Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND

Adult E
Safeguarding Adults Review

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1. Introduction

1.1.1 A Safeguarding Adults Review (SAR) was commissioned by Leicestershire and Rutland Safeguarding Adults Board (SAB) following agreement at Leicestershire and Rutland Adult Case Review Group meeting, in accordance with section 4 of the Care Act (2014)[1] that the criteria for a mandatory SAR in this case were met.

1.1.2 Adult E had a diagnosis of Emotionally Unstable Personality Disorder[2] (EUPD) with dissocial[3] traits and had died whilst he had been subject to a section 117 aftercare[4] plan to manage his care and support needs. Adult E had requested accommodation away from Leicestershire; this request was met by the Local Authority (LA).

1.1.3 There were concerns about how people were being safeguarded, and how people with specific needs were receiving services to meet those needs and manage the risks, when accommodated in another area.

2. Methodology

2.1.1 The methodology used was a hybrid methodology incorporating aspects of a traditional case review model with single agency summary reports and an action learning approach through practitioner events.

2.1.2 This review examined the period from the 1st of May 2019 until the 9th of May 2020. This timeframe includes a substantial period when Adult E was placed out of area in a supported living establishment, and a short period in the last few weeks of his life when he lived in several different places and was under several different agencies.

2.1.3 Each agency reviewed their records and drew up chronologies of their involvement with Adult E, including some analysis. Each agency then produced a Learning Summary Report of their involvement with Adult E which included single agency learning and recommendations.

2.1.4 Two learning events were held to explore the key lines of enquiry; one for practitioners and the other for commissioners and managers.

2.1.5 An additional meeting was held with key individuals from all the mental health services involved, to explore aspects of Adult E's condition, his care and treatment and what influenced practice and decision making.

2.1.6 Partner organisations via the Panel were given an opportunity to agree actions to address the learning identified.

3. Succinct summary of case

3.1.1 Adult E was in his mid-thirties when he died of heroin toxicity. Adult E had been in contact with mental health services since the age of 21.

3.1.2 Adult E had spent a significant period of his life accommodated in 24-hour care establishments, either following offences or, as a result of his mental health condition.

[1] Care Act (2014) legislation.gov.uk

[2] Emotionally Unstable Personality Disorder is also known as Borderline Personality Disorder; the two terms are used throughout the report.

[3] Dissocial traits – include impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness

[4] Mental Health Act (1983) Section 117a aftercare.
https://www.legislation.gov.uk/ukpga/1983/20/section/117A

3.1.3 Adult E was convicted of 31 offences between 23 June 2005 and 18 March 2016. Most were for minor misdemeanours however some related to holding of offensive weapons.

3.1.4 Adult E had two admissions to an in-patient mental health unit (Hospital 1) in Leicestershire. On the second occasion Adult E spent 4 months there Under Section 3 of the Mental Health Act (MHA) after his former placement had broken down and due to high levels of self-harm.

3.1.5 On discharge from the Leicestershire in-patient mental health unit Adult E was subject of a section 117 aftercare plan, due to his need for care and support.

3.1.6 Adult E was admitted to an out of area supported living facility in September 19 where he remained for seven months. Adult E was relatively settled for the first 8 weeks.

3.1.7 There were two occasions when Adult E self-harmed sufficiently to require attendance at hospital 2. Firstly, in December 2019, and in February 2020 when Adult E was transported to hospital 2 by ambulance following a heroin overdose which had caused respiratory arrest.

3.1.8 In March it came to light that Adult E and a staff member, a person in a position of trust (PiPoT) from the supported living facility, were having a relationship. Adult E was also using illicit substances and alcohol. Adult E's self-harming behaviours became so concerning that the supported living facility felt they could not keep Adult E safe and communicated this to relevant agencies.

3.1.9 Adult E had several out of area Accident & Emergency (A&E) attendances and mental health assessments in both Warwickshire and Leicestershire in late March-early April 2020. Adult E refused to return to the supported living accommodation. Adult E was found accommodation in a Bed and Breakfast (B&B) in Leicestershire, where Adult E took a significant overdose of his prescribed medication. An assessment in Warwickshire at that time suggested the need for admission. Adult E was arrested the same day, for an offence against the PiPot, by Warwickshire police who released Adult E into the care of mental health services believing Adult E would be admitted. Adult E was seen at the Leicestershire Mental Health Hub and, following assessment and agreement that an admission was not in Adult E best interests, he was released with a short supply of his usual medication to another Leicestershire B&B.

3.1.10 Within 24 hours Adult E had caused criminal damage and was to be arrested; to avoid arrest Adult E reported he had taken an overdose. Adult E was seen by his social worker (SW) and alternative B&B accommodation found.

3.1.11 Over the next three weeks the Leicestershire local crisis team provided Adult E with his medication and tried to support Adult E whilst his SW continued to search for a suitable placement.

3.1.12 Adult E struggled to gain registration with a Leicestershire GP. The usual mode of registration was not open to Adult E as he was categorised as homeless. Adult E was directed to Assist/Inclusion Healthcare where he needed to complete some forms; Adult E was due to attend the day after he was found deceased in his room, from a suspected drug related death by a member of the B&B staff.

4. Key lines of enquiry

4.1.1 The following terms of reference were agreed by the panel:

1. Explore service provision to support and manage Adult E's impulsive self-harming behaviours as a consequence of his diagnosis. Consider the impact of cross boundary working on services abilities to work with and for Adult E.

2. How did professionals work together to keep Adult E safe? Consider collaborative working under Section 117 of the Mental Health Act – Did your agency identify a need for, or complete, a review/ what was the multi-agency response? Please include trusted assessments.
3. Consider the impact of Covid-19 – did that affect the service offer or the way in which agencies engaged with Adult E?
4. Examine Adult E's access to ongoing healthcare and Adult E's request for informal admission. Who was responsible for Adult E's medical care at point of discharge from Leicestershire mental health service as Adult E was not registered with a GP in Leicester; consider the barriers that created for Adult E and for other services – e.g., did the inclusion team accept him / begin any work with him?
5. Consider how Adult E's impending homelessness was managed and his transition between supported and B&B accommodation. Consider the management of Adult E's mental health throughout this period. Was the mental health homeless service still operating at that time and did they have any input whilst Adult E was in the hotel – did any professionals have any direct or indirect contact with Adult E whilst he was living there?
6. Consider what plans, including risk management and safety plans, were put in place to address Adult E's vulnerabilities and behaviours following the allegation of an inappropriate relationship with a staff member. Was this relationship considered in the context of exploitation? Was Adult E identified and managed as a victim or perpetrator or both.
7. Consider services response to family members' concerns.
8. What services are available locally and nationally for those with Emotionally Unstable Personality Disorder.

5. Engagement with family

5.1.1 The Board wrote to Adult E's mother to invite her to participate in the review. Adult E's mother met with the reviewer, to discuss her understanding of the services offered to Adult E and to provide insight into Adult E's perceptions of the services offered. The reviewer is grateful to Adult E's mother for her input, not only during the meeting but also through the documented evidence she subsequently provided.

6. Review team and timeline

6.1.1 The Review Team was led by Nicki Walker-Hall. Nicki has a background in health, an MA in Child Welfare and Protection and an MSc in Forensic Psychology; she is an experienced reviewer of both adult and child safeguarding reviews. The review team consisted of members of the Leicestershire and Rutland Safeguarding Adults Board's Case Review Group and included senior safeguarding representatives from all the agencies involved in Adult E's care.

6.1.2 The Care Act 2014 identifies that Safeguarding Adults Reviews should be completed '*within 6 months of initiating it, unless there are good reasons for a longer period being required*[5]'.

[5] Department of Health (2017). Care and support statutory guidance
[online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 21 August 2019].

6.1.3 In this instance, the review took 8 months from commissioning to the Overview Report being drafted. All agencies worked well together to ensure this review was completed within a reasonable timeframe, so that learning can be progressed whilst it remains current.

7. Analysis of the key lines of enquiry

7.1.1 Service Provision

7.1.1 EUPD is a mental disorder characterised by affective instability, interpersonal problems, and chronic suicidality, associated with reduced functioning, poor quality of life, and lower life expectancy. The suicide rate is fifty times that of the general population and one in ten people with a diagnosis of EUPD will die by suicide.[6]

7.1.2 Whilst Adult E was in hospital detained under the Mental Health Act, he continued to display impulsive self-harming behaviours; this is not uncommon. Adult E had a plan of care and was in a situation where he was being observed and there was immediate help available to him.

7.1.3 Prior to 2009 people with EUPD were being contained through admission with no treatment plans. As a consequence of these admissions becoming longer and longer, with no seeming improvement to the patients, there was a change made to how patients with EUPD should be managed. The National Institute for Health and Care Excellence (NICE) drew up guidance for EUPD which recommended considering acute psychiatric admissions for the management of crises on a short-term only basis. This was in recognition of the unintended adverse effects of admission[7].

7.1.4 That is not to say the person with EUPD should not be cared for. The same guidance indicates that teams working with people with EUPD should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person). The care plan should:

- Clearly identify the roles and responsibilities of all health and social care professionals involved
- identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them
- identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims
- develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough
- be shared with the GP and the service user.

7.1.5 Teams are advised to use the Care Programme Approach (CPA) when people with EUPD are routinely or frequently in contact with more than one secondary care service. This is particularly important if there are communication difficulties

[6] E. Björkenstam, C. Björkenstam, H. Holm, B. Gerdin, and L. Ekselius, "Excess cause-specific mortality in in-patient-treated individuals with personality disorder: 25-year nationwide population-based study," *The British Journal of Psychiatry*, vol. 207, no. 4, pp. 339–345, 2015.

[7] National Collaborating Centre for Mental Health, *Borderline Personality Disorder: Recognition and Management*, NICE guidelines, National Institute for Health and Care Excellence Clinical Guidelines website, 2009

between the service user and healthcare professionals, or between healthcare professionals.[8]

7.1.6 As Adult E neared discharge, certain actions were proposed in a care plan drawn up with Adult E by his responsible clinician (RC). The plan was articulated to the out of area supported living facility who agreed to Adult E's admission anticipating certain measures would be in place. The plan included a Community Treatment Order[9] (CTO) with support from Warwickshire community mental health team. A decision was taken that to apply for a CTO would delay discharge and so Adult E was to be discharged with Section 117 aftercare with a view to applying for a CTO.

7.1.7 Leicestershire mental health service had expected Adult E would be cared for by Warwickshire community mental health team and had shared Adult E's extensive history and the risks; however, there was a difference of opinion between Leicestershire mental health service and Warwickshire community mental health team. The RC in Leicestershire mental health service felt a CTO would be appropriate and the receiving clinician was of the opinion it would not. A final decision was taken between the discharging consultant and Warwickshire community mental health team, only after the out of area supported living facility had accepted Adult E into the service, that a CTO was not appropriate. The discharging consultant agreed to inform the out of area supported living facility. Leicestershire mental health service felt the out of area supported living facility would not meet Adult E mental health treatment needs alone and would need external psychiatric Multi-Disciplinary Team (MDT) support. Numerous discussions were had between all parties and Adult E's mother, but no Section 117 aftercare meeting was held.

7.1.8 Following discharge an assessment by Warwickshire community mental health team found Adult E did not meet the services criteria at that time. Leicestershire mental health service indicated they were not able to influence mental health services in Warwickshire but had Adult E remained in Leicestershire he would have been accepted by Leicestershire community mental health services. Leicestershire mental health service discharged Adult E as he was no longer living in their area, leaving Adult E's new Warwickshire GP to oversee his care plan. This combination of factors left the Warwickshire GP and the out of area supported living facility in difficult positions, without the support envisaged, and the Warwickshire GP responsible for Adult E's mental health care.

7.1.9 Adult E went from an extended admission in hospital 1 under Section 3 of the MHA, with extensive psychiatric input, to care by his new GP. Extensive efforts were made by the Warwickshire GP and supported living facility to follow Adult E's care plan. Staff at the supported living facility communicated their concerns regarding escalations in Adult E's levels of risk, and his extreme behaviours, regularly with the previous Leicestershire MDT, Local Authority (LA) commissioners, and the Clinical Commissioning Group (CCG), but a lack of response left them feeling powerless. The only option left to the supported living facility, when they felt they could no longer manage the risks Adult E's behaviours presented, was to decline his return from hospital as they felt they could not keep him safe; this met with Adult E's own

[8] https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#general-principles-for-working-with-people-with-borderline-personality-disorder

[9] CTO - A CTO is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation, and other services while living in the community.

expressed wish that he did not want to be returned. The Warwickshire GP made referrals to Warwickshire community mental health team; Adult E did not meet the service threshold for treatment for his impulsive behaviour and expressed that he had no wish to engage with mental health services. This left Adult E, his GP, and the supporting living facility to manage his impulsivity. The Warwickshire GP also made referrals to the crisis team who acted upon them. Despite requests, Adult E had not received support from drug and alcohol services to manage his addictions.

Learning point: Each LA and CCG has different thresholds for services and configures its services to meet its populations needs. Current differences in thresholds and the way services are configured across neighbouring areas, and differing service criteria, means there are gaps in service that are impacting on patients who are accommodated out of area, having access to mental health services, they have been assessed as requiring. How services assess clients against their criteria is crucial. Following Adult E's discharge into the supported living facility, in a bid to achieve Adult E goals, a framework was put around him with his consent. Adult E was shadowed and therefore under constant supervision, to manage his impulsivity, when he left the facility. This was effective in containing Adult E, initially reducing Adult E's impulsive behaviours, stopping him acquiring drugs and alcohol, thus keeping him safe.

7.1.10 Mental health workers indicated that they would not have expected a person with EUPD to be receiving such a high level of support, as this is contrary to more recent thinking that patients with EUPD need to take responsibility for their own behaviours.

7.1.11 Two changes happened simultaneously which appear to have had a significant negative effect on Adult E's impulsive behaviours. The first was the beginning of an inappropriate relationship by a person in a position of trust (PiPoT). The second followed a conversation with a psychiatrist who, on being informed by Adult E that he was unhappy with the out of area supported living facility staff restricting his movement as he wanted to be able to move around independently and use his time constructively, made it clear to Adult E that he was not under any restrictions. Adult E's mother informed the reviewer that Adult E had believed the boundaries were part of restrictions relating to the Mental Health Act. The boundaries that had initially been agreed between the out of area supported living facility and Adult E, were not maintained as Adult E was no longer happy to do so. Adult E's self-harming behaviours escalated.

7.1.12 Following a serious self-harm incident Adult E indicated to Hospital 3 staff that he would agree to an informal admission. However, when transferred to Leicestershire services, and following further assessment, it was determined Adult E would not benefit from admission. This was in line with NICE guidance[10]. Adult E agreed discharge to a Leicestershire B&B accommodation.

7.1.13 NICE guidance on self-harm[11] suggests all episodes of self-harm require the person to have an assessment of need and an assessment of risk. An assessment of risk was completed but the assessment of need did not take sufficient account of Adult E's living situation, the on-going relationship with the PiPoT, and the increased frequency and severity of self-harm. The guidance states temporary admission

[10] https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#general-principles-for-working-with-people-with-borderline-personality-disorder

[11] https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance#referral-admission-and-discharge-following-self-harm

should be considered following an act of self-harm, for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment.

Learning point: NICE guidance[12] suggests admission to an acute psychiatric unit for a person with EUPD should only be considered after referral to crisis resolution, home treatment team or other locally available alternatives has occurred. Admission should only be considered when

- the management of crises involving significant risk to self or others that cannot be managed within other services, or
- detention under the Mental Health Act (for any reason).

Clinicians also need to consider the patient's circumstance, and environmental factors, before determining if a short admission is the best option. Of interest to the reviewer and in contrast to the NICE guidance on management of patients with EUPD, there is some evidence in recent literature to suggest that longer term integrated inpatient treatment programmes sustainably improve core symptoms, reduce emergency department visits, and prevent readmission.[13][14][15]

7.1.14 Adult E was directed by the GP to register with Inclusion Health however at the time of his death he had yet to register.

7.2 Use of Section 117 (S117) of the Mental Health Act[16]

7.2.1 Adult E had been detained under sections 3 of the Mental Health Act (MHA), this made him eligible for S117 aftercare upon discharge from hospital. S117 places an enforceable duty on the Clinical Commissioning Group (CCG) and Local Social Services Authority (SS) to provide or arrange to provide aftercare services to patients on discharge from hospital.

7.2.2 The duty on the CCG and SS is to ensure the patients after care needs, which have arisen from or are related to the patient's mental disorder, are met. This can be a need for continued treatment for a mental disorder, and/or to prevent a deterioration in a mental disorder reducing the risk of return to hospital. An aftercare service can include services to assist in learning, regaining, or enhancing skills to assist with living in the community such as supported living accommodation, and will last as long as there is a need to be met and until the CCG and LA agree the person no longer needs aftercare services. Such services should be sourced prior to discharge. Robust discharge planning is part of the prevention of future admissions and as such, should commence at the point of admission and consider social risks.

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[12] https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#general-principles-for-working-with-people-with-borderline-personality-disorder

[13] A. Bateman and P. Fonagy, "8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual," *The American Journal of Psychiatry*, vol. 165, no. 5, pp. 631–638, 2008.

[14] F. Lana, C. Sánchez-Gil, L. Ferrer et al., "Effectiveness of an integrated treatment for severe personality disorders. A 36-month pragmatic follow-up," *Revista de psiquiatría y salud mental*, vol. 8, no. 1, pp. 3–10, 2015.

[15] L. M. C. van den Bosch, R. Sinnaeve, L. H.-v. Roijen, and E. F. van Furth, "Efficacy and cost-effectiveness of an experimental short-term inpatient Dialectical Behavior Therapy (DBT) program: study protocol for a randomized controlled trial," *Trials*, vol. 15, no. 1, p. 152, 2014.

[16] Mental Health Act (1983) Section 117

7.2.3 Latterly, had a Section 117 aftercare meeting with all appropriate parties including, health, social care, the supported living accommodation and Adult E and his mother been held, these differences of opinion and differences in service threshold could have been identified and considered on a multi-agency basis, prior to the decision to discharge.

7.2.4 In Adult E's case the lines of accountability and responsibility were unclear; the supported living accommodation continued to communicate with the Leicestershire mental health service MDT long after discharge. Whilst discharge planning appeared robust, Adult E's choice and subsequent move out of Leicestershire impacted on the aftercare plan being followed. The decision by Warwickshire community mental health team that Adult E did not meet their service criteria, meant the plan for continued care by a community mental health team could not be enacted.

7.2.5 It is not clear how in Adult E's case those needs were being overseen. Managers at the supported living establishment were corresponding their concerns on a regular basis with multiple people within the CCG and LA but, due to issues with emails (see section 7.4.2), these were not being acted upon.

7.2.6 Later when Adult E was served notice by his supported living accommodation, the Local Authority made efforts to address this issue (see section 7.4).

Learning point: CCGs, as part of their responsibilities for S.117 must act if there are difficulties' in progressing an aftercare plan. The CCG needs to have clear lines of accountability and responsibility for each person subject to S.117 that are shared with partner agencies. When difficulties arise in providing a patient the aftercare they have been assessed as requiring, due to boundary issues or differences in service criteria, a rapid escalation process needs to be in place so that issues can be resolved quickly with minimal impact to the patient.

7.3 The impact of Covid-19

7.3.1 Whilst at the beginning of Covid-19 the appropriate infrastructures were not in place, services reported that whilst there were lots of challenges in the system, most agencies indicated that practice changed little during Covid-19. The national picture was one of the needs to free up beds and pressure to discharge patients as quickly as possible. There were extra pressures as professionals adapted to new ways of working. Leicestershire Adult Social Care indicated that there was no guidance for practitioners regarding visiting clients or the use of personal protective equipment (PPE). However, during the first lockdown, there was an expectation that practitioners would carry out risk assessments prior to seeing clients face to face, and they were not visiting hospitals. This impacted on the support provided to the hospital with transition planning and developing care plans, and on strategies to manage Adult E's move to temporary accommodation.

7.3.2 The most recent publication by The National Confidential Inquiry into Suicide and Safety in Mental Health, whilst recognising that data collection was suspended during the first few months of the pandemic, indicates Mental Health Trusts identified 133 suspected suicide deaths between 23rd March and the 30th of September 2020. Most were in the community rather than acute or crisis settings and two thirds of the patients who died had reported adverse experiences related to the pandemic, particularly feelings of anxiety, isolation, and loneliness, whilst

over a third had experienced disruption to their usual mental health care,[17] as is apparent in this case. The most common diagnoses of those suspected suicide deaths were affective disorders (bipolar disorder and depression; 37, 28%), followed by personality disorders (22, 17%).

Learning point: Covid-19 added an additional layer of complexity to the already difficult task for the SW to find suitable long-term accommodation for Adult E. Adult E's mental health care was Crisis driven during this time. Agencies now have the infrastructure in place to help keep services running if such a situation were to arise again.

7.4 Accommodation arrangements for Adult E

7.4.1 At the start of the review period arrangements were being made, with Adult E's input, for a move to supported living. Those arrangements took four months to put in place. Initially Adult E was settled in his supported living facility. Adult E started to express a wish for a change of placement in February 2020. At the same time the supported living facility were also expressing their concerns as to whether they could keep Adult E safe. Despite initially refusing to have Adult E back following admission in February when Adult E expressed concern at his homeless status and stated he wanted to return, he was allowed to do so. The supported living facility communicated with the previous MDT, CCG, and commissioners in Leicestershire.

7.4.2 These communications were received but had not been added to the Adult Social Care system, meaning senior managers were not aware of the breakdown of placement and the issue had not been escalated to senior managers. This issue is subject to internal review. Communication between the supported living accommodation and the CCG was via email to multiple people. Unknowingly this was sent to a person on maternity leave. No out of office alert had been set. There was no response from anyone; it may be that they all assumed others were taking care of the concerns. The CCG has now introduced a single point of access where emails are dealt with centrally. This was a missed opportunity for Leicestershire Local Authority Adult Social Care/CCG to take action to assess whether Adult E care needs were being met and whether he was in a placement suitable for his needs.

7.4.3 In March 2020 following admission to hospital Adult E stated he took the overdose to act as a catalyst for him moving out from his current supported living facility and stated clearly and consistently he did not want to go back there. On two occasions he stated he would self-discharge from the ward, and he was frequently off the ward to go outside for cigarettes and to buy alcohol or meet his girlfriend. Adult E expressed concern at being homeless and that his possessions remained at the facility. It is documented Adult E was reassured about not being discharged to the streets and agreed with temporary accommodation pending a social care review. The housing team were contacted, and temporary accommodation was sourced. The initial accommodation subsequently withdrew their offer. A second accommodation was sourced. Social care, GP and Adult E's mum were all made aware of the plan. CCG identified that Adult Social Care would be acting as the main coordinator for Adult E in terms of him accessing community services and support; the CCG role being to support in providing suitable accommodation.

[17] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland and Wales. 2021. University of Manchester.

7.4.4 It is clear frontline professionals were placed in a very difficult situation. The need to find suitable accommodation was foremost in their minds. However, the reviewer is of the opinion that it was an impossible task for the SW to find suitable accommodation immediately. There is a national shortage of this type of provision and all such provisions are duty bound to undertake a thorough assessment of suitability before accepting a new resident. It had taken four months to plan and prepare Adult E placement to the supported living facility; there would be no quick solution. This issue needed to be escalated and managed at a more senior level. Adult E's mother expressed concern about Adult E being discharged to temporary accommodation. The Covid-19 situation was explained which she fully understood. Adult Social Care practitioners understood that as the local Mental Health team were not currently seeing Adult E, this meant his status was 'homeless' so transferring Adult E to temporary accommodation was seen as the best option.

7.4.5 Adult E was placed in B&B accommodation by Adult Social Care, as he was entitled to S.117 aftercare. The Leicestershire mental health service crisis team and Adult Social Care liaised well regarding this. Adult E was offered support from the crisis team during this period, which he superficially engaged with in terms of receiving prescriptions from them; this appeared to be the sole reason for Adult E agreeing to have a service from them. Professionals from the crisis team had multiple direct and indirect contacts with Adult E whilst he was living at the hotel. The crisis team reviewed Adult E's presentation and risk at each contact. The Homeless Mental Health Team did not have input with Adult E during this time, as he had yet to be referred to their service.

Learning point: There was an over reliance on email communication. All suggestions that a person placed in a supported living facility as part of their s.117 after care, wishes to leave that facility or the facility can no longer manage their needs, should be reported to the persons with responsibility within the CCG and Local Authority. If the issue is not resolved this should be challenged and escalated to senior management.

7.5 Response to Adult E abuse by a care worker

7.5.1 The Sexual Offences Act[18] is clear that a sexual relationship between a person with a mental disorder and a person providing care or assistance to the person with a mental disorder, is an offence. The supported living accommodation followed procedures and reported this abuse of power to the Local Authority safeguarding teams, the Police and the Care Quality Commission appropriately. The service took swift action to suspend and then terminate the staff member's contract, informing all the appropriate services of the actions taken.

7.5.2 Adult E was not considered to be being exploited by Warwickshire Local Authority Safeguarding Team or Warwickshire Police. A decision was made to take no further action as both individuals were considered to have capacity and, it was thought, the relationship appeared consensual; one service commented that it wasn't clear who was exploiting who. It is difficult for professionals when an individual is both being abused and displaying abusive behaviours to manage both simultaneously, hence the need for a multi-agency approach.

7.5.3 The lack of a strategy meeting to discuss all that was known, meant the relationship was not considered in the context of what was known about Adult E and the PiPoT.

[18] Sexual Offences Act (2003) – section 38/42

Adult E's care and support assessment included the need to develop and maintain good relationships and an awareness that Adult E was open to influences, substance misuse and criminality. Further exploration might have provided additional information regarding the ongoing nature of the relationship. No plans, either risk management or safety plans, were put in place to address Adult E's vulnerabilities and, as a consequence, partner agencies were not fully considering the impact of this abuse of trust on Adult E's behaviours and any further support needs he might have. As further disclosures were made these were not referred as per procedure.

7.5.4 Adult E's mother reported that this relationship had a profound effect on Adult E. It has been alleged that this member of staff had been supplying and using drugs with Adult E, a known trigger for his violent self-harming behaviours.

Learning point: The case was not managed as per safeguarding procedures by those services that could have taken further action. Those making decisions did not have sufficient understanding of safeguarding in these circumstances. Whilst Adult E might have been able to consent, issues of trust, coercion and control needed greater consideration. All allegations of abuse by a person in a position of trust should be fully investigated on a multi-agency basis and the victim provided with tailored support to meet their needs.

7.5.5 Threats made by Adult E to kill the PiPoT and other offences led to Adult E being arrested. On this occasion, to comply with the provisions of PACE, Adult E was assessed in custody to establish if he was fit to be detained and interviewed by health care professionals. Adult E was interviewed and released on police conditional bail. Due to concerns around Adult E's mental wellbeing, whilst he was in custody, Leicestershire mental health services were contacted and they offered for Adult E to be assessed at the Leicestershire in-patient mental health unit, which was facilitated with Adult E's consent.

7.5.6 Adult E answered his police bail, but no further action was taken regarding the threats to kill and harassment as the PiPoT had withdrawn her complaint.

7.5.7 The panel discussed how patients become managed within forensic mental health services. How they are generally (but not always) subject to mental health or criminal justice legislation following a serious offence. Apart from bail conditions for a more minor offence of criminal damage, Adult E was subject to neither. For many offenders with mental health diagnoses, this means being detained in hospital or being subject to compulsory measures in the community. Where mentally disordered offenders have committed serious offences and/or pose an ongoing risk of serious harm then they may also be placed on Restriction Orders by the courts. It is clear that the period when Adult E 's mental health was most stable was when he had a framework around him with boundaries that helped him control his behaviours. The decision to take no further action in this case was purely down to a lack of evidence but may have prevented a structure that could have been helpful to Adult E and reduced subsequent frontline officers and mental health colleagues understanding of the seriousness of the offences committed. Adult E was charged with criminal damage and bailed to appear at Magistrates Court at a later date

Learning point: The unintended consequence of a decision to take no further action or divert people with mental health disorders from the criminal justice system, is that this may reduce their eligibility for forensic services and may have

implications that mean further down the line, certain disposals/outcomes/orders are not available to that individual.

7.6 Consider services response to family members concerns

7.6.1 Services noted Adult E had not seen his mother for a number of years; whilst this is accurate this does not give a true representation of their relationship. Adult E's mother was in almost daily contact with her son and was making great efforts to act as an advocate for Adult E. The lack of direct face to face contact with Adult E's family impacted on some professionals thinking and considering this as a significant relationship. The reasons for Adult E's mother not visiting were not explored and were largely not understood.

7.6.2 Adult E's mother made multiple telephone contacts to the Leicestershire mental health service crisis team, to which they responded appropriately and shared relevant information, with Adult E's consent. There is also evidence in the notes that the crisis teams also involved Adult E's mother via telephone calls to update her about his care and treatment plan. It is documented that Adult E and his mother had not had face to face contact for 9 years, therefore, it is appropriate that the Crisis Team had only telephone contact with her. There is evidence that the Crisis Team consultant discussed the pros and cons of admission with Adult E's mother, and it is documented that ultimately, she agreed that inpatient admission was not beneficial for him. Mother indicated to the reviewer that this is not her recollection and that she was of the view Adult E required admission and possibly under the Mental Health Act. Mother was of the opinion that B&B accommodation was better than Adult E being on the streets.

7.6.3 There is some evidence to suggest that Adult E's mothers' concerns influenced the decisions made by professionals. On one occasion Adult E was supplied with one week's supply of medication rather than the planned month's supply, as mother had indicated Adult E was likely to overdose. However, latterly, when Adult E's mother indicated that he was at significant risk of killing himself through overdose and self-harm if he was discharged to B&B accommodation, this did not result in alternative accommodation being sourced or an admission.

7.6.4 The last Social Worker involved stated that he had a lot of contact with Adult E's mother but had reflected that this was of a practical nature, such as trying to get Adult E registered with a GP and sorting benefits arrangements. The Social Worker would contact Adult E's mother when they could not make contact with Adult E, and she was also trying to resolve issues with all agencies separately. There was recognition of the need to focus more on the emotional impact of the situation on her. The pressure to find appropriate accommodation and support for Adult E was understandably the Social Worker's focus.

Learning point: Over the review period, there was limited consideration of the impact of trying to advocate for and support Adult E on his mother. Mother was providing Adult E with emotional support to help him cope with the symptoms of his mental illness. Mother informed the reviewer that she had never had a Carer's assessment and had received no offer of additional support. Carers have a right to an assessment and should receive additional support if necessary. Carers should be supported to stay strong and healthy whilst fulfilling their carer role. Further education and understanding of the role of a Carer is required across the partnership and communities.

Learning point: Throughout the review period, when decisions are being taken regarding individuals during self-harm episodes, professionals need to be cognisant of the views of those people, both family members and professionals, who know the person best. Assessments completed on an individual in isolation can be manipulated by individuals who know the system well. Whilst mental health assessments are by their very nature an assessment at a point in time, they need to consider contextual information to inform their decisions.

7.7 What services are available locally and nationally for those with Emotionally Unstable Personality Disorder.

7.7.1 It is recognised both locally and nationally that there are insufficient services for all mental health conditions. EUPD is a particularly difficult condition to manage and until recently this has not received sufficient attention. Nationally and within Leicestershire, historically, there was a reconfiguration of services which had a significant impact on the therapeutic offer in Leicestershire. Adult E was not accepted by the only therapeutic service available as he did not meet their criteria; he fell through the gaps between services. Currently within Leicestershire there are changes being made to the care and treatment model for patients with severe and complex EUPD.

7.7.2 Recent thinking through SARs and within research suggests there is a need for specialist services for those with EUPD but nationally currently there are only two specialist National Health Service (NHS) personality disorder units in the UK, with much of the provision for patients with EUPD being provided by the private sector with a lack of evidence of their effectiveness. Overall, there is insufficient provision to meet demand with inevitable high threshold of acceptance and waiting lists. A very recent study by Henry et al. (2021)[19] suggests that a one-year structured inpatient programme in an NHS specialist unit can be transformative in the recovery of EUPD patients with complex needs and ultimately reduce healthcare dependency. Further research is likely to be needed.

7.7.3 Dialectical Behavioural Therapy (DBT) has been found to be effective in the management of EUPD however this was not part of Adult E's care plan as Adult E was not deemed to be able to engage in psychological therapies at that time. Access to such treatment is subject to waiting lists and acceptance. An individual would need to be in a stable enough position to engage in psychological therapies.

7.7.4 Locally PD pathways have been developed and out of hours services and transitioning have been strengthened so crisis services become more accessible.

7.7.5 Within Warwickshire there is an IPU 3-8 service for people with anxiety, depression and EUPD which supports them to manage their behaviours and help regulate their emotions. Treatment may be short or longer term, but treatment requires the person to be 'ready' to engage and be motivated to change. Adult E was seen by this service on one occasion. Adult E expressed that he did not want support from this service. At that time, he was described as having a stable mental state, had no plans to harm himself, was displaying no psychotic signs and was compliant with medication, suggesting this would be an optimal stage to engage in therapeutic interventions. A decision was made that he did not warrant input from secondary

[19] Jessica Henry, Eddie Collins, Amanda Griffin, Jorge Zimbron, "Treatment of Severe Emotionally Unstable Personality Disorder with Comorbid Ehlers-Danlos Syndrome and Functional Neurological Disorder in an Inpatient Setting: A Case for Specialist Units without Restrictive Interventions", *Case Reports in Psychiatry*, vol. 2021, Article ID 6664666, 6 pages, 2021. https://doi.org/10.1155/2021/6664666

mental health services. Contact with his supported living facility to further inform the assessment might have provided a different picture.

Learning point: Locally and Nationally there is a shortage of provision for patients with EUPD who self-harm. Lack of treatment to address the triggers for acute episodes, and a lack of joint approach, is reducing the potential for such patients to move forward and lead normal lives.

8. Multi-Agency Recommendations

Recommendation 1: Leicestershire & Rutland Safeguarding Adults Board to seek assurance that all mental health assessments are taking into account NICE Guidance, the patients' environmental factors, and the views of parents/advocates for the patient before decisions on whether to accept for treatment are taken.

Recommendation 2: Prior to placing a person subject to s 117 aftercare out of area, the Local Authority and Clinical Commissioning Group need to assure themselves that the patient will be provided with, and receive, the treatment they are assessed as requiring, as outlined in their mental health discharge plan, making it safe to do so.

Recommendation 3: The Local Authority and Clinical Commissioning Group to review the lines of accountability and responsibility in relation to Section 117 of the Mental Health Act to ensure they are compliant. The Local Authority and Clinical Commissioning Group to introduce a rapid escalation process to address issues relating to their aftercare responsibilities.

Recommendation 4: Leicestershire & Rutland Safeguarding Adults Board to seek assurance that the Police have systems in place that identify when a serious offence has occurred that has resulted in no further action or has been diverted this is easily identified, and that when no further action is taken or a case is diverted from the criminal justice system, there has been full consideration as to whether restriction orders might have been of benefit in the case. Leicestershire & Rutland Safeguarding Adults Board to share this learning with the Home Office.

Recommendation 5: Warwickshire Safeguarding Adults Board to update their procedure and training to provide direction to and upskill its frontline workers, to recognise and respond to situations where there has been a breach of a position of trust, as a safeguarding issue.

Recommendation 6: Leicestershire & Rutland Safeguarding Adults Board to seek assurance that a process is in place that will ensure that all family members who are advocating and supporting a family member either physically or emotionally are being offered a carer assessment.

Recommendation 7: Leicestershire & Rutland Safeguarding Adults Board to seek assurance that the views of family members supporting and advocating for a person are being fully considered in assessments of mental health.

9. Conclusion

Adult E was in his mid-thirties when he died of heroin toxicity. Adult E was diagnosed with EUPD, a mental health condition, in his early twenties. Adult E was an intelligent man who, following discharge from a Leicestershire Mental Health facility, was trying to move forward with his life, enrolling on courses and articulating goals; he was much loved and well supported emotionally by his mother. Adult E's condition meant that he expressed his distress through his

behaviours which were, at times, extreme, leaving him as a risk to himself and to others. Managing and caring for a person with EUPD presents challenges for professionals due to the persons rapidly fluctuating mental state and associated behaviours. It should be acknowledged that those behaviours can evoke feelings of fear, powerlessness, and anxiety amongst professionals. Adult E benefitted from structured support. The inappropriate, abusive relationship in the months prior to Adult E's death, coupled with an increased use of substances, and a reduction in Adult E's acceptance of structured support, appears to have negatively impacted on Adult E's mental health. Whilst the professionals directly involved with Adult E's demonstrated care and empathy towards Adult E, cross boundary issues including differing thresholds, resource issues, and breakdowns in communication led to Adult E being effectively homeless, however he was temporarily placed by the Local Authority in B&B accommodation. This, coupled with Covid-19 restrictions, brought an extra layer of complexity to an already complex situation, in the weeks leading to Adult E's sad death.