Safeguarding Adults Review

Learning from the circumstances around the death of Sam

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1. Introduction

1.1This Safeguarding Adults Review (SAR) is commissioned by the Hampshire Safeguarding Adults Board (HSAB) in response to the circumstances surrounding the death of Sam on the 16th August 2018. The cause of Sam's death was recorded as a 'mixed drug overdose'.

Southern Health Foundation Trust (SHFT) undertook a Serious Incident Review investigation after Sam's death and produced their report in August 2019. This review did not identify that Sam's death was potentially related to abuse or neglect and a SAR was not therefore considered. Sam's family requested a multi-agency review, in response SHFT made a SAR referral to HSAB in February 2020.

The HSAB Leaning and Review subgroup considered this referral in March 2020 and determined that a proportionate and timely approach was to initiate a learning review, led by SHFT, using a partnership model methodology which had previously supported learning well. Sam's family contacted the HSAB Business Manager in July 2020 to continue to ask for a SAR. By September 2020 it was acknowledged that SHFT did not have the capacity to lead the learning review and alternative options needed to be considered. In December 2020 the HSAB Learning and Review subgroup confirmed that the new Hampshire SAB Rapid Review methodology would be used to take the review forward as a discretionary SAR. Terms of reference for the SAR were agreed in January 2021 and the reviewers commissioned in late February 2021. The terms of reference note that:

'the circumstances were such that the Board would use its power to hold a discretionary SAR in order to gain learning about young adults experiencing mental ill-health as they make the transition to adult mental health services'.

1.2 Although discretionary, s44 of the Care Act applies to this SAR which is conducted in accordance both with section 44 of the Care Act 2014 and the HSAB Procedures.

Under section 44 of the Care Act 2014 a Safeguarding Adults Board (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 there:

- is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,
- and the adult has died,
- and 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).

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.

1.3 Pen Picture of Sam.
Sam was a white UK citizen. He was 22 years old when he died. Sam's family and those who knew him describe him as someone who had a good sense of humour and

could make people laugh. He loved music, especially Frank Sinatra and could sing. He kept himself and his flat immaculately clean and enjoyed DIY activities.

Sam volunteered with a sailing charity, helping disabled people in and out of the boats. He wanted to help people, to be valued. Sam had a good memory and observed people and their behaviour carefully. Sam identified as bi or pan sexual and in his early adulthood was subject to taunting by 'friends' about his identity which distressed him greatly. One of these incidents was reported by the South Coast Ambulance Service (SCAS) as a safeguarding concern in 2014.

Sam took a very keen interest in the uniformed professions and had done so since the age of three. His family thought that this might be because they made him feel safe, and perhaps because there are rules in those professions that must be followed. In childhood Sam spent hours educating his mother about first aid kits, makes and models of police cars and ambulances. Other children would use computers to look up childhood interests, whereas Sam would be researching defibrillators. The Head of Sam's special school said that Sam had his '*heart set on becoming a paramedic'* In adulthood Sam purchased and collected paramedic equipment and uniformed professions memorabilia. He kept these carefully packed in a cupboard, bringing them out to self soothe by unpacking and packing the equipment.

A large number of organisations worked with Sam throughout his childhood and into adulthood. Diagnoses of the nature of Sam's difficulties had not been firmly established at the time of his death. In childhood he had several diagnoses with autism thought to be the most useful in terms of supporting him, in adult hood this diagnosis appears to have been set aside with diagnoses of personality disorders, namely emotionally unstable personality disorder (EUPD) and anti-social personality disorder (A-SPD) being considered by clinicians.

2. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 Timeframe: The timeline for the SAR is the 1st August 2017 until the 16th August 2018.

Contextual information was provided by services who worked with Sam during his childhood in order to understand the nature of Sam's childhood experiences (key line of enquiry b) together with the planning and actions undertaken to support Sam's transition to adulthood (key line of enquiry a).

Some organisations also submitted information from the years before the timeframe of the SAR as they considered this relevant and helpful to understanding the events of 2017-2018 in terms of context and explanation for their responses and dilemmas during the year examined. This information is included within the Report in order to address the key lines of enquiry specified in the terms of reference and where useful for learning.

During the course of the review the lead reviewers were made aware of significant processes during the years 2015 – 2017 that had been omitted from the reports of the organisations who were following the timeframe specified in the terms of reference,

but which were highlighted by other organisations in their reports. The lead reviewers have made a recommendation regarding the need to clarify information about these processes in order to complete the learning available from this SAR.

2.2 The key lines of enquiry specified in the terms of reference were:

- Transitions.
- Adverse Childhood Experiences.
- Legislation including the Care Act 2014; Mental Health Act (MHA) 1983; Mental Capacity Act (MCA) 2005 and the Human Rights Act 1998.
- Barriers to engagement.
- How Sam's family were involved in his care.
- Responding to crises.
- Safeguarding and risk assessment.

3. Methodology

3.1 The methodology used was a 'Rapid Methodology' designed by the HSAB. This methodology uses a systems perspective to build on existing reports over a shortened timescale. Within this methodology organisations presented their findings and the recommendations for their own and other organisations in a learning event. This was the first time this methodology has been used in an HSAB commissioned SAR. The lead reviewers have submitted a reflective account to contribute to the HSAB Learning and Review subgroup evaluation of the effectiveness of the Rapid methodology.

An advocate from VoiceAbility was commissioned by HSAB to represent Sam's likely views and wishes in relation to the SAR and the learning which can be taken from this. In order to understand Sam's views, the advocate spoke with professionals who had worked with Sam and with his family members. The advocate also examined a range of documentation relating to Sam's life. This exploration provided a detailed and coherent picture of Sam's perspective and wishes, both at the learning event and via a non-instructed advocacy report. The advocacy report has contributed useful information to the SAR report with Sam's perspective included in section 6.1.

Other activities undertaken by the lead reviewers have included

- analysis of reflective audits from the organisations involved with Sam.
- examination of documents relating to Sam's support and management of his behaviour during crises.
- access to the Southern Health Foundation Trust (SHFT) Root Cause Analysis following Sam's death.
- further questioning of involved organisations.
- a learning event held on the 2nd June 2021, involving all organisations who worked with Sam, where themes and potential findings were discussed.

3.2 The following organisations have contributed to the SAR:

- Hampshire Children's Services (Care Leavers Team).
- Child and Adolescent Mental Health Service (CAMHS).
- Southern Health Foundation Trust (SHFT) which also included information. about the Hampshire Pathfinder Service.

- Hampshire Constabulary (HC).
- New Forest District Council – Housing and Community Safety Services (NFDC).
- The National Probation service (NPS).
- Hampshire Adults Health and Care Adult Mental Health (AHC).
- Hampshire Multiagency Adult Safeguarding Hub (MASH).
- University Hospital Trust Southampton (UHS).
- South Coast Ambulance service (SCAS).
- Two GP Practices.

In addition, individual staff at HMP Winchester responded to a request for information from the advocate. HMP Winchester did not submit a report to the SAR.

4. Family involvement

4.1 Sam's family have met on separate occasions with the HSAB Business Unit, the lead reviewer and with Sam's advocate. Sam's family were active in bringing the potential for learning from Sam's case to the attention of the SAB. They contributed a good deal of information about Sam and the events of his life to the SAR. Sam's family have read through the final draft report, commented upon its' accuracy and have made suggestions regarding amendments prior to submission of the final draft to the HSAB. Sam's family attended the HSAB meeting where the SAR recommendations were considered and made a verbal response to the Report. They will provide a written response to accompany the published SAR Report.

5. Summary of Sam's childhood experiences and transition to adulthood.

5.1 Hampshire children's services and CAMHS together with Sam's mother provided information about Sam's early years. Relevant aspects of this information are summarised below.

5.2 At birth Sam had a number of physical health issues including bi-lateral fixed talipes for which he stayed in plaster for eight months of his first year before surgery and then 'boots', as a consequence of the fixed position of his legs he developed bowel problems. Sam had to endure intrusive examinations and surgeries. It is understood that he also had heart problems. As a young child his life was all about doctors, hospitals, medical emergencies. Sam was a very anxious child and saw a psychologist when he was two and a half years old as he banged his head repeatedly and was frightened to be left alone.

5.3 Sam's father was abusive to his mother, displaying violent and controlling behaviour. Although Sam's mother had left and divorced him by the time Sam was 14 months old, Sam heard stories about his father, and could describe his violence to his mother and the arson attack on his grandparents' house. Sam's father was sentenced to six years in prison for arson. He subsequently tracked down Sam and his mother to their new home in Hampshire on his release in 2002.

5.4 Sam and his mother moved to Hampshire when Sam was five to be with a new partner. Sam did not cope well with primary school, between the ages of 6 and 8 he

attended a Pupil Referral Unit, from eight years old he attended a specialist primary school where he did well. He went to mainstream secondary school at 11 and struggled again, it was hard for him to cope with the large number of children and noise.

5.5 Sam had an early onset of puberty at eight years old, though to be connected to the use of Risperidone, and by eleven years old was under the care of an endocrinologist. Early onset of puberty and the drugs Sam was prescribed to manage his behaviour led to weight gain. He put on a stone in weight for every year of his life. At eight years old Sam weighed 8 stone, aged 12 he weighed 12 stone and by the time he was 22 he weighed 21 stone and was six feet tall.

5.6 Throughout his adolescence Sam and the people who cared for him were supported by CAMHS and forensic CAMHS teams.

5.7 Following a serious assault on his mother children services accommodated Sam under section 20 of the Children's Act 1989. Sam's mother thought she was only to have a period of respite from Sam, but subsequent professional reports documented a concern for Sam's mothers safety from his behaviour and as a result he did not return to her care. Sam's first overdose occurred six weeks after he had been separated from his mother. Sam had his first encounter with the police at this point, he was arrested and reprimanded for assaulting his mother. Six weeks later he was given police warnings for assaulting a fellow foster child and foster father. Sam was admitted to a mental health unit after his first overdose and remained there for six months. He continued to self-harm, two incidents involving use of a ligature.

5.8 Between the age of 12 and 17 Sam had numerous placements in hospitals, children's residential homes and a residential school. He is described as fluctuating between periods of stability and engagement and periods of assaulting staff and disrupting placements. Sam loved school and was at one point academically fourth out of 177 pupils. At the age of fourteen Sam was in a stable placement that lasted over two years, he had medication which appeared to help him and was able to engage with a programme of Cognitive Behavioural Therapy. Approaching him as a person with autism was found to have positive benefit, although it was acknowledged that this diagnosis did not explain all of his behaviours. Assessments undertaken by forensic CAMHS at the time highlight the need to consider Sam's sensory needs at all times. A CAMHS consultant concluded that Sam had difficulties associated with autism spectrum disorder, '*the effect of this on Samuel is profound and significant'*

5.9 Sam struggled with changes in his residential placement including an influx of new and more troubled children. After a serious incident in which he tried to hang himself he was admitted to a psychiatric hospital in August 2011. This admission ended only a few weeks later as Sam had assaulted staff by throwing water over them. After a temporary placement in a children's home, he was admitted to the ARC, a therapeutic community. Sam was sixteen years old.

5.10 Between the ages of 16 to17 Sam disputed his diagnosis of autism energetically. In a letter dated 12th December 2012 Sam's consultant child and adolescent psychiatrist wrote that '*Sam obviously still displays many of the features of autistic spectrum diagnosis, he still carries around his medical bag and uses it to calm himself down. He is also very self-centred. He is however able to judge where other people*

are coming from very quickly I was happy to say that there have been conflicting reports in the past about whether he has an autism diagnosis and if he personally is particularly keen not to have it then it is not helpful in any way for him' Sam's consultant noted that Sam's diagnosis of autism was removed *'at his request'*

Other professionals who worked with Sam at the time were concerned about the implications of removing a diagnosis that was useful in understanding Sam and getting the right support for him. The CAMHS psychiatrist also expressed concern that Sam had undergone many different assessments and seen many different professionals and a cohesive team approach to his difficulties was still lacking.

5.11 By February 2013 Sam was living in a placement in Portsmouth. Shortly after his move to the new placement Sam was admitted to a coronary care unit following a dangerous overdose. The main trigger cited for the overdose was the disclosure Sam made of sexual abuse by his stepfather between the ages of three and eight years old. The allegation was reported to the police but did not reach the evidential threshold for a criminal prosecution. It is unclear whether Sam received any support regarding this disclosure although the police did complete a safeguarding referral.

5.12 After this overdose Sam was assessed by forensic CAMHS who concluded that there was no evidence that Sam had a '*full mental health disorder*.' In August 2013, two months before Sam's eighteenth birthday, he was discharged from CAMHS. It was noted that Sam *'might have difficulties interpreting appropriately social cues in terms of interaction with other people'* but there was no evidence of risk to others.
The assessment that Sam did not have a full mental health disorder excluded the possibility of Sam being referred onto adult mental health services post 18 and no transition planning from child to adult mental health services took place.

5.15 In July 2013 Sam and his social worker completed a housing waiting list application form requesting accommodation in the New Forest. The New Forest District Council (NFDC) report that the application form contained no indication of Sam's support needs with no mention of mental health or specific accommodation requirements. In his application, Sam indicated he was looking to be housed in the New Forest area after leaving post 16 supported accommodation in the Portsmouth area.

Sam then decided that he wanted to move to a different part of the UK to be closer to his birth father. This arrangement only lasted a few weeks before he was back in Portsmouth. On Sam's return he was placed in emergency accommodation in a hotel in Southampton, but this arrangement could not continue after August 2013.
Children's Services requested emergency accommodation for Sam from New Forest District Council (NFDC).

Sam's care and support needs were assessed by the Hampshire Independent Futures team in 2013, before the implementation of the Care Act 2014 and the wider range of eligibility criteria now used[1]. There was little information recorded on his assessment apart from the fact that he was assessed as having 'moderate 'needs and did not meet the eligibility criteria for services from adult social care.

[1] Care and Support (Eligibility Criteria) Regulations 2014 at https://www.legislation.gov.uk/ukdsi/2014/9780111124185

5.16 Reflection on key lines of enquiry a) transition, b) adverse childhood experiences

5.16.1 Adverse childhood experiences (ACEs)

ACEs are traditionally understood as a set of ten specified traumatic events or circumstances occurring before the age of 18 that have been shown through research to increase the risk of adult mental health and physical health problems.
Sam experienced a number of traumatic events during his childhood, these experiences do not all correspond with the ten 'ACEs' used in current debates about prevention/early intervention. We must be person-centred in our thinking about how 'ACEs' may have impacted on Sam's development, or we risk rendering an individual child's traumatic experience invisible[2] and fail to use trauma informed or trauma aware responses in supporting them.

Sam experienced bullying and sexual assault as a child. He reported re-experiencing trauma as an adult when restrained or medically examined. Sam 'lost' his birth father who retained some significance to him, he tried to live with him once he had reached adulthood. We do not know how Sam interpreted the stories he knew about his father's behaviour in relation to his own behaviour. Sam 'lost' his mother aged 12, although she remained a strong support in his life, Sam took his first overdose shortly after leaving her care. Sam lived with children who had also experienced trauma, this has an impact on a young person's perception of themselves and of life. Sam was also bullied in relation to his sexual identity. These traumas in Sam's young life did not feature in the accounts of how practitioners and organisations worked with Sam in his adult life, or how Sam's behaviour in crises related to previous traumatic experiences or childhood beliefs.

5.16.2 Transition to adulthood.

Sam had experienced emotional distress for some years and had been supported by CAMHS for much of his childhood and teenage years. At 18 he had no ongoing support for his mental or emotional health. Like many other care leavers his support from CAMHS ceased around the same time he left care[3] and he did not transition to mental health services. Sam had no support from mental health services in the first few years of adulthood, and we cannot know whether any preventative work could have been undertaken then regarding Sam's reactions to anxiety or other emotional stimulus.

Sam's landlord was not told about his support needs or mental health history.
Sam could have had different accommodation and more support from the District Council had his needs been known. Sam struggled in the accommodation he lived in, it was not appropriate for his needs, something that his mother tried to address in the last year of Sam's life. NFDC now have electronic application forms which do not allow

[2] Asmussen,K; Fischer, F and McBride, T (2020) Adverse Childhood Experiences, what we know, what we don't and what should happen next' Early Intervention Foundation at https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

[3] Smith, N (2017) *Neglected Minds* Barnardos at https://www.barnardos.org.uk/sites/default/files/uploads/neglected-minds.pdf

sections to be left blank which may help to support discussion with people who do not consent to have their information shared

Sam appears to have had great difficulty in managing many aspects of everyday life including his own safety and personal relationships. His care and support needs were assessed by the Hampshire Independent Futures team in 2013, before the implementation of the Care Act 2014 and the wider range of eligibility criteria now used[4]. There is little information recorded on his assessment and we do not know what dialogue occurred as part of the assessment with those who knew Sam's needs as a young adult including the impact of his sensory difficulties and trauma.

Sam did have the support of the care leavers team until he was 21 who focused on supporting Sam to access housing, education, employment, benefits, and the Princes Trust. The team thought that Sam had a high level of dependency on their support, that he was institutionalised and struggled to make his own decisions. Sam was not involved in drug or alcohol use; he was interested in keeping healthy and had a gym membership. Sam appears to have disengaged from the team in June 2016. His case was closed in October or November 2016 when Sam was 21, as the legislation at the time required. Support from the care leavers team began again in May 2018 following a change to legislation[5] that meant that Sam could access support up to the age of 25.

6. Key Events and Analysis from the time covered by the SAR: August 2017 – August 2018

6.1 Sam's perspective on events from the Report of his advocate.

From speaking with family and professionals who knew him Sam's advocate was able to report on his potential perspective.

Based on the information I have gathered; it appears possible that Sam may have been communicating with his desperate behaviours his wish to be heard in relation to the following:

- *for all professionals to have a clear understanding of the known historic environmental triggers and how these interact with different contexts.*
- *for behaviours that challenge others not to be seen as aggressive or dangerous but as a form of communication.*
- *to be seen positively even in the worse moments.*
- *to be provided with mental health treatment for childhood trauma.*
- *to be provided with a consistent and high level of person-centred support.*
- *to live independently but have someone to engage with constantly.*
- *to live in an environment that takes into account Sam's sensory needs and does not conflict with his support needs.*
- *to feel safe in his home environment.*

Being perceived as dangerous would upset Sam. Sam wanted people to see him positively, he was sensitive to the view of himself as a '*problem.'* He would quickly pick

[4] Care and Support (Eligibility Criteria) Regulations 2014 at https://www.legislation.gov.uk/ukdsi/2014/9780111124185

[5] Children and Social Work Act 2017. Implemented April 1st 2018. Statutory Guidance at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683701/Extending_Personal_Adviser_support_to_all_care_leavers_to_age_25.pdf

up a negative manner in health staff. Sam's mother gave an example of a nurse who worked well with Sam because she saw past the image of him being '*violent'.*
Sam's distressed behaviours always had a reason but that if misunderstood, could compound Sam's distress and additionally impact negatively on the support he received. He found hospital environments distressing and noisy, as an inpatient as he would have witnessed other patients distress and restraint.

In the last year of his life Sam told his grandmother, '*I'm supposed to have access to mental health services, but they won't engage, no-one will speak to me'*.
Sam's mother felt that as Sam's desperation grew, and his needs for support were not being met, his mental illness increased. It appeared to his family that the increase in his mental health needs led to a decrease in support being given.

Whereas at first Sam was getting more 'extreme' because he was not being heard, the accumulative effect of these difficult experiences began impacting on his mental health more seriously. Sam's mother reported that whereas many of the difficulties earlier on could be located in environmental factors, things became more internal to Sam, and he developed a psychosis. Sam would speak to a woman in his head called Mary and he believed worms were eating his brain. His mother said at times he seemed far away, harder to reach, that his '*lights had gone out'.*

6.2 Organisations who knew Sam. Sam was 21 years old in August 2017. In the three years since he left care he had become known to several organisations.

6.2.1 Sam had his first tenancy in May 2014 and lived in this property until March 2017. Sam had positive relationships with the New Forest District Council (NFDC) Tenancy Management Team and made direct contact with them throughout his tenancy. Sam worried about complaints and pre-empted these by contacting staff in advance, seeking reassurance and taking the opportunity to discuss his concerns. Sam was not identified as a high-volume contact or vexatious tenant; he was not considered as someone who should be on a warning marker register regarding his conduct toward staff. NFDC staff found Sam to be likeable and friendly. One member of the team described him as a being an intense character who she preferred to meet face to face as Sam always remained calm and focused whereas he could become tearful and emotional on the phone.

6.2.2 Sam registered with GP surgery 1 in May 2014. At the time he was still upset about having an autism diagnosis and asked the GP how this could be removed from his records. Sam had a good relationship with the GP Surgery who took a person-centred approach, working with and consulting Sam, to resolve problems.

6.2.3 SHFT note that the local Community Mental Health Team (CMHT) first came into contact with Sam in 2014 and that he continued to have an 'open referral' from 2015 (aged 19) until his death. He was not always allocated to a professional during this time, this would vary depending on presenting needs and risk. This arrangement lacked any clarity for Sam and other organisations working with him, there was often no lead worker to speak with and on occasion organisations were told that Sam's case had been closed. The care leavers team noted that Sam struggled to engage with mental health trust staff '*he had a level of paranoia about mental health services which made it hard to join up services for Sam'*. They report that Sam would not turn up for mental health appointments and his case would subsequently be closed.

6.2.4 Sam first became involved with the Probation service in June 2015, following his conviction for the offence of Putting People in Fear of Violence (Protection from Harassment Act 1997). The victim of this offence was his mother. He was subject to a 12-month community order with the Community Rehabilitation Company (CRC) for this offence. This was transferred to the National Probation Service (NPS) in October 2015. Apart for his time in prison between February and April 2018 Sam was in regular contact with an Offender Manager (OM) until his death.

6.2.5 Hampshire Constabulary and the NPS note that Sam was discussed at meetings under the Multi-Agency Public Protection Arrangements (MAPPA) potentially from 2015 to 2017. Who attended these meetings, the nature of these discussions, the risk management arrangements in place via MAPPA and how these interacted with other risk management arrangements is not yet known.

6.2.6 By the time he was 20 years old Sam had a history of assault and challenging behaviour toward staff in some of the organisations working with him. In the acute trust emergency department Sam was involved in a number of incidents whilst in crisis including one in March 2016 when he self-harmed and assaulted security staff. It was planned to detain Sam under s2 of the Mental Health Act on this occasion, but no bed was available. United Hospital Southampton NHS Trust (UHS) made an adult safeguarding concern referral and undertook a serious incident report. On the 12th September 2016 Sam committed an offence against hospital staff in Poole whilst detained under s136 of the Mental Health Act 1983 (MHA), for which he received a suspended sentence order.

One of the outcomes of this and other incidents was the creation of a high intensity user plan by UHS in December 2016 which was subsequently updated in January 2018. This plan was not formulated with Sam, however his GP subsequently wrote a care plan agreed with Sam and entered it on the 24th February 2017 to the National Summary Care record[6] in the hope of assisting other clinicians who might encounter Sam. The GP records that his intentions in doing so was to attempt to advise, using Sam's ideas, on techniques that might de-escalate Sam's behaviour during a crisis. This plan, co-produced with Sam, does not appear to have been utilised in the acute trust.

6.2.7 Sam stopped seeing the care leavers team, either stopping contact himself in June 2016 or when his entitlement to their support ended in October 2016 when he turned 21.

6.3 In the six months prior to the time in scope.

6.3.1 In March 2017 Sam told his GP that he was facing three charges of assault relating to incidents at UHS and he knew that there was a high likelihood of a custodial sentence. Organisations working with Sam believe that his suicidal behaviour escalated from this point.

[6] Summary CARE Records (SCR) are an electronic record of important patient information, created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system involved in the patients direct care

6.3.2 Sam was worried about appearing in court and showed his probation officer '*a letter stating he is no longer under the CMHT services, and he expressed concern about his upcoming Court hearing for sentencing'*.

In May 2017 Sam's GP referred him to the Acute Mental Health Team (AMHT) asking for urgent input:
'*Over the last few weeks he has been particularly down which has culminated in him being detained under Section 136 MHA on 3 occasions …. when he has been displaying suicidal behaviour. Certainly, his mood and behaviour has been destabilised by the current risk of him being sent to prison for assault on medical staff which took place earlier in the year...He has pleaded guilty and is currently awaiting a decision on whether or not he will receive a custodial sentence. He is already under a suspended sentence order.*

Following a risk assessment carried out by AMHT a 'My Crisis Plan' was developed with Sam for him to use to use in crisis. Sam said that he had no sense that things were building up, but indicators might be rocking backwards and forwards, pacing, speaking in a monotone voice and swearing. In the lead up to a crisis Sam identified that he could '*ride his bike, use selected music, watch video / picture slideshow on my phone, look at helpful stuff on the internet including sites on managing anger, use prescribed Lorazepam and contact 111 or use emergency services'*. What he had not found helpful when he was in crisis was '*people telling me it's behavioural*'.
What people could do was *'listen, try and understand, reflect what I say'.*

By the end of June 2017 Sam's OM was also concerned about his mental health and offered telephone support over the weekend. The NPS Offender Personality Disorder (OPD) Service agreed that Sam's case was eligible for a case consultation.

6.3.3 Sam's GP recorded that after a health professionals meeting on the 13th July 2017 '*CMHT and AMHT are in agreement that diagnosis is Antisocial-Personality Disorder - appropriate treatment should be through Probation Services'.* Probation services were not invited to this meeting, and it is unclear whether they were aware of this decision.

6.3.4 On 27th July 2017, Sam was referred to the Hampshire Pathfinder Service by the Hampshire and Liaison Diversion Service but thought not to be eligible. It is unclear why this should have been concluded as the criteria for the service was that Sam had to have an open referral to the CMHT or probation service. Sam was open to the probation service at this time. His status regarding the CMHT was confusing. He was 'open but not allocated' to the CMHT who reported that they were '*limited in regard to the support they were able to offer, this was in regard to the risk presented by Sam towards staff due to his forensic history'*. At that time Sam and health professionals thought that Sam was closed to CMHT

6.3.5 By mid-July the South-Central Ambulance service NHS trust (SCAS) had a 'patient management plan' in place. The plan was similar to the UHS HIU care plan and included the information that Sam had been assessed and '*deemed not to be autistic'*, and that he was closed to the CMHT '*due to no mental illness'* and that advice should be taken from the AMHT should Sam be presenting with a mental health need. The plan advises that '*It is deemed by Southern Health (sic) that the*

patient has capacity and that he is able to weigh up his risk-taking behaviours, making informed decisions'.

6.3.6 In mid-July 2017 GP staff were concerned for their safety, Sam had attended the GP Practice following an overdose '*Clearly very agitated with signs of struggle between competing voices in his head'.*

6.4 August 2017 – February 2018

6.4.1 On the 1st August 2017 Sam attended the acute trust emergency department after a 'significant poly-pharmacy overdose'. He was considered extremely high risk to himself due to his mental health, and UHS made a priority plan to discuss with CMHT and to escalate his mental health care planning. Sam is noted to have made '*Fifteen suicide attempts in the last eight weeks*'. Sam was discharged with an urgent appointment for CMHT.

Later that night Sam called the police saying that he had stabbed his mother and taken an overdose. This was found not to be true, but Sam told the police that he was hearing voices telling him to harm his mother. Police and SCAS attended and stayed with him for seven hours overnight. Sam was then taken to a Place of Safety pending a bed becoming available at a mental health ward where he was an informal patient for three days. Emergency services are reported to have been concerned for both Sam's mother's safety and Sam, they could not leave the scene but used creative and committed de-escalation and distraction techniques for hours to keep everyone safe. The police subsequently submitted a PPN1 safeguarding referral form detailing concerns about Sam's condition and the risk of violence from him, and that his mother was struggling to cope with supporting him. This information was not subsequently shared with NPS. AHC has recorded that these risks were managed as Sam was admitted to hospital under section. No further action was taken in response to the PPN1, Sam's mother was not contacted to ask if she would appreciate a carer's assessment or if the risks to her safety were in fact long standing.

6.4.2 On the 31st August 2017 Sam was transferred from hospital to an out of area psychiatric unit, Hospital A. He was admitted to a Psychiatric Intensive Care Unit under s2 of the MHA 1983. He was subsequently detained under section 3 of the MHA. A forensic assessment was carried out, the view of the consultant psychiatrist was that Sam met the criteria for both A-SPD and EUPD.

6.4.3 A multidisciplinary meeting of health staff was held on the 29th September which Sam's GP attended, Sam's history of violence toward NHS staff was discussed, the GP decided that in view of reports at the meeting of Sam's 'escalating' violence and an incident at the surgery of July 2017 it may not be safe to continue to provide GP services for Sam, he may need referral to a GP surgery signed up to the Violent Patient Enhanced Service.

6.4.4. On 29th November 2017, Sam was again referred to the Hampshire Pathfinder Service who undertook a joint assessment with the consultant psychiatrist whilst Sam was still a patient at Hospital A. The Pathfinder Service works with individuals who have been diagnosed or are suspected of having a personality disorder, who have committed violent offences and are at high risk of re-offending. The Pathfinder Service is predominantly a consultation and support service for professionals and its purpose

is to enhance the work undertaken with offenders by services in the statutory, voluntary and private sectors.

In November 2017 Sam expressed a motivation to engage in therapeutic work and reported that his meetings with the psychologist on the ward had been helpful, he had felt more stable and settled over the last few weeks and believed this to be in part to the changes in his medication. Sam gave consent for the Pathfinder service to liaise with the CMHT and NPS, in order to establish what community support may be available under Sam's entitlement to support under s117 of the MHA, and whether there was a role for Pathfinder in supporting services working with Sam. At the time Sam's mother contacted NFDC, informing staff that Sam's psychotherapist thought it unlikely that he would be discharged directly to his flat and would be moved to supported accommodation.

The CMHT responded to the Pathfinder service via email by reiterating the outcome of the Professionals meeting dating 29th September 2017 (6.4.3 above), advising that *'local primary and secondary services would resist discharge into their care, if Sam is discharged prior to addressing his anger and aggression'.*

The Pathfinder psychologist subsequently met with a CMHT/AMHT consultant psychiatrist to discuss the challenges of managing Sam in the community which were listed as:

1. *He cannot safely use medication unsupervised - he took regular overdoses of all prescribed medication.*
2. *He has been aggressive and cannot be seen in the community without police protection for staff.*
3. *He declines to engage in the group/individual therapies offered for people with personality disorders.*

The CMHT reported that they were keen for Sam to undertake a period in a secure setting where he could address some of his issues relating to risk in a contained environment before returning to the community.

6.4.5 On the 4th January 2018, Sam assaulted multiple members of staff at Hospital A. He is reported to have 'acquired a weapon' and police were called. On 8th January 2018 Sam smashed the window panel of a door and then used it in a threatening manner toward hospital staff. Sam was discharged from the MHA Section 3 by a hospital A consultant and was then arrested for damaging hospital property. Sam was charged with criminal damage and received a fine from the Magistrates Court on 9th January 2018.

Sam was assessed under the Mental Health Act but as there had been no change in his mental state following the removal of the Section he was deemed not detainable. The Acute Mental Health Team (AMHT) manager explored the possibility of Sam's admission to a medium secure unit but as Sam was no longer detained forensic services were not able to support an admission as patients were not admitted on an informal basis. Sam was discharged to his mother's address with AMHT follow up but with no s117 aftercare planned or in place.

His consultant psychiatrist in the community later clarified that Sam need not have been taken off his section and discharged in order to 'go to court', the discharge plan

being discussed between the Pathfinder service and community mental health services should have continued. At the point Sam was discharged community services stated that he could not be seen safely in the community and was not safe to administer his own medication. Discussions about a move to supported living or any further support from community or specialist services had not been concluded.
On discharge Sam's support was telephone contact from AMHT and no medication as he was deemed not safe to use it.

6.4.6 On Sam's release from Hospital A, a number of changes had occurred in the services closest to him. His OM had changed. His GP saw him and explained that because of the risks to healthcare staff at the surgery Sam would be better served by a surgery that was signed up to the 'Violent Patient Enhanced Service'. The GP felt it was a 'shame' that it was not possible to keep Sam on his list and offered to support Sam in the transition to another surgery. The GP noted that Sam had been discharged from a section 3 with no medication. He liaised with the AMHT team and agreed short-term medication.

There are notes that suggest that following his discharge from Hospital A Sam had input from AMHT. His GP records that this input ceased on the 12th January '*as no treatment options considered to exist*' and '*now reached the limit of what mental health services can realistically provide'.*

6.4.7 From the 11th January onward Sam made several suicide attempts, Sam was detained under s5(2) MHA in UHS ED. This was lifted following review by the liaison psychiatry team and Sam was discharged.

UHS reviewed the High Intensity User plan created in December 2016 on the 12th January 2018, although the plan was still dated 2016. The plan records that the diagnosis of autism '*has been ruled out'* by mental health services, Sam experienced periods of emotional dysregulation/anger and also that Sam had '*no current mental illness'*.
The HIU plan recorded that Sam '*generally knows when he is distressed and/or going into crisis and seeks help through the Acute Mental Health Team (AMHT)'.* The key professionals involved with Sam are recorded as his probation officer and his GP. The plan includes inaccurate information, the source of which is unknown, for example that Sam's accommodation situation is 'tenuous' and that he was in care from the age of eleven months. It contains instructions for the police and ambulance service although these agencies are not listed as having agreed to the plan. The HIU Plan does recognise that Sam became very agitated if restrained and advises that such restraint should be avoided, Sam was to be treated with professional kindness with an avoidance of rejection.

Discounting autism and the accompanying sensory sensitivities from the plan together with minimal information from the people or organisations who knew Sam well meant that the plan had little detail on how to support Sam in crisis. Sam himself was unaware of the HIU plan and was not consulted as to how he thought his attendance could be managed safely for others and himself or how he might be supported.

6.4.8 Hampshire Constabulary subsequently met with Sam and his mother together with Sam's consultant psychiatrist. The meeting acknowledged how high-risk Sam's behaviours were to himself with the idea that risks were higher for Sam if the police

kept responding to him. Professionals at the meeting were concerned to '*break the cycle of Sam's behaviour'* and minimise the risk of violence to staff in the hospital setting. Based on the views and knowledge of the consultant psychiatrist expressed at this meeting Hampshire Constabulary developed a deployment plan for responding to calls from Sam which stated that there should be no police deployment to reports if the risk was to Sam only. Requests to support ambulance crews should not be on a 'just in case' basis. The plan warned that Sam could be violent and should be signposted to AMHT if he was experiencing mental health symptoms.

In the event police continued to respond to reports that Sam's life may be at risk. The police author explains this by the apparent conflict of the action plan with one of policing's core responsibilities; namely to preserve life, and to support colleagues from other emergency services who are at risk. Furthermore, whilst others may not be at risk when, for example, Sam was thought to be planning to throw himself in front of a train, such an act would have significant consequences for the other individuals involved and cause disruption, officers would have to be deployed to the scene.

6.4.9 Sam continued to take overdoses and to be conveyed to the ED. On two occasions he appeared to be hearing voices and on one was assessed as lacking capacity to make decisions around his health and immediate treatment. Sam was not detained under the MHA but advised to seek support from AMHT.

6.4.10 Analysis:
Focus on key lines of enquiry a) transition, c) legislation d) barriers to engagement f) responding to crises and g) safeguarding and risk management.

6.4.11 Sam's transition back into the community was unplanned and uncoordinated. For the reasons already discussed in section 6.4.5 he was discharged from hospital without section 117 aftercare arrangements being finalised. Sam did not have a mental health care co-ordinator but had telephone access to AMHT having been discharged from the CMHT. This is contrary to the Mental Health Act Code of Practice which states that: '*Section 117 of the Act requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained….It applies to people of all ages, including children and young people'*[7].

6.4.12 Sam had a statutory right to an advocate whilst detained, the right to advocacy from an Independent Mental Health Advocate (IMHA) was introduced in 2007 under amendments to the 1983 Mental Health Act[8]. Hospital A report that they had limited insight to how Sam experienced the Hospital environment, but that being in a hospital was exacerbated rather than calming Sam's aggression toward staff and that he was 'not ready' to engage with treatment. An IMHA may have been able to convey Sam's thoughts and feelings constructively to hospital staff and facilitate any changes in the environment etc. Hospital A is outside of Sam's area, his mother reports that she was told by Hospital A that because of this he could not have an IMHA from that area.

[7] Mental Health Act Code of Practice (2015) Chapter 33 at https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
[8] Mental Health Act 2007 Chapter 30.3 at https://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf

Hospital A report that the majority of their patients are out of area and have a choice of either hospital commissioned or external local authority funded IMHAs.

6.4.13 The fear of or actual aggression from Sam may have acted as a barrier to consulting him about his own care when in crisis. Consideration should have been given to how Sam could be supported to participate. Early recognition of Sam's difficulty in verbally expressing his needs should have resulted in identification of an advocate to support him, either through statutory arrangements (IMHA/Care Act/ Care leavers advocate (available up to 25 years old) or voluntary arrangements.

6.4.14 By February 2018 emergency services and the acute trust had plans in place regarding how to respond to Sam when in crisis. The plans appear to have been informed by SHFT information and Sam's diagnosis but lack coherence across the system, the emergency services could not implement them, there was no sustained monitoring or review by a lead agency, plans were not developed by a multi-agency group composed of all organisations working with Sam or informed by Sam himself.

These plans were not supported by any meaningful person-centred work with Sam or informed by any professional curiosity about his behaviours or current/previous trauma but served to try to minimise the considerable damage Sam inflicted on staff and property. As such they did not protect Sam, staff or property.

NPS were not involved in Sam's hospital discharge planning or involved in discussion about his use of services, they appear to have not been considered as a relevant agency. NPS received information about what was happening to Sam from his mother or when appropriate from the police after incidents had happened.

6.5 February 2018 – May 2018

6.5.1 Sam was convicted of offences under Section 4 of the Public Order Act and an offence of Common Assault and Battery. He was sentenced to 24 weeks imprisonment on the 1st of February 2018. Sam initially struggled to cope in prison and was mute for the first few weeks. SCAS attended Sam after he was thought to be having a heart attack on the 9th February 2018, they were concerned about his mental state and submitted a safeguarding adult concern to the local authority. This was passed onto the prison mental health service and assurances sought as to Sam's welfare both from the prison and from his psychiatrist.

6.5.2 Sam was moved to the prison healthcare unit the day after he arrived at the prison. Prison staff were concerned about his presentation when he arrived, are reported to have identified him as autistic and telephoned his family for further information. Prison healthcare staff report that Sam had a positive experience on the unit. He was taken under the wing of the two healthcare orderlies and enjoyed helping out with cleaning, painting and some aspects of healthcare. It is thought that Sam felt valued on the unit.

6.5.3 A Pathfinder service psychologist first saw Sam in prison on the 12th March 2018 and continued the assessment process on the 26th March when Sam's OM joined them to discuss the remit of both Pathfinder and NPS in the community and how the services would work together. The Pathfinder service emphasised Sam's s117

aftercare entitlement and the need for mental health community services to be involved in his release from prison.

6.5.4 On the 4th April 2018 West Hampshire Magistrates Court granted a criminal behaviour order in respect of Sam to last for two years. The provisions of the order were that he should not;

- Enter any non-public area of Southampton General Hospital (SGH).
- Remain on SGH property if asked to leave by staff.
- Obstruct any employee of the NHS body or associated staff at the hospital in the course of their work.

6.5.5 On 13th April 2018 a pre-release Care Programme Approach (CPA) meeting took place with Sam, the AMHT psychiatrist, Pathfinder and prison service in attendance. It was reported that Sam had not posed a risk to self or others during his custodial sentence. It was felt that the containing environment and availability of staff potentially contributed to this. It was agreed by those attending the meeting that Sam's presentation appeared to be best explained by issues associated with EUPD.
The plan was that

- on release from prison Sam would work with the Pathfinders psychologist and team.
- Sam would be allocated a care co-ordinator via the CMHT.
- Sam would be referred to the High Intensity User Group.

6.5.6 On 25th April 2018, Sam was released from prison.
Sam's mother wrote to NFDC just before his release from prison to tell them that Sam was afraid of his neighbour who was intimidating him, and to ask if options of supported accommodation for Mental Health could be explored. This request was referred to the Housing Options team. Sam's mother also spoke with an AHC Mental Health commissioner about how to refer for one to one mental health support for Sam. On 13th April 2018 Sam's SHFT consultant wrote a supporting letter to housing to advocate that a move for Sam should be considered. Probation services were also aware that Sam was afraid of his neighbour.

This concern was not referred as a safeguarding concern by any organisation. NFDC were not contacted to discuss Sam's experiences or to contribute useful information as to what was happening or how Sam could be supported. NFDC have recorded that the neighbour in Sam's new tenancy had indeed made two complaints by telephone about noise from Sam's flat between May and July 2017 but had never submitted a written complaint. Sam and his neighbour had both called NFDC to report that they had an 'verbal altercation' in May 2017 about which Sam had called the police and according to NFDC, wanted the police to know but take no action.
The neighbour complained that he could hear phone calls that Sam was making to someone about him and was exaggerating the content of the conversations they had. NFDC told Sam that the matter had concluded in July 2017 as no further complaints or reports were made about him and Sam updated NFDC on the 9th July to say that he and the neighbour had been speaking and both acknowledged the difficulties of sound transference within the building.

After this neither Sam or the neighbour contacted NFDC about the matter and it was assumed by the district council to have been resolved. Sam is reported to have phoned his family after this time to say that the neighbour was intimidating him, but he

was afraid to go to the police. From mid-July 2017 onward this alleged dispute between Sam and his neighbour was held to be one of the sources of Sam's mental ill-health with the neighbour allegedly both verbally and physically threatening Sam.

On the 31st May 2018 the NFDC Housing Panel considered evidential information submitted from Tenancy Management, Sam's psychiatrist and his mother regarding neighbour issues and the need for alternative accommodation. The outcome was to refer Sam to the Housing Options service for allocation.

6.5.7 The day after his release from prison Sam registered with GP surgery 2. This was not a surgery signed up to the Violent Patient Enhanced Service. The new surgery reports that they were aware that Sam had a history of A-SPD and possibly EUPD and also that he had a history of violence and threatening behaviour towards healthcare professionals and that he had a long psychiatric history and was well known to CMHT. They knew that he had a neighbour who had a profound effect on his mood and mental state. He also had several other comorbidities including severe back pain and was said to have suffered with acute coronary syndrome.

Sam's new GP either spoke with him on the phone or saw him in the surgery fourteen times before his death. The surgery used good practices in engagement - a flexible approach to engaging with Sam, booking in extra time at appointments and allowing them to overrun, and felt they had a 'reasonable relationship' with him, never experiencing any threatening or violent behaviour. GP surgery 2 thought that Sam was '*heavily involved'* with CMHT so dealt mainly with his physical problems, taking advice from CMHT as needed. On reflection GP2 has noted, *'how important it is to get as much background information on patients with complex psychiatric disorders before seeing them and making decisions about their care. It might have been useful at the outset to have discussed his case with CMHT and found out if his previous surgery had any major concerns'.*

6.5.8. On his release from prison Sam had a new Offender Manager (OM), who was not a qualified probation officer. This appears to have occurred as a result of changes in the structure of the probation office. The NPS author believes that this allocation may not have been appropriate given Sam's history. NPS focused on Sam's emotional wellbeing, temper control and understanding of the views of others post release, reinstating liaison with his GP, CMHT (as required) and one to one work in supervision and also worked with the NPS personality disorder team and Pathfinder service. The OM had difficulties in engaging with the CMHT but did not escalate this to their management. The OM completed home visits and checked in with Sam regarding his medication and contact with his GP. Upon initial release Sam presented positively to NPS and willing to engage in voluntary work.

6.5.9 The local authority care leavers service wrote to Sam on 2nd March 2018 advising that he was entitled to further support until he was 25 years old. Sam agreed to renew contact and his case was opened again on the 27th April 2018. Sam was on occasions threatening to his care leavers support worker, believing that she was related to someone from his past. These risks were kept under continuous review with the support worker meeting Sam in the company of the OM during this period.

6.5.10 On the 1st May the Pathfinder service began their work with Sam in the community. It was noted that the agreement for Sam to have a care coordinator under CPA had not yet been actioned and the Pathfinder psychologist agreed to contact the CMHT manager to follow this up. Sam was advised to continue to follow his crisis plan (My crisis plan') which was to contact the AMHT and/or CMHT by telephone, because of the risk he presented to mental health staff he could not have face to face contact. The OM arranged to meet with Sam and CMHT on the 1st May, but the CMHT did not attend.

6.5.10 Analysis
Focus on key lines of enquiry a) transition, g) multi agency coordination.

6.5.11 Sam's planned transition from prison to community was not fully implemented, not because of a reaction to crisis as with the discharge from Hospital A, but because agreed actions were not completed. Sam's entitlement to s117 aftercare and an assessment of what support he might need was not observed. Sam was not, as agreed, on a Care Programme Approach (CPA) which would have been another opportunity for multi-agency work through regular CPA meetings. Mental health services appeared to have strong reservations about working with Sam and the CMHT's concerns do not appear to have been resolved through either multi agency discussion or support/direction to the mental health teams by SHFT management. Sam may have been expecting a level of support on release which was not provided, particularly after CMHT did not attend the meeting of the 1st May. The NPS OM did not escalate this failure in interagency working to NPS management.

6.5.12 Sam's GP recommended to the NHS England Primary Care team that Sam would be better supported by a GP signed up to Violent Patient Enhanced Service, but the GP's recommendation was not acted upon. It is understood that GP surgery 1 has followed this up with NHS England. Sam transferred to a new GP surgery who had some information about him, but not enough about his impulsive and self-harming behaviours or what support he was getting from CMHT, in retrospect they have reported that they wished that they had discussions with CMHT in order to understand these areas. At the point at which GP2 thought that the CMHT were '*heavily involved*' with Sam the CMHT were not involved with him. Whilst secondary health services were concerned about risk to staff Sam's new GP continued to see him and support him face to face.

6.6 May – August 2018

6.6.1 Sam continued to self-harm. On 15th May 2018 SCAS attended Sam who was on railway tracks at a level crossing and hearing voices. SCAS are reported to have thought that the police attending should use s136 MHA to detain Sam. The police deployment plan said that this should done after obtaining the advice of AMHT, but AMHT could not be contacted as it was 8pm at night and 'out of hours'.

The ambulance crew agreed to convey Sam with police assistance. Once at ED it was established that Sam's medication via his GP had been stopped by CMHT due to the risks CMHT had assessed previously about how Sam managed his medication, a view confirmed by his continuous self-harm. Sam was angry, saying his medication had been stopped by a doctor who he had never seen. ED staff attempted to contact someone at CMHT who knew Sam, but no-one was available. The liaison psychiatry

team saw Sam and assessed his capacity, Sam was unable to understand or retain information at the time, he lacked capacity to make decisions about his treatment. He was assessed being a high risk to himself, he was at the time unmedicated and emotionally dysregulated. He was deemed low risk to others, however his previous conviction for assault of medical staff was noted. Sam was discharged with a plan for the CMHT to follow up. Sam's OM later contact the CMHT and the Offender Personality Disorder team to highlight concerns about Sam's mental health and his frustration with the CMHT.

6.6.2 There was an increase in the number and severity of Sam's mental health and self-harm episodes from May 2018 onward. Sam's mother contacted the Pathfinder Service on the 11th May expressing concerns regarding the level of care Sam was receiving from AMHT and the uncertainty around who was involved and what the plan was for crisis management. The Pathfinder service told her that a professionals meeting would be arranged over the next few weeks, after which there should be some clarity over who was involved and what the plan was.

6.6.3 Sam made a threat to throw himself under a train on the 16th May 2018. Police were contacted by Sam's mother to say that he was on the train tracks after being discharged from hospital. She said that the AMHT were '*not helping and neither are the CMHT team. He is under the Pathfinder service. He feels he is not getting any help and therefore wants to end his life'*. Sam was detained under s136 on this occasion but afterwards discharged as he did not meet criteria for detention under the MHA. He had been threatening and had assaulted a member of staff at the hospital. Police submitted a PPN1. This was sent to the care leavers team for information by the AHC front door team.

6.6.4 A professionals meeting was held on the 31st May and was attended by AMHT, CMHT, the police, the Hampshire Pathfinder service, and the Probation service. The outcome was that the CMHT would refer the case to their management team for a decision about whether they would offer services to Sam. They were still concerned about the risk Sam posed to staff. It was also agreed that Section 117 aftercare arrangements would be discussed at Sam's next CPA meeting.

No formal CPA meeting or discussion of Section 117 aftercare took place following this meeting however, the OM contacted CMHT on the 11th June to establish the outcome of the agreed actions and was told there was no management decision to date. The OM told the CMHT that they were concerned about Sam's mental health and suicide attempts. They were advised that should Sam contact the CMHT there was a crisis plan in place.

6.6.5 Sam continued to make attempts on his life. He also tried to implement his own measures to keep himself and others safe, asking to be kept at the police station as it was 'the safest place' or to be restrained before speaking to the doctor at ED as he didn't want to hurt anyone. Sam would usually be conveyed to ED or detained under s136. If the police could speak with the AMHT they were advised not to detain under s136 and that a care plan was in place.

6.6.6 During this time Sam contacted the CMHT continuously, he was advised to maintain his contact with his GP, continue taking his medication and reduce the

amount he was contacting the CMHT. Sam saw his OM on the 6th June, he said he was having out of body experiences where he felt he could not control himself.

6.6.7 The events of 1st July 2018 demonstrate the impact of the absence of a shared and agreed plan to support Sam in crisis. Each organisation involved has described events slightly differently, but as far as can be ascertained Sam was conveyed to UHS ED after attempting to drown himself. A clinical review at ED indicated no medical concerns and concluded that '*his primary presentation was psychiatric*'.
As per the HIU plan in place CMHT were contacted for community review following Sam's discharge from ED.

Later that night SCAS contacted the police reporting that Sam was having a 'psychotic episode' and was becoming violent. SCAS report that they contacted '*a mental health team*' who are reported to have said they could not be involved because of Sam's violence, Sam was transported by the ambulance with police in attendance to UHS ED. Sam was not detained under s136, and concerns were expressed by liaison psychiatry who said that the HIU plan stated that the police should detain Sam under s136 if he was found to lack capacity. The psychiatric consultant expressed concern that Sam was bought to ED in conflict with his HIU plan. The psychiatric liaison consultant agreed that the HIU plan should be adhered to and advised that the Sam should contact the AMHT.

Sam then left ED, but later returned. Police were called by a senior nurse at 4.15 am saying that Sam was increasingly agitated. The nurse said that he was presenting as psychotic but as he had a personality disorder it was hard to know. Sam left ED with a plan that Sam's mother was to contact the AMHT that night, or CMHT in the morning. Sam's mother did not always find this advice helpful, on one occasion she called AMHT who told her to call CMHT, who had already said that they could not support Sam. She reports '*feeling desperate'* she was watching Sam's mental health deteriorate on a daily basis but felt that there was no appropriate help being offered to him.

6.6.8 The OM was made aware of these events and Sam's deteriorating mental health. The OM contacted CMHT and was informed no one linked to the case was available and a message would be left for them to call him back, CMHT did not return the OM's call. The OM also contacted UHS to get information about Sam's attendances, but this too proved unsuccessful. Both NPS and SHFT were aware that Sam been aggressive toward his mother over the weekend and that she felt fearful of Sam. The CMHT spoke with her about risk management and keeping herself safe.
No clear plan was recorded, or further action taken.

6.6.9 On 4th July, Sam emailed CMHT requesting to be discharged and to withdraw his consent to share information with other organisations. On the 19th July Sam attended an assessment with the CMHT consultant, his mother and psychologist from the Pathfinder service where he discussed the points he made in his email and advised that he was happy for information to be shared. Sam's crisis plan was reviewed with him.

6.6.10 In July 2018 the Pathfinder team contacted Sam's mother to offer a number of family work sessions. It was agreed that she would have sessions with the Pathfinder Service and met twice with the practitioner.

6.6.11 On the 29th July 2018, Sam told police that he had killed a nurse, this was not true. It is likely that the nurse was 'Mary', a voice that Sam heard when mentally unwell. The police took Sam to a hospital where he was assessed and released later that day. Police submitted a PPN1 which was sent onto the care leavers team by CART.

6.6.12 The OM called NFDC on the 9th August to request an update from Housing Options. It was confirmed that Sam's case had been discussed at an Operational Mental Health group as a multi-agency discussion with housing. The Housing Options Case Worker confirmed that at this time a move was not being considered as support was being sought with CMHT to manage Sam's mental health in the current accommodation.

6.6.13 Analysis
Focus on key lines of enquiry c) legislation d) barriers to engagement, f) responding to crises, g) safeguarding and risk management

6.6.14 Throughout this period of Sam self-harming emergency services and the hospital trust had contingency plans in place. There were significant differences in how organisations viewed Sam's presentation and how they should respond to his distress.

SCAS did not consider Sam a high intensity user, eleven call outs over four years did not bring him into this category, SCAS reports that 'o*n the occasions SCAS attended we treated this patient based on the information that was available and clinical presentation… I don't believe we actually followed the patient management plan. If we had have done we would not have dispatched ambulances. It is the author's view that we actually provided more care by attending and conveying'.*

Hampshire Constabulary (HC) did identify Sam as a 'high intensity user of professional agencies'. Between 2014 and 2017 Sam had been involved in over 130 'occurrences' most often related to his mental health. HC developed a deployment plan in January 2018 but like SCAS found it impossible to follow in practice as Sam would never be the only person at risk from his own behaviour and they also had a commitment to supporting SCAS and other services on request.

The UHS HIU plan was not reviewed regularly following Sam's attendances or with any of the organisations also working Sam or with Sam himself. There was no framework within which services could respond confidently or with coordinated effort to crises. Two of these plans were created during the period that Sam was reportedly being managed under MAPPA arrangements, an opportunity to create a consistent multi agency risk management framework.

6.6.15 Sam's situation with regard to his increasing mental health needs but reduced mental health support needed escalation to senior management in both NPS and SHFT. Neither organisation appear to have had sufficient management oversight of the case. The ambivalent involvement of the CMHT in particular led to a lack of clarity for Sam and for other organisations. Sam was said to have 'care plans' and 'crisis plans' but these contained little more than self-management advice and telephone contact support. The position that CMHT appear to have taken up with regard to Sam's care needed to be urgently addressed by SHFT managers, in terms of support

to staff who were highlighting health and safety concerns, as well as decision making about allocation and the resources needed to try to address Sam's needs.

6.6.16 Until April 2018 Sam was described by the SHFT psychiatrist as having 'anti-social personality disorder' – SHFT are not commissioned to work with people with this diagnosis. After the Pathfinder service assessed Sam in April 2018 he was given a diagnosis of EUPD. Along with the quality standard (QS 88) for AS-PD and EUPD NICE (2015)[9] noted that the care that people with diagnoses of either AS-PD or EUPD are given is often fragmented.

The current narrative around standard 88 (NICE 2020)[10] advises that *'Some mental health professionals may find working with people with borderline or antisocial personality disorder challenging. People with personality disorder can experience difficulties in communication, building trusting relationships and respecting boundaries. This can be stressful for staff and may sometimes result in negative attitudes. Mental health professionals have a varied remit when supporting people with borderline or antisocial personality disorder. This means that the level and frequency of support and supervision that mental health professionals receive from their managers needs to be tailored to their role and individual needs*'. NICE 2020

Sam's family report that he looked up AS-D on Google, becoming frightened that 'this is me' and that he was destined to behave in the manner described.

6.6.17 Sam needed person centred strengths-based assessment and support. The impact of the approach taken to Sam's care needed regular monitoring. Within the ED, the location of many of Sam's crises, UHS authors found '*a deficit in holistic care assessment whilst medical teams focused on physical aspects of the Sam's care and liaison psychiatry focused on the mental health aspect of Sam's care there seems to be a lack of communication between the two specialties*'. Sam's care was fragmented, even when in one location (ED) but seen by practitioners from different organisations. UHS has since taken steps to improve the integration of mental health services in ED.

By working together organisations could have facilitated coherent assessment, approaches and monitoring, including creating opportunities outside of the environments and situations where Sam exhibited challenging behaviour to staff. The role and responsibility of each organisation could be positively utilised in a well led and coordinated support plan. As noted in above, SHFT teams in particular needed the support of senior managers in decision making and planning responses.

6.6.18 Organisations supporting Sam report that the dilemmas about Sam's diagnosis and what support he could receive from mental health services had a significant impact on Sam and how they were able to work with him. The Pathfinder service struggled to engage the CMHT in their work as did NPS. The care leavers service has reported that the changing /lack of clear diagnosis made it hard for them to support

[9] National Institute for Health and Care Excellence (2015) Personality disorders: borderline and antisocial; Quality standard [QS88] at https://www.nice.org.uk/guidance/qs88/chapter/introduction

[10] National Institute for Health and Care Excellence (2020) Organising and planning services for people with a personality disorder, Staff training, supervision and support at https://pathways.nice.org.uk/pathways/personality-disorders#content=view-quality-statement%3Aquality-statements-staff-supervision&path=view%3A/pathways/personality-disorders/organising-and-planning-services-for-people-with-a-personality-disorder.xml

Sam at times and have concluded that efforts need to be made to avoid allowing such situations to hinder effective planning. A key learning point for this team has been to avoid allowing the uncertainty of partners to inhibit their own planning and intervention. SHFT report authors conclude that the lack of agreement about Sam's diagnosis and whether he had an impairment or disturbance of mind or brain limited how his mental capacity was assessed.

6.6.19 In contingency plans Sam was described as 'having capacity' as a general statement. On a few of his later attendances at ED he was assessed as not having capacity to understand or retain information about his treatment at the time, this assessment does not appear to have resulted in use of a best interest checklist to inform further decision making. UHS have commented that the quality of mental capacity assessments completed was questionable, '*in some cases there was no indication of task (decision) for which the capacity was being assessed'*.
The proforma used to assess capacity has now been updated utilising the Hampshire Mental Capacity Tool Kit with the aim of improving the quality of the documentation of patient Mental Capacity Assessments.

The professional view that Sam had capacity in relation to risk behaviours to himself and to others resulted in a management plan which did not encourage organisations to assess and understand each presentation but to assume that Sam had volition and intent, that he was choosing how to behave. This in turn had the potential to obscure Sam's deteriorating mental health in the months before his death.

6.6.20 Sam's voice is hardest to hear within the mental health and acute trust systems. There are several potential reasons for this:

- There were incidents when Sam presented in emergency departments with violence to staff and property. For the organisations and the staff at risk of harm this behaviour needed to be managed. The attempts to reduce the risks presented by Sam's behaviour were not informed by professional curiosity about the potential causes of the behaviour – which Sam, his family and professionals from the system around Sam may have been able to help with.
- Sam's diagnoses of anti-social and/or emotionally unstable personality disorder appears to have led to an over-emphasis and reliance on the interpretation of Sam's behaviour by mental health clinicians. The label of anti-social personality disorder in itself can lead to discounting the person's perspective as the person is described as 'manipulative, deceitful and reckless' in NHS guidance[11].

6.6 21 All organisations who have contributed to this review noted the absence of coordination, of leadership or ownership in Sam's case. This appears compounded by some misunderstanding of others role and responsibility, particularly in terms of which teams and organisations are invited to multiagency discussions, and by an absence of escalation when organisations do not undertake crucial actions.
The identification and mitigation of risk was particularly impacted by the lack of a 'lead agency' or collaborative working and risk sharing between organisations.

[11] https://www.nhs.uk/mental-health/conditions/antisocial-personality-disorder/

6.6.22 Areas of risk:

a) Risk to Sam. It does not appear that the HIU care plan around Sam was reviewed or updated in the light of Sam's presentations and risk assessments. Sam was continually rated as high risk of harm to self by SHFT after incidents. At times Sam was also assessed as not having capacity to make decisions about his treatment or safety. Yet Sam continued to be discharged in the belief that to detain him in a psychiatric hospital him would increase his risk to himself. Throughout 2018 he was continually assessed by SHFT as likely to cause his suicide through accidental overdose. How this risk to his right to life would be mitigated or monitored is not recorded.

Sam's GP believed that the HIU plan was reviewed at the 'Southampton High Intensity User Group' whereas SHFT do not believe it was reviewed or had multi-agency oversight due to the absence a HIU group for the South-West of Hampshire. The HIU plan lacks vital information for emergency services, the plan emphasises the need to seek the advice of mental health services but does not detail what can be done to reduce the risk to Sam.

When incidents occurred, they were not reviewed with Sam in order to identify with him the patterns or trigger points for his distress or aggression. Practitioners who use trauma informed approaches[12] are aware of the importance of history, of the possibility of re traumatisation and the reactions associated with this.

Since this time UHS have developed a multi-agency High Intensity Service User group (HISU). This has a particular focus on patients with complex mental health needs. A medical consultant has been allocated to support HISU and the development of HISU care plans. The UHS Vulnerable Adult Support Team (VAST) coordinate information for high intensity service users and liaise with community services so that care plans can be put into place. This has improved communication with the UHS Safeguarding Adult Team who are notified of High Intensity Service User and attend the meetings to discuss patients.

b) Risk to Sam's mother. Sam was also consistently assessed by SHFT as a high risk to others. This included his behaviour toward his mother. Sam's mother was a strong advocate and ally for Sam in his life. The risks to her were acknowledged but not acted upon. Whilst risk to professionals forms much of the planning around Sam, risk to Sam's mother, and how the actions of organisations can increase or mitigate this, did not feature in any documented plan. Sam's mother was discussed at a MARAC in 2015 but after this no action was taken to find support for her to protect herself whilst helping Sam. Sam's mother could have had a carers assessment under section 10 of the Care Act 2014. The Act considers the provision of emotional, as well as practical, support as defining who is a carer, and this may have given Sam's mother an opportunity to identify her own needs for support.

[12] Research in Practice 'Trauma- informed approaches with young people'. Dartington. At https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Trauma-informed-approaches-with-young-people-Frontline-briefing.pdf

c) Identification and reaction to accumulating risk. Hampshire Constabulary highlighted concerns about Sam and his mother via the 'PPN1' police notification system. The majority of those PPN1s went to the local authority front door, CART, and were sent on to relevant local community team (in Sam's case the care leavers team or mental health teams) for information with no involvement from the Hampshire MASH. MASH is involved where specific safeguarding concerns are identified and in Sam's case what was happening to him and his mother was not seen as a safeguarding concern.

We do not know what expectation there was on either local team to understand and act upon the escalating risk to Sam's life. There appears to be no central opportunity for the PPN1s to be used as an indicator of the escalating and cumulative risks to Sam and his mother outside of the MASH process, something that could provide an opportunity for multi-agency discussion.

There were opportunities for organisations to work together to problem solve and support each other, via CPA meetings, re-referral to MAPPA, or by responding to concerns by making referrals to adult safeguarding highlighting the impact on Sam of his fears about his neighbour. If these routes failed and Sam was still experiencing an unmanageable level of risk it was still possible for any organisation to call a multi-agency risk management meeting[13] in order to work together to assess risk and implement any safeguarding reduction measures. Such a response is now coordinated through the 4LSAB Multiagency Risk Management framework[14] agreed in June 2020.

6.6.23 In the face of uncertain support from mental health services in the last year of his life Sam's care was usually managed by his GP. GP practices who contributed to the SAR noted that *'it is difficult to manage risk when 'labels' of different diagnoses mean that individuals do not fit into mental health criteria for treatment and support. The guidance then is that a referral is made back to the GP Practice, who do not have always have adequate resources. This is also an issue in terms of managing risk with individuals with a tendency to violence.'* If GPs are to manage risk they must be supported with a detailed handover by the organisation discharging the person which also specifies where the GP can pragmatically access continued support. GP referrals to the NHS England Primary care team need a timely and proactive response.

6.6.24 From mid-July 2018 onward Sam would have perhaps started to experience the beginning of cohesion from the teams supporting him in the community. Sam had been engaging in therapeutic support from the Pathfinders team and the meeting of 19th July saw Pathfinders, Probation and CMHT together in a meeting with Sam. For the first time there were plans to move toward seeing Sam and his mother together. Sadly, Sam died before this work began.

6.7 Sam's last two days

6.7.1 On the 14th August the SCAS received a 999 call at 10pm. Sam had taken an overdose in a public place. The crew carried out an assessment and deemed that

[13] HSAB (2016) *Multi-Agency Risk Management Framework* at http://www.hampshiresab.org.uk/wp-content/uploads/Multi-Agency-Risk-Management-Framework-16-02-16.pdf
[14] https://www.hampshiresab.org.uk/wp-content/uploads/4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2020.pdf

Sam was at mild risk with some thoughts of killing himself. The crew checked the drugs Sam said he had taken on 'Tox base' and concluded that he would not experience harm from the dosage stated. The crew recorded that he had capacity and spoke to his mother who was happy to have him at her house. The crew gave advice about what to do if Sam's condition deteriorated and completed a safeguarding referral. Sam's mother agreed to observe him overnight. The referral was sent to the local authority on the morning of the 15th August.

6.7.2 Sam had attended his GP surgery on three occasions in August. He said that his back pain was increasing in severity and affecting his quality of life. Each time he was given a small supply of analgesia. He attended again on the 15th August and said that he had left his medication with his mum and needed another prescription. His pain seemed to be genuine and the cause of considerable physical distress.
At the time his mental health appeared stable, and he did not mention suicide.

Sam attended a joint meeting with his OM and care leavers support worker later on the 15th August. Sam was told that there was as yet no decision regarding an accommodation move. Sam said he was tired due to his medication and the session was ended. Sam's family report that at this time he was also pre -occupied with worries about two further operations on his feet.

6.7.3 SCAS received a call from Sam's mother at 18.25 pm on the 16th August.
She had found Sam unresponsive at his home. She had been trying to contact him all day, but his phone was not connecting. The ambulance crew recognised that Sam had died. The police attended, reporting a large amount of empty pill packets around Sam's bed.

7.Findings and Learning Points

7.1 Introduction. Each key line of enquiry in the SAR terms of reference is addressed below. Findings and learning points are informed by the findings about multiagency learning that organisations made, either in their reports or at the learning event, as well as the observations and analysis undertaken by the lead reviewers.

7.2 Transition

Transitions in Sam's life were not always managed well.

7.2.1 Sam transitioned into adult hood at 18 with the support of the care leavers team. He did not transition into adult mental health services and is unclear if the clinicians or practitioner who worked with him through his teenage years had opportunity to discuss their experience of his needs and presentation with adult mental health services. Previous understanding of his needs as a person with autism were 'discounted' by adult psychiatrists and it is unclear how much his own rejection and subsequent 'removal' of the diagnosis influenced this.

7.2.2 Sam's care and support needs were assessed by Hampshire AHC. He was assessed as having 'moderate' needs and, under the criteria used at the time, not eligible for services. New legislation (Care Act 2014) means that we now consider the

Wellbeing principle[15] and use holistic and strengths-based assessments rather than the eligibility criteria of the time. It is unclear how this assessment was informed or whether Sam was signposted to any other supportive services.

7.2.3 Sam may have benefitted from support via his landlord. But NFDC had no information about Sam's mental health, sensory or emotional needs and therefore no opportunity to consider what type of accommodation and support they could offer. The type of accommodation Sam lived in caused him to feel anxious from the outset.

7.2.4 The care leavers team supported Sam as much as they could, supporting his engagement with mental health services, ensuring they could continue to work with him by making new arrangements in response to risk assessment and by providing support to Sam during the two periods they worked with him. This support was not enough for a person with Sam's complex needs.

7.2.5 These findings echo those of the HSAB SAR 'Sasha'[16] presented to the HSAB in December 2019. SAR 'Sasha' also references the Healthcare Safety Investigation Branch (HSIB) investigation report into the transition from child and adolescent mental health services into adult mental health services (2018).[17] The HSIB investigation findings and recommendations (HSIB 2018 *pages 7- 8*) have relevance to this SAR, in particular with reference to the need for well-planned flexible services for young people with needs that adult mental health services are limited in addressing.

Care leavers often have unmet needs for emotional and mental health support following traumatic experiences in childhood[18]. Some local areas have considered these needs within their local transformation plans, others (Gloucestershire) are creating a service to provide mental health and emotional support to care leavers, other options may be to embed expertise in mental health support within care leavers teams. Addressing such needs early in a young person's life not only contributes toward breaking generational cycles of harm but also reduces the huge cost to public services of distress and self-harm.

Learning Point 1: Young people leaving care who have complex mental and emotional health needs must have a person-centred plan informed by the organisations who have and will work with them. Rather than leaving young people and their families to negotiate the complexities of eligibility criteria, the range of different teams in an organisation or the absence of a commissioned service to meet need, we must focus on the person and what support they need to maximise their wellbeing and quality of life. Such holistic plans take time, and they must be informed by the young person.

Learning Point 2: Whilst a care leaver may not be eligible for adult mental health services, they may be experiencing emotional needs which need a response in order to prevent harm and intensive use of public services.

[15] Care Act 2014 section 1
[16] https://www.hampshiresab.org.uk/wp-content/uploads/Sasha-SAR-Final-Overview-Report-HSAB.pdf
[17] https://www.hsib.org.uk/documents/44/hsib_summary_report_transition_from_camhs_to_amhs.pdf
[18] Smith, Nicola (2017) *Neglected Minds* Barnardos at https://www.barnardos.org.uk/sites/default/files/uploads/neglected-minds.pdf

7.2.6 Sam's unplanned discharge from Hospital A before discharge plans could be made left him without support in the community, including support that that he may have been entitled to under s117 of the MHA. Sam was left at risk of further admissions and mental health crises. Sam's SHFT consultant psychiatrist was clear that it was not necessary to discharge Sam from his section and the hospital in order for him to be arrested. At this point the local community and in-patient services were advocating that Sam should have a period in a secure setting with time to work with professionals on some of his behaviours that caused such risk to himself and others.

The absence of an agreed discharge plan meant that Sam did not have sufficient support to cope with mental distress and other organisations working with him had no coordinated and clearly led plan to follow. Sam could have had an assessment of his needs once back in the community[19], and through this route the need for a short-term secure placement discussed again.

Learning Point 3. Any discharge from an MHA section 3 with no agreed discharge plan in place needs timely resolution by the organisations involved once the person is in the community. S117 entitlement should be assessed before the person leaves hospital, but an assessment can still be carried out once they are in the community.

7.2.7 Plans agreed at a CPA meeting on the 13th April 2018 for Sam's support post release from prison were not put into place until 19th July 2018. During this time Sam's mental health had deteriorated. The plan for Sam's care to be coordinated via the CPA whilst the Pathfinder service worked with him was not actioned. Plans for his aftercare under s117 were not finalised. The delay in SHFT's decision making about whether Sam could be offered a service by the CMHT meant that both Sam and other organisations were unclear as to whether CMHT was offering a service to him or not.

The delay or absence of timely completion of agreed actions needed to be escalated between organisations via an agreed escalation pathway. In discussion Hampshire representatives thought that the Hampshire SAB escalation protocol[20] should have been used. It is unlikely that organisations will think of using this process as the protocol states that '*The process outlined in this document relates to cases where there are safeguarding concerns that meet the statutory threshold under section 42 of the Care Act 2014*'. Sam was not seen as a person who met that criteria in the situations where organisations were failing to work together, and matters needed to be escalated between managers.

Learning Point 4. Organisations need an escalation process to use when multi-agency arrangements in situations of high risk have broken down. These escalation arrangements need to be timely with clear decision-making pathways. The existing SAB escalation protocol may be suitable for this purpose, but this will need to be made clear within the protocol and with partners.

[19] Hampshire County Council and Hampshire CCGs s117 after care policy (2015) at https://archive.westhampshireccg.nhs.uk/wp-content/uploads/2020/07/FOI-7484-APPENDIX-C-NHS_Hampshire_and_Hampshire_County_Council_117_policy_2015_v5.pdf

[20] http://www.hampshiresab.org.uk/wp-content/uploads/Safeguarding-Adults-Escalation-Protocol.pdf

7.2.8 The NHS England Primary Care team do not appear to have responded in a timely way to the GP request for Sam to be transferred to a GP who was part of the enhanced service for violent patients. Whilst Sam's prison sentence may have impeded GP1 supporting Sam through this, the transfer was made by Sam's family and left GP2 without detailed information and clear advice.

Learning Point 5. The evidence from this case indicates that transfer of violent patients to the GP enhanced service is not always timely, well managed and informed by up-to-date information and contact arrangements. These transfers are not frequent, and the GP surgeries involved have taken steps to ask the CCG to clarify the arrangements. Well managed transfers are especially important when GPs are trying to address the health needs of people who mental health services are no longer able to support.

7.3 Adverse Childhood Experiences (ACES)

7.3.1 Although several organisations reported that they knew of Sam's 'ACEs' this knowledge was not translated into documented trauma aware or trauma informed approaches. In their reports to the SAR several organisations recommended further development of trauma informed approaches when working with adults together with more understanding of the impact of childhood adversity. The Hampshire police and crime commissioner is currently offering training on trauma informed approaches[21], although this currently focuses on people under the age of 25.

7.3.2 ACE's are a useful concept when planning public health or community safety responses. People can be traumatised by events that are not on the current list of ACEs. Person centred approaches are important in understanding trauma throughout the life course, and what may retraumatise a person later in life.

Although it was understood that, for example, being restrained would make Sam agitated, there was little professional curiosity apparent as to what Sam thought had happened to create this response and what would help to support or, in times of crisis, contain him. Sam's GP involved Sam in thinking through a crisis management plan for hospital attendances, his NFDC workers preferred to see him 'face to face' recognising that he was more distressed and harder to communicate with over the phone, these were good person centred and potentially trauma aware responses.

Learning Point 6. It is not enough to recognise 'ACEs' in a person's life. We need to understand trauma and re-traumatisation and be confident in using trauma-aware and trauma informed approaches in working with people. These approaches will be supported through the development of professional curiosity in all organisations.

7.4 Legislation – the Care Act, Mental Health Act, Mental Capacity Act and Human Rights

7.4.1 We have highlighted in section 6 above how Sam's entitlement to support under the provisions of s117 of the MHA was not progressed after his discharge from Hospital A and was not acted upon after his release from prison.

[21] https://www.hampshire-pcc.gov.uk/free-ace-trauma-training-for-professionals

7.4.2 Sam's mother was not considered as a carer under section 10 of the Care Act 2014, despite being Sam's close emotional and practical support through the last years of his life.

Learning point 7: Organisations working with the adult should identify who the carers are in a person's life and the impact that caring responsibilities have on them. This should lead to a referral being made to the local authority (Adult Health and Care) who have a statutory duty to assess carer's needs for support and to advise them or provide support.

7.4.3 Sam did not have the support of an advocate, either as a statutory right under the provisions of the Mental Health Act or as a young person in transition during key points in his life.

Learning point 8: The statutory right to advocacy is vital, and in cases similar to Sam's can make a real difference in outcomes. Responsible organisations must ensure that there are well understood and used provisions for advocacy, even when a person is away from their local area. Consideration should be given to monitoring the uptake of advocacy by people detained on section.

7.4.4 UHS reports have noted that when seen in crises Sam's mental capacity was sometimes not clearly recorded, although significant steps have now been taken by the Trust to address this. On two occasions Sam was assessed as lacking capacity to make a specific decision but no best interest decision making process appears to have been used.

Assessments of Sam's capacity were also limited by the uncertainties about his diagnosis and whether he had an 'impairment of or disturbance in the functioning of the person's mind or brain'[22]. The assertions made that Sam had mental capacity in relation to risks to himself and others within the HIU plan and other deployment plans risked leading to a presumption of capacity without further assessment.

Learning Point 9: Organisations need to ensure that all staff are confident and competent in using the provisions of the MCA 2005, in particular those working in Emergency Department settings.

7.4.5 The Human Rights Act 1998 underpins the Care Act 2014 duties, including the duty of organisations to refer concerns about adult safeguarding (Care Act 2014 section 6). Sam was recognised as experiencing emotional abuse as a result of his neighbours alleged actions, but no safeguarding concern referrals were made.

Sam was assessed as high risk of accidental and fatal harm as a result of his actions, but this assessment did not result in review of the HIU plan or mental health crisis plans around him.

Learning Point 10: All public authorities have an obligation to uphold Human Rights. This obligation can take many forms, but includes regular review of

[22] Mental Capacity Act 2005 section 1 (2) at https://www.legislation.gov.uk/ukpga/2005/9/section/2 act

plans, especially when risk to life is escalating, and understanding what an adult safeguarding concern is, and when to refer to the local authority.

7.5 Barriers to engagement.

7.5.1 Sam experienced significant barriers to getting support for his mental health needs and emotional distress. These barriers were exacerbated by the lack of clear and coordinated plans to support him in the community, disputes about which mental health team should see him or whether indeed he should see a mental health team at all. The care leavers team report that they allowed the uncertainty of what mental health responses might be forthcoming to influence their own intervention and planning about Sam's community support.

7.5.2 Sam's diagnoses influenced how organisations saw him, and the labels of EUPD and in particular A-S PD may have obscured Sam's actual needs. It is unclear how such labels were explained to Sam, his family or other organisations working with Sam. In July 2017 the diagnosis of A-S PD appeared to mean that SHFT could not offer a service to Sam and that criminal justice organisations, in particular NPS, should be the lead agency. This was not discussed with criminal justice services at the time. The SHFT determination that Sam did not have autism meant that sensory impacts in his environment were not considered when using health services or his support needs in understanding situations and agencies' responses to him.

7.5.3 Sam does appear to have responded well to the Pathfinder team and toward the end of his life began to engage in working with them. If a coordinated approach to Sam had been in place any insights achieved through this work could have been used to review the plans made by other involved organisations.

Learning point 11: Attention should be paid to the effect that the mental health diagnostic process is having on the person and their care and support. The purpose of diagnosis is to determine the most useful treatment approach. The person still needs support whilst this process is on-going.

7.6 Family involvement

7.6.1 The high level of emotional and practical support that Sam received from his mother did not result in planned support for her. Sam's mother was his carer[23] (ADASS 2011) and as such the local authority has a general duty to promote her wellbeing, including protection from abuse, and a duty (Care Act 2014 s10) to offer her an assessment of her needs.

7.6.2 Although probation and SHFT were at different times concerned for her safety they gave her advice but did not initiate any further support, for example via offering referral to the local authority. Police did made referrals to MASH, but concerns were thought to have been resolved by Sam's detention. In 2015 Sam's mother was identified as being at risk from Sam's behaviour, this was the only time that domestic

[23] Adass (2011) Advice note - Carers and Safeguarding Adults – working together to improve outcomes at https://www.adass.org.uk/adassmedia/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf

abuse provisions appear to have been considered as a potentially helpful resource for her.

Learning Point 12: Organisations must be aware of the domestic abuse services that exist to support people to reflect on their circumstances and consider how to protect themselves from abuse by a family member.

7.7 Responding to Crisis

7.7.1 The efforts to manage the risk posed by Sam in either acute or mental health locations were not developed using a multi- agency approach which would have created understood contingency plans which organisations, particularly those in the community, could support.

7.7.2 With the exception of the plan formulated by Sam and his GP plans did not involve Sam or his family and may have appeared unfair and incomprehensible to them. Sam stated on several occasions that he could not understand the actions of mental health teams and the absence of an agreed multi- agency plan meant that other organisations did not understand what other organisations were doing or the rationale for decisions or actions either.

7.7.3 Plans were not always based on accurate information and were implemented in a piecemeal fashion over a period of time. The arrangements were not pragmatic and did not result in any change in Sam's behaviour. As discussed elsewhere the HIU plan was not monitored or reviewed. The emergency service deployment plans were impractical and could not be followed.

Learning Point 13: It is essential that High Intensity User Plans are developed with the involvement of the person involved who may be able to advise on strategies to reduce risk. With their permission family members may also be involved. Plans should also be made with the collaboration of all organisations involved in order to understand the system around the person and the potential impact of HIU or emergency service deployment plans. Plans must detail who the lead agency is who will review each incident with the person and try to identify triggers to behaviour and what can be done differently in the future. If the person is engaging in harmful behaviours it is also essential to have a documented regular monitoring and review process to understand the impact of plans and mitigate risk to the person or others.

7.8 Safeguarding and risk management

7.8.1 The majority of organisations who participated in this review have emphasised that the lack of a recognised lead agency to coordinate multi-agency risk assessment and planning was a key factor in the inability to identify cumulative risk and agree actions to support Sam and his family, or other organisations working with Sam.

The lack of leadership and coordination of a multi-agency risk management plan meant that the increasing number of PPN1 notifications submitted by the Hampshire Constabulary were not received and analysed, and the cumulative nature of risk to Sam was not recognised.

Partner agencies had concerns about Sam's needs, his overwhelming difficulty in coping with his everyday life and the struggle of services to meet his needs or reduce his self-harm. Most organisations who participated in the review recognised that a Multi – Agency Risk Management meeting (MARM) would have been helpful but were uncertain as to who the lead agency should be in calling such a meeting.

There were opportunities to use existing multi-agency meetings, including the MAPPA arrangements and CPA. It is not known on what basis the MAPPA arrangements around Sam ceased and what impact they had on the plans made during 2016 and 2017.

If these provisions were not available organisations could call a Multi-Agency Risk Management meeting (MARM). It is vital that these meetings are understood and attended by all organisations, including those who work primarily with children, young adults and care leavers.

Learning point 14: There are a range of arrangements available to enable organisations to collaborate and use collective responsibility to share risk, these need to be understood and confidently used by all organisations, including those who support care leavers. In order for these arrangements to be effective all organisations need to understand and appreciate each other's role and responsibility. Organisations need to commit to attending meetings and to carry out the actions they have agreed.

Learning Point 15: Arrangements at the MASH are intended to provide opportunities for early information sharing, analysis and decision making to prevent further harm. Escalating risk from numerous safeguarding concerns and police notifications may need to be identified by the front door team (CART) and thought given as to how escalating risk is identified, particularly when referrals are sent on to locality and care leavers teams.

8. Recommendations to Hampshire Safeguarding Adults Board.

8.1 HSAB is recommended to lead on the promotion of a) professional curiosity and b) trauma aware or trauma informed approaches in services in the local area.
(Learning point 6)

8.2 HSAB is recommended to receive assurances from UHS and any other relevant health provider as to how 'High Intensity User' plans are being developed, implemented, monitored and reviewed in the in the local area.
(Learning Point 13)

8.3 HSAB is recommended to consider whether the development of collaborative working and collective responsibility throughout the partnership needs further review. ADASS/LGA suggested guidance[24] (LGA November 2020) will provide a useful starting point.
(*Learning points 10; 14*)

[24] LGA/ADASS 2020 'Understanding what is a safeguarding concern and how to promote effective outcomes' at https://www.local.gov.uk/sites/default/files/documents/25.168_Understanding_what_constitutes_a_safeguarding_07.1.pdf

8.4 HSAB is recommended to be assured that provisions to support and prevent harm to carers are understood by all organisations. This will include assurance that there is a commonly held understanding of who carers are, that the local authority duty toward carers is known and understood and that familial abuse of carers is seen as domestic abuse[25] with appropriate support available.
(Learning points 7 and 12)

8.5 HSAB is recommended to consider whether the safeguarding escalation protocol is appropriate for use in other risk situations when organisations have not undertaken actions or agreements and there is likely to be an impact on service user(s) as a result.

If the HSAB decides that use of the safeguarding escalation protocol is not appropriate it is recommended to seek assurance from partner organisations that they have escalation arrangements in place. Organisations should ensure all staff are aware of how to use such arrangements ***(Learning Point 4).***

8.6 HSAB is recommended to request that the local MAPPA strategic management board
- review the impact that MAPPA arrangements concerning Sam had on risk management plans made by the organisations working with him during 2016-2017 and
- share the learning from this review with the HSAB.

Further detail regarding this recommendation can be found in appendix 2 of this Report.

9. Recommendations to Hampshire Safeguarding Adults Board and Hampshire Local Safeguarding Children Partnership.

9.1 Hampshire Safeguarding Adults Board and Hampshire Local Safeguarding Children Partnership are recommended to consider the findings of this SAR in the development of transitional safeguarding. The principles of Making Safeguarding Personal will support a needs-led, personalised approach to risk and safeguarding across partnerships. The Adult's and Children's partnerships are recommended to work together to promote a shared understanding about risk, approaches to risk enablement, planning and contingency. The partnerships should also consider how the mental and emotional health of care leavers in Hampshire is currently being addressed and whether services need to be developed to address this need.
(Learning Points 1,2, 6,8)

10.Recommendations to individual agencies:

10.1 When developing pathways for care leavers **Hampshire Adult Health and Care and Hampshire Children's Services** are recommended to take note of the findings of this SAR. In particular it is important to ensure that organisations who have worked

[25] DH 2013 information for local areas on the change to the definition of Domestic Violence and Abuse page 2 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

with young people have retained transition information to inform adult services on request. Work on plans encompassing all aspects of the young person's wellbeing needs to begin in advance of the young person's 18th birthday, in the case of young people who have presented risk behaviours and/or are ambivalent about vital information sharing this work should be initiated at an early stage to allow time to resolve uncertainties and challenges. Advocacy should be considered for young people who struggle to understand or communicate their needs.
(Learning Points 1,2 and 8)

10.4 **UHS and SHFT** are recommended to undertake regular mini audits of the quality and consistency of decision making, recording mental capacity assessments and the use of best interest checklists in ED departments and the psychiatry liaison teams.
(Learning point 9)

10.5 **Hampshire CCGs and Hampshire local authority commissioners** are recommended to ascertain from SHFT and other relevant health providers that agreed s117 arrangements are working effectively, particularly for those discharged from hospital settings before s117 arrangements are confirmed, and that the rights of those who are eligible are being met.
(Learning Point 3)

10.6 **Hampshire CCG** is recommended to report completed actions regarding NHS England Primary Care team arrangements for patient transfer to the violent patient enhanced service to local GPs.
(Learning Point 5)

10.7 **Commissioners of mental health in-patient services** are recommended to ensure that there are monitored arrangements to guarantee that patients in out of area hospitals have their right to statutory advocacy respected.
(Learning Point 8)

10.8 The CCG is recommended to support a reflective meeting with staff from SHFT, GP surgeries, NPS and other interested partners to consider the findings of this SAR with particular reference to:

- The impact of the diagnostic process on a patient, particularly when the diagnosis is considering personality disorder
- The support the patient will need during this process.
- The meeting is also recommended to consider how aware and confident frontline practitioners are in using a person-centred approach with people who are diagnosed with personality disorders and how organisations in the community can be supported whilst working with this group.

(Learning Point 11)

10.9 **AHC** is recommended to consider how escalating risk indicators within notifications and referrals can be identified and acted upon across the existing safeguarding pathway.
(Learning Point 15)

11.Glossary of terms used

A-S PD	Anti-social personality disorder	**ACE(s)**	Adverse childhood experience(s)
ADHD	Attention deficit hyperactivity disorder	**AHC**	Adult Health and Care
AMHT	Acute Mental Health Team	**CAMHS**	Child and Adolescent Mental Health Service
CART	Contact Assessment and Resolution Team		
CMHT	Community Mental Health Team	**CPA**	Care Programme Approach
CRC	Community Rehabilitation Company	**ED**	Emergency Department
EUPD	Emotionally unstable personality disorder	**GP**	General Practitioner
IMHA	Independent Mental Health Advocacy	**HC**	Hampshire Constabulary
HIU	High intensity user	**HMP**	Her Majesty's Prison
MAPPA	Multi agency public protection arrangements	**MARAC**	Multi agency risk assessment conference
MARM	Multi agency risk meeting	**MASH**	Multi agency safeguarding hub
MCA	Mental Capacity Act 2005	**MHA**	Mental Health Act 1983 or 2007
NFDC	New Forest District Council	**NPS**	National Probation Service
OCD	Obsessive Compulsive Disorder	**OM**	Offender Manager
PPN1	Public Protection Notification.	**SAB**	Safeguarding Adults Board
SAR	Safeguarding Adults Review	**SCAS**	South Central Ambulance Service
SHFT	Southern Health Foundation Trust	**UHS**	University Hospital Southampton

Appendix 1 Terms of Reference

Introduction

1.1 This case was referred on 3rd February 2021 to the Hampshire Safeguarding Adults Board (HSAB) for a Safeguarding Adult Review (SAR). The referral was considered by the HSAB Learning and Review Subgroup which decided that although statutory criteria under S44 of the Care Act were not met in this case, the circumstances were such that the Board would use its power to hold a discretionary SAR in order to gain learning about young adults experiencing mental ill-health as they make the transition to adult mental health services. This review will be undertaken using our newly developed Rapid SAR methodology.

Case summary

2.1 At the time of his sad death in August 2018 by suicide, Sam was 22 years old. He was single, unemployed and he lived alone. Sam was well known to secondary mental health services for just under a year and a half. He was placed in care at the age of 12 due to frequent aggression towards his mother and a diagnosis of Autism was made. Sam had 4 mental health admissions in his teens and was prescribed several anti-psychotics. Until recently Sam did not have a working diagnosis as consultants differed in opinion. At the time of his death however, he had a diagnosis of Emotionally Unstable Personality Disorder and Dissocial Personality Disorder.
Sam had a long history of suicide attempts with the first attempt occurring at the age of 12.

2.2 Upon leaving care, Sam lived relatively independently. However, he was unsettled when he moved into his most recent accommodation in March 2017 as he reported that he was being bullied by a neighbour who lived above him. Sam had reported that this neighbour had smeared dog excrement on his front door, had physically threatened him with a hammer, had driven his vehicle towards him in a threatening manner, had made numerous verbal threats towards him, had repeatedly disrupted him with his noise levels, and had damaged his ceiling through his behaviour.
These issues with his neighbour were a major source of stress for Sam and contributed to his mental instability. Sam had applied to the New Forest District Council for a housing transfer and was being supported by his Responsible Clinician, who completed a supporting letter for his housing application of transfer.

2.3 Sam also had a history of harm to others mostly aggression aimed at his mother, harassment of a social worker and probation officer by text. He also had a history of assault on members of Accident and Emergency staff including a consultant, for which he faced criminal prosecution for battery. Sam was sentenced and imprisoned at HMP Winchester in February 2018 serving 3 months of a 6-month custodial sentence, with a further 12 weeks served on licence when released. Whilst in prison, Sam was accommodated in the health care wing for the duration of his sentence during which time he was placed on suicide watch.

2.4 Sam had a long forensic history and was assessed under the Mental Health Act on a number of occasions, after being detained on a Section 136 of the Mental Health Act. In most cases, he was usually discharged. In July 2018, Sam was arrested for murder after he called the police reporting that he had killed a nurse called Mary. Sam was later de-arrested after it was established he had not killed anyone.

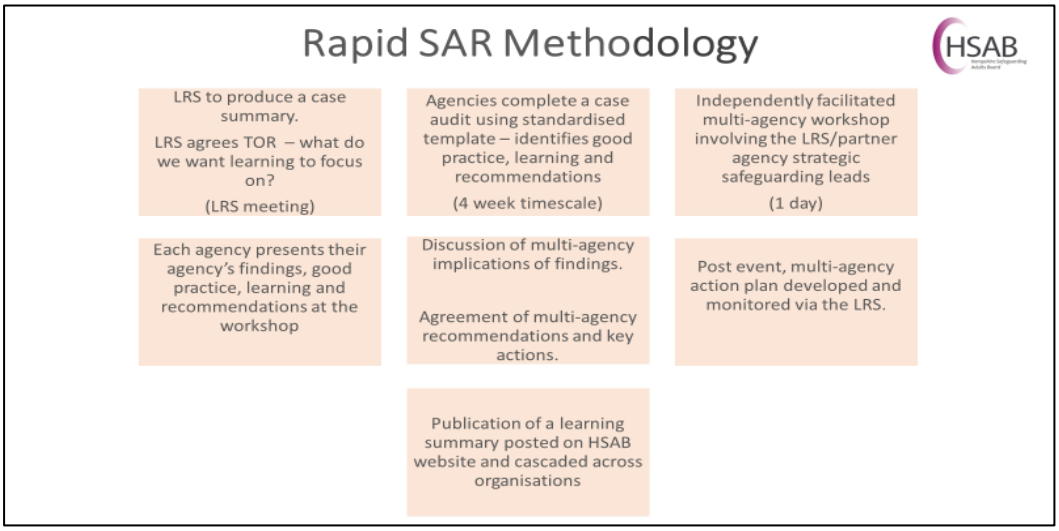
2.5 In July 2017, Sam was referred to the Hampshire Pathfinder Service based at Ravenswood Medium Secure Forensic Hospital by the Hampshire and Liaison Diversion Service (HLDS). The Pathfinder Service is a Hampshire and Isle of Wight Multi Agency Personality Service that works with individuals who have been diagnosed or are suspected of having a personality disorder, who have committed violent offences and are at high risk of re-offending. The Pathfinder Service is predominantly a consultation and support service for professionals working with the client group and its purpose is to enhance the offering of other services in the statutory, voluntary and private sectors. In a small number of cases, Pathfinder may offer direct intervention for the service user, but this should always act to enhance and not replace existing services.

2.6 To support Sam in the Community and during a crisis, Sam had telephone access to the New Forest (West) CMHT in hours and AMHT out of hours. Sam was also supported by the Hampshire Pathfinder Team with whom he had contact on a regular basis.

2.7 On 14th August, Sam had contacted his mother to tell her he had taken an overdose stating he had sought help from the emergency services. Paramedics had carried out an assessment and tests on Sam at the scene and concluded that he did not require conveyance to hospital. His mother agreed for Sam to be dropped off at her home and she dropped him back to his own residence on the morning of 15th August with an arrangement made to visit him on 16th August. When she arrived at his property she found him deceased as a result of an overdose.

SAR Methodology

3.1 The timeline for the SAR is 1st August 2017 until 16th August 2018.
Seek contextual information from children's services back to 2014 (see KLOE section A Transition and Section B ACES). A key principle underpinning the SAR is to build on existing reviews/investigations already carried out and so the SAR methodology has been adjusted accordingly. The SAR will be carried adopting the following process which includes facilitation by an independent reviewer:



3.2 The following agencies have been identified as organisations who were involved in Sam's care and support and as such, will be expected to engage in the SAR process including submission of relevant information and participation in a Multi-Agency Learning Event:

a) Hampshire Children's Services South West Care Leavers Team.
b) Child and Adolescent Mental Health Service (CAMHS).
c) Hampshire and Liaison Diversion Service (HLDS).
d) Hampshire Pathfinder Service (Ravenswood Medium Secure Forensic Hospital).
e) Southern Health Foundation Trust (SHFT).
f) S117 Team (SHFT, West CCG and HCC Adults).
g) Hampshire Constabulary.
h) Probation.
i) Hampshire Adults Health and Care Adult Mental Health.
j) Hampshire MASH.
k) University Hospital Trust Southampton (UHS).
l) South Coast Ambulance service (SCAS).
m) GP Practice.
n) New Forest District Council – Housing and Community Safety Services.
o) HMP Winchester.

3.3. A key part of the SAR is to gather the views of the family and share findings with them prior to publication. Sam's mother has indicated a desire to be involved. The Board Manager will meet with her prior to the commencement of the review in order to ascertain her views against the established Key Lines of Enquiry (KLOE).

3.4 It will be the responsibility of each participating agency to brief relevant managers and staff about the SAR engaging them in the information gathering process and once completed, to brief them on the outcomes of the review.

3.5 Each agency will be responsible for developing an action plan to address any learning and recommendations arising from their review and audit of the case review/audit.

3.6 Each agency may wish to convene a local 'learning into to practice event' to consider discuss the policy and practice implications of both internal and multi-agency recommendations.

3.7 Each agency will be asked to nominate a person to act as the single point of contact with the HSAB team and additionally, a designated person to undertake the case audit.

4. Key Lines of Enquiry (KLOE)

4.1 The following KLOE will be examined as part of the review. Agencies will be requested to complete a case audit using a standardised template addressing all areas indicating good practice, learning and recommendations against each:

a) Transition

Critically analyse:

1) The longer-term input and support provided from children's' social care in particular, the care leaving and pathways teams.
2) The mental health support provided or offered as the adult transitioned through adulthood as a care leaver with support requirements until the age of 25 years old.
3) Impact of indeterminate diagnosis, changing diagnoses, removal of autism diagnosis.
4) Discharge and support planning adopted following discharge from acute hospital services, mental health settings (e.g., s117)
5) The discharge planning process adopted leading up to release from prison.
6) Evidence of timely information sharing and multi-agency risk assessment and planning to mitigate risks identified.

b) Adverse Childhood Experiences (ACES)

Critically analyse:

1) Steps taken to identify vulnerability and risk factors presented by ACEs, which impacted on the adult's mental illness and evidence that identified risks were addressed in transition planning
2) Impact of the undetermined diagnosis on the treat, care and support offered

c) Care Act, Mental Health Act, Mental Capacity Act and Human Rights

Critically analyse:

1) Effectiveness of these Acts in supporting risk management and keeping the adult safe.
2) How the treatment of mental health as a child was considered during the development of an adult mental health treatment plan.
3) Meeting adult's care and support needs post 18 years
4) Robustness of S.117 arrangements, coordination and leadership of care and evidence that relevant agencies engaged in these.

d) Barriers to engagement

Critically analyse:

1) Strategies adopted to manage the adult's refusal to engage and/or disengagement.
2) Impact of the adult's verbally and physically abusive behaviour towards staff and how this may have influenced responses.
3) How the continuity of care and support was maintained during transition and at key crisis points.
4) Quality of case coordination and clarity of leadership

e) Family involvement

Critically analyse:

1) How your agency engaged with the adult's mother.
2) How she was included in assessments, planning and crisis responses.
3) What you understood about the relationship between the adult and his mother.
4) Whether there were any issues of consent and confidentiality and how these were managed.

f) Responding to Crisis

Critically analyse:

1) How your agency engaged in responding to the crisis points the adult experienced..
2) Strategies adopted to manage the adult's high intensity use of your service.
3) Analyse the effectiveness of responses and suggest learning from this.

g) Safeguarding and risk management

Critically analyse:

1) How risk management and safeguarding processes were applied.
2) Evidence of multi-agency coordination and timely information sharing, risk assessments and planning.
3) How your agency responded to community safety concerns e.g., housing / neighbour dispute and anti-social behaviour
4) experienced by the adult and whether there was a victim focus.
5) Analyse the effectiveness of responses and suggest learning from this.

Appendix 2

1. In order to extend the learning from the Safeguarding Adults Review 'Sam' Hampshire Safeguarding Adults Board (HSAB) has been recommended to request that the local MAPPA strategic management board
- review the impact that MAPPA arrangements concerning 'Sam' had on risk management plans made by the organisations working with him during 2016-2017 and
- share the learning from this review with the HSAB.

2.The focus of SAR 'Sam' was on the last year of his life, from August 2017 to August 2018. However, the plans made by various organisations to manage risks posed by Sam were made from 2016 onward and the HSAB needs to learn how these plans were informed and formulated.

3.During the course of the SAR lead reviewers were made aware that MAPPA arrangements concerning 'Sam' were in place from 2015 to 2017. During that time secondary health services experienced risks from Sam's behaviour and accordingly, between 2016 – 2017, formulated plans to manage those risks. Staff in the acute trust and other organisations were in fear of and assaulted by Sam during this time.

4.The care leavers service involved with Sam has reported that he was subject to MAPPA arrangements and '*a high level of information, and risk assessment was completed as part of this process. Key agencies were aware of 'Sam', and the concerns for his behaviour and his mental health. There were a number of risk assessments in place, and a review of the case records within the scope of this review showed that the relevant safeguarding processes were in place. There is good communication and information sharing across the agencies, and risks related to behaviour and offending were well managed through the MAPPA arrangements'*

5. The HSAB wishes to learn

- how risk management considered by MAPPA meetings informed or influenced the various plans made by United Hospitals Southampton Foundation NHS Trust, South Coast Ambulance Service, Hampshire Constabulary and Southern Health Foundation Trust
- with an emphasis on the years 2016 – 2017 when plans made by the organisations above were being utilised.