Southampton Safeguarding Adult Board

Safeguarding Adult Review

‘Diana’
Safeguarding Adult Review

October 2021

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2 INTRODUCTION BY INDEPENDENT AUTHOR

2.1 I was commissioned to undertake this review in January 2020 by the Local Safeguarding Adult Board (SAB). There were delays in commencing the review due to the COVID-19 restrictions.

2.2 This review focuses on Diana's (a pseudonym) final 18 months and uses her story to open a window on the system in Southampton in relation to people with care and support needs. The case involves the multi-agency network including mental health services, housing, adult social care and the police. It also shines a light on situations where there are issues arising from domestic violence and abuse as well as neighbourhood discord.

2.3 I was able to speak to Diana's sister who gave me a virtual portrait of Diana's life. I am grateful to her sister for being open about Diana's life and for agreeing to the name of Diana being used.

2.4 After I spoke with her sister, I was left with her view that, at the end of her life, Diana was:

'alone, nobody cared'

2.5 Having reviewed the timelines, some reports from the key agencies and spoken to those professionals who knew Diana, I realise that the statement above does not reflect the complexity of Diana's life. She had access to help and people who did care but there was a disconnect between what Diana felt she needed as opposed to what others considered they could offer.

2.6 I am grateful to all those who contributed to the review. I was impressed by the way the practitioners came together at the virtual event on 5th November 2020 in an open and reflective way to enable the learning to be taken forward.

2.7 It must be noted that, this review has been undertaken over a year after Diana's death and the agencies involved have already made some changes to their services.

3 METHODOLOGY

3.1 The Southampton SAB Case Review Group recommended that a multi-agency review workshop (Discretionary Safeguarding Adult Review) was convened for this case.

3.2 The period for the review was set from 1st January 2018 to 10th June 2019 and a full chronology was requested from agencies for this period, along with a summary of key events for 1st January 2015 to 31st December 2017.

3.3 The Case Review Group set the following Key Lines of Enquiry (KLOE):

- *This review will centre on the issues of partnership working and communication between agencies working with Diana; specifically:*

  - Housing support provision including assessment of risk for Diana from other tenants

  - Liaison between housing, police, and mental health services

  - Presence of joint and collaborative responses to Diana's physical and mental health needs/care planning including appropriateness and quality of responses

  - Concerns raised by family regarding support provided following property move and that Diana was 'being taking advantage of'

  - Any relevant findings from Independent Office for Police Conduct (IOPC) investigation

3.5 The chronologies were analysed and then complemented by a practitioner event, on 5th November 2020, to clarify facts and consider why actions were taken. Due to the Covid-19 pandemic individual conversations were not possible but those at the event were given the opportunity to request a conversation if they felt there were issues not addressed at the event. No one asked for a conversation.

3.6 Themes considered at the practitioner event:

- Mental Illness history
- Housing
- Safeguarding
- Relationships: Domestic Violence and Abuse, exploitation and support networks
- Ex-partner carer status

3.7 The findings from the chronologies and event formed the context of the report:

- Key episodes
- Analysis of agency responses to Diana
- Learning themes
- Recommendations for changes to practice

3.8 Diana's family were invited to contribute to the review. Her younger sister accepted and was spoken to via a virtual call. During this call it was agreed that the report would be shared with the sister when completed and she acknowledged the use of the name 'Diana' to ensure anonymisation.

4 BACKGROUND, HISTORY, KEY CIRCUMSTANCES AND CONTEXT OF THE CASE

Background

4.1 Diana was 50 years old when she died. She had a long history of physical and mental health issues. She had received care and treatment from mental health services for over 30 years.

4.2 Diana was one of four children. Her childhood had been traumatic. She did not have a good relationship with her father and found it difficult to relate to her brother who had been away in the Navy for much of Diana's childhood. Diana was asked to leave home at 16 years. However, she retained a close relationship with her mother who, according to Diana's younger sister, was her best friend. When Diana's mother died in 2013, Diana struggled to grieve and became depressed, leading to a hospital admission.

4.3 Following their mother's death Diana's siblings tried to support her, and she wanted to be close to them. However, Diana was unable to regulate her behaviour and she struggled to establish a relationship with brother which resulted in her, again, becoming estranged from her family.

4.4 Diana had complex health problems. She suffered with psoriasis and musculoskeletal issues which led to her reporting high levels of pain. She was supported by the GP, pain clinic and orthopaedic specialist. Additionally, she had been under the care of mental health services for over 30 years. Her initial diagnosis was Bi-polar Disorder, but this was changed to Emotionally Unstable Personality Disorder (EUPD) a few years prior to her death.

4.5 Diana had a long-term, volatile, relationship with her partner until they reportedly split at the end of 2017. There had been a history of reports of domestic abuse from her partner that led to Diana receiving contact from the IDVA service in 2010. However, they continued their relationship, on and off. There had been a breakdown of the relationship in June 2015 and then a further one in 2016, following episodes of physical aggression on both sides. At this point, Diana requested a housing move but refused to inform the

police about her partner and so it was not possible for services to support her in a rapid move. She recommenced her relationship with her partner, although continued to report that the partner was controlling and critical. By the end of 2017 they split up but remained living in the same housing complex. At this point, Diana's ex-partner continued as her carer and had reported to the Community Mental Health Team (CMHT) that Diana was suicidal. Diana was reported to be 'non-concordant' with her medication and spending most of the day in bed. The CMHT had arranged a support worker to help with cleaning and household tasks, following an assessment found that there were no acute risks.

4.6 During 2018, Diana increasingly reported that she was afraid of her ex-partner and that she was being harassed by her. Arrangements were made over several months to enable Diana to move home in April 2019. At this point she also changed her GP and was discharged from the Community Mental Health Service.

4.7 In the days before her death, there had been significant problems with her "new" neighbours which led to police and housing association involvement.

4.8 On 10th June 2019, her ex-partner raised concerns that she had not heard from Diana for a few days. They asked a mutual friend to check at the flat. This friend could not access the flat and so called the police. When the police entered the flat, they found Diana deceased.

4.9 The death was thought to be by suicide and, at the current time, is awaiting a coroner's inquest.

Key aspects of timeline

4.10 The terms of reference set out the timeline to commence from January 2018 and go through until Diana's death. This timeline has been separated out into key aspects to show what happened to Diana in the final months of her life.

January 2018- April 2018: Noted to be separated from partner, home cluttered and safeguarding issues considered

4.11 During January 2018, the CMHT attempted to contact Diana without success. However, she contacted them on 2nd February 2018. This contact led to a series of, weekly, home visits with a focus on helping Diana to declutter. A support worker was arranged to help her with cleaning.

4.12 At this time Diana spoke about dying and wanting to be with her mother who had died in 2013.

4.13 In March 2018, the Care Coordinator reviewed Diana and reported her to be in a brighter mood but still feeling depressed and anxious, as well as having a painful knee. The Care Coordinator discussed the relationship between Diana and her ex-partner which led to advice as to how Diana could seek support regarding housing options. Diana lived in the same housing complex as her ex-partner.

4.14 On 12th April 2018 Diana attended an Outpatient appointment with the Consultant Psychiatrist. At this appointment, her medication was adjusted, and she reported that her ex-partner remained controlling. The action taken was for consideration of a safeguarding referral regarding the ex-partner's control.

May 2018-December 2018: Harassment, potential for exploitation and management housing move request

4.15 During 3rd/4th May 2018, Diana contacted the CMHT. She reported that her flat had been broken into by, in her belief, her ex-partner. Diana wanted her locks changed but did not feel able to contact the housing association.

4.16 The Care Co-ordinator (CCO) supported Diana to contact the housing association and considered a safety plan. Diana refused to call the police but continued to contact the CMHT about threats from her ex-partner and requested help to pay a bill. The CMHT Multi-Disciplinary Team (MDT) discussed the case on 13th June 2018 and agreed not to complete a safeguarding referral as Diana had refused her consent to taking this on a safeguarding route.

4.17 On 13th June 2018, Diana informed the CCO that she had taken an overdose of her medication a couple of weeks earlier. Over the following few weeks Diana reported incidents of threats by her ex-partner towards her friends and, at times, towards her. Diana reported that she was reliant on her ex-partner for some aspects of her care and felt she could not change this as it would enflame their relationship.

4.18 On 20th June 2018, Diana reported to the CCO that she felt threatened by her ex-partner, was frightened of her, and wanted to move. This led to a referral to the High-Risk Domestic Abuse Panel (HRDA) in relation to safeguarding.

4.19 On 28th June 2018, the HRDA panel discussed Diana. The trigger for the panel was noted as:

- Abuse and getting worse
- Diana's vulnerability
- Diana's overdose
- Financial issues as the ex-partner was Diana's registered carer

4.20 The outcome of the meeting was that there needed to be a safeguarding referral under s42 Care Act 2014, and a management housing move for Diana.

4.21 On 30th June 2018, Diana reported to the police that her ex-partner was banging on her door. Diana said that she feared the person and was afraid of retaliation for calling the police. Police attended and completed a Public Protection Notice (PPN1) this included the DASH[1] assessment. It was reported that the Multi-Agency Safeguarding Hub (MASH)[2] assessed this as medium risk.

4.22 Diana continued to report threats and was very anxious. On 5th July 2018, Diana reported to the police that she had received further threats from her ex-partner.

4.23 On 7th July 2018 there was a follow up medium risk safeguarding visit conducted by a Police Community Support Officer (PCSO). Diana's phone was checked and there was no evidence of one-sided threats from the ex-partner but mutually abusive texts from both sides. The risk level was changed to standard by the police coordinators who are based within the children's MASH.

4.24 At this time Diana stated that she wanted her ex-partner to cease being her carer.

4.25 On 4th July 2018, the CCO commenced the safeguarding referral which was in the form of liaison with the housing association to see if it was possible for a management move to be completed for Diana.

4.26 Between 13th July and 30th August 2018, there were meetings between the CMHT and housing association regarding a management move for Diana. Support letters were needed, Diana reportedly became frustrated

[1] https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf

[2] The chronologies noted the involvement of the MASH. However, at the event held on 5th November 2020 it was reported that there was no formal MASH for adults. However, the DVA police coordinators are based within the children's MASH.

about the delays and was verbally aggressive to the CCO. She said she was in fear of her life and told police and housing that she would try to take her life again if things did not get better.

4.27 On 15th August 2018 the housing association phoned Adult Social Care (ASC) requesting information about social services involvement with the recent incidents with Diana They were advised that the support was coming from the CMHT and not ASC.

4.28 By September 2018, Diana was struggling to cope. She reported feeling intimidated by her ex-partner and had reported this to the police, which had resulted in the identification of mutually abusive texts between the two people. The housing association was trying to build a case to enable her to move and sent a letter to the ex-partner, also a tenant, telling her to stop banging on Diana's door.

4.29 Diana did not attend her mental health review and did not engage with her Psychiatrist. The decision of the CMHT was to continue to support Diana with the housing move and then consider discharging her.

4.30 At the end of September 2018, Diana had problems with a neighbour which resulted in an antisocial behaviour complaint against her. She became very stressed and the CMHT were asked to do a welfare check on her. They offered support.

4.31 On 18th October 2018, the housing officer emailed the CMHT to report that she had spoken to Diana who had disclosed that she had made a new friend to whom she had given her debit card to withdraw £30. Diana later found out that the 'friend' had withdrawn £40 and the 'friend' also said they would help her tidy the flat, but she then found items went missing. A referral was made to ASC and the Welfare Benefit Advisor in relation to who was receiving Diana's carer's allowance.

December 2018 – 29th April 2019: Reported not to be mentally well, fears about ex-partner regarding Carer's allowance, management move completed

4.32 On 6th December 2018, it had been arranged for the CCO to support Diana in her Work Capability Assessment but when the CCO arrived she found Diana there with her ex-partner who stated that they had been back in contact for several weeks. Diana reported that her ex-partner had been supporting her with shopping, cooking and company for the previous few weeks. Diana's ex-partner also reported to the CCO that a male friend had taken £2000 from Diana and had supplied her with amphetamines for several months. Diana reported that she wanted to think about the housing move now she and her ex were on good terms and what support she needed going forward. The support from the ex-partner appears to have only continued, consistently, for a few weeks.

4.33 The CMHT advised the housing association that Diana had taken steps to safeguard herself from the male friend and so no further action was needed in terms of a referral.

4.34 On 13th February 2019, CMHT advised that Diana was not 'mentally well', and this was increasing her anxiety and overall deterioration in her mental health. On 20th February 2019, Diana reported that she was anxious as she was aware that her ex-partner had appealed the decision not to allow her to have carers allowance. Her ex-partner was supposed to be providing 30 hours of care. Diana was very concerned that if her ex-partner found out that she was part of the decision making that their relationship would deteriorate again. The CMHT social worker wrote to the Benefits office to highlight the safeguarding concerns for Diana. On 28th March 2019, Diana reported that her ex-partner had received some back dated allowance. Diana was not happy about this but reported that she did not want to challenge until she had moved.

4.35 In April 2019, the CMHT were helping Diana to prepare for her move, and she expressed fear that her ex-partner would find out.

29th April 2019- 10 June 2019: New home, change of GP, discharge from MHT, trouble with neighbours

4.36 Diana moved to a new flat in April 2019. She continued to be supported by the CMHT during the move and the team checked she was settled. On 29th April 2019, when two team members visited, they noticed two older males leaving the flat and evidence of drinking. Diana appeared to have done some unpacking. It was agreed that the support worker would continue to help but there was no further role for the mental health nurse.

4.37 On 30th April 2019, the CMHT sent a letter to the GP to confirm that Diana had not attended her appointment and so the Psychiatrist was not planning on seeing her again unless a need was identified.

4.38 On 3rd May 2019, Diana reported that she was in pain following a fall and asked the CCO to buy milk on her way to the flat. The CCO explained that she could not buy milk but wanted to visit to assess Diana's mental health and offer support. Diana became aggressive towards the CCO and team. She refused to see them as she wanted a change of CCO.

4.39 Between 7th and 8th May 2019, Diana contacted the housing association to report that someone was lifting her letterbox and scaring her. She would not speak to the CCO but contacted the out of hours service to report that she was self-harming. She had burned her arm with a cigarette. She asked for a GP home visit, but this was refused by the practice as she was now out of area. On 9th May 2019, Diana registered with a new GP.

4.40 In mid-May, the Mental Health MDT reviewed Diana's case and decided to discharge her due to her not wanting to engage with the treatment plan. It was recognised that her risks might escalate but there needed to be boundaries and Diana had missed last three outpatient appointments. She was signposted to other services. The discharge paperwork was completed. On 16th May 2019, Diana phoned the CMHT expressing frustration with the CCO and explaining that she had physical health problems. She was advised to see her GP. During this time, the CMHT received a call from the ex-partner stating that Diana had phoned threatening to end her own life and her ex had not heard from her since. The team responded that there had been contact from Diana. The ex-partner reported that Diana had invited her to the new flat, but she had declined, did not want to know the address, but would meet on neutral ground.

4.41 From 20th May 2019, Diana reported a series of harassment incidents to the police which culminated in reports that Diana had been assaulted by a neighbour. She told police she was in fear of her life and she was feeling suicidal. She was advised to call 111 in relation to any assault injuries and suicidal ideation.

4.42 On 30th May 2019, Diana was seen by her new GP. The GP reported that she was agitated and was saying she must have help and blood tests. The GP had received a letter from the Care Co-Ordinator explaining that Diana was being discharged from the mental health service and that the GP would need to set clear boundaries for her. The GP suggested to Diana that she might like to try a period of independence, but Diana was adamant that she needed help. Diana told the GP that she had little support, no family, no friends other than one man.

4.43 On 3rd June 2019, an ambulance was called by Diana and said she had been assaulted by another resident in the building last night. Police had been informed and Diana reported being generally harassed by others in the building. Diana said she would not leave the property and go to A&E as the assailants lived next door and she was waiting for Police to attend. Diana was reported to have sustained an injury to her neck and face and finger bruises to her arms. She complained that her mental health was worsening, and she felt suicidal but continued to refuse to go to A&E after the police had attended.

4.44 On 5th June 2019, the CMHT reviewed the Mental Health Act s117 aftercare provision for Diana and discharged her as her needs had changed and were being met by others. Diana had an appointment with the new GP who reported that Diana demanded a referral to the mental health services and said she was being harassed in her accommodation. She reported being unhappy at the flat, not eating and not getting any support from anywhere. The GP reminded Diana that she had all the crisis numbers from the CMHT and that she could not be referred to the mental health service. The GP advised Diana to contact social services if there was a problem with her housing. After the consultation Diana was reported to have stormed out to reception and told staff she was going to kill herself. The GP spoke to her and advised her that she needed to try and manage her problems independently. Diana was then heard to head butt the wall many times. The GP suggested calling an ambulance to take Diana to A&E for an assessment, but she stormed out.

4.45 On 10th June 2019, one of the neighbours reported Diana's antisocial behaviour to the housing officer. The neighbour was advised not to speak to her.

4.46 At 18.54 on 10th June 2019, Diana was found dead by the police following a phone call from her ex-partner raising concerns that she had not heard from Diana for a few days.

5 ANALYSIS OF PRACTICE

5.1 The terms of reference identified 5 key themes for exploration:

- Housing support provision
- Liaison between housing, police, MH services
- Presence of joint and collaborative responses to Diana's physical and MH needs
- Safeguarding referrals and action
- Concerns from the family regarding the support following property move and Diana 'being taken advantage of'
- Any relevant findings from IOPC investigation

Good Practice

5.2 Prior to the move the CMHT tried to work with Diana to support her in the move and in general home management. The CMHT continued to support Diana in raising concerns about the ex-partner receiving Carer's Allowance. This team included Community Mental Health Nurses (CMHN), one of whom acted as her Care Coordinator, Social Worker and Support Workers.

5.3 There was good liaison between the CMHT and the housing association which was responsive in organising a management move for Diana. Following the move, arrangements were made to provide help in preparing the flat. There was also the involvement of a Welfare Benefits Officer.

5.4 The PCSOs who visited Diana's flat in May 2019, following the altercation with neighbours, showed kindness, spent time listening to Diana's concerns and even moved some of the stacked boxes as they recognised that there was a risk of injury. These PCSOs spent time listening to Diana and appropriately identified the need for support and referred to Adult Social Care via a PPN1.

5.5 The police responded promptly to the concern raised by her ex-partner on the day Diana was found.

Theme 1: Housing support

5.6 When asked to arrange a management move the housing association acted in a way to promote Diana's welfare but it could be questioned whether the move was rapid enough to protect her.

5.7 The new flat was not in an area of significant concern regarding antisocial behaviour, thus there was no reason to consider the flat inappropriate for Diana, someone escaping an abusive relationship. There does appear to have been some support in place to help prepare the flat. However, at the end of Diana's life there were reports of boxes being piled too high for her to reach. It is not clear whether this was due how the items were placed at the time of Diana's move or whether these were placed in this way after the move, as she had been seen to have other people in the flat. Nevertheless, it is of concern that her physical capability was not thoroughly considered to ensure she could unpack and settle into her new flat safely.

5.8 The housing team offered support to Diana but recognised that she was dependent on the CMHT. There seemed to be a concern that with the CMHT discharging her to reduce her dependency, this would transfer to the housing association. This did not prevent the housing team from providing advice and support for Diana but was limited to addressing the incidents with her neighbours rather than advocating for a multi-agency response to how to develop a safe network of support for her. The liaison between the CCO and housing officer was to look at the care package Diana needed. There was recognition that she needed support, but this was not done from a full multi-agency perspective which might have helped Diana, although the incidents in her final days happened in quick succession and would not have led to an emergency multi-agency meeting. Despite this there should have been more recognition of her physical needs and vulnerability without a carer in place. She had experienced problems with her ex-partner and another neighbour prior to the move and so it was wrong to assume that she would cope within a new community, especially knowing that she was being obstructive to workers who tried to help her following her move.

Theme 2: Liaison between housing, police and mental health services

Domestic violence and abuse consideration when there is a formalised caring role in place.

5.9 At the HRDA panel in June 2018, it was known that the alleged abuser was Diana's registered carer but there was no explicit action within the plan to address this, just the wider safeguarding referral. There should have been thorough consideration of how Diana's needs would be met when she reported abuse from her registered carer. This issue should have been made explicit on the safeguarding referral.

Safeguarding Responsibilities

5.10There seemed to be a reliance on the CMHT to address safeguarding issues. This might be due to the role of the CMHT in having the social care responsibility for care and support needs for those with mental health input. Nevertheless, there were periods of time when Diana disclosed information that strongly suggested that she was at risk of exploitation and, therefore, the workers in direct contact with her should have considered safeguarding referrals at these points, to include the police and social care.

5.11 There was an impression from the chronologies that there was a MASH system. However, when this was considered at the practitioner event it was reported that there was not a functioning MASH. This suggests that there is not a clear understanding of the roles and decision making for safeguarding referrals, including the links to domestic abuse.

Neighbourhood Disputes

5.12 When the police became involved in the neighbourhood incidents and reports of an assault there was limited liaison between the services. There appears to have been an assumption made that she was still actively receiving mental health care although, by this time, the CMHT was in the process of discharging Diana.

Nevertheless, there was considerable empathy and care shown towards Diana and a referral was made to Adult Social Care. However, there needed to be a multi-agency review of her needs to identify the best course of action to support Diana in protecting herself.

5.13 There were several missed opportunities to explore the risks to Diana from a multi-agency partnership perspective: firstly, in April 2018, Diana reported her ex-partner to be controlling. There was no formal review of how her care and support needs should be met. The CMHT certainly organised support but this does not appear to have been considered as a long term need to replace the carer arrangements that had been in place with the ex-partner.

5.14 It is positive that the CMHT have reviewed their actions during this time and recognise that Diana should not have been discharged at the speed with which she was. The team confirm that this was unusual, but, at the time, they were struggling to engage with her following the complaint about the CCO not being able to buy milk for her.

5.15 The police reported that there were decisions made that they were not aware of. Diana made 14 calls to the police from the end of May to shortly before her death. The call handlers were left not understanding why mental health services were no longer involved. These calls appear to have been dealt with as a neighbourhood dispute and antisocial behaviour, of which Diana was acknowledged to be a victim, but no wider consideration of why these problems were occurring and what help Diana was receiving. It is positive that the police have already reviewed this and now they have a local, dedicated officer to work with those with mental health problems and engage with the wider partnership.

Theme 3: Joint working to cover physical and mental health needs

5.16 Diana had physical and mental health issues. She appeared to attend some appointments for her physical needs, but the mental health issues overshadowed her physical disabilities. Nevertheless, it needs to be noted that she struggled to move around easily, and this was where she needed support. When she moved there does not appear to have been consideration of what adaptations were needed for the flat. However, there were reports of Diana not being willing to allow the help of those who could facilitate the adaptations.

5.17 Diana's mental illness diagnosis was not clear to all of those involved with her. There had been a historical diagnosis of bipolar disorder[3], but this had been changed 4 years previously to Emotionally Unstable Personality Disorder[4]. Diana had spent more than 30 years as a service user of mental health services. She was reported to be institutionalised and dependent on the services. This led to her wanting to know how they could help her, although the service had changed some years ago to a recovery model which promotes the development of self-management skills. Diana resisted the way that professionals tried to get her to engage in developing any skills to enable her to cope emotionally.

5.18 She was well known to her previous GP1 but had to change GP2 following her move. She had contacted her GP1's practice for a home visit due to having had a fall but was informed by the receptionist that she would have to change GP as she was now out of area. It is not clear whether GP1 was aware of this action. As Diana

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[3] Bipolar disorder is a mental health condition that affects moods which can swing from one extreme to another, depression to periods of elevated mood. https://www.nhs.uk/Conditions/Bipolar-disorder/

[4] Emotionally Unstable Personality Disorder is a disorder of mood and how a person interacts with others, characterised by intense negative emotions and disturbed patterns of thinking. https://www.nhs.uk/conditions/borderline-personality-disorder/symptoms/

had an emergency it was valid that GP1 could not undertake a home visit but there should have been advice for Diana to either visit the practice or access another practice for an urgent home visit.[5]

5.19 Diana was well known by the CMHT and GP1. She was known to take overdoses of medication following, reported, episodes of drinking too much alcohol and having arguments with her ex-partner. She was viewed as being resourceful, resistant to change and not always honest with professionals. She was seen to 'live in the moment.' This view of Diana led to services struggling to work with her at times. When she moved, she seemed to settle very quickly and was 'ticking along'. It could be argued that this was a misreading of the situation as she quickly became in opposition to some of her neighbours and there was the evidence of her being previously vulnerable to exploitation.

5.20The CMHT did not view her as high risk compared with some other service users, whilst other agencies seemed to place the issues she was having as being addressed by the CMHT. There was insufficient recognition of the impact a rapid discharge could have. It was noted that she had a support network comprising her neighbours and her ex-partner carer. This was rationale seems to be totally at odds with the whole reason she had asked for a move, to get away from her ex-partner and the history of poor relationships with neighbours. Additionally, the ending of the s117[6] provision should have included an assessment of how Diana would manage without the care and for her to be provided with a full explanation of this.

5.21 A key incident was when Diana asked the CCO to buy her some milk. It was not possible for the CCO to do this on that occasion and was a reasonable refusal by the CCO. However, what the situation suggests is that Diana was struggling physically and was missing the support network that had been in place in her previous home, due to her ex-partner being nearby. Her needs and vulnerability appear to have been overlooked due to the response workers received from her when trying to engage with her.

5.22 When the CMHT discharged Diana, she was moving GP practice from where staff knew her very well, to one which only had the discharge letter from the CCO which emphasised the need to maintain boundaries around the work done with Diana. Although this was a well presented and accurate assessment of Diana, the interpretation of it, by GP2, meant that she was not sufficiently listened to by the practice staff when she told them she was going to kill herself. Although an ambulance was called, Diana had left before it came. There should have been follow up of this. Diana was alerting the GP to acute anxiety, not eating and the harassment from neighbours. Given that there had been previous attempts to take her own life, there should have been a follow up call to the Mental Health Crisis Team, ambulance service or police for a welfare check. It is acknowledged that the police are moving away from welfare checks but they should be involved in considering the risks to individuals in the community.

5.23 The actions of the CMHT were understandable after all the work that they had done to support Diana through her move and her refusal to engage as she was angry with the CCO. However, by discharging her at a point when she was in a new situation with a new GP, she had no one who knew her well enough to assess her level of risk. The team did acknowledge that this was not how they would normally discharge someone, but it was done because she refused to engage. This left her isolated and unable to cope physically or emotionally. Given the knowledge that this was a patient with a complex mental health history, there should have been a direct handover between GP1 and GP2.

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[5] NHSE (2020) Standard General Medical Services Contract section 13
[6]Mental Health Act 1983 section 117 aftercare: https://www.legislation.gov.uk/ukpga/1983/20/section/117

Theme 4: Safeguarding Referrals and action

5.24 Safeguarding referrals were made but were not well understood in how Diana needed protection. There was a safeguarding referral made by police which was not allocated to a social worker in an appropriate timeline. This is recognised as being lacking and there have been changes to the system during the Covid-19 pandemic which means that social workers are active at the weekend and the other learning is that there would be more proactive work instigated, including approaching the GP. The practitioner group considered the need to develop a Multi-Agency Safeguarding Adults Hub to ensure that there is a timely, multi-agency response to safeguarding concerns. Additionally, ASC did not receive all the alerts for Diana that would have escalated their concerns. The police described some calls being made to their contact management system which, at the time, did not result in a request for officers to be deployed and consideration of a PPN1 to be completed and shared with ASC. The police have, since this case, trained the contact management staff to request officers complete a follow up visit with clear rationale and requesting a PPN1 if they believe there are risks identified.

5.25 When the CCO raised the need for a management move with the housing team, there was a DASH risk assessment undertaken which noted a score of 14 which is high risk. There was a referral to MARAC, which was dealt with by the HRDA panel. It is not clear to what extent Diana was at risk from her ex-partner. Some practitioners commented that the ex-partner was very caring and supportive of Diana, but they had a volatile relationship. Nevertheless, it is of significant concern that agencies continued to record the ex-partner as Diana's registered carer when services were actively arranging a move to enable Diana to escape the reported abuse. It was known that the ex-partner was still receiving carer's allowance for 30 hours care per week, as she had successfully challenged when it was stopped. Diana had reported that she was worried about arguing about the allowance and workers accepted Diana's view and no one questioned the allowance. This meant that there was no opportunity to discuss with Diana who could take on the role of carer. Assumptions were made about the friendships she reported making as soon as she moved. She should have received an assessment of her care and support needs prior to her move to ensure that she was not reliant on individual agencies or informal networks.

5.26 Diana reported to professionals on several occasions that she had suffered abuse from her ex-partner as well as indicating that she had been exploited by some 'friends'. The workers seemed to accept Diana's wish not to involve the police. She seemed to have the capacity to make decisions. However, there was insufficient consideration of her vulnerability and that of others who might also be at risk of exploitation. There seemed to be an acceptance by the professional network that the CMHT would address any safeguarding issues rather than Adult Social Care. This seems, in part, to be due to an impression that Diana would not tell professionals enough to facilitate action against any alleged perpetrators. Nevertheless, in the timeline of the review there were several examples of potential exploitation of Diana which should have been explored by the multi-agency network to help her to protect herself but also to protect others who might be at risk of exploitation.

5.27 The Care Act 2014[7] includes the responsibility of a local authority to undertake a safeguarding enquiry for those who have care and support needs and, '*as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect'.*

5.28 In Diana's case, the safeguarding concerns were addressed by the CMHT rather than taken on by ASC. In the final referral made by the police via the PPN1, the referral was left waiting for allocation by ASC.

5.29 This system is not robust in allowing for multi-agency assessment or discussion and is too open to practitioners minimising concerns when an individual changes their account or states that they do not want any action taken.

[7] Care Act 2014 S42(1c)

5.30 The Care Act 2014[8] statutory guidance states that there must be recognition of the impact of complex interpersonal relationships on the individual's ability to understand their personal risks.

5.31 In Diana's situation the safeguarding concerns seemed to be overshadowed by the practitioners' experience of Diana's response to advice and support. At the point of discharge, the CMHT considered that Diana was reporting that she was settling in well and there were no risks. However, it was at a time when her ex-partner was still known to still be involved, despite Diana having previously articulated that she did not want her involved in her life, and there was also evidence of growing disharmony with the neighbours.

5.32 Subsequently, there was no multi-agency meeting called for by any agency. This was a missed opportunity to thoroughly examine her needs and the risks from herself and others. It would have also been a chance to consider the status of her ex-partner in her life as carer.

Theme 5: Support following move: Support networks and poor decisions

5.33 Diana was identified as a person with care and support needs under the Care Act 2014. There had previously been an assessment of her needs and a carer's assessment for her ex-partner which had resulted in the payment of a carer's allowance. It appears that Diana's ex-partner had been assessed as providing 30 hours of care a week.

5.34 Diana had reported that she was fearful of her ex-partner. She had been subject of a HRDA panel. Considerable work had been undertaken to enable her to move away from her ex-partner.

5.35 Services were aware that Diana's ex-partner had successfully appealed the removal of her carer's allowance and that Diana reported that she was afraid of disputing this. The CMHT SW wrote to the benefits office to raise safeguarding concerns but there has been no evidence of this being escalated.

5.36 There appears to have been no review of Diana's care and support needs or the use of an advocate to enable her to dispute the carer's allowance[9]. This meant that she was limited in the extent to which she could access care and support in her new home.

5.37 Given that the move was due to the risk of domestic abuse it is of concern that professionals knew that Diana was still getting support from her ex-partner. Their relationship was deemed to be volatile, but they were reliant on each other.

5.38 Diana was clearly still seeing her ex-partner following her move. Indeed, it was her ex-partner who alerted a friend to call the police that they had not heard from Diana for several days. They indicated that they had asked Diana not to tell her the new address and that they had met on neutral ground. They also expressed concern about Diana being discharged from the mental health service. This would suggest that, perhaps, if the issues were not considered to be domestic abuse, then mediation[10] could have been utilised prior to the move to enable the relationship to be maintained. However, the agencies were working with Diana, at that time, reporting that she was fearful of her ex and did not want her to know she was moving. There seems to have been one line of action of addressing domestic abuse, in which case Diana should have been supported in finding an alternative carer; whilst another line of action was the acceptance that Diana was not at risk from her ex-partner who was known to still be her carer.

5.39 There appears to have been insufficient professional curiosity as to how Diana was receiving support once she had moved. She had reported that she was getting on well with those in the local community, but this seems to have been short-lived as in the days before her death there were significant reports of difficult

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[8] DHSC (2016) Care Act: Care and Support Statutory Guidance para 14.7
[9] DH (2016) Care and Support Statutory Guidance, para 14.10
[10] Mediation would not be used in DVA situations

relationships with neighbours. At the same time, she had been discharged early by the CMHT due to relationship problems following the move. Additionally, she had been told to change GP from one who knew her extremely well to one who saw her just twice before she died.

5.40 Diana's sister described her as being *"alone, nobody cared, abandoned".*

5.41 Services and individuals had tried to help Diana for many years. There were several examples of professionals going above and beyond to help her to have a successful move. However, there was no joined up thinking about the impact losing those who knew her well at a time when she had not established safe, long term relationships to enable her to access support. She was described as institutionalised by the mental health services following over 30 years of receiving care and treatment. She was reported to be unwilling to engage in honing the self-help skills she had been taught as part of the recovery model used by mental health services. However, Diana was a product of the old mental health system which did create dependency on services, and it is difficult for someone to become independent after spending most of their life in that structure. Furthermore, Diana had identified care and support needs. She might not have required intensive mental health treatment but did need support in maintaining her daily living. This might have been more due to her physical needs but there has been no clear evidence of how the services monitoring her physical needs were informed about the changes to her circumstances. The GP was informed but the focus of the transfer was her mental health and the boundaries needed to manage her. There had been appointments with services for her physical needs which she continued to attend with her ex-partner.

5.42 When the CCO told Diana that she was unable to buy milk for her, Diana became very angry and complained. It is reasonable for a mental health professional to decline doing shopping for a patient in the community. It would be expected that a patient would have other support to enable shopping to be done. However, the CMHT was responsible for the social care side of Diana's care as well. Therefore, the request for shopping should have triggered questions about how successful her support networks were in her new community, as she had previously reported that she was getting on well. This is a further example of how Diana's care and support needs should have been formally reassessed following her move to enable the identification of an individual to provide her care and receive their own carer's assessment.

5.43 The incident regarding the milk seems to have been the catalyst in Diana's life, the moment she was demonstrating that she was not sure about her decision to move. She was used to being near to her ex-partner who, despite their volatile relationship, did provide shopping and, at times, company. The move to an area where Diana needed to establish new relationships with the community and professionals, she was lost and vulnerable. When she was not able to control the situation, she was known to become angry. Following the 'milk' incident, she continued her anger against the CCO. Despite there being people around to help her with unpacking and setting the flat up for her needs, she did not recognise this help. And pushed them away.

5.44 When the ex-partner contacted the CMHT in May 2019, she stated that she would support Diana with her needs. On 5th June 2019, the MDT had agreed that Diana no longer needed to be subject to Section 117 due to her living independently for years, demonstrating she could be resourceful and resilient, and able to get her needs met by her (ex) partner and neighbours. This was 5 days after Diana had reported being assaulted by a neighbour and there seems to have been no consideration that the 'partner' was the same person who Diana had reported to be abusive and the reason Diana had asked for a management move. Given the extent of the information provided for this review, the assessment that Diana had been independent and was able to sort her own access to help to meet her needs, seems to be flawed. Rather, Diana appears to have been a woman who had difficulty in maintaining relationships. She would give the impression she could cope when she became angry with those trying to help her but needed a significant amount of help to attend to her daily life due to her physical problems and did not always make sound decisions about who to ask for help,

which made her vulnerable to exploitation. She did appear to have the capacity to make decisions, even if these were unwise, but she was also assessed as having care and support needs. Thus, she was assessed as being able to cope from a mental health perspective, but this did not bring in her physical needs. She had been dependent on others all her life. Her one constant protective person, her 'best friend', was her mother who had died several years earlier. This meant that she had no one she could totally trust to guide her to the right help or stay near when she was being uncooperative. It would not be expected that this role would be taken by a statutory service but there should have been the assessment of who was willing to take on the role safely.

6 LEARNING POINTS

Changes to services since 2019

6.1 The learning event, held on 5th November 2020, gave practitioners the opportunity to demonstrate how they had already made changes to their services:

- For patients who do not engage with mental health services they would refer to the SO:Linked[11] service at the point of discharge. This service was not in place until October 2019. It is a mode of supporting people to navigate the range of community activities there are in the city.
- The housing association now has a service which provides support to individuals during their first year of tenancy.
- Housing have had training in arranging a Multi-Agency Risk Management Meeting.

6.2 Although these changes might not have made a difference to Diana, they are positive ways of trying to provide wider community support to those who might be isolated from society.

Carer

6.3 This case demonstrates the need for clarity in relation to who is responsible for the care and support plans in the area, i.e., if the role has been delegated to the CMHT then consideration should be given to how this is monitored to ensure that there is compliance with the Care Act 2014 (s10). [12]

6.4 This case also highlights the risks to an individual who reports domestic abuse but is reliant on the alleged perpetrator to provide their care. It is of significant concern that a formal carer can receive an allowance when there are reports of abuse or violence towards the person in their care.

6.5 It would seem pertinent to review the arrangements in place to support an individual, without the involvement of the alleged abuser. Where the individual indicates that they feel threatened by the carer then professionals should call a multi-agency meeting to ensure that all services involved are aware of the risks and able to support with a safety plan. In this case there was no suggestion of using an advocate at this point. It would be of benefit that an advocate is offered to the individual when considering a change in the provision of care.

Suicidal Ideation

6.6 This case shows how there can be missed opportunities to recognise and respond to someone articulating suicidal intentions. This is a crucial area for all services to have systems in place to recognise and respond to people who do show signs of wanting to die by suicide.

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[11] www.solinked.org.uk

[12] https://www.legislation.gov.uk/ukpga/2014/23/section/10/enacted

6.7 Although the GP Practice called for an ambulance, there was no follow up, or alert to the mental health team or police once Diana had left the building. It is essential that GP practices have policies and emergency procedures for what to do when a patient becomes distressed and expresses the intention to attempt suicide.

6.8 This case identified how there is a need for contact management staff (call handlers), working within the police, to be trained to listen to a caller and to respond in a safe way if the caller indicates any suicidal ideation. This should be a requirement for any service in contact with the public.[13] Furthermore, when an individual expresses suicidal ideation there should be a follow up with the individual and alerting the mental health team for those known to the service.

Safeguarding

6.9 This case suggests that there is an unclear system for responding to adult safeguarding concerns in the city. There have been improvements to how safeguarding referrals are now dealt with, as urgent referrals are allocated in a timely way. During the Covid-19 pandemic there has been ASC cover at weekends.

6.10 The practitioner event identified this as a clear area to continue to improve and shows a need to develop a formal Adult MASH to make the volume of referrals manageable to meet the needs of those at risk. This would ensure that the Local authority is meeting the requirements of the Care Act 2014.[14]

6.11 There has already been learning undertaken by housing regarding this case, but it would be useful to measure the impact of their training about calling a Multi-Agency Risk Management Meeting to ensure that a resident can be supported in a well-coordinated way.

6.12 The CMHT worked hard to try to support Diana. However, this case showed the challenges faced when the relationship between service user and professional breaks down. Given the, long term, significant concerns for the safety and welfare of the individual, this meant that she lost her, previously, trusted support. This demonstrates the need for formal multi-agency working to ensure that the most appropriate support is put in place for a service user, with continued care and support needs, prior to discharge from the co-ordinating service.

6.13 This case reveals the risks when there is no formal multiagency care and support plan in place to manage the safe move of home for a potentially vulnerable person, particularly one who reports a history of domestic abuse.

Learning from Single Agency Investigations

6.14 It is acknowledged that both police and the Mental Health Trust undertook internal investigations of their actions in relation to Diana prior to the start of this review.

Southern Health NHS Foundation Trust

6.15 The serious incident investigation found that there was a care delivery problem in that Diana was discharged from the mental health services 'very quickly and without robust risk and contingency planning with key people such as her GP, (ex) partner and housing. There was no consideration given to the length of time she had been under the care of Mental Health services nor of her current risk factor such as her recent move, historic safeguarding and being registered with a new GP'

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[13] https://www.zerosuicidealliance.com/training

[14] DHSC (2016) Care Act: Care and Support Statutory Guidance section 14. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

6.16 This led to a recommendation within the investigation report that:

> '*All discharge planning will be undertaken during a CPA and should involve all relevant parties including GP, families/carers, housing etc. Robust planning will include all agencies and take into consideration risks as well as safeguarding, with an up to date My crisis and Safety Plan and arrangements for medication monitoring and reviews with the GP. A copy of the discharge plan should be sent to all parties alongside an up to date My Safety and Crisis Plan'*

Hampshire Constabulary

6.17 The case was appropriately referred to the IOPC[15] to conduct an independent, internal investigation into actions taken by the police. This identified gaps in the knowledge and skills of those taking the calls from the public when the caller reports suicidal thoughts and expresses their vulnerability due to physical and mental health problems.

6.18 There were also lessons in relation to the clarity of force policy regarding how reported assaults and harassment are investigated, as well as the role of the police in responding to people with mental health problems and safeguarding issues.

Primary Care

6.19 The IMR identifies that good practice for changes of practice are for this not to happen during times of stress. It would be expected that a patient would be given 30 days to make alternative arrangements as set out in the GP contract[16]. This is not an unusual issue with some practices, and it is vital that this raised with all GPs in the City to ensure there is care available for patients in distress.

7 CONCLUSION

7.1 In conclusion, this review has identified how individual workers tried hard to help Diana. However, the help seemed to diminish too rapidly following Diana's move of home. This meant that Diana, as someone who had lived most of her life dependent on others, was left without clear support because services interpreted her behaviour as meaning that she was resourceful enough to access the help she needed. Yet she was seen as having care and support needs as set out in the Care Act 2014 and, as such, should have continued to have some form of measurable care and support in place.

7.2 It could be said that the reason this had not been in place was due to Diana's aggressive response to those involved. Nevertheless, someone who has been deemed to have vulnerabilities, even if they are refusing, must not left without constructive contact to regain their trust and agreement to move forward. There should have been a professional network firmly in place to provide the access for Diana to make her voice heard and to support her to keep herself safe.

7.3 This case raises questions about how the multi-agency network addresses reported domestic abuse when the partners are known to be reliant on each other or, as in this case, one is the formal carer for the other.

[15] The IOPC carries out its own independent investigations into complaints and incidents involving the police, HM Revenue and Customs (HMRC), the National Crime Agency (NCA) and Home Office immigration and enforcement staff. We are completely independent of the police and the government. All cases are overseen by the Director General (DG), who has the power to delegate their decisions to other members of staff in the organisation. These individuals are referred to as DG delegates, or decision makers, and they provide strategic direction and scrutinise the investigation

[16] NHSE (2020) Standard General Medical Services Contract Section13.13

7.4 Additionally, there are questions for multi-agency partners as to how individuals who have care and support needs are facilitated to access the help, they need to live more independent lives.

8 Recommendations for SAB

8.1 The reviewer endorses the recommendations from the single agency investigations. These are shown in the appendices.

8.2 The reviewer has identified further recommendations from the findings that need to be taken forward from a multi-agency perspective.

Item	Review Finding	Recommendation
1.	There was insufficient follow up of who could, or should, provide carer support for an individual with care and support needs who has a broken relationship with their registered carer.	The SAB must request a review of how Carers' assessments are completed and reviewed, and how the person requiring the care is able to express their views without interference. The review should include how advocates are utilised in these circumstances.
2.	There was insufficient understanding of how to respond to an individual expressing suicidal thoughts.	The SAB should gain assurance that first line contact staff in agencies have undertaken suicidal awareness training. E.g. https://www.zerosuicidealliance.com/training
3.	An individual with care and support needs was discharged from the mental health service without a multi-agency discharge plan.	When a person has been identified as having care and support needs which they cannot totally manage themselves, there must be an agreed multi-agency plan in place prior to discharge from a long term service.
4.	Not all agencies were confident in calling MARMs	The SAB should ask for assurance from the agencies that there is guidance in place for MARMs, that staff have had training and have access to supervision regarding complex cases.
5.	Safeguarding arrangements are not managed in a multi-agency hub. This leads to the onus being placed on a single agency and the process lacks rigour. The participants at the Practitioner Workshop viewed this as a vital area of development.	There should be a review of how agencies identify safeguarding concerns and work together to implement early intervention and appropriate assessments. This should include consideration of the development of a MASH for adults. The SAB should seek assurance that this is done and that there is compliance with the Care Act 2014.

9 APPENDICES

9.1 INDIVIDUAL MANAGEMENT REVIEW (IMR) RECOMMENDATIONS

Item	Recommendations
1	**Southern Health NHS Foundation Trust**
1.1	All discharge planning will be undertaken during a CPA and should involve all relevant parties including GP, families/carers, housing etc. Robust planning will include all agencies and take into consideration risks as well as safeguarding, with an up to date My crisis and Safety Plan and arrangements for medication monitoring and reviews with the GP. A copy of the discharge plan should be sent to all parties alongside an up to date My Safety and Crisis Plan.
2.	**Hampshire Police**
2.1	Hampshire Constabulary should consider a review of force policy with regards to mandating a renewed risk assessment/adult at risk notification where further incidents or information regarding a safeguarding concern occurs within a set period of time.
2.2	When tasking NPT to conduct a reassurance visit following an ASB or neighbour harassment call, Hampshire Constabulary Contact Management call handlers should be explicit in their reason for requesting visit and highlight if the tasking is with the intention of safeguarding and may require completion of a PPN1 should risk be verified.
2.3	Hampshire Constabulary should review Stalking and Harassment FPP specifically in relation to section 2.11.6 directing use of the DASH risk assessment tool or the stalking assessment tool (AD344a). If stalking and harassment is to remain as a combined FPP it should provide clarity as to the most appropriate risk assessment tool to use dependant on the nature of the circumstances i.e. neighbour dispute Vs intimate partners or stalking.
2.4	Hampshire Constabulary should ensure that any staff dealing with members of the public are able to identify indicators of self-harm and suicidal ideation.
2.5	Provide assurance to the SAB regarding the progress of any recommendations made by the IOPC in its investigation of Hampshire Constabulary practice.
3.	**Primary Care**
3.1	Digital: GP to GP notes transfer. This is not commissioned at local level, but we can raise concerns about how well this system works and the timeliness of this. Paper notes are often slow to reach practices and difficult to navigate so a digital solution or improvements need to be explored.
3.2	DNA Policy for Vulnerable Adults. The 4LSAB policy needs to include follow up reasons for DNA.
3.3	Discharge planning for complex mental health patients should be done collaboratively so that agencies are aware of the risks and safeguards and processes are in place to manage these. The input from other agencies may help understand wider risks that may influence decision making. In this case the new primary care team who yet have a rapport, the change in housing etc.
3.4	Changing GP practice: Patients must not be asked to re-register at times of distress. Best practice would be to give the patient 30 days in which to make alternative arrangements.
3.5	Dealing with patients in crisis: It would be useful to discuss this case with our mental health clinical lead and make sure that clear advice is distributed to primary care about how we can deal with patients who are distressed and leave our practices. Making sure it is clear what processes to follow, how to identify those at risk and who they should and could call. This could include asking to speak to the duty worker at CMHT do request help in assessing this presentation and the level of risk. There is also the opportunity to provide some education around de-escalating in EUPD.

9.2 Virtual Practitioner Workshop 5th November 2020

The practitioner workshop was conducted via Microsoft Teams due to COVID-19

The workshop was attended by:

- Chair and Independent reviewer
- Safeguarding Partnership Coordinator – Southampton Safeguarding Partnerships Team
- Serious Case Reviewer - Hampshire Constabulary
- Neighbourhood Policing Team – Hampshire Constabulary
- Team Leader - Community Mental Health Team, Southern Health NHS Foundation Trust
- Community Mental Health Nurse - Community Mental Health Team, Southern Health NHS Foundation Trust
- Specialist Practitioner - Safeguarding Adults Team, Southern Health NHS Foundation Trust
- Support Worker - Community Mental Health Team, Southern Health NHS Foundation Trust
- Area Head of Nursing - Southern Health NHS Foundation Trust
- Safeguarding Facilitator - Solent NHS Foundation Trust
- Adult Safeguarding Facilitator – Solent NHS Foundation Trust
- Head of Safeguarding/Designated Nurse – Southampton City CCG
- Safeguarding Adults GP Lead – Southampton City CCG
- Service Manager for Mental Health and Adult Safeguarding – Southampton City Council
- Community Safety Officer – ABRI (Previously Radian)
- Tenancy Sustainment Manager - ABRI (Previously Radian)
- Welfare Benefits Officer - ABRI (Previously Radian)
- Housing Manager - ABRI (Previously Radian)

9.2 Terms of Reference

Reason for Review

Diana was found dead at home in June 2019 after a friend expressed concerns to the Police for her welfare after she had not been seen for 4 days. Diana's suspected cause of death is suicide. Diana had a history of physical care needs, substance misuse and complex mental health diagnoses. She was also a survivor of high risk domestic abuse.

There are issues with regard to partnership working and communication between agencies regarding Diana and the care she received from a number of agencies.

Scope of the review and methodology

The Southampton SAB Case Review Group recommended that a multi-agency review workshop (Discretionary Safeguarding Adult Review) was convened for this case. **The time period review will be from 1st January 2018 to 10th June 2019 and a full chronology will be requested from agencies for this period. A summary of key events will be requested from agencies for 1st January 2015 to 31st December 2017.**

The review will involve practitioners and their managers/case review group representative and take the form of individual practitioner conversations and a practitioner's workshop. Information to be included in the scope of the review are an integrated chronology summarising engagement from agencies with Diana which will help inform the learning and recommendations. The recommendations arising from the review will be summarised

in a short report and presented to the Southampton SAB. The family will be invited to contribute to the review, although they will not attend the workshops.

Key Lines of Enquiry (KLOE)

This review will centre on the issues of partnership working and communication between agencies working with Diana; specifically:

- Housing support provision including assessment of risk for Diana from other tenants
- Liaison between housing, police and mental health services
- Presence of joint and collaborative responses to Diana's physical and mental health needs/care planning including appropriateness and quality of responses
- Concerns raised by family regarding support provided following property move and that Diana was 'being taking advantage of'
- Any relevant findings from IOPC investigation

Agencies to be involved with the Review:

Primary Care
University Hospital Southampton NHS Foundation Trust
Southern Health NHS Foundation Trust
Independent Domestic Violence Advisors (IDVA)
Southampton City Council Adult Social Care
Radian
Solent NHS Foundation Trust
Hampshire Constabulary