

**Safeguarding Adults Review**

**Executive Summary**

**Tower Hamlets Safeguarding Adults Board**

**Title**: Ms C – Safeguarding Adults Review Executive Summary

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# Background to the review

1. Ms C was a white British woman in her mid-twenties, who took her own life by hanging. She had a range of mental health diagnoses: personality disorder, Asperger Syndrome, depression and anxiety. At the centre of her life was the dog she had acquired the year before she died, which gave her a level of emotional support that was recognised by some of the professionals who worked with her. When Ms C’s landlord gave her notice to leave a shared house where she was a tenant in Tower Hamlets, Ms C and professionals at the voluntary sector organisation who knew her well, made the point, repeatedly, that moving would be exceptionally stressful for a young woman with her range of conditions and mental health problems. They explained clearly that separation from her dog would leave Ms C feeling hopeless to the point of not wanting to carry on living and spelt out the risk that she would take her own life. Initially Ms C received a consistent and thoughtful response from the Housing Options Singles Team in Tower Hamlets, which seeks accommodation for single adults confirmed as homeless or at risk of homelessness, and for whom the local authority has a responsibility under housing law.
2. Ms C used a wide range of services provided by the East London Foundation Trust, nine in total, during the period under review and a panel member made the point that this meant professionals should have shaped their practice with Ms C as they would with a transient person. Although a Tower Hamlets resident, she registered with a Hackney GP, after her move into Tower Hamlets, giving her previous address which was in fact in Hackney. Being registered with a Hackney GP meant that the GP referred Ms C not to Tower Hamlets services provided by the mental health trust, but to Hackney provision by the same mental health trust. Ms C’s history was not fully understood because of the way she moved between services, and the risk to her was not fully assessed partly because professionals tended to rely on Ms C’s own account of past mental health problems and trauma. This was compounded by the difficulties of assessing risk in any adult who has Asperger Syndrome or Autism, who do not always show emotion or give signals to professionals about their level of distress. The voluntary sector counsellor had the best understanding of Ms C’s needs but other professionals from organisations did not always liaise with the organisation in Ms C’s best interests.
3. On two occasions, professionals from different organisations, firstly voluntary and then statutory, clearly reported safeguarding concerns about Ms C to the local authority, which were not followed up as they should have been. This meant that the escalating level of risk for Ms C, as eviction day approached, was not assessed or recognised. This has raised questions on the robustness of reported improvements at the local authority ‘front door’ where risk is assessed and initial safeguarding concerns dealt with. These improvements were said to be in place by 2016, the year Ms C took her life, in response to another woman of very much the same age, Ms L, taking her own life the previous year. A Safeguarding Adults Review was carried out into Ms L’s case and the summary published by Tower Hamlets Safeguarding Adults Board in 2018. A series of further changes to the way concerns are received and assessed, along with reported improvements in joint working between organisations, and the introduction of a “High Risk Transitions Panel” are detailed this report, along with recommendations about testing their robustness.
4. From the outset, HOST workers were clear about the lack of housing stock in Tower Hamlets, which meant that finding somewhere that Ms C could move to with her dog was highly challenging. Initially, housing professionals explored what might be available, with some of their well-intentioned efforts suggesting a lack of clarity about housing and mental health pathways and provision that could respond to the risks in Ms C’s situation. Ms C’s eviction date came two days before a Bank Holiday and following a period when feedback from the Housing Options Singles Team had fallen silent. The chief officer and counsellor at the voluntary sector organisation spent an anxious 48 hours pressing housing professionals for news of what might be available, with the offer being that of a room in a hostel, where Ms C could not have her dog. The only thing to commend it was that the location was familiar to Ms C. As it happened Ms C, who was accompanied throughout the move day by the counselling professional, felt so unsafe that she was admitted to an impatient bed on a mental health unit. She chose to go to Hackney for the assessment process that led to this admission, which as a result, meant the admission was also in Hackney.
5. On discharge, this time to a different hostel in the London Borough of Newham, which was not familiar to her, Ms C was supported by the appropriate Newham service of the mental health trust. Her dog remained with friends. Ms C remained at the hostel for two weeks but asked to be readmitted to the ward, which she was, again as a voluntary patient, which may have affected some of the planning for her. She sadly took her own life during a period of home leave from the ward which was followed up in line with expected practice by the Newham mental health service. She had made some plans for the future which provided a possible reassurance that she was looking ahead, but at the inquest into her death, it was shared that Ms C had also concealed well developed plans to end her life. She had visited her dog on both of the two days before she took her life and although on the second of these days, she reported to mental health workers that she had enjoyed the visits, and had plans to seek a home where she could look after the dog again, it is not certain that these positive comments could be taken as true statements of how she was feeling about the future.
6. Communication and discharge planning for Ms C was impacted by the fact she was out of her home borough. There is a variation in what is available to inpatients in Tower Hamlets and Hackney. For instance, Tower Hamlets has a housing worker to liaise on behalf of patients as part of discharge planning, but Hackney does not. Despite the voluntary sector organisation communicating constantly with statutory organisations, there was not communication back to them. Ms C was discharged, not to the room in Tower Hamlets, but to one in the neighbouring, but to her, unknown, borough of Newham. Despite asking to be told of discharge plans so they could provide familiar support, the voluntary sector professionals only learnt of her discharge when they rang the ward for an update. Meanwhile the consultant from the ward was concerned to accurately assess the risk of Ms C self-harming or taking her own life, a particular challenge due the way that adults with Asperger Syndrome (or other conditions on the Autistic Spectrum) and mental health problems as well as personality disorder, can come across. An autism professional from the Hackney service, who had previously assessed Ms C, visited and provided a troubling picture of risk. In line with expected good practice, the ward consultant asked for a second opinion from a colleague with relevant expertise but this appears to have been declined. The reasons for this are not understood and assurances have been provided to the review panel that changes to services mean this should not happen again. The third factor was the great pressure on housing stock in Tower Hamlets which resulted in Ms C being placed in another borough.
7. Ms C had a complex combination of diagnoses – Asperger Syndrome, anxiety and personality disorder. Some services designed to help adults with one of those conditions also contained elements that are not recommended at all for adults with one of the other conditions. Her needs were not always understood or responded to. In this respect, there is systems learning from this review, and a new Autism Strategy is intended to further develop Tower Hamlets services. The other strands of learning from this review – about responding to the mental health needs of those who are made homeless, when there is such huge pressure on housing stock, and of the need to coordinate the care of adults with complex diagnoses who move between services and local authority or GP areas, have implications for all three east London boroughs where Ms C used services. The loss of housing where she felt safe, which in turn meant she had to part with the dog which provided her with her main support, appears to have had tragic consequences for Ms C.

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

1. The following agencies had worked with Ms C during the period under review

* East London Foundation Trust
* City and Hackney Autism Service
* City & Hackney Therapeutic Community Outreach Service
* Hackney Primary Care Liaison Service
* Hackney Centre for Mental Health
* Newham Centre for Mental Health
* Newham Home Treatment Team
* A Tower Hamlets voluntary sector organisation providing services to young people in the borough
* London Borough of Tower Hamlets Adult Social Care
* London Borough of Tower Hamlets Housing Options Singles Team (HOST)
* A Hackney GP practice where Ms C was registered from 2014
* Metropolitan Police Tower Hamlets
* Barts Health Trust

# **Summary of findings**

1. The following issues were discovered as part of the review:

* Ms C's safeguarding needs were only identified by a minority of professionals working with her, and her situation was not seen through the lens of adult safeguarding.
* Co-ordination of care is particularly important for service users with Ms C's complex combination of Asperger Syndrome, personality disorder, anxiety and chronic suicidal intent, who are known to a number of services. This co-ordination should have been delivered by one of the statutory services working alongside Ms C and the voluntary sector organisation that she trusted. Instead this co-ordination was entirely lacking, with the consequence that Ms C's level of risk was not fully understood or responded to**.**
* At the time they were working with Ms C, professionals lacked, or were unclear about, an agreed pathway for those at high risk, homeless and suicidal. Links between Housing Options, mental health and adult safeguarding were insufficiently robust at the time and did not include the voluntary sector as partners.
* The difficulties of assessing suicide risk are compounded in adults with autism. Professionals in services such as housing advice and at the front door of adult social care need sufficient awareness to be able to engage with adults with autism, or form working relationships with other professionals who can assist them. For psychiatrists and other mental health professionals with specific responsibilities under the Mental Health Act, and set out in NICE guidance, this judgment is particularly important, as is the ability to call in help from other professionals with relevant expertise.

# Recommendations

1. The board needs to assure itself of the extent to which professionals from the relevant agencies in Tower Hamlets are able to identify a safeguarding risk and tenaciously follow it up as set out in local policy and processes.
2. The board should test out assertions about improved coordination and pathways between mental health, housing and adult social care - for example that the High Risk Transitions Panel is 'very successful' and understand what these mean for adults at risk of suicide and self-harm.
3. The board should assure itself, linked to a Tower Hamlets Autism Strategy, of the level of awareness and related skills that professionals in assessment services for housing and social care, have in communicating with and understanding how to make reasonable adjustments for, people with autism.