

**Safeguarding Adults Review**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Ms C: Safeguarding Adults Review

**Author**: Fran Pearson

**Date of publication**: 29th July 2019

How the report is set out

|  |  |  |
| --- | --- | --- |
|  | Summary of the case | Page 3 |
|  | Why this case was chosen for review under the Care Act 2014 | Page 4 |
|  | The Care Act guidance on Safeguarding Adults Reviews | Page 5 |
|  | Terms of Reference and the agencies involved in this Safeguarding Adults Review | Page 6 |
|  | Methodology for the Review, process, and reflections on its use | Page 9 |
|  | Key dates in the period under review | Page 12 |
|  | Analysis of the quality of professional practice | Page 18 |
|  | Conclusion and Recommendations | Page 33 |

**Section 1 Summary of Ms C's case**

1.1 Ms C was a white British woman in her mid-twenties, who in October 2016, took her own life by hanging. Ms C was a talented artist and engaging person, who used mental health services, but had a life and friendships that extended well beyond the professional contacts that are covered in this review. At the centre of her life was the dog she had acquired the previous year. Ms C had a range of mental health diagnoses: personality disorder, Asperger Syndrome, depression and anxiety. The difficulties and stresses arising from these conditions had been with her for much of her life although she was only diagnosed with Asperger's in 2015. [Asperger syndrome is part of a broader category called autism spectrum disorder (ASD). According to the National Autistic Society website, People with Asperger syndrome are of average or above average intelligence. They don't have the learning disabilities that many autistic people have, but they may have specific learning difficulties. They have fewer problems with speech but may still have difficulties with understanding and processing language.]

1.2 In mid-June 2016 Ms C learned that her shared tenancy in a house in the London Borough of Tower Hamlets, was due to end. This was because the landlord had served notice on all the tenants. Ms C approached the housing advice section of the local authority. She was supported by a Tower Hamlets voluntary sector organisation whose staff had come to know her well, and who made the case unequivocally that she should be rehoused with her dog. They were clear about the risk that would arise otherwise. Without her dog, she would have no reason to live. The local authority's housing advice team assessed Ms C 's level of priority for rehousing. The outcome of this assessment meant she could go to temporary accommodation pending a permanent allocation, but nowhere could be found that would take a dog. Ms C was offered a hostel place in the borough and made arrangements for a friend to look after her dog.

1.3 At two points, professionals, firstly from the voluntary sector organisation, and secondly from the housing advice section of the local authority, sought advice on safeguarding Ms C, by contacting the local authority's adult social care 'front door' and spelling out the risks that made safeguarding necessary in their view. On neither occasion did adult social care professionals respond correctly. Housing advice workers asked for the same advice from the mental health trust and were advised of the process for urgent mental health assessment. Ms C's mental health deteriorated as the move grew nearer, culminating on the move day with her seeking emergency help and being admitted as a voluntary patient to a unit in Hackney run by the mental health trust that covers Tower Hamlets, Hackney, Newham and City of London. She spent two weeks on the ward, and when plans were in place for her discharge, Ms C was discharged to a hostel in the adjoining borough of Newham with an agreed package of care from the Mental Health Home Treatment team - provided by the same mental health trust, but in this instance by their Newham service. The Tower Hamlets room could not be retained because of the length of Ms C’s hospital stay. Ms C was readmitted, again as a voluntary patient, after two weeks in the hostel. This readmission lasted for one week and at the end the period, whilst on weekend home leave to the hostel room, she did not return to the ward as agreed. She was found in the hostel, having taken her own life.

**Section 2 Why this case was chosen for review under the Care Act 2014**

2.1 Section 44 of the Care Act 2014 requires Safeguarding Adults Boards to carry out a Safeguarding Adults Review of cases involving an adult with care and support needs if particular criteria are met. These are set out in section 2.3.

2.2 Ms C's case was considered twice by the sub group of Tower Hamlet's Safeguarding Adults Board that considers new cases and decides whether the threshold for section 44 has been met, or whether some other form of learning is more appropriate. On the first occasion Ms C's case was considered, the conclusion was that it did not on balance meet the criteria for a SAR, but a learning event should be held. However, what prompted a second discussion was a coroner's inquest into Ms C's death. This opened on 17th March 2017, and raised questions about the way agencies had worked together to support Ms C. As a result of this (which was adjourned to October 2017), a re-referral for a Safeguarding Adults Review was made, supported by the information from the Coroner’s Inquest. This resulted in a recommendation from the sub group meeting of 20th July 2017, to the Chair of Tower Hamlets Safeguarding Adults Board, that the threshold for a SAR had been met.

2.3 Section 44 of the Care Act 2014 says that:

*An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if -*

1. *there is reasonable cause for concern about how the SAB, members of it or other persons worked together to safeguard the adult, and*
2. *condition 1 or 2 is met*

*Condition 1 is met if -*

1. *the adult has died, and*
2. *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)*

*Condition 2 is met if -*

1. *the adult is still alive, and*
2. *the SAB knows or suspects that the adult has experienced serious abuse or neglect*

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult’s case, and

(b) applying those lessons to future cases.

2.4 In Ms C's case, there was concern about the way agencies had worked together to support her and as a result the Tower Hamlets Safeguarding Adults Board arranged the review.

**Section 3 The Care Act 2014: guidance on Safeguarding Adults Reviews**

3.1 The purpose of SARs is described very clearly in the statutory guidance as to ‘promote effective learning and improvement action to prevent future deaths or serious harm occurring again’. *The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.*

*What SARs are not is also explained: The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for that purpose, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council etc.* (SCIE 2015)

3.2 The Care and Support Statutory Guidance, as well as saying that Safeguarding Adults Reviews should follow the broader principles of the Care Act, sets out in s14.167 the principles that should be applied by SABs and their partner organisations to all reviews:

* there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
* the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
* reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
* professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
* families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively (DH 2018).

**The involvement of Ms C’s family**

3.3 The Chair of Tower Hamlet’s Safeguarding Adults Board first contacted Ms C’s mother and father individually by letter, through the link of the Coroner’s Court in late 2017 to let them know that this Safeguarding Adults Review was taking place. The Chair wrote for a second time as a second draft of this report was being developed, and invited their participation, offering the liaison services of the voluntary sector organisation that had worked with their daughter, if this might help them to participate. Of these second letters, one was received, insofar as tracking can confirm this, but with no response, and the letter to the other parent returned. Ms C’s parents did participate in her inquest.

**Section 4 The Terms of Reference for this Review**

4.1 The period under review was agreed as August 2013 - when Ms C was believed to have moved into the London Borough of Tower Hamlets, to 3rd October 2016, which was very sadly, the date of her death.

4.2 At its first meeting, in February 2018, the panel for the Review developed some overarching questions about the local safeguarding system that they wanted the Review to answer. Behind these sat some more detailed lines of enquiry from the panel, for agencies to base their analysis on. It is not unusual for the lines of enquiry in a SAR to be adjusted as information is gathered. In this Review, the chair of Tower Hamlets SAB and the independent reviewer revisited the lines of enquiry following the second panel meeting - a meeting which considered all the IMRs.

4.3 The lines of enquiry that the Tower Hamlets SAB wanted to explore through the Safeguarding Adults Review into the case of Ms C were agreed as:

4.3.1 What are the challenges in working with adults at risk who are autistic, including with Asperger Syndrome, and / or complex and less common mental health diagnoses?

4.3.2 How can the Tower Hamlets SAB be assured that following Ms C's tragic death, links between Housing Options, mental health and adult safeguarding are sufficiently robust and that there is an agreed pathway for those at high risk, homeless and appear, and are, suicidal. What cultural change can be demonstrated?

4.3.3 A minority of agencies looked at Ms C through a safeguarding lens - why did this happen? and what barriers could be removed to reduce the chances of it happening again?

Related questions that lay underneath these overarching ones, and to be addressed in the Recommendations and Findings section, were also agreed::

4.3.4What is the culture around escalation of safeguarding concerns in Tower Hamlets? and how are professional decisions made about which cases to escalate?

4.3.5 Planned changes to the 'Front Door' into Adult Social Care are due - what is the understanding of all agencies about how to use the process currently for safeguarding concerns, and how to refer those concerns directly?

4.3.6 Another more recent development in Tower Hamlets is the Multi Agency High Risk panel - how well is this working? What is its role in relation to adults at risk who are autistic, including diagnosed with Asperger Syndrome and / or complex and less common mental health diagnoses? The board needs to be assured that its purpose is understood by agencies as well as where the future of this panel lies in transformation plans for the service which it is a part of.

4.3.7 What measures are in place in agencies for working in a person-centred way with adults at risk who are autistic, including diagnosed with Asperger Syndrome and / or complex and less common mental health diagnoses?

4.3.8 In Ms C's case, there were a number of very specific assessments commissioned, as there are for many people in need - how are these reflected in assessments of safeguarding and risk?

4.3.9 Tower Hamlets Suicide Prevention Strategy was published and promoted in January 2018 - what impact has this had so far?

**Agencies who had worked with Ms C during the period under review**

1. East London Foundation Trust

* City and Hackney Autism Service
* City & Hackney Therapeutic Community Outreach Service
* Hackney Primary Care Liaison Service
* Hackney Centre for Mental Health
* Newham Centre for Mental Health
* Newham Home Treatment Team

1. A Tower Hamlets voluntary sector organisation providing services to young people in the borough
2. London Borough of Tower Hamlets Adult Social Care
3. London Borough of Tower Hamlets Housing Options Singles Team (HOST)
4. A Hackney GP practice where Ms C was registered from 2014
5. Metropolitan Police Tower Hamlets
6. Barts Health Trust

**Section 5 Methodology for the Review, process, and reflections on its use**

5.1 Tower Hamlets has its own local Protocol for initiating and conducting Safeguarding Adults' Reviews. This Protocol provides a detailed guide to implementing the multi-agency London Safeguarding Adults Procedures, which all London Safeguarding Adults Boards are signed up to. The Tower Hamlets SAR process is overseen by a panel, chaired by the Independent Chair of Tower Hamlets Safeguarding Adults Board. The protocol is that the board takes the same approach for all SARs - that of agreeing Terms of Reference then asking relevant agencies to complete analyses of their own practice, known as Individual Management Reviews. These reports form the data about practice and context in Tower Hamlets that an independent person, commissioned to write the Safeguarding Adults Review, uses for the final report.

5.2 Other processes relating to Ms C's death were completed before the Safeguarding Adults' Review began. These were:

* A Serious Incident Investigation by the Mental Health Trust. The Trust provided the independent reviewer with a copy of this
* An inquest, which opened at Walthamstow Coroner's Court in March 2017 and was adjourned and completed in October 2017.

The Serious Incident Report and comments about the inquest made to the panel by agency representatives or IMR authors, some of whom attended it as witnesses, are included in this report.

**The Reviewer**

5.3 The Care and Support Statutory Guidance sets out the expectations about the skills and experience of the person who will lead a Safeguarding Adults Review. In this instance, the person appointed to undertake the review was Fran Pearson. Fran is an experienced reviewer and chair of Safeguarding Adults and Children's Boards. She has carried out one Safeguarding Adults Review for Tower Hamlets SAB in the past. Fran is independent of the agencies involved in this Review, however due to Children's and Adults' safeguarding board chair roles that she has held in the past, or holds currently, her work has brought, and continues to bring, her into regular contact with senior managers from the acute hospital and mental health trusts involved in this Review. In addition, having been commissioned to take on the role of independent reviewer, it emerged that Ms C had ended her life in temporary accommodation in the London Borough of Newham, where Fran is Safeguarding Adults Board chair. The panel discussed whether this created any conflict of interest and felt it did not. An appropriate panel member from Newham was invited to join the review in order to support the separation between Fran's role in this review and in Newham.

The Panel

5.4 The panel members for this review were:

|  |  |
| --- | --- |
| **Title** | **Organisation** |
| Panel Chair | Tower Hamlets Safeguarding Adults Board |
| Independent Lead Reviewer |  |
| Chief Officer | Step Forward Voluntary Sector organisation |
| Ms C’s General Practitioner | GP |
| Mental Health Commissioning Manager | Tower Hamlets Clinical Commissioning Group |
| Mental Health Transformation Manager | Clinical Commissioning Group (for first panel meeting only) |
| Detective Chief Inspector Public Protection and Safeguarding | Metropolitan Police – Tower Hamlets and Hackney |
| Joint Adult Safeguarding Lead | Tower Hamlets Clinical Commissioning Group and Tower Hamlets Council |
| Service Manager: Safeguarding | Adult Social Care Directorate, Tower Hamlets Council |
| Service Director | Adult Social Care Directorate, Tower Hamlets Council |
| Borough Director | East London Foundation Trust |
| Senior Advisor, Safeguarding Governance Team | Adult Social Care Directorate, London Borough of Newham |
| Head of Adult Safeguarding | Barts Health Trust (this post was vacant for part of the review) |
| Head of Housing Options | Place Directorate, London Borough of Tower Hamlets |

**Section 6 Key dates in the period under review**

|  |  |
| --- | --- |
| August 2013 | Ms C moved into LB Tower Hamlets to a shared house, privately rented, with an Assured Short-hold Tenancy for 12 months, subsequently renewed yearly |
| August 2013 | Ms C self-referred to the Tower Hamlets Early The consultant psychiatrist there concludes that Ms C is suffering from Border Line Personality Disorder, and referred her to Tower Hamlets Personality Disorder Service |
| September 2013 | Ms C’s first assessment with the Personality Disorder Service |
| September 2014 | One year later, Ms C takes an overdose of 30 paracetamol tablets. She regrets it and seeks help at Royal London Hospital Emergency Department |
| 2nd October 2014 | Ms C contacts Tower Hamlets Personality Disorder Service, saying that she was moving back to Hackney and they should refer her to the equivalent service in Hackney, called Therapeutic Community Outreach Service |
| 3rd October 2014 | Ms C has not in fact moved out of Tower Hamlets, but registers with a Hackney GP practice, giving a Hackney address as her home |
| October 2014, | Ms C sees the psychiatry service at her university – a worker from there writes to Ms C’s GP asking that they refer Ms C for assessment at the Hackney personality disorders service, and the GP in turn makes this referral |
| Late 2014 | Ms C contacts a voluntary sector organisation in Tower Hamlets that works with young people. She asks to access their counselling service and is assessed |
| January 2015 | Ms C has her first counselling session at the voluntary sector organisation. Her allocated worker remains the same throughout the period under review |
| March 2015 | The result of assessment at TCOS is referral to psychodynamic psychotherapy department for once-weekly 1:1 therapy |
| 11th March | Referral from GP to CHAMHRAS (single point of entry for all mental health referrals in City and Hackney) requesting assessment for Autism |
| Early to mid-2015 | Ms C takes on a rescue dog for companionship |
| June – July 2015 | Diagnosis of ‘Asperger’s Disorder’ and follow up at City and Hackney Autism Service |
| July 2015 | In discussion with a psychotherapist at Hackney Therapeutic Community Outreach Service further treatment is offered to Ms C, but she says that she prefers to use the voluntary sector organisation, as she can take her dog there |
| October 2014 to January 2016 | 12 GP consultations (the majority on the phone) related to self-harm; suicidal thoughts or psychiatric symptoms |
| October 2015 to March 2016 | Ms C attends 4 of the available peer support groups run by the Hackney Autism Service |
| June 2016 | Ms C tells counsellor that she is going to be evicted at end of August 2016 |
| 3rd June 2016 | Counsellor speaks to Ms C's GP in Hackney and describes Ms C as having suicidal thoughts and low mood. Ms C is not currently on anti-depressants. The GP explains the booking system at practice |
| 7th June 2016 | GP consultation - GP prescribes new anti-depressants and refers Ms C to Primary Care psychiatry service run by the mental health trust - having offered another service - the Home Treatment Team - which Ms C declined as she did not want people coming into her home |
| 21st June 2016 | Due to the level of anxiety and associated risk the counsellor sees in Ms C, she obtains Ms C’s consent, as long as Ms C was not named, to contact LBTH Adult Social Care for advice. A "First Response Officer" emails back suggesting the *Homeless Persons Unit* as the first place to approach *& if client consents, refer to Adult Social Care for assessment of her social care needs* |
| 23rd June 2016 | Ms C allocated a case worker from HOST (Housing Options Singles Team) |
| 4th July 2016 | First of three meetings at the voluntary sector organisation’s offices by HOST case worker to meet Ms C in safe space. Ms C emails supporting documentation three days later |
| 5th July 2016 | Ms C assessed by consultant psychiatrist from ELFT's Primary Care Service who prescribes a new antidepressant. By 14th July Ms C contacts the GP surgery chasing the letter from the psychiatrist. It has yet to reach the surgery and as a result the GPs cannot prescribe the new medication |
| 7th July 2016 | Following a request from the allocated HOST worker, the counsellor emails supporting documentation |
| 8th August 2016 | Letter from Primary Care psychiatrist scanned to GP system. This comments on Ms C's mental state, associated risks and suggests future medication plan. The psychiatrist has not arranged to see Ms C in clinic again as she was 'already engaged with another service' of 'independent psychotherapy' (namely the voluntary sector organisation) |
| 9th August 2016 | Ms C has a telephone appointment with one of the GPs to follow up on what the Primary Care Psychiatrist discussed with Ms C as a plan, and what is now in writing – although over a month has gone by since that appointment, the first part of the plan involved stopping one medication by tapering it down, and having one week drug free before starting a new medication. The new medication was started following this telephone consultation |
| 9th August 2016 | Caseworker puts Ms C's case forward to the Housing Options Private Rented Sector Scheme which finds temporary accommodation via private landlords |
| 11th August 2016 | Further discussions at LBTH Housing Options about fast tracking Ms C to Private Rented Sector Scheme   * Caseworker discusses Ms C again with supervisor, but advice is that no landlord in the area will accept a dog * caseworker talks to Temporary Accommodation team about possibility of self contained unit in a hostel, person he speaks to says she would not be prepared to place Ms C in a hostel as this would be detrimental to her mental health |
| 11th August 2016 | Senior Practitioner from Autism Service telephones Ms C to discuss her lack of attendance at the peer support groups. She said she had a lot going on and would try to come in the future. She was closed to the service at this point |
| 12th August 2016 | Caseworker explores Learning Disability route for accommodation but learns that the team use Housing Options anyway |
| 18th August 2016 | HOST caseworker & manager agree the only way for Ms C to have access to self-contained accommodation is by passing her case to Assessments |
| 22nd August 2016 | Ms C’s Caseworker goes on leave for 3 weeks |
| 23rd August 2016 | Considerable email traffic between the voluntary sector organisation and Housing Options, which includes an email from a housing advice worker who is covering for the worker on leave. It says that they have met with Ms C and offered her a hostel place |
| 24th August 2016 | Ms C's case passed from Housing Options service to Assessments Service. Ms C is offered a room in a hostel in the Bow district of Tower Hamlets |
| 25th August – the Thursday before August Bank Holiday | The Chief Officer of the voluntary sector organisation is so concerned about Ms C that she pursues a range of options that she believes might help. This includes   * exploring the possibility of provision known as the Crisis House, which it transpires can only be accessed via the mental health trust's Home Treatment Team * Setting out all her concerns in an email to three housing managers, including asking what was being done to safeguard Ms C and if the GP or psychiatrist were involved and if a mental health pathway can be triggered |
| 25th August 2016 | The Housing Options manager emails the Adult Social Care Safeguarding Manager - and the senior operational lead for community services East London Foundation Trust asking that safeguarding action be taken and a psychiatric assessment be progressed. The email explains the significance of Ms C’s dog and provides an email trail of what work HOST have done and why. Ms C is identified by name |
| 25th August 2016 | Ms C comes for counselling and confirms she had tried to hang herself the evening before |
| 26th August 2016  Day of eviction and the Friday before August Bank Holiday | The Adult Social Care safeguarding manager, replies to his Housing Options colleague- saying that he is currently on annual leave himself. He copies in a colleague - the Assessment and Intervention Team Manager. There is no follow up and no entries made on the system about this safeguarding referral |
| 26th August  Day of eviction and the Friday before August Bank Holiday | Counsellor has a telephone consultation with one of the GPs – outlining her concerns about Ms C’s situation and is advised to call back later that morning or in the afternoon with the outcome of the latest discussions with the local authority and then they can decide a plan for the weekend – the call later on in the day is not necessary because events move on |
| 26th August  Day of eviction and the Friday before August Bank Holiday | Ms C 's counsellor spends day with her familiarising her with room at the allocated hostel - but feels Ms C feels so unsafe that they go to the acute hospital in Hackney, from where Ms C is admitted as a voluntary patient to Hackney Centre for Mental Health |
| 26th August - 13th September | The first of Ms C’s two admissions, as a voluntary patient, to Gardner Ward, Hackney Centre for Mental Health |
| 8th September 2016 | The Operational Lead of City and Hackney Autism Service visits Ms C on the ward 'as a favour' to the consultant there, because Ms C was not engaging with staff. The consultant asks if the consultant from the Autism service will give a view on the risk of suicide but this appears to be declined. The Operational Lead feeds back her view on Ms C's suicide risk, a risk which she judges to be considerable |
| 9th September 2016 | A discharge plan is agreed on the ward - discharge date set for 13/09/2016 with support from ELFT’s Home Treatment Team |
| 13th September 2016 | Housing Management Team book Ms C into a hostel room. This is in the adjoining London borough of Newham |
| 15th September | The Housing Options Service accepts that it owes a duty to accommodate Ms C temporarily under s193 of the Housing Act 1996. A permanent offer through the Housing Register [is] made because the council accepts a full housing duty under homelessness legislation |
| Thurs 15th September | Ms C comes into the offices of the voluntary sector organisation, and has to go through whole process of signing up for a hostel place again |
| 16th September | The counsellor from the voluntary sector organisation telephones the ward. Despite having previously asked to be updated, she learns from a Welfare Officer that Ms C has been discharged to a hostel in London Borough of Newham |
| 27th September 2016 | Review with consultant psychiatrist who, due to elevated risk, suggests a second voluntary admission. Ms C is admitted to the same ward in Hackney |
| 28th September 2016 | The voluntary sector organisation’s counsellor speaks to a nurse on the ward and explains that due to the age range for the counselling service, it is due to end on 10th November. The counsellor asks the nurse’s opinion on whether to tell Ms C. The nurse says it is up to her. The counsellor subsequently emails Ms C to give date for final session |
| Thurs 29th September | Ms C responds by email indicating she was initially shocked and anxious about counselling ending but is grateful to have received it, and knows she has other forms of support |
| Fri 30th September | Ms C returns to the hostel on weekend leave after review with consultant on the ward. Over the weekend she visits her dog and speaks with Home Treatment Team workers by telephone, and on the Sunday, two Home Treatment Team workers visit her at the hostel |
| Monday 3rd October | Ms C does not return as agreed for review on the ward. An NHS support worker came to see Ms C, master key at hostel does not work, police called for Welfare check and her body discovered |
| After Ms C's death | Ms C's mother shares with Serious Incident reviewer for the mental health trust that Ms C had *maintained a journal viewed after her death and in it she detailed definitive plans to kill herself for several weeks prior to her death and clearly stated she had deceived staff purposefully, even stating her hope the staff would not be blamed after her death allegedly* |

**Section 7 Analysis of the quality of professional practice**

7.1 Tower Hamlets SAR Protocol sets out the aim of an Individual Management Review (IMR). It is:

*to look openly and critically at individual and organisational practice to assess whether the case indicates whether changes and improvements could be made and to identify how these changes should be brought about (TH SAB, 2017)*

This section of the report considers whether the practice of professionals in relation to Ms C met the relevant standards for their different professions, and local and national frameworks for delivering services to adults with Autistic Spectrum Disorder including Asperger Syndrome, anxiety, personality disorder and the complex range of conditions that Ms C had.

Source materials for the conclusions about practice are

* The Individual Management Reviews;
* Discussion at panel day;
* Supplementary interviews by the independent reviewer.

**Practice issue 1: Ms C's safeguarding needs were only identified by a minority of professionals working with her, and her situation was not seen through the lens of adult safeguarding.**

7.2 Since Ms C’s death, two reports have highlighted a growing body of new research about suicide risk in adults with autism spectrum conditions, of which Asperger Syndrome is one. First of all, in October 2017 (NCISH 2017), the annual report on suicide trends picked out adults with autism spectrum disorder as a group of people at risk and for whom an upward trend in suicide rates was such that the annual report authors wanted to draw attention to it.

*There were 119 suicides by patients with a diagnosis of autism spectrum disorder (ASD) in 2005-2015 in the UK, an average of around 11 deaths per year. The annual figure has risen during the report period and our estimate for 2015 is 17 suicides. Certain risk factors, including alcohol misuse, were less frequent in this group compared to all patients who had died by suicide, while previous self-ham was more common*. (NCSIH 2017: p3)

Locally meanwhile, the mental health trust’s autism services in Tower Hamlets and City and Hackney (Newham does not have an equivalent service although one is under development) were inspected in 2018 as part of a Care Quality Commission inspection, (CQC 2018), the report from which was published in June 2018. Community services for adults with autism were rated as ‘good’, and therefore in a position to support further research-based service development. This is happening in line with the borough’s Autism Strategy and includes the aim of offering services beyond the point of diagnosis.

7.3 Secondly, during the writing of this report, research was published (Cassidy et al 2018) on Risk markers for suicidality in autistic adults. This concluded that although the area of research was relatively new, ‘Camouflaging [concealing one’s autism] and *unmet support needs* [my emphasis] appear to be risk markers for suicidality unique to ASD’.

In a large sample of 374 adults newly diagnosed with Asperger syndrome (AS; autism without language delay or intellectual disability), 66% had contemplated suicide, significantly higher than the general population (17%) and patients with psychosis (59%).

And

… the highest rates of suicidal ideation (66%) were reported in adults newly diagnosed with AS who struggled without support

(Cassidy et al, p2)

Although it is early days with this research, the implications for adults with Ms C’s Asperger Syndrome diagnosis, and for adults with autism are significant. An action is included at the end of this report for East London Foundation Trust to keep abreast of this emerging research and share it with partners.

Ms C's case was referred for a second time to the SAR sub committee for consideration when the service manager for safeguarding in Tower Hamlets Adult Social Care division realised from conversations with colleagues in the Housing Options Team and the voluntary sector organisation that had worked with Ms C, that two attempts had been made to refer Ms C for safeguarding to the local authority. As the Adult Social Care IMR says:

*On both occasions the staff who received the referrals failed to commence the safeguarding process set out in the policy and procedure of the organisation.*

7.4 When firstly the counsellor at the voluntary sector organisation, and secondly a manager in the Housing Options Service, sought advice from Adult Social Care about safeguarding Ms C due to her risk of suicide, the responses they received did not suggest that professionals were thinking or acting differently as the result of the changes that had reportedly been made after another adult service user’s death. The requests were made to professionals with very different levels of seniority and authority, but both instances resulted in responses that

*failed to action safeguarding referrals which were clear and well-evidenced about the risks involved and the need to support the vulnerable adult [,] and in that they failed to record the referrals received by them on the case management record as required by policy and procedure* (Adult Social Care IMR).

7.5 The Adult Social Care IMR considers that the voluntary sector counsellor made a "referral for safeguarding action [that] was specific and also detailed and analytical in providing a rationale for intervention" yet the officer who received it did not meet "the safeguarding procedural requirement... to make contact with the referrer and seek further information." Of equal concern was the lack of outcome from the request by the senior manager from Housing Options to management level staff, neither of whom "actioned any safeguarding response". The Adult Social Care IMR also identifies that for both the safeguarding requests that the other professionals made, "there was also a failure to record according to policy". All comments in quotation marks are from the Adult Social Care iMR.

7.6 On the day Ms C had to leave her property, she was supported throughout the day by the counsellor from the voluntary sector organisation. From 10.15am till 3pm, according to her account, the counsellor and Ms C were at the local authority housing advice offices. At one point, the acting Team Principal for the HOST, who had been corresponding with the counsellor about Ms C's situation, called her over and advised

*if I was concerned about [Ms C's] safety that I should take her to A&E. I asked her, as Tower Hamlets council are a statutory service what they were going to do about safeguarding [Ms C] and she said [Ms C] and I would have an opportunity to speak to the assessments team about this later on.*

7.7 During an interview with a Housing Benefits officer (one of the six people who Ms C and the counsellor reportedly had to deal with in the housing advice building), the counsellor *"then asked if we could speak to someone in the assessments team about safeguarding as promised and we were told to go back to reception and to speak to the duty assessments person".* The counsellor and Ms C did this and according to the counsellor's written account, a further worker *"then took us to a private room and gave us the forms to complete for the social worker. I asked why the HOST team had not already applied for an adult social worker on [Ms C's] behalf during the previous 3 month period and she said because it was a different department in a different building"*

(from voluntary sector file notes provided to the Review).

7.8 Although a Housing Options manager contacted their peers in the local authority and mental health trust about the safeguarding risk associated with Ms C, as the Housing Options IMR recognises, when no response came from Adult Social Care, this silence was not flagged up as inadequate. All housing staff are now advised, through workshops set up because of Ms C's death,

*"that they must continue to pursue an interdepartmental or cross agency referral or safeguarding concern until such a time that they are satisfied that action has been taken... Staff are also now very aware that they must also escalate matters to more senior managers in the event that there is no, or no satisfactory, response to a request for action"* (HOST IMR, s3 *Staff Knowledge and Awareness)*

7.9 In summary, practice by a range of professionals did not recognise that Ms C was in need of protection. Only the voluntary sector organisation was persistent and consistent in naming this risk. Housing Options staff promptly identified the safeguarding risks arising from Ms C's housing need, but although they tried to raise this with Adult Social Care and the mental health trust, they stopped short of escalating their concerns when Adult Social Care's managers did not reply to them. The Housing Options IMR notes the undisputed good practice in the way that some of their officers dealt sensitively with Ms C and tried to find housing where she could take her dog, but balances this with comment about the lack of escalation which should have happened when Adult Social Care did not respond. The failings in Adult Social Care's response are set out clearly in the IMR for that service. Of particular cause for concern is that around the same time, the service was reportedly improving its response to safeguarding concerns about suicide risk, by immediately implementing improvements following the suicide of another woman the year before.

**Practice issue 2: Co-ordination of care is particularly important for service users with Ms C's complex combination of Asperger Syndrome, personality disorder, anxiety and chronic suicidal intent, who are known to a number of services. This co-ordination should have been delivered by one of the statutory services working alongside Ms C and the voluntary sector organisation that she trusted. Instead this co-ordination was entirely lacking, with the consequence that Ms C's level of risk was not fully understood or responded to.**

7.10 Ms C’s use of services across boroughs meant that she was, despite being housed, needing the sort of professional response that a transient adult, moving around, would require. The two most important elements of this would be coordination of her care arrangements, and use of all relevant records to understand her history and risks, rather than relying on Ms C’s own account.

7.11 Ms Cinevitably and understandably found certain services were of more value to her than others, and chose to use services across the London boroughs of Hackney and Tower Hamlets. She moved to Tower Hamlets in 2013, but in 2014 gave a Hackney address in order to register with a Hackney GP. This had implications for the location of some of the services that were available for the GP to refer Ms C to, but she seemingly used Tower Hamlets Services earlier in 2014 including the Personality Disorder Service and an assessment service for young people concerned about their mental health. Ms C was also diagnosed with Asperger Syndrome in 2015. She used the Autism service in Hackney, which has a very specific diagnostic remit, and this then raised questions about where she could go for longer term support. Shortly before she was assessed by the Hackney Autism Service, she used the personality disorder service in Hackney. London Borough of Newham, and services provided there, were also of significance - not because Ms C chose to use them, unlike some of the provision she attended - but because this was where she was ultimately placed in temporary accommodation. The one thread running through all this provision was the East London Foundation Trust, which provides the majority of mental health services in the three boroughs.

7.12 As set out in the previous section, both the Housing Options team, and the voluntary sector organisation working with Ms C, made attempts to refer her because of her safeguarding risk to Adult Social Care, with the hope that this would result in the allocation of a professional to assess her risk and, ultimately, coordinate her care. Because this did not progress, the voluntary sector organisation by default took on the role of trying to coordinate services. The remit of this organisation with Ms C grew far beyond what they were commissioned to provide. On the one hand this was well-intentioned and arose from that organisation's knowledge and understanding of Ms C and the risk that her impending loss of housing and separation from her dog posed to her mental health. This risk was something that the counsellor at the organisation and the chief officer were able to articulate, as the Adult Social Care IMR noted, in a clear and analytical way. However it meant that they filled a gap which arguably other organisations should have been picking up, and it meant that the counsellor went far beyond her therapeutic remit with Ms C at a time when that therapy was nearing its conclusion due to Ms C's age, rather than having time to explore the implications of the nearing end of therapy. At panel it was pointed out that theoretically, Ms C could have asked for a social care assessment at any time, herself. The voluntary sector chief officer explained that Ms C considered the initiation of two different safeguarding referrals with her consent as being the way of making exactly this request happen.

7.13 Having taken on a co-ordinating role for Ms C's care by default, the voluntary sector organisation's attempts to carry out this role were thwarted on more than one occasion because other organisations did not communicate with them. This issue of parity between statutory and non-statutory organisations is explored further in the next section about pathways. For the purposes of illustrating where coordination could have resulted in a different outcome for Ms C, the following example is relevant. During Ms C's first admission to Gardner Ward in Hackney, a Welfare Officer on the ward emailed the voluntary sector organisation on 7th September at Ms C’s request, saying - "please can you contact me at your earliest convenience". The counsellor responded the next day, asking about the ward's plans to help Ms C in the future. No reply came, and on 14th Sept, the counsellor again contacted the Welfare Officer to ask for an update and received an email one hour later "*I have spoken with staff and [Ms C] has been discharged as of yesterday. She is now in temp accommodation in Newham [address given]. Referral has been made to Newham [Home Treatment Team] who should have seen her today."* An opportunity for a co-ordinated response to Ms C's discharge, which the voluntary sector organisation that knew her so well was trying to facilitate, was therefore, strikingly, missed.

7.14 The Housing Options IMR sets out what perceptions were in that service of the care co-ordinating role of the mental health trust

*[Ms C] was in receipt of support from clinicians within the ELFT, the expectation is that this service will liaise internally to ensure that social worker support is offered according to the assessed level of need. The social care support was offered by an ELFT team in a neighbouring borough, due to the link between the team and that team and the hospital where [Ms C] had been admitted.* (Housing Options IMR: s3 Staff Knowledge and Awareness)

7.15 The role of Care Coordinator, a function that forms part of the Care Programme Approach for people with mental health problems, can be filled by a professional from a range of disciplines. The intention behind the role is exactly as its title suggests. A recent Safeguarding Adults Review carried out by Newham Safeguarding Adults Board considered whether East London Foundation Trust should have allocated a Care Coordinator to ‘Afnan’ a man in his mid-twenties, with learning disabilities and mental health problems, and concluded that he, like Ms C, would have benefited greatly from a coordinating professional, to deal particularly with housing problems.

7.16 The ELFT Serious Incident report notes that between 27th and 30th August, a Care Coordinator was allocated to Ms C, and care plan and risk assessment documentation commenced. But this does not appear to have happened. From discussion with the panel member from the mental health trust, it seemed that 3rd October was the more likely date when it was planned to allocate a Care Co-ordinator to Ms C. Following her agreed weekend leave at the Newham hostel, Ms C was due to return to the ward for a meeting. This was because of the seniority and range of ELFT colleagues going to that day's meeting, which made it seem a likely forum for a discussion about who would take on the role of her Care Coordinator. Sadly, Ms C never returned to the ward, and it has not been possible to be establish for certain what the care co-ordination arrangements were that the mental health trust planned to put in place for her discharge.

7.17 As a final complicating factor, not all services in East London Foundation Trust with the same remits - for example inpatient units - have identical staffing establishments with identical functions. The borough director for Tower Hamlets shared with the panel that if Ms C had been admitted to the inpatient unit in Tower Hamlets, there is an embedded housing officer who would have gone with her on housing-related appointments, and that is likely the issue of social care would have been quickly picked up. The Hackney ward might have speculated that someone else other than them picking up the safeguarding. This and all the other factors explored in this section, only serves to emphasise the value that a coordinating professional could bring to someone with high levels of risk combined with use of multiple, dispersed services.

**Practice issue 3: At the time they were working with Ms C, professionals lacked, or were unclear about, an agreed pathway for those at high risk, homeless and suicidal. Links between Housing Options, mental health and adult safeguarding were insufficiently robust at the time and did not include the voluntary sector as partners**

7.18 The Management Reviews and chronologies from Housing Options and the voluntary sector organisation contain several references to the attempts that both organisations made to get Ms C onto some kind of pathway for people with mental health problems in housing priority, as Ms C was. Some of the options that they asked about turned out not to exist - for example at one point a manager from Housing Options approached the Learning Disability Service in Tower Hamlets, believing they had access to housing. This was in fact misinformation, they had no access to housing stock other than, it turned out, via Housing Options. Meanwhile the Chief Officer of the voluntary sector organisation was aware of an option called the Crisis House, for people with mental health problems, and explored this, explaining the significance of Ms C's dog. It transpired that the manager of this provision recognised the potential importance of support dogs to people with mental health problems but the route into the service was through Tower Hamlets Home Treatment team. All this discussion was happening in the two days before Ms C had to leave her property and because she was admitted to the mental health unit in Hackney, the Tower Hamlets Crisis House was not followed up any further.

7.19 The Crisis House in Tower Hamlets was a service that existed but what is of note from the IMRs are various references to pathways or provisions that it is not ultimately clear do in fact exist. There is reference to a mental health pathway in housing, which no one was able to confirm to the Review is a pathway that was or is in place. In the HOST IMR, on 29th August - [the voluntary sector counsellor] 'made further representations' to HOST asking 3 things, one of which was to 'obtain housing through ELFT's housing service' - which suggests that at least the voluntary sector organisation and possibly the Housing Options Services were under the impression that such a 'housing service' existed, unless this was an allusion to the Crisis House.

7.20 The Adult Social Care refers to a newer pathway - the High Risk Transition Panel - established in January 2018. It is intended for *situations where a person needs to transition into adult services, the risks of serious harm are high and there are difficulties or the case has become stuck. There is a general expectation that staff use regular safeguarding processes first and only refer to the panel if things get stuck but we will take a case directly to the panel if risks are very high and imminent [email exchange between the independent reviewer and the service manager for safeguarding].*

7.21 A new pathway was signed off between Housing Options and Adult Social Care in September 2016 (LB Tower Hamlets 2016), the month before Ms C’s death. This *Pathway into and out of the adult supported housing sector including the use of B&B* was a joint document from the Housing Options Service and the Vulnerable Adults Commissioning Team. One of its four stated principles is that *the council supports other agencies working with clients with significant support needs who are homeless*. The document sets out context about demand for housing in Tower Hamlets which is relevant to this review and its recommendations.

*Single homelessness in Tower Hamlets has remained stubbornly high for a number of years. HOST continues to receive on average more than one new episode of single homelessness every hour of the working week. In 2015-2016 alone, this amounted to the team working with 2099 new homeless presentations (LBTH 2016: 4)*

A recommendation included at the end of this report is that any statements made as a result of this review must be realistic and based on the context of such huge demand on housing.

7.22 A further issue that emerged strongly during this review was that the organisation Ms C was most engaged with, the one in the voluntary sector, was not part of any existing pathway, nor able to refer into services like the Crisis House. For the voluntary sector organisation, having had seemingly good partnership working with Housing Options initially, there was a striking phase in the week before Ms C’s eviction date when officers in HOST stopped being so responsive and did not answer questions. Some of these questions such as ‘what can we tell Ms C in order to help you?’ were asked in a spirt of continued joint working which did not feel as though it was being reciprocated. Not responding is something that would have consequences for staff in the voluntary sector organisation if they are found to have behaved in this way.

**Practice Issue 4 - the difficulties of assessing suicide risk are compounded in adults with autism. Professionals in services such as housing advice and at the front door of adult social care, need sufficient awareness to be able to engage with adults with autism, or form working relationships with other professionals who can assist them. For psychiatrists and other mental health professionals with specific responsibilities under the Mental Health Act, and set out in NICE guidance, this judgment is particularly important, as is the ability to call in help from other professionals with relevant expertise.**

7.23 There is 2012 guidance from National Institute for Health and Care Excellence (NICE 2012) on ***Autism spectrum disorder in adults: diagnosis and management*** . This covers the expectations of health and social care professionals and sets out the responsibilities of a local autism strategy group.

7.24 In preparing this report, the panel and the independent reviewer heard positively about the difference it made when professionals took advice on how to interact most sensitively and effectively with Ms C, and negatively about the limited way in which some professionals' understood autism and its implications. A letter from Step Forward of July 2016 sets out very clearly some of the difficulties that the combination of Borderline Personality Disorder, Asperger Syndrome, and "symptoms associated with depression and severe anxiety which is not uncommon for people with Asperger’s" cause for Ms C. The counsellor and Chief Officer of Step Forward repeatedly explained to other professionals how they could work with Ms C in ways that would best help her to manage the associated feelings and result in the most productive engagement with her. At the same time, in the summer of 2016, professionals from the mental health trust, in their services provided in Bedfordshire, were working with a woman in her thirties with Personality Disorder and ‘High Functioning Autism Spectrum Disorder’. Tragically this woman also took her own life the month before Ms C did. Although there were many different issues in the Safeguarding Adults Review (BB&CBSAB 2017) into her death, one recommendation does conclude that

*There is clear evidence throughout the period of this Review that the services offered and provided to Miss A did not consistently accord with the ... principles of good practice of working with adults with autism.*

The difference in Tower Hamlets and Ms C’s experience, was that the limitations in understanding the impact of Borderline Personality Disorder and Asperger Syndrome, came principally from professionals in services other than the mental health trust, whereas in the Bedford review, the comments were directed towards ELFT staff. Nonetheless the needs of these two women arising from their Borderline Personality Disorder and Asperger Syndrome were not met, for different reasons, but with tragic consequences in both cases.

7.25 All the organisations working with Ms C operate within the legal Framework of the Equalities Act 2010. This legislation protects people from discrimination on the basis of age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex and sexual orientation (Equalities Act 2010). Ms C was therefore protected not just on the basis of disability (as her Asperger Syndrome and Personality Disorder fall into the definition of disability under the Act), but also on grounds of her sexual orientation because she identified herself as Lesbian. The Pathway (Tower Hamlets 2016) *into and out of the adult supported hostel sector including the use of B&B*, has as its first principle, a stated recognition of the Act

* Equality – to ensure that all clients have equal access to services and are not unfairly advantaged or disadvantaged by using the adult hostel sector.

As a result, the awareness of autism for more generic professionals, and the explicit responsibilities for health and social care professionals set out in the NICE guidance, that this section explores in more detail, should have been underpinned by an understanding of the duty to protect Ms C from specific types of discrimination. The actual practice did not at all times indicate that professionals grasped this.

7.26 The Housing Options team took the advice of the voluntary sector organisation and as a result, the first worker allocated to assess Ms C's needs was able to work with Ms C in the ways most guaranteed to make a distressing process as easy as possible for Ms C to navigate. This included recognising that Ms C's Asperger Syndrome made unfamiliar surroundings particularly unsuitable as places to meet - and as a consequence the Options and Prevention Officer held all three of the face to face meetings with Ms C that were needed during the assessment process at the offices of the voluntary sector organisation. Section 7.7 which analyses the lack of joined up working between council departments, draws on an extract from a very full account by the counsellor of the day she and Ms C spent together on the date Ms C had to leave her accommodation and register as homeless in order to secure her hostel place. The full account contains examples of the many ways in which the staff at the council's housing advice building lacked awareness of dealing with people with Asperger's. In fairness to them, the whole process was set up to be particularly difficult for an adult with autism, but one example was:

*then a different person called us over and told her about the new accommodation, she gave her a map and a cont[r]act for her to read through and sign. [Ms C] was rushed through the process and the person was talking to her in a loud voice which really confused [Ms C]. Again this person was not trained in how to work with someone with Aspergers When I asked for her name she refused to give it by saying "you don't need my name, I just give accommodation details".*

7.27 Once the hostel place was allocated, the counsellor spent time looking round it with Ms C and trying to help her feel as settled as possible. This room was in Tower Hamlets, in a locality that Ms C knew and which the voluntary sector professionals had argued formed an important piece of familiarity for someone with Ms C's complex combination of conditions. The counsellor also risk assessed the room for ligature points. Section 7.13 outlines the greater risks the counsellor foresaw when Ms C was due to be discharged to a different and unknown hostel room, and her efforts to find out in good time what the plans were. This offer to the ward staff was completely missed. As a result, Ms C had gone to an unfamiliar room in an unfamiliar borough before the Welfare Officer on the ward responded to the counsellor, so it was too late to draw on the knowledge that the voluntary sector organisation had, and to use that knowledge in order to better support Ms C. As section 7.14 highlights, if Ms C had been admitted to a Tower Hamlets inpatient unit, that service, unlike Hackney, has a housing support worker who could have responded to some of the needs arising from her Asperger Syndrome by accompanying her to the Newham hostel place in the same way that the voluntary sector counsellor did with the initial allocated room in Tower Hamlets.

7.28 One of the lines of enquiry for this review asks about the sharing of information between agencies. This had a direct impact on the ability of relevant professionals at the organisation running the hostel in Newham to make any judgments about risk of suicide to Ms C. In fact they were unaware there was a risk of suicide for her at all. The Housing Options colleague on the panel for this review said that they believed the HOST had sent a risk assessment to the hostel management firm. However, this was not at all what was presented to the panel by the area manager of that firm, or in their Individual Management Review. The area manager said that, if he knew Ms C was at high risk of committing suicide, she would not have been offered a room at the hostel as she would have not been in the right place as it is not supported accommodation. Staff in the hostel were aware of regular visits to Ms C by some NHS professionals, but had not been told of any help Ms C needed. The workers coming in to see her, from the Home Treatment Team, indicated to staff there were concerns and on one occasion said that they would be returning the following day. The company running the hostel does not have a process in place for managing suicide risks.

7.29 Another piece of practice relating to risk and Ms C’s need for protection is included here, although it relates to practice within an organisation, rather than the interface between organisations. The consultant on the ward, whilst planning Ms C’s first discharge in September 2016, sought expert advice about how to draw conclusions on suicide risk from the way a person with Asperger Syndrome presents themselves. This request was made firstly to the Operational Lead of City and Hackney Autism Service who did visit Ms C on the ward 'as a favour' to the consultant, because Ms C was not engaging with staff. She reported her view on Ms C's suicide risk, a risk which she judged to be considerable. The ward consultant then asked if the consultant from the Autism service would give a view on the risk of suicide, but this appears to have been declined. Within East London Foundation Trust, requests for a second opinion are regarded as good practice. The ward consultant exemplified this by trying to reach the most robust possible conclusion about suicide risk for Ms C. The panel was given assurances that changes mean a second opinion would now always be provided in similar circumstances.

**Section 8**

**Conclusion and Recommendations for Tower Hamlets Safeguarding Adults Board**

After a tragic incident such as this, it is an expectation that all organisations will immediately begin to make changes that they need to, without waiting for a process such as a Safeguarding Adults Review. Rightly this has happened in Tower Hamlets.

**Conclusions**

8.1 Ms C was a white British woman in her mid-twenties, who took her own life by hanging. She had a range of mental health diagnoses: personality disorder, Asperger Syndrome, depression and anxiety. At the centre of her life was the dog she had acquired the year before she died, which gave her a level of emotional support that was recognised by some of the professionals who worked with her. When Ms C’s landlord gave her notice to leave a shared house where she was a tenant in Tower Hamlets, Ms C and professionals at the voluntary sector organisation who knew her well, made the point, repeatedly, that moving would be exceptionally stressful for a young woman with her range of conditions and mental health problems. They explained clearly that separation from her dog would leave Ms C feeling hopeless to the point of not wanting to carry on living and spelt out the risk that she would take her own life. Initially Ms C received a consistent and thoughtful response from the Housing Options Singles Team in Tower Hamlets, which seeks accommodation for single adults confirmed as homeless or at risk of homelessness, and for whom the local authority has a responsibility under housing law.

8.2 Ms C used a wide range of services provided by the East London Foundation Trust, nine in total, during the period under review and a panel member made the point that this meant professionals should have shaped their practice with Ms C as they would with a transient person. Although a Tower Hamlets resident, she registered with a Hackney GP, after her move into Tower Hamlets, giving her previous address which was in fact in Hackney. Being registered with a Hackney GP meant that the GP referred Ms C not to Tower Hamlets services provided by the mental health trust, but to Hackney provision by the same mental health trust. Ms C’s history was not fully understood because of the way she moved between services, and the risk to her was not fully assessed partly because professionals tended to rely on Ms C’s own account of past mental health problems and trauma. This was compounded by the difficulties of assessing risk in any adult who has Asperger Syndrome or Autism, who do not always show emotion or give signals to professionals about their level of distress. The voluntary sector counsellor had the best understanding of Ms C’s needs but other professionals from organisations did not always liaise with the organisation in Ms C’s best interests.

8.3 On two occasions, professionals from different organisations, firstly voluntary and then statutory, clearly reported safeguarding concerns about Ms C to the local authority, which were not followed up as they should have been. This meant that the escalating level of risk for Ms C, as eviction day approached, was not assessed or recognised. This has raised questions on the robustness of reported improvements at the local authority ‘front door’ where risk is assessed and initial safeguarding concerns dealt with. These improvements were said to be in place by 2016, the year Ms C took her life, in response to another woman of very much the same age, Ms L, taking her own life the previous year. A Safeguarding Adults Review was carried out into Ms L’s case and the summary published by Tower Hamlets Safeguarding Adults Board in 2018. A series of further changes to the way concerns are received and assessed, along with reported improvements in joint working between organisations, and the introduction of a “High Risk Transitions Panel” are detailed this report, along with recommendations about testing their robustness.

8.4 From the outset, HOST workers were clear about the lack of housing stock in Tower Hamlets, which meant that finding somewhere that Ms C could move to with her dog was highly challenging. Initially, housing professionals explored what might be available, with some of their well-intentioned efforts suggesting a lack of clarity about housing and mental health pathways and provision that could respond to the risks in Ms C’s situation. Ms C’s eviction date came two days before a Bank Holiday and following a period when feedback from the Housing Options Singles Team had fallen silent. The chief officer and counsellor at the voluntary sector organisation spent an anxious 48 hours pressing housing professionals for news of what might be available, with the offer being that of a room in a hostel, where Ms C could not have her dog. The only thing to commend it was that the location was familiar to Ms C. As it happened Ms C, who was accompanied throughout the move day by the counselling professional, felt so unsafe that she was admitted to an impatient bed on a mental health unit. She chose to go to Hackney for the assessment process that led to this admission, which as a result, meant the admission was also in Hackney.

8.5 On discharge, this time to a different hostel in the London Borough of Newham, which was not familiar to her, Ms C was supported by the appropriate Newham service of the mental health trust. Her dog remained with friends. Ms C remained at the hostel for two weeks but asked to be readmitted to the ward, which she was, again as a voluntary patient, which may have affected some of the planning for her. She sadly took her own life during a period of home leave from the ward which was followed up in line with expected practice by the Newham mental health service. She had made some plans for the future which provided a possible reassurance that she was looking ahead, but at the inquest into her death, it was shared that Ms C had also concealed well developed plans to end her life. She had visited her dog on both of the two days before she took her life and although on the second of these days, she reported to mental health workers that she had enjoyed the visits, and had plans to seek a home where she could look after the dog again, it is not certain that these positive comments could be taken as true statements of how she was feeling about the future.

8.6 Communication and discharge planning for Ms C was impacted by the fact she was out of her home borough. There is a variation in what is available to inpatients in Tower Hamlets and Hackney. For instance, Tower Hamlets has a housing worker to liaise on behalf of patients as part of discharge planning, but Hackney does not. Despite the voluntary sector organisation communicating constantly with statutory organisations, there was not communication back to them. Ms C was discharged, not to the room in Tower Hamlets, but to one in the neighbouring, but to her, unknown, borough of Newham. Despite asking to be told of discharge plans so they could provide familiar support, the voluntary sector professionals only learnt of her discharge when they rang the ward for an update. Meanwhile the consultant from the ward was concerned to accurately assess the risk of Ms C self-harming or taking her own life, a particular challenge due the way that adults with Asperger Syndrome (or other conditions on the Autistic Spectrum) and mental health problems as well as personality disorder, can come across. An autism professional from the Hackney service, who had previously assessed Ms C, visited and provided a troubling picture of risk. In line with expected good practice, the ward consultant asked for a second opinion from a colleague with relevant expertise but this appears to have been declined. The reasons for this are not understood and assurances have been provided to the review panel that changes to services mean this should not happen again. The third factor was the great pressure on housing stock in Tower Hamlets which resulted in Ms C being placed in another borough.

8.7 Ms C had a complex combination of diagnoses – Asperger Syndrome, anxiety and personality disorder. Some services designed to help adults with one of those conditions also contained elements that are not recommended at all for adults with one of the other conditions. Her needs were not always understood or responded to. In this respect, there is systems learning from this review, and a new Autism Strategy is intended to further develop Tower Hamlets services. The other strands of learning from this review – about responding to the mental health needs of those who are made homeless, when there is such huge pressure on housing stock, and of the need to coordinate the care of adults with complex diagnoses who move between services and local authority or GP areas, have implications for all three east London boroughs where Ms C used services. The loss of housing where she felt safe, which in turn meant she had to part with the dog which provided her with her main support, appears to have had tragic consequences for Ms C.

**Recommendation 1**

**The board needs to assure itself of the extent to which professionals from the relevant agencies in Tower Hamlets are able to identify a safeguarding risk and tenaciously follow it up as set out in local policy and processes.**

**What lies behind this recommendation?**

8.1.1 The year before Ms C's death, another young woman had sadly taken her own life. This led to reported rapid improvements in awareness and responsiveness at the Adult Social Care front door, to requests for advice about adults who were felt to be at risk of suicide. That two requests for safeguarding from other professionals, that were explicit about the risk of suicide in Ms C's case were not followed up in Adult Social Care, raises questions about assurances previously given, that practice had already begun to change in 2016. Section 3 of this report, sets out the purpose of SARs. One of which is that *there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults.* It is of concern, then, that two of the main findings for the earlier review

* The sharing and coordination of information at key points;
* Appropriate responses to feelings of self-harm and actual self-harm.

appear not to have improved a year later when Ms C needed help.

8.1.2 The local authority should work seamlessly from the point of view of adults at risk and other professionals, to make sure that the right team and individuals respond to such risk. This includes knowing when to ask for a social care assessment. One of the most striking quotes in Ms C's case was attributed to a housing assessment worker, who said, when asked by Ms C's counsellor, why Housing Options had not referred Ms C for adult social care's involvement *" because it was a different department in a different building".*

8.1.3 Professionals whose main role was not safeguarding, correctly identified safeguarding concerns. When knocked back by other professionals, they were not always able, especially in the case of the Housing Options Service staff, to escalate such a refusal and the unresolved risk.

**What has changed already?**

8.1.4 Adult social care responded to the learning from Ms C's death by making what are described as ‘very significant changes’. A safeguarding hotline with dedicated tracking which only takes safeguarding calls and staffed by experienced social workers was set up. In October 2018, substantial changes were also made to the triage process for safeguarding cases. These changes were then reviewed as part of a wider piece of work to further improve the robustness of the front door, and managers continue to keep them under review.

8.1.5 Much closer working between Adult Social Care and the Housing Options Service began right away. Safeguarding workshops were immediately implemented. A High Risk Transitions panel was set up in January 2018, membership of which includes Adult Social Care; Police Safeguarding; Service Managers from Housing Options; and various relevant children’s services.

8.1.6 The Housing Options Service and East London Foundation Trust have run joint sessions, led by a mental health professional, to help HOST staff identify which sort of mental health risks they need to escalate. Managers of both services report that this has resulted in increased awareness of appropriate escalation and how to do it.

**Recommendation 2**

**The board should test out assertions about improved coordination and pathways between mental health, housing and adult social care - for example that the High Risk Transitions Panel is 'very successful' and understand what these mean for adults at risk of suicide and self-harm.**

**What lies behind this recommendation?**

8.2.1 Ms C was left at risk because neither service that could have provided a professional to coordinate her care, based on the roles and responsibilities that the law assigns to them – East London Foundation Trust or the Adult Social Care directorate of the council – did so, although East London Foundation Trust may have been planning to allocate a Care Coordinator to her on the day of her death. Instead a voluntary sector organisation, going beyond its remit, took on this role.

8.2.2 There were a number of ''pathways" into housing for adults at risk with mental health problems that professionals believed to exist when they were doing their best to help Ms C, some of which were never established to be real, and others of which turned out not to exist. With no prospect of increased housing stock and every prospect of increased need, some more robust and comprehensive understanding of pathways would help underpin the initiatives that Adult Social Care and Housing Options are already working on. In addition, one national policy change - the Homelessness Reduction Act, needs to be understood and built in to pathways. Finally, pathways did not include the voluntary sector at all, let alone as an equal partner.

**What has changed already?**

8.2.3 Individuals at high risk are no longer accommodated in Bed and Breakfast placements like the one used for Ms C, as it is now recognised that neither the Housing Options service, nor housing providers, whether they are private landlords or social landlords, have the expertise to support adults at such risk.

8.2.4 Housing Options are updating their policies to include a section on what to do in similar situations to that of Ms C. This is with the aim of ensuring adults at risk are not placed in temporary accommodation of any sort until they receive appropriate advice and treatment and a risk mitigation plan from East London Foundation Trust or a similar agency.

**Recommendation 3**

**The board should assure itself, linked to a Tower Hamlets Autism Strategy, of the level of awareness and related skills that professionals in assessment services for housing and social care, have in communicating with and understanding how to make reasonable adjustments for, people with autism.**

**What lies behind this?**

8.3.1 One of the direct quotes from Ms C that appears in the material for this Review is in the account of her 'eviction' day - the day when she had to move out of her accommodation and attend the council's housing advice building to be made the offer of a hostel place. This account was written by the counsellor from the voluntary sector organisation who accompanied her.

*"This was a very complex and long winded process. [Ms C] had to speak to 6 different people which again is not suitable support for a vulnerable person with Aspergers. During our visit [Ms C] said 'how do people cope with this when they don't have anyone to help them'. She then took a comments/feedback form which unfortunately she never had the opportunity to complete".*

**What has changed already?**

**8.3.2** An autism Strategy is under development and will be presented to the March 2019 Safeguarding Adults Board meeting. The local commissioner of NHS services has completed and submitted a nationally required assessment of local services for adults with autism and this is regularly reviewed at the local relevant meeting of senior managers. NICE guidance sets out the expectations of the local groups that develop such strategies:

* Autism strategy groups should be responsible for developing, managing and evaluating local [care pathways](http://www.nice.org.uk/guidance/cg142/chapter/glossary#care-pathway). The group should appoint a lead professional responsible for the local autism care pathway. The aims of the strategy group should include:
  + developing clear policy and protocols for the operation of the pathway
  + ensuring the provision of multi-agency training about signs and symptoms of autism, and training and support on the operation of the pathway
  + making sure the relevant professionals (health, social care, housing, educational and employment services and the third sector) are aware of the local autism pathway and how to access services
  + supporting the integrated delivery of services across all care settings
  + supporting the smooth transition to adult services for young people going through the pathway
  + auditing and reviewing the performance of the pathway

(NICE 2012)

8.3.3 A Care Quality Commission Inspection of the East London Foundation Trust found services for people with autism in Tower Hamlets to be good. This provides an opportunity for further development of the points recommended by NICE.

**References**

BB&CBSAB 2018; *Safeguarding Adults Review - Case A – Overview Report;* Bedford Borough and Central Bedfordshire Safeguarding Adults Board

Cassidy, S; Bradley, L; Shaw, R and Baron-Cohen, S (2018), *Risk markers for suicidality in autistic adults,* Molecular Autism, Open Access

CQC, (2018); *Inspection of East London Foundation Trust*, Care Quality Commission, London <https://www.cqc.org.uk/search/site/East%20London%20Foundation%20Trust?location=&latitude=&longitude=&sort=default&la=&distance=15&mode=html>

DH, (updated July 2018), Care and Support Statutory Guidance, Department of Health, London

England, R; Burningham, D (2017), presentation to NHS London Senate <http://www.londonsenate.nhs.uk/wp-content/uploads/2017/11/Primary-Care-Mental-Health-Service.pdf>

Equalities Act, 2010, United Kingdom, found at <https://www.gov.uk/discrimination-your-rights>

London Borough of Tower Hamlets, 2016, *Pathway into and out of the adult supported hostel sector including the use of B&B,* Housing Options Service (Development and Renewal Directorate) Vulnerable Adults Commissioning Team (Adult Services), Tower Hamlets

NCISH (2017), *Annual Report from the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness,* University of Manchester

# NICE (2012), *Autism spectrum disorder in adults: diagnosis and management,* National Institute for Health and Social Care Excellence, nice.org.uk

# =SCIE (2015), Safeguarding Adults Reviews (SARs) under the Care Act - Implementation support, Social Care Institute for Excellence, London

**Appendix One**

**Remit and location of Mental Health Services that Ms C used - (1-9) or was referred to (10)**

With one exception, the information is taken from East London Foundation Trust's website

1. **Tower Hamlets Early Detection Service** - a service for 16 - 25 year olds living in Tower Hamlets "who are concerned about what's going on in their head and how that is affecting their life"

Ms C self-referred herself to this service in August 2014 because she was worried about her mental health.

1. **Tower Hamlets Autism Service** - The Tower Hamlets Autism Service is a diagnostic and brief intervention service for adults living in Tower Hamlets. Provides assessments and diagnosis of autism spectrum conditions. Following a diagnosis, the service provides up to 12 autism specific interventions which includes support for any difficulties being experienced.
2. **Tower Hamlets Personality Disorder Service** - offers a service for people with histories of emotional, interpersonal and behavioural difficulties. The approach used is Mentalization-Based Treatment (MBT)
3. **Hackney** **Therapeutic Community Outreach Service (TCOS)** - this provides consultation, diagnostic assessment and evidence-based specialist mentalisation-based therapy (MBT) programmes for individuals with complex needs, particularly those with a diagnosis of borderline personality disorder. (East London Foundation Trust website)

Ms C's GP referred her for assessment by this service at the request of the psychiatry service at Ms C's university.

1. **Hackney** Autism Service. The City and Hackney Autism Service offers diagnosis, brief interventions and advice to adults living in City and Hackney who have not had a previous diagnosis of Autism Disorder.

Ms C was referred to this service by her GP in June 2015 and diagnosed with Asperger Syndrome as a result of assessment there.

1. **Hackney** Primary Care Liaison service (England /Burningham 2017). This provides predominantly Consultant Psychiatrist input to support primary care; regular multi-disciplinary team meetings at GP practices – range from monthly to 3 monthly depending on practice size. Advice, support, case based discussions and education. Comprehensive psychiatric assessment and formulation – at GP surgeries, or at locality bases. Some short term follow up provided where indicated following assessment, referred on or advice to GP.

Ms C was referred to this by her GP in June 2016 - the GP first offered the Home Treatment team which Ms C declined as she did not want people coming into her home

1. **Hackney Centre for Mental Health** - Gardner inpatient ward - A 20-bedded acute admission ward specialising in the treatment, care and support of women in City and Hackney who need a period of hospital admission. Ms C had two admissions here - the first started on August Bank Holiday and lasted two weeks; she was then readmitted for a few days following two weeks in her hostel room in Newham
2. **Newham Centre for Mental Health** - Ruby Triage Ward - A 15 bedded triage ward which is the single point of admission for all people requiring admission to acute inpatient care in Newham. The ward is the first stop for all service users admitted to the unit where they will undergo initial assessment and monitoring. They will then be transferred to another ward or discharged to another service appropriate to their needs.
3. **Newham Home Treatment Team** The Home Treatment Service provides assessment and treatment to people who are experiencing a mental health emergency of a nature or severity that would otherwise require admission to inpatient services.   
   The team provide prompt, intensive support to people at the time they most need help, aiming to avoid further deterioration and alleviate distress as quickly as possible.
4. **Hackney North Recovery Team** - Ms C was referred here on discharge from Gardner Ward - it is a Community Mental Health Team that provides a specialist service for adults aged 18-65 years who require a period of support maintaining their mental wellbeing. Ms C may have been referred here because her GP was in north Hackney.