Safeguarding Adult Review – Lisa

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Executive summary

Lisa was a 43 year old white British woman who completed suicide by hanging in April 2023. She had been known to Mental Health services since 2007 and had a history of substance use disorders and epilepsy. A note that she left, and her reports in the last weeks, suggest that her life had become intolerable because of demands for money from drug dealers.

A Section 44 referral for a safeguarding adult review (SAR) was submitted as a result of concerns about whether agencies acted in a timely manner to provide a safe service, and whether there was a wider public interest in communicating with relevant statutory agencies, particularly the Police.

Nothing suggests that there were any problems in the clinical management of her mental health conditions or the epilepsy. The central questions are:

- Were safeguarding processes pursued appropriately?
- Were her drug and alcohol use disorders addressed?
- Was risk identified and managed?

Sub-themes about the management of people that services find difficult to engage and the use of multi-agency approaches are also covered.

Safeguarding

A Section 75 agreement is in place between the Mental Health Trust and the Local Authority, this means that much of the safeguarding process is internal to the Trust. The information received from the Mental Health Trust suggested a number of areas for review:

- Were safeguarding concerns raised by agencies (not just the Mental Health Trust) at appropriate points in her care?
- Was her presentation as someone who was being exploited as a result of drug use seen as a safeguarding issue?
- Is the process of safeguarding within the Mental Health Trust straightforward for staff?
- Can the Local Authority carry out their statutory responsibility and track all safeguarding concerns?

Safeguarding by other means

A particular point of concern is that Lisa was living in fear of drug dealers using violence to extort money from her. How can a vulnerable person in that situation safely report concerns to the authorities without risking violence from the dealers? This is a question that should be given careful consideration.

Drug and Alcohol Use Disorders

The review highlights the need for all agencies to be using robust drug and alcohol screening tools to ensure that alcohol and drug-related risk is identified at the earliest point.

Lisa would have benefited from contact with Drug and Alcohol Services. However, the prevailing model was that the individual needed to be motivated to engage, Lisa

was not. She would have benefited from an assertive outreach approach which would have attempted to build a relationship with her in order to understand what lay behind this refusal of care. For this more vulnerable group, professionals need to move beyond the expectation that clients will engage with them and move towards recognising that efforts will need to be made to engage them.

The Mental Health Trust has a co-occurring conditions (mental health and substance use) service. Lisa might have benefited from this service. This is probably because this service has very limited resources. This raises the question of whether its role needs to be extended to cover people like her.

Risk

A significant concern is how agencies assessed the risk of harm (including self-harm) to Lisa, particularly in the last month of her life. One concern is that the Mental Health Trust's "zoning" and other considerations of her risk varied, at times significantly, from day to day. The level of risk with someone like Lisa simply does not change that quickly and even if it appears to have changed on the surface, the underlying risk is very unlikely to have changed. As a result, a review of these risk assessment processes seems to be required.

More generally, it was commented that: *many referrers are not trained to risk assess or produce a quality referral report.* Therefore, these comments about risk assessment and risk management could be considered across the partnership.

Multi-agency management

A clear finding was that Lisa would have benefited from regular multi-agency discussion. This could be addressed in a number of ways; but whichever way this is approached, clients like Lisa would benefit from a group that can step back from the day to day interventions and see the overall picture of the problems she presented and consider ways in which these could have been better addressed.

People that services find difficult to engage

Practitioners often found Lisa difficult to engage in services. This highlights the need for individual professionals to have training to support a specific focus on engagement. At the organisational level, it highlights the need for a published, multi-agency procedure to guide professionals in dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

Recommendations

The report has eight recommendations covering the following themes:

- Recommendation A - reviewing safeguarding processes

- Recommendation B – the use of drug and alcohol screening tools

- Recommendation C - assertive outreach capacity in the adult drug and alcohol treatment system.

- Recommendation D - an expansion in the capacity and role of the local co-occurring conditions service.

- Recommendation E - a review of risk management systems and the provision of training

- Recommendation F - guidance to professionals on how to respond to vulnerable individuals whom agencies find difficult to engage.

- Recommendation G – escalation pathways.

- Recommendation H - considering how vulnerable people can most safely report concerns about threats from criminals.

1. Introduction

Lisa was a 43 year old white British woman who completed suicide by hanging in April 2023. She had been known to Mental Health services since 2007 and had a history of substance use disorders. A note that she left, and her reports in the last weeks, suggest that her life had become intolerable because of demands for money from drug dealers.

A Section 44 referral for a safeguarding adult review (SAR) was submitted by NHS South East London Integrated Care Board as a result of concerns about whether the agencies concerned acted in a timely manner to provide a safe service, and whether there was a wider public interest in communicating with relevant statutory agencies, particularly the Police.

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The Safeguarding Adults Board (SAB) agreed that the case highlighted a number of areas of potential learning, and decided that that a SAR should be undertaken and should consider a period from April 2021 until Lisa's death in April 2023.

2. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- To review the effectiveness of procedures both multi-agency and those of individual agencies.
- To inform and improve local inter-agency practice.
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- To improve practice by acting on learning.

There is a strong focus on understanding issues that informed agency/professionals' actions and what, if anything, prevented them from being able to properly help and protect Lisa from harm.

3. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of over twenty-five SARs as well as drug and alcohol death reviews, domestic homicide reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly

on developing responses to dependent drinkers that services find difficult to engage. Mike was assisted by Jane Gardiner who is being mentored to write SARs. She has a background in working with Alcohol Use Disorders, Domestic Abuse and Professional Boundaries.

4. Methodology

A multi-agency panel of the Greenwich Safeguarding Adult Board was set up to oversee the SAR and commissioned the author to complete the review. Initial information was sought from agencies involved with Lisa by requesting chronologies.

The following agencies were involved in the process:

- Royal Borough of Greenwich Occupational Therapy Services
- NHS South East London Integrated Care Board
- Metropolitan Police
- Oxleas NHS Foundation Trust (Mental Health Services)
- Lewisham and Greenwich NHS Trust (Acute Services)
- London Ambulance Service
- Southern Housing Association

Agencies were then asked to submit Individual Management Reviews (IMRs). Some of the information provided included information from outside the review's time period enabling a fuller picture of Lisa to be developed. All of the material was analysed by the authors and an initial draft of this report went to the Review Panel in August 2023. Further changes were made over the next two months, and a final draft was completed in September 2023.

5. Family contact

An important element of any SAR process is contact with family. Lisa had two daughters; however, they did not respond to contact and it has not been possible to engage them in this review.

6. Parallel processes

There were no Police inquiries that coincided with the review. However, the Coroner's verdict was still awaited at the time of writing.

7. Background and personal Information

Lisa was born in Greenwich and her parents separated when she was still young. Her father had long-term mental health problems and a serious alcohol use disorder. She was expelled from secondary school twice and left at 16 with no formal qualifications.

She worked for a brief period, but had been unemployed since 1997 and living in social housing since 1998. She had two adult daughters and was living alone at the time of her death.

She had a long history of contact and involvement with the Police as victim, perpetrator and witness. This covered a wide range of incidents including childcare problems, aggression to others and being the victim of crime. The vast majority were long before the review period and over time she became more likely to be a victim of crime rather than a perpetrator. Between 2004 – 2021 Police Officers also submitted approximately 25 Merlins[1]. Two were submitted during the review period.

Lisa was known to Secondary Care Mental Health Services from 2007 and had diagnoses of depression, mental and behavioural disorders due to use of cocaine / harmful use, and emotionally unstable personality disorder. As a result of the personality disorder, services found her difficult to engage and she found it difficult to trust people. She had six mental health inpatient admissions from 2010 to 2020 and there were several attempts to end her own life.

In the period from 2015 to March 2023, Lisa was receiving support and input from the Mental Health Trust's specialist team on anxiety, depression, personality disorders and trauma, ADAPT, through care coordination and outpatient reviews. Lisa's father died in 2016 and one of the IMRs asked whether this was a significant factor in her decline. Her last inpatient admission was in January / February 2020; this was following an attempt to hang herself from a tree in a park using a dog lead: prefiguring her eventual death.

Lisa also had a history of alcohol and illicit substance misuse from at least 2008 until 2023. Over the years, Lisa reported taking ecstasy, cocaine, LSD and cannabis. Heavy alcohol use was also reported and prior to the review period appears to have been the more commonly mentioned problem. However, she was never in contact with Drug and Alcohol Services.

The Ambulance Service had three contacts with Lisa during the review period, two of these were for suicidal ideation / overdose and the last was the call to her death. Three calls were identified outside this period following reports of Lisa drinking excessively and again expressing suicidal ideation or overdosing.

She had eight A&E attendances from 2019. These were usually associated with mental health crises; however, seizures were also a factor. As a result, she was followed up in a Neurology Clinic to explore whether she had epilepsy. Some seizures were reported to be definitely related to alcohol and substances; but it was not possible to know if a number of the seizures were due to epilepsy because Lisa was never able to abstain, and investigations such as EEGs were not completed. The Neurology Team were of the view that Lisa's history was strongly suggestive of epileptic seizures.

[1] Police reports of concern about vulnerability

Despite these complexities, she had a stable home in a social housing flat. Her housing provider had only two specific concerns reported about her, one from before the review period, another from the very start of the period. In January 2020, an anonymous man was reported to be living at the property with a dog and not picking up its mess. In April 2021, fly tipping was reported by a neighbour; an external contractor had to be sent to clear it up.

In November 2019, Lisa self-referred to the Local Authority's Occupational Therapy and Sensory Service (OT). Lisa was described as having arthritis, depression and increased body weight which adversely impacted her level of function i.e. being able to manage personal care and mobility. She had had a recent fall due to poor mobility on stairs. A problem focused assessment was undertaken by phone and in person which offered both interim assistive equipment and support with possible rehousing.

She was assessed again in November 2020 and reported that she was unable to access the bath safely and had experienced falls at the top of her stairs. She also reported mental health diagnoses, seizures and that her health impacted on activities of daily living. She said that she had been sectioned under the Mental Health Act in 2020 and while an inpatient had assaulted another patient on the ward. She had past feelings of paranoia/anger and frustration about 'people' and a preference not to socialise with other people. It was therefore agreed that OTs would visit Lisa in pairs.

There were a series of contacts with Lisa over 21 months until August 2021 and coinciding with the Covid lockdown. This culminated in her changing her mind about, and declining, the OT's recommendations and the case being closed. In the next 12 months there was no reported contact with services other than a neurology clinic appointment.

In September 2022, a more chaotic period seems to begin, which culminated in her death seven months later. A police report of burglary was filed by Lisa as someone borrowed her Dyson hoover and, she believed, sold it for cash. This same incident was referenced by the Mental Health Trust in October 22 as '*Lisa unhappy about a friend of a friend who had borrowed her hoover without returning it'*.

In November 2022 Lisa told Mental Health Trust staff over the phone that "*she had fallen out with her friend who is using heroin. Lisa had been going to pick up heroin for her. Lisa took her to a "good friends" house and the woman stole £1,200 worth of clothes from her* (the dealer)*."* The staff member told Lisa that "*another patient had arrived so said she would call Lisa back. Lisa told CCO*[2] *not to bother and hung up. Call back attempted with no response*."

Lisa had been on a regular depot injection for many years. This was to help with aspects of her personality disorder rather than to treat psychosis. In late January 2023, the Mental Health Trust made – "*four attempts … to remind Lisa of her depot. Last attempt connected and Lisa said she had given her freedom pass to her friend*

[2] Care Coordinator

so could not come in." Mental Health Trust staff commented on this and said that at this period Lisa *"wasn't keen on engaging with Mental Health services so was distant at times. She wasn't very 'open.' She was always 'busy', would attend for her depot injection but wasn't keen to stay. She'd receive phone calls that she seemed wary of and was often in a hurry because someone was waiting for her in a car. In recent times there was an increase in her rushing off and not wanting to talk."*

In February 2023, she asked to be taken off the depot because of its effects on her. This was viewed as a capacitous decision, and she was helped to come off via a prescription of an oral anti-psychotic. However, there was concern at the Practitioners' Event that this may have been a key change. The view at the event was that she became more challenging to manage following this decision. This appears to be reflected in the notes.

However, at this point, staff were also worried that Lisa's dog was very ill with cancer, and she had said that she would end her life if the dog died. She considered the dog to be a key protective factor.

On 19 March 2023, Lisa attended Hospital following an overdose on multiple medications. Her friend contacted the Ambulance Service, and she was taken to Accident and Emergency.

She was reviewed in the early hours of 20 March 2023, by the Mental Health Liaison Team (MHLT). Lisa reported that she owed a drug dealer £800, and they were threatening her for the money. She was advised to contact the Police. Lisa reported that she would be killed should she contact the Police, and she felt overwhelmed and stressed with her situation. Therefore, she took the overdose with the intention of ending her life. Lisa reported that she felt low, depressed with psychotic symptoms, which included paranoia. She stated that she felt hopeless, worthless and she was having poor concentration, lack of motivation and low self-esteem. She reported: *'I have had enough, and I can't see any way out of this, I am going to end it all'.*

Following the assessment, she was discharged to the Mental Health Trust's Home Treatment Team (HTT) between 22 March and 18 April 2023. During this period, Lisa spent time in a Crisis Recovery House for respite and support. This facility is described as providing a safe, homely alternative to psychiatric inpatient admission; aiming to prevent unnecessary inpatient admission, reduce distress and anxiety and enhance wellbeing.

During an initial review with a Psychiatrist on 23 March 2023, she reported that her symptoms of suicidality were linked to the threat from drug dealers. It was recommended that a referral to Drug and Alcohol Services be completed; however Lisa was adamant that she did not want their input.

Lisa was again reviewed on 27 March 2023. During this review she reported that she had paid half of what was owed to the drug dealers, and that she would pay off the

remainder when she was next paid. Lisa reported that she was *'now better'*, and she wanted to go home to *'sort out some things'*.

Home Treatment Team input continued upon her discharge from the Crisis Recovery House and she reported that she continued to owe money to drug dealers. She was advised to contact her care coordinator in the ADAPT team to discuss her financial issues and she was given food vouchers.

Around this time, it was planned to refer her to a Housing Service that works to find people permanent and affordable social housing. It was hoped that Lisa would leave her local accommodation and move to Bermondsey to be away from the dealers. However, these plans were not followed through.

On 3 April, she attended A&E feeling suicidal. She told an Acute Trust clinician that she may get *'chopped up'* and is frightened to go home; they contacted the Police.

The same day, a further review was conducted by Home Treatment Team, however on this occasion, she was accompanied by two unknown men whom Lisa called 'friends'. One of the men went into the meeting room with her and it was noted that he did most of the communication, reporting that there continued to be a debt. It was suggested that the Police should be contacted, however Lisa was adamant that she did not want to contact them, as this could put her further at risk.

On 4 April, Lisa attended Hospital due to depression and suicidal thoughts, expressing a sense of insecurity and a fear of being pursued by others. Lisa was subsequently placed in the Mental Health Act Assessment area and later transferred to the Crisis Recovery House again. While there, Lisa received regular face-to-face reviews from Home Treatment Team.

On 6 April, the ADAPT team on contacted Lisa. She reported that a 'friend' had allowed others into her home, and they stole her clothes, her TV was broken and there was urine and faeces in her premises. She stated that she had allowed another 'friend' to use her bank card and now she was in debt.

The next day, Lisa reported that she was not looking forward to leaving the Crisis House and she felt in danger, and she could not return to her home address. She requested an extension of her stay for another three days to enable her to sort out accommodation.

Lisa agreed to be discharged from the Crisis House on 9 April. During a discharge meeting, she continued to talk about individuals that wanted money from her. She was advised to contact the Police; however, she remained adamant that she did not want their involvement.

On 12 April, the Mental Health Trust reported that "*Lisa picked up the phonecall and spoke in a low tone of voice. Living at friend's house due to fear of drug dealer who*

still thinks that Lisa owes him money." The next day "*Lisa said she is staying with a friend as too scared to return home. Lisa ended the call suddenly saying she had to use the toilet. Called back later. Lisa is hoping to move to a new property."*

On 14 April, the Home Treatment Team contacted Lisa via telephone; she reported that her situation remained the same in that she owed money to drug dealers. She denied suicidal ideation and reported that she was compliant with her medication regime. Lisa's risk zoning was noted to be 'Green'.

On 18 April, she was "*Staying at a friend's who is quite supportive".* The next day she said*:* '*she is afraid to go home due to drug user threatening her. He is demanding £400 from her and she has already paid it. Advised to contact police as she is being threatened but Lisa refused due to possible repercussions. Staying at friend's house...*'

On 19 April, Lisa attended her scheduled Outpatients appointment with the ADAPT team, also present was a friend of Lisa and her Care Coordinator. Lisa reported that her main issues related to her accommodation and her financial situation. She denied alcohol and substance use and denied any active suicidal ideation, despite fleeting suicidal thoughts.

The Mental Health Trust raised a safeguarding concern on the grounds of financial abuse. A safety plan was put in place (to stay with her friend). It was decided the same day that the concern met the threshold for a Section 42 enquiry under the Care Act because she: *"has a history of illicit substance misuse, she denies any current use, and has paid £400 to a drug dealer owed, they are asking for further £400, and may have cuckooed her flat, she remains vulnerable threats of harm & cannot return home."* The plan was to refer her to the Problem Premises Panel; contact her Housing Association and maintain weekly contact.

A letter from a doctor at ADAPT was sent to her GP on 19 April. It began by describing the following diagnoses:

- *Mental and behavioural disorders due to use of cocaine harmful use*
- *Emotionally unstable personality disorder, borderline type social personality traits*
- *Back pain, seizure disorder, chronic kidney disease*
- *Unemployed*

Medication: clonazepam, pre-gabalin, dihydrocodeine, amitriptyline, aripiprazole

Lisa attended for the booked medical review appointment with X one of her (male) friends and he and the CCO accompanied us with her consent. As she came to the centre 30 minutes late, it was a quick review. She reported that she's doing okay in general. Her sleep is a regular, mood is normal. Her main issues are related to her accommodation and financial situation. . She informed us that she doesn't want to use trazodone as it does not work.

She denied drinking alcohol and using illicit drugs but smokes 15 cigarette rolls a day. She denied any active suicidal plans despite having fleeting suicidal thoughts

Risk assessment
Risk to self: low
Risk from others: low
Risk to others: low
Risk of health: low to moderate due to poor self-care
Risk of alcohol and substance misuse: low to moderate
Risk of non-engagement: moderate
Safeguarding concerns currently none

Mental health capacity - she demonstrated good capacity to assessment and treatment. She was able to express her emotions, opinions, concerns, needs, values, and consent in detail and was able to understand and retain the information provided regarding the decision-making process of her treatment plan.

However, on the 20 and 24 April, ADAPT held two multi-disciplinary team meetings, it was noted that Lisa was categorised as 'Red' on the "zoning" risk management system and the plan was to make contact with her.

On 27 April, the Care Coordinator attempted to contact Lisa via telephone, however there was no answer. One of her daughters was contacted, and she said that Lisa had completed suicide by hanging herself in nearby woods using a dog leash. She left a note which read: *"I have done this because a drug dealer is demanding another £800.00 from me. His name is (*name*) and is based at (*address listed*). I am also dead because all my friends take the piss. Had enough of my life, I'm in a better place now. Tell my (daughter) I love her and will be looking down on her from a better place. My name is xxx and my DOB xxx. Bye cruel world. Please take my* (dog) *to get put to sleep so he will be with me."*

8. Analysis

Lisa's life, and the care provided, highlight a number of themes that will be explored in this report.

- Safeguarding
- Risk assessment and management
- Responding to drug and alcohol use disorders / co-occurring disorders
- The consideration of residential options
- Multi-agency management
- The impact of Covid

9. Safeguarding Lisa

9.1 The Section 75 agreement

The central question for this review is whether appropriate steps were taken to safeguard Lisa?

A Section 75 agreement[3] exists between the Local Authority and the Mental Health Trust. This means that, for Mental Health Trust clients, the safeguarding process is internal to the Trust. This is supported by the secondment of Adult Social Care staff to the Mental Health Trust. The author of this review has written two other SARs on areas with a Section 75 agreement and, in both cases, the recording of the safeguarding process was unclear and did not allow the local process to be easily tracked. This means it can be challenging for the Local Authority to oversee the safeguarding process for which they retain statutory responsibility.

However, Mental Health Trust staff were very positive about the impact of the agreement. One said: *"We work across three boroughs. All these boroughs accept our safeguarding process. We constantly apply ourselves to the principles of integrated working across the mental health service. Local authority social workers are placed within our teams. This is valued. The section 75 works well to have one over three boroughs and we report on everything we do."*

This chapter of the report will explore the safeguarding process. This does not mean that Lisa could have been prevented from taking her life if either process or recording had been clearer. Nor does it mean that no steps were taken. It is also acknowledged that safeguarding is always challenging when services find people, as was the case with Lisa, difficult to engage in the process. However, a lack of clarity in the process is something that needs to be carefully considered.

9.2 Does Lisa have care and support needs?

For a safeguarding concern to be raised there had to be cause to suspect that she had care and support needs. Drawing on the list of care and support needs on the local authority's website[4], she is probably unable to:

- *Use her home safely*
- *Maintain a habitable home environment*
- *Develop and maintain personal relationships*

In addition, she is clearly unable to manage her money safely.

There may have been subsequent debate about whether she did meet these criteria. Nonetheless, the requirement for submitting a safeguarding is that there was

[3] Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

[4] Request a care assessment for adult support | Adult support services overview | Royal Borough of Greenwich (royalgreenwich.gov.uk)

"reasonable cause" to suspect that she had care and support needs. This appears to be the case with Lisa.

9.3 Is she at risk of abuse, neglect or self-neglect?

The second requirement for a safeguarding concern is that she is "experiencing, or is at risk of, abuse or neglect".[5] However, there appears to be doubt about whether this applied to her on the part of some staff.

The Mental Health Trust IMR states that: '*In situations where someone cannot be seen to have been coerced, abused or neglected and had capacity to purchase drugs knowing the likely consequences of not paying would not in general fall under the safeguarding remit and the SGA decision form completed by the SAM later in April confirms no abuse and neglect to Lisa. When staff are aware of threats of the kind made to Lisa, we would see this as a criminal matter and not one where the SGA process could be used effectively, the correct advice was given to contact the police which Lisa refused to do'*

It is difficult to reconcile this comment with some of the things that were being said by Lisa. The Mental Health Trust's chronology records that:

- 20 March 23 – Lisa was scared to go back home because drug dealers were threatening her. *'Feeling suicidal'.*
- 21 March 23 – Someone had fraudulently used her bank cards.
- 2 April 23 – '*Owed a drug dealer £400 by tomorrow or it will double to £800. Thinks she would be better off dead.'*
- 6 April 23 – She had given her house key to a friend who allowed others into her home. She had clothes stolen, a TV cracked, house soiled with urine and faeces. She informed Recovery House staff that she was unable to return home due to the risk posed by the drug dealers. She threatened to go to the woods to harm herself if discharged.
- At various subsequent points she reported that she was of no fixed abode as she was too scared to return home.

During this period Lisa also told Acute Trust staff that she feared being *"chopped up"* by drug dealers. It may well have been useful to report this situation to the Police, that does not mean it should not also be a safeguarding concern. Indeed, raising a safeguarding concern may have been a safer and more effective way of considering how to involve the Police given Lisa's, probably very realistic, fears about contacting the Police.

Very specifically, the situation in which Lisa is accompanied to a health appointment by one or two unknown men could also have been the trigger for a safeguarding referral. The Mental Health Trust's Root Cause Analysis report highlights this as a point for further investigative action and this incident was a key concern for the ICB in

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

their section 44 referral. More fundamentally, it cannot be good practice to allow unknown men to "chaperone" anyone, let alone a woman with a history of abuse, to a health appointment.

9.4 Was a safeguarding concern raised?

The key question is whether a safeguarding concern was raised in March/April 2023? The very fact that the answer to that question is not a simple "yes or no" must suggest a need for review of processes under the Section 75 agreement.

The Mental Health Trust RCA report lays the situation out in some detail: *The panel located a document named 'Rcvd Safeguarding Adult Referral safeguarding' dated 21st March 2023, this document revealed a summary of concern as follows: 'Lisa has reported that she took overdose to escape drug dealers. Reported that drug dealers were occupying her house and demanding £800. Patient has refused to report the matter to the Police.'*

A further RiO entry dated 24th March 2023 completed by ADAPT administrative staff reports that a 'safeguarding referral was uploaded in RiO documentation and forwarded to ADAPT (staff member)...'

This form was incorrectly completed, and a Safeguarding Adult at Risk part 1 form should have been completed in its place. Following part 1 completion, the referring team should send the document to a Safeguarding Adult Manager to start the safeguarding process.

The panel asked if (the staff member) received the 'Rcvd Safeguarding Adult Referral safeguarding' document mentioned in the RiO entry... They confirmed that the document had not been forwarded to them and they were unaware that safeguarding was considered around 24th March 2023. However, they clarified that ADAPT was fully aware of the patient's situation and that CRHTT were providing input at that time. Therefore, they believed it was CRHTT's responsibility to complete a referral. The panel asked if there was a consideration to complete a referral on 6th April 2023, whereby ADAPT contacted Lisa. Lisa reported that her 'friend' allowed others into her home, and they stole her clothes, her TV was broken and there was urine and faeces in her premises…the staff member again reported that this fell upon CRHTT to complete the referral.

Separately, the Mental Health Trust chronology notes that:

- 24 March 23 – Recovery House notes document *'Safeguarding referral uploaded -unclear who this has been sent to'*.

The Mental Health Trust's IMR report comments on this: "*the information in RIO was an email that was cut and paste into a word document and saved in clinical documents but had no information included from the sender, these emails can be how the trust*

receives information from other partners such as LAS[6] or acute trust's and it is suspected from the details provided that this was from LAS, (NB this does not seem to be the case)*… The process should be that information in the referral email is reviewed by the team but would not be an automatic raising of a SGA concern on RIO. The trust flow chart for action would have the team review the third-party info first, this was not completed at the time but may have been impacted by the referral going to the ADAPT team while Lisa was under CRHTT at that time. Notes do show that staff were fully aware of the situation that Lisa was in during March and that was why she went to the crisis house, for her to feel safe and recover from the overdose."*

None of these quotations suggest a simple or clear-cut safeguarding process. It is positive to note that the RCA report recommends that:

- *Safeguarding awareness needs to take place to ensure that staff are aware of their roles and responsibilities in relation to adult safeguarding*

and that the IMR states that:

- *We will continue to raise the profile of safeguarding adults with our staff and supporting them with client safety especially when working with complex cases. We will do this through our SGA hubs that we hold monthly in each borough where staff can bring cases for review by senior trust staff.*

Safeguarding concerns are mentioned at other points. The Mental Health Trust Chronology '*Noted that (on 6th April) the mental health liaison team have raised a safeguarding alert.* It is unclear what became of this referral.

On 19 April, the Mental Health Trust chronology states 'Safeguarding Part 1 completed' at the end of an entry regarding a telephone call with Lisa. The chronology states separately for the same day '*Section 42 safeguarding enquiry required. CCO to refer case to the problem premises panel. Mattress has been observed on the floor of Lisa's property, door kicked in, excrement on floor. CCO to inform Lisa that she will contact the Housing Association to enquire about housing support. Zoned RED*.' This referral was just a week before Lisa's death.

9.5 Safeguarding concerns from other agencies

The Mental Health Trust are not the only people who could have raised a safeguarding concern. If the concern was about a Mental Health Trust client this would have gone to the Trust, otherwise to the Local Authority. No information about safeguarding concerns was received from the Local Authority.

The Acute Trust in particular could have raised a concern. For example, in April 2023 Lisa tells Acute Trust staff that *she is at risk of 'being chopped up' a police referral is made, without discussion of consent as there is a clear public interest*.' A Police referral is made by a staff member but no safeguarding concern is raised. As was

[6] London Ambulance Service – SAR author's clarification

said above, it may well have been useful to report this situation to the Police, but that does not mean it should not also be a safeguarding concern.

A concern for the Acute Trust seems to have been that Lisa might not have met the criteria for a safeguarding adults referral due to *"unclear level of care and support needs"*, but the Acute Trust IMR acknowledges that *"this could have been considered"*. The question of her care and support needs was addressed in the earlier section of the report.

The IMR also suggests that *acute staff assume that the Mental Health team will take responsibility for managing referrals and signposting to substance use services.* This would appear to be another area for staff training.

It is unclear whether Lisa's GP saw her sufficiently in this period to feel that she required a safeguarding concern; however, the Police did submit Merlins[7]. Between 2004 – mid-2021 Police Officers submitted approximately 25 Merlins about her. However, two were submitted during the review period. One of these was in October 2021 following a call expressing suicidality. The latter was in early April 2023 following an incident of aggression by Lisa at a friend's house. No further action was taken by the Police on these incidents. No record has been found of what happened as a result of this Merlin.

More generally, the lack of safeguarding concerns raises two questions:

- Is there an erroneous perception across services that client consent is required to raise a safeguarding concern?
- Are negative images of people with substance use disorders as people who are making "lifestyle choices" deterring practitioners from raising safeguarding concerns?

Neither of these are proven by the material but are questions that should be considered by partners and the SAB generally in any review process.

9.6 Safeguarding Lisa by other means

Raising a safeguarding concern is not the only route to "safeguarding" Lisa. Two other means are highlighted in the IMRs:

- Alerting the Police to her situation
- A referral to the Problem Premises Panel.

The original SAR referral said that: *"There is concern that the services…did not act in a timely manner to provide a safe service, and whether there was a wider public interest in communicating with relevant statutory agencies, particularly the police."*

The Mental Health Trust IMR acknowledges that *"It is well documented that those involved in her care made every effort to encourage Lisa to inform the Police about the risk to her personal safety from the drug dealer."*

[7] Police reports of concern about vulnerability

However, Lisa was concerned that reporting to the Police would put her in danger. According to the Acute Trust IMR: "*Lisa repeatedly tells (Acute Trust) staff she is 'not a grass' and so this is a challenge for staff who hear her allegations of threats from drug dealers."* It is only when she says that drug dealers are threatening her with *"being chopped up"* that staff report this to the Police without her consent.

This fear of reporting abuse is a situation found in other SARs, e.g. Adult N (Newcastle). The question is whether staff, across the partnership, should have alerted the Police to Lisa's situation without her consent and whether there are mechanisms for doing this without jeopardising her well-being.

It should be noted that the threats to Lisa are not simply about attacking her. Her aggressors also threaten to burn her flat down. This would obviously have put many other residents in her block at risk and this might provide a justification for sharing information under section 115 of the Crime and Disorder Act 1998.

The Problem Premises Panel[8] and talking to her Housing Association offered two other routes. (The former was in train, but Lisa died before this could be undertaken). Again, consideration would need to be given to how either of these can be done without further jeopardising Lisa.

This situation suggests a need for a discussion at the SAB about how individuals who are being threatened by drug dealers can safely report their fears and be safeguarded.

10. Mental health

Lisa's diagnoses and involvement with Secondary Care Mental Health Services were set out in section 7. This is clearly an important part of her presentation; however, at no point in the review was it suggested that her care fell short of expected standards. Lisa herself seemed satisfied with the mental health care she received. The focus for this review is the safeguarding process.

Questions were asked in the review about her mental capacity and, separately, about whether there might have been any evidence of cognitive impairment. It was uniformly felt that Lisa did not lack capacity regarding key decisions and that there were no problems with cognitive functioning.

The one point that was flagged in the Practitioners' Event was her decision to stop having a depot injection[9]. This appears to have been undertaken with due consideration; however, practitioners did question whether this was a contributory factor to her developing problems in the last two months.

[8] It is reported that this will be replaced by the Police-led Community MARAC in 2025.
[9] A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it lasts longer. Depot injections can be used for various types of drugs, including antipsychotics.

This review cannot revisit that medical decision and no-one has suggested that the decision was "wrong" in any sense. However, it is flagged here as a point for consideration by both clinicians and by staff working with individuals who have stopped taking a depot, so that they are aware of the risks.

11. Tackling drug use disorders

11.1 Drug and alcohol screening and identification

It is clear that Lisa had a drug use disorder. This is focused on non-opiate illicit drugs including cocaine. However, the notes also contain reference to problems related to alcohol use, particularly before the review period. It is unclear the extent to which this was a problem for her but it seems that she may have had an alcohol use disorder earlier in her life and, according to the Epilepsy Service, have cut down in later years. She also told that team that she was "sensitive" to cannabis.

At the very least, therefore, Lisa's case is a reminder of the importance of robust alcohol and drug screening processes to ensure that all alcohol and drug-related risk is identified and highlighted by all the agencies that are working with an individual. In accordance with NICE Public Health Guidance 24, professionals working with the public need to be alert to the possibility of alcohol use disorders and should ensure that the AUDIT alcohol screening tool[10] is routinely being used by all relevant professionals, whether in Primary Care, Mental Health Services, Adult Social Care, Housing or any other adult service. NICE make the same recommendation about screening for drug use disorders and the Department of Health recommends the use of the Assist-lite screening tool for this purpose.

11.2 Tackling drug use disorders: a community pathway

The notable thing about Drug and Alcohol Services in Lisa's care, is their absence. It is clear that practitioners recognised the need for her to be referred to services; but she seems to have been adamant about refusing these suggestions.

It was suggested at the Practitioners' Event that people have to want to engage and access drug services. This may be the requirement of local services but national evidence suggests that there are ways of working with these apparently resistant individuals.

Individuals like Lisa, who seem to resist the help offered by services, have long been a challenge to agencies, in particular, Drug and Alcohol Services. However, a range of evidence now identifies "what works" with this group. This is most clearly summarised in Alcohol Change UK's Blue Light project manual.[11] However, the Office for Health Improvement and Disparities' *UK Clinical guidelines for alcohol treatment*, the Carol SAR from Teeswide, the Alan SAR from Sunderland and other SARs also endorse the same approach.

[10] Alcohol Use Disorders Identification Test (AUDIT) (auditscreen.org)

[11] For transparency purposes it should be noted that the author of this report is the co-author of the Blue Light project manual.

At its core is: a care package centred on intensive assertive outreach, the willingness to be consistent and persistent and to allocate time to the task.

Lisa could have benefited from an assertive outreach approach which would have attempted to build a relationship with her in order to understand what lay behind this refusal of care. Is it shame about the way she is now living? Is it fear that intervention might interrupt her supply of drugs? Is it concern that she may lose her independence? Is it even cognitive impairment?

An assertive outreach approach is built on the recognition that with complex individuals such as Lisa, agencies are going to need to sustain the relationship rather than expecting her to be able to do that. This will require an approach that is:

- Assertive – using home visits
- Focused on building a relationship
- Flexible – client focused – looking at what the client wants
- Holistic – looking at the whole person
- Coordinated – linking with other agencies
- Persistent and consistent

This is resource and time intensive but can be justified by the repeated impact that Lisa was having on public services. Such a service could be based in specialist Drug and Alcohol Services.

This is not a criticism of existing Services. Rather it is a recognition that these services have not been commissioned and developed to have the capacity to work effectively with this type of individual. Similar services in other parts of the country e.g. Sandwell, Northumberland, Westminster or Surrey have been designed with this capacity.

More fundamentally with people like Lisa, all professionals need to move beyond the expectation that clients will engage with them and move towards recognising that, for this more vulnerable group, efforts will need to be made to engage them.

11.3 COMHAD

It is interesting to note that the Mental Health Trust itself funds a co-occurring conditions (dual diagnosis) service, *Co-Occurring Mental Health, Alcohol and Drugs* - COMHAD[12], that works with people with mental health disorders and substance use disorders. According to the Mental Health Trust website it *offers "support to people who are experiencing both mental health and substance use difficulties".* The COMHAD programme explores *"the connection between substance misuse and mental health to better develop holistic wellbeing and self-management".* It "*offers a range of clinical and psychosocial interventions including one-to-one support and groupwork".*

[12] COMHAD (Co-Occurring Mental Health, Alcohol and Drugs) - Bexley, Bromley and Greenwich Mental Health Hubs

Lisa does not appear to have been considered for this service. It is possible that this is because the *"aim is to ensure service users who face challenges with substance misuse have equal access to mental health services".* This would not apply to Lisa because she was integrated into Mental Health Services but was refusing Drug and Alcohol Services.

At the Practitioners' Event it was commented that COMHAD has a complex funding arrangement and is minimally resourced - one person for the borough. It was acknowledged that having a clear understanding of COMHAD services and local Alcohol and Drug services would be useful and more specifically consideration needs to be given to extending the role of COMHAD to cover people like Lisa.

11.4 Hospital alcohol liaison

It is noted that the Acute Trust has an Alcohol Care Team: this is good practice and represents an opportunity to positively intervene with drinkers at a point where they may be more receptive. No mention is made in the notes of them working with Lisa. This may be a recording issue; however, it may represent a practice issue and the Acute Trust may wish to consider whether there are any lessons from this scenario. No recommendation has been made about this.

12. The consideration of residential options

The ideal care pathway for Lisa may have been a period of residential care/rehabilitation in a "drug-free environment". Dame Carol Black's *Review of drugs part two: prevention, treatment, and recovery* (states)*: "Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs."*

Such a placement would have enabled:

- A time away from her vulnerable home situation in a protective environment.
- A chance to properly assess her physical and mental health
- The opportunity to address her drug and alcohol use disorders and develop an appropriate long-term care plan.

At the end of March 2023, Lisa was placed in the Mental Health Trust's Recovery House. She appeared to do reasonably well there, although this was not a long term option. She was also asking for / or considering a move to Bermondsey at points. The SAR referral also states that at one point the plan was to refer Lisa to a Housing Service but this was not followed through. Again this was not a rehab option but it would have been a chance to house her away from her current environment.

Residential rehabilitation does not appear to have been pursued as an option. This would not have been an easy option with Lisa; however, it is important that all clinicians are considering this possibility with people like her and that local commissioners are ensuring that this option is reasonably available. Nationally, there are residential facilities which work with people with co-occurring disorders which could be accessed with local funding.

13. Epilepsy

As was stated in section 7, Lisa probably suffered from Epilepsy. (The doubt is the role of substance use in precipitating seizures). She was referred to the local Epilepsy team in February 2020. As with Mental Health Services there has been no question about the quality of the work undertaken with her by the service. There was follow-up in a Neurology Clinic to determine the origin of the seizures and a Nurse worked with Lisa very assertively to help keep her engaged with services, especially during the Covid period. They also contacted other services to ensure her care was appropriate. In particular, some epilepsy medications can exacerbate mental health problems, so this was carefully reviewed.

14. Was risk identified and appropriately addressed?

A significant concern is how agencies assessed the risk of harm (including self-harm) to Lisa, particularly in the last month of her life? This again focuses on the Mental Health Trust, who had the most contact with her, but also the Police and the Acute Trust.

A different angle on Lisa's risk assessment comes from the Local Authority OT service. They undertook a lone working risk assessment (home visiting) in response to Lisa's self-reported mental health symptoms i.e. paranoia, anxiety and dislike of social situations. As a result, they decided Lisa posed a risk to staff and that she should be visited in pairs. Interestingly, this is not a concern identified by other agencies.

Both the Police and the Acute Trust made some form of risk assessment:

- On 4 April 2023, Lisa was readmitted to the Recovery House following an incident involving damage to a friend's TV and telling A&E staff that she is '*suicidal and unable to keep herself safe. Said if she is sent home then she will kill herself because people are after her.'* At this point the Police assess her risk level as 'BRAG AMBER'
- At the same point Acute Trust staff consider that the risk of violence to her is so acute that they report it to the Police even without Lisa's consent.

However, inevitably the main agency involved in risk assessing Lisa is the Mental Health Trust. As with the safeguarding process there are questions about the system.

The Mental Health Trust "zone" individuals as red, amber or green. It was explained that this is not the risk assessment tool; however, the Trust's documentation describes this zoning system as a means for the *communication of risk for community teams.* A red zoning means that someone is at *high level of risk to self or to others*. It also, therefore, determines the intensity of contact with the client.

However, the risk zoning of Lisa and other risk related processes appear to highlight some confusion. At points, Mental Health Trust staff view the risk that she may attempt suicide or further self-harm very seriously, and arrange for her admission to

the Recovery House. The Mental Health Trust chronology notes that Lisa was also 'zoned red' on several occasions prior to her death e.g. 2 April, 9 April and 16 April.

However, there are a number of contradictions around this process. Lisa was also zoned green on 14 April, then Red again on the 16 April and Amber on 19 April. However, on 19 April, following a face to face meeting with Lisa, ADAPT sent a letter to her GP in which she is described as:
Risk to self: low
Risk from others: low
Risk to others: low
Risk of health: low to moderate due to poor self-care
Risk of alcohol and substance misuse: low to moderate
Risk of non-engagement: moderate
Safeguarding concerns currently none

However, on this same date the Mental Health Trust chronology notes *'Section 42 safeguarding enquiry required'.* In discussion with Mental Health Trust staff, comments were made that different teams zone in different ways and that the Doctor might have used a standard letter template and not changed text (this was conjecture).

The level of risk with someone like Lisa simply does not change that quickly and even if it appears to have changed on the surface, the underlying risk is very unlikely to have changed. As a result, a review of Mental Health Trust risk assessment processes seems to be required.

More generally, it was commented at the Practitioners' Event that: *many referrers are not trained to risk assess or produce a quality referral report.* Therefore, these comments about the need for further work on risk assessment and risk management should be considered across the partnership.

The concern about risk raises two other issues which are considered in the next sections:

- Multi-agency management
- Clients that services find difficult to engage.

15. Multi-agency management

A clear message from the Practitioners' event was that Lisa would have benefited from regular multi-agency discussion, not simply multi-disciplinary discussion within the Mental Health Trust. This would have supported clear and positive inter-agency liaison and multi-agency working. The notes refer to a "case discussion" a week before her death but there is no evidence of regular multi-agency discussion.

This could have been addressed in a number of ways: as part of a safeguarding process; by having a clear policy on dealing with clients that services find difficult to engage; by having a specific policy on calling multi-agency meetings; through referral to an existing multi-agency group; or through individual initiative by a professional.

Whichever way this is approached, clients like Lisa will benefit from a group that can step back from the day to day interventions and see the overall picture of the problems she presented and consider ways in which these could have been better addressed.

16. Difficulty of Engagement – the need for a policy

The Practitioners' Event also commented that it is *"very difficult to manage risk and safeguard when people don't want to engage."*

The key challenge with many clients is not that they have a drug use disorder or a mental health disorder or a physical health problem. The concern is that services find it difficult to engage them into the care they need for those problems. Throughout the notes there are repeated examples of these challenges with Lisa:

- *There was possibly a pattern of non-response to calls from OT…Letter sent to Lisa stating we have been unable to contact her and requesting that she contact the service to advise if she wishes to pursue an assessment.*
- *Referred to Neurology team but Lisa declines EEG …and does not attend MRI.*

The Acute Trust write that it is: *Very challenging when working with adults who are apparently able to consent to care plans, but whose behaviours are driven by addiction. What intervention can staff actually effectively offer when work with a person is only during crisis presentations or as part of an outpatient telephone clinic.*

Lisa is not unusual in presenting difficulties of engagement. The Manchester Safeguarding Partnership *Carers Thematic Learning Review 2021* identifies the same issue: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way…* It also recognises failures to escalate these individuals.

This highlights the need for individual professionals to have a specific focus on engagement. However, at the organisational level, it highlights the need for a published, multi-agency procedure to guide professionals in dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate concerns and where they should be escalated to.

It will need to cover themes including:

- Multi-agency management
- Care coordination
- Assertive outreach
- Guidance on engagement techniques

17. Additional point - Covid 19

The first part of the period under review, and the period immediately preceding it, coincided with the Covid-19 restrictions. This did have an impact on Lisa's care and, for example, some interventions were over the phone rather than face to face. However, the key phase in her care, March-April 2023, was at a time when restrictions had been lifted. Moreover, many services continued to operate throughout the period with no restrictions or limitations to the service offered.

It is not possible to draw a direct line between the Covid restrictions and Lisa's death. As a result, no comments have been made on Covid's impact. Particularly as these were a unique set of circumstances.

18. Key Learning Points

Lisa was a 43 year old white British woman who completed suicide by hanging in April 2023. She had a history of mental disorders and physical health problems such as epilepsy. However, the central focus of this review is not the management of these conditions but rather the safeguarding of someone who also has substance use disorders, is being threatened by drug dealers and is very difficult to engage with services.

Nothing suggests that there were any problems in the clinical management of her mental health conditions or the epilepsy. The central questions are:

- Were safeguarding processes pursued appropriately?
- Were her drug and alcohol use disorders addressed?
- Was risk identified and managed?

Within these are sub-themes about the management of people that services find difficult to engage or the use of multi-agency approaches.

Safeguarding

A Section 75 agreement is in place between the Mental Health Trust and the Local Authority, this means that much of the safeguarding process is internal to the Trust. The information received from the Mental Health Trust suggested a number of areas for review:

- Were safeguarding concerns raised by agencies (not just the Mental Health Trust) at appropriate points in her care?
- Was her presentation as someone who was being exploited as a result of drug use seen as a safeguarding issue?
- Is the process of safeguarding within the Mental Health Trust straightforward for staff?
- Can the Local Authority carry out their statutory responsibility and track all safeguarding concerns?

The review suggests that there are legitimate questions about all of these areas and that a thorough review of the safeguarding process is undertaken to ensure that the questions above are being addressed to the SAB's satisfaction.

Safeguarding by other means

A particular point of concern is that Lisa was living in fear of drug dealers using violence to extort money from her. How can a vulnerable person in that situation safely report her concerns to the authorities without risking violence from those same dealers? This is a question that was not resolved in Lisa's care; but is one that is repeated in other SARs nationally and, therefore, should be one that is given consideration at either the local or the national level.

Drug and Alcohol Use Disorders

The review highlights the need for all agencies to be using robust drug and alcohol screening tools to ensure that alcohol and drug-related risk is identified and highlighted by all the agencies that are working with an individual at the earliest possible point.

More importantly, despite evidence of drug and alcohol use disorders, Lisa never had contact with Drug and Alcohol Services. Agencies acknowledged that referrals had been made but that the prevailing model was that the individual needed to be motivated to engage with those services.

Lisa would have benefited from an assertive outreach approach which would have attempted to build a relationship with her in order to understand what lay behind this refusal of care. This approach is built on the recognition that with complex individuals such as her, agencies are going to need to sustain the relationship rather than expecting her to be able to do that.

This is not a criticism of existing services. Rather it is a recognition that these services have not been commissioned and developed to have the capacity to work effectively with this type of individual. Similar services in other parts of the country have been designed with this capacity.

More fundamentally with people like Lisa, all professionals need to move beyond the expectation that clients will engage with them and move towards recognising that, for this more vulnerable group, efforts will need to be made to engage them.

The Mental Health Trust has a co-occurring conditions (dual diagnosis) service that works with people with mental health disorders and substance use disorders. Lisa does not appear to have been considered for this service. This is probably because this service has very limited resources but does raise the question of whether consideration needs to be given to extending the role of COMHAD to cover people like her.

Risk

A significant concern is how agencies assessed the risk of harm (including self-harm) to Lisa, particularly in the last month of her life. This again focuses on the Mental Health Trust, who had the most contact with her, but also the Police and the Acute Trust.

The concern is that the Mental Health Trust's "zoning" of her risk varied, at times significantly, from day to day. For example, Lisa was also zoned green on 14 April, then Red on the 16 April and Amber on 19 April. However, on 19 April, following a face to face meeting with Lisa, a Doctor sent a letter to her GP in which she is described as low risk on virtually every area of concern. On the same day the Mental Health Trust chronology notes *'Section 42 safeguarding enquiry required'.*

The level of risk with someone like Lisa simply does not change that quickly and even if it appears to have changed on the surface, the underlying risk is very unlikely to have changed. As a result, a review of these risk assessment processes seems to be required.

More generally, it was commented at the Practitioners' Event that: *many referrers are not trained to risk assess or produce a quality referral report.* Therefore, these comments about the need for further work on risk assessment and risk management could be considered across the partnership.

The concern about risk also raises questions about:

- Multi-agency management &
- People that services find difficult to engage.

Multi-agency management

A clear message from the Practitioners' event was that Lisa would have benefited from regular multi-agency discussion. This could have been addressed in a number of ways: as part of a safeguarding process; by having a clear policy on dealing with clients that services find difficult to engage; by having a specific policy on calling multi-agency meetings; through referral to an existing multi-agency group; or through individual initiative by a professional. Whichever way this is approached, clients like Lisa will benefit from a group that can step back from the day to day interventions and see the overall picture of the problems she presented and consider ways in which these could have been better addressed.

People that services find difficult to engage

The Practitioners' Event commented that it is *"very difficult to manage risk and safeguard when people don't want to engage."* This highlights the need for individual professionals to have training to support a specific focus on engagement. However, at the organisational level, it highlights the need for a published, multi-agency procedure to guide professionals in dealing with client non-engagement. To make that procedure useful it will need to provide guidance on:

- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
- how to practically intervene with hard to engage clients; and
- how to escalate these concerns and where they should be escalated to.

It will need to cover themes including:

- Multi-agency management
- Care coordination
- Assertive outreach
- Guidance on engagement techniques.

19. Good practice

Many agencies made efforts to help Lisa. Most professionals appear to have worked appropriately with her within the framework of their individual disciplines. In particular, some of the work undertaken with her was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and maintain services during that difficult period.

However, at least one specific points of good practice did emerge:

- The Epilepsy Nurse who worked with Lisa demonstrated a very flexible approach to her needs including more assertive follow-up than she was required to undertake.

20. Recommendations

Recommendation A

Greenwich Safeguarding Adults Board should review the safeguarding process within the Mental Health Trust and beyond to ensure that:

- People who are being exploited as a result of involvement with drug dealers or because of drug use are not seen as making a “lifestyle choice” and may require a safeguarding concern.
- Safeguarding concerns are being raised by all agencies (not just the Mental Health Trust) about people with complex presentations like Lisa.
- Appropriate questions are raised when individuals are being chaperoned to appointments by people who are not known to staff.
- The process of safeguarding within the Mental Health Trust is clear and straightforward, so that it is understood by all staff.
- Client consent is not viewed as a requisite for submitting a safeguarding concern.
- The Local Authority can track all safeguarding concerns so that they can carry out their statutory responsibility to oversee this process.

Recommendation B

Greenwich’s Public Health Team should ensure that all frontline services are aware of, and are able to use, robust drug and alcohol screening tools such as the AUDIT or Asist-lite tools to identify and record the level of drug and alcohol related risk for clients. Frontline staff should also be aware of referral pathways into these services.

Recommendation C

Greenwich’s Public Health Team should review whether;

- there is a need for the development or expansion of assertive outreach capacity in the adult drug and alcohol treatment system.
- Residential rehabilitation for serious drug and alcohol use disorders is both sufficiently available and being considered by local professionals.

Recommendation D

Greenwich's Public Health Team and the Integrated Care Board should consider an expansion in the capacity and role of the local co-occurring conditions service (currently funded by the Mental Health Trust) which works with people with mental health and substance use disorders in order to ensure that people like Lisa can be considered for this support.

Recommendation E

Greenwich SAB should ensure the Mental Health Trust undertakes a review of their risk management system and should:

- Ensure that training and guidance is available to ensure consistent application of the process.
- Ensure training on risk assessment with complex individuals like Lisa is widely available across the partnership.

Recommendation F

Greenwich SAB should lead the development of local procedures that guide professionals on how to respond to vulnerable or high-risk individuals whom agencies find difficult to engage.

Recommendation G

The SAB should ensure that individuals with substance use disorders who are vulnerable to abuse and / or exploitation can be escalated to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about such clients is cascaded as widely as possible through their own and partner agency communication systems.

Recommendation H

Greenwich SAB should hold discussions with the Police and other partners to identify how individuals like Lisa can most safely report concerns about threats from criminals.

Appendix 1 Terms of reference

The SAR (and by extension all contributors) will consider and reflect on the following:

- Accessing Lisa's voice:
  - (a) When, and in what way, were Lisa's wishes and feelings ascertained and considered?
  - (b) How was Lisa supported to make decisions for herself?
  - (c) Were the needs and voices of her family considered?

- Were criminal justice and other agencies appropriately involved in the context of exploitation and cuckooing? Were all reasonable strategies used to tackle this?
- Risk: Was risk identified and appropriately addressed?
- Substance misuse: Were appropriate steps taken to address her substance use disorder? What challenges and barriers exist for people experiencing substance use disorders?
- Mental health: Were appropriate steps taken to address her mental disorder?
- Did agencies identify or explore the interplay between poor mental health and substance dependency?
- Are there procedures and pathways for the management of individuals that services find difficult to engage?
- Multi-agency management: To what extent did consistent multi-agency management feature in her care? Was information sharing and communication between agencies and services appropriate and timely?
- Safeguarding: Were safeguarding needs considered and addressed appropriately and were there missed opportunities to raise a safeguarding concern at any stage?
- Mental capacity: Was the Mental Capacity Act 2005 appropriately considered and implemented in practice? Was Lisa's voice actively listened to in any mental capacity considerations?
- Other legal options: Does it appear that all legal options, including seeking legal advice where appropriate, were explored to safeguard Lisa?
- Systemic issues: Did any systemic issues impact on Lisa's care / service delivery, including, for example, agency resource / capacity issues, austerity, the COVID pandemic, workforce knowledge and training in relation to supporting people with substance/alcohol use disorder?
- Escalation: Were senior managers involved at points where they could have been?
- Good practice: Was there any good or notable practice with Lisa that should be flagged?

Appendix 2 – Assessment against SCIE SAR quality markers

Quality Marker 1: Referral	√
Quality Marker 2: Decision making – what kind of SAR, if any	√
Quality Marker 3: Informing the person, members of their family and social network	As far as was possible
Quality Marker 4: Clarity of purpose	√
Quality Marker 5: Commissioning	√
Quality Marker 6: Governance	√
Quality Marker 7: Management of the process	√
Quality Marker 8: Parallel processes	√
Quality Marker 9: Assembling information	√
Quality Marker 10: Practitioners' involvement	√
Quality Marker 11: Involvement of the person, relevant family members and network	As far as was possible
Quality Marker 12: Analysis	√
Quality Marker 13: The Report	√
Quality Marker 14: Publication and dissemination	TBA
Quality Marker 15: Improvement action and evaluation of impact	TBA