KENT & MEDWAY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Mary Smith

Overview Report

Author: Paul Pearce

Commissioned by: KMSAB Safeguarding Adults Review Panel

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KMSAB Safeguarding Adults Review Panel

Overview Report

1. Introduction

1.1 This Safeguarding Adults Review (SAR) was commissioned by the Kent & Medway Safeguarding Adults Board (KMSAB) following the death on 3 April 2014 of Mary Smith, a woman aged 43 years, in Town A, Kent. It considers the contact and involvement that Mary had with statutory agencies in the years leading up to her death.

1.2 The key purpose for undertaking this SAR is to enable lessons to be learned. In order for this to happen as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 This report is an anthology of information and facts gathered from agencies that had involvement with Mary between 1 January 2009 and the date of her death.

1.4 Seven agencies have records of contact with Mary during that period:

- Kent Police
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- Kent County Council Older People & Physical Disability Division (OPPD)
- NHS England (Kent & Medway Area Team)
- Dartford and Gravesham NHS Trust (DGT)
- Kings College Hospital NHS Foundation Trust (KCH)
- South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

1.5 Each of these agencies, with the exception of SECAmb was required to provide an Independent Management Review (IMR) detailing their involvement with members of the Family. SECAmb was required to produce a free text report.

2. The Review Process

2.1 Safeguarding Adults Review Panel

2.1.1 The members of the SAR Panel were:

Paul Pearce	Independent Chairman
Kate Bushell	NHS Dartford & Gravesham CCG
Nick Sherlock	KCC OPPD
Tim Smith	Kent Police
Katherine Stephens	Interim KMSAB Board Manager
Cecelia Wigley	KMPT
Sallyann Baxter	Medway Council

2.1.2 The Independent Chairman of the SAR Panel is a retired senior Police Officer. He did not serve with Kent Police and has no association with any of the agencies represented on it. He has experience and knowledge of safeguarding issues and legislation, and a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to safeguarding. He has a background in conducting reviews and investigations, including those involving disciplinary matters.

2.2 Review Meetings

2.2.1 The SAR Panel first met on 22 September 2014 to discuss the terms of reference, which were then agreed by correspondence. A briefing was held for IMR writers on 2 October and the SAR Panel then reconvened on 17 February 2015 to consider the IMRs. Its next meeting was on 27 April 2015 when this Overview Report was considered in draft form. Amendments were agreed by correspondence and the Report was then submitted to KMSAB.

2.2.2 The Terms of Reference of this SAR are at **Appendix A**

2.3 Family & Friends Involvement

2.3.1 The Review Panel considered which family members and friends should be consulted and involved in the review process. The following have been contacted:

Name	Relationship
Maria Smith	Mother

Rose Smith	Sister
David Smith	Brother
Stephen Price	Neighbour

2.3.2 The initial contact was by way of letters of introduction sent on 18 December 2014. As a result of responses received, the Independent Chairman has spoken to one person by telephone and has had a meeting with another. The information they provided has been very helpful to the review and where appropriate it has been included in this report, but not attributed.

2.3.3 Following the drafting of this report, further contact was made with family members to meet with the Independent Chairman to discuss its findings.

3. Background

3.1 Events Surrounding the Death of Mary

3.1.1 About midday on Thursday, 3 April 2014, a neighbour of Mary's called SECAmb and told the call taker that he had found her in her flat: she was unresponsive with no signs of life. He was unable to confirm whether she was breathing.

3.1.2 The ambulance crew that attended confirmed that there were no signs of life and that Mary was beyond medical help. Kent Police were notified and also attended.

3.2 Inquest

3.2.1 The inquest into the death of Mary was held on 11/12 February 2015 in Town A. HM Coroner for the area in which Mary lived recorded a verdict of Drug Related Death.

3.3 Living Arrangements

3.3.1 Mary lived at the same address in Town A for several years before her death and throughout the period covered by this review. Her home was a privately rented ground floor flat in a two-storey building that contained four flats, each of which had its own entrance door.

3.3.2 A number of agencies participating in this review refer to a man who lived opposite Mary as her boyfriend or partner. The consistency with which they do this suggests that either he or Mary, or both, referred to him as such when dealing with agencies. Her family state that he never lived with her and he was neither her boyfriend nor her partner. This man is referred to as SP in this report.

3.3.3 Her family said that Mary could be difficult to deal with at times because of her mental health problems but at other times she would be friendly and amenable. She did not always want to engage with agencies, even when they were trying to help her. In particular, she was worried about being admitted to hospital because she was concerned that there would be nobody to take care of her dog.

3.3.4 Her family say that she took a lot of prescribed medication and that she drank reasonably heavily, usually wine. They also say that Mary would often stay awake all night and sleep during the day.

3.3.5 Throughout the period covered by this review Mary was involved in a dispute with the tenant who lived in the flat directly above her. This is covered in more detail in the report.

3.4 Glossary

3.4.1 A glossary of acronyms and terms used in this report, which may be unfamiliar to those who are not safeguarding professionals, forms **Appendix B** to this report.

4. Agency Involvement

This section considers in detail the involvement that each agency had with Mary. Following an explanation of any relevant organisational context, a summary of their involvement with her is followed by an analysis and conclusions.

4.1 Kent Police

Context

4.1.1 Kent Police had more involvement with Mary than any other agency. During the period of this review they had contact with her in excess of 200 (two hundred) times.

4.1.2 In 2009, Kent Police operated Response Teams and Neighbourhood Policing Teams (NPT). The former provided a 24/7 response to emergency and other time critical calls, while the latter dealt with less urgent calls, follow-up visits and some minor crime.

4.1.3 In November 2011, the force was restructured and NPTs were replaced by Community Safety Teams (CST). These performed a similar role to NPTs, including dealing with ongoing cases of anti-social behaviour (ASB). Ongoing disputes between neighbours, such as one Mary was involved in, will often be classed as ASB.

4.1.4 Electronic files for ongoing ASB cases were created and updated on a computer system. At the start of the period covered by this review, the system in use was called the Joint Problem Solving (JPS) database. Towards the end of 2013 this was replaced by a new system called THEMIS. Files that were held on JPS were transferred to THEMIS and a file relating to Mary was available to the review.

4.1.5 The Kent Police computer system that manages calls made by people calling 999 or the non-emergency number, which is known as STORM, flagged Mary as a repeat victim. This triggered standard questions to be asked by the call taker, which assist in prioritising the police response. The ongoing problems that Mary had with the upstairs tenant, and the fact that he was subject to a restraining order, would also have been flagged.

4.1.6 Mary's case was one of many that Town A CST were working on during this period. Victims of ASB are assessed against the Association of Chief Police Officers (ACPO) ASB Risk Assessment Matrix as Standard, Medium or High risk, dependent on the answers they give to questions on the matrix. An

example of this matrix is **Appendix C**. At the time of her death Mary was one of five ASB victims in Town A who were graded as High risk.

4.1.7 Following Mary's death, Kent Police referred this case to the Independent Police Complaints Commission (IPCC). The IPCC responded to Kent Police, stating the investigation should be carried out by the force's Professional Standards Department (PSD). The PSD investigation concluded that there were no breaches of any code of conduct and no evidence of any criminal matters concerning Kent Police officers and staff.

Summary of Involvement

4.1.8 In 2009, Kent Police had involvement with Mary on two occasions. The first was in June when she reported being harassed by neighbours. As a result, two women were issued with written harassment warnings.

4.1.9 The second occasion was in December when she and SP were arrested for assaulting each other in what was described as a *'domestic incident'*. No further action was taken because neither wished to pursue the matter.

4.1.10 Between 2010 and 2014, Kent Police created at least 180 reports about incidents involving Mary. They also had an unknown number of unrecorded contacts with her.

4.1.11 In January 2010, Police Officers went to Mary's home following a call from an anonymous person who was concerned about her welfare. They could hear a dog in the flat but could not make contact with Mary. She had not been seen for some time, so the officers forced entry and found her in bed. She declined to engage with them and as they had no further concerns for her welfare, they left.

4.1.12 On 17 February, Mary called Kent Police late in the evening and said that she had been assaulted by a man, and that another man had exposed himself to her. SP confronted the two men and he too was assaulted. Both men were arrested and subsequently convicted of offences arising from this incident. One received a restraining order as part of his sentence. These two men were either staying at or visiting the flat above Mary's, although neither was the tenant.

4.1.13 During the remainder of 2010, Kent Police had involvement with Mary on at least 20 occasions, most of which were related to people in the upstairs flat.

4.1.14 On a number of occasions, suspects were arrested or issued with harassment warnings. On 19 October, the upstairs tenant was arrested for abusing Mary in a way that focused on her disability. She was a wheelchair user and

reported that she suffered from multiple sclerosis (MS). Following the man's arrest, he was charged with harassment. He was subsequently convicted at court and his sentence included a restraining order.

4.1.15 On 13 November, the man who had been arrested in February and given a restraining order was arrested for breaching it. Kent Police were then unable to contact Mary to take a statement from her so he was released without charge. The following day he and the upstairs tenant were arrested again for harassing Mary. On this occasion they were charged.

4.1.16 Mary next called Kent Police in April 2011, and during that year she made 10 calls that resulted in incident records being created. All related to the ongoing issues with the upstairs tenant and his associates.

4.1.17 During 2011, due to the difficulty of making contact with Mary, SP agreed to be a single point of contact for Kent Police if they wanted to speak to her. However, on occasions he was also reluctant to engage with them.

4.1.18 On one occasion, a Police Officer recognised that Mary was a vulnerable adult and suggested that an **Achieving Best Evidence (ABE)** interview was the appropriate way to record her evidence, rather than taking a statement from her.

4.1.19 On another occasion when dealing with harassment by the upstairs tenant it was recorded that his restraining order did not have a power of arrest attached.

4.1.20 In 2012, there were 29 calls from or relating to Mary that resulted in an incident record being created. 19 of these were about noise, disturbance or harassment by the upstairs tenant.

4.1.21 On 8 February, Mary reported that the upstairs tenant was in breach of his restraining order because he had verbally abused her on more than one occasion, again in a way that focused on her disability. A number of enquiries were made and a Police Officer tried to corroborate Mary's complaint by speaking to other residents who lived in the street. A number of them refused to support her allegations and said that she was a greater problem.

4.1.22 A further three calls made by Mary in February about noise and abusive language resulted in no further action, although a statement was taken from her on one occasion in an effort to support the prosecution of the upstairs tenant for breaching his restraining order.

4.1.23 On 31 March, Mary's mother, who lived in Ireland, contacted Kent Police after speaking to Mary by telephone and forming the opinion that she was going to

take her own life. Police officers went to Mary's flat and found her there with SP. She was intoxicated.

4.1.24 On 18 May, Mary reported that the upstairs tenant was shouting abuse about her disability through an open window in her flat. She was in the flat with SP at the time. As a result of this call, Police Officers attended but Mary denied them access to the flat; she spoke to them through an open window. A crime report was completed as a result of this incident, on which it was again stated that there was no power of arrest attached to the restraining order.

4.1.25 In the early hours of the following morning, Mary reported noise and fighting in the flat upstairs. Police officers attended on the first two occasions and they again spoke to her through an open window because she declined to let them into her flat.

4.1.26 On 27 June, Mary called Kent Police complaining about noise coming from the flat above all night and about the tenant and his friends being abusive to her. She said that she could not take it anymore and it was making her ill, adding that her life was becoming a misery and she just wanted peace and quiet. The upstairs tenant was spoken to and he entered into a Restorative Justice agreement to keep the peace and maintain a low level of noise.

4.1.27 An ASB risk assessment matrix was also completed with Mary for the first time. This was graded as Medium.

4.1.28 During July and August, Mary contacted Kent Police three times to give them information about what she believed was drug dealing in the flat upstairs. This included the fact that she had been offered cocaine by a man who had visited in a car, of which she gave the registration number. On one occasion Police Officers attended and she subsequently contacted Kent Police to thank the officers for the way they had dealt with the incident.

4.1.29 In September, she reported that the upstairs tenant was harassing her, pointing out that a restraining order had been issued in November 2010 prohibiting him from contacting her. She said that she suffered from MS and cancer, and that she used mobility aids such as a stick or a wheelchair. There was insufficient evidence to charge the upstairs tenant.

4.1.30 On 1 November, Kent Police received an anonymous telephone call in which the caller said they were concerned about Mary's welfare and that she may have been drugged and raped by a named man. She was spoken to in private and made no allegations against the man, although she did not trust him and was afraid of him. She said that she bruised easily and that sometimes when he left in the morning she had more bruises than the night

before. When asked how these were caused she was unable to say. Following this incident an adult protection referral was made to KMPT on 8 November.

4.1.31 On two occasions later in November Mary called Kent Police to thank them for their actions in response to her calls.

4.1.32 After Police Officers attended a call made by Mary in December, an adult protection referral was completed and sent to *'SSD'* on 19 December. Neither Kent Adult Services Older Persons and Physical Disability (OPPD) division nor KMPT have a record of this referral.

4.1.33 In 2013 Kent Police created 92 incident records relating to Mary, of which 60 related directly to issues with the upstairs tenant. This was a significant escalation in the volume and frequency of calls compared to previous years.

4.1.34 In January 2013, an email was received by Kent Police from a KCC Environmental Health Officer, in which he wrote that he had not received a reply to a letter he had sent to Mary a month previously.

4.1.35 In March, Mary called Kent Police about problems with the upstairs tenant. She said that she had contacted the Samaritans and that she felt like killing herself because the police were not helping her. Police officers forced an entry to her flat when she did not answer the door. They found her in bed and when she did not respond to them, and because there were lots of tablets and wine in the flat, they called for an ambulance.

4.1.36 On 27 and 30 March, she called Kent Police specifically to thank them for the way in which a call taker and Police Officers had responded to two incidents that she had reported.

4.1.37 On 30 March, a Police Community Support Officer (PCSO) made enquiries with the local authority regarding sheltered housing for Mary but was told that she did not qualify.

4.1.38 On 11 May, Kent Police recorded that they were setting up a *'professionals meeting'* to discuss Mary's case. A few days later a PCSO contacted the local authority, Mary's landlord and KMPT community and *'the health team'* about this.

4.1.39 On 2 June, a resident of the street in which Mary lived contacted Kent Police to complain about her and two men from the flat upstairs making a noise. Police officers attended and spoke to both parties.

4.1.40 On 5 June, Mary reported a domestic incident involving her and an ex-partner, who had shouted at her. Officers attended and dealt with this as a domestic abuse incident. Both were spoken to and given advice.

4.1.41 From the middle of June through to the end of July, many calls were made by Mary concerning noise and abuse from the upstairs tenant and one of his associates. During that period an officer took a statement from SP about the verbal abuse that Mary was being subjected to. There was insufficient evidence to proceed because SP and Mary changed their accounts.

4.1.42 Mary and SP were advised not to approach the occupants of the upstairs flat, to consider installing their own CCTV and to contact the local authority environmental health service about the noise nuisance. They were further advised to maintain an ASB diary and to consider mediation. On 30 July, a referral was made to KMPT by a Police Officer.

4.1.43 On 17 August, a Police Officer spoke to a letting agency about Mary moving but was told that she (Mary) was required to self-refer.

4.1.44 On 17 September, Police Officers went to Mary's home as a result of her complaining that the upstairs tenant was throwing stones at her window, and that he and another neighbour were abusing her. When spoken to, the other neighbour said that Mary had started the problem by shouting and swearing at the door of the upstairs tenant.

4.1.45 The following day, a man who lived with the tenant in the upstairs flat called Kent Police to report that Mary had knocked on the door and woken him at 5.30am, accusing him of playing music loudly. He said that she then hit him on his head, although he was uninjured. Mary also called Kent Police and made counter allegations of verbal abuse against those in the upstairs flat. A crime report was completed showing Mary as the offender but as the man did not wish to pursue the matter, this was filed.

4.1.46 During the rest of that month and into October, further calls were made by Mary about noise and abuse from those in the upstairs flat. Police officers attended on a number of occasions but did not find evidence that any offences had been committed.

4.1.47 On the late evening of 7 October and into the early hours of the following morning, Mary made a number of calls to Kent Police. In one, she said that she had previously written a suicide note. On the third call she did not answer the call taker when asked whether she had harmed herself. As a result, Police Officers went to her flat and forced entry. She was conscious and breathing but would not engage with the officers. An ambulance was called

and she was taken to hospital. Following this incident Mary's ASB risk assessment was graded as High.

4.1.48 On 11 October, a PCSO who had visited Mary's home three days earlier raised concerns about the state of it. She said that there was *'medication lying around everywhere'* and that the condition of the flat had deteriorated since her previous visit.

4.1.49 On 18 October, Mary's case was reviewed by Town A CST. Options considered included delivering a letter to all the residents in her street asking if they had ASB concerns about Mary, and liaison with KMPT. A further discussion took place about a *'professionals meeting'* to share police information about the impact Mary was having locally. The need for a mediation update and liaison with her landlord was recorded. Consideration was being given to an overt CCTV camera being installed, but Kent Police did not have that facility.

4.1.50 On 8 November, a Police Officer spoke to a KMPT Social Worker, who said he was happy to engage further but felt that there was insufficient evidence to support an application for a warrant under S.135 of the Mental Health Act 1983. The Police Officer had previously spoken to the KMPT Crisis Resolution & Home Treatment Team (CRHTT) and asked for Mary's mental health to be assessed at A&E.

4.1.51 On 24 November, Mary complained to Kent Police about their response and said that they were fobbing her off. A further ASB risk assessment was carried out and this was graded High.

4.1.52 On 3 December, a PCSO spoke to Mary to offer her reassurance and described her as being in good spirits. However, she was increasingly *'disappointed/disillusioned'* with Kent Police, who were not doing enough to support her.

4.1.53 Kent Police received further calls in early November, including one from a resident of the street reporting that Mary was sitting on the wall at the front of her flat at 9.30pm. She was drinking with another woman and Mary's dog was loose in the street.

4.1.54 On 12 December, a Kent Police call taker, who was taking a report from Mary about neighbour problems, called SECAmb because it appeared that she was struggling for breath. An ambulance and Police Officers attended but Mary refused to go to hospital, against the advice of the ambulance service.

4.1.55 As a result of an incident reported by Mary, a crime report was created, in which the upstairs tenant was recorded as the offender for breaching his restraining order. He denied this and no witnesses were found. Mary could not be contacted by the police and the crime report was filed in February 2014 because there was insufficient evidence to proceed.

4.1.56 Further calls were received from Mary through December and into January 2014. Police officers attended on most occasions but there were no offences disclosed.

4.1.57 On 8 January, the upstairs tenant complained that Mary had been to his flat and slapped his face. Police officers went to Mary's flat on 17 January, intending to arrest her for common assault. When they tried to gain entry to her flat, she held a knife against her wrist and then to her throat. A police negotiator was called and eventually Mary was arrested.

4.1.58 She was taken to a police station where she was assessed by a Community Psychiatric Nurse. She was then charged with common assault and bailed to appear at North Kent Magistrates Court on 20 February 2014.

4.1.59 On 20 January, a police inspector *'mentioned that this may be a good time for an agency/charity to try and engage with [Mary].'* A telephone call was made to the KMPT who were fully updated. A Police Officer spoke to Mary's landlord and he said that she had not opened the door to him in the last 10 years. Kent Police offered to carry out a joint visit with him to Mary's flat; his response is not recorded and there is no record that such a visit took place.

4.1.60 On 23 January, a Police Officer received a telephone call from NHS Talking Therapies who said that they were unable to help Mary because she was not engaging with them.

4.1.61 Mary continued to report abuse and harassment by the upstairs tenant and at the end of January a crime report was generated about him breaching his restraining order. This was filed on 9 February with a previous similar report because Mary would not engage with the police. The same day another crime report for common assault was created in which Mary was the victim and the upstairs tenant was the suspect. This was filed the following day because a statement taken from a witness supported the upstairs tenant's account.

4.1.62 On 11 February, a further crime report was created for breach of restraining order by the upstairs tenant. When he was interviewed under caution he denied the offence and because there was no witness evidence or other corroboration, no further action was taken.

4.1.63 On 17 February, a *'professionals meeting'* was held at North Kent Police Station. KMPT and OPPD attended and stated they would be happy to assist if Mary was willing to engage. They also indicated that *'they would support action against her re wasting police time.'* From the minutes recorded on THEMIS, actions from this meeting were to:

1. *Contact GP about medication review and disclosure about [Mary's] engagement with them and her medical condition.*
2. *Contact Environmental Health and Kent Fire & Rescue Service about attending the address to assess safety regarding her hoarding.*
3. *Contact the duty [OPPD] Assessment and Engagement team for a visit to be made to Mary to assess her.*

4.1.64 A THEMIS record dated 19 February states that *'[Mary] often by her own admission confronts her neighbour as he leaves his address, which often negates her injunction against [him]. Environmental Health are looking into issues concerns originally noise etc. more recently concerned about the state of her address. KFRS also concerns re [safety] of home.'*

4.1.65 It goes on to say *'Multi-agency meeting to be called with KFRS, police, landlord and local council private landlord officer and any charities or help groups may provide assistance with those who are orders. Discuss with landlord re-'gift' CCTV camera to him for his property.'* Mary was retained as a High risk ASB subject.

4.1.66 On 20 February, Mary appeared at North Kent Magistrates Court charged with common assault. She was further bailed to 27 August 2014.

4.1.67 Further calls were received from Mary during February and into March about problems with the upstairs tenant. This resulted in him being interviewed under caution again, and he denied being in breach of his restraining order. This case was not pursued because of Mary's death.

4.1.68 On 14 March, a weekly review of Mary's ASB case recommended a multiagency meeting, consideration of an Acceptable Behaviour Agreement between Mary and the upstairs tenant and speaking to the landlord about providing him with a *'gift'* CCTV camera that might assist with evidence capture.

4.1.69 On 16 March, Mary called complaining about the lack of police action and a further dispute with the upstairs tenant. On 27 and 28 March, a PCSO went to Mary's house for welfare checks but got no reply. The PCSO spoke to the upstairs tenant who said that Mary was in hospital and when she spoke to SP he confirmed this.

4.1.70 On 31 March, Kent Police had their last contact with Mary before she died. She said that she had been the victim of an assault by the upstairs tenant, and the police and ambulance attended. The bruising which she had described in her call was not visible and she had no other injuries. She said that she had been intending to take an overdose when the incident occurred. When Mary was describing this there were inconsistencies and contradictions, and the officers decided that no assault had taken place. Referrals were submitted to OPPD and KMPT as a result of this call.

4.1.71 At 12.15pm on 3 April 2014, Police Officers went to Mary's flat where she had been found dead.

Analysis of Involvement

4.1.72 In 2009 and 2010, Mary was the victim of harassment by the upstairs tenant and his associates. This resulted in two men, including the tenant, receiving a restraining order. The actions taken by Police Officers during those years, when Mary was the victim, were positive.

4.1.73 The other man who had been given a restraining order was arrested shortly after he received it and was charged with breaching it. Despite many calls by Mary to Kent Police during the next four years in which she complained about the actions and behaviours of the upstairs tenant, it was not until February 2014 that he was arrested for breaching his restraining order.

4.1.74 The allegations Mary made against the upstairs tenant after he received a restraining order were of the same nature as those she made before. It is therefore likely that there were grounds for arresting him for breaching it on at least some of the occasions before this was done in February 2014. However, Police Officers lacked an understanding of the power of arrest for breaching a restraining order.

4.1.75 It seems that some, if not all, of the officers dealing with the ongoing problems experienced by Mary believed that a restraining order must contain an explicit power of arrest. This is wrong; breaching any restraining order is a criminal offence under S.5 of The Protection from Harassment Act 1997 and the power of arrest for a breach derives from Code G of the Police and Criminal Evidence Act 2004. In short, the officers believed that they had no power to arrest the upstairs tenant for breaching his restraining order, when in fact they did.

4.1.76 Many of the officers who dealt with these issues would have been on the Response Team but this was an ongoing problem that was also the subject of work by the Town A NPT/CST. The latter were responsible for dealing with

the type of problems that frequently result in the imposition of a restraining order, such as neighbour disputes and cases of domestic abuse.

4.1.77 Supervisory officers were involved in Mary's case, which makes this lack of knowledge all the more concerning and there is a need for Kent Police to address this. It is not an issue that needs in-depth training; a reminder needs to be circulated to every officer and staff member who is likely to deal with the person who is the subject of a restraining order.

4.1.78 Kent Police must ensure that their officers and staff understand the power of arrest for breaching a restraining order. **(Recommendation 1)**

4.1.79 During 2010, there were numerous examples of positive action taken by Kent Police. These included a referral to the *'Noise Liaison Officer'* (many of Mary's complaints were noise related) and warnings given to a couple who lived in the same street who had been abusive to Mary and SP following an incident involving Mary's dog.

4.1.80 10 calls were made to Kent Police during 2011, which is a relatively small number in the context of ongoing long-term disputes. Following one incident, there was recognition by a Police Officer that Mary was a vulnerable person, as a result of which he suggested that an Achieving Best Evidence (ABE) interview be conducted. This is recognised as good practice.

4.1.81 In September 2011, the Kent Police Hate Crime Officer for North Kent had been attempting to contact Mary without success. This suggests that she was recognised as a hate crime victim, probably because of her physical disability. Several messages were left with SP, who was referred to as a single point of contact (SPOC), who Kent Police would call when they wanted to speak to Mary.

4.1.82 The use of a SPOC, who could be a family member, friend or professional advocate, can be an effective way for agencies to make contact with a vulnerable person who they are finding hard to reach. However, there is a need to ensure that the choice of SPOC is in the vulnerable person's best interest and that the SPOC is not pursuing their own agenda. There is no evidence that SP was doing this, but Kent Police do not seem to have had any more success in contacting Mary by calling him. Nevertheless, it is an indication that they were making efforts to engage with her at this time.

4.1.83 In summary, at the end of 2011, there was an established ongoing neighbour dispute involving Mary. Apart from the power of arrest issue, Kent Police acted positively when attending incidents. However, there is little evidence

they were seeking to address the causes of the problem rather than responding to individual incidents, and this was to continue.

4.1.84 During early 2012, the pattern of complaints by Mary about the upstairs tenant continued and Police Officers attended these and dealt with them on the basis of the evidence they were presented with. In June, the upstairs tenant signed an agreement as part of a Restorative Justice process, in which he promised to keep the peace and maintain a low level of noise. Mary also engaged in this process and signed the agreement, which was the first substantive attempt by Kent Police to use a problem-solving approach. Restorative Justice usually refers to the resolution of low-level crime by the offender making reparation to the victim. Obtaining a commitment to follow a course of action in future was an innovative interpretation of the process.

4.1.85 It was while dealing with this incident that Kent Police completed the ASB risk assessment matrix with Mary for the first time. She was graded as Medium risk. The risk can relate to a person either as an ASB victim or perpetrator. In neighbour disputes, it is not unusual for a person to be both.

4.1.86 Mary contacted Kent Police in August 2012 to compliment officers for the way they had listened to her reports of drug dealing in the upstairs flat, which indicates they had a degree of empathy with her. She made further complimentary calls in September and October about other action taken by officers.

4.1.87 The anonymous information that Mary had been raped and drugged by SP was investigated and when she was spoken to in private she made no allegations against him. Had she indicated that there was some substance to the report, it would have been appropriate to interview her by way of ABE. After dealing with Mary, Kent Police made a referral to KMPT, which was a good acknowledgement of her vulnerability and potential mental health problems.

4.1.88 In December, Mary told police that she was suffering from cancer and MS, and that she was seeking treatment and taking medication for these conditions. The police also thought that she had an alcohol problem, combined with the medication that she was taking. There is no evidence that consideration was given to sharing this concern with any other agencies, particularly her GP practice.

4.1.89 Following this interaction an entry was made on THEMIS that *'[Mary] refuses to engage with police and will make allegations about patrols that have let her down. Patrols should make every effort to attend double crewed as a result of*

this.' This seems a rather defensive response and an indication that Police Officers were beginning to regard Mary as a problem rather than a victim.

4.1.90 In summary, to the end of 2012, Mary was still making calls and reporting the same issues with the upstairs tenant. The fact that an ASB risk assessment had been completed indicates that the situation that she was involved in was increasing in profile.

4.1.91 In 2013, the number of interactions that Kent Police had with Mary escalated significantly. As before, most of these centred on the dispute with the upstairs tenant. In the first three months of that year the response was generally to continue dealing with incidents on an individual basis but a PCSO did make enquiries with the local authority about sheltered housing, which was an indication that her vulnerability was recognised.

4.1.92 In April, Mary told a Kent Police call taker that she had experienced problems with her neighbour for over four years and said that the only option was to *'top herself'*. The call taker referred the call to her team leader and when Mary was spoken to she said that she was not suicidal and did not want Police Officers to attend her address. Police officers were deployed and although the nature of her call might have prompted further adult protection referral, this was not done.

4.1.93 In May, the CST were considering setting up a professionals meeting and a PCSO contacted the Borough Council, Mary's Landlord and DGS CMHT about this. However, it was to be another nine months before this meeting was held.

4.1.94 PCSOs are routinely deployed by police forces to work on ongoing ASB problems such as neighbour disputes. This is appropriate when there is no requirement for the powers of a Police Officer. However, trying to bring agencies together to consider a joint approach to problems about which they may have no previous involvement is not an easy task. It is something that is likely to require liaison between agencies at a relatively senior local level. In this case there does not appear to have been any supervisory input into trying to arrange the meeting.

4.1.95 Although highlighted in this section, there is a theme in this SAR about the need for agencies to ensure that multi-agency working is well established at practitioner level. Agencies that are the subject of this SAR must ensure that their processes for engaging with partner agencies at practitioner level are robust enough to ensure that meaningful outcomes can be achieved. **(Recommendation 2)**

4.1.96 In July, following an incident when Mary posted a letter through the door of the upstairs flat, the comment in the Kent Police incident log that *'[named Police Officer] is building a case against [Mary]'* was a clear indication that she was now being viewed as a potential offender rather than as a victim. The proactive use of the criminal justice system as the primary means of dealing with a vulnerable disabled person is not good practice.

4.1.97 However, at the end of July a Police Officer made a referral to KMPT, which indicates a recognition of a more appropriate approach. In August, another Police Officer spoke to a letting agency about assisting Mary to move. Assuming that it was driven by the officer, it was another good example of individual officers thinking about options for resolving her situation.

4.1.98 When Mary called Kent Police on 7 October, the decision to deploy Police Officers when she did not specifically request attendance was good, as was the decision of the officers to force entry to her flat to check on her welfare and then to call an ambulance.

4.1.99 It was following this incident that Mary's ASB risk assessment was graded as High. It appears that from then on there was more attention focused on trying to address the long term issue and more engagement by the CST. This was positive but should have begun sooner.

4.1.100 In the case of ongoing problems that are open on THEMIS and being managed by the CST, it is usual to have regular reviews. A review was held in October and a number of actions were considered. The need for a professionals meeting was discussed again, five months after it had previously been raised, but it would still not be held for a further four months.

4.1.101 A welfare visit to Mary in early December by a PCSO was positive and indicated that with an appropriate approach she would engage with them. However, her focus was on her increasing disappointment with Kent Police, who she felt were not doing enough to support her. She repeated this when speaking to a Police Officer on the telephone three days later.

4.1.102 Police officers found Mary hard to reach when they were attempting to substantiate complaints that she made about criminal offences. Her family have said that she was often reluctant to engage with agencies and at times she could be challenging. Police officers recorded on a number of occasions that the reason they could not pursue prosecutions was because they could not make contact with Mary to take a statement from her. There is no evidence that they considered whether any other organisations could help to facilitate this, for example voluntary agencies who specialise in

communicating with people with mental health conditions or those who support people with physical disabilities.

4.1.103 When experiencing difficulties engaging with people with disabilities, Kent Police should consider contacting other agencies with relevant knowledge and experience. **(Recommendation 3)**

4.1.104 The joint visit to Mary's flat by a Police Officer and a Social Worker in December showed Kent Police engaging with OPPD. However, it was initiated by OPPD and given the length of time that Kent Police had been involved with Mary compared to SECAmb (who made the referral to OPPD that resulted in this visit), it highlights the lack of multi-agency engagement initiated by Kent Police.

4.1.105 The start of January 2014 saw the continued pattern of calls to neighbour disputes. Mary was arrested on 8 January and charged with assaulting the upstairs tenant. She was charged and bailed to court, and was still on bail at the time of her death.

4.1.106 The call from NHS Talking Therapies received by a Police Officer on 23 January suggests that there was work being undertaken to try and think of more imaginative ways to resolve the issue.

4.1.107 In late January and early February, the frequency of calls made by Mary escalated. On 9 February the upstairs tenant was arrested for assaulting her and, for breaching his restraining order. This was the first time in over three years that he had been arrested for the latter, although the complaints Mary made on this occasion were very similar to those she had made many times before.

4.1.108 A CST review recorded on THEMIS on 14 February provides an indication of Kent Police's approach to Mary at that time. The third of six actions listed was to *'continue to identify if Mary's allegations are malicious'* and the fourth action is to *'consider the work required to prove an ASBO' or [a] charge of wasting police time.'* There is no reference to Mary as a victim. The fact that she *'presented as a vulnerable person with possible mental issues'* was referred to as a factor that would make an ASBO application difficult, rather than one that suggested a recognition that she needed additional support.

4.1.109 It seems that Kent Police had now moved away from treating Mary as a vulnerable adult who needed help towards an approach focused on dealing with her through the criminal justice system.

4.1.110 The professionals meeting that had been discussed previously was held on 17 February. OPPD and KMPT attended; both agencies indicated they would be willing to engage with the police in working to resolve Mary's problems. However, it was also recorded that *'[OPPD and KMPT] also stated that they would support police action against [Mary] re wasting police time etc.'*

4.1.111 The representation by Kent Police at this meeting was a police constable. By this time Mary had been classified as High risk on the ASB matrix for five months and incidents involving her were consuming an inordinate amount of police time. It is questionable whether this level of representation was appropriate when dealing with the problem. Three specific actions arising from this meeting were recorded on THEMIS. There is no record that any of them were progressed nor that other agencies attending received minutes of the meeting.

4.1.112 Kent Police must ensure that when they initiate multi-agency meetings, representatives attending have authority to commit the resources necessary to achieve the aims of the meeting. Furthermore, they must ensure that the aims of the meeting are made clear when invitations are sent so that other agencies send representatives with an appropriate level of authority. **(Recommendation 4)**

4.1.113 There was a subsequent entry made on THEMIS that Mary's landlord had been spoken to. Kent Fire & Rescue Service had been asked if they could assist, probably due to concerns about the fire risk caused by Mary's tendency to hoard.

4.1.114 In March, Kent Police were told that Mary was in hospital but there is no evidence that they made any contact with the hospital or her GP practice. This was a missed opportunity to gain an insight into any medical or mental health issues that might better inform the way in which they interacted with her.

4.1.115 Mary's final call to Kent Police was on 31 March when she reported being the victim of an assault. Following that call, it was positive that referrals were submitted to KMPT and OPPD. At Mary's inquest HM Coroner specifically mentioned that Kent Police dealt well with this incident.

Conclusions

4.1.116 In analysing the way in which Kent Police dealt with Mary in the last five years of her life, a number of examples of good work by individual officers and staff have been highlighted.

4.1.117 The issue of officers not understanding the power of arrest associated with the breach of restraining order is the subject of a recommendation.

4.1.118 There are two significant concerns about the way Kent Police dealt with Mary. The first is the length of time that it took them to begin treating the issues surrounding her as an ongoing set of circumstances rather than as a series of unconnected incidents. The second is that having done so, they lost sight of the fact that she was a vulnerable person and concentrated subsequently on trying to criminalise her.

4.1.119 The change in approach and attitude was most marked from October 2013, when Mary was graded as a High risk ASB subject. Until 2013, the nature and frequency of calls from or about her were not exceptional and each would have been dealt with on its merit. Whether the sharp increase in frequency from early 2013 was due to Mary being victimised more often, her becoming less tolerant of her situation or her mental health condition deteriorating is unclear.

4.1.120 Whatever the reason, the demand being placed on Kent Police to continually attend incidents at her address became such that it must have come to the notice of senior officers responsible for policing Town A. However, there is no evidence that it led to a coordinated effort to find out the cause of the situation and to seek to resolve it.

4.1.121 The most positive view of the focus on getting Mary into the criminal justice system in the last few months of her life is that it was an attempt to get her access to mental health services that she would not otherwise have got. Even if that was the case, it was the wrong approach.

4.1.122 Kent Police are obliged to investigate criminal offences and pursue offenders, regardless of who they are. However, when dealing with a vulnerable person, it is not appropriate to seek to criminalise that person's behaviour as a primary means of resolving a situation.

4.1.123 Kent Police must ensure that its officers and staff deal sensitively with vulnerable people, engaging with other agencies when appropriate, and do not seek to criminalise their behaviour as a primary means of resolving a situation. **(Recommendation 5)**

4.1.124 There is a lack of evidence of the leadership required to resolve an ongoing situation of this nature by working in partnership with other agencies who have the experience and skills to engage vulnerable disabled people.

4.1.125 Mary was one of five High risk ASB victims in Town A during the period from October 2013 to her death. The efforts to resolve the issues that were affecting her were not commensurate with that risk nor were they appropriate when dealing with a vulnerable disabled person.

4.2 Kent & Medway NHS and Social Care Partnership Trust (KMPT)

Context

4.2.1 During the period covered by this review (and currently), KMPT provided mental health services to people aged over 14 living in Kent. Most of those services were provided through Community Mental Health Teams (CHMT), outpatient clinics and inpatient units. These are generally split into services for working age adults and services for older people.

4.2.2 Mary's contact with KMPT was through the Dartford, Gravesham & Swanley (DGS) CHMT covering Town A. This CMHT initially had separate Access and Recovery teams, each of which was managed by a Service Manager. Following a restructure that began in late 2012, the two teams were amalgamated under one Service Manager.

4.2.3 Within DGS CMHT there are Social Workers, Community Mental Health Nurses, Support Time & Recovery Workers, Clinical Psychologists, Medical Staff and Administrative Staff.

4.2.4 DGS CMHT had staffing issues during the period covered by this review. By the end of 2011 there was a high rate of staff absence due to sickness, maternity leave and vacancies. The restructure in late 2012 was in part focused on the high number of serious patient safety incidents that happened in the area covered by the CMHT.

4.2.5 At the time this report was written there were a significant number of Social Worker vacancies and although a recruitment process was run, it was unsuccessful in filling these.

4.2.6 DGS CMHT provides safeguarding training for its staff. Overall, 77% of staff had received the appropriate level of training when the records were examined for this review. This is below the 85% required for a 'Green' rating on the NHS performance framework.

Summary of Involvement

4.2.7 The first contact that KMPT had with Mary during the period covered by the review began with a telephone call taken by a Social Worker (SW1) on 30 December 2009 from one of Mary's sisters. She was concerned about Mary's

mental state and reported that Mary had held a knife to her mother's throat while her mother was asleep and said *'Wouldn't it be easy to kill you as you lay asleep?'* Her sister also told SW1 that Mary was *'mixed up with'* with a man who spent time looking at pictures of young children on the Internet.

4.2.8 As a result of this telephone call and following instructions from a KMPT Doctor, SW1 telephoned Mary's GP surgery to ask for information about her. A receptionist said that the GP would return SW1's call but he did not. There is no record that KMPT confirmed the request in writing or followed up the call.

4.2.9 The following day, 31 December, SW1 called Mary's home telephone and left a message asking her to return the call.

4.2.10 On 4 January 2010, a Community Psychiatric Nurse (CPN1) took a telephone call from Mary's mother, who said she was worried about Mary's mental health. It was agreed that a letter would be sent to Mary inviting her to contact DGS CMHT if she felt she needed assistance.

4.2.11 Mary did not return the call made on 31 December, and on 20 January 2010 another KMPT Social Worker (SW2) made a further telephone call and left a message for her. On the same day, a letter was sent to Mary by SW2 asking her to make contact with the duty team and explaining that attempts had been made to contact her by telephone.

4.2.12 On 5 February a mental health needs assessment was completed by a KMPT Community Psychiatric Nurse (CPN2) using Mary's name and date of birth. This contained information that she was three months pregnant and it was clear that the assessment had been carried out following a meeting with the person to whom it related. As there is no record of any KMPT contact with Mary since the call from her sister and no subsequent information about pregnancy, it appears that this assessment did not relate to Mary and was entered in error in her record.

4.2.13 On 9 February, a Triage Team meeting was held to discuss Mary's referral following the telephone call from her sister. There is no record of the outcome of this meeting.

4.2.14 On 16 February, a telephone call was made to Mary but it was not answered. On the same day a letter was sent to her by a Social Worker (SW3) offering her the opportunity of a home assessment. Mary must have responded to this because the assessment was arranged for 26 February.

4.2.15 The home assessment did not go ahead as planned due to staff sickness and following two telephone calls made to Mary, which were unanswered, a letter was sent to rearrange the appointment for 12 March. SW3 visited Mary that day but she would not open the door. A conversation took place through a closed window, during which Mary said she had not received the appointment letter. She did not want to be seen that day and agreed that SW3 would make another appointment.

4.2.16 A further letter was sent to Mary advising her that the home assessment had been rearranged for 14 April. On that day a message was left for SW3 by SP advising that Mary was unable to keep the appointment that day. It is recorded that SP was Mary's partner. When SW3 tried to contact him on his mobile that day, there was no reply.

4.2.17 Two further telephone calls were made to Mary and two letters were sent to her, both of which explained that due to her not making contact she would be discharged by KMPT. The second letter was copied to a GP at Mary's surgery. A further letter was sent to the GP when she was discharged on 13 May.

4.2.18 Mary's second contact with KMPT began on 8 November 2012 when DGS CMHT received a fax from a Kent Police officer based in the Central Referral Unit (CRU). This said that an anonymous telephone call had been received there expressing concern about Mary. The caller said that Mary may have been raped and drugged by SP.

4.2.19 Following this referral a member of KMPT staff, described as a student Social Worker, made two telephone calls to Mary's home; the first on 14 November, the second the following day. The first was unanswered but SP answered the second. He said that Mary would not be awake before 5pm; he was not given any further details.

4.2.20 On 19 November, Mary was sent an opt-in letter in which she was told that if she did not contact the team by 26 November it would be assumed that she did not want the service. A copy of this letter was sent to her GP practice.

4.2.21 On 18 December, a letter was sent by a KMPT Senior Practitioner to a named doctor at Mary's GP practice discharging her back to his care. Mary was sent a copy of this letter.

4.2.22 Mary's third contact with KMPT began on 6 August 2013 and this again resulted from a fax from Kent Police staff in the CRU. A Police Officer working in Town A (PO1) had contacted the CRU to say that she was dealing with an ongoing neighbour dispute involving Mary, who was the *'alleged*

victim' and that Mary was repeatedly calling her, including at unsocial hours. She went on to describe the inconsistency in Mary's moods and concluded by saying *'Her behaviour is very disconcerting from a human and professional point of view.'*

4.2.23 This referral was discussed the following day at a KMPT Multi-Disciplinary Team meeting and it was agreed that the Duty Officer would investigate further, as the referral contained no clear symptoms or risk concerns. A KMPT Social Worker (SW4) made contact with Mary's GP and found out that the GP had attempted a home visit in June 2013 but was unable to gain entry because the door was jammed. The GP did note some concerns about Mary's mental health but there was no record of a follow-up or a referral to KMPT. SW4 also attempted to contact PO1 and left a message asking for a return call.

4.2.24 On 12 August, at a Referrals Screening Meeting, a Community Psychiatric Nurse (CPN3) and a KMPT doctor discussed Mary's referral and made a decision that she should be discharged back to her GP practice with advice that re-referral could be made if the GP felt that she required secondary mental health care.

4.2.25 On 27 August, before the discharge was actioned, SW4 spoke to PO1, who provided additional information including the fact that Mary had been found wandering in the street in her underwear. It is unclear whether she had been found in this state by a Police Officer or if it had been reported to the police. If it was the former, the Police Officer could have considered detaining Mary under S.136 of the Mental Health Act 1983.

4.2.26 It was agreed that SW4 and PO1 would make a joint cold call visit to Mary at home later that day. PO1 later cancelled her attendance but SW4 went to Mary's home as planned. There was no answer but there appeared to be a radio playing in the background. SW4 made a note to contact PO1 to rearrange the visit when he (SW4) returned from leave. There is no record that this contact was made.

4.2.27 On 8 November another Police Officer (PO2) contacted SW4 and reported that on 8 October Mary had gone to the Accident & Emergency department of an unspecified hospital due to deterioration in her physical health. PO2 had contacted the KMPT CRHTT to request an assessment of her at the hospital. This would have been undertaken by a member of the KMPT Mental Health Liaison Team at the hospital but it did not take place, either because the CRHTT did not pass the request on or because A&E staff did not request it. Mary went home following her discharge from A&E. SW4 recorded that he

and PO1 would undertake a cold call at Mary's home in an attempt to undertake an assessment.

4.2.28 When SW4 and PO1 made cold calls to Mary's flat on 2 January and 13 January 2014, there was no answer. Following the second occasion it was decided that the case would be closed because there were no further concerns identified by other agencies including the GP and the police.

4.2.29 On 20 January, before the case was closed, Mary was assessed by a Community Psychiatric Nurse (CPN4) working for KMPT Police Custody Court Liaison and Diversion Service (PCCLDS) at North Kent Police station where she had been taken following an arrest for assault.

4.2.30 The conclusion of CPN4's assessment was that there was *'No clear evidence of acute mental illness or incapacity to make decisions about her health, she may hold over-valued persecutory ideas about her neighbour however further assessment over time and further information from other sources (police, family, neighbours and other professionals) is required to fully ascertain Mary's mental state in any needs. She does not appear to present an immediate risk to herself or others.'* In short, she did not meet the criteria for a full mental health assessment. Had she done so, it would have been carried out by a psychiatrist and doctor while she was still in custody.

4.2.31 While Mary was in custody CPN4 spoke to SP. He confirmed that he had witnessed Mary being intimidated by her neighbour and the neighbour's lodger, and that this had been going on for about five years. Mary's account of the intimidation was not the result of mental illness. He added that he did not believe that she was at risk of harming herself or committing suicide or that she was a risk to others. SP also said that he was happy to act as her next of kin as she had no family in the UK. This was not correct as she had two sisters and brother living in England.

4.2.32 The decision from the meeting was that the PCCLDS would contact SW4 to discuss assessment and referral to CMHT. This was done on 22 January, and at a new referrals meeting it was agreed that Mary would be offered an assessment.

4.2.33 On 17 February, CPN4 attended a multi-agency professionals meeting called by Kent Police. One of the decisions taken was that KMPT would close Mary's case. The rationale for this decision was not recorded.

4.2.34 A telephone referral to CRHTT was made about Mary on 31 March by a Police Officer, who had been to her flat following a report that she had been assaulted. SECAmb were also present and as there was a suggestion that

Mary had taken an overdose, CRHTT advised the officer that she should be taken to hospital where she could be seen by the mental health liaison service if there were concerns about her mental health.

4.2.35 On 3 April, CPN2 was informed by Kent Police that Mary had been found dead in her flat earlier that day.

Analysis of Involvement

4.2.36 The first referral to KMPT about Mary during the period covered by this review was made by her sister in late December 2009. The case was closed five months later without any assessment being made of Mary's mental health.

4.2.37 KMPT staff did make efforts to contact Mary by telephone and letter, and on one occasion she was spoken to through a window at her flat when she refused to let the Social Worker in. After her repeated failure to attend appointments she was discharged to her GP practice.

4.2.38 A few days after Mary's sister's referral to KMPT, her mother called and spoke to a CPN. The CPN's response was that a letter would be sent inviting Mary to make contact with DGS CHMT. This suggests that at the time, the CPN did not realise that a referral was open. She may have found this out subsequently because there is no record of the letter being sent. Equally, there is no record of Mary's mother being contacted to find out if she could assist in getting KMPT access to her daughter.

4.2.39 During the period that this referral was open, an attempt was made to get information about Mary's medical history from her GP practice. This was not received and not followed up, which was a missed opportunity to more accurately assess how important it was to make contact with her.

4.2.40 KMPT must have a process that ensures requests for information are followed up if no reply is received. **(Recommendation 6)**

4.2.41 The Triage Team assessment of Mary's sister's call was made over five weeks later and the decisions arising from it were never recorded.

4.2.42 During the referral made by her sister, the information that Mary was involved with a man who looked at internet images of young children was not explored, but more significantly KMPT did not pass it to Kent Police. Sharing this information with the police would probably have resulted in KMPT getting more information about Mary, given how much police involvement there had been.

4.2.43 Where KMPT receive information that may indicate that serious criminal offences are being committed, it must be referred to Kent Police. **(Recommendation 7)**

4.2.44 The second referral to KMPT, made in November 2012, came from Kent Police. It was closed about six weeks later following telephone calls and letters that were unanswered. It is reasonable that KMPT and other NHS agencies have policies and procedures that are applied when contact cannot be made with service users. These usually specify the means and number of attempts that will be made before a person is discharged.

4.2.45 However, there is a concern that there is no record that the KMPT student Social Worker who made the contact attempts was supervised. In this case there does not appear to have been any attempt to contact Kent Police, the referring agency, to establish whether they could provide assistance in contacting Mary or whether they had any further relevant information to add to the initial referral. Supervision of the student Social Worker may have resulted in this action.

4.2.46 KMPT must ensure that they have a process in place to ensure that work done by student Social Workers is effectively supervised. **(Recommendation 8)**

4.2.47 The third referral, which was received by DGS CHMT on 6 August 2013, also came from Kent Police and six days later it was decided that Mary would be discharged back to her GP practice without contact having been made with her. The discharge letter stated that if the GP felt that Mary needed secondary mental health care, she could be re-referred. This decision does not seem to have been made in the context that it related to Mary's third referral to KMPT and that in the previous two she had not been assessed. As such, although the latest referral did not in itself suggest a mental health condition, the decision does appear to be another missed opportunity to attempt further engagement with her.

4.2.48 Although a discharge was made, it was not implemented because a discussion took place between a Social Worker and the Police Officer who made the referral, in which further concerns were identified. This is a positive example of contact with the initial referrer, which was lacking on the previous occasion.

4.2.49 Following unsuccessful attempts to make contact with Mary by way of joint visits (KMPT and Kent Police) and in the absence of further concerns, the decision was again taken to discharge her. This was reasonable given that efforts to contact a service user who is unwilling to engage have to be finite.

4.2.50 The next referral to KMPT was following Mary's arrest in January 2014, which resulted in her first assessment by a mental health professional. As a result, she was referred back to DGS CMHT and two days after her arrest a decision was taken at a new referrals meeting to offer her an assessment. The grounds for this decision are not recorded and are unclear given that she had been assessed by a CPN two days previously, the conclusion or which was she was not suffering from an acute mental health condition and did not present a risk to herself or others.

4.2.51 The assessment was not carried out prior to the multi-agency meeting convened by Kent Police on 17 February and attended by a CPN, when it was agreed that Mary would be discharged by KMPT.

4.2.52 It seems that contradictory decisions were made between the post arrest assessment, the new referrals meeting and the discharge. This suggests a lack of communication between professionals who were considering Mary's needs. The decision to discharge was a missed opportunity. Had an assessment been arranged and conducted it might have provided a greater insight into Mary's mental health condition.

4.2.53 KMPT should examine the contradictory decisions made following Mary's final referral to establish whether there is a need to make their internal communication process more effective. **(Recommendation 9)**

4.2.54 The advice given by CRHTT at the time of the telephone referral by a Police Officer on 31 March was appropriate.

Conclusions

4.2.55 Apart from the last referral, when Mary was in custody, she did not have any interaction with mental health professionals that would have enabled them to assess her condition.

4.2.56 The lack of any meaningful contact with Mary's GP practice during any of the referrals was a missed opportunity on each occasion to find out more about her medical history, which may have been recognised as being relevant to her mental health.

4.2.57 Given the medication that she was being prescribed by her GP practice and the likelihood that she was addicted to prescribed drugs, stopping her repeat prescriptions would almost certainly have made her engage with her GP practice. This may have given KMPT the opportunity to make contact with her. In Mary's case, KMPT seem to have failed to recognise the value of a

two way liaison with her GP practice, rather than simply informing them of discharges.

4.2.58 Similarly, useful information may have been obtained by going back to Kent Police before discharging Mary after their first referral. An enquiry with OPPD may also have been productive because they had more success in engaging with her.

4.2.59 KMPT need a policy for dealing with people they cannot engage with but it appears there may have been an overly formulaic approach that failed to recognise that other agencies may have provided a route into accessing Mary.

4.2.60 KMPT are in the process of reviewing this, which is referred to as the DNA (did not attend) policy. When reviewing and amending their DNA policy, KMPT should emphasise the need to consider consulting other agencies who the person might be more willing to engage with. **(Recommendation 10)**

4.3 Kent Adult Services Older Persons and Physical Disability (OPPD) Division

Context

4.3.1 OPPD is a Division of the Social Care, Health and Wellbeing Directorate of Kent County Council. At the time of Mary's involvement with Dartford, Gravesham, Swanley and Swale (DGSS) area of OPPD in which she lived, it consisted of an Assessment & Enablement Team that received referrals and a Coordination Team which managed ongoing cases.

4.3.3 During the period covered by this review the DGSS teams were experiencing significant staffing problems. In March 2013 the demand in the service was increasing and there was a 2 to 4 week waiting time for assessments. However, urgent cases were prioritised and if the need warranted a same day response this was given.

4.3.4 Across Kent, OPPD have designated Safeguarding Adults Coordinators in each area for Older Person/Physical Disability, Mental Health and Learning Disability teams. The role of the coordinator includes raising the awareness of safeguarding, supporting and mentoring staff, coordinating and managing complex safeguarding cases, and developing effective multi-agency working. At the time of the involvement with Mary, DGSS OPPD did not have a coordinator in post and safeguarding work was allocated to Senior Practitioners and/or Case Managers.

Summary of Involvement

4.3.5 On 29 December 2009, Mary contacted OPPD Contact & Assessment Service to request an assessment. This was the day before her sister rang KMPT with concerns about Mary's mental health.

4.3.6 The referral was passed to the local Care Management Team and it was allocated to a Social Worker (SW5). Following contact with Mary and her mother, an assessment was undertaken on 5 January and a care package was arranged to begin on 25 January. This consisted of assistance with shopping and light domestic tasks due to Mary's poor mobility, which prevented her from going out to shop.

4.3.7 Between the date of the assessment and the care package beginning Mary called OPPD complaining about noise disturbance from her neighbours. This was followed up by the OPPD Out of Hours team liaising with Kent Police and Town A Borough Council. Advice was also given to her mother in respect of service provision by Kent County Council and local voluntary services.

4.3.8 Allied Healthcare, who were commissioned by OPPD to provide care services, went to Mary's home on 25 January but were unable to gain entry. OPPD checked local hospitals and confirmed the Mary had not been admitted. Two members of OPPD staff went to her flat that morning. They got no reply and, having spoken to neighbours, they called the police who gained entry and found Mary in bed. She asked the OPPD staff to leave and at her request the care package was suspended.

4.3.9 OPPD had no further contact with Mary for over 2 years, although during that time they received a telephone call from her mother asking whether domestic help could be provided for her. Her mother was given advice about contacting voluntary organisations and also services that could be provided by Kent County Council.

4.3.10 On 10 April 2012, a Kent Police Officer (PO4) made a request for an assessment of need of Mary, and a vulnerable adult referral was subsequently received from another Police Officer (PO5). The OPPD Central Duty Team assessed that this was not an adult protection issue and passed the referral to the Assessment and Enablement Team. A number of attempts were made to contact Mary by telephone without success. On 19 April a member of OPPD staff made a home visit and posted a letter through her door when no reply was received.

4.3.11 On 23 April 2012, a Social Worker (SW6) received a telephone call from Mary's mother, who was at home in Ireland. Mary had asked her to make contact with OPPD to arrange for them to visit.

4.3.12 Although SW5 attempted to contact Mary he was not able to and an assessment visit was arranged through her mother. This took place on 9 May 2012, when a full needs assessment was completed. This included an assessment of Mary's mobility and a request for appropriate aids. Advice was given about a housing application and other benefits. Mary was given information on the Home Support Scheme and care providers who could assist with household tasks. She was advised that the referral would be closed when the equipment was in place.

4.3.13 A Social Worker (SW7), who had also been present at the needs assessment, sent a letter to Mary on 18 May to advise her that a Housing Needs Assessment (HNA) had been sent to Town A Borough Council. A copy of this was enclosed with the letter.

4.3.14 On 22 May, SW6 telephoned Mary to tell her that the OPPD case was closed but advised her to contact OPPD if her circumstances changed. Mary was happy with the equipment she had been provided with and had received a letter about the HNA.

4.3.15 On 1 November 2012, an anonymous call was made to the Families & Social Care Out of Hours Team reporting that there had been an *'allegation of rape involving Mary.'* This was passed by email to the County Duty Team, who contacted Kent Police. It was agreed that the police would visit Mary and refer to OPPD if required.

4.3.16 In July 2013, Mary was admitted to Darent Valley Hospital but she self-discharged and refused a social care assessment.

4.3.17 On 9 October 2013, DGSS OPPD received a referral from Kent Police expressing safeguarding concerns about Mary, in particular her inability to manage her daily living needs. This was passed to the Locality Referral Management Service (LRMS), who made three attempts to contact Mary by telephone, which were unsuccessful. They sent her a letter and closed her case.

4.3.18 SECAmb made a vulnerable adult referral to OPPD on 16 December. As a result, a Social Worker (SW8) liaised with a Police Officer (PO5) from the Town A CST and they carried out a joint visit to Mary's flat on 23 December. She would not let them in and a conversation took place with her through an open window. She declined any assistance but said that she would contact

the Case Manager after Christmas. This she did on 30 January 2014 and mentioned her arrest on 17 January. When the Case Manager tried to get more details from Mary, she hung up.

4.3.19 On 17 February 2014, DGSS OPPD were invited to a professionals meeting called by Kent Police. A Social Worker (SW9) attended and his understanding of the purpose of the meeting was that it was for the police to agree a way forward. He recorded that Kent Police would contact OPPD to advise them of their plan of action following the meeting. However, no contact was made and OPPD did not follow this up.

4.3.20 On 1 April 2014, a vulnerable adult referral was sent from a Police Officer in the Public Protection Unit to the OPPD Central Duty Team. This was forwarded to the DGSS Assessment & Enablement Team because Mary's case was open with them. The details in the referral were that she had been visited by Kent Police on 31 March following further allegations made by her about her neighbours. She told the officers that she had intended to take an overdose at the time of the incident. The police were asking for an OPPD assessment and suggested that she might need mental health intervention.

4.3.21 This referral was emailed to SW9 by an administration officer working in the Assessment & Enablement Team. When the email was sent to him, SW9 was on leave until 3 April. When he returned he did not read the email and it was when he was interviewed as part of this SAR on 27 November 2014 that he first became aware of it.

Analysis of Involvement

4.3.22 There is no evidence that the staffing issues affecting DGSS CHMT during the period covered by the review had an adverse impact on the service provided to Mary, other than there being no Safeguarding Co-ordinator in post to consult with during the later stages of the OPPD involvement

4.3.23 In late December 2009, the request from Mary that she be assessed by OPPD resulted in her receiving a care package. She subsequently refused to allow the care worker into her flat but OPPD had provided her with a good service on this occasion. The call they received about noise nuisance was referred to Kent Police and Town A Borough Council, which was good practice.

4.3.24 The next referral in April 2012 was from a Kent Police officer and OPPD demonstrated persistence in finally making contact with her and carrying out a needs assessment. She was given equipment to support her needs and

advice about a number of issues. A letter was sent by OPPD to Town A Borough Council supporting Mary's wish for a housing needs assessment.

4.3.25 Following the action taken, OPPD closed Mary's case but offered their services if she needed further assistance. She was happy with the service she received and this referral was well managed by experienced Social Workers.

4.3.26 The allegation of rape received in November 2012 was passed promptly to Kent Police and OPPD offered their assistance if required. This was a good example of identifying the appropriate agency to deal with a referral.

4.3.27 The referral that OPPD received from Kent Police in October 2013 was sent to LRMS, who closed the case after receiving no response from three telephone calls and a letter. No visit was attempted and there is no record of Mary's mother being contacted, although she had previously facilitated contact between Mary and OPPD. More effort should have been made in this case and it contrasts with previous persistence shown by OPPD.

4.3.28 OPPD do not have a policy setting out either how many attempts should be made to contact a service user before a case is closed or the methods that should be used. This means that inconsistency across Kent is inevitable. Social Care Health & Wellbeing Directorate/OPPD should produce and implement a policy containing directions and guidance about the methods of contact and number of attempts that are before a case is closed without contact. **(Recommendation 11)**

4.3.29 The joint visit carried out with Kent Police in December 2013 following a referral from SECAmb was a positive example of multi-agency working and resulted in Mary making a subsequent telephone call to the Social Worker following the incident when she was arrested. This indicated a level of trust in the Social Worker.

4.3.30 A Social Worker attended the meeting organised by Kent Police in February 2014. Kent Police did not pursue the actions from the meeting with OPPD, who in turn did not seek to clarify what they were expected to do. Although the onus was primarily on Kent Police, who organised the meeting, OPPD should have followed this up.

4.3.31 The final referral to DGSS OPPD on 31 March was sent by a member of the Assessment & Evaluation Team administration staff by email to a Social Worker. As a result it was not actioned. Administration staff who receive referrals are not permitted to make decisions about where they are sent; they must always be forwarded to the Duty Senior Practitioner for allocation. The

fact that the Social Worker to whom this referral was sent was on leave and did not read the email on his return (after Mary's death) is a clear example of why the correct procedure must be followed.

4.3.32 OPPD workers do not appear to have considered contacting Mary's GP to establish whether there were any issues that might have been relevant to the referrals they received. An example was in the referral where she was provided with aids to assist her mobility, when contact with her GP practice to query her medical condition may have better informed the decisions about what equipment was most appropriate.

4.3.33 There is no record that OPPD workers had concerns about Mary's mental health, which may be why there was no reference to consideration of a capacity assessment under the Mental Capacity Act 2005. In 2010, Mary's mother queried with OPPD about a mental health assessment and was advised to speak to her doctor or mental health charities.

4.3.34 The allegation of rape could have been treated as a safeguarding issue and the referral from Kent Police in October 2013 is recorded as a safeguarding concern. It may have been appropriate to consider a strategy discussion or planning meeting in either or both of these cases. There is no record that this was considered.

Conclusions

4.3.35 There are examples of good work done with Mary by OPPD and these were in line with their policies, practices and procedures. In these cases, where they liaised and worked with other agencies, this was appropriate.

4.3.36 Her family will say that Mary did not always trust organisations even if they were trying to help her, but OPPD did appear to gain her trust on a number of occasions.

4.3.37 In common with other agencies, OPPD need to be continually aware of the opportunities for inter-agency working, particularly in relation to service users who are hard to reach. It is for this reason that there is a recommendation about the methods used and the number of times that OPPD attempt to contact a service user before a referral is closed without contact.

4.3.38 The issue of the referral that was incorrectly emailed to a Social Worker rather than the Duty Senior Practitioner (via a generic, rather a personal, email account) may have been made with the best intentions as that Social Worker had had recent involvement with Mary. However, it resulted in the referral not being actioned.

4.3.39 OPPD must ensure that all staff who may receive referrals understand what action they must take to ensure that the appropriate response is provided. **(Recommendation 12)**

4.3.40 OPPD must ensure that urgent work is covered when staff are absent and there are systems to support this. **(Recommendation 13)**

4.4 NHS Kent & Medway

Context

4.4.1 Mary was registered with the Practice A in Town A from 31 December 1987 until her death. This is a six doctor training Practice operating on two sites in Mary's home town, one near the town centre (which Mary attended) and the other in a suburb.

4.4.2 Mary's GP notes were available to this review. Given the number of entries, particularly about the prescribing of medication, it would have been impractical to transcribe every record of contact and involvement into the chronology. The chronology therefore contained only the most relevant contact and involvement with GPs.

4.4.3 Although Mary would have been allocated to a named GP at the practice, given the period of time that she was registered and the number of doctors that worked there during that period, she would have had contact with a number of GPs. This review considers the actions of the practice rather than of individual GPs.

Summary of Involvement

4.4.4 The quantity and combination of medications that Mary was prescribed on repeat prescription in the years leading up to her death raise significant issues. The prescribing records during the period covered by the terms of reference show that the type and dosage of drugs that she was prescribed, and the frequency with which they were prescribed, were largely the same throughout. A family member was present on more than one occasion when prescription medication was delivered to her flat in what is described as a 'big bag'.

4.4.5 Prior to the period covered by this review Mary had been diagnosed as suffering from multiple sclerosis (MS). However, in January 2011 she was seen by a neurologist at Kings College Hospital, London, who confirmed that there were no abnormal clinical findings and nothing to indicate that she had MS.

4.4.6 In the years prior to her death Mary reported symptoms that included: loss of vision, facial hair, painful marks on her face, difficulty in swallowing, decreased appetite, muscle spasms, hot flushes, being easily bruised, joint pains, headaches, falls, leg weakness, poor memory, bleeding gums, urinary infection, respiratory infection, retention of urine, diarrhoea, vomiting, pins and needles, lower back pain, abdominal pain and rectal bleeding. Intense pain was a consistent symptom that she reported.

4.4.7 During that period she was diagnosed with slight abnormality in her cervical spine, mild enlargement of her liver and moderate degenerative arthritis in her knees. Apart from the last of these, for which she was given a one-off intramuscular steroid injection, she received no specific treatment.

4.4.8 In short, in the five-year period covered by this review, Mary repeatedly reported a combination of symptoms affecting almost all parts of her body. She was never diagnosed with any specific condition that could have caused this combination. In particular, she was never diagnosed with the condition that would have caused her to suffer intense general pain.

4.4.9 Mary made reference to physical and sexual abuse in an undated letter she wrote to the Practice in 2011. It is not known whether any of the GPs had prior knowledge of this but there is no record that the letter was acknowledged or that any further action was taken.

4.4.10 There was no note of the date of Mary's death or its cause in her GP notes. They do not contain a copy of the Coroner's report or the letter sent to him by the GP following her death.

Analysis of Involvement

4.4.11 Mary consistently reported multiple symptoms to GPs. In an effort to establish a diagnosis, in particular whether she was suffering from MS, she was appropriately referred to the neurology clinic at Kings College Hospital, London. It is not clear when, where or by whom she was diagnosed with MS but the examinations she underwent during the period covered by this review did not find any clinical evidence to support that diagnosis.

4.4.12 The concerns about the GP involvement with Mary are the combination and quantity of drugs she was prescribed, the lack of review of repeat prescriptions and the apparent lack of a link between the prescriptions and a diagnosed medical condition.

4.4.13 The frequency and number of prescriptions is illustrated by those issued for three drugs in the month before Mary's death. During that period she

received three prescriptions for a total of 600 Remedeine tablets, five prescriptions for a total of 280 Tramadol 50 mg capsules and five prescriptions for a total of 70 MST (morphine) 60 mg tablets.

4.4.14 It is unclear why three different pain relief drugs were being prescribed simultaneously and why the total quantity was far in excess of that which could be safely taken. For example, 600 Remedeine tablets taken over a month would average at 20 tablets per day. 15 tablets taken together would be sufficient to result in death.

4.4.15 This high level of prescribing was neither isolated nor restricted to the period immediately before her death. Taking February 2010 as an example, Mary was prescribed 400 Remedeine tablets, 448 Tramadol tablets and 56 MST tablets. This level of prescribing was routine in Mary's case.

4.4.16 The table below illustrates the consistency of prescribing:

Drug	**1/1/2009**	**3/4/2014**
Remedeine	n/k	n/k
Tramadol	50mg	50mg
Diazepam	10mg tablets	10mg tablets
Diazepam	Rectubes	Rectal Solution 2.5mg
Paroxetine	20mg	20mg
Baclofen	n/k	10mg
Cyclizine	n/k	50mg
Co-danthramer	n/k	n/k
Senna	n/k	15mg
Zolpidem (from 14/01/09)	n/k	10mg
MST	60g	60g
Amitriptyline		25mg

4.4.17 The GP practice should have been alert to this excessive prescribing, which could have resulted in the stockpiling of drugs. Although there is no evidence that Mary disposed of drugs unlawfully, there is a significant illegal market for prescribed drugs, in particular strong opioids such as MST.

4.4.18 There was an inconsistency in the way that repeat prescriptions were issued to Mary. She was given weekly prescriptions for diazepam, amitriptyline and MST but not for any of the other drugs that she was prescribed. Weekly prescriptions are usually given when there is concern that a patient is addicted to a drug. Although there appeared to be several attempts to reduce or stop her medication, these were not sustained and always resulted in her receiving repeat prescriptions at the dose she requested. It seems that Mary may have been dictating the medication that she was prescribed rather than it being prescribed for a diagnosed condition.

4.4.19 Mary consistently reported severe pain, the cause of which was not diagnosed. As described, she was prescribed a 'cocktail' of pain relief drugs but these do not seem to have alleviated her symptoms. Despite this there is no evidence of a specific review of her pain relief medication.

4.4.20 There are several entries in Mary's GP notes recording that a medication review had been carried out, but there was no evidence of what was discussed with her and what, if any, changes were made to her prescriptions.

4.4.21 Mary had been on a complex mix of medication since before 1 January 2009. She remained on this until her death. There was no written plan in her GP notes, agreed by all the clinicians, about managing her medication.

4.4.22 On at least two occasions there was a note of a discussion between a pharmacist and the Practice, which resulted in only short term changes in her medication. The only entry to suggest positive management of medication was in February 2014 when a GP recorded *'Telephone encounter message left for [Mary] to call scripts – Dr [Name] unwilling to issue another script for Zolpidem'*

4.4.23 The polypharmacy (prescribing four or more medications to a patient) and the combination of medications prescribed to Mary is a cause for concern. As well as receiving a high daily dose of MST (60mg) she was also on two other opioids: Tramadol and di-hydrocodeine (a constituent of Remedeine). The British National Formulary guidance states:

> *"Regular use of a potent opioid may be appropriate for certain cases of chronic non-malignant pain; treatment should be supervised by a specialist and the patient should be assessed at regular intervals*

This was not applied in Mary's case.

4.4.24 She was also on a high dose of Diazepam, both in tablet form and as a rectal solution. It is unknown why she was prescribed rectal diazepam as this would

normally be given to stop an epileptic seizure. There was no evidence that Mary suffered from epilepsy.

4.4.25 Although she was being treated with a low dose of an antidepressant for a long period of time (Paroxetine 20mg), there is no formal diagnosis of depression recorded in her notes.

4.4.26 With the combination of medications she was prescribed, there would have been interactions between the sleeping tablets, antidepressants and analgesics. These interactions had the potential to be harmful.

4.4.27 There would also have been interactions between her reported high alcohol intake and her medications. There are entries in GP notes referring to her alcohol consumption e.g. *'She drank 7-9 units of alcohol a day; a bottle of wine a day'* and *'her breath smelt of alcohol.'*

4.4.28 There is no record of any actions being taken following Mary's letter to her GP practice in which she wrote that she had been the victim of physical and sexual abuse. There was no recognition that this might have been linked to the symptoms she was reporting or that she was asked to visit the GP to discuss this further. Her complaint about being the victim of serious criminal offences were not referred to any other agencies.

4.4.29 Mary's GP records contain letters from KMPT indicating that they had had referrals about her but that they have been unable to make contact with her. There is no record that the GP Practice replied to KMPT to discuss ways in which GPs might be able to assist them in gaining access to her. Equally, there is no recorded consideration of whether her medical and mental health issues might be linked.

4.4.30 In short, there is no evidence that any GP considered initiating referrals to Kent Police, KMPT or OPPD despite the evidence of safeguarding concerns.

4.4.31 GPs must review their approach to safeguarding adults and children, which must include the requirement to refer safeguarding concerns to other agencies when appropriate. **(Recommendation 14)**

4.4.32 In Mary's GP notes there is an absence of significant documents about her death. The death of a relatively young woman from an overdose of prescribed drugs should have been treated as a 'Significant Event' by the Practice. The clinicians and Practice Managers should have met to discuss Mary's treatment prior to her death, including the prescribing of drugs, and to examine whether there were lessons to be learned for the future. There is no

evidence that this took place, which raises concerns about the leadership and management of the Practice.

4.4.33 In the last five years of her life Mary was not diagnosed with any condition that would have resulted in the combination of symptoms that she presented with. It seems that there was no determination to reach a diagnosis and that GPs relied on prescribing medication for which no diagnosis had been made.

4.4.34 Taking opioids over a long period of time can result in a person building up a resistance to their effects. In order to achieve for example, the same level of pain relief, the dose may need to be increased. This is a reason why their prescription needs careful and active management, which is not evident in this case.

4.4.35 It is acknowledged that a small minority of patients seek ways of getting the medication they want by being dishonest about their symptoms and even attempting to manipulate GPs into prescribing drugs that are not required. There is some evidence that Mary may have done this. Following her attendance at Darent Valley Hospital (DVH) on 8 March 2013, a letter sent to her GP practice by the hospital stated *'Ongoing diarrhoea and vomiting unable to take normal MST…..Switched to Fentanyl.'* After speaking to Mary by telephone on 14 March, a GP records *'Fentanyl patches making patient vomit- want[s] to remain on MST- okd [sic]…'* Having said at DVH that she was unable to take MST, within a few days she was requesting it again. There is no evidence that the GP queried this or reviewed her medication as a result.

4.4.36 The fact that a patient may be dishonest and manipulative is not a reason or excuse for overprescribing or mismanaging prescriptions; GPs should be alert to this issue and apply more rigour when a patient appears to be attempting to dictate their medication.

Conclusions

4.4.37 Given that the cause of Mary's death was an overdose of drugs, the lack of management by her GP practice in prescribing drugs to her is of significance.

4.4.38 The frequency, quantity and lack of review of prescribing is of concern. Linked to the fact that there was no apparent connection between Mary's medication and a diagnosis of any medical condition in the years leading up to her death, that concern is raised.

4.4.39 There is no evidence that Mary's GP practice gave consideration to wider safeguarding issues, in particular to the possibility that she may have been

suffering from a mental health condition. This was despite the fact that they knew that KMPT had been trying to make contact with her without success.

4.4.40 There was no acknowledgement of the potential significance of her stating that she had been physically and sexually abused, either on her mental health generally or as a potential cause of the symptoms that she had consistently reported.

4.4.41 The issues identified raise serious concerns about the clinical and management standards at the practice The over prescribing of medication, the failure to consider and upon the risk of that the polypharmacy presented in this case and the failure to consider the impact of Mary's alcohol consumption combined with her prescribed medication all put her health at risk. There was also an absence of any safeguarding considerations.

4.4.42 NHS England must ensure that there is a review of the medication prescribed to all other patients at Practice A who are subject to polypharmacy. **(Recommendation 15)**

4.4.43 NHS England must consider what action is appropriate in the light of the serious concerns about Practice A that are described in this review. **(Recommendation 16)**

4.4.44 Given that Mary's death was not treated as a Significant Event by the Practice, there is significant concern that this may not be an isolated case and that other patients are at risk of harm.

4.4.45 The Chair of KMSAB should seek to establish the outcome of the NHS England investigation of this case in order to ensure that patients at Practice A are not at risk of harm resulting from the issues identified during this review. **(Recommendation 17)**

4.5 Dartford & Gravesham NHS Trust (DGT)

Context

4.5.1 All the contact that Mary had with DGT resulted from her attendance at Darent Valley Hospital (DVH), which is one of three hospitals run by the Trust. There are no contextual issues recorded that would have impacted on the service provided to her.

Summary of Involvement

4.5.2 During 2009 and 2010, Mary was seen in the Obstetrics and Gynaecology outpatient clinic at DVH on a number of occasions following a cervical smear

that had been taken in August 2009. She did not have any admissions to hospital nor did she present to the Accident and Emergency department (A&E) during this period.

4.5.3 On 27 June 2012, Mary was brought to A&E by ambulance. She was suffering chest pain and finding it difficult to take deep breaths. She was triaged as Priority 2 and it was reported in the triage notes that she had *'had a domestic incident with a neighbour that morning'*. No diagnosis was recorded and Mary was discharged with Ibuprofen to be taken three times a day.

4.5.4 She was brought to A&E by ambulance again on 1 July; on this occasion she presented with various symptoms. There was no written entry in her medical notes following this attendance.

4.5.5 The next involvement that DVH had with Mary was when she was brought to A&E by ambulance in 5 March 2013. She had been suffering chronic pain but was unable to take analgesia because she had been vomiting. She was seen as a Priority 3 patient and examined before being discharged for follow up by her GP and Neurologist. There was no diagnosis recorded following this attendance.

4.5.6 Mary was next brought to A&E by ambulance on 8 March. On this occasion she had called police to her flat due to noisy neighbours. They felt that she was depressed, acting inappropriately and might self-harm. The triage notes record that she was alert but acting 'strangely', although no explanation was recorded as to what that meant. She was triaged as Priority 4. Various tests and investigations were undertaken and it was noted that Mary was eager to be discharged.

4.5.7 Mary was given advice about her medication, in particular the safe use of a Fentanyl patch that she was prescribed at the hospital. She was also advised about taking steps to look at her living situation, as it was felt that she may need sheltered housing. A letter was sent to her GP practice, asking that a referral be made to a gastroenterologist following a history of Mary presenting at A&E with vomiting and diarrhoea. There is no record that a mental capacity assessment (MCA) was undertaken as a result of her reported strange behaviour and her eagerness to be discharged.

4.5.8 On 26 March, a GP referred Mary to a gastroenterologist and rheumatologist for further investigations. In the referral letter the GP noted that she had a history of alcohol use.

4.5.9 Mary cancelled the outpatient appointment she had been given to see a gastroenterologist, which was scheduled for 20 June. A letter was sent to her

offering a further appointment on 5 September. This letter included results of blood tests and offered Mary advice about her alcohol intake.

4.5.10 She was next brought to A&E by ambulance on 23 July. She had not been eating or drinking as she had been vomiting and feeling unwell. She had fallen and been on the floor for three hours before calling for help. It was felt that she had perhaps had a relapse in the multiple sclerosis that she said she suffered from, or alternatively that she was suffering from arthritis.

4.5.11 During this visit to DVH, Mary had an assessment of her daily living skills and a core care plan was completed. This looked at all aspects of her care while she was in hospital to ensure that her needs were being met while she was an inpatient. She also had a falls risk assessment chart completed. On this occasion she was admitted to the Clinical Decisions Unit and then transferred to a rehabilitation ward.

4.5.12 DVH prepared a referral asking OPPD to provide an input to Mary while she was in hospital about her personal care. This referral was faxed to OPPD but she self-discharged the following day and the input was not provided.

4.5.13 Mary was assessed by an Occupational Therapist (OT), who noted that she was unable to explain how she would cook for herself and what she would do if she fell at home. She felt that she needed help with her housework. She had difficulty focusing on things at times and was demonstrating inappropriate behaviour, although the type of behaviour was not documented. She declined to go to rehabilitation. The notes do not record whether an MCA was carried out to establish her capacity to make a decision about this.

4.5.14 Mary self-discharged on 24 July against medical advice. She booked herself a taxi, to which she was taken by a nursing assistant. There is no record that an MCA was carried out to determine whether she had the capacity to make the decision to discharge herself.

4.5.15 Mary did not attend her outpatient's appointment on 5 September with the gastroenterologist nor did her attend an outpatient's appointment with a consultant rheumatologist which was scheduled for 4 October. There is no record that further appointments were offered.

4.5.16 Mary was again brought to A&E by ambulance on 8 October when she was triaged Priority 3 case. She had a worsening headache with vomiting and photophobia, and had experienced right sided weakness for the last five days. She had been unable to pass urine or open her bowels. She was examined and various investigations were undertaken including a CT scan; which did not show anything abnormal. She was then discharged.

4.5.17 On 19 March 2014, DVH had the final and most lengthy contact with Mary following her being brought to A&E by ambulance again. She was complaining of a lump on the side of her head that she said was affecting her left side including her arm and leg, as well as her speech. She reported that the pain was intense and that she had been 'laid up' in bed for an unspecified period of time. She also said she had suffered the pain in the back of her head for a year and it had been making her eyesight worse since September 2013. She was triaged as Priority 2 and admitted to the hospital.

4.5.18 Examinations were undertaken to look for further lumps on her head and neck. Referrals were made to neurology and gynaecology but no plan was put in place to manage these referrals. It was recorded that Mary was generally unwell with an unknown cause but was *'biochemically stable'*.

4.5.19 On 20 March, an MS Specialist Nurse wrote to Mary's GP practice asking that any recent correspondence be faxed to her. The last letter that the nurse had access to was from Kings College Hospital stating that Mary did not have MS but she would be investigated further. There is no record of DVH receiving any correspondence from the GP practice in response to the nurse's letter.

4.5.20 Mary was transferred to the Clinical Decisions Unit in the hospital and then to a general medical ward, where she stayed until she self-discharged on 29 March.

4.5.21 On that day, Mary made an allegation that staff on the ward were bullying and neglecting her, and that she felt that the nurses were ignoring her. She said that she was bullied and ignored for three days, she had not been given her lunch and her bed had not been changed. She also said that she had not passed urine for two days. She said she did not know why she was still in hospital and it was explained to her that the staff were waiting for the results of her MRI scan. Mary was told that her complaint would be shared with the Matron.

4.5.22 A meeting was held, which was attended by Mary and SP (who was recorded as being her partner). She shouted throughout the meeting, not allowing the Matron to make any points. It was reported in the notes of the meeting that it was impossible to reach a solution because Mary and her partner were talking loudly. She then said she wanted to self-discharge and at that point it was necessary to call the hospital security staff. Mary would not allow anyone to check whether she still had a cannula in place before she signed a self-discharge form and left the hospital.

Analysis of Involvement

4.5.23 Mary's involvements with DVH increased in frequency from 2012 until her death. Initially these were brief visits; she was not admitted and there were no follow up appointments. She was subsequently admitted twice, the second occasion being a 10 day stay.

4.5.24 On the first occasion that she was brought to A&E by ambulance, in June 2012, she was discharged without a diagnosis but with Ibuprofen to be taken three times a day. As she complained of pain and Ibuprofen is a drug that is unlikely to have side-effects if taken in accordance with the correct dosage, it was reasonable to give these to Mary on the basis of her self-reporting.

4.5.25 It seems unlikely that Mary ever disclosed to doctors or staff at DVH the quantity, variety and strength of pain medication that she was being prescribed by her GP practice. There is no record that the GP disclosed this when making referrals to a gastroenterologist and a rheumatologist. The nature of the drugs that she was being prescribed meant that there was a risk of interaction and/or excessive dosage if she was prescribed medication by hospital doctors. An example was when she was given a Fentanyl patch without any apparent enquiry with her GP practice about whether she was being prescribed other opiates.

4.5.26 In short, there was no meaningful liaison between DVH and Mary's GP about medication that she was being prescribed and there was a reliance on self-reporting. In circumstances where urgent acute intervention is required at a hospital there would be no time for this, but this did not apply in Mary's case.

4.5.27 On the first occasion that she was brought to A&E, her triage notes state that Mary 'had had a domestic incident with a neighbour that morning' but it does not appear that this was explored any further nor is there any consideration given to sharing that information with any appropriate agency such as the police or social services.

4.5.28 Following her next attendance at A&E the following month there was again no evidence of a diagnosis nor is there any record of what treatment she received or whether she had been prescribed medication.

4.5.29 There was again no diagnosis made following her third attendance at A&E in March 2013. Records of A&E attendance at DVH are retained within that department. It is not clear whether the doctors who saw her on the second and third visits referred to the notes of the previous attendance. If they did, and particularly on the third occasion, it might be expected that professional curiosity would have caused them to consider why it was not possible to come

to a diagnosis. However, three presentations at A&E in three months would not be exceptional and may not have aroused any concerns even if the records had been consulted.

4.5.30 Notwithstanding this, the actions recorded show that DVH were trying to establish the cause of Mary's symptoms. They also considered some safeguarding aspects, such as the request for an assessment by OPPD. This was good practice. This request was sent by fax, which remains a very common form of communication within the NHS. Although its weakness is that there is no confirmation that the fax has been received, in this case OPPD records show that it was.

4.5.31 There is no record that a mental capacity assessment was carried out with Mary, despite there being a number of occasions when her behaviour should have given rise to concerns about this. It is not clear whether these assessments did not take place or whether they did but were not recorded. If the former applies, the assessment should have been carried out. If they were simply not recorded, they should have been because the information about the result could have informed future decisions.

4.5.32 Dartford & Gravesham NHS Trust must ensure that a mental capacity assessment is undertaken in appropriate cases and that this, together with the results of the assessment, are clearly recorded. **(Recommendation 18)**

Conclusions

4.5.33 The absence of a diagnosis on the first three occasions that she was brought to A&E is not surprising, given that there is no record of any diagnosis during the period covered by this review that would have accounted for the symptoms that Mary said she was suffering from.

4.5.34 Overall, DVH provided a good service to Mary and were seeking to diagnose the cause of her symptoms. This was not made any easier for them by her decision to self-discharge on two occasions.

4.5.35 There was a lack of meaningful liaison with Mary's GP. The relevance that this contact would have had is probably rare, given that it relates to significant overprescribing of a combination of drugs. However, it does illustrate the potential value of contact between hospitals and GPs.

4.5.36. The lack of evidence of a mental capacity assessment is subject of a recommendation.

4.6 Kings College Hospital NHS Foundation Trust (KCH)

Context

4.6.1 Mary was referred to KCH by a GP, who requested a second opinion for her neurological symptoms. There are no contextual issues recorded that affected the involvement she had with KCH.

Summary of Involvement

4.6.2 Mary was referred to KCH by a GP in November 2010. On 29 January 2011, she was seen in the Neurology Clinic at KCH and she arrived in a wheelchair. She could stand but walked only with great difficulty. Her symptoms included muscle spasms, joint pains, headaches, falls, leg weakness, poor memory and poor vision in her left eye. There were no abnormal clinical findings and nothing to suggest multiple sclerosis.

4.6.3 Mary said that it was the first time she had visited a neurologist for six years. She had been seen at KCH 12 years earlier, at which time MRI scans of her brain and spinal cord were reported as negative (normal). Following that previous assessment she had been seen by two other neurologists elsewhere.

4.6.4 Investigations continued until September 2011 and all the results were normal. At her follow up appointment that month she was offered referral for psychological services, which she declined. A further investigation by way of lumbar puncture was arranged.

4.6.5 An appointment was made for this to be carried out on 15 November 2011. Mary did not attend and the appointment was rescheduled for 24 January 2012, which she also did not attend. A further appointment was made for 7 February and Mary had a blood test but not the lumber puncture.

4.6.6 Another appointment was made for 12 April for the lumber puncture. The procedure was completed and she was discharged the same day. There is no evidence, either from KCH or in Mary's GP notes, that the lumbar puncture identified any medical conditions.

Analysis of Involvement

4.6.7 The investigations undertaken at KCH did not provide a diagnosis for the symptoms that Mary was suffering from.

4.6.8 Following the results of the investigations, KCH offered Mary psychological services which she declined. They then offered her a lumbar puncture, which she had after some delay due to her not attending appointments.

Conclusions

4.6.9 KCH conducted the investigations they were required to and offered an additional service. They were persistent in ensuring that all the tests they could offer were carried out.

4.6.10 Although there was no explicit suggestion that her issues were psychological, the offer of that service indicates that it was considered. KCH provided Mary with a thorough service and there are no recommendations arising from their involvement with her.

4.7 South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

Context

4.7.1 In the SECAmb Emergency Operations Centre (EOC) where 999 calls are handled, there are clinicians who can manage calls. These staff are a mixture of paramedics or registered nurses who offer 'hear and treat' advice over the telephone. This can prevent ambulances being dispatched unnecessarily.

4.7.2 There are no other contextual issues relevant to SECAmb involvement with Mary.

Summary of Involvement

4.7.3 Between April 2010 and Mary's death, SECAmb had 17 contacts with her: fourteen 999 emergency calls and three contacts via NHS 111, the non-emergency number.

4.7.4 The first contact was in April 2010 when Mary made a 999 call reporting a possible exposure to scabies. This was managed over the telephone by a clinician, and an ambulance was not dispatched.

4.7.5 In 2012 Mary called SECAmb twice: in July and September. The first time was when she complained of chest pain and shortness of breath: and she was taken to DVH by ambulance. On the second occasion she reported generalised pain. An ambulance attended but she did not want to go to hospital. The out of hours GP was contacted to make a home visit to review pain and anti-sickness medication.

4.7.6 Mary had contact with SECAmb seven times in 2013. Three of these were in March. The first followed an out of hours GP advising her to call an ambulance so that her symptoms could be assessed fully. She was taken to DVH.

4.7.7 The second call in March 2013 was made by Kent Police, who Mary had called about a noisy neighbour. She told them that if she did not see any results she would self-harm. When Police Officers arrived, they gained entry to her flat and found her unresponsive with drink or diazepam consumption. The SECAmb crew recorded that Mary might have had underlying mental health issues. She was taken to DVH by ambulance.

4.7.8 Later the same month Mary called NHS 111. An ambulance was not dispatched and the case was referred to the out of hours GP service to visit within 6 hours.

4.7.9 In July 2013, Mary called SECAmb because she had collapsed at home and was suffering with pins and needles in all limbs. She was possibly dehydrated because she hadn't eaten or drunk properly for about a month. She was again taken to DVH by ambulance.

4.7.10 Mary made the first of two calls in October 2013 when she dialled 999 suffering from a severe headache. She described this being accompanied by other symptoms. She was taken to the DVH by ambulance. The SECAmb patient record notes that Mary suffered from depression, which she presumably self-reported.

4.7.11 Later that month she called SECAmb reporting abdominal and back pain. The out of hours GP service that was tasked to contact her within 2 hours. An ambulance was not dispatched.

4.7.12 The first of two calls in December 2013 originated from Kent Police. Mary was described as being short of breath. The ambulance crew wanted to take Mary to DVH, but she declined because there was nobody to look after her dog. A vulnerable person referral was made because the crew had concerns over self-neglect. This was sent to OPPD the next working day.

4.7.13 The second call in December was when Mary called 999 with shortness of breath. She believed she was having a panic attack following a dispute with her neighbour, who had verbally abused her. An ambulance was dispatched but she refused this against SECAmb advice. She was passed to a SECAmb clinical advisor who again advised her that an ambulance should attend. She continued to decline and began to feel slightly better during the call, which lasted 28 minutes. She was advised to notify her own GP of the symptoms

she had experienced. Mary told the clinical advisor she was able to manage the panic attack from home. An ambulance did not attend.

4.7.14 SECAmb received the first of three calls involving Mary in 2014 on 17 January. This came from Kent Police, requiring an ambulance at her home, where they were present while she was holding a knife to her throat. When they arrived, the ambulance crew were unable to make direct contact with Mary because she had barricaded herself into her flat. The police were in contact with her during this time. SECAmb Hazardous attended but were stood down by police once it was established that Mary had no clinical need.

4.7.15 On 19 March, Mary called the NHS 111 service reporting that she was suffering from headaches, blurred vision and a lump behind her ear. The call was passed from the 111 service to the 999 service and an ambulance was dispatched. Mary was taken to DVH by ambulance.

4.7.16 The last contact that SECAmb had with Mary while she was alive was on 31 March. Kent Police again called them, stating that she had been assaulted. The ambulance crew found that Mary had not been injured, having been pushed by her neighbour. Their patient record stated that she had taken an extra two painkillers (above the normal prescribed amount) because of the altercation. It went on to note that she was clearly agitated but refused transport to DVH and asked for no further intervention. She said that she would contact her own CPN.

4.7.17 The final involvement SECAmb had in respect of Mary was on 3 April 2014 where she was found by SP (described as her partner), unresponsive and with no signs of life, in her flat. The first SECAmb vehicle arrived 6 minutes after the call was made and the crew found that Mary displayed no signs of life and was beyond help. The attending crew undertook the necessary assessment to confirm that she had died. The police were notified and attended in accordance with protocols for an unexpected death.

Analysis of Involvement

4.7.18 SECAmb had intermittent contact with Mary from 2010 until her death for a variety of issues. These calls became more frequent in the last 18 month of her life. Nine of the calls had a predominantly medical focus related to her underlying physical health conditions. These included a need for improved pain management, chest pain, shortness of breath and other conditions. It is apparent that SECAmb were told, probably by Mary, that she was suffering from MS because they note that the symptoms she described were consistent with that condition

4.7.19 Five of the calls were linked to problems that Mary experienced following disputes with neighbours: these ranged from an anxiety related panic attack to her barricading herself into her home and police negotiators being required. Four of these incidents were ultimately managed by the police who were on scene and initiated the 999 call and one was managed over the telephone by a clinical advisor. There was only one occasion where Mary needed to be taken to hospital by ambulance following one of these incidents, when there was a possibility that she had taken an overdose.

4.7.20 The thresholds for SECAmb classing a person as a frequent caller are 5 calls in one month, or 10 calls within 3 months. Mary did not reach these levels on any occasion, and given her complex medical history, the volume of calls relating to her was not exceptional and would not have given SECAmb cause for concern.

4.7.21 Although a number of the calls to SECAmb were linked to problems being encountered with neighbour disputes, these appeared to have been managed by the police. Mary did not have a clinical need to attend hospital following these, so there was no further role for the ambulance service.

4.7.22 There was an example of good practice when a vulnerable person referral was made to OPPD after Mary told an ambulance crew that she had unmet care needs.

4.7.23 SECAmb responses to both the 999 and 111 calls appear to have been appropriate from the information available. There was an appropriate use of clinical advisors offering advice and support over the telephone when Mary declined an ambulance attending her home. Her wishes seem to have been taken into account when offers of referrals, ambulance attendance and transportation were refused. SECAmb staff appear to have taken appropriate steps to ensure that Mary had sufficient information to make informed decisions about her care.

4.7.24 With the exception of the incident in which she was found unresponsive due to drink or drugs in March 2013, when the ambulance crew recorded that they were undertaking a best interest decision to treat her, the crews recorded that Mary had the capacity to make decisions about her treatment.

Conclusions

4.7.25 SECAmb provided an appropriate service to Mary, taking her to DVH when required and always recording a clear rationale for their decision making.

5. Inter-Agency Working

5.1 The Kent and Medway Safeguarding Adults Board (KMSAB) has been established for some years and it ensures that all member agencies are working together to help keep adults living in Kent and Medway safe from harm and protect their rights. The core duties of the Board are set out on its website.

5.2 KMSAB is chaired by Kent County Council's Corporate Director of Social Care, Health and Wellbeing and meets 4 times a year. Member agencies are:

- Kent County Council
- Medway Council
- Kent Police
- Healthcare Providers
- Clinical Commissioning Groups
- Healthwatch Kent
- Healthwatch Medway
- National Probation Service (NPS) Kent Local Delivery Unit
- Kent, Surrey, Sussex Community Rehabilitation Company (KSS CRC)
- Kent Fire and Rescue Service
- HM Prison Service
- Kent Community Safety Partnership
- Medway Community Safety Partnership
- District Councils
- elected Members from both Kent County Council and Medway Council
- Independent provider organisations
- Further Education providers

5.3 KMSAB publishes the Multi-Agency Adult Protection Policy, Protocols and Guidance for Kent & Medway and is responsible for ensuring that all agencies and services in Kent and Medway are committed to working to it.

5.4 In Section 5 of this report, inter-agency working is examined in the context of individual agencies sharing information and working with partners, predominately at a tactical level. Where there has been a failure in inter-agency working, this has been highlighted.

5.5 Inter-agency working is not a substitute for the duty that individual agencies have for discharging their responsibilities for safeguarding adults. For inter-agency working to be effective, there must be a culture of information sharing within each agency that has responsibility for safeguarding vulnerable adults. In order to share information effectively, comprehensive and accurate record

keeping is essential. Where actions are delegated and/or recommendations are made, the results must be fully recorded and attributable to an individual.

5.6 A number of issues have been identified and recommendations made with the aim of making inter-agency working more effective in safeguarding adults in Kent and Medway. Where appropriate the Review Panel has made recommendations about these.

5.7 The policies and protocols by KMSAB are produced at a strategic level but most inter-agency working that directly affects service users is delivered by practitioners at a tactical level. The main aim of inter-agency working is rightly to improve safeguarding but it is not wrong to emphasise the practical advantages to practitioners if it helps to ensure that inter-agency working is effective in delivering that aim.

5.8 This review shows that there is a continuing need to emphasise the benefits of inter-agency working and ensure there is an understanding by safeguarding practitioners in all agencies of what services other agencies deliver. In times of increasing demand and finite resources, effective inter-agency working does not increase workloads. Information sharing and ensuring that services are delivered by the most appropriate agency will enable practitioners to work more efficiently.

6. Conclusions

6.1 Section 5 of this report sets out detailed conclusions about the way in which individual agencies delivered services to Mary. This section summarises those that were most significant during the period covered by this SAR.

6.2 Kent Police had the most contact with Mary during that period. Despite most of their attendances being initiated by her, they found her hard to reach. She frequently refused to cooperate with their efforts to deal with crimes that she reported. However, there was insufficient recognition that she was a vulnerable person or that she may have had mental health issues, despite the fact that there were clear indications of both.

6.3 Individual officers did make referrals to mental health services and other agencies but it was not until the last few months of her life that the approach was coordinated. During that period the focus seemed to be on criminalising Mary's behaviour in order to deal with her situation. The one multi-agency meeting that Kent Police convened to discuss Mary was ineffective because actions were not progressed.

6.4 Kent & Medway Partnership Trust (KMPT) also found Mary hard to reach. If people have a mental health disorder, the nature of that may make them reluctant or even unable to interact with others, particularly organisations. This is something that KMPT professionals understand and deal with on a regular basis, so they are more likely to appreciate the need to be more flexible and creative when attempting to engage with people. Despite this, potential avenues for contact, such as through Mary's GP, were not explored and there were missed opportunities to engage with her and undertake a full assessment of her mental health.

6.5 Kent Adult Services Older Persons and Physical Disability (OPPD) division had some positive interventions with Mary and appear to have gained her trust on occasions. There were judgements to be made as to whether two of the referrals they received amounted to safeguarding concerns and it is not recorded whether the decisions taken were considered or intuitive. At present OPPD do not have a policy for dealing with non-contact following referrals and this is the subject of a recommendation.

6.6 The actions of Mary's GP practice raise significant concerns. The combination and quantity of medication that she was prescribed and the frequency at which it was prescribed do not appear to correlate with any medical diagnosis. The combination of medication, together with the knowledge that she was a heavy drinker, was such that it presented an obvious risk of harm to her health.

6.7 There does not appear to have been any recognition of the safeguarding concerns that GPs were made aware of, none of which were referred to agencies that could have dealt with them more effectively.

6.8 In summary, there was good work done with Mary but opportunities were missed to carry out coordinated multi-agency work to support her and establish the causes of her problems.

6.9 On 10 September 2014, Kent & Medway Safeguarding Adults Board (KMSAB) approved the Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect, which were revised on 1 April 2015 to take account the provisions of the Care Act 2014. While there is no statutory definition of self-neglect, Mary displayed a number of the indicators that would have resulted in the policy being invoked had it been in place in the months and years preceding her death.

6.10 The policy and procedures will address the gaps in multi-agency working that have been identified in this review **providing that all agencies know of its existence, understand it and implement it**. If they do, there is a real likelihood that people like Mary will receive appropriate support. All agencies subject to this review are represented on KMSAB and it is incumbent on them to ensure that staff at all levels have a knowledge and understanding of it.

6.11 All agencies represented on KMSAB must ensure that staff at all levels are aware of the Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect, and that they understand and implement it. **(Recommendation 19)**

7. Lessons Learned

The Review Panel has identified the following lessons that should be learned from this review:

7.1 Agencies must adopt a flexible and creative approach to engaging with vulnerable adults using all possible means, including contact with family and other agencies.

7.2 There is a need for agencies to ensure that the policies, protocols and guidance produced by Kent & Medway Safeguarding Adults Board are consistently put into practice.

7.3 Agencies need to be constantly reviewing whether the service users would benefit from services provided by other agencies. If they believe that to be the case, they must make appropriate referrals.

7.4 Agencies must continually be aware that self-reporting by service users may need to be corroborated before it is acted upon.

8. Recommendations

8.1 The Review Panel makes the following recommendations:

	Paragraph	Recommendation	Agency
1.	4.1.84	Kent Police must ensure that their officers understand the power of arrest for breaching a restraining order.	Kent Police
2.	4.1.95	Agencies that are the subject of this SAR must ensure that their processes for engaging with partner agencies at practitioner level are robust enough to ensure that meaningful outcomes can be achieved.	All Agencies
3.	4.1.103	When experiencing difficulties engaging with people with disabilities, Kent Police should consider contacting other agencies with relevant knowledge and experience.	Kent Police
4.	4.1.112	Kent Police must ensure that when they initiate multi-agency meetings, representatives attending have authority to commit the resources necessary to achieve the aims of the meeting. Furthermore, they must ensure that the aims of the meeting are made clear when invitations are sent so that other agencies send representatives with an appropriate level of authority.	Kent Police
5.	4.1.123	Kent Police must ensure that its officers and staff deal sensitively with vulnerable people, engaging with other agencies when appropriate, and do not seek to criminalise their behaviour as a primary means of resolving a situation.	Kent Police

6.	4.2.40	KMPT must have a process that ensures requests for information are followed up if no reply is received.	KMPT
7.	4.2.43	Where KMPT receive information that may indicate that serious criminal offences are being committed, it must be referred to Kent Police.	KMPT
8.	4.2.46	KMPT must ensure that they have a process in place to ensure that work done by student Social Workers is effectively supervised.	KMPT
9.	4.2.53	KMPT should examine the contradictory decisions made following Mary's final referral to establish whether there is a need to make their internal communication process more effective.	KMPT
10.	4.2.60	When reviewing and amending their DNA policy, KMPT should emphasise the need to consider consulting other agencies who the person might be more willing to engage with.	KMPT
11.	4.3.27	Social Care Health & Wellbeing Directorate / OPPD should produce and implement a policy containing directions and guidance about the methods of contact and number of attempts that are before a case is closed without contact.	OPPD
12.	4.3.39	OPPD must ensure that all staff who may receive referrals understand what action they must take to ensure that the appropriate response is provided.	OPPD
13	4.3.40	OPPD must ensure that urgent work is covered when staff are absent and there are systems to support this.	OPPD

14.	4.4.30	GPs must review their approach to safeguarding adults and children, which must include the requirement to refer safeguarding concerns to other agencies when appropriate.	NHS England
15.	4.4.40	NHS England must ensure that there is a review of the medication prescribed to all other patients at Practice A who are subject to polypharmacy.	NHS England
16.	4.4.41	NHS England must consider what action is appropriate in the light of the serious concerns about Practice A that are described in this review.	NHS England
17.	4.4.43	The Chair of KMSAB should seek to establish the outcome of any NHS England investigation of this case in order to satisfy the Board that patients at Practice A are not at risk of harm resulting from the issues identified during this review.	Chair of KMSAB
18.	4.5.34	Dartford & Gravesham NHS Trust must ensure that a mental capacity assessment is undertaken in appropriate cases and that this, together with the results of the assessment, are clearly recorded.	Dartford & Gravesham NHS Trust
19	6.11	All agencies represented on KMSAB must ensure that staff at all levels are aware of the Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect, and that they understand and implement it.	All KMSAB Agencies

TERMS OF REFERENCE

These Terms of Reference were agreed by the Review Panel in advance of this SAR being conducted.

1 Introduction

1.1 Following the death of Mary, the Kent & Medway Safeguarding Adults Board (KMSAB) has commissioned a Safeguarding Adults Review (SAR).

2 Methodology

2.1 All agencies are asked to check if they had contact and/or involvement with Mary in the period from 1 January 2009 to 3 April 2014 (date of Mary's death). If so, they are further asked to secure those records and notify the Independent Chairman of the SAR Panel.

2.2 The SAR will be based on IMRs and reports submitted by agencies which had involvement with Mary during the period of this review in circumstances that were relevant to her death.

2.3 Whether an agency is required to submit an IMR or a report will be dependent on the extent and relevance of its involvement with Mary and/or her family.

3 Independent Management Reports (IMRs)

3.1 Each IMR will be prepared by an appropriately skilled person who did not have any direct involvement with Mary, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

3.2 Each IMR will include a chronology and an analysis of the involvement that the agency submitting it had with Mary. IMRs must be submitted using the version of the template that is current at the time of completion. The KMSAB Business Unit will supply the current template.

3.3 The chronology will include each occasion that the agency had contact with Mary between the relevant dates, in circumstances that led to or should have led to safeguarding concerns.

3.4 The analysis of agency involvement should include:

- the key and priority practice episodes (these will be drawn from the agency chronology);

- the agency's involvement, commenting on the work undertaken and the adherence to intra and inter agency policy and procedures, or accepted best clinical/professional practice, in use at the time;
- the agency's and inter-agency assessment of Mary's needs, including emotional needs; and any risk identified, including signs or disclosures of neglect or abuse;
- the direct work undertaken with Mary and, if relevant, her family members;
- inter-agency information sharing and co-operation to meet Mary's identified needs;
- the decisions, actions taken and timescales, noting any gaps, errors and successes and why these occurred;
- the views of the practitioners involved and any management or supervisory oversight of the work, seeking to understand the work undertaken by what was known at the time, not through hindsight, but noting any gaps; and
- the context in which the agency undertook its work, and any factors intrinsic to the agency or external to the case which may have impacted on the work.

3.5 The analysis should highlight good and poor practice by both individuals and the agency. It should include issues such as the resourcing, workload, supervision, support, and the training and experience of the professionals involved.

3.6 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

3.7 The IMR should note the key lessons, including concerns and good practice, which have been learned as a result of the agency review, and any recommendations to be taken as a result within the agency or by other bodies. It should include whether the agency has accepted such internal recommendations as formal actions.

3.8 NHS IMRs will be overseen by the Designated Nurse from the Clinical Commissioning Group (CCG) covering the area in which Mary lived.

3.9 Completed IMRs will be considered at a meeting of the SAR Panel and an Overview Report will be drafted by the Independent Chairman. The draft Overview Report will be considered at a further meeting of the SAR Panel and a final, agreed version will be submitted to the Chair of KMSAB.

4. Safeguarding Adults Review Panel

4.1 The Panel will be commissioned by the Chair of KMSAB.

4.2 KMSAB will appoint a panel of senior and experienced practitioners with experience in safeguarding to draw together the learning from the IMRs and to comment on the work undertaken. The SAR Panel members should be independent of the line-management for this case.

4.3 An Independent Chairman of the SAR has been appointed and he will also author the Overview Report.

4.4 The Panel will be made up of an Independent Chairman and representatives from:

- NHS Dartford, Gravesham, Medway & Swale CCG
- Kent Police
- KMPT
- KCC
- KMSAB Board Manager
- KMSAB Admin Support (non-participating role)
- Medway Council

4.5 None of the Panel Members have had direct involvement in the management of Mary's case.

4.6 The Panel is able to co-opt specialist advice as needed.

5. Involvement of Family Members

5.1 Close relatives will be advised of the SAR at an early stage by the Panel Chairman. They will be told of its purpose, how it will be conducted and how they may be involved; including by direct conversation with the Independent Chairman.

5.2 The SAR Panel Independent Chairman will contact family members during the period when IMRs are being conducted in order to allow them the opportunity to express any views they may have about agency involvement during the period under review.

5.3 The SAR Panel Independent Chairman will contact family members on completion of the draft Overview Report to tell them about the conclusions, lessons learned and recommendations.

6. Safeguarding Adults Review Governance

6.1 The SAR Panel Independent Chairman will be responsible for telling the KMSAB Chair of any emerging findings that require attention before the SAR is completed.

6.2 The SAR will be signed off by KMSAB.

6.3 KMSAB will be responsible for the co-ordination of any media management in relation to this SAR in line with an agreed media strategy.

6.4 HM Coroner for the area in which Mary died will be informed of the review by the Chair of KMSAB.

GLOSSARY

This glossary contains explanations of acronyms and terms that are used in the main body of the Overview Report.

Acronyms

A&E	Accident & Emergency
ABE	Achieving Best Evidence
ACPO	Association of Chief Police Officers
ASB	Anti-Social Behaviour
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CRHTT	(KMPT) Crisis Resolution & Home Treatment Team
CRU	Central Referral Unit
CST	(Kent Police) Community Safety Team
DGS	Dartford, Gravesham and Swanley
DGSS	Dartford, Gravesham, Swale and Swanley
DGT	Dartford and Gravesham NHS Trust
DNA	Did Not Attend
DVH	Darent Valley Hospital
EOC	(SECAmb) Emergency Operations Centre
GP	General Practitioner
HNA	Housing Needs Analysis
HART	(SECAmb) Hazardous Area Support Team
IMR	Independent Management Report
IPCC	Independent Police Complaints Commission
JPS	Joint Problem Solving
KCC	Kent County Council

KCH	Kings College Hospital NHS Foundation Trust
KFRS	Kent Fire & Rescue Service
KMPT	Kent & Medway NHS and Social Care Partnership Trust
KMSAB	Kent & Medway Safeguarding Adults Board
LRMS	Locality Referral Management Service
MCA	Mental Capacity Assessment
MS	Multiple Sclerosis
MST	Morphine Sulphate
NHS	National Health Service
NPT	Neighbourhood Policing Team
OPPD	(KCC) Older People & Physical Disabilities Division
OT	Occupational Therapist
PCCLDS	Police Custody Court Liaison & Diversion Service
PCSO	Police Community Support Officer
PO	Police Officer
SAR	Safeguarding Adults Review
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SPOC	Single Point of Contact
SW	Social Worker

Terms

Achieving Best Evidence (ABE)

An ABE interview is one conducted with a child (or a vulnerable adult), usually the victim of or witness to, a criminal offence. It is video recorded, and conducted jointly by a Social Worker and a Police Officer. The video can be presented as the child's evidence in chief in court proceedings.

NHS Talking Therapies

Talking Therapies provides help for people with anxiety, depression and other similar difficulties. The service is free; funded by the NHS. In Kent and Medway it is currently provided by Insight Healthcare.

Clients take part in an initial assessment, which allows the therapist to get an understanding of their current difficulties. At the end of the assessment the therapist will discuss the next steps. Talking Therapies can offer a range of treatment options and the best way forward will depend on the client's individual needs. For example, counselling, cognitive behavioural therapy (CBT), psychotherapy or group work. The therapy may be provided in the client's GP surgery or at another venue convenient for them. Therapy can also take place over the telephone or online if that is suitable and convenient.

Crime Report

This is the report that must be completed when a Police Officer attends an incident where there is evidence that a crime has been committed. It is recorded on a computer system and contains details of the crime, including the victim and suspects/offenders.

Restorative Justice

Restorative justice brings together people harmed by crime or conflict with those responsible for the harm, to find a positive way forward. It gives victims the chance to tell offenders the real impact of their crime, get answers to their questions and get an apology. Restorative justice holds offenders to account for what they have done and helps them understand the real impact, take responsibility, and make amends.

Acceptable Behaviour Contact (ABC)

An Acceptable Behaviour Contract is a formal agreement in written form, which is made between an individual and their 'registered landlord', housing department, school, or the police. By entering into an ABC, individuals are agreeing that they will not display or act in an antisocial manner in future. Individuals who fail to keep to an ABC do not commit a criminal offence.

Central Referral Unit (CRU)

The CRU contains staff from Kent Police, Kent Social Services, Health and Education. Its main purpose is to manage safeguarding referrals, facilitate the sharing of information with partner agencies and to conduct initial strategy discussions about child and adult safeguarding.

S.136 Mental Health Act 1983

If a Police Officer finds a person in a public place who appears to be suffering from mental disorder and to be in immediate need of care or control, the Police Officer may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety (as defined by S.135 of the Act).

A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling them to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional.

KMPT Crisis Resolution and Home Treatment Team (CRHTT)

The CRHTT treats people with severe mental health conditions who are currently experiencing an acute and severe psychiatric crisis that, without the involvement of the CRHTT, would require hospitalisation. Because of the nature of their work, CRHTT offers a 24-hour service, and cases are often referred to them through accident and emergency (A&E) departments or the police.

NHS A&E Priorities

When patients attend NHS A&E departments they will be triaged into one of the following categories:

1 Immediate Resuscitation
Patients in need of immediate treatment for preservation of life.

2 Very Urgent
Seriously ill or injured patients whose lives are not in immediate danger.

3 Urgent
Patients with serious problems, but apparently stable condition.

4 Standard
Standard A&E cases without immediate danger or distress.

5 Non-Urgent
Patient's whose conditions are not true accidents or emergencies.

ACPO Anti-Social Behaviour Risk Assessment Matrix

3. RISK ASSESSMENT MATRIX (RAM)

Name:		Incident Number:	
Address:		Incident file Number:	
Tel No:		Score	Scoring options
Offence	Other than this occasion how often do you have problems?		0 – none previously
			3 – occasionally
			5 – Frequently
	Do you think that incidents are happening more often and/or are getting worse?		0 – No
			2 – Yes
Offender	Do you know the offenders?		0 – No
			1 – Yes
			2 – Know each other well
	Is anyone in particular being specifically targeted by this behaviour?		0 – No
			1 – A number of people
			2 – Your family
			3 – You
	Do you feel that this incident is associated with your faith, nationality, ethnicity, sexuality, age, gender or disability?		0 – No
			3 – Yes
	Does the perpetrator (or their associates) have a history of or reputation for intimidation or harassment?		0 – No
			2 – Have not harassed the complainant, but have a history or reputation for harassment or violent behaviour.
			3 – Have harassed the complainant in the past.
			5 – Currently harassing the complainant
Impact	How affected have you been by what has happened?		0 – Not at all
			2 – Changed routine or avoid locations
			4 – Distressed.
			6 – Affected physical or mental health
	Do you have any friends, family or professionals to go to for support?		0 – A close network of people to draw on for support.
			1 – A few people to draw on for support.
			3 – Lives alone and is isolated.
	In addition to what has happened, do you feel that there is anything that is increasing you or your household's personal risk (e.g. because of personal circumstances?)		0 – No
			3 – Yes
Scale	Are any other agencies involved with this problem?		
	Apart from any effect on you, do you think anyone else has been affected by what has happened?		
OFFICER'S PERSONAL ASSESSMENT Reasons: Officer's assessment: STANDARD/MEDIUM/HIGH			
SCORE:	0-11 = STANDARD 12-23 = MEDIUM 24+= HIGH	OVERALL RISK ASSESSMENT: STANDARD / MEDIUM / HIGH	
Officer completing assessment: Signature: Name: Collar Number:		Officer supervising: Signature: Name: Collar Number:	

CONSENT TO INFORMATION SHARING

I consent to agencies obtaining and sharing information (including the 'internet cloud based IT system') as part of the multi-agency work to help and secure my safety and that of my family. If there are child protection concerns, information will be shared regardless of whether this form is signed.

SIGNATURE: _____

PRINT NAME: _____ DATE: _____