SAFEGUARDING ADULT REVIEW REPORT

“Kasey”

2023

HAVERING SAFEGUARDING ADULTS BOARD

Havering
Safeguarding Adults Board

Contents

1. Introduction

This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of Havering Safeguarding Adults Board (HSAB), relating to the care of an adult (referred to as Kasey throughout this report to preserve her anonymity). The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Havering in the future.

The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews. The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The Department of Health Care and Support Statutory Guidance – published to support the operation of the Care Act 2014,(14.168).

"SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[1].

1.1. Why was this case chosen to be reviewed?

The SAB Case Review Working Group met in October 2021 to discuss the circumstances of Kasey's death and to determine if the case met the criteria for a statutory Safeguarding Adults Review (SAR). The case review working group could not reach a conclusive decision, and so the minutes and briefers templates were sent to the SAB Independent Chair. The SAB Independent Chair decided in November 2021 that a SAR should go ahead on the basis that Kasey had care and support needs and she died; the level of interventions about her mental health including suicidal ideations indicated that her death was due in part to self-neglect and self-abuse.

The case was subject to a Health Serious Incident Review and the Review's conclusion was that there were missed opportunities for agencies to have improved co-ordination and the Serious Incident Review recommended a SAR. It is also acknowledged that through the challenges Kasey faced, it is not clear if greater co-ordination would have changed the eventual outcome. There were indications that there were opportunities for greater multi agency co-ordination/ownership. There were also indications that services which faced challenges working with individuals with Personality Disorders, whose presentations often seemed "chaotic", may not have been in place. The SAB Chair concluded that there was potential learning from this case, but recommended a very focused approach rather than a wide-ranging SAR.

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

1.2. Brief Summary of the case

Kasey was 31 when she died by suicide in November 2020. She first became known to services when she was 2 years of age due to behavioural difficulties. She continued to have problems at school and was statemented. In 2007 she was housed under the Homeless Act. By this time, she had been diagnosed with complex mental health issues and her family found it hard to cope.

Over the following years Kasey came to the attention of several services such as housing, mental health, substance use and criminal justice, and it is evidenced that she was subject to numerous interventions. Kasey was also subject to several multi-agency panels such as the Integrated Offender Management (IOM) Panel[2],the Housing multi agency Vulnerable Persons' Panel (VPP)[3] and the Community MARAC (CMARAC)[4]. Kasey was the subject of numerous referrals to Adults Social Care (ASC) but was never subject to a Care Act assessment. In 2020 Kasey attended the Emergency Department on 5 occasions with suicidal ideations. Many referrals were made to agencies working with Kasey.

1.3. Timeframe, Terms of Reference, Methodology and Scope

SAR Panel was established to work with the Reviewer, and this met regularly during the Review period. An integrated chronology was produced by the Independent Reviewer, covering the period from November 2016 to November 2020, establishing the involvement of all agencies that provided services to Kasey. The examination of the chronology highlighted key issues regarding the following focussed points as raised by the SAB Chair and agreed as the focussed Terms of Reference for this review:

1) The co-ordination of Partnership working to focus on the effectiveness of multi-agency groups, including those previously highlighted in this response;

2) Examination of the circumstances of referrals/concerns passed to ASC to establish if Kasey reached the Care Act level of care and support needs which should have triggered a Care Act assessment. Would this have improved provided improved multi-agency co-ordination?

3) Is the level of services potentially required to have supported Kasey currently accessible to partners?

A workshop event was held for practitioners and managers involved in providing services to Kasey, and decision-making in relation to this case, so that their accounts could form part of the developing evidence base. This event was held virtually using MS Teams, with support from the SAR Panel members to facilitate 3 small group discussions around learning from each of the above areas for the review. Liaison with Kasey's mother has also taken place for her views, which also formed part of the developing evidence base (see 1.7).

[2] https://www.gov.uk/guidance/integrated-offender-management-iom

[3] To coordinate actions that will support vulnerable residents whose needs are challenging and complex AND who live in Havering Council managed, own or rented accommodation.

[4] https://www.havering.gov.uk/info/20096/community/643/anti-social_behaviour_in_our_community/4

1.4. Agencies that had involvement in the review:

- London Ambulance Service NHS Trust (LAS); submitted a brief chronology of the occasions they were called to Kasey's address.
- Advance Minerva, a charity who work with women known to the criminal justice system, submitted a chronology and were represented on the SAR Panel.
- Havering Adult Social Care submitted a chronology of safeguarding referrals made to them and were also part of the SAR Panel.
- Havering Children's Services submitted a brief summary of the history of their involvement with Kasey, her son and her mother.
- Havering Housing Services, Homeless Accommodation Manager, sent a summary of Kasey temporary accommodation in a series of hostels and were represented on the SAR Panel.
- Havering Community Safety Partnership, as the lead for the Integrated Offender Management Panel submitted minutes of meetings where Kasey was discussed and was also on the SAR Panel.
- Havering Probation Services submitted a chronology of their involvement and as part of the IOM Panel, they were also represented on the SAR Panel.
- The Department of Work & Pensions (DWP) submitted a chronology of their contacts over Kasey's benefit applications and were also on the SAR Panel.
- Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) submitted a chronology of contacts with Kasey, they were also represented on the SAR Panel.
- North East London Foundation Trust (NELFT) submitted the Root Cause Analysis report, as well as a chronology of the involvement of a number of mental health teams with Kasey; The Havering Access, Assessment and Brief Intervention Team (HAABIT), The Community Recovery Service (CRS), The Home Treatment Team (HTT), IMPART Personality Disorders Services for Psychological therapies, and inpatient services at Goodmayes Hospital. They were represented on the SAR Panel.
- Metropolitan Police Service submitted a chronology of their involvement with Kasey, as both a victim and perpetrator of offences, and involvement of the Public Protection Team as part of the IOM service, they were also represented on the SAR Panel.
- Havering Clinical Commissioning Group (CCG), now the North East London Integrated Care Board (NEL ICB) submitted a summary of GP involvement as well as a period when Kasey was provided with primary care via the Special Allocations Scheme (SAS). They were also represented on the SAR Panel.
- Westminster Drug Project (WDP). Submitted a chronology of their involvement and periods of engagement with Kasey regarding substance misuse issues.
- In addition to the above agencies, information was provided to the review regarding the multi-agency panels where Kasey was discussed (IOM, CMARAC, VPP), including the Terms of Reference, Policies & Procedures and individual meeting minutes. Also, the Findings and Conclusions of the Inquest held into Kasey's death by HM Coroner's was provided to the review.

1.5. Reviewing expertise and independence

An Independent reviewer (Mick Haggar) was appointed by the SAB Chair to undertake the SAR and is the author of this report. Mick is a registered social worker, has worked in safeguarding adults, mental health and learning disabilities for over 25 years and is an experienced reviewer, having completed more than 20 reviews (SARs, SCRs). This report has been completed on the basis of submissions of Individual Agency Documents, conversations with individuals, reports and Chronologies (outlined above).

1.6. Structure of the Report, Acronyms and terminology explained

Section 2 of the report considers what happened in the period subject to review, this is sub-divided into a series of periods of the chronology, called Key Practice episodes which hare based on her time at different accommodation. Section 3 then analyses the practice found against each of the Terms of Reference for the SAR (see 1.3.). The Findings with associated recommendations for the HSAB following this review are set out in Section 4. In Appendix 1 the abbreviations used are explained. References are also made to professional jargon and key supporting documents, which are both in footnotes throughout the report and these are further explained in Appendices 2 and 3 respectively.

1.7. Involvement of family members

The input and opinions of family members is an important aspect of the SAR process, both to inform them of the review, and to take account of their first-hand experience of services provided to them/their relative. For this SAR Kasey's mother was spoken to on several occasions by the Lead Reviewer and also provided a number of statements and documents relevant to the care provided to Kasey, including her statement to the inquest and Kasey's presentation to Magistrates, where she talked about her experiences (see 1.10, below).

Her mother felt that mental health services struggled to provide the help that Kasey needed and in her mother's view, the services were too quick to resort to medication. Over the years, Kasey had received mental health diagnoses of ADHD[5]; PTSD[6]; Oppositional Defiant Disorder[7]; Borderline Personality Disorder[8]; drug and alcohol dependency. Kasey's mental health condition manifested in emotional dysregulation; anger problems; chronic suicidal thoughts. Over time, Kasey had multiple hospital attendances – her mother recalled around fifty-seven. Her mother had care of Kasey's son born in XX. He was placed with Kasey's mother via a voluntary agreement in May 2011 and returned to the care of Kasey

[5] Attention deficit hyperactivity disorder https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

[6] Post-traumatic stress disorder https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/about-ptsd/

[7] https://www.webmd.com/mental-health/oppositional-defiant-disorder

[8] https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/symptoms/

in October 2011. He was made the subject of Child Protection Plan between December 2011 – July 2012.

In March 2012 her mother applied to the court for a Residence Order [9](s8 Children Act 1989) and Children's Services completed a welfare report in January 2013 recommending this be weekly contact to Kasey and the biological father, the Court granted the order. Her mother then made a private application for a Special Guardianship Order[10] which was granted in November 2018 with supervised weekly contact with parents. Her mother took steps to ensure that she was very knowledgeable about Kasey's mental health. She began studying for a degree in Integrative Counselling and Psychotherapy. She completed a dissertation relating to the maternal perspective of borderline personality disorder. There was a family history of suicide/suicide attempts (uncle and great grandmother).

Kasey had 5 prior attempts to hang herself. She had thrown herself in front of vehicles (resulting on one occasion in a fractured neck). Her mother considered that Kasey needed to be detained under the MHA for 6 months, for her to be assessed and for her medications to be observed for efficacy. In addition, she needed weekly intense therapy, which she didn't receive. Kasey's mother felt that often professionals were dismissive, or at least not sufficiently supportive of Kasey, both in times of crisis and during her periods of attempting to engage with offers of help.

She heard the way mental health staff spoke to Kasey and felt that this often provoked an angry reaction from Kasey, where she then was discharged from services due to her non-engagement with them. She felt this was particularly the case when Kasey was detained in hospital after a serious suicide attempt, when staff were unpleasant to her in order to pressure her into leaving hospital, within days of her admission. Her mother expressed if a hospital should not be a loving, caring compassionate place where vulnerable people with severe mental health issues and diagnosed as being a chronic suicide risk can be safe. They should be able to ask for what they want without fear of being manipulated or vilified for stating how they feel. She shared that in the end there was rawness in her sadness and a deeper expression of pain evident.

1.7.1. Comments on Report Findings and Recommendations

Kasey's mother has had an opportunity to review this report and a summary of her comments are as follows;

Services records of their interactions with Kasey focus on her statements and actions, which were overwhelmingly negative, with no positive records, or clarity as to what their responses were going to be in terms of actions subsequent to their numerous contacts with her. She felt that agencies lacked accountability and passed responsibility to each other, without sufficient information sharing between the services/professionals. Further, that the duty of care to her was not met and this contributed to her subsequent death by suicide. She would like acknowledgement that mistakes were made and an apology for failures in Kasey's care. Finally, that she agrees with the SAR Findings and Recommendations which she would like agencies

[9] https://www.legislation.gov.uk/ukpga/1989/41/section/8

to respond to, in order to consider how to improve services for individuals who struggle with both mental health and substance misuse issues.

1.8. Kasey in her own words

(Extract from a statement Kasey made at a magistrates' bench meeting about her life, 2014)

I grew up with 3 sisters and my mother and father in a dysfunctional family suffering from domestic violence watching my mother be emotionally and physically hurt by my father. My eldest sister and I suffered from this abuse more so than my two younger sisters as they were younger and weren't physically hurt so they suffered from the emotional side of things not the physical. I was bullied in all my years at school and would come home and be bullied in a place where I should have felt safe. I first found cannabis at the age of 14 and once I started, I would not stop from that day on, as it gave me the unconditional comfort that I needed, I was now in control of something. I thought that as long as I had the cannabis, I would be ok, but I was not, it suppressed my emotions even more. My mother and father split up when I was 16 years old.

I had a baby in XX and for a while was okay and abstained from cannabis, however I relapsed when my son was 8 months old which led to my behaviour deteriorating and consequently got arrested for my actions and was sent to prison for one week for my own safety on remand, I was then released on a tag. Months later I had been arrested again and many times thereafter, I was then required to complete a DRR. After everything I have learned and from my own personal experiences, I believe that a DRR could contain an added requirement to support people in their longer-term recovery. I feel that providing counselling and psychotherapy in a separate agency would be more beneficial. My reason for this is because within the drug and alcohol service too much emphasis is placed on the substance misuse rather than the focus being on what lead them there in the first place.

Although support is available for addressing such issues in people's lives, I believe that a separate agency would facilitate a more unbiased maybe non-judgemental approach whilst addressing a person's deeper-rooted issues and exploring the underlying causes of their substance misuse. However, I am aware that for this to happen a person has got to be willing and want to change their life before such services will work but I would argue if it was a requirement whereby, they had to attend a certain number of sessions they may begin to actually learn something and acquire during this process a new found awareness that opens their eyes and prompts them to move forward.

2. SUMMARY OF THE CASE

The section below sets out a brief summary of the multi-agency chronology of services involvement with Kasey and family members. As outlined above, the integrated chronology for the case was then divided into a number of Key Practice Episodes (KPEs) from 2016 until the time of her death in November 2020, which are set out below and based on changes in her accommodation. These are then analysed further for learning and recommendations in Section 3 of the report.

2.1. Summary of events prior to the Period subject to review

One of 4 siblings, Kasey endured many years of emotional, social and behavioural difficulties. Her mother first noticed these when Kasey was 2 and at 6, her teachers asked her to take her to the children and family service, as they felt she was reacting badly to family bereavements. Kasey was bullied at school, and she periodically became very angry; shouting and throwing things. At 10 she was diagnosed with attention deficit hyperactive disorder (ADHD) and was prescribed Ritalin. At 14 Kasey was "statemented" at school because of sustained social and behavioural problems. She continued to experience bullying and left school without completing her GCSE's. She was by then smoking cannabis.

Kasey started college; however, her attendance did not last, and her drug and alcohol misuse had escalated. At 16 she was not coping with the separation of her parents and had an admission to Mascalls Park Hospital (a mental health unit) in 2006. In 2007 she was housed in a 9th floor flat in Rainham under the Homeless Act as she could no longer live with her family. Kasey was open to the Early Intervention in Psychosis (EIP) Service, and she was offered an assessment with a consultant psychiatrist although there is no record of the outcome of this assessment.

In 2009 Kasey moved to Romford, nearer to her mother. She was in a relationship with a man, who gambled and drank daily. In January 2009 Kasey was arrested (related to an argument with her boyfriend) and was irritable and angry. She had tried to engage with "First Stop" Westminster Drug Programme (WDP) but felt this did not help. Kasey received systemic therapy[11] from July 2009 until March 2010 via the Havering Psychological Therapy Service.

In 2011 Kasey had split up from her partner, was drinking heavily and regularly getting into trouble with the police. Her son was still in his maternal grandmother's care and Kasey had been given a suspended sentence for common assault. In November 2011 she attended Queens Hospital A&E with low mood from stopping smoking cannabis. She was prescribed Diazepam 5mg PRN and Concerta, referred to the Havering Access and Assessment Team (HAAT) and referred to the Improved Access to Psychological Therapy (IAPT) Service. In December Kasey was admitted to A&E after being involved in a road traffic incident. She denied it had been a deliberate suicide attempt and was discharged. Kasey chose not to attend sessions at IAPT when offered counselling in July 2012, she was receiving private counselling via "You and Me Counselling".

[11] https://www.bacp.co.uk/about-therapy/types-of-therapy/systemic-therapy/

In 2012, Kasey moved home to another property in Romford and attended rehabilitation through the Amy Winehouse Foundation. She was offered a 12-week residential programme and attended half, she was discharged after forming a relationship with another patient, she remained clean of drugs and alcohol for a while. In December Kasey was added to the IAPT waiting list again for cognitive behavioural therapy[12] (CBT) for anger management, after her private counselling ended. She received support from WDP, but her GP also referred her back to HAAT because of deterioration in her mental health; mood swings and misuse of alcohol.

In 2013 Kasey was assessed again in HAAT and diagnosed with borderline personality disorder. The plan was for her to be referred to the IMPART Personality Disorder Service, but she was sentenced to 12 weeks in prison for an assault on a paramedic after breaching the earlier suspended sentence from 2012. She was prescribed XL Concerta and reviewed by the HAAT psychiatrist after her release. Kasey was referred to IMPART Personality Disorder Service and she commenced group therapy, Cognitive Behavioural Therapy (CBT) in July 2014. She found it difficult to manage due to drug sales operating in her block of flats. She reported this issue several times and complained to the local authority housing department, asking to be moved.

In October 2014 Kasey was offered a second round of group therapy-CBT, however she struggled to attend regularly or to complete the homework due to continued behavioural and social difficulties. In December 2014 Kasey attended a review with IMPART and she was offered individual sessions in addition to CBT group therapy. She was also offered telephone skills coaching and dialectical behavioural therapy (DBT) skills group. In March 2015 the strategic and clinical lead for Personality Disorder Services met with Kasey and her mother to undertake some family work but they only managed one appointment. Kasey was eventually discharged from IMPART in May 2015 because she did not attend sessions and she was not engaging with homework. IMPART recorded that they would only accept a new referral on the condition that she was engaging with Drug and Alcohol Services.

In August 2015 the Kasey contacted Mental Health Direct (MHD) and shared that she was prescribed Zopiclone and Citalopram from her GP, but she did not think they were working. She also said that she had been sexually abused a few weeks prior by a taxi driver and she had terminated a pregnancy. The following day Kasey took an overdose of her Zopiclone, Citalopram and Concerta with alcohol and cocaine and she was admitted to Queens Hospital. She had been found lying in the road intoxicated saying she wanted to die. HAABIT were consulted however the team deemed that there was no role for them because the immediate issue that needed addressing was drug use. She was advised to re-refer herself to the WDP and she was referred back to IMPART Personality Disorder Service. However, IMPART also declined the referral because the Kasey's presentation was too chaotic, and she was thought to need to address her use of drugs and alcohol first.

2.2. Key Practice Episode 1 (Feb 2016-Feb 2017, Residing in temporary private sector leased accommodation, Flat 1)

[12] Cognitive behavioural therapy

In February 2016, Kasey was arrested for assault and possession of cannabis outside her property, which breached her tenancy agreement. The outcome was a suspended sentence for 10 months and this was part of a continuation of the pattern of offending by Kasey whilst intoxicated. She was allocated to an officer from the community rehabilitation company (CRC)[13], part of probation services.

Adult Safeguarding received 6 referrals from the police and LAS, following concerns over overdosing or suicidal ideation, over the next 6 months. Kasey felt insufficiently supported from mental health services, as services focussed on her substance misuse rather than on her mental health. The first example of this was when a Kasey had alleged an assault by police, related to the above arrest in February 2016. Housing interviewed Kasey, due to complaints from neighbours about her conduct (noise and drug use), in July 2016. Kasey stated she was not taking her medication (Zopiclone and Olanzapine) and wanted to be moved. She threatened self-harm and suicide by hanging herself from a tree. She had been referred to HAABIT, but was not seen.

Following the above probation order Kasey was seen for weekly supervision at CRC, she attended the first 2 appointments. She stated she had been refused help from mental health services on the basis of her substance misuse. She had been offered help from WDP but hadn't engaged with them, she was not required to do this at this stage, so it could not be enforced. She was then arrested again while driving and failing to give a specimen on request, for which she was fined.

She was started on the IOM Panel which aided with referrals to treatment services and unified approach to seeking rehab. However, Kasey became resistant to co-operating with agencies and for agencies sharing information, which affected the Panel coordinating her care. She was assessed by IMPART and was interested in mother daughter counselling. Kasey was discussed at a Community MARAC (CMARAC), following referral by an Anti-Social Behaviour (ASB) officer in August 2016 due to her behaviour and the ongoing conflict with neighbours. Minutes of the meeting showed that she was struggling to see her GP, had suicidal thoughts and wanted to move, but this was not approved as housing were due to hold a case conference with the Housing Allocations scheme.

In September NELFT received a MERLIN[14] report, from Sexual Offence Investigation Technique (SOIT) officer who had been allocated to Kasey, after her serious sexual assault allegations in April 2016, which was later abandoned due to lack of evidence. There was an incident involving racial abuse, violence and criminal damage to a neighbour's door in October 2016, she was arrested and bailed not to return to her flat. Housing served a notice to quit, and Kasey moved in temporarily with her mother and son. She was again given a suspended sentence, including a requirement to attend Drug & Alcohol services. She began weekly Dialectical Behavioural Therapy[15]

[13] https://en.wikipedia.org/wiki/Community_Rehabilitation_Company
[14] https://en.wikipedia.org/wiki/MERLIN

[15] https://www.nice.org.uk/guidance/cg78/ifp/chapter/glossary

An intensive psychological treatment that focuses on enhancing a person's skills in regulating their emotions and behaviour. It aims to address and alter patterns of behaviour by finding a balance or resolving differences (this is what is meant by 'dialectical'). The therapy can

(DBT) arranged via IMPART. She missed her next appointment with CRC and was re-allocated to a specialist female worker, she engaged well initially.

She was discussed at CMARAC in August, it was noted that her son was under the parental responsibility of her mother and the discrepancy between her not being allowed unsupervised contact whilst now living with them both. In September 2016 CMARAC recorded she had an appointment with a doctor, had begun with IMPART and hadn't supplied documents requested for her housing application. There are only very brief notes of multi-agency updates contained in the CMARAC Minutes.

She pleaded guilty at a court appearance in November for the incident with her neighbour and she was bailed again until full trial in February 2017. On the same day she attended court she was conveyed under Section 136 (S136) Mental Health Act 1983[16] to Goodmayes Hospital, as police had been alerted that she threatened to hang herself. She was discharged the same day, as deemed at low risk and advised to call the Crisis Line. The next day she phoned probation to state she was homeless, due to a breakdown in relationships she was now unable to stay at her mother's. She was advised to contact the Public Advice and Service Centre, a free advice service. Later she reported she was staying with an uncle, she didn't attend her next appointment with CRC, this was followed up and she made more threats of suicide.

She was then noted to have failed to attend 3 scheduled appointments with IMPART during the month, she also missed her next appointment with CRC, an enforcement letter was sent. She attended a CRC appointment in December 2016, at which she was described as argumentative. She refused to engage or divulge her current address, had failed further appointments with IMPART and was in danger of being discharged due to non-attendance. An injunction was obtained vs Kasey by Housing, and she was given temporary housing at a hostel.

2.3. Key Practice Episode 2 (March 2017-September 2017, Residing at Hostel 1, Abercrombie House)

She was referred by CRC to Advance Minerva, for support with her mental health and substance misuse, which she did not engage with well. Her placement at the Hostel was already at risk due to her behaviour which agencies found anti-social. IOM records noted she was still in danger of being removed from IMPART because of poor engagement. Copies of her notes were shared with her solicitor for a psychiatric report to be prepared for court. These were both done, resulting in an order at court to comply with drug treatment (DRR), with a further hearing due in February 2017**.** She was also found in breach of her probation order, was subsequently threatening and abusive to her CRC officer, this was then later withdrawn.

help a person gain control of behaviour such as self-harm and substance misuse. The therapy usually takes place over 1 year with weekly one-to-one and group meetings.

[16] https://www.legislation.gov.uk/ukpga/1983/20/section/136
If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—(a)remove the person to a place of safety within the meaning of section 135, or(b)if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

Kasey met with CRC after the court order, initially she was positive about the order and also met the drug worker from WDP, as required by the DRR[17]. She did attend groups, as part of the order although was sometimes late and inconsistent. This did break terms of the 3-month DRR, initially she was motivated to address her drug use, which was regular consumption of cannabis and occasionally binge drinking. Kasey reported feeling suicidal to police while at her mother's address, an ambulance was called, but later cancelled. She had not engaged with and had been removed from the IMPART group therapy by March 2017.

She saw her Advance Minerva worker with her solicitor to make a plan for engagement about her behaviour, to demonstrate this to the court ahead of the further hearing in May 2017. She reported her relationship had broken down with her mother and wanted support from Advance Minerva to go to the doctors. She had been rude and aggressive at CRC and had missed appointments with WDP as required by her DRR. She had stayed with her mother as she didn't like being in the hostel, but her mother had "kicked her out".

HAABIT received a Safeguarding Concern from the hostel in March 2017, as she was threatening suicide. A MERLIN was also received by HAABIT as Kasey reported mum threatened her with a knife. Further updates from police after they'd been called to her mother's address, that Kasey had been shouting at her son that he was not hers, police advised her to leave or be arrested, she then admitted her allegations over threats of a knife had been false.

She made an impulsive and serious suicide attempt in April 2017, by running in front of oncoming traffic and sustained injuries to her shoulder. She was detained again under S136 and initially taken to BHRUT for her injuries, then conveyed onto Goodmayes. She had been restrained by police with handcuffs and leg restraints, she was intoxicated with alcohol and remained at Goodmayes until she sobered up. She attended the Emergency Department (ED) x3 more during April, with further suicidal ideas and ongoing pain in her shoulder (X-rayed, no fractures), she was discharged home the same evening on all 3 occasions (on one of these she did not wait to be seen).

She was later seen by her Advance Minerva keyworker and hostel keyworker about her behaviour and related threat of eviction, she requested support and medication for her mental health. She was open to a worker from HAABIT by this time. Her probation worker had feedback from that she had been discharged by IMPART in April and was told she was on a waiting list for individual therapy, which she never received. IMPART stated to WDP they were unable to work with her until she was abstinent from drugs and alcohol. HAABIT follow up a referral from WDP for their assistance with Kasey and urgent Mental Health support, stating that "Personality Disorder and her associated behaviour was not mental health", but they agreed a joint assessment at a home visit with WDP. This was attempted once but she refused to be seen. She was arrested again for a public order offence. During April ASC received 4 MERLIN reports

[17] https://www.legislation.gov.uk/ukpga/2020/17/schedule/9/part/10/enacted
In this Code "drug rehabilitation requirement", in relation to a relevant order, means a requirement that during a period specified in the order ("the treatment and testing period") the offender—(a)must submit to drug rehabilitation treatment, which may be resident treatment or non-resident treatment, and (b)for the purpose of ascertaining whether there is any drug in the offender's body during that period, must provide samples in accordance with directions given by—(i)the responsible officer, or (ii)the treatment director.

(self-harm and suicidal, hit by car, cutting wrist in public, threatened suicide) 2 of these resulted in S136 assessments, she was discharged with advice to call Crisis Line if needs be, but not thought to be in need of detention for assessment in hospital under the MHA '83.

HAABIT attended a professionals meeting at the end of April 2017 with CRC to discuss services available to meet her needs, they felt that she ought to engage with WDP prior to them providing any input. WDP were not invited to this meeting, which was problematic for joint working between them and Mental Health. Her request for 1-1 therapy was closed in May without her being seen. Her CRC worker's view was she wasn't engaging with WDP and although psychiatrist had recommended Promethazine (an antihistamine, that can cause drowsiness, sometimes used for sedation/insomnia) as Kasey was not registered with a GP at this time, it couldn't be prescribed.

Her Advance Minerva keyworker again raised concerns with HAABIT about risks arising from Kasey's behaviour, and a social worker from HAABIT was due to do an unannounced visit with her manager for an assessment. The Advance Minerva keyworker attempted to follow this up with x4 in April, but there was no response, and the visit did not take place.

In May Kasey was discharged from an orthopaedics appointment for her shoulder, as she didn't attend and also didn't attend another WDP appointment. WDP were contacted by Advance Minerva to request a referral for residential rehabilitation, while they continued to attempt to engage with Kasey, with little success. As she hadn't engaged in groups through WDP she wouldn't have met the criteria for residential rehab and was thought unlikely to abide by the rules. Although unusual for cannabis use rehab would in theory have been a possibility if she had been sufficiently motivated to engage with treatment.

Kasey then made an allegation of rape to the police, which she later retracted, and made a suicide attempt by cutting her wrist.The Advance Minerva keyworker arranged a professionals meeting which took place at the CRC Office (CRC worker, mental health social worker and the hostel worker attended) to raise concerns about Kasey's mental health and need for specialist professional support for these needs. Feedback from the IMPART Senior Psychologist ahead of meeting was that IMPART received a phone call from Kasey. She was angry that she has been discharged and was requesting medication (diazepam). The meeting discussed rehab but for this to happen, Kasey would need to engage with WDP for a Care Act Assessment, which she hadn't been doing.

At the end of the month Kasey then requested a Care Act Assessment from ASC, but this was passed to NELFT as she was under their care. No Care Act assessment was completed. She made a further suicide threat to police from the hostel. She attended her GP making suicide threats related to the impending possible eviction from the hostel and requested diazepam, having been refused this (she was now prescribed promethazine). Another mental health assessment 4 days later led to her being conveyed to Goodmayes under S136, following further suicide threats. She was discharged with a plan for engagement with HTT and a trial of Olanzapine. Her hostel keyworker emailed professionals in June to say that they had spoken to one of the

consultants from the HTT there was an agreement the Lead psychologist would visit the hostel to see her, would give her anti-psychotic medication and carry out an assessment. She remained under the care of HTT until August 2017.

A similar referral was made via police the next day, Kasey was at her mother's address in Hornchurch. She was conveyed to the ED at BHRUT, although left before a full assessment was completed. She did say she was impulsive, didn't want to die, but felt at risk of violence and sexual assault in the hostel. Her GP noted a letter from HAABIT with a summary including the change in medication, planned engagement with IMPART and WDP.

There was a similar referral sent to Kasey's CSC worker by the LAS following a call out re suicide threats, a Police MERLIN was received at ASC the next day as Kasey stated she wanted to hang herself and another was sent 3 days later after aggression to her mother and her sister, when she visited for her son's birthday. Between June and Sept 2017 ASC received a total of 9 MERLINs and LAS referrals. Contact made with her mother by CSC to follow up the Police Notifications, she advised that Kasey, was not to come near the family home.

Advance Minerva closed her case as she was not engaging with them and her needs were too challenging. In July minutes of the IOM meeting noted that her behaviour at the hostel was increasingly chaotic, the hostel was seeking an injunction as they were unable to evict her, due to a court order, she was reported as equally chaotic at WDP. Her GP noted she had been discharged from HTT and had agreed to engage with IMPART for psychology, she had also independently applied for and been assessed by Sheffield Adult Residential Services Team for admission for rehab. She wasn't engaging with WDP by August, and her DRR order had ended, she was likely to be evicted from the hostel and was accepted for the residential rehab placement in Sheffield, but declined this, which she later regretted. She was arrested again at the hostel for affray in September, she then made more suicide threats. A MERLIN was raised by police. At probation she reported she had been drinking, stopped her medication but had started therapy with IMPART.

A safeguarding referral was sent to Mental Health by hostel staff, as Kasey was thought to be pregnant but still drinking and smoking cannabis. This was due to be investigated by IMPART, Kasey denied being pregnant, DBT pre-treatment and a crisis plan were formulated. She was again arrested for alleged assault (threatened to throw acid in the face of neighbours) and released on bail. Temporary Housing moved Kasey to another hostel in September 2017 (Queen Street Villas).

2.4. Key Practice Episode 3 (October 2017- September 2018, Residing at Hostel 2, Queen Street Villas)

She was seen again by WDP in October 2017, and she regretted not going to the placement which she had found in Sheffield, was re-referred to Advance Minerva by probation, was accepted and allocated to a new worker. The Hostel had taken out an ASB injunction against Kasey due to her behaviour in November 2017, WDP reported she was attending a group, but leaders found her behaviour to be disruptive. Housing believed she continued to smoke cannabis at the hostel.

An Initial assessment with a new Advance Minerva keyworker, noted her support needs and they chased up CMHT input following a GP referral. The Advance Minerva keyworker undertook an initial assessment of her as a new referral, and offered practical, emotional and advocacy support over the following 12 months, worked with Kasey's CRC and IOM workers. Kasey's mother applied for a Special Guardianship Order for Kasey's son, in December 2017 and an SGO assessment was completed by HCS in Feb 2018.

Kasey was discharged by WDP for non-attendance in February 2018, probation was also due to end in February, cannabis had been found in her hostel room. She reported low mood and anxiety about an impending court case. Her GP noted a letter from HAABIT who had diagnosed Emotionally Unstable Personality Disorder[18], with relapse indicators outlined, including confrontational behaviour. A medical review was held with a consultant psychiatrist, but Kasey did not attend x3 subsequent appointments, she continued under the care of IMPART, but again compliance was sporadic with them.

ASC were contacted via her hostel worker, in February 2018, as Kasey had been followed back to the hostel, by a man who said she owed him money, this was noted in another MERLIN which was passed onto Mental Health Services to follow up. Kasey threatened suicide by hanging, but a security guard "had to step in". Housing obtained an outright possession order for her flat, to which Kasey appealed. DWP invited her to claim PIP as Kasey was no longer eligible for DLA. Probation order ended, but Kasey remained with the IOM scheme. She was again arrested due to a public order offence.

A meeting of the Community Safety Partnership (CSP) felt she had been improving and Advance Minerva were made the new IOM lead agency in March, due to their engagement with Kasey, her risk rating for re-offending was reduced from red to amber.

Kasey lost her appeal vs eviction at court in April 2018 and was given notice, she threatened suicide to her housing worker. She was reported to be the victim of an assault. At the end of the month, she was again detained by police under S136, outside her mother's address threatened suicide and was taken to Goodmayes Hospital, a MERLIN was raised to ASC. Kasey reported to CSP in May that she had been punched in the back which was looked into by the IOM police team. Kasey was arrested for a common assault, was taken to ED, where she was found to be intoxicated and had scratches from restraints used by police, she was discharged the same day. Her case was transferred to a new worker at Advance Minerva, she was re-arrested for cannabis possession and again later in the month for another public order offence. She had not engaged with offers of group therapy at IMPART.

Kasey was seen twice more at ED during June, with vomiting and headaches, having called LAS both times, after being intoxicated the previous night. Kasey continued to call DWP about her benefit claim for PIP. The HTT contacted police about Kasey leaving hospital, stating she would kill herself. Police found her back at the hostel,

[18] https://www.mind.org.uk/information-support/types-of-mental-health-problems/borderline-personality-disorder-bpd/about-bpd/
Emotionally Unstable Personality Disorder is another name for Borderline Personality Disorder

Kasey refused to engage or speak on the phone. A MERLIN was raised with ASC about this, she later returned home. Kasey engaged in an assessment in June with WDP and subsequently attended 5 face to face key work appointments. Kasey reported that she did not wish to attend groups at that time.

Her WDP worker requested for a Care Act Assessment from HAABIT, it was unclear what the outcome was for this. DWP noted her change of address to Hornchurch, and she contacted DWP about her DLA ending but that she was only put on standard rate for PIP, she was very distressed on the call and requested the decision be reconsidered.

2.5. Key Practice Episode 4 (October 2018-June 2019, Residing at Hostel 3, Will Perrin Court)

She was evicted from the hostel, in September 2018, she called her CRC worker threatening to kill the hostel manager and herself. A Judge ordered Housing to reconsider and offer her interim housing. Staff changes at Advance Minerva led to another change in worker, who supported her request for Housing to offer her something else. Her GP wrote to housing at Kasey's request to ask for an accommodation change out of the area. She requested an extension to the DWP deadline to supply extra info in support of her PIP claim.

Housing then offered her a temp flat in Tilbury, in October, she viewed this and said she would accept it, although her solicitor then wrote saying she needed something in borough to be near her support network (family, Advance Minerva and WDP). She was then offered temporary housing at another hostel (Will Perrin Court). Work was done on her benefits change, after she had contact with DWP about a Universal Credit application. Support was provided by her new keyworker at Advance Minerva. Severe Disability Premium was awarded by the DWP. Further support from Advance Minerva in November 2018 about her housing appeal and Housing Benefit, Kasey made a complaint about the quality of this support, which was investigated by the service manager.

Kasey's mother was granted the Special Guardianship Order[19] by the Family Court in December 2018 and Kasey contacted HCS due to frustration in accessing her son. Police were involved with an incident with another hostel resident, in January 2019, who declined to give evidence, Kasey made counter allegations that she'd been hit with a fire extinguisher. She called an ambulance and was taken to ED for vomiting, this happened twice during the month, on the second occasion she admitted taking cocaine. Her GP re-referred again her to HAABIT and IMPART. Kasey called 111 in February 2019, as she needed prescription for quetiapine, advised to contact her GP.

Kasey was conveyed to ED following threats of suicide, in March 2019, but left after verbal aggression to staff, she made complaints that they were ignoring her. She contacted police again, claiming to have been a victim of theft at the hostel. Kasey

[19] https://www.familylives.org.uk/advice/your-family/fostering-adoption-kinshipcare/special-guardianship-orders
A special guardianship order is an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement.

was referred to ASC from Housing in April 2019, as Kasey was due to be evicted from the hostel for non-payment of her rent and threats of suicide, this was passed onto Mental Health services for their attention, she was referred onto WDP again by HAABIT. IOM Panel noted she was £14K in rent arrears and was arrested for shoplifting. Despite not being subject to probation at this time she contacted the office x5, was noted to be abusive to staff.

Police again were called as she alleged she had been a victim of a public order issue (no details). The next day Advance Minerva records show she was re-referred to them by IOM, with a request to be the lead agency for the IOM panel. However, they were not working with her at the time, due to her previous non-engagement. At this time Mental Health workers were not attending the IOM.

Kasey wrote to Housing in May 2019, to complain about an offer of accommodation, being in a shared property, her mother also wrote re her housing needs in support of re-housing offers. Her Advance Minerva keyworker liaised with IOM and probation during May. She once more was taken to ED by the police, on this occasion Kasey had jumped out of a hostel window with a phone cord round her neck, she was rescued by police who were onsite at the time. She was discharged into the care of her mother and sister. Information was shared with ASC, who deemed that the S42 threshold was met for a safeguarding enquiry, due to the high risks of suicide, this was passed to MH services, but no enquiry was attempted. Further similar suicide threats happened again shortly afterwards, this time at her mother's house, which resulted again in police attendance and a S136, whereby she was conveyed again to Goodmayes for assessment. A MERLIN was sent to ASC, which was passed onto Mental Health services for information.

2.6. Key Practice Episode 5 (June 2019-November 2020, Residing in temporary private sector leased accommodation, Flat 2)

Housing noted her application and accepted their duty to house her, they continued to look for suitable accommodation which led to a private sector leased accommodation being found in Harold Hill (Straight Road), where she moved in June 2019. Kasey had been discharged from IMPART and HAABIT services due to her non-engagement in July 2019, she phoned 111 as she had run out of medication, she was advised to attend her GP, Kasey threatened suicide then hung up the phone to 111. BTP Police attended an incident where Kasey was on a railway track and staff had called, 5 officers were needed and she was violent (punched officer) and aggressive in the police van, when she was brought again to ED. She later called 111 again about injuries sustained during this arrest incident.

Advance Minerva keyworker was again in touch with Kasey, but closed her case at ' Kasey s request. There was a pending court case for assault on the police (as above), Kasey had been due at her mother's but went missing for 24 hrs, so her mother alerted police which was shared with other agencies. She again attended ED after vomiting, having drunk Gin and taken amphetamine in August 2019, a one-off event, not indicating regular use. She had assaulted police when they attended the scene, she head-butted an officer, when other officers attended she bit one on the hand and spat at another. Police shared information on this with Advance Minerva worker.

An unannounced visit was made by IOM police and a Peabody support worker in September 2019, Kasey requested her case by closed to IOM, but the decision was made not to do this, and Peabody were made the lead agency for IOM purposes. Some further contact was then initiated by Kasey with 111 about her medication.

Kasey was due to start a nail course, she'd been banned from the library and requested money for a laptop. Monthly IOM summary for November, stated she had started the nail course had engaged with the Princess Trust, she had received an advance from DWP and hadn't come to police attention, apparently reported a 3 yr relationship with a man who had weapons, which police were to explore. IOM again referred her to Advance Minerva, with the advice of no lone working, due to the above weapons link alert.

Another incident at her mother's led to police attendance, she was again suicidal and smashing up the house, on this occasion 6 officers were needed to convey her to ED. She was not allowed in hospital due to her violent behaviour; she was released home after assessment. The Princess Trust offered £500 towards the cost of a laptop. IOM Panel monthly summary noted she wasn't coming to police attention, some hit n miss engagement with Advance Minerva, attempted 3-way meeting for assessment and a support plan but Kasey didn't engage with this.

Advance Minerva keyworker shared another concern about suicide with IOM and completed a safeguarding referral to ASC. Police records show she contacted them threatening to hang herself but refused to open her door when they attended her address. The Risk RAG rating was lowered to green at the IOM, as Kasey had been housebound and had received her laptop. Kasey didn't respond to Advance Minerva worker's attempts to contact her. Kasey had contacted 111 again about medication (quetiapine and gabapentin). Kasey then attended ED for medication, but she was removed by security and advised to contact her GP.

Kasey was then brought to ED again by police in February 2020, who attended her flat, where she had pulled a radiator off the wall while intoxicated, leading to flooding and was banging her head on the floor. She was given IV Lorazepam and CT scan at ED, then moved to psychiatric exam room, where Kasey was found to have "no mental health disorder" and thought not to be in need of mental health services, so discharged home.

In February 2020, ongoing issues of alcohol and abusive conduct to probation were documented, she was arrested for breach of a court order. Kasey was again discussed at the IOM panel with Kasey requesting to be left alone. By this time Kasey had been known to IOM for 3.5 years and the decision taken by a majority at the panel (9 for this, 2 against it) was to remove her from IOM, but they noted also she had the option to engage with services (Catch 22, Advance, WDP) and that increasing independence might work better for her.

A letter was sent to Kasey advising her of GP services, which were now to be provided through the "special allocation scheme"[20] also 3 surgeries she wasn't allowed to attend, but she was given a list of others. She was under their care from Feb 2020 until the time of her death in November 2020. This was a decision taken due to 4 events of violence and aggression to staff between 2017-2020. As her surgery no longer held the contract for this she was transferred to the new provider (Loxford Polyclinic) in Ilford and subsequently to a clinic in Catford.

The referral to Advance, was closed at the start of March 2020, due to her non-engagement without her being seen. There was another serious incident at home on the 13th March which led to police attendance after a call by a neighbour, due to noise of shouting at night. When they arrived, Kasey had jumped out of the window and the police caught her by her ankles where she was hanging out of the window. Kasey was restrained by 4 officers, her legs were strapped together as she was kicking at officers, who then took her to Queens Hospital under S136.

Due to seriousness of this suicide attempt she was subsequently placed on MHA'83 S2, she was sedated, due to the level of disturbance and admitted to Knight ward Goodmayes when a bed became available. In the interim she made allegations of inappropriate conduct by a security guard who had given her his number. This was noted as a potential safeguarding concern, which were sent to ASC, and he was suspended pending investigation. A ward discussion she recorded on her phone on the 24th, showed that Kasey was distressed and didn't want to go home as she felt unsafe, due to her impulsiveness. Staff stated the ward was not the best place for her, partly due to Covid risks and also due to her difficulties being chronic rather than acute.

On the 26th March the UK government introduced the first national lockdown as a response to the Coronavirus pandemic[21]. The impact of this on Kasey was not commented on by agencies. She was transferred to Picasso ward the next day, another recording by Kasey at this time noted she now wanted to go home, during her admission she was seen by both OT and Psychology, encouraged to engage with D&A service post discharge.

Prior to discharge in early April, Kasey met with an assistant psychologist and Kasey stated she wanted support, but not through IMPART as she found them too rigid, and they never addressed underlying her PTSD after a historic sexual assault. Kasey was discharged home following a 2-week admission. Kasey made several calls to police re; neighbour, who she felt was trying to get her evicted. Kasey was then allocated to HTT[22] for follow up in community, as was standard practice after an admission.

HTT contacted her at home, where she reported to be self-isolating due to the pandemic and that she didn't need follow up over next 14 days. HTT continued daily telephone support, Kasey reported neck pain after police arrest prior to admission,

[20] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/safety-and-quality/if-you-are-a-patient-assigned-to-the-special-allocation-scheme/
Special Allocation Schemes were created to ensure that patients who have been removed from a practice patient list can continue to access healthcare services at an alternative, specific GP practice. NHS England has a responsibility to ensure that all patients can access good quality GP services and that patients are not refused healthcare following incidents that are reported to the police.

[21] https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

[22] Home Treatment Team

denied suicidal thoughts. Then Kasey was phoned by a STR[23] worker, she was out at Tesco, shouted at the worker that MH services not supporting her with a care coordinator over an impending court case. She had been referred to IMPART but she said she wasn't being listened to.

The following day 7x unsuccessful calls from HTT were made. She was spoken to the next day and made complaints about conduct of HTT, repeated that she wanted a care coordinator but was told the criteria for this was "severe and enduring Mental Health Problems". HTT referred Kasey back to HAABIT, which was refused due to Kasey's GP being in Lewisham as a result of the SAS (in previous KPE) due to funding issues, the manager stated that she would need to be referred to Lewisham. This led to a delay in her care being accepted by HAABIT. Kasey informed Housing that she could not access her GP for medication and no Havering GP would accept her. HTT attempted further telephone support, which was unsuccessful so discharged her from the service and sent discharge summary to her GP (in Lewisham).

A MERLIN received at ASC noted further police attendance after another dispute with her neighbour over noise, she was judged safe to leave at home as she refused an ambulance. Further phone contact by the HTT with Kasey in April and a similar discussion was held again, explaining discharge from HTT but she could contact for next 2 weeks, HTT referred again to HAABIT but again this was declined, on the basis of her GP in Lewisham. Another similar x2 calls to police due to noise from her neighbour, who was spoken to by police, with No Further Action. Information was shared again via a MERLIN raised to ASC, which was passed to MH services for information only.

Kasey was also discussed at Housing Vulnerable Persons Panel in April 2020, where the recent incident with police attendance and her pulling a radiator off the wall, which she claimed as an accident while intoxicated. Her Diagnosis was recorded, as was the issue of her having no access to a local GP, she felt she did not need WDP support. Her behaviour including noise at night, with her pacing around her flat (multiple complaints to police) and the area were recorded, as were concerns from neighbours about her mental health and threats of suicide.

An update form NELFT noted was that she had a Personality Disorder, was no longer in treatment with them, IMPART, nor a GP. She was noted to like her flat and a recommendation was included for her to be supported to keep her flat. She was then discharged from the VPP in May 2020, with no actions recorded. ASC noted 4 more MERLINS were received in May, due to ASB, violence and risk of overdose, noted no local GP surgery. Kasey phoned Mental Health Direct, re flashbacks to her admission under the MHA '83 in April and the security guard's conduct, she also stated further suicidal thoughts, an email was sent to HAABIT about the call from Mental Health Direct.

She then called LAS expressing suicidal thoughts and she was conveyed to Queen's hospital, where she was assessed by Psychiatric Liaison and said she wouldn't kill herself so was discharged home and advised to self-refer to HAABIT. Police noted

[23] Support Time Recovery Worker

Kasey remained stressed about losing her accommodation again, due to conflict with her neighbour.

Police forced her door again in May following a call about a suspected overdose, they found medication strewn over her flat and she was found in a local park from where she was taken to hospital. A safeguarding referral was made by the hospital to ASC, which was triaged and closed as Kasey didn't meet the threshold, due to this behaviour being viewed as a mental health problem, related to an overdose rather than a safeguarding concern. She subsequently denied the overdose, and this was referred to Mental Health for them to follow up through Care Management and practical help to secure her door. Unclear whether any action was taken about these issues.

Kasey called her TAMO[24] to report the above incident, who also made a safeguarding referral and initiated a support plan. She called HAABIT, again asking for a care coordinator and a psychiatrist, Kasey was spoken to by a nurse and asked to call back when she had calmed down. Kasey was called back and wanted PRN medications to help manage her anxiety and to talk to someone, but then she hung up. A risk assessment was done by HAABIT, and Kasey was then referred to CRS (Community Recovery Service) in June 2020. CRS discussed the referral 4 days later and a CPN was due to follow it up, notes from the following week stated several unsuccessful attempts to contact Kasey by phone.

A second discussion was held at the Housing Vulnerable Persons Panel in May 2020, at which it was agreed to close her case to the VPP, as she was in touch with services and not thought to be at risk of eviction. 2 further unsuccessful calls were attempted by the CPN from CRS. She was spoken to briefly by a CPN in June. CRS discussed her case at a team meeting the next week, at which it was noted Kasey was requesting a Care Coordinator and CRS were continuing to offer short term structured input

NELFT received another MERLIN report in June as Kasey had phoned police with threats of suicide, if police charged her with an offence in connection with her neighbour. A subsequent plan by CRS was to do a joint visit for an assessment, which was undertaken 2 days later. At this Kasey was negative and tearful, worried about a conviction and requesting help with making a complaint to police. She was told CRS were unable to help with this, but could refer her on elsewhere. She became upset, admitted ongoing cannabis and alcohol use, but didn't want another referral to WDP. She agreed instead to a referral to the Anger Management and Emotional Control Service (AMEC) and agreed she would engage with CRS. A CRS team discussion led to plan to allocate Kasey a care coordinator later in June.

The next update meeting at CRS, noted she was still waiting for the allocation of a care coordinator, no other action had been taken. She was then allocated in July and her care coordinator (CC) contacted her mother the next day. This was accidental as the number on record was her mother's instead of Kasey's, her mother explained the care she provided for Kasey's son and current weekly contact arrangements with Kasey. CC then made an unsuccessful call to Kasey's number after this was shared by her mother.

[24] Temporary Accommodation Management Officer

A CPA meeting was held in August, at which a plan was made to reduce her quetiapine and consider short-term prescribing due to the risk of Kasey taking an overdose, and a plan to refer to AMEC and that Kasey was viewed as currently low risk of suicide, she placed in the "green zone" due to this view of her risk as settled and that her symptoms were well managed. Kasey presented to the sexual health clinic in August for a replacement contraceptive implant, at which she disclosed her previous partner had been in prison, on remand, for the past 8 months. She expressed reluctance to continue with her current partner, but felt compelled to as she was lonely. Also, acknowledged increased alcohol consumption and how this was having a detrimental effect on her mental health.

In summary evidence to the inquest her consultant psychiatrist with the CRS stated that it was also agreed that her CC would arrange a support worker to support Kasey with daily living/social activities. Also, to refer for Anger Management and Emotional Control Service (AMEC) – Kasey had agreed to this. The consultant was asked how the service managed the issue of fluctuating risk to self and stated that this was through: Repeated discussion with her about the crisis and contingency plan, Sharing information about risk, Communicating with different agencies such as the GP. In relation to the sharing of risk information, the Dr stated that she considered the risk in August 2020 to be low. The long-term risk was however medium to high. The longer-term risk was not communicated to the GP or in the Rio records. Her Dr accepted that it should have been. There were no records of potential risk factors affecting suicide, such as a consideration of her attachments and protective factors, nor motivating factors explored to contextualise the statements regarding risks of suicide.

Police were again called by her neighbour, who had a civil prevention of harassment order taken out vs Kasey, which she had breached. A MERLIN with this info was shared again with ASC. Her CC phoned Kasey and offered re-referral to WDP which she refused and was told that she would be allocated a Support Time Recovery (STR) worker. Kasey again called 111 for a repeat prescription, which was sent out for her collection at a local pharmacy.

In August 2020 police and ambulance attended due to further ongoing disputes and issues with her neighbour. Kasey said she was suicidal and was also self-harming, so police placed her on S136 again and conveyed her to the ED at hospital where she was given Lorazepam and seen by psychiatric liaison services. A Safeguarding referral was made by ED to ASC. There was no requirement for hospital admission at this time, as Kasey said she was no longer suicidal when interviewed via a video link by the AMHP and the crisis was resolving. The MDT, Kasey and her mother agreed that Kasey could be reviewed in the community, and she was discharged. Her CC and psychiatrist agreed this was part of usual pattern and Kasey could be discharged without HTT referral, as she didn't present a current risk to self or others. CC called Kasey who was by now at home and given support and reassurance. Another similar call 2 days later was made by her CC, at which Kasey reported feeling better. Kasey was then allocated a male STR worker who called Kasey, but she requested a female worker. CRS allocated Kasey a female Social Worker in September 2020. Housing reviewed Kasey's behaviour, and an unacceptable code remained on her TAMO records.

A psychologist was allocated in October from AMEC, she phoned Kasey and scheduled a video session for 10 days' time. Further contact with her STR about support available from college re an assignment that Kasey was struggling with completing on time. A further call with her STR worker, noted that Kasey had not accessed Learning Support at college, further phone support was offered to her for the next week. A follow up call with Kasey was made by AMEC, at which she declined the offer of online group therapy, subsequently on a call with CC Kasey wanted to raise a complaint about not being offered individual therapy. This was repeated in a subsequent call with her CC, who explained the impact of the pandemic on services and gained her consent to refer Kasey to advocacy and 1-1 counselling. Kasey then contacted the AMEC assistant psychologist and agreed to the sessions.

Kasey made threats to her mother via text to kill herself on 01/11/20, and police attended her address at 3.30pm, they broke her door down and found her with a noose round her neck in her kitchen, her lips were blue, and she wasn't breathing. Police gave life support until an ambulance arrived and Kasey was taken to hospital, she was admitted to ITU and resuscitated, but she deteriorated and sadly died. Her cause of death was recorded as brain ischemia and self-hanging. Her mother and father had been contacted and were with her when she was pronounced deceased.

3. Analysis of Practice against Terms of Reference

This section contains comments on the practice found in this case, set out against the agreed 3 Terms of Reference for the SAR. These are taken from a review of the information set out in Section 2 and subsequent follow up discussions with key personal involved with Kasey during the period subject to review.

3.1. The co-ordination of partnership working to focus on the effectiveness of multi-agency groups, including those previously highlighted in this response. (ToR 1)

There were 3 strategic/client review forums to share case related updates in the following areas, which are each set out below, with a brief description of the remit for each panel and some analysis of how these functioned for agencies working with Kasey along with areas of wider learning;

3.1.1. Integrated Offender Management

- Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
- In 2015 due to Pan London Changes there was a massive increase in the client group, up to 100 people. Further changes are taking place and currently there are 60-70 offenders on the Havering IOM at any given time,
- Kasey first referred to IOM in Sept 2016, due to her prolific offending, she remained open to IOM until Feb 2020, with monthly updates and her case escalated to the Main Panel on 17 occasions during this time.

Learning Points

1. A useful forum for updates between agencies on contacts with Kasey, this was hampered by the large volume of cases, Kasey's sporadic compliance and the absence of a representative from Mental Health or other Health Services.

   The Mayor's Office for Policing and Crime (MOPAC) are in the process of recruiting Pan London - IOM Mental health Practitioners, these workers will be a dedicated resource for the IOM to utilise in Havering. These mental health practitioners will be conducting consultations, assessments, addressing dual diagnosis of mental health and substance misuse, offer treatments (5-8 sessions) make onward referrals and attend our IOM panel meetings. The projected start date for this service is April 2023. (*The IOM hope that using these specialist practitioners the IOM can develop a stronger working relationship with local MH providers to better understand and address the needs of the shared client group)*

2. A Lead Agency role was assigned, at various times this was Probation, Advance Minerva and Peabody, (but not Mental Health), although the role/responsibility of this Lead Agency was unclear it appeared to be based on who was in contact with Kasey rather than what tasks were deemed a priority.

(The IOM hope that the above specialist will assist with the provision of advice and support to to aid reintegration, rehabilitation and reduce reoffending.)

3. The dedicated IOM Police support the other agencies involvement, but they would also benefit from dedicated Mental Health input, to advise and support work with knowledge of Personality Disorders.

(The IOM Met Police now do have an internal specialist Mental Health Police Officer they can go to for support and guidance.)

4. Plans for the IOM Panel, include to update information sharing with a secure shared IT system (E-cins), subject to sign off by all agencies. This will be helpful for both the mid monthly IOM forum for updates and where necessary for subsequent escalation to the Main IOM Panel, for appropriate decision making.

3.1.2. Vulnerable Persons Panel

- To coordinate actions that will support vulnerable residents whose needs are challenging and complex AND who live in Havering Council managed, owned or rented accommodation.
- To ensure that multi-agency communication and information sharing about vulnerable residents takes place on a regular basis.
- To support practitioners and managers in managing the most challenging and concerning cases where Anti-Social Behaviour and Tenancy Sustainment policies and procedures and multi-agency working have been unable to reduce or remove the risks, including of eviction
- Kasey was only discussed twice at the VPP, in April and May 2020
- Very little information about the VPP involvement in this case, Minutes of May VPP just state she was to be removed from VPP
- (Since the time of this case, VPP is now held virtually using MS Teams, which is recorded, allowing access to a transcript of the meeting)

Learning Points

1. Kasey was evicted from her housing 4 times so should have been discussed at other points in the period subject to review, given problems maintaining her tenancies, outlined in summary, it was unclear why this was not done earlier. (See appendix 4)
2. Suitability of available temporary housing stock for her being found in hostels for most of the periods under review. These seemed quite unsuitable for her given her repeated problems with others in the hostel, it raised risks for both Kasey and others.
3. Housing needs were met, but hostel life can have a significant detrimental impact on mental health and resulting behaviour, exacerbating stress arising from conflict in the hostels, this could have been considered through the VPP Process
4. Clarification of the role of the VPP and how this might address the repeated issues arising would be potentially useful in similar cases in future.

3.1.3. Community Marac

- The Havering Community MARAC (Multi-Agency-Risk-Assessment-Conference) is a meeting where information is shared on the highest risk/Complex cases between representatives of Community Safety, local

police, Mental Health, housing practitioners, Safe-guarding Advisors and other specialists from the statutory and voluntary sectors.

- After sharing all relevant information, they have about an adult at risk / person causing harm, the representatives discuss options for increasing the safety of any adult at risk and turn these into a co-ordinated action plan.
- The main focus of the Havering Community MARAC is on managing the risk to the vulnerable victim but in doing this it will also consider other persons affected and managing the behaviour of any person causing harm.
- The panel will decide on the best approach to managing the overall risk to the adult at risk /the community at large and on effective safety planning strategies.

Community MARAC involvement in KE's case

- Referred to CMARAC by ASB Officer (August 2016) when she was in her first flat at beginning of chronology.
- 2 relatively brief periods of involvement, which were similar to the VPP involvement, in that some information was shared between agencies, but this was very limited.
- Difficult to evaluate the effectiveness of the CMARAC from the materials supplied to the SAR.
- There did not appear to have been any risk assessment or risk management plan made for Kasey at the CMARAC

Learning Points

1. Unclear what actions were to be taken, how for example her conduct was related to her mental health problems and what support the CMARAC could arrange to avoid her losing her housing.
2. The CMARAC seemed to be an appropriate forum for discussion at the points where ASB were involved with disputes and problems with temporary accommodation. However, it was unclear how agencies were using the panel to assess and share risk management plans related to housing needs.
3. CMARAC would be more effective if it included a commitment from all involved agencies to attend and agree coordinated risk management plan to address the factors affecting anti-social behaviour, for example mental health, substance misuse
4. For cases not to be closed to the CMARAC until actions are completed and reviewed, with clear outcomes balancing the client's needs with their impact on others.

(It is noted that since the time of this case, the CMARAC referral form and minutes templates for the CMARAC have been updated to improve risk assessment, management and action planning, with this to be monitored by the Community Safety Officer, via a tracker system and with escalation for uncompleted actions)

3.2. Examination of the circumstances of referrals/ concerns passed to ASC to establish if Kasey reached the Care Act level of Care and Support needs which should have triggered a Care Act assessment (ToR 2). Would this have provided improved multi-agency co-ordination?

Summary of referrals to ASC and the response to these

- 46 separate Merlin Reports, or other referrals to ASC/CSC, all were sent straight onto Mental Health Services for their attention and response. No other action was taken by ASC, other than 2 Safeguarding referrals which were thought to meet the S42.1 threshold (see below).
- 2 Requests for a Care Act Assessment (1 from Housing, 1 from Kasey) both were raised directly with Mental Health Services, unclear what was the response to these.
- 1 Care Act Assessment was also begun by WDP, specifically for the potential referral for Kasey to have residential rehab for her cannabis addiction, but this was not completed.
- 2 Referrals for Safeguarding Adults triaged to meet the S42 Criteria, and both were passed to Mental Health Services to complete a Safeguarding Enquiry.
- Mental Health Services never completed a S42 Enquiry or a S9 Care Act Assessment following receipt of these referrals.

Most of the referrals which were sent to ASC were by the police using the Merlin system to notify of an incident of either violence/ASB which Kasey was usually the perpetrator of, but also several where she was the victim.

3.2.1. Duties under Section 9 Care Act 2014[25],

Where it appears to the Local Authority that a person may have needs for Care and Support, the Authority must assess:
Whether they do have needs for Care and Support; and If so, what those needs are.

The duty to carry out a needs assessment applies regardless of the Local Authority's view of: The level of the person's appearance of need for Care and Support; or the level of their financial resources. The assessor must understand how any Care and Support needs impact on the person's ability to achieve their personal goals in relation to their Wellbeing.
An assessment must involve the adult, an advocate in some circumstances, any carer and anyone else that the adult wishes to be consulted, it is **not** about determining whether the person's Care and Support needs are eligible; determinations on eligibility are made after the assessment is completed.[26]

Learning points

- Kasey had an appearance of needs and so should have had entitlement to a Care Act Assessment and this duty did not appear to have been met, it was

[25] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs/enacted

[26] https://www.proceduresonline.com/resources/careact/p_leg_req_needs_assess.html#3.-who-must-be-involved-in-the-assessment

identified in ASC and then transferred to NELFT (as part of S75 agreement) but did not result in an assessment of needs in line with the above duties.

- If a Care Act assessment had been done, it would have given Kasey an opportunity to have advocacy (under S67[27]) and the involvement of her mother, who provided a lot of care, as well as parental responsibility for her son.
- It would have been useful to identify the links between her mental health, physical health problems and her addiction to cannabis with the overall impact on her wellbeing
- At the least an outcome from the process of a Care Act assessment, would have given her, her family and all agencies a structure with which to share information, opinions and perspectives about her complex circumstances for a strengths-based approach to work with Kasey and her networks of support.
- It would have also given an opportunity for the development of better operational multi agency integration as part of both the assessment of and potential for meeting of her eligible needs, as it would have given more time for professionals working with Kasey to share information than was available in the 3 Panel Meetings discussed above (3.1)

3.2.2. Duties under Section 42 the Care Act 2014

S42(1) i. has needs for care and support . ii. is experiencing, or is at risk abuse or neglect, and iii.as a result of their needs is unable to protect themselves

S42(2) iv. making (or causing to be made) whatever enquiries are necessary v. deciding whether action is necessary and if so what and by whom.

The S42 duty on the local authority exists from the point at which a concern is received. This does not mean that all activity from that point will be reported under the duty to make enquiries (S42(2) of the Care Act). It may turn out that the S42(2) duty is not triggered because the concern does not meet the S42(1) criteria (points i.-iii. above)[28].

Learning Points

- Given that Kasey was a significant risk to herself from impulsive acts of self-harm, this could have met the S42 threshold on numerous occasions, under the broad definition of "self-neglect" which is set out in the Care Act Statutory Guidance, as follows.
- "This covers a wide range of behaviour *neglecting to care for one's personal hygiene, health or surroundings*". An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by

[27] https://www.legislation.gov.uk/ukpga/2014/23/section/67

[28] https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf

controlling their own behaviour. There may come a point when they are no longer able to do this, without external support."[29]

- Also given that she was the victim of incidents, including sexual and physical abuse these ought to have also been addressed through a S42 Enquiry and on 2 occasions the ASC MASH Team identified that the S42 duty was triggered following referrals to them which were triaged prior to passing onto NELFT.
- The development of clear guidance for NELFT to instigate a S42 in these circumstances and how a safeguarding plan for the adult who may be impulsive and suicidal would be of benefit for future cases.
- This could be a good way to incorporate crisis and contingency arrangements, shared as part of multi-agency work as well as with the client and carers.

In summary, the Care Act 2014 sets out duties in relation to the assessment of needs for care and support, and for safeguarding adults in certain circumstances. Neither of these duties were met in this case when the thresholds were clearly met on several occasions for both areas. These are both local authority responsibilities but are transferred to NELFT, as part of the S75[30] agreement with Havering Council.

If these duties had been met in line with the statutory guidance, then they would have given a statutory structure for collection of information, coordination of multi-agency decision making and formulating joint care & support planning, or risk management/safeguarding planning. In many ways the process of undertaking these would be just as important as the outcomes insomuch as one of the themes of this review is that Kasey had complex, multiple areas of need and despite the forums (set out above in 3.1) there was insufficient coordination of services and support for her.

3.3. Is the level of services potentially required to have supported Kasey currently accessible to partners?

3.3.1. Services requested by Kasey and her Mother;

a) 1-1 Counselling.

IMPART offered counselling but only DBT group counselling was available, which she was offered at several points, but did not consistently engage with.

Anger Management and Emotional Control Service offered group counselling remotely via video, (referred in August 2020, offered assessment in Oct 2020, spoke to assistant psychologist in Nov 2020)

Kasey did not want this and was angry at the delay/level of service offered to her

Mother-daughter counselling (service not available)

b) Residential Rehab (assessed by WDP but did not show required level of engagement with)

c) Support Worker (advised in 2016 to contact WDP, but did not meet criteria, much later she was offered a Support Time Recovery Worker in 2020)

d) Medication (Kasey frequently requested diazepam, which was declined. Was prescribed Olanzapine, quetiapine, gabapentin and promethazine at various times, but

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

[30] https://www.legislation.gov.uk/ukpga/2006/41/section/75

didn't find it helpful, frequently noted she was not taking medication, but also requested this often from 111, LAS and her GP, several medication reviews with HAABIT noted)

Learning Points

- Counselling was offered repeatedly, but Kasey didn't engage well with IMPART as struggled with the group and homework aspects of DBT. This was also the case with AMEC referral in 2020,
- Could 1-1 therapy have been provided at any time in response to the requests which Kasey and her mother made, or is this a gap in service provision?
- A longer-term support worker would have offered Kasey a more consistent point of contact, support was offered by Advance Minerva, Peabody and a STR Worker but engagement with this was sporadic, there could be a different service model rather than repeatedly closing her case when she disengaged and refused help.
- Medication was offered on many occasions, but Kasey struggled with it, although frequently asked 111, LAS and GP for some sedation at times of crisis, different medication seemed to be tried, but not effectively monitored or reviewed either at her GPs or the different psychiatrists that worked with her.

3.3.2. Access to a GP

Kasey was with a GP locally in 2016, de-registered in 2017, assisted to get re-registered in April 2017, but refused to leave surgery resulting in S136 arrest. Referred to Special Allocations Scheme in February 2020 and subsequently to a surgery in Catford.

- The Special Allocation Scheme (SAS). NHS Regulations allow a GP practice to immediately remove a patient from their list following any incident where a GP or member of practice staff has feared for their safety or wellbeing, resulting in the incident being reported to the police. Special Allocation Schemes were created to ensure that patients who have been removed from a practice patient list can continue to access healthcare services at an alternative, specific GP practice. NHS England has a responsibility to ensure that all patients can access good quality GP services and that patients are not refused healthcare following incidents that are reported to the police. Patients are registered on the scheme by the submission of a Violence Reporting Form to NHS England, or CCG with Delegated Authority by a GP practice[31].
- Special Allocation Services were previously commissioned for each borough by the CCG but with the formation of STPs (Sustainability and Transformation Partnerships), the SAS was commissioned in larger multiborough groups.
- Base is at Hawstead Road in Catford, but One Health Lewisham provide clinics locally at Loxford Clinic in Ilford and Kenworthy Road Health Centre in Hackney.
- Kasey's care was transferred on 01/02/20 from the previous SAS provider King's Park Surgery. Patients were registered in a holding practice in NEL, the Orient Practice, until a new NEL SAS practice, with its own EMIS code could be established.

[31] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/safety-and-quality/if-you-are-a-patient-assigned-to-the-special-allocation-scheme/

- Kasey was considered to have had ready access to services, with a dedicated SAS phoneline and access to see a GP locally on specific days as well as to come to Catford.

Learning Points

- Unintended consequences of the SAS were that as GP registration was out of area, HAABIT refused referrals to them from HTT in 2020, which led to unnecessary delays for this to be escalated for senior managers.
- Also, Kasey did not actually see a GP for a review or examination in the final 6 months of her life.
- Criteria for SAS was 4 incidents of violence at a Practice, but at least one reported was at A&E, when taken there under S136, so in time of mental health relapse, should this be re-evaluated in this context to consider whether she should have been removed from access to local GPs?
- Guidance on SAS to be reviewed as SAS decisions were not known to other agencies, (e.g., NELFT)

3.3.3. Mental Health Services Learning Points

- Frequent referrals passed to Mental Health from ASC (Merlin reports, LAS referrals, Probation and Housing) most did not seem to lead to any clear response from receiving Team and dealt with as information only by the receiving mental health team.
- At times of IMPART holding sole case responsibility they did not address any crises referrals (as above) as this service doesn't have capacity for this, at other times it was unclear who held case responsibility and most referrals were noted for information only and not acted upon (including for S9 & S42 Care Act duties, as in 3.2).
- Frequent S136 assessments, mostly discharged with no follow up apart from advice to call a Crisis Line. On one occasion in 2020, the S136 resulted in a two-week formal admission under S2 MHA'83 for assessment, due to suicide attempt being deemed particularly serious.
- Recognize difficulty of risk assessments for potential suicide, although was viewed as low risk in period before her death. Could a format for this be looked at, given large number of threats of suicide by hanging and Kasey's impulsivity, especially at times of stress/intoxication.
- Lots of other agencies did direct work with Kasey (Advance, WDP, Housing, Peabody) and she was discussed at various forums, but there was no evidence of support, consultancy and education being offered to these agencies on how to work with an adult with BPD, from mental health services. There were also very few joint visits or professionals' meetings and where these were done, they were no instigated by mental health services
- For most of chronology Kasey's care was not subject to Care Coordination or CPA, this would have offered a better model for coordination of services attempting to work with her.

3.3.4. Substance Misuse Learning Points

- Contact with WDP was at times because of DRR order from Court, at other times this was on a voluntary basis, throughout she only attended sporadically.

- WDP reported that they were not informed of or contacted by mental health services and did not get involved with any joint assessments, when HAABIT were contacted by WDP they said there was nothing they could until Kasey was abstinent.
- WDP did attend multi agency forums (IOM, VPP, CMARAC), due to nature of these groups there was some information shared but minimal joint work done following Kasey being presented at these panels.
- WDP offered group counselling sessions, motivation interviewing and CBT models, also some limited 1-1 support.
- Given Kasey always struggled with group work, due to her BPD, individual support would have been more successful in engaging her, especially with some consultation/joint work with Mental Health Services, rather than the response being that she needed to address her substance misuse before mental health could work with her.

3.3.5. Probation Learning Points

- Kasey was subject to Probation Supervision on 23/2/2017 for criminal damage, she was already known to Probation and was subject to a Suspended Sentence Order.
- An ATR and DRR assessment by WDP, informed disposal of a Suspended Sentence Order with a drug treatment requirement.
- An initial risk assessment was done but this was never reviewed following significant changes (e.g., housing, mental health relapse etc)
- Very little multi agency work done, with most information about WDP/NELFT shared by Kasey herself, rather than between professionals. Given Kasey's diagnosis and potential for splitting professionals this impacted on role of CRC in managing risk she posed to others and indeed to herself.
- Kasey would have benefitted from a more unified approach to her case and a joined-up treatment plan involving all agencies involved including mental health, drug treatment, Housing and probation

3.3.6. Advance Minerva Learning Points

- Advance Minerva (AM) had the longest period of engagement during the first 2 referrals, but Kasey refused to engage with the service in 2019 and 2020
- Better engagement between Mental Health services WDP and AM keyworkers may have informed a better joint approach to coordinate her support.
- Given that Kasey's mental health and substance misuse were significant risk factors for her, specialist guidance on how these aspects of her life affected her responses to attempts to engage her, may have been useful to inform AM's practice when Kasey refused offers of support. She was open to a range of mental health services during the period subject to review, but as with WDP (above) there was little evidence of joint work, despite several requests from AM staff for this.

3.4. Reflections on the challenges raised by Kasey arising from her BPD and substance use, implications for wider practice arising from this SAR

Research shows that around 1 in 100 people live with BPD. It seems to affect men and women equally, but women are more likely to have this diagnosis. This may be because men are less likely to ask for help. BPD is sometimes called emotionally unstable personality disorder (EUPD)[32].

3.4.1. Impact of Borderline Personality Disorder on Kasey and how this affected her interactions with agencies during the SAR period

A diagnosis of BPD is indicated with at least five of the symptoms below.[33]

- Extreme reactions to feeling abandoned.
- Unstable and intense relationships with others
- Confused feelings about your self-image or your sense of identity.
- Being impulsive in ways that could be damaging. For example, spending, sex, substance abuse, reckless driving, and binge eating
- Regular self-harming, suicidal threats or behaviour.
- Long lasting feelings of emptiness or being abandoned.
- Inappropriate or intense anger. And difficulty controlling your anger. For example, losing your temper or getting into fights.
- Intense, highly changeable moods.
- Paranoid thoughts, or severe dissociation, when you're stressed.
- Dissociation is a feeling of being disconnected from your own body. Or feeling disconnected from the world around you

From a review of multi-agency information about Kasey it was clear that she showed many of the above signs of difficulties in relationships both with her family and staff from all agencies who tried to work with her. She was clearly impulsive, self-harming and got into lots of conflict with people around her in all the different housing offered to her. She used cannabis to soothe her extreme and unpleasant emotions, but this caused further difficulties for her and led to several contacts with the criminal justice system and using cannabis was also part of the reason for evictions from hostels and PSL flats.

Another common feature of working with adults with BPD, which was evidenced in this review was of maladaptive relationships between her and staff from the range of agencies working with her. This is referred to as splitting;

"Splitting is a term used in psychiatry to describe the inability to hold opposing thoughts, feelings, or beliefs. Some might say that a person who splits sees the world

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[32] [1] National Institute for Health and Clinical Excellence. *Borderline Personality Disorder: Recognition and Management.* Clinical Guidance 78*..* London: national Institute for Health and Clinical Excellence; 2009. Para: introduction.

[2] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (5th ed.).* US: American Psychiatric Association: 2013. Para301.83 (F60.3).

in terms of black or white—all or nothing. It's a distorted way of thinking in which the positive or negative attributes of a person or event are neither weighed nor cohesive.

What makes splitting all the more confusing is that the belief can sometimes be iron-clad or shift back and forth from one moment to the next. People who split are often seen to be overly dramatic or overwrought, especially when declaring that things have either "completely fallen apart" or "completely turned around." Such behaviour can be exhausting to those around them"[34].

This was evidenced in the review of Kasey where she formed but could not maintain working relationships with people from any agency that attempted to engage her, despite the best efforts of a wide range of staff. The extent to which this was understood in the context of staff responses to her as a manifestation of her Personality Disorder was however less clear. It would have been helpful for staff to come together from the various agencies for reflective supervision and support to explore the transference and countertransference reactions to this, rather than to respond to this by closing her case and withdrawal of support.

3.4.2. Impact of Cannabis on Kasey and how this affected her interactions with agencies during the SAR period

Some common effects of prolonged cannabis use include;

- it can make it harder to learn and concentrate
- it can be addictive
- it affects short-term memory so can make people forgetful
- it can affect motivation, users can lose interest in things and lose touch with their friends
- regular use of cannabis, is associated with an increased risk of later developing psychotic illness, including schizophrenia
- around 10% of users become dependent and experience withdrawal symptoms when they stop. They could lose their appetite, become tired and irritable, experience mood swings and have difficulty sleeping
- who smoke it with tobacco can also become addicted to nicotine[35]

In terms of how Kasey's addiction to cannabis combined with the effects of her BPD were never fully explored in the information available to the SAR, but it would seem reasonable to assume that she faced lots of additional hurdles to overcome in relation to both. Seeking and maintaining therapeutic relationships and activities would have been adversely affected by both these aspects of her life, making it harder for to change and to cope with the stresses of everyday life. She was likely to lack consistent motivation to change partly due to the effect of cannabis on her ability and motivation

[34] https://www.verywellmind.com/what-is-splitting-425210
[35] https://www.keep-your-head.com/assets/2/cannabis-find-out-the-facts.pdf

to change and engage with agencies. She also experienced the frequent closure of her case as rejection when her lack of engagement led to services taking this decision.

There are a number of references to “her choice” in relation to her substance misuse, however this did not take account of the effects of the cannabis addiction on her decision making and this was further complicated by negative reactions to her BPD.

In some ways this is similar to the work done with the Blue Light Project for Alcohol Change UK[36], which reveals how professional attitudes and services to work with vulnerable dependent drinkers needs to change to better address this issue;

In the Ms. H and Ms. I SAR, the partner of a woman who had died having experienced multiple exclusion homelessness, commented that she had been unable to maintain abstinence from substance misuse because past traumas and adverse life experiences “kept bubbling up.” This captures quite graphically how individuals can be governed by impulses to distance themselves from emotional distress. She was caught in a *life-threatening double-bind, driven to avoid suffering through ways that only deepened her suffering*.[37]

In conversations with her mother and from reports provided Kasey had certainly experienced trauma from a young age, which she struggled with and so she was also affected by this “double-bind”. The work of the Blue Light Project identified the need for 7 step approach when working with this marginalised client group and from reviewing Kasey’s case there are grounds for considering whether this might also have been more effective for her, (Identification, Engagement, Harm reduction, Motivation, Preparation for Treatment, Treatment itself, Support).

3.4.3. Challenges to staff raised by how Kasey presented to services during periods of crisis.

These were significant and to some extent found to be in line with recent research identifying this for both frontline staff and NHS Trusts.

“Increased suicidal ideation in persons with BPD also occurs during minor crises in life, when experiencing intensified flashbacks about past abuses, during minor losses, after significant conflicts with others and after the separation from influential people in their social network.

At the same time, healthcare professionals are discouraged by the complex management of patients with BPD, which, in combination with their tendency to challenge or make unwarranted allegations against their health carers, results in feelings of sadness, rejection and alarm in the latter.

[36] https://proceduresonline.com/trixcms2/media/14068/safeguarding-vulnerable-dependent-drinkers.pdf

[37] Preston-Shoot, M. (2020) Ms H and Ms I: Thematic Safeguarding Adults Review. Tower Hamlets SAB

Nonetheless, it is also likely that some healthcare professionals might have some preconceived ideas about people with Borderline Personality Disorder, which might reduce the depth of health carers' empathy towards these patients and lead to burnout after prolonged treatment of BPD in hospital or community.

Attempts to treat and to reduce suicidal ideation and self-harm in this group of patients are often thwarted as they challenge medical decisions and endeavour to sabotage the proposed care plans. The strain on the doctor-patient relationship is determined by the underlying 'Mistrust/Abuse' scheme of patients with BPD who expect from others, and are thus sensitive to, signals of relational wound, treachery and abuse[7].

Consequently, a chronic feeling of inadequacy in patients with BPD translates itself in enduring dissatisfaction with any therapy and healthcare professionals. Hence, in the authors' experience, any attempt to establish a long-term therapeutic relationship with BPD patients might have limited outcomes. Frustration in healthcare professionals aiming to create an enduring therapeutic alliance with patients with BPD happens as these patients tend to interpersonal biases and to ascribe undesirable experiences to people (hence to healthcare professionals) as opposed to circumstances[8].

Therefore, social interactions with primary carers result in dissatisfaction of people with BPD about any medical or psychiatric plan is set up for them. Consequently, community teams, general practitioners and hospital staff feel hopeless due to recurrent readmissions of people with BPD and the lack of definitive treatment for such pathology. Stress caused by difficulties encountered in ensuring that BPD patients comply with the therapy regularly places doctors and nurses at crisis point.

What is needed is a frank and constructive dialogue between healthcare managers, leaders and medical staff in the hospital and in the community. Furthermore, *clear and regional guidelines should exist to improve the efficacy of care which is offered to BPD patients at home and to reduce the constant risks which patients pose to themselves, their sense of solitude and their tendency to seek hospital admission in order to solve chronic existential difficulties.*

The collaboration of all those involved parties is also important to reduce the risk of 'silo management' where confined and regional policies do not embrace a wider perspective for the management of specific problems while responding only within the confines of the own guidelines and procedures[14].In these cases, integrated care in communities can halt self-harming and suicidal attempts of patients with BPD'[38].

In a study of attitudes towards patients with BPD, it was noted that nurses and psychiatrists had the lowest levels of empathy, when compared with social workers and psychologists[39].

This lack of empathy from mental health professionals and frequent rejection of Kasey was something which her mother identified as a major factor in her relationships with mental health services, especially when her case was closed due to her substance misuse issues.

[38] https://www.bjmp.org/files/2018-11-2/bjmp-2018-11-2-a1112.pdf
[39] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-014-0380-y#Sec9

Undoubtedly her demands on services and professionals were extreme and hard to manage, but services all seemed to get into a very negative cycle with her making demands/requests which were unmet, leading to her disappointment/disengagement and ultimately services then withdrawing as a response to her lack of engagement.

From a review of this case there were signs of a negative spiral for Kasey and a sense of hopelessness even between the frequent crises, leading to contact with police often when intoxicated, S136 assessments and subsequent discharges from psychiatric assessments.

During these crises periods Kasey frequently complained about the excessive force used by police to restrain her, (at least of one of these was subsequently upheld upon investigation by IOPC). Her perception of these were certainly negative and the fact she had so many admissions under S136 following police involvement but then no treatment undoubtedly adversely affected her relationships with staff.

It is noted that since the time of the review Housing services have now commissioned a housing provider with onsite support for people with complex needs, throughout their application to consider their needs for support via a complex needs register and dedicated workers. This would have been helpful for Kasey and may have been a better option than her experience of moving between hostel accommodation following her placement breakdowns.

4. Findings from the Review

This section contains the priority findings from this SAR, from analysis of the work done with Kasey and her family. Recommended actions in response to each Finding for service improvement are set out for consideration by Havering Safeguarding Adults Board in this section of the report.

4.1. Finding 1

The use of multi-agency panels or forums as a model for case discussions is based on an agreed cohort of agency representatives' regular attendance at these meetings to discuss a number of clients that are known to all the agencies. This varied depending on the panel (IOM, VPP, CMARAC). This can be said to be a "top down" approach as a means of information sharing between the agencies who attended the meetings.

This "top down" model has benefits in that multiple cases can be discussed rapidly in one meeting between the agency representatives, but given the large number of shared clients discussed at any one meeting, this gives very little time for each case, especially where the individuals have complex needs. The same clients may arise in several different panel meetings during the same time periods, but as there is no information shared between the panels this may lead to gaps of case oversight/knowledge as different agencies attend different panels. This allows for limited updates on agencies' contacts but does not allow for shared operational case decision making, nor for sufficient follow up of any recommended or outstanding actions from one meeting to the next. The other issue, from this review, relates to the individuals attending the forums, who tend to be at a relatively senior level within their organisations and so are unlikely to have first-hand knowledge of the case, relying on written information from front line staff.

It was unclear what, if any, links there were between the panels and due to the overlap between the panels for clients like Kasey this would be useful. Due to the complexity of factors including mental health, substance misuse, offending and Anti-Social Behaviour, it would be beneficial if shared risk assessments and related joint work between statutory services are agreed and followed up to manage the identified risks, prior to cases being removed from the oversight afforded at the various panel meetings.

Recommendations for the Board to consider

1. The HSAB to request that the Chairs of each Panel (VPP, IOM, CMARAC) review current working practices, including membership and secure information sharing agreements to ensure that where clients are known to more than one Panel the work overseen is coordinated across relevant panels and their trusted Single Point of Contact (SPoC) to ensure adequate engagement by all agencies and appropriate use of escalation policy where required.

4.2. Finding 2

The IOM Panel met on a monthly basis, with Kasey open to the IOM system from Sept 2016-Feb 2020, her case was escalated to a main panel for more complex case discussions on 17 occasions. The overall aim of this panel is to reduce the risk of re-offending. Kasey's risk of re-offending was RAG rated as being red for most of this time, although was reduced to green during the final months of involvement prior to her case being closed.

Given the link between Kasey's mental health, substance misuse and offending behaviour (violence and aggression to neighbours, professionals, driving and drug related offences) the work of the IOM was hampered by mental health not attending, as they would have been an ideal lead agency, given the amount of contact they had which was for the longest period of time of all agencies subject to this review.

Without the specialist input of the Personality Disorder Mental Health Services (IMPART) it was unclear whether these features of how Kasey's mental health affected her feelings and behaviour were sufficiently understood in this context (as expected of someone with BPD), but rather were taken at face value and used to justify decisions to close her case when she struggled to maintain consistent engagement.

The VPP Panel was intended to support vulnerable tenants, but mainly dealt with tenants whose behaviour put their tenancy at risk, despite the policies of Tenancy Sustainment and ASB. Kasey was only subject to the VPP discussions on 2 known occasions, with very limited updates given and no clear actions agreed prior to her being removed from the VPP. This seemed not to add anything that assisted housing providers, nor Kasey, when problems arose with her neighbour in the final KPE, although she was discussed at the VPP. Access to secure and supported housing was not available to her, despite frequent temporary placements breaking down. VPP is a housing led forum, it was noted during the review that neither ASC nor NELFT attended meetings regularly, although they do now.

The CMARAC is led and now also chaired by the Director of ASC, it was also intended to address potential eviction related issues and if this was thought to be an issue identified at the VPP, then a referral to CMARAC was considered at the meeting. The balance between the security of the temporary housing options, with support offered to Kasey (via keyworkers at the hostels for example) to maintain these placements, with the impact of her ASB on the other tenant's wellbeing remained a dilemma throughout the review period. The "top down" approach of the 3 panels was insufficient to resolve this dilemma, resulting in repeated evictions and subsequent housing moves for Kasey.

Recommendations for the Board to consider

2. Complex cases which are known to more than 1 of the above multi agency panels (within an agreed timeframe), are all designated a consistent lead professional from an appropriate statutory service, who will attend all relevant panel meetings to ensure that consistent operational decision making, including risk assessment/management, including crisis plans are both undertaken and shared with Panels.

4.3. Finding 3

The current arrangements for Care Act duties with adults who have a personality disorder are transferred to NELFT as part of the S75agreement with Havering Adult Services. This meant for Kasey that all requests for assessments were forwarded from ASC to the HAABIT team for their attention. HAABIT received many referrals from different agencies for Kasey, sometimes via ASC from police MERLIN reports, but also directly from Probation, Housing, Advance, WDP for assessments. Whilst not always requesting a S9 Care Act assessment, the number and nature of these referrals should have led to the duty under S9 being triggered as there was an appearance of need. Some of the referrals were forwarded onto specialist mental health teams (IMPART, HTT, CRS, AMHP) often HAABIT noted these, but they did not result in any assessment under the Care Act.

This raises the issues of both the general level of awareness of Care Act responsibilities in mental health services and the thresholds for the duties and responsibilities to be triggered upon receipt of referrals. The trigger to instigate the duty for Care Act S9 assessments for the relevant social work service needs to be considered by the receiving team, even when this has not been explicitly requested. The subsequent process should ensure that the person, their carers/families and any advocacy input are also involved in completing the assessment. Eligibility for services is one outcome of this process, but importantly it should ensure sufficient involvement of other services working with the adult, for example Housing, Probation and 3rd sector organisations (such as Advance Minerva).

This "bottom up" model for bringing together agencies would give a more holistic understanding of how a mental disorder (in this case Borderline Personality Disorder) can give rise to unmet needs for care and support, including risks to the adults Wellbeing and safety, whether at times of crisis or for more chronic difficulties experienced by the adult and their network. It would enable a joint health and social care plan to meet any eligible needs arising from a mental disorder, following assessment. This would also cover any longer term needs for support in education and employment for the adult, as recommended in Nice Quality Standards (www.nice.org.uk/guidance/qs88).

"People with borderline or antisocial personality disorder have their long-term goals for education and employment identified in their care plan."[40]

Recommendations for the Board to consider

3. The HSAB to receive assurance from NELFT that Section 9, Care Act assessments are being appropriately undertaken, either as part of the current clinical assessments, or as stand-alone work done by the relevant mental health service, in response to the thresholds being met for adults with Personality Disorders, following referrals to NELFT, in line with the Care Act Statutory Guidance.

[40] https://www.nice.org.uk/guidance/qs88/resources/personality-disorders-borderline-and-antisocial-pdf-2098915292869

4. That the outcomes from these assessments are also shared with the adult and any relevant organisations, to ensure there is awareness of how any eligible needs will be met and that this also can improve multi agency coordination

4.4. Finding 4

Section 42 duties under the Care Act 2014 for Safeguarding enquiries are also transferred from Havering Adult Social Care to NELFT, as part of the S75 agreement. These will also usually be done by social workers seconded to NELFT, upon receipt of a concern meeting the 3-stage test of eligibility. For Kasey there were multiple referrals for safeguarding concerns sent initially to ASC and subsequently passed to HAABIT for the duty to be instigated. On 2 occasions ASC triaged referrals which were felt to meet the duty for an enquiry. However, for both of these there was no evidence of an enquiry being done, following concerns about physical and sexual abuse of Kasey. Decision making by HAABIT following these 2 referrals was unclear.

There were also many concerns about threats of suicide, or suicide attempts of various levels of risk to her. Most of these concerns were just noted for information purposes, often in the context of police MERLIN reports after S136 Assessments, where officers detained Kasey for the purposes of a Mental Health assessment. None of these resulted in inpatient assessments of her mental health, other than on one occasion (in March 2020) where she was detained under S2 MHA'83 for a 2-week hospital admission. In all other occasions the outcome of the S136 assessments were that Kasey was discharged with variable advice/follow up from mental health services in the community.

An implication of these judgements was that Kasey did not require inpatient mental health assessment or treatment and that her suicide attempts were often in the context of intoxication. Once her intoxication had resolved the crisis had also been thought to have been resolved and so she was considered safe to return home. However, the nature and volume of these suicidal thoughts, or feelings could have given rise to a more general safeguarding duty, to at least consider S42.1 eligibility under the broad Care Act Definition of Self-Neglect as requiring a safeguarding assessment, or S42.2 Enquiry *(neglecting to care for one's personal hygiene, health or surroundings)*, specifically the question as should suicidal threats/attempts be viewed as neglecting one's health for the purposes of S42 responsibilities?

This would not necessarily "open the flood gates" to all threats of suicide automatically being framed in terms of safeguarding duties under the S42.2 Enquiry function, but could lead to a S9 assessment, for example, as a more appropriate response to prevent or delay needs arising. Again, as in Finding 3 above, this "bottom up" approach would enable a statutory structure for information sharing and coordination of the multi-agency network, at an operational level. It would also enable adults and carers to be involved in any risk assessment and proportionate protection plans, rather than viewing threats or attempts of suicide purely in context of a need for the person to receive inpatient or community mental health services alone.

Recommendations for the Board to consider

5. HSAB to receive assurance from NELFT that safeguarding concerns regarding suicidal adults, received by HAABIT, are suitably recorded and triaged against the S42.1 criteria, including the relevant management decisions from the safeguarding team as to whether the S42.2 duty is then considered to have been met, or whether an alternative response is deemed to be more appropriate by NELFT (for example an assessment, a review or an admission) and if so on what basis?

6. HSAB to consider guidance across the borough to establish whether and in what circumstances suicidal thoughts or behaviour ought to be addressed as a safeguarding issue, under S42 of the Care Act, (for example, as an indicator of self-neglect i.e. failing to care for one's health).

Finding 5

Kasey received many services from a wide range of agencies, over the period subject to review to support her, both in times of crisis and attempts were made to engage her in therapy and longer-term problems arising from her behaviour at times of crisis/arrest. However, due to her non-engagement outside of a statutory arrangement (e.g., DRR with WDP, or Probation requirements) most agencies made periodic attempts to work with her before closing her case.

This was noted in relation to offers of therapy from IMPART, which was something she requested but felt unable/unwilling to engage in the repeated offers of group DBT (2014, 2016, 2017, 2018) or virtual group therapy via AMEC (2020). She made frequent requests for individual therapy although this was not available to her, due to the way therapy was provided at the time. Group DBT is recognised as an effective treatment for people with Borderline Personality Disorders, as set out in NICE Guidelines; "For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme"[41].

However, it is also recognised that this may not be right for everybody and in more recent Nice Quality statements, Statement 2 recommends that; "People with borderline personality disorder are offered psychological therapies *and are involved in choosing the type, duration and intensity of therapy".* The rationale for this standard goes on to state; "Because of the variety of symptoms and the variation in needs, flexible approaches that are responsive to the needs of each person with personality disorder are important. Involving people with borderline personality disorder in decisions regarding their own care is key for their engagement with treatment"[42].

[41] https://www.nice.org.uk/guidance/cg78/resources/borderline-personality-disorder-recognition-and-management-pdf-975635141317

[42] https://www.nice.org.uk/guidance/qs88/resources/personality-disorders-borderline-and-antisocial-pdf-2098915292869

Kasey's engagement with the one type of therapy she was offered was minimal and therefore other options that she could have been involved with may well have been more beneficial for her. There may be wider resource and commissioning considerations that would need to be explored for alternative models of psychological therapies, but it seemed from the records that DBT was the only psychological treatment available.

Recommendations for the Board to consider

7. Commissioners at ICB to explore with NELFT the current approaches to providing psychological therapies for people with Personality Disorders, including 1-1 sessions if requested by the adult and thought appropriate as part of person-centred care, to enable adults to have choice about options for the most suitable treatment for them.

Finding 6

As set out in the report for the majority of the last 4 years of her life Kasey was open to various combinations of mental health, substance misuse, probation and Advance Minerva. Involvement with these services tended to be sporadic and problematic for her, with frequent demands for services but then frequent difficulties in maintaining relationships and engagement with these services. Whilst there was no shortage of resources and commitment to work with her, nearly all services closed her case repeatedly before being re-referred and attempting once more to build some rapport with her.

These difficulties in maintaining working relationships with her were complicated by features of her Personality Disorder and related behaviour, with mental health services finding her too chaotic to engage in therapy and substance misuse services finding her personality disorder meant she was unsuitable for attempts to address her addiction to Cannabis. A theme was that her mental health needed to be addressed alongside her substance misuse, but one service would close and refer her to the other, a cycle which was unhelpful, and Kasey found frustrating. It was noted that there existed little joint working with Kasey around both her mental health and substance issues. There was no Care Coordination under CPA for Kasey, for the majority of the period subject to review and her care was marked by a lack of coordination across health and social care services as a consequence of this.

It is noted that in Nice Guidelines 58 (Coexisting severe mental illness and substance misuse: community health and social care services) there were several standards for improvements in working with people that experience both mental health and substance misuse problems;

"1.3.1. The person's care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the person's care plan. This includes substance misuse services, primary and secondary care health, social care, local authorities and organisations such as housing and employment services.

1.3.7 Consider the suitability of the type of housing (for example, high to low support or independent tenancies), employment, detox, rehabilitation services or other support

identified for the person, in collaboration with relevant providers. Take the person's preferences into account.

1.3.8 Ensure agencies and staff communicate with each other so the person is not automatically discharged from the care plan because they missed an appointment. All practitioners involved in the person's care should discuss a non-attendance"[43].

Recommendations for the Board to consider

8. NELFT to ensure that adults with complex issue of personality disorder and substance misuse are Care Coordinated with regular multi agency reviews, which are shared with all relevant services.

9. HSAB are assured that sufficient specialist mental health professional advice, training, supervision and support on working with people with Personality Disorders is available to relevant partner services in direct contact with this client group.

Finding 7

Kasey was known to a number of GP services in Havering, however, due to people finding her behaviour confrontational she was de-registered and subsequently provided with primary care services via the Special Allocations Scheme. As a consequence of this, Kasey was allocated to a GP in Catford shortly prior to the pandemic and was not able to see a GP in the final 9 months of her life, although she did make telephone contact with the surgery. After being allocated to the SAS, Kasey made frequent use of emergency health services, such as 111, LAS and ED, sometimes as a consequence of not having sufficient medication at times of acute distress, or crisis.

Whilst Primary Care staff have a right to work without fear of violence or abuse, the way the SAS scheme was implemented did have foreseeable and detrimental consequences for Kasey. This included a delay in a referral from the Home Treatment Team to HAABIT as this was refused, on a funding basis, based on the fact Kasey was registered with a GP in Lewisham. Also, the SAS eligibility criteria identified 4 incidents involving police attendance, with at least one of these for Kasey appearing to be at ED, after she was brought there under S136 by police, in a mental health crisis. This would appear to lack some understanding of the relationship between her mental health and related crisis for which she received a disproportionate sanction. It did not appear to take into account her personal circumstances when the decision was made.

Recommendations for the Board to consider

10. North East London Integrated Care Board (NEL ICB) to ensure the HSAB that all referrals to the SAS, which are made by local GPs are considered for both the appropriateness of the referral and consequences for the patient when allocated to a

[43] https://www.nice.org.uk/guidance/ng58

suitable alternative GP practice, including whether this should be inside or outside the area.

11. NEL ICB to review local guidance on the SAS and ensure that there is a process for sharing information of SAS decisions with other services (e.g., NELFT) so that this does not affect the provision of specialist mental health services for patients.

Finding 8

Challenges raised by Kasey were significant for the front-line staff from all agencies, whether in mental health services or in other areas, due to a combination of factors, specifically the severity of her BPD combined with the effects of addiction to Cannabis.

These manifested in splitting staff/agencies and led to confrontation, escalating risk taking behaviour and a cycle of crisis brief admissions to hospital, following restraint/arrest by the police under S136. Her mother felt that a lot of interactions she witnessed between Kasey and mental health staff were characterised by minimal empathy and experienced by Kasey as rejection. It's difficult to establish the quality of personal interactions from documents provided to the review, but there was little evidence of person-centred work undertaken by individuals and also little coordination between agencies to coordinate support offered to her. What there was significant evidence of was of repeated referrals which were closed due to her non-engagement with services. This would appear to have been draining both on service resources and on staff that had little benefits to Kasey either in the short or long term. As a significant issue common to working with people with BPD, this review has identified that the current arrangements to how both individuals and multi-agency approach the challenges posed by this client group is in need of re-appraisal.

Recommendations for the Board to Consider

12. HSAB to explore attitudes of staff to people with BPD and consider how to address this with a programme of education, support, reflective supervision to be explored in partnership with service users and carers.

13. HSAB to receive assurance that staff from both substance misuse and relevant mental health services will seek to work together to undertake joint assessments and shared Care & Support plans for people with addictions and BPD.

Mick Haggar, Independent Author

February 2023

Appendix 1

List of Abbreviations used in the report

Abbreviation	Full Version	Explanation
HSAB	Havering Safeguarding Adults Board	The overarching purpose of the HSAB is to help and safeguard adults with care and support needs: The Safeguarding Adults Board oversees the strategic development of safeguarding adults work in Havering and is responsible for protecting each person's right to live in safety, free from abuse and neglect. The Board meets four times a year and has an Independent Chair.
SAR	Safeguarding Adult Review	A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. It is a statutory review, commissioned by SAB, under Section 44 of the Care Act 2014.
KPE	Key Practice Episode	Building on the work of Charles Vincent and colleagues (Taylor-Adams and Vincent, 2004) we have coined the term 'key practice episodes' to describe episodes from the case that require further analysis. These are episodes that are judged to be significant to understanding the way that the case developed and was handled. They are not restricted to specific actions or inactions but can extend over longer periods. The term 'key' emphasises that they do not form a complete history of the case but are a selection. It is intentionally neutral so can be used to incorporate good and problematic aspects. https://www.scie.org.uk/publications/guides/guide24/concepts/episodes.asp

Abbreviation	Full Version	Explanation
NELFT	North East London Foundation Trust	NELFT provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock. We provide an Emotional Wellbeing Mental Health Service for children and young people across the whole of Essex. We are the provider of all age eating disorder services and child and adolescent mental health services across Kent and Medway. With an annual budget of £490 million, we provide care and treatment for a population of circa 4.3 million. We employ approximately 6,500 staff who work across 210 bases in London, Essex, Kent and Medway. https://www.nelft.nhs.uk/about-us
HAABIT	Havering Adult Access, Assessment And Brief Intervention Team	The access, assessment and brief intervention team (HAABIT) is a service for adults from age 18 needing community mental health services in Havering. Our team consist of psychiatrists, community mental health nurses, mental health social workers, support time and recovery workers, occupational therapists. We provide an initial mental health assessment and once assessed we may refer to other mental health services/organisations (e.g., social services). The team can offer brief interventions for up to six months. https://www.nelft.nhs.uk/services-havering-access-assessment-team/

CRS	Community Recovery Service	The Havering community recovery team is split into two localities, Romford and Upminster, and provides specialist mental health services for adults aged 18 to 65 with serious and/or enduring mental health problems. This includes multidisciplinary assessments to identify needs with each client/carer, community interventions and a range of community-based services formulated in a care plan and delivered through the CPA process. The team works with clients, carers and other agencies to promote recovery. https://www.nelft.nhs.uk/services-havering-community-recovery-team/
HTT	Home Treatment Team	The Barking and Dagenham and Havering Home Treatment Team (HTT) provides acute home treatment crisis interventions for adults aged 18 to 65 whose mental health crisis is so severe that they would otherwise have been admitted to a psychiatric hospital. This integrated service for people with severe and complex mental and behavioural disorders such as schizophrenia, bipolar affective disorder, and severe depressive disorder is usually provided in the person's own home. https://www.nelft.nhs.uk/services-barking-havering-home-treatment-team/
DRR	Drug Rehabilitation Requirement	Drug Rehabilitation Requirements (DRR) and previously, Drug Treatment and Testing Orders (DTTO), are community sentences issued to drug users that are designed to help them overcome their problems. https://www.matrixdiagnostics.co.uk/drug-testing-and-rehabilitation-requirements-drr/
IMPART	personality disorder service	IMPART is a psychological therapies service which provides evidence-based treatments for individuals with a personality disorder. IMPART offers dialectical behavioural therapy (recommended by NICE guidelines), cognitive behavioural therapy (CBT), and motivational interviewing based on the needs of the individual. In addition, IMPART offers a range of workshops and support for families and friends supporting the clients being seen by IMPART.

		IMPART also provides consultation to services supporting those with a personality disorder in the local health area. https://www.nelft.nhs.uk/services-bdhvrbwf-impart/
ADHD	Attention deficit hyperactivity disorder	Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. Symptoms of ADHD tend to be noticed at an early age and may become more noticeable when a child's circumstances change, such as when they start school. https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/
PTSD	Post-traumatic stress disorder	Post-traumatic stress disorder (PTSD) is a mental health problem you may develop after experiencing traumatic events. The condition was first recognised in war veterans. It has had different names in the past, such as 'shell shock', but it's not only diagnosed in soldiers. A wide range of traumatic experiences can be causes of PTSD. https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/about-ptsd/
MHA ’83, amended 2007	The Mental Health Act 1983, amended in 2007	The legislation governing the compulsory treatment of certain people who have a mental disorder is the Mental Health Act 1983 (the 1983 Act). The main purpose of the 2007 Act is to amend the 1983 Act. It is also being used to introduce “deprivation of liberty safeguards” through amending the Mental Capacity Act 2005 (MCA); and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004. https://www.legislation.gov.uk/ukpga/2007/12/notes/division/3

CC	Care Coordinator	A CPA care co-ordinator (usually a nurse, social worker or occupational therapist) will manage a patients' care plan and review it at least once a year. A care plan will say who the care co-ordinator is. https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/
HCS	Havering Children's Services	Social work Services for children and families in Havering https://www.havering.gov.uk/info/20017/children_and_families
HASC	Havering Adult's Social Care Services	Social work Services for Adults in Havering https://www.havering.gov.uk/info/20015/adult_social_care
AMHP	Approved Mental Health Professional	The Approved Mental Health Professional role was developed by the 2007 Mental Act amendment. Prior to this the role was known as Approved Social Worker or ASW. The amendment to the Act broadened who could undertake the role beyond social workers to other registered Mental Health Professionals such as Nurses and Occupational Therapists who underwent specific training. https://www.lscft.nhs.uk/Approved-Mental-Health-Professional
CBT	Cognitive Behavioural Therapy	CBT is based on the concept that your thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a negative cycle. CBT aims to help you deal with overwhelming problems in a more positive way by breaking them down into smaller parts.

		https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/
CRC	Community Rehabilitation Company	**Community Rehabilitation Company** (CRC) was the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation. In June 2020 the government announced it would terminate all CRC contracts by June 2021 and services would be transferred to the newly formed Service run by the government.[1] https://en.wikipedia.org/wiki/Community_Rehabilitation_Company
CSP	Community Safety Partnership	The Havering Community Safety Partnership is a statutory body established under the Crime & Disorder Act 1998 and the Police Reform Act 2002. It works in partnership to keep Havering a safe place to live, work and visit through the continuing reduction of crime and disorder. https://democracy.havering.gov.uk/mgOutsideBodyDetails.aspx?ID=206#:~:text=The%20Havering%20Community%20Safety%20Partnership,reduction%20of%20crime%20and%20disorder.
STR	Support Time and Recovery Worker	A support, time and recovery (STR) worker **help adults and young people with mental health problems or a learning disability**. By offering practical support and advice, they are improving people's lives across the local community. STR workers provide support and give time to the service user to help their recovery.

TAMO	Temporary Accommodation Management Officer	The Homeless Accommodation Team will be responsible for ensuring that your household is safe and has been provided with the quiet and peaceful enjoyment of the temporary accommodation. Our Homeless Accommodation team are here to help you and you will be allocated a Temporary Accommodation Management Officer (TAMO) for the management of your property. https://www.havering.gov.uk/info/20051/information_for_tenants/873/temporary_accommodation_in_the_private_leased_sector/2

Appendix 2
Terminology used in report

Terminology	Explanation	Reference
Merlin	Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason. This can range from being a victim of bullying to being present whilst a property is searched, this may be with a warrant or under the Police and Criminal Evidence Act. It also holds data for missing persons. They can be of any age. Entries on the database can be accessed by police officers and civilian workers	https://en.wikipedia.org/wiki/Merlin_(database)
Oppositional Defiant Disorder	Oppositional defiant disorder (ODD) is a behaviour disorder in which a child displays a pattern of an angry or cranky mood, defiant or combative behaviour, and vindictiveness toward people in authority. The child's behaviour often disrupts their daily routine, including activities within the family and at school.	https://www.webmd.com/mental-health/oppositional-defiant-disorder
Borderline personality disorder	Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into 4 main areas. • emotional instability – the psychological term for this is "affective dysregulation" • disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions" • impulsive behaviour • intense but unstable relationships with others	https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/symptoms/

Emotional **Dysregulation**	Emotional dysregulation is an inability to manage your emotional states. This means you're unable to control feelings of sadness, anxiety, or anger. It's difficult to soothe yourself when you feel overwhelmed, sad, or angry, and you find it hard to return to "normal" after these feelings come up.	https://psychcentral.com/blog/what-is-affect-or-emotion-dysregulation
Integrated Offender Management	Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.	https://www.gov.uk/guidance/integrated-offender-management-iom
Vulnerable Persons Panel	To coordinate actions that will support vulnerable residents whose needs are challenging and complex AND who live in Havering Council managed, own or rented accommodation.	
CMARAC	The MARAC (Multi Agency Risk assessment Conference) deals with. 1. To deal with complex/high level cases of anti-social behaviour arising from individuals where mental health, safeguarding or extremism is a major feature. 2. To deal with complex/high level safeguarding cases which cannot be resolved locally and need the support of the Community MARAC. (These cases do not need to involve any evidence of anti-social behaviour)	
Residence Order	A residence order **establishes where a child will live,** and a contact order sets out who the children should spend time with. Residence orders are	https://www.legislation.gov.uk/ukpga/1989/41/section/8

	now referred to as child arrangement orders in Court, but many people still refer to them as residence orders and contact orders.	
Special guardianship order	Special guardianship is **a court order which allows parental control over a child by individuals other than the parent**. They are usually made to members of the extended birth family or other significant people, such as a child's long term foster carer.	https://www.familylives.org.uk/advice/your-family/fostering-adoption-kinshipcare/special-guardianship-orders
Systemic therapy	From families to orchestras, co-workers to sports teams – systemic therapy focuses on relationships between a group of people, rather than solely on an individual's thoughts and feelings. It's often used as an umbrella term to cover family therapy or couple's therapy. But it's much broader than this. It can help any group or system where people work together or have a relationship.	https://www.bacp.co.uk/about-therapy/types-of-therapy/systemic-therapy/
Splitting	Common in those with borderline personality disorder (BPD), splitting is considered a defence by which people with BPD view others, events, or even themselves in all-or-nothing terms.[1] Splitting allows them to readily discard things they have assigned as "bad" and to embrace things they consider "good," even if those things are harmful or risky.	[1] https://www.verywellmind.com/what-is-splitting-425210

Appendix 3
Reference documents cited in report

1. The Care Act 2014, Statutory Guidance. Section 14.168

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

2. The Care Act 2014, Section 9

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