIE typology of underlying patterns of interaction in the way that local systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

2.73 They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Summary of Findings

2.74 The review team have prioritised five findings for TSAB to consider. Findings are also linked to a typology category to assist in the wider analysis of findings. The findings are:

Findings	Typology
FINDING 1 **The care pathway in Hartlepool for people with a dual diagnosis including personality disorder has insufficient appropriate senior clinical oversight, early specialist input, close clinical case management and multi-agency understanding.**	**Management systems**
FINDING 2 **There is confusion between frontline efforts and the commissioning system which risks unreliable information being given to individuals which may have a negative impact.**	**Culture of communication and collaborative working**
FINDING 3 **Among professionals the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex, limiting the risk assessment and professional response.**	**Management systems**
FINDING 4 **There is a lack of clarity on thresholds, inconsistent process and ownership for multi-agency adult safeguarding, leaving some frontline professionals managing complex and high risk cases, and hindering vital information sharing and effective responses.**	**Management systems**
FINDING 5 **There is a disjoint between both children's and adults safeguarding processes and community safety services, leaving community safety services insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.**	**Management systems**

3. Findings in detail

3.1 The aim of a Learning Together case review is to use a single case as a 'window on the system', to uncover more general strengths and weaknesses in the safeguarding system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case specifics, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the reconstruction of the unfolding case, documentation and an examination of the key practice episodes.

3.2 The second step is to consider whether the issue observed in this case is 'underlying and that it is not simply a 'quirk' of the case. The third step is to consider how geographically widespread and prevalent the issue is within the national system. Sometimes it is not possible within the scope of a review to collect this data. The sources for these steps will be information from the review team and case group; any performance data; national research and other reviews in a variety of combinations.

3.3 The last step is to articulate why this issue matters and what are the risks to the safeguarding system. The findings reflect the wider national context and challenges for safeguarding children and questions are formulated for the SAB.

3.4 FINDING 1: The care pathway in Hartlepool for people with a dual diagnosis including personality disorder have insufficient appropriate senior clinical oversight, early specialist input, close clinical case management and multi-agency understanding. *(Management systems)*

Introduction

3.4.1 Personality disorders have been controversial in terms of classification and what is beneficial in terms of treatment. Over 5000 reports have been published on the subject of classification of personality disorder and the specialty has struggled for many years to reach agreement.[8]

3.4.2 What does seem to be widely accepted, however, is that individuals with this condition are more prone to suicide, to seek out and utilise health care services and can present with significant levels of functional impairment. The literature also indicates that personality disorder and substance use disorders, such as alcohol dependency, frequently occur together with individuals 'drinking to cope' with negative emotions and to gain some relief[9].

What is the issue?

3.4.3 An individual as complex as Carol requires a senior and specialist clinical response as early in the pathway as possible. The care should also be underpinned by strong clinical governance linked with national guidance to support frontline professionals. The care pathway can be shared accordingly with other services to promote a strong interface and common understanding of Carol's condition and risk as well as consistency of approach.

3.4.4 The care pathway for people with personality disorder is not fully implemented, and the integrated mental health team manages the care of such complex individuals alongside others, with limited input of a 'supervisory' nature from the single Consultant Psychologist available**.**

How did the issue manifest in this case?

3.4.5 The lack of a fully defined care pathway with appropriate senior clinical oversight, early specialist input, close case management and multi-agency understanding meant that Carol's care fell outside the national expectations and guidance for personality disorders.

---

[8] Tyrer, P., Reed, G.M., & Crawford, M. (2015). Classification, assessment, prevalence, and effect of personality disorder. *The Lancet, (385) pp.717-725.*

[9] *Borderline Personality Disorder and Substance Use Disorders: A review and Integration Trull, T.J., Sher, K.J., Minks Brown, C., Durbin, J and Burr, R – Clinical Psychology Review, Vol 20 No 2 pp2351253 2000*

3.4.6 The National Institute of Clinical Excellence provides clinical guidance around specialist personality disorder services (2009). This states:-

Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders. These teams should have specific expertise in the diagnosis and management of borderline personality disorder and should:

- Provide assessment and treatment services for people with borderline personality disorder who have particularly complex needs and/or high levels of risk.
- Provide consultation and advice to primary and secondary care services.
- Offer a diagnostic service when general psychiatric services are in doubt about the diagnosis and/or management of borderline personality disorder.
- Develop systems of communication and protocols for information sharing among different services, including those in forensic settings, and collaborate with all relevant agencies within the local community including health, mental health and social services, the criminal justice system, CAMHS and relevant voluntary services.
- Be able to provide and/or advise on social and psychological interventions, including access to peer support, and advise on the safe use of drug treatment in crises and for comorbidities and insomnia.
- Work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services.
- Ensure that clear lines of communication between primary and secondary care are established and maintained.
- Support, lead and participate in the local and national development of treatments for people with borderline personality disorder, including multi-centre research.
- Oversee the implementation of this guideline.
- Develop and provide training programmes on the diagnosis and management of borderline personality disorder and the implementation of this guideline.
- Monitor the provision of services for minority ethnic groups to ensure equality of service delivery.

3.4.7 Frontline professionals in the integrated mental health team were therefore without well led, specialist, senior clinical leadership for Carol's complex care needs. The frontline mental health professionals committed hugely to Carol. However senior clinical oversight and specialist input was appropriate at an early stage. This would have also avoided the disproportionate amount of responsibility placed upon the frontline professionals.

3.4.8 The mental health experts assisting in this review consider detention under the Mental Health Act (MHA) could have been appropriate. This would have compelled Carol to receive treatment under law. Further, this possibility had been raised by Carol's GP. Carol had been detained under the Mental Health Act in May 2011. This had been seen as providing an opportunity to detoxify and engage in therapeutic work in a secure setting. Carol appealed the section and the Mental Health Review Tribunal (MHRT) released her and she was permitted to leave hospital. At the time the Team Manager from the Affective Disorder Service did challenge this decision but was unsuccessful. There was no more they could have done at that point.

3.4.9 Mental health experts assisting in this review consider this was potentially a missed opportunity to treat Carol's primary condition in an appropriate setting, namely a unit with provision to provide appropriate therapy.

3.4.10 The mental health experts are also of the view that given the nature of Carol's illness, with frequent relapses and non-engagement in the community, it would nevertheless have been reasonable to provide such treatment under a Community Treatment Order with appropriate personality disorder specialist input (given her complexity) – but there is an appreciation of the legal hurdles to overcome. In the absence of this being achievable, they state that early specialist personality disorder input with senior clinical oversight would have been immensely helpful on an ongoing basis to provide closer case management at a clinical level.

3.4.11 In March 2012, Carol was admitted to hospital again because of her inability to cope with her increasing distress. A further MHA assessment was planned following her deterioration. Carol had lost weight and had recently alleged she had been seriously sexually assaulted. She appeared increasingly confused and complained of hearing 'lodgers' continually in her head. The formal MHA assessment did not take place because Carol was admitted informally, i.e., with her cooperation and consent. She was discharged on 5 March 2012. The mental health experts advising the review state that the question of whether detention under the MHA would be appropriate appears to have been lost again here and was not followed up despite a MHA assessment having been the objective.

3.4.12 Further, the alcohol service work being done with Carol was not meeting set goals and that service withdrew in December 2013. The rationale was that Carol's behaviours, which she could not self manage, undermined any positive engagement.

3.4.13 The frontline professionals did seek specialist senior personality disorder expertise in June 2014 after a further placement broke down. The advising consultant psychologist in personality disorder worked through Carol's history and the current challenges Carol was posing with frontline professionals.

3.4.14 At a professionals' meeting in June 2014 the decision was made to formulate a discharge plan to include determining how Carol could be supported by the Council to manage her money, recognising that there was a risk she might not manage her money and there might be some element of exploitation by others. It was also agreed to arrange appointments with alcohol services to discuss services available should Carol decide she wanted to access support in relation to her alcohol abuse.

3.4.15 This decision making process has been considered by the mental health experts assisting in this review and they question the decision to discharge Carol. The meeting held on 6 June 2014 to discuss discharge noted 'an absence of any clear consistent or significant presence of severe psychosis, mania or depression'. The mental health experts raise concerns that there is no reference to Carol's personality disorder, which is a legitimate reason to have access to secondary mental health services.

3.4.16 There is concern that assertion was made without a review by a psychiatrist and without a much more detailed formulation over a longer period of time and with much wider input from others and Carol herself. There is a question over the formulation then, also in the context to Carol's vulnerability and risk at that time which was known and knowable. Carol's life had become more chaotic at the time, her drinking had increased and there was a tangible escalation of risk around her, particularly harm from others and exploitation.

3.4.17 It should be emphasised that the discharge decision was designed to trigger in Carol some empowerment and reduce her dependency upon services and the professionals who were close to her. There appears to have come a point that there was a view that following extensive input from frontline professionals, failed placements and no real improvement a new approach was needed with the relevant safeguards and in a timescale tolerable to Carol. At the time of Carol's death the plan was being worked through.

3.4.18 The decision to alter the approach and seek to achieve discharge from service was therefore in order to attempt to promote greater responsibility from Carol, and this decision could have been altered at review to one of 'low-level' support if she had been able to achieve some of the goals to independent functioning which were planned.

What makes it a broader underlying issue as opposed to only specific to this case?

3.4.19 This case is not unique in terms of the management of those with personality disorder but there are moves to bring the care pathway more into line with national expectations and best practice. This will bring better communication around these clients: earlier specialist input and increased senior clinical supervision and leadership.

What is known about how widespread or prevalent the issue is?

3.4.20 Personality disorders are not uncommon[10], although a spectrum of severity exists. Its complexity and the challenges of managing such a condition, particularly with alcohol abuse, are not unique to Hartlepool.

3.4.21 Substance abuse (drug or alcohol) is recognised as an important clinical disorder within which to evaluate and treat personality disorder. The need to develop or modify existing treatments to better meet the special needs of personality disordered substance abusers has been documented and therapeutic attention to the symptoms of the personality disorder may reduce the severity of the substance abuse and other associated psychiatric problems such as depression, anxiety, paranoia[11]. TEWV state that they are working toward an enhanced model of care and there is sound evidence of that. However, professionals report the linkage with alcohol services remains challenging. Carol was discharged from alcohol services on December 2013 mainly as a result of lack of engagement. This was not challenged at the time by the integrated mental health team or any other agency.

3.4.22 From a multi-agency perspective, there continues to be a widespread lack of understanding of personality disorders across the agencies, its impacts upon an individual such as impulsivity, and also the interplay between substance abuse and personality traits. Greater understanding would inform the approach and understanding of individual's behaviours and why they may be unable to engage or comply at times and associated risk. Dual diagnosis cases remain difficult to navigate but mental health systems in Hartlepool are taking positive steps to address this as stated.

3.4.23 Alcohol services are also described as having less continuity in terms of service delivery. Professionals in the review state that contracts for this service change because of commissioning decisions every few years. Professionals have explained in the review that when the provider changes those who had been cared for within the service lose established contacts and rapport with workers. In dealing with those who need support around alcohol dependency this is unfortunate and merits further consideration in the context of integrated commissioning and partnership working.

[10] Coid, E., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry,* 188, pp. 423-431.

[11] Ball, S.A., & Young, J.E. (2000). Dual Focus Schema Therapy for Personality Disorders and Substance Dependence: Case Study Results. *Cognitive and Behavioural Practice pp. 270-281.*

What are the implications for the reliability of the system?

3.4.24 Without senior clinical and specialist input to complex cases with closer case management, frontline professionals are left managing a high risk and complex individual with reduced prospects of positive outcomes. Without a shared, well informed care pathway around complex individuals such as Carol care across the agencies may become fragmented and reactive only. This in turn increases risk to the individual, and puts agencies at odds with each other in their management of the individual. The strength of the care pathway system also relies upon understanding developments nationally. There are sound nationally recognised programmes such as The Blue Light Project[12] which specifically targets those individuals who are alcohol dependent, not engaging with treatment and who are high volume users of public services.

Questions for the Board

1. How will the Board gain assurance that commissioners and providers of mental health services in Hartlepool provide an effective service that is compliant with national guidance?
2. How will the Board seek assurance that mental health and alcohol services are working together in an optimal way to meet the needs of those with a dual diagnosis?

[12] Holmes, M., & Ward, M. (2014). *Alcohol Concern's Blue Light Project – Working with Change Resistant Drinkers.*

3.5 FINDING 2: There is confusion between frontline efforts and the commissioning system which risks unreliable information being given to individuals which may have a negative impact. *(Culture of communication and collaborative working)*

Introduction

3.5.1 Commissioning health services is a core function of the NHS. Predominantly, commissioning is managed locally by Clinical Commissioning Groups (previously called Primary Care Trusts). There are some specialised services that are commissioned direct by NHS England. These include services listed in the national specialised definition set. There has been a great deal of change in commissioning in recent years and the NHS has faced its biggest restructure since inception. Commissioners carry a great deal of responsibility to use the funds allocated to them to best meet the needs the local population they serve and with defined priorities. The spectrum of commissioning is vast but there is a model of care for personality disorders[13].

What is the issue?

3.5.2 Applications for care packages or placements in a health facility require formal authority, whether this is being commissioned by health or social care. The placement being sought here was primarily health care. Using the correct process is essential to ensure that there is clarity around what can be provided, where and at what cost. Unless this is achieved, professionals and the individual may be provided with inaccurate information as to what is available and achievable. There must a well informed and comprehensive consideration and rationale for the commissioner to justify the placement is the best option for the individual and use of public money in the most cost effective way. Specialist placements by their nature can be expensive to provide and commissioners do at times need to use non NHS, i.e. private providers to be able to provide what is appropriate for an individual's needs. Decision making should take into account the impact upon the service user should a placement not be possible or available for any reason and both process and decision making should be transparent.

[13] Recognising Complexity: Commissioners guidance for Personality Disorder Services" (Department of Health 2009)

How did the issue manifest in this case?

3.5.3 The mental health professionals for Carol drove forward an application for funding and directly contacted and selected a provider before the application for funding was made which is unusual. They did not first explore with the commissioner what was actually available and the commissioning parameters.

3.5.4 At the time, the integrated mental health team were not aware that this might not be the most appropriate approach and were advised later by a senior colleague at TEWV that it did not adhere to the mechanism being developed, but there was no clear guidance that the mental health team could elicit at the time.

3.5.5 The consequence was that the integrated mental health team believed after various communications with a number of personnel in commissioning that the placement was agreed and funded to take Carol in an agreed timescale. They relied upon this and informed Carol. The integrated mental health team state this was an optimum time in terms of Carol's motivation to receive therapeutic help.

3.5.6 The NHS commissioning system is not set up to ascertain the likely impact of commissioning decisions on the person concerned, whether or not those decisions are made within a defined commissioning process.

3.5.7 Therefore when the placement fell through for whatever reason the commissioner did not consider what impact such a decision would have had on an individual with complex needs.

What makes it a broader underlying issue as opposed to only specific to this case?

3.5.8 On discussing other applications for funding and placements, the review team advised that some applications are processed smoothly and others are problematic. The commissioning processes and decision making should be defined and equal for all. Further, professionals referring patients say that the commissioning decision making remains unclear, and question whether the decision maker has the requisite knowledge to understand individual needs, particularly when the individual has complex needs. To address this professionals are encouraged by the commissioners to arrange a case conference to discuss in detail what is required.

What is known about how widespread or prevalent the issue is?

3.5.9 There have been commissioning improvements following CCGs becoming more established within the NHS structure, but there remains some uncertainty with professionals about what a CCG can commission in terms of specialist placements and what NHS England are accountable to commission. This is also likely to change again as NHS England seek to devolve more commissioning to CCGs.

What are the implications for the reliability of the system?

3.5.10 Without a clear and well governed commissioning system, care pathways will become confused and service users like Carol may be left without the care they need at the optimal time. Users of the NHS are entitled to have certainty as to what the NHS can offer them for their health problems, and preferably with choice. Choice is a cornerstone of the NHS Constitution. Nationally, funding for mental health services is being reviewed to ensure parity of funding between mental health and physical health services. The provision of mental health services has been reviewed in the Five Year Forward View for Mental Health[14].

3.5.11 It would be beneficial for frontline mental health workers to understand the commissioning process with support from clinical line management. This would enhance awareness and improve work with commissioners for the benefit of all patients. This will help with understanding purpose clarifying roles and responsibilities and building good relationships.

3.5.12 Today, both Carol's assessment of need and her care provision would need to meet the provisions of the Care Act 2014. The Care Act now provides:-

A general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind when making decisions about them or planning services.

3.5.13 Wellbeing can relate to:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support);
- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal relationships;
- suitability of living accommodation; and
- the individual's contribution to society.

[14] *Five Year Forward Review. (2014). NHS England.*

3.5.14 Before the Care Act, individual users of services had different entitlements for different types of care and support. These were spread across a number of Acts, some over 60 years old.

3.5.15 The Care Act replaces these and now provides:-

1. That the law focuses on the needs of individuals. The Care Act is based on the premise that the individual is always at the centre.
2. A clear framework to enable service users to better understand how the system works and how decisions about them are made.
3. Law that is fair and more consistent and removes anomalies that treated particular groups of people differently.
4. A clear legal framework for how local authorities and other parts of the health and social care system should protect adults at risk of abuse or neglect.

3.5.16 The commissioning process for funding of specialist care and treatment remains unclear with the various bodies, such as NHS England, Risk Share and Individual Funding Requests (IFR), being offered as potential funding sources. However, no clear guidance exists on who or how to identify the correct resource, or how to ensure adequate and relevant information is presented to secure funding. This has been further complicated by constant national changes in NHS commissioning. There does not appear to be information provided on how to challenge or appeal decisions made which also negatively impacts upon professionals and clients understanding of the processes involved.

Questions for the Board

1. How will the Board seek assurance from the commissioners that they have robust systems and processes to consider the needs of complex individuals like Carol?

2. Is the Board satisfied that the provisions of the Care Act will be met when assessing the needs and risks of complex individuals like Carol?

3.6 FINDING 3: Amongst professionals the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex; limiting the risk assessment and professional response. *(Management systems)*

Introduction

3.6.1 The Mental Capacity Act 2005[15] protects and supports those individuals who lack mental capacity and outlines who can and should make decisions on their behalf. The Mental Capacity Act covers important decision-making relating to an individual's property, financial affairs, and health and social care. The two stage test and principles of the Act are set out below:-

3.6.2 The first stage is a diagnostic test:

1. Is there an impairment of or disturbance in the functioning of the person's mind or brain?
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

3.6.3 The second stage is a functional test. Can the individual:-

1. Understand information about the decision to be made?
2. Retain that information in their mind?
3. Use or weigh-up the information as part of the decision process?
4. Communicate their decision?

3.6.4 If a person lacks capacity in any of these areas, then this represents a lack of capacity (Mental Capacity Act 2005; Code of Practice).

3.6.5 The five principles of the Act are:-

1. The presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. People must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. That individuals retain the right to make what might be seen as eccentric or unwise decisions.
4. Anything done for or on behalf of people without capacity must be in their best interest.

[15] *Mental Capacity Act 2005, Code of Practice*

5. Anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic needs - as long as it is still in their best interests.

3.6.6 The Court of Protection[16] has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

3.6.7 The High Court[17] also has powers to protect those who lack mental capacity. This is under its inherent jurisdiction. The inherent jurisdiction can be invoked for cases where an individual may, on the face of it, have mental capacity but whose capacity is being undermined by factors such as undue influence, duress or coercion which may prevent an individual weighing up a decision in the balance. There are various cases that outline what constitutes undue influence, duress and coercion. Where there are concerns that an individual needs to be removed from an abusive environment evidence is gathered and placed before the court with the vulnerable adult legally represented.

3.6.8 More complex cases where there may be multiple factors impacting upon a person's mental capacity can be more challenging for professionals to assess. In some cases, mental capacity needs to be considered formally by a senior clinician weighing up all factors that may be impairing mental capacity. In these complex cases legal advice may be required as to whether the Court of Protection or the High Court may assist.

What is the Issue?

3.6.9 Whether an individual has mental capacity to make decisions defines how an individual is managed in the context of their finances, health and social care needs. An individual who is deemed to have full mental capacity may make unwise and what may seem irrational choices but they are entitled to do so. Those who lack mental capacity are managed using best interest considerations.

[16] The **Court of Protection** in English law is a superior **court** of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

[17] The **High Court** is the third-highest **court** in the country. It deals with civil cases and appeals made against decisions in the lower **courts**. The **high court** is divided into three parts, which deal with different kinds of cases.

3.6.10 However, the concept of “executive capacity” is relevant where the individual has addictive or compulsive behaviours. This is explored by Preston Shoot and Braye et al[18]. This highlights the importance of considering the individual’s ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity)[19]. Therefore, for an individual such as Carol the assessment of mental capacity is unlikely to be as straightforward as a simple yes or no.

How did the issue manifest in this case?

3.6.11 Professionals say they did assess Carol’s mental capacity on occasions but there is no formal record of this and from information before the review these may have lacked the requisite formality. It would therefore seem that professionals thought they had fulfilled their duty to assess when actually a more detailed consideration was required.

3.6.12 It has been difficult to fully ascertain in the review to what extent Carol’s mental capacity was formally assessed in the community by the many agencies who had contact and involvement with her. The last formal mental capacity assessment recorded was in 2008. There are some references to mental capacity in a number of agency records but no detail about whether a formal assessment was done, by whom, how this was tested or how conclusions were reached and in consideration of which factors. This is surprising given Carol’s complex needs and the challenging nature of the assessment.

3.6.13 Professionals working with Carol expressed concern that assessing Carol’s mental capacity formally and too often would have been an imposition upon her. In exploring this, what has emerged is a clear and objective indication that professionals across the services do not fully understand the potential complexities of a mental capacity assessment for an individual such as Carol and all the factors that needed to be taken into consideration. While any assessment would seek not to impose, it is an important assessment and informs professionals on what basis they should support an individual, so this outweighs a short imposition if that is how it is viewed.

3.6.14 In relation to personality disorder and mental capacity, there is ongoing learning about how the components of a personality disorder may affect an individual’s mental capacity particularly in reference to emotional distress.

[18] SCIE report 46:*Self Neglect and Adult Safeguarding: Findings from research*

[19] *Naik 2008*

3.6.15 This is indicated in case law[20]. In one case, both the Mental Health Act and Mental Capacity Act was considered where a refusal to eat in order to self harm by a personality disordered offender was overridden by the Court and he was deemed to lack mental capacity. This was on the grounds that his ability to weigh information *was "impaired by the emotions and perceptions he had at the time … related to his personality disorder … his spectacles are blinkered … Although he weighs facts, his set of scales are not calibrated properly …"* (R v Collins and Ashworth Hospital ex parte Brady).

3.6.16 Other relevant factors beside Carol's alcohol addiction, personality disorder traits and moderate cognitive and memory problems, were undue influence, coercion and her deferent attitude toward young people. The latter aspect arose out of an historical incident where there were serious consequences for Carol when she had an altercation with a younger teenager when she was a young adult. Carol told professionals she would never retaliate against a young person and this experience from her past informed her attitude toward young people and made her more vulnerable.

What makes it a broader underlying issue as opposed to only specific to this case?

3.6.17 The discussions with the review team and frontline professionals as part of the review indicate that mental capacity assessments for more complex cases presents a real challenge across agencies.

3.6.18 Professionals are much more confident and comfortable applying a yes/no approach to mental capacity assessments but are less equipped to deal with more complex assessments or a fluctuating picture. Certainly not all professionals or agencies are aware of how factors such as duress or coercion can affect a person's mental capacity and that further expertise and/or legal advice may need to be sought.

What is known about how widespread or prevalent the issue is?

3.6.19 Considerations around the Mental Capacity Act and its application have been raised previously in an adult review in Hartlepool and subsequently training on the Mental Capacity Act became part of the action plan for that review. Training for mental capacity was delivered in 2016 by a national lead.

3.6.20 Agencies and their professionals will need to consider mental capacity on a daily basis. Therefore recognising the more complex consideration for mental capacity and where to get help is key.

[20] Pickard, H. (2015). Choice, deliberation, violence: Mental capacity and criminal responsibility in personality disorder. *International journal of law and psychiatry, 40, 15-24.*

What are the implications for the reliability of the system?

3.6.21 Recording and evidencing mental capacity assessments is good practice. Using the formal legal tests for assessing decisions provides a sound structure which teases out the individual's ability to make decisions. Without this structure, key factors influencing mental capacity may be missed and assessments become superficial. A full consideration, taking into account all relevant factors, informs professionals and services of options for intervention where appropriate.

3.6.22 Frontline professionals should be encouraged to seek support for complex cases. This may involve a senior clinical specialist opinion or a more comprehensive deliberation in partnership with other agencies. Professionals should know how to escalate concerns and be supported in difficult mental capacity assessments both clinically and legally where necessary.

3.6.23 A safe system equips professionals and services to appreciate that some mental capacity assessments can be incredibly complex, ethically and legally.

3.6.24 Clear guidance is needed on when and how to document a formal assessment of capacity within case management when issues arise and are dealt with in real time and in fluid and complex situations. This should include comment in relation to what decisions one is assessing, including how to identify duress or coercion.

Questions for the Board

1. How is the Board assured that staff are competent in fully assessing mental capacity and receive appropriate training?

2. In what way can the Board further test the quality of mental capacity assessments across the agencies?

3.7 FINDING 4: There is a lack of clarity on thresholds, inconsistent process and ownership for multi-agency adult safeguarding leaving some frontline professionals managing complex and high risk cases, and hindering vital information sharing and effective responses. *(Management systems)*

Introduction

3.7.1 The safeguarding system for adults pre April 2015 was informed by a national guidance document 'No Secrets', 2000 (reviewed 2009). The lead agency for safeguarding adults was and is the local authority who are a contact point for safeguarding alerts and referrals. Referrals generally come into a central point within the local authority, are considered on a case by case basis and then appropriate cases taken through a formal safeguarding process which necessitates a multi-agency strategy meeting and a formal plan on how to safeguard the individual.

What is the Issue?

3.7.2 The safeguarding process is a framework within which services can share what they know around the individual, share risk information, assess risk and take proactive steps to safeguard an adult at risk. The system is now placed on a legal footing with the provisions of the Care Act 2014. The danger of an informal or inconsistent safeguarding system is that professionals become unclear who is leading the process, where roles and responsibilities lie and the adult at risk may not be afforded the protection they require or should be able to expect under the adult safeguarding system.

How did the issue manifest in this case?

3.7.3 Risk assessments were made around Carol by the integrated mental health team using appropriate risk tools but these were limited in application as they were not multi-agency. While CPA meetings were held as required, with some consideration of risk, these cannot take the place of a formal safeguarding process or system.

3.7.4 The thresholds and criteria under which safeguarding referrals were made concerning Carol were applied differently and inconsistently by agencies, meaning that Carol's risks, multiple and accumulative, were not fully considered multi-agency. This was compounded by a lack of independent challenge or oversight around the safeguarding process.

3.7.5 Carol was discussed at a “complex needs” meeting around her high level of attendance at A&E (71 attendances) in an initiative to manage frequent attenders in July 2014. This was initiated by the A&E team. This did include a number of the professionals working around Carol. However, the wider safeguarding risks to Carol were not discussed. Carol was advised after this meeting that she would no longer be provided with taxis to get home after attending A&E and the ambulance service recognised they had a default position that meant that they always brought Carol into hospital at her request and that needed a more robust consideration. This is an example of a specific problem around Carol being seen in isolation, without the overview that a safeguarding process can bring.

3.7.6 When young people became more prominent in Carol’s life and were harassing her there was no link up with children’s social services due to the lack of an adult safeguarding consideration of Carol’s situation. A multi-agency mechanism to determine her risk and possibly identify the young people was simply not there. Even now it is pure speculation who these young people were or whether they were known to services. There is no clear evidence linking Carol and the two girls who came to harm her, though it is believed by some agencies that the night of the murder is unlikely to have been the first time they would have met Carol.

What makes it a broader underlying issue as opposed to only specific to this case?

3.7.7 Hartlepool Borough Council received an adult safeguarding peer challenge which was presented in November 2014 which identified that “clarity about ownership of safeguarding across all mental health teams could be increased and safeguarding practice and governance appears to be inconsistent and need to be aligned with the rest of the council”.

3.7.8 Further, a Serious Case Review reported in 2014 recommended that there be an options appraisal for a Multi-Agency Safeguarding Hub (MASH) for children and adults to enhance information sharing and the multi-agency response to adults at risk. This was appraised in February 2014 though primarily for children safeguarding. The children’s MASH is being piloted with no immediate plans to move to an adults’ safeguarding MASH.

3.7.9 The review team were able to share that the approach to safeguarding and their understanding of how the adult safeguarding system worked then was not specific to Carol but applied to other individuals, particularly where mental health services were involved.

What is known about how widespread or prevalent the issue is?

3.7.10 Lack of consistency on process and clarity around thresholds about when to raise a safeguarding referral appears to apply pre and post the Care Act 2014 so making these aspects fairly widespread and prevalent. This would merit further evaluation.

3.7.11 There is positive work being done around self neglect and the TSAB website clearly outlines the risk indicators for this which is helpful.

What are the implications for the reliability of the system?

3.7.12 There is a great responsibility within law to protect adults at risk. The local authority are the lead agency and hold the responsibility for this working in partnership with other agencies. This includes those who self neglect and Carol would be seen in that category now. If the safeguarding system does not work effectively and all services do not know how and when to use it to good effect then there is a real danger that the most vulnerable adults in society will come to unnecessary harm.

Questions for the Board

1. How can the Board seek to bring independent challenge to the adult safeguarding system?

2. Is the Board satisfied that all agencies understand the TSAB thresholds of when to make a referral to adult safeguarding?

3. How can the Board evaluate how agencies understand high indicators and self neglect?

4. How can the Board be assured that the duties and responsibilities of the Care Act are being met in terms of safeguarding adults at risk?

5. Will the Board consider the views expressed by Carol's family on home invasion?

6. How can the Boards best strengthen the links between adult and children safeguarding systems?

3.8 FINDING 5: There is a disjoint between both children's and adults safeguarding processes and community safety services, leaving community safety services insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence. (*Management systems*)

Introduction

3.8.1 More recently, professional responses to community safety are directed by legislation such as the Anti-social Behaviour, Crime and Policing Act 2014. This reformed anti-social behaviour powers and places an emphasis on putting the victim first. This statutory guidance covers a wide range of powers and is particularly focussed on early intervention.

What is the issue?

3.8.2 Carol was known to live in a street that was a difficult place in which to live with certain elements impacting upon her. This context was not well appreciated at the time. The Community Safety Partnership Joint Action Group team had the powers and tools to tackle the problems being encountered in the street, such as criminal damage to property, residents being targeted and other anti-social behaviours, but they were unable to best target these around the vulnerable adults in the street or in a timely way because they had no formal mechanism to fully capture comprehensive frontline intelligence.

How did the issue manifest in this case?

3.8.3 Over the review period there were 472 reported incidents to the police concerning Carol. Carol made 219 calls, the rest were made by other people either concerned for Carol or about her behaviour. Neither this nor other information around Carol, including her high level of agency contacts and problems she had with adults and young people being at home and causing damage, informed the targeted work that the Community Safety Partnership Joint Action group was doing in this area. This was despite Carol being identified by Cleveland Police as a repeat caller and designated a priority through the Problem Orientated Policing process (POP).

3.8.4 The PCSOs knew Carol well and sought to support her but they did not have full police powers to intervene nor any link up with the wider community strategy. There was a wealth of intelligence with the PCSOs, Carol's integrated mental health team and landlord but this intelligence about the community was not being systematically linked with assessment or protection of an adult at risk.

3.8.5 It should be noted that while Carol would disclose to the integrated mental health team and others the problems she was having with adult and young people coming into her home and exploitation more generally, she would be reluctant to name people or make formal complaints for fear of reprisals, and with young people she was anxious about repercussions upon her.

Safeguarding adults and children at risk is the responsibility of all agencies and strategic partnerships. The Community Safety Partnership does have powers that can be usefully deployed such as using CCTV, and assertive outreach teams for young people. Vulnerable, Exploited, Missing and Trafficked group (VEMT), which was in its early development at the salient point are now in place. Frontline intelligence is key to make sound decisions on how and when such resources should be deployed and to protect whom. CCTV was set up in the street but was unable to identify in Carol's case who was breaking her windows, for instance. Carol was not considered as part of the vulnerable victims group. The review team report that the removal of the Police Mental Health Liaison Officer position had a significant impact upon the sharing of relevant intelligence and may have made connection to the Community Safety more transparent and consistent.

What makes it a broader underlying issue as opposed to only specific to this case?

3.8.6 The disjoint between frontline community knowledge and a wider consideration of community safety in a given area is not unique to Carol's case. Community safety leads state that they don't always know the level of vulnerability of individuals in a Crime and Disorder "hot spot" and agree the system could be improved.

3.8.7 There has been further development work in this area and confidence that this will improve communications and intelligence gathering.

What is known about how widespread or prevalent the issue is?

3.8.8 The mid 2014 community safety strategy to tackle the problems in Carol's street was an approach used in other areas of Hartlepool which had become problematic and similar problems are encountered in capturing frontline intelligence. There is positive work underway using E-CINS[21] which is a 'Complete Neighbourhood Management Solution' but some services have yet to use this and this is work still being developed.

[21] www.empowering-communities.org/software/e-cins

What are the implications for the reliability of the system?

3.8.9 The intelligence shared by agencies such as the police and those leading wider safety initiatives within a community are key to identifying those who are anti-social or are bringing criminal activity into a community. It is not true to say that all residents will be affected by crime or anti-social behaviour but sharing intelligence between frontline and at a strategic level will strengthen community safety and positively feed into safeguarding systems. This is particularly important to detect when a vulnerable individual may be being targeted by adults or young people. The difficulty in Carol's case was that there was not an effective system to share this frontline intelligence fully and therefore further action was not planned to help her specifically.

Questions for the Board

1. How can TSAB work in partnership with HSCB and the Community Safety Partnership to ensure that the development work currently being undertaken by the Community Safety Strategic Partnership strengthens the links for both adults and children?

4. Appendices

4.1 Methodology and Process of the Review

4.1.1 This review has used the SCIE Learning Together model – a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and child protection work (Munro, 2005; Fish et al, 2009).

1. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

2. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

3. The basic principles – the 'methodological heart' of the Learning Together model – are in line with the systems principles outlined in Working Together 2013:

    - Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?

    - Provide adequate explanations – appraise and explain decisions, actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.

    - Move from individual instance to the general significance – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency safeguarding system.

    - Produce findings and questions for the Board to consider.

    - Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

4.1.2 Typology of underlying patterns: To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

4.1.3 Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

4.1.4 Anatomy of a finding: For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency adult safeguarding system?

4.2. Bibliography

Anti-Social Behaviour, Crime and Policing Act 2014: Reform of anti-social behaviour powers. Statutory guidance for frontline professionals. (2014). Home Office.

Ball, S.A., & Young, J.E. (2000). Dual Focus Schema Therapy for Personality Disorders and Substance Dependence: Case Study Results. *Cognitive and Behavioural Practice* pp. 270-281.

Bateman, A.W., Gunderson, J., & Mulder, R. (2015). Treatment of Personality disorder. *The Lancet (385),* pp. 735-743.

Bornovalova, M.A., Lejuez, C.W., Daughters, S.B., Rosenthal, M.Z., & Lynch,T.R. (2005). Impulsivity as a common process across borderline personality and substance use disorders. *Clinical Psychology Review (25),* pp-790-812.

Borschmann, R., Henderson, C., Hogg, J. Philips, R., & Moran, P. (2012). Crisis interventions for people with borderline personality disorder (review). *Cochrane Database of Systematic Reviews* (6), pp. 1-23.

Bowden-Jones, O., Iqbal, M.Z., Tyrer, P., Seivewright, N., Cooper, S., Judd, A., & Weaver, T. (2004). Prevalence of personality disorder in alcohol and drug services and associated comorbidity. *Addiction (99),* pp*.* 1306-1314.

Care Act 2014

Care and Support Statutory Guidance. (2016). Department of Health.

Coid, E., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry,* 188, pp. 423-431.

ECINS. The 'Complete' Neighbourhood Management Solution.

Five Year Forward Review. (2014). NHS England.

Glenn, C.R., & Klonsky, E.D. (2009). Emotion Dysregulation as a core feature of Borderline Personality Disorder. *Journal of Personality Disorders 23(1),* pp. 20-28.

Holmes, M., & Ward, M. (2014). Alcohol Concern's Blue Light Project – Working with Change Resistant Drinkers.

Integrated Personal Commissioning. Emerging Framework. (2016). NHS England Publications.

Kessler, R.C. (2004). The Epidemiology of Dual Diagnosis. *Biol Psychology (56),* pp. 730-737.

Lieb, K., Zanarini, M.C., Schmahl, C., Linehan, M.M., & Bahus, M. (2004). Borderline Personality Disorder. *The Lancet (364),* pp. 453-461.

Livesley, W.J. (2012). Integrated Treatment: A Conceptual Framework for an Evidence-Based Approach to the Treatment Of Personality Disorder. *Journal of Personality Disorders, 26(1),* pp.17-42.

Mental Capacity Act 2005, Code of Practice.

Mental Health Act 1983 & 2007 and Code of Practice

Morris, K., Brandon, M., & Tudor, P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice. BASPCAN ISBN 13 978 085358 287 8

NICE guidance https://www.nice.org.uk/guidance/cg78

No Secrets-2000, revised 2009

Note for Adult Safeguarding Boards on the Mental Health Crisis Concordat. Directors of ADASS, adult social services. 2015

Pickard, H. (2015). Choice, deliberation, violence: Mental capacity and criminal responsibility in personality disorder. *International journal of law and psychiatry*, *40*, 15-24.

Recognising Complexity: Commissioners Guidance for Personality Disorder Services (Department of Health 2009)

SCIE report 46: Self Neglect and Adult Safeguarding: Findings from research

Sethi, A., & Mitchell, M. (2016). London's compulsory sobriety pilot. MOPAC.

Statement of Government Policy on Adult Safeguarding. (2013). Department of Health.

The Role of Public Health in the Prevention of Violence. (2016). A statement from the UK faculty of Public Health.

Tragesser, S.L., Sher, K.J., Trull, T.J., & Park, A. (2007). Personality Disorder Symptoms, Drinking Motives, and Alcohol Use and Consequences. *Exp Clin Psychopharmacol, 15(3),* pp. 282-292.

Trull, T.J., Sher, K.J., Minks-Brown, C., Durbin, J., & Burr, R. (2000). Borderline Personality Disorder and Substance Use Disorders: A review and Integration. Clinical Psychology Review, 2(20), pp.235-253.

Tyrer, P., Reed, G.M., & Crawford, M. (2015). Classification, assessment, prevalence, and effect of personality disorder. *The Lancet,* (385) pp.717-725.