Safeguarding Adults Review Overview Report in respect of

Miss Y

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1 Forward

At the centre of any Safeguarding Adults Review is the person who the case review is about, in this case Miss Y. As part of the review process we had the opportunity to engage and speak with Miss Y's family. We realise that this must have been extremely difficult for them and we are grateful that they shared their stories and experiences of Miss Y and helped to ensure Miss Y's voice was heard through the report. The circumstances of this review are particularly sad and the Cambridgeshire and Peterborough Safeguarding Adults Board, when receiving and accepting this report wishes to express to the family their condolences and convey to them their determination to learn from the tragic circumstances that led to Miss Y's death.

2 Introduction

This Safeguarding Adults Review (SAR) focuses on the case of Miss Y, who was murdered on 27th November 2019. Miss Y had care needs and suffered from non-specific phobias in the context of Borderline Learning Disability with Obsessive, Compulsive traits. Miss Y was a resident in a low support care setting (the setting), which is a part of the Cambridgeshire County Council's Mental Health Supported Accommodation Pathway.

In November 2019, Miss Y was attacked and strangled by another resident in the communal lounge area of her accommodation, leading to her death. The other resident, Mr A, suffered from Paranoid Schizophrenia and other medical conditions. Mr A had in the past, on several occasions expressed hostile feelings towards females, described as misogynistic behaviour[1] at his subsequent trial.

Mr A was arrested following the attack and charged with the offence of murder. After contesting the charge of murder on the basis of diminished responsibility Mr A was convicted of the offence of murder and sentenced to life imprisonment.

The case was referred to the Cambridgeshire and Peterborough Safeguarding Adults Review Group in July 2020, where it was decided that the case fitted the criteria for a Safeguarding Adult Review (SAR).

3 About the Author

The author is Independent of this case and any of the agencies involved. He is the chair of the Cambridgeshire and Peterborough Safeguarding Adults Review sub-group.

Mr Chapman is a retired senior police officer and senior investigating officer. He has since been involved in working with local authorities, the health and third sector and the Church of England in a safeguarding capacity.

He has authored Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

1 Judge's sentencing remarks February 2021

4 Methodology and terms of reference

The purposes of a SAR[2] are: -

- To establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard vulnerable adults;
- To review the effectiveness of procedures;
- To inform and improve local inter-agency practice and
- To improve practice by acting on learning (developing best practice)

The Cambridgeshire and Peterborough Adults Review sub-group established a panel to oversee the SAR process and assist the author with identifying learning opportunities from the case.

Terms of reference for the review were agreed and it was decided that the timeframe in scope for the review would be from 1st January 2018 to the date of Miss Y's death in November 2019.

The agencies who had engaged with Miss Y and Mr A within this timeframe were asked to prepare an Individual Management Report (IMR) and a chronology covering this period. The authors were also asked to consider any information which was outside the scoping period but may be relevant to safeguarding and learning opportunities. The authors were asked to particularly focus on the following areas identified by the panel.

- Were there any early indicators that the perpetrator could cause harm, and if so, were the correct steps taken to prevent harm?
- Was Miss Y sufficiently safeguarded, did professionals share information adequately to ensure she was kept safe?
- How were risk and protective factors identified, assessed and managed?
- What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?
- Are there any areas of good practice?

The agencies identified as having relevant involvement in the case, who provided a chronology and IMR, and took part in the reflective discussions were: -

- Cambridgeshire County Council – Adult Social Care (ASC)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- GP's for Miss Y and Mr A
- Sanctuary Supported Living
- Metropolitan Thames Valley Housing

2 Cambridgeshire and Peterborough Safeguarding Adults Review Policy and Procedure – https://www.safeguardingcambspeterborough.org.uk/wp-content/uploads/2018/05/SAR-Policy-and-Procedures-April-2018.pdf

5 Family perspective

Miss Y has a mother and sister, both of whom wished to be involved in the review. They state that Miss Y was a very happy, loyal and likeable person. Miss Y attended mainstream school and managed well, although she had slight learning difficulties. She had a number of long-term good friends. Miss Y was very honest and had some childlike qualities.

There were incidents in Miss Y's life which had a significant impact on her. Her father, maternal grandmother and grandfather all died suddenly, within the space of 13 months and this is something that she never came to terms with and was a source of her anxiety. As an adult she was, for a period, living independently and during this time her house was subject of a night-time burglary and she confronted the intruder, which caused her considerable ongoing distress.

Miss Y wanted to be involved with people, some people did not understand Miss Y and when this happened Miss Y could be perceived as being difficult, but this was not really what she was like.

The family have strong views on what they perceive was a decline in support that was offered to Miss Y at the setting. This, they feel, was more prevalent over the previous two years. There are a number of areas where the family would disagree or hold different views to those recorded by agencies. Where this is the case it is highlighted in the report.

6 Background

Miss Y's psychiatric history dates back to 1994 at which time she was displaying anxiety symptoms/low mood and some eating disorder symptoms. Her diagnosis, as recorded by the mental health trust, was phobic anxiety disorders, with differential diagnoses of learning difficulties, obsessive compulsive traits and emotional dysregulation traits. At the practitioner event, the psychiatrist stated that there was not a differential diagnosis and that Miss Y had a borderline learning disability.

In her early twenties, Miss Y developed panic and anxiety attacks which led to three informal admissions to hospital (30.10.02 – 31.10.02, 3.11.02 – 29.11.02, 4.12.02 – 6.1.03). Miss Y went voluntarily into hospital after her house was broken into in the middle of the night when she was home alone. She felt unable to stay in her own home after this. On her last discharge, it was decided that she would not return to her own home and she moved into supported accommodation. She was also referred to learning disabilities services. Miss Y moved to the setting in 2004.

The setting is accommodation comprising of 16 self-contained flats and a communal area, for people with mental health difficulties requiring low level support. The landlord is Metropolitan; however, the support staff are employed by Sanctuary. Miss Y's placement was commissioned by the Adult Mental Health Locality Team and funded by the Adult Mental Health Social Care Team. Miss Y was subject to a care package review by the Adult Mental Health Locality Team on an annual or more frequent basis.

Cambridgeshire County Council and Peterborough City Council commission CPFT to deliver their adult social care function under Section 75 of the NHS Act (2006)[3]. As a result of that the responsibility for delivery of The Care Act function, including relevant MCA assessments, care act assessments, safeguarding enquires, commissioning of individual care packages, carers assessments and HRA assessments has all been delegated to CPFT under the S75 agreement.

Miss Y received support from the setting and was entitled to five hours per week, although Sanctuary would state that the support that was afforded to her often exceeded this. Whilst this is their view, the daily record sheets they maintained for Miss Y do not support this.

In September 2017, provision of care at the setting moved from Metropolitan to Sanctuary, after Sanctuary were awarded the contract for care by Cambridgeshire County Council, with Metropolitan retaining the responsibility as landlords. The setting is a scheme that is commissioned for visiting support with no permanent on-site staff presence required. Miss Y's family would say that it was at this point that support levels within the setting were reduced and this was a source of tension between the care providers and the family. The family would say that the staffing levels suffered as did the apparent morale of staff and responsiveness to the service users. Any reduction in staffing levels is refuted by Sanctuary who are able to demonstrate that on a weekly basis the staffing levels were adequate to meet the commissioned level of support.

Miss Y was well known in the local area and had a part time job, which she attended intermittently.

Mr A first came into psychiatric services in November 2002, when he was sectioned under the Mental Health Act. He was detained in semi-secure accommodation until his condition improved. Mr A moved to a rehabilitation unit before moving to supported accommodation. He moved to the setting in August 2007.

Mr A has a long history of paranoid schizophrenia and moderate depressive episodes. His condition has been managed by medication. In March 2012, Mr A reported gradual deterioration of his mental state with moderate persecutory delusions, social withdrawal, low mood and temporarily stopped most of his day activities, becoming more withdrawn.

Mr A had two periods of admission into Fulbourn hospital[4] in 2012 and 2016 with suicidal ideation. He became increasingly isolated and developed bowel and stomach problems, which were being investigated. He was seen fortnightly by his care co-ordinator, who also administered his depot injection[5]. Mr A, was generally responsive to his care coordinator and complied with his depot medication.

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3 Section 75 Agreement - 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.

4 Fulbourn Hospital has a number of inpatient units providing mental health care.

5 A depot injection is an injection formulation of a medication which releases slowly over time to permit less frequent administration of a medication

Both Miss Y and Mr A had nominated support workers at the setting provided by the care provider. They also both had a CPFT care coordinator, Miss Y had a social worker and Mr A had a Community Psychiatric Nurse (CPN).

Miss Y had an assessment under the Care Act (2014) which assessed her needs and how those needs impacted on her wellbeing. The assessment identified which areas Miss Y was unable to achieve as (1) develop and maintain family and personal relationships (2) access and engage in work, training and education and (3) use facilities/services in the local community. The assessment identified the rationale why these could not be achieved as caused pain/distress, took longer and that she required assistance. The section which would have been completed by Miss Y is left blank with no reason for this. This assessment is dated March 2016, it should be updated annually but this did not happen.

7 Summary of Facts

At the start of the period of this review, January 2018. Both Miss Y and Mr A were living in separate flats at the setting. Mr A's flat was located below Miss Y's.

In January 2018, Miss Y was seen by her Occupational Therapist and she expressed a desire to move to be nearer to her mother. She stated that she was not happy living at the setting, she was anxious. Miss Y's feelings on wanting a move fluctuated as later in the month during a review with CPFT and Sanctuary she stated that she no longer wanted to move. Miss Y stated that her desire to move was usually based on a particular incident at the setting and it was agreed that she would discuss any future issues at her daily support sessions.

At around the same time Mr A was seen by his CPN and he expressed that he had stomach pains. It was apparent that this stomach condition was also increasing his level of stress.

Often when Mr A was seen by his CPN he was not very communicative and described as 'monosyllabic'. Mr A continued to complain regularly of stomach pain and was advised to get remedy from the pharmacy. During visits from the CPN, support staff expressed a concern that Mr A was not accessing them for the allocated weekly support. There were early indications that Mr A was self-neglecting himself with regard to personal care.

In early April 2018, Mr A attended the Emergency Department at Addenbrookes Hospital. Hospital records show that he attended for physical health reasons not mental health. He refused to leave, and hospital security were called. Police records show they were called, and it was alleged that Mr A had assaulted the security guard. No further action was taken as a result of the security guard not wishing to pursue the matter. Neither police or the hospital had any grounds to be concerned regarding Mr A's mental health at this time and therefore no follow up information was shared.

In April 2018, CPFT conducted an annual review of Miss Y's Care Programme Approach (CPA). In this review, the risk assessment recognised a high risk of Miss Y being abused or assaulted in the community due to her own behaviour. The support staff considered that there was a risk of Miss Y being harmed in the local area, due to her behaviour as opposed to being harmed in the setting.

In May 2018, a Sanctuary support worker and Miss Y's social worker discussed concerns regarding Miss Y and in particular her recent behaviour in the community. It is recorded that Miss Y had been approaching members of the public and businesses for money. When this was not forthcoming Miss Y's behaviour was said to be challenging, which in turn led to her

being excluded from premises. It was agreed that a mental capacity assessment would be undertaken with Miss Y regarding her ability to undertake decisions regarding her financial and social wellbeing. In this conversation the support worker disclosed that at weekends Miss Y stayed with her mother and Miss Y had said that her mother is '*verbally abusing her and slapping/hitting her'*. The record infers that when the support worker challenged Miss Y's mother, she refused to discuss this. Miss Y's family state that at no time were these issues raised with them by staff. There is no evidence that this disclosure was subject to any further action.

The social worker and support worker attempted a mental capacity assessment. Miss Y was receiving £100 over 7 days, divided into envelopes by her mother but Miss Y was clear that she wanted her own access to money. This system had been set up by Miss Y with her bank.

In June 2018, support staff reported to the CPN that Mr A, was still suffering stomach problems, he had been to see his GP but following blood tests no problem was noted.

At the end of June 2018, Miss Y was seen by the consultant psychiatrist. Miss Y stated that she had not been reviewed for 18 months and that she felt neglected by services. It was the opinion of the psychiatrist that Miss Y continued to struggle to manage her emotions, which was partly due to her limited intellectual capacity and her ability to understand and manage her frustration and anger. It was obvious that her allocated support worker was struggling to meet Miss Y's needs and it was recognised that additional support should be sought. It was recorded that consideration should be given to sourcing a female support worker. This change in support worker did not occur. At this time Sanctuary would state that staffing was over provisioned by one full member of staff until early 2020. There was an available female member of staff, but they were not qualified to undertake key working.

In July 2018, Miss Y attended a Family Therapy Formulation Group, this was attended by a number of professionals involved in Miss Y's care. It was recognised that Miss Y did not attend any activities arranged by the setting, the reason given being her disruptive behaviour. Miss Y had previously undertaken activities with the setting prior to July 2018 which involved barbecues, holidays, and pub evenings. The plan involved undertaking a mental capacity assessment for Miss Y, with particular regard to her managing her finances. There was also consideration for advocacy for Miss Y and the offer of a carer review for her mother.

In August 2018, CPFT recorded that one of the factors for Miss Y's anxiety was her ability to manage her money. It also stated that her mother was emotionally abusive towards her. During a later meeting with her mother Miss Y became upset and her mother stated that Miss Y was not able to manage her own finances. The family would dispute that they were ever emotionally abusive, there is no record of the family being challenged on this or any safeguarding referrals made regarding her mother's relationship.

At this time considerable effort was put into understanding Miss Y's desire to control her own finances. It was recorded that she wished greater control of her finances but did not wish to upset her mother. Three options were identified. (1) Arrangements remained the same and Miss Y's mother managed the finances (2) If Miss Y was deemed to have capacity, she took control of her finances (3) Her finances were managed by a nominated third party. At this time Miss Y clearly stated her desire to manage her own finances and the social worker recorded that she had capacity to do so.

In September 2018, there were continued concerns regarding Mr A's physical health and he attended a hospital appointment with support staff. Mr A was given advice for his stomach condition.

At the beginning of October 2018, during a review of Miss Y's care it was agreed that there would be a review of Miss Y's medication and the social worker would contact her mother. It was also noted that her support worker was struggling to meet Miss Y's demanding behaviour. This was not the first time this had been raised.

A safeguarding enquiry under s42 of the Care Act[6] was made, regarding the ability for Miss Y to manage her finances and the anxiety that this caused her. Miss Y made the decision that she did not want the s42 enquiry to continue and it was closed.

At the end of October 2018, Mr A was seen by his CPN. Mr A was distressed, stating that he felt he was going to die and that he wanted to be admitted to Fulbourn Hospital. Mr A had failed to attend hospital for an endoscopy appointment for his stomach condition and he was self-neglecting himself. The CPN opened a safeguarding enquiry on the basis that Mr A was neglecting himself and contacted Mr A's GP.

This referral initiated an email discussion between the CPN and the CPFT Safeguarding Team. The CPFT safeguarding team advised that a mental capacity assessment for Mr A would be required. The CPN stated an assessment had not taken place but they felt Mr A possessed capacity for decision regarding his health. On the basis that all the necessary agencies were involved with Mr A's care the safeguarding enquiry was closed and that if the situation did not improve the case could be further discussed.

At the beginning of November 2018, the GP recorded that they had concerns regarding Mr A's mental capacity and that they felt he warranted a full psychiatric assessment. For reasons that are not clear, CPFT recorded that the GP had a view that Mr A maintained mental capacity. Mr A continued to request admittance to Fulbourn Hospital and the CPN discussed this with the mental health crisis team who felt that admission would not assist Mr A at this stage.

A couple of days later there was an incident involving Mr A and one of the support workers. Mr A entered the common room at the setting stating that he wanted to kill someone. He then made a gesture towards the support worker, as if to strangle him. Mr A was told to return to his flat which he did. Mr A returned some 25 minutes later and took a metal dining fork from the kitchen area and approached the support worker and gestured as if to stab him in the neck. Mr A was physically removed from the common room and the fork taken from him. Mr A again returned to his flat. He made numerous attempts to re-enter the common room, but his access was blocked. During these incidents Mr A made comments regarding being cared for and wanting to be at Fulbourn Hospital. The CPFT report for this review records that during this incident that Mr A made threats to kill others and this included Miss Y, who he felt made excess noise.

6 Section 42 Care Act 2014 - https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

Staff at the setting, attempted to contact Mr A's CPN, but when an immediate response could not be achieved, they called the IMHT[7], which was located with the Police. Whilst speaking with the police the CPN made contact and on this basis, it was agreed that the police would not attend.

The CPN first liaised with the consultant psychiatrist and was advised to call the Home Treatment Team (HTT) to see Mr A, assess him with a view to an admission to Fulbourn. The HTT was contacted and were unable to see Mr A on this day. The CPN was asked to visit Mr A and establish whether this behaviour was linked to a deterioration in mental health or his desire to access a place at Fulbourn.

The following day it is recorded by CPFT that the Crisis Team saw Mr A and assessed him. Mr A was assessed using the DICES[8] mental health assessment tool. The assessment recognised that Mr A was suffering physical ill health in the form of sickness and stomach complaints and was failing to care for himself. The assessment recorded that the GP had recently undertaken a Mental Capacity Assessment and Mr A was deemed to have capacity to decline medical interventions. This was not in fact the case. The GP had seen Mr A and questioned his capacity and conveyed the concern to the care coordinator at CPFT. The GP suggested a joint meeting and that a formal psychiatry assessment/mental capacity assessment was needed.

The assessment stated that the member of staff who had been threatened had been spoken to and there had been no actual physical contact in either incident the previous day. It is recorded by the HTT that Mr A had been assessed by the CPN and at that time had voiced 'I am going to hurt people, I am going to attack people, I am going to kill people'. Mr A had stated that he wanted to be admitted to Fulbourn. Sanctuary staff would state that they were not informed of these comments and therefore they did not form part of their risk assessment.

During the assessment Mr A discussed his physical illness and some of the reasons why he did not seek medical support. He also said that he sometimes had sick/evil thoughts, but he did not want to repeat them. Mr A did acknowledge that this was linked to the recent incident with the support member of staff.

The assessment discussed other areas of concern for Mr A such as self-esteem and his feelings of isolation. It was recorded that most of his reported issues were linked to his physical health, he was expressing remorse and an inpatient admission at Fulbourn would not assist this. Some advice on accessing medical support was given.

The following day there was a professional meeting regarding Mr A. This was attended by the GP, psychiatrist and support worker (the CPN was not available) It was noted that he was losing weight and not eating properly. It was stated that an admission to a psychiatric unit was not appropriate. The plan included supporting Mr A to attend hospital for his medical condition and to request psychological input to help manage his anxiety.

In mid-November 2018, a support worker and the social worker discussed Miss Y. The support worker was concerned that her behaviour was becoming worse. The previous week the

7 Integrated Mental Health Team

8 DICES - The DICES® acronym is a registered trademark used by APT, the Association for Psychological Therapies, in risk assessment and management in mental health. It stands for; **D**escribe the risks; **I**dentify all the possible options; **C**hoose your preferred option; **E**xplain your choice; **S**hare the decision with others.

records show she had been banned from a local bank, again the family would dispute the fact that she was banned. Her anxiety was heightened by her lack of personal funds and this led her to ask others for money including other residents. The support worker felt that a medical review and professionals meeting should be arranged.

On 21st November 2018, there was a CPA meeting attended by the consultant psychiatrist, the CPFT CPN and support worker in relation to Mr A. Mr A was seen and appeared low and anxious with a fear of dying. Mr A reported hearing voices which were directing him not to seek medical treatment and also to kill others and it was this which he acted on when he attacked the support worker. Mr A maintained that his mental health was poor, and he needed to be admitted to Fulbourn Hospital. It was the view of the consultant psychiatrist that Mr A's mental capacity in relation to medical care fluctuated as did his mental health. The care plan decision was to monitor his mental health and support him to access medical care.

The following day a professionals meeting was convened for Miss Y, which included the consultant psychiatrist, the social worker, the support worker and the setting manager. The relationship with her mother was discussed and the impact on the management of Miss Y's finances. The group believed that Miss Y's mental capacity fluctuated. Miss Y was said to alienate herself from other residents. There was a query regarding Miss Y's learning disability and advice was to be sought regarding making a referral to the learning disability team. The support worker stated that he was struggling to meet Miss Y's demands. This was the third occasion the fact that the support worker was struggling was recorded.

On the 23rd November 2018, Mr A was reviewed by the consultant psychiatrist and it was agreed that he would be stepped down from the crisis team to the community team.

In mid-December 2018, Mr A was seen by his CPN, it was noted that he was not taking care of his personal hygiene and there was a strong odour in the flat. It was apparent at this time, and subsequently, that Mr A was neglecting his care. He was offered support with this but he declined.

Around the same time, Miss Y had a mental health review with the consultant psychiatrist and social worker. It is recorded that the care package would continue. There was discussion over concerns raised by Miss Y's mother regarding how the setting staff interacted with Miss Y. It was suggested that a different support worker should be involved at least once a week as the current support worker was feeling overwhelmed. This was the fourth occasion this had been recorded. This was followed up with the manager, who stated that she was to be on leave for two weeks and would address it on their return. An emotional dysregulation plan recorded that there was medicine advice, an assessment from the occupational therapist and psychological formulation.

At the beginning of January 2019, there were four incidents where it is alleged that Miss Y was verbally abusive to other residents. These incidents were reported as anti-social behaviour incidents to the landlord of property, Metropolitan.

It is apparent that there was a tension between Miss Y and the staff at the setting with the staff believing Miss Y was demanding on their time and that her behaviour was impacting on other residents. It was felt much of this tension and Miss Y's behaviour emanated from her lack of money resulting from her poor weekly money management of her allowance, which her mother controlled. This resulted in incidents with other residents, which the landlord was meant to address by sending a warning letter to Miss Y, which did not happen.

In mid-January 2019, a professionals meeting was held regarding Miss Y. The staff discussed Miss Y's unsettled behaviour and the impact that this was having on other residents and staff. Miss Y continued to say that she wanted to move from the setting, it was discussed that a safeguarding referral could be made in relation to other residents and that advice would be sought on making a referral to the learning disability team. This was the second occasion that a referral to the learning disability team was discussed and there is no evidence it was progressed.

The following day the CPFT social worker followed up with a conversation with Miss Y's mother, during this conversation it was suggested by the social worker that a consideration should be given to medium to high supported accommodation, that the setting offered low support and it was clear that Miss Y did not wish to remain there. The social worker highlighted that it would be necessary to undertake a Mental Capacity Assessment regarding accommodation. The family requested that any further contact be undertaken by email so a written record would be available for all.

At this time there was tension between Miss Y and other residents. Miss Y continued to say that she wanted to move. It is further recorded that this tension was caused by Miss Y requesting money from the other residents.

Through January and into February 2019, support staff at the setting recorded that Miss Y's anxiety seemed to be getting worse. This was reported to the CPFT social worker towards the end of February. The previous behaviours of asking residents for money continued and this was believed to stem from Miss Y's lack of ability to manage her money. Miss Y repeatedly stated that she wanted to leave the setting. The social worker agreed to request more money from Miss Y's mother on a weekly basis. This was requested by email and it was followed by a phone call from Miss Y's mother to the social worker stating that Miss Y no longer wished to work with them. This was later retracted by Miss Y when she contacted the social worker and stated that she did want to continue to work with them. CPFT recorded that Miss Y stated that it was her mother who had influenced her. The social worker undertook to contact the consultant psychiatrist regarding Miss Y's medication.

In the middle of March 2019, CPFT again recorded that consideration should be given to referring Miss Y to the Learning Disability Team (3rd occasion). This was mentioned as an option as early as November 2018 and did not appear to have been progressed.

Towards the end of March and into April 2019, there were several alleged anti-social behaviour incidents involving Miss Y. These involved Miss Y making alleged comments to other residents. These were reported to the setting landlord, Metropolitan, who wrote to Miss Y. The setting support worker reported the situation as being 'at breaking point' and requested immediate action.

Towards the end of April 2019, the setting support worker contacted the CPFT social worker to request a professionals meeting to discuss Miss Y's behaviour, which was said to be having a negative impact on other residents.

In mid May 2019, the consultant psychiatrist and the CPFT social worker reviewed Miss Y's case. The plan was to adjust medication for anxiety and the method of delivery (blister pack). Miss Y was to receive a sensory integration assessment and a meeting was to take place with Miss Y, her mother and sister. During the review Miss Y continued to request a move from the setting, she stated that she had not attended her voluntary work placement for 9 weeks. It

was the view of the consultant that Miss Y's anxiety had increased and that she was suffering a 'borderline learning difficulty'. Her mental state had worsened over recent months, and this was partly due to 'unresolved conflicts between the provider and family'.

At the end of May 2019, Mr A was reviewed by the consultant psychiatrist, with the CPN and setting support staff. It was recognised that Mr A still needed an endoscopy for his stomach condition. Mr A stated that his mental condition and mood was still poor and that in his view staff at the setting were 'unsympathetic, unhelpful and bullied him'.

Around the same time in May 2019, there was a professionals meeting in relation to Miss Y, which the family attended. It was agreed that the current care plan would continue but a new social worker would be introduced. Miss Y was to stay at the setting until appropriate accommodation could be found, and she was to be registered on Home Link. A sensory assessment was to be arranged and carried out together with a Mental Capacity Assessment. There is no evidence that the sensory assessment was ever undertaken. This had been requested by the family for some time as they wished to explore the possibility of an ASD diagnosis effecting Miss Y. This was followed in early June by another professionals meeting to discuss housing options, which were thought to be limited but would be explored.

During June 2019, there were a number of complaints made about Miss Y by other residents, this mainly involved Miss Y requesting money. This culminated in a meeting with Miss Y, Sanctuary staff and Metropolitan Housing staff. There was also a separate meeting with the complainants. The result was that Miss Y would be asked to apologise to the residents and would receive another warning letter from Metropolitan. This resolution is a source of distress to the family as they see this as Miss Y being singled out, as similar incidents with other residents had not attracted the same response. Miss Y complied with this request and wrote fifteen letters to all residents of Metropolitan to apologise for her shouting.

In July 2019, the new CPFT social worker had a positive conversation with Miss Y's mother regarding possible accommodation options. Staff noticed that seemed to have a positive impact on Miss Y's mood.

At the beginning of August 2019, there was a risk assessment review for Miss Y undertaken by CPFT. The IMR author from CPFT recognises that this risk assessment was inadequate. It did not include details of recent incidents and what the triggers for these might be. It did not reference the continued desire of Miss Y to leave the setting and what the impact of this was on Miss Y's behaviour.

In mid-August 2019, the landlord Metropolitan sent a further warning letter to Miss Y following a further complaint from a resident. This letter warned Miss Y regarding the possible breach of her tenancy.

In August 2019, Mr A was seen by his CPFT CPN for his two weekly depot injection. He told the CPN that he had been in pain resulting from some spicy food he had eaten. Whilst the CPN was present Mr A vomited and choked and had to be assisted. He was advised what to do if the similar situation arose. The CPN handed this over to the setting staff to contact the GP. Miss Y's family state that Miss Y had heard noise previously from Mr A's flat indicating that he was being ill and had passed these welfare concerns to Sanctuary staff.

At the end of September 2019, Mr A asked staff to call an ambulance as he was suffering from severe stomach pains. Ambulance staff attended and found medication discarded in his flat. Mr A was conveyed to hospital, given painkillers and discharged.

At the beginning of October 2019, support staff recorded that Miss Y had been abusive to other residents in the common room, resulting in the other residents leaving the room. None of these residents are recorded as being Mr A.

In mid-October 2019, Mr A was seen by the CPN and it was noted that his self-care and personal hygiene was very poor. He stated that he had not slept for over one week due to pains in his stomach. Mr A stated that he was not going to attend his imminent endoscopy appointment.

Around the same time, Miss Y continued to request a move from the setting, she stated that she needed counselling for her anxiety, which was getting worse. It was agreed that a meeting would be arranged to discuss accommodation and to invite Miss Y's mother to the meeting.

In mid-November 2019, The CPN visited Mr A to administer his depot. It was noted that Mr A had a sore on his buttocks nearing broken skin. It was also noted that he was unclean. Mr A was advised to wash the area and to get some cream from his GP. The information was passed to the support staff to contact the GP.

On 11th November 2019, Miss Y was found in the communal lounge, upset and crying due to arguing with other residents. Miss Y was calmed down by staff.

On 13th November 2019, there was a professionals meeting attended by Miss Y's mother. Miss Y had declined to attend. Accommodation options were discussed, and Miss Y's mother expressed concern on how previous complaints against Miss Y had been dealt with. A number of shared accommodation offers were made but Miss Y's mother stated that the move should not be temporary, and that Miss Y was able to do quite a lot for herself. Following the meeting a letter was sent to Miss Y's mother offering a review of her carer's assessment.

On 27th November 2019, the CPN visited Mr A in his flat, at this time Mr A was laying on the sofa and seen to be shaking. He told the CPN that he needed to be sectioned and then put his hand around the CPN's neck as if to strangle her. The CPN broke away and left the flat to go to the office where a support worker was present. She was followed to the office by Mr A, who stated that he wanted to be sectioned and said, 'I'm going to murder, you, I'm going to murder you and I'm going to murder Miss Y'. Mr A indicated at the CPN and support worker. The CPN felt that Mr A was crying out for help. The support worker is partially deaf and states he did not hear this comment. He stated he only heard a mumble.

The CPN updated the consultant psychiatrist and tried to call the mental health crisis team. There was no answer and the CPN realised that the crisis team would be handing over, so they travelled to the hospital to see the crisis team personally.

The CPN liaised with the crisis team who were aware of Mr A. The crisis team were unable to see Mr A that day due to other pre-planned assessments and agreed to see him the following day. This decision was also based on the information that the crisis team were given and an assessment of the risk at the time. The CPN returned to the setting and updated the support worker and Mr A. The CPN saw Mr A in the communal lounge, where he apologised for his actions. The CPN informed him of his appointment for the next day and asked if could keep himself and others safe. The CPN and the support worker then left the setting. At the time

they departed Mr A was left in the common room. No approach was made to Miss Y or consideration given to what the risk was to her. The family state that it is significant that Miss Y was a person of routine and would have attended the common room at around 4.30 p.m. daily.

A very short record was made in Mr A's care notes at the setting, there was no record made in Miss Y's care notes. The entry made did not include follow up actions or involve notifying any management. The management for the setting were only made aware of the incidents once Miss Y had been attacked. The CPN made a record in the CPFT incident recording system. It is not clear when this record was made and whether it initiated any management oversight or action.

At around 4.40 pm the same day police were called to the setting on the report of Mr A having attacked Miss Y in the communal lounge. Police and ambulance attended, and first aid was administered to Miss Y but unfortunately, she did not respond.

8 Analysis

8.1 Were there any early indicators that the perpetrator could cause harm, and if so were the correct steps taken to prevent harm?

There are some recorded incidents where Mr A, either threatened or demonstrated aggression or violence towards others. Outside the scope of this review but within Mr A's records, it shows that in 2002, there is a record that Mr A attempted to strangle his mother, although the recorded detail is limited on this, except to say that she did not take this act seriously. In 2016, Mr A was approached by another resident who was disinhibited, and Mr A acted aggressively and had to be restrained, although Mr A did not initiate this interaction. There are also records dating back to 2016 stating that Mr A had expressed hostile feelings towards women.

In April 2018, Mr A presented at Addenbrookes Hospital and after refusing to leave he was removed by security officers and during an altercation it is alleged he assaulted one of the security staff and fell causing an injury to himself, which was treated at the hospital. There were no concerns noted regarding Mr A's mental health by police or the hospital. As there were no concerns there was no basis on which to share this information with other agencies at this time.

In November 2018, Mr A was involved in an incident in the communal area at the setting where he acted threateningly towards a member of support staff who was in fact his key worker. In this incident Mr A gestured as if to strangle the support worker and then threatened him with a metal dining fork. There was no contact in this incident and no injury caused. The matter was appropriately reported to both police and the mental health crisis, although the police did not attend the incident. The CPN attended the setting and spoke with Mr A. This incident was noted as being out of character, but his behaviour was unpredictable, and he was anxious. The crisis team did not attend on the day of the incident but did attend the following day and there followed a thorough assessment by a social worker and senior mental health practitioner.

At the time of the incident Mr A had voiced his desire to be sectioned and it was recorded that he made various verbal threats including *"I am going to hurt people, I am going to attack people, I am going to kill people".* During the assessment Mr A disclosed that he sometimes

has *'sick/evil thoughts',* but he would not expand on this. The assessment concluded that the majority of Mr A's issues were linked to his physical health and inpatient admission would not alter this. Mr A was no longer voicing intent to harm others and was remorseful for recent events. As a result of this incident Mr A was accepted onto the case workload of the crisis team for a few weeks.

A professionals meeting followed the assessment, and it was decided that an inpatient admission would not assist Mr A and an emphasis should be put on him accessing his medical treatment. It was acknowledged that Mr A would benefit from a psychological support to help with his anxiety. This support was later declined by Mr A. There is no indication as to what risk or increased risk Mr A presented by declining psychological support or whether this was considered.

The mental health agency report and the section 42 enquiry report[9] for this review states that during this incident it is recorded that Mr A made threats to others and that one of these people was Miss Y. There is no record that any further consideration was given to this particular threat or that Miss Y was aware or made aware of it.

Sixteen days following the incident the consultant psychiatrist attended a CPA meeting for Mr A, during this meeting Mr A spontaneously disclosed that he heard voices and it was these voices that had told him to attack the support worker. He acknowledged that he did not usually act on the voices. It was the psychiatrist's impression that he presented with low mood and was anxious, asking to be admitted as an inpatient. It was assessed that his mental health fluctuated as did his mental capacity. It was agreed that his mental and physical health would continue to be monitored. It was recorded that treatment in Mr A's best interest would have to be considered if his health deteriorated and an intervention was necessary. The day following this assessment the consultant psychiatrist agreed that Mr A's care would be stepped down from the crisis team to monitored community care.

The psychological support that was suggested for Mr A was declined by him. This followed a pattern of Mr A declining medical treatment for his Barretts Oesophagus[10] condition. It was assessed that he understood the implications of not undertaking his medical treatment, but it was the view of the psychiatrist that his mental health and mental capacity fluctuated.

Over the following period there was a continued decline in Mr A's physical health and a continued decline in the care he afforded himself and he did not attend endoscopy appointments to investigate his condition despite being offered support to do so. With Mr A declining medical treatment and further mental health support, consideration could have been given as to the impact of Mr A declining these services.

It has to be concluded that there were indications that Mr A's mental health and physical health were declining and there were indications that he posed a risk. He had on at least one occasion made specific threats regarding Miss Y. The care and risk plans did not adequately reflect or mitigate this.

9 Cambridgeshire County Council section 42 enquiry into Miss Y

10 Barrett's oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus caused by long-term reflux.

Learning Risk assessments and Care and Support Plans need to be up to date and include all risk information with measures to mitigate the risk. This should be person centred and include the voice of the subject of the plan. A full mental health review is being undertaken by NHS England into the support afforded to Mr A.

Recommendation 1: Cambridgeshire and Peterborough NHS Foundation Trust and Sanctuary should ensure, and be able to demonstrate, that their care plans and risk assessments are current, person centred, with the voice of the subject represented and contain all relevant information. This should be evidenced by way of internal audit activity.

Recommendation 2: Cambridgeshire and Peterborough NHS Foundation Trust should reassure the Cambridgeshire and Peterborough Safeguarding Adults Board that they meet the requirement for Care Act compliant assessments, Care and Support Plans and Reviews to ensure legal compliance where there are clear social care needs within the terms of the Section 75 agreement.

8.2 Was Miss Y sufficiently safeguarded, did professionals share information adequately to ensure she was kept safe?

All *persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual)*[11]

Miss Y had resided at the setting since 2004. Her family would say that the care and support that was provided to her initially was good. At this time both the duties of the landlord and the support was provided by one organisation. When this changed in 2017 to the original provider retaining the role as landlord and a new provider delivering the care packages the family view is that the service and therefore the safeguarding arrangements for Miss Y suffered.

Miss Y had a care coordinator (social worker) from the mental health trust and a care support worker from the care provider. The care provider was commissioned to provide 3 hours per week to Miss Y, this was increased to 5 hours per week. The care provider would state that the care in terms of time spent with Miss Y exceeded the commissioned hours. The family would take issue with this and state that less support was offered. The daily records maintained by the care provider indicate that that there was regular contact with Miss Y but the daily hours sheets breaking down that time had not been completed since 2018. Therefore, evidence of the actual time spent with Miss Y is not available.

The care support workers found it difficult to be able to provide the commissioned hours on a face to face basis. The care provider states that of the 5 commissioned hours, not all of these had to be face to face as time was to be spent on administration and record keeping. Staff felt that the number of hours that they were expected to be face to face with service users was difficult to achieve, particularly as the ability to carry administrative functions was removed from the setting, requiring staff to visit another location.

11 Cambridgeshire and Peterborough Safeguarding Adults Partnership Multi Agency Safeguarding Policy 2018

The care provider states that they raised a number of concerns to commissioners that they were struggling to meet the needs of clients with the commissioned service. There is insufficient evidence to support the fact that these concerns were appropriately escalated.

Learning It is important that records of care are accurately maintained and that the expectation for this to happen is supported. Where there are concerns regarding the ability for a care provider to meet the needs of a commissioned service these concerns should be appropriately escalated.

Recommendation 3: Sanctuary should ensure that all the required case file recording is in accordance with policies and is factual, accurate and up to date.

Recommendation 4: Sanctuary should ensure that it has measures in place to appropriately escalate any concerns regarding the provision of a commissioned service and that it can evidence this escalation.

The setting landlord acknowledges that there was a lack of consideration of any risk that may have presented to Miss Y as a result of the disputes with other residents. In these disputes, that were managed as anti-social behaviour incidents, Miss Y was very much viewed as the aggressor and as such within the setting it feels like there was a view that Miss Y did not require safeguarding. The view on Miss Y's behaviour was well summed up in the notes of the professionals meeting in November 2019, not long before her death. The social worker said '*… the term anti-social behaviour is not an accurate description of Miss Y's behaviour, Miss Y suffers from anxiety which manifests itself in her shouting and becoming upset easily rather than her doing something to purposely upset others'.* The care provider considered that if there was a risk to Miss Y, it existed from her behaviour outside of the setting.

The mental health care and support plan sets out goals for Miss Y, one of these added in January 2019 regarding managing risk, states that Miss Y puts herself at risk from other members of the public. There are no interventions or outcomes against this goal. The family would take issue with the fact that Miss Y was a risk to herself from her interaction with others outside of the setting. They state that the greater risk was from other residents at the setting, with some of the significant incidents occurring in the communal area.

The family state they raised concerns regarding the risk the communal area presented, in particular when there were no staff on the site. The communal area was important to the residents for social activities and other important functions, such as laundry.

Learning It is important that there is an appropriate understanding of risk that the communal area of the setting presents. Whilst this is an important resource, like all areas of communal life the risk needs to be identified and mitigated, in particular when there are no staff on the premises.

Recommendation 5: Sanctuary and Metropolitan should review the risk assessments and policies for the use of the communal area at the setting and other such settings. Whilst acknowledging the important role that the facility presents, it should include what safety and security measures are required to ensure the safety and wellbeing of all residents.

CPFT recorded that Miss Y had been the subject of a previous threat by Mr A. Both the landlord and care provider state that this was not known to them, which is an indication of poor inter-agency communication on an important issue. It had been known since at least the November 2018 incident when the threat was made, that Mr A had been unhappy with Miss Y over the

noise he claimed she made from the flat above his[12]. Had this been properly understood consideration could have been given to alleviating the situation by relocating either Miss Y or Mr A.

The incident which preceded Miss Y's murder was similar to the November 2018 incident in many ways. The initial incident was focused on a member of staff and in both incidents, this involved the act of strangulation either real or feigned. There then followed threats to kill to others, which included a threat to kill Miss Y.

In both incidents the crisis team was involved and after assessment agreed to attend and speak with Mr A the following day. Another factor that was common in both incidents was that no consideration was given to making Miss Y aware of the threat. In the most recent incident, the CPN reported the incident to the crisis team and returned to the setting to see Mr A, to check that he was able to keep himself and others safe. Mr A agreed that he could and was told that if he needed assistance, he would have to borrow another resident's phone as he did not have one. Both the CPN and care support worker left the setting. It was within 45 minutes of staff leaving the setting that police were called to Miss Y's attack.

There is no evidence that the most recent incident was risk assessed to ensure that all elements of risk had been considered and the necessary mitigation put in place. Miss Y had the right to know that a threat had been made against her, to weigh up the risk and to make decisions regarding her own safety. This may have included not attending the communal area or indeed leaving the setting to stay with her family, as she was intending to do as a matter of routine the next day. The situation of making Miss Y aware would have required careful management so as to not exacerbate the risk. As it was the situation was left for crisis team intervention the next day without any protective measures being put in place.

Learning Consideration needs to be given to risk at every stage, the consideration needs to be dynamic and continuous and take into account all available information. There needs to be a clear recognition of what the risk factors are, how they are going to be mitigated or accepted and a clear record made of this. If this risk assessment had been systematic it would have included who needed to be notified, this would have identified Miss Y as one of those persons. There also needs to be clear oversight and all persons involved in the management of that risk have a responsibility to challenge and build on the mitigation of risk.

Recommendation 6: Cambridgeshire and Peterborough NHS Foundation Trust should review their policy and procedures on assault of staff and threats to life to ensure that all aspects are considered, appropriately recorded and the factors are reflected in a coherent risk management plan. This should include reporting appropriate incidents to the police.

Recommendation 7: Cambridgeshire and Peterborough NHS Foundation Trust should ensure that where there are assaults on staff or threats made to life that there is appropriate management oversight.

Recommendation 8: The mental health crisis team, as professionals in the assessment and management of risk, should ensure that all risk factors are considered and where an assessment is undertaken advice is given to referring parties or other relevant parties on how any aspects of identified risk can be managed.

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12 Cambridgeshire County Council section 42 enquiry report and CPFT agency report

Recommendation 9: Sanctuary should review their policy on critical incidents to ensure that there is clear guidance on recording incidents, identifying and managing risk, and management oversight. This should include reporting appropriate incidents to the police.

There is evidence that there was ongoing tension between Miss Y and other residents. Staff state that this was due to Miss Y's manner with other residents. The family would state that this was largely due to staff and the other residents not understanding Miss Y's needs. On a number of occasions in Miss Y's care plan it was recommended that Miss Y was either assessed or received support from the learning disability team (November 2018, January 2019, March 2019 and May 2019) but this was never progressed. There are no records of a referral being received by the learning disability team. It is not clear, despite repeated recognition, why this did not happen.

In May 2018, there was a professional discussion between Miss Y's support worker and social worker during this conversation the support worker mentioned that Miss Y has previously disclosed that on weekend visits her mother verbally abuses her and slaps/hits her. There is an indication that the support worker tried to discuss these allegations with Miss Y's mother, but she refused. There was no immediate raising of concerns or reporting this, as would be expected and required within the care provider's safeguarding policy. Once the disclosure was repeated to the mental health social worker the allegation likewise should have been recorded and acted upon. The professional's discussion also raised the inability of Miss Y to manage her finances as her mother did this for her. A safeguarding enquiry under the Care Act was initiated but only in relation to the financial issues and not the alleged abuse.

This section 42 enquiry was closed some five months later in October 2018, on the basis that Miss Y did not wish it to be progressed. Why this took 5 months to conclude is unclear. The issue of finances was a continued source of tension for Miss Y and was believed by staff to be at the root cause of tension with Miss Y and other people when she tried to borrow money. This lengthy process did nothing to resolve the issue. More concerning is the lack of consideration and action on the disclosures of abuse alleged to have been made by Miss Y. The lack of investigation not only potentially failed to protect Miss Y but has also led to these matters not being resolved in Miss Y's lifetime, which is distressing to Miss Y's family.

Learning All staff must respond to safeguarding concerns adhering to their own policies and those of the Cambridgeshire and Peterborough Safeguarding Adults procedures. Where there is recognition of support that is required for a learning disability this should be assessed and the necessary support provided.

Recommendation 10: Cambridgeshire and Peterborough NHS Foundation Trust and Sanctuary should assure the Cambridgeshire and Peterborough Safeguarding Adults Board that their staff are aware of and comply with safeguarding adult policy and procedures.

Recommendation 11: Cambridgeshire and Peterborough NHS Foundation Trust should ensure that where support is identified for a learning disability that the person is assessed, and appropriate support follows.

Miss Y's mental capacity was considered at various stages within the scope of this review. It was considered and explored in some detail between June and August of 2018 in relation to Miss Y's ability to manage her own finances. In August 2018, following assessment by her then social worker Miss Y was deemed to have mental capacity in relation to her finances. There then followed a discussion that there may need to be a further assessment regarding

Miss Y's understanding of safeguarding. The social worker involved took safeguarding advice regarding Miss Y's ability to make decisions independent of her mother and consideration was given to the involvement of the Independent Mental Health Advocates Service.

A safeguarding enquiry was opened but was subsequently closed on the wishes of Miss Y, who was deemed by the social worker to have capacity in relation to this. At a professionals meeting in November 2018, the consultant psychiatrist stated that, in their view, Miss Y's capacity fluctuated and required to be constantly monitored. In June 2019, Miss Y's capacity in relation to accommodation was again raised and discussed. A mental capacity assessment was to be undertaken by the social worker but there is no evidence to suggest this occurred.

There is evidence that Miss Y's capacity was considered at various stages. In particular in relation to finances, once it was deemed that she had capacity the consideration was Miss Y's ability to make independent decisions without undue influence. Miss Y had stated clearly that she wanted control of her finances but did not wish to upset her mother. Professionals then rightly considered safeguarding but after initiating this Miss Y requested that the safeguarding enquiry was closed. Professionals felt that in this decision Miss Y was influenced by her mother. There was no consideration of whether there was coercive control in the relationship and if it was considered present what further action could be considered and what would have been in Miss Y's best interests if indeed it did exist. This may have included consideration of involving the courts, although any action to access inherent jurisdiction[13] through the Courts would have to be deemed necessary and proportionate.

There is clear evidence that the care support worker allocated to Miss Y was struggling to meet her needs. He and other staff involved with her state that she was overly demanding and required attention that far exceeded the commissioned hours (5 hours per week). Sanctuary records would not support this level of attention and if this was the case, records should reflect it. Within the chronology of the case there is a sense of the support worker facing challenges in supporting Miss Y that they were finding difficult to meet. At times a change of support worker and a female support worker being allocated to Miss Y was discussed, but this did not transpire.

It does appear that the challenges faced by the care support worker and the overall tension with Miss Y's family lacked management oversight, had this been effectively in place there would have been up to date records to show the level of contact. The family's perception is that staff were demoralised and this impacted on their ability to provide consistently good care. Whilst this is not directly evidenced, there is a staff view that the ability to meet all the requirements for service users was difficult and as a result record keeping suffered.

Recommendation 12: Sanctuary should ensure that they have robust management oversight to ensure that the necessary support is provided to service users and this is appropriately reflected in records and that where there are concerns regarding the ability of staff to meet a service users' needs they are addressed and where necessary escalated.

Overall there are areas of concern as to how Miss Y was safeguarded and how central Miss Y was to the support she was afforded. The most significant area of which is the knowledge

13 Inherent jurisdiction' is a term used to describe the power of the High Court to hear any case which comes before it unless legislation or a rule has limited that power or granted jurisdiction to some other court or tribunal to hear the case. This means that the High Court has the power to hear a broad range of cases including those in relation to the welfare of adults, so long as the case is not already governed by procedures set out in rules or legislation.

that Mr A had previously made a threat to kill Miss Y, and shortly before her death this threat was repeated, and Miss Y was not made aware of this. The section 42 enquiry undertaken post Miss Y's murder states *'However her (Miss Y's) care and support commissioned by social care was not formally reviewed regularly by the organisations. The documentation by both the care provider, the mental health team and social care was inadequate, and could be argued to the extent within these systems to constitute organisational neglect despite there being some areas of good practice.'*

The setting does not meet the requirement to be registered with the Care Quality Commission (CQC) as the setting does not deliver personal care[14]. The oversight for the setting comes from the Cambridgeshire County Council Commissioning Service.

Recommendation 13: The Cambridgeshire County Council Commissioning and Contract Management Service should ensure that there are measures in place to provide assurance that all aspects of the commissioned service are met and in particular those in relation to safeguarding.

The section 42 enquiry post Miss Y's death concludes *'Based on the balance of probability, organisational abuse/neglect did not contribute to Miss Y's death but there is evidence to suggest she was not adequately safeguarded from risk of harm'* This review would have to concur with this view.

8.3 How were risk and protective factors identified, assessed and managed? What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?

As far as Mr A is concerned the main document used by the mental health provider is the core assessment. The core assessment is made up of various sections one of which covers capacity, safeguarding and risk. The Sanctuary policy dictates that each person has a support plan and related risk management plan, which is drawn from the mental health core assessment.

The core assessment for Mr A contains identification of risks and what is described as broad guidance to manage these. Whilst the plan directs that staff need to be aware of the triggers that will influence Mr A's behaviour, it does not identify what the triggers and warning signs are. The care provider risk plan identified that a decline in Mr A's mental health could be: -

- Being delusional in respect of interactions with others
- Present in an aggressive manner including making threats
- Neglect his personal hygiene
- Neglect his medication by either not taking it or not following his prescription guidance.

All of these factors can be identified as escalating during the period covered in this review.

There is evidence that Mr A had demonstrated aggressive behaviour, the incident of threats and aggression to the support worker and this was not reflected in the risk management plans. There was also recorded information that Mr A had issued direct threats regarding Miss

14 CQC – Housing with Care – Guidance on regulated activities for providers of supported living and extra care housing 2015 - https://www.cqc.org.uk/sites/default/files/20151023_provider_guidance-housing_with_care.pdf (accessed 09/04/21)

Y around the incident in November 2018 and this did not feature in any risk plan for either Mr A or Miss Y. The reason for Mr A's threats in 2018 was recorded as the alleged noise that Miss Y made in the flat above that of Mr A's. There was no evidence to indicate that this issue was addressed or considered as an ongoing risk. Both Sanctuary and Metropolitan state they were not aware of this threat and this would indicate that the communication between CPFT and other agencies involved was ineffective in this regard.

It was recognised that the mental health trust risk assessments and subsequent plans were not robust enough. The plans were not personal to Mr A and did not take into account historical information.

During the practitioner reflective workshop it was stated by the setting that they did not routinely receive risk assessments from the mental health trust. The CPN stated that risk assessments, care plan and core assessment were sent to the setting every six months or every time there was a change. These were sent to the support worker by post as he was unable to receive these by email. These documents did not feature in the setting records. There was a breakdown in communication between the mental health trust whereby conversations of relevance were not recorded by the setting and there was no record or evidence of aligned or coordinated risk management plans.

Miss Y's mental health care and support plan was last updated in January 2019, the trust policy states that the plan should be reviewed and updated every 6 months. The s42 enquiry completed post Miss Y's murder finds that the risk assessment was dated August 2019. The content had not been updated for a long time, was of poor quality and was out of date. The clinical notes were not reflected in the assessment and it lacked strategies which mitigated or reduced the risks. It was the view of the author of the s42 'the *standard of mental health trust mental health risk assessment is below the standard expected by the organisation and this aspect, under Adult Safeguarding, constitutes a neglect in patient care, although it is recognised that there are some other areas of good practice'*

The same report comments on the setting risk assessment, which was significantly out of date having been last updated in April 2018. The risk assessment is said to have been more thorough than that of the mental health trust. It contained both identified risks to Miss Y, and those that staff considered Miss Y presented to others, by her behaviour. Although it is regarded as being as thorough, by being 18 months out of date it lacked current information.

Overall it has to be considered that the risk assessments and plans were poor and uncoordinated. This does not reflect the overall working and level of communication between the mental health trust Care Coordinators and support workers. The records indicate that there was regular contact, but this is not reflected in the plans. The care support staff in the cases of Miss Y and Mr A, and the CPN in the case of Mr A, knew their clients very well and over an extended period of time. It is possible that this familiarity led to the belief that records did not have to be as thorough as they should have been.

There was continual evidence of self-neglect by Mr A, this was subject of a referral made to the ASC safeguarding team but was not progressed on the basis that the right agencies were involved with him at the time. This neglect included medical neglect in the form of Mr A repeatedly missing medical appointments for his medical condition. His physical health appeared to have a bearing on this decline in mental health. Whilst self-neglect was regularly recognised and recorded there is a lack of evidence that there was any coordinated activity to

address this with consideration to Mr A's mental capacity and mental health. There is no evidence of a mental capacity assessment for Mr A on his medical records.

This self-neglect was more acutely evidenced in November 2019, when the CPN recorded Mr A suffering from a pressure sore, where the skin was near to breaking and evidence of self-neglect. The response was advice given to Mr A, which experience had shown he was unlikely to follow. A review by Cambridgeshire County Council found that organisationally they failed to meet all Mr A's needs to which the Care Act applied and therefore in this respect failed their statutory duty.

There is evidence that both Miss Y's and Mr A's voices were recorded and to an extent heard. The enduring requests from both of them was to leave the setting but for different reasons. There were times where consideration of the support of an advocate would have been appropriate for both Miss Y and Mr A. As already mentioned professionals close to Mr A knew him very well and whilst this relationship can be beneficial it is also possible that this familiarity over a period of time can lead professionals to be more accepting of situations, considering them to be the norm and therefore not questioning or challenging in a way that they might.

Learning Agencies need to be aware of the guidance on self-neglect[15] and what action can be taken to address this. In particular how this is impacted by mental capacity and mental health. Professionals and managers need to be aware of situations where they can become desensitised to situations due to familiarity. More consideration could be given to the use of advocates for persons who may have a substantial difficulty in being fully involved in the care and support process or would benefit from independent advice and support.

Recommendation 14: The Cambridgeshire and Peterborough Safeguarding Adults Board should consider what further can be done to support professionals to deal with self-neglect.

Recommendation 15: All agencies involved in the care and support of adults should consider whether the support of an advocate is required to not only ensure they have a voice but to facilitate and maximise their involvement in a whole range of adult Care and Support processes.

9 Conclusions

From the time that the care provider at the setting was changed there was tension between Miss Y's family and the setting. This impacted on Miss Y with her family and the setting and was never effectively resolved, despite efforts made by all parties. The care provider would state that Miss Y was demanding of support time, far above that which was commissioned but this is not evidenced in the records. Over a period of time various aspects of Miss Y's care came into focus, her management of finances, her increasing anxiety, her relationship with other residents and future plans for accommodation. These issues were not addressed holistically and not reflected in her care plan and risk assessments. There had been tensions between Miss Y and Mr A in the past and this was not referred to when the threats, just prior to her death were made. Miss Y was not made aware of the threat that was made about her

15 Multi Agency Policy and Procedures to support people who self-neglect - https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/selfneglect/#Mental_Health_Act_19838211 (accessed 25/05/21)

some hours before her death and there was not enough consideration regarding her safety. The CPFT section 42 enquiry concludes that Miss Y was not effectively safeguarded.

Mr A's mental and physical health were in decline, he was regularly requesting to be sectioned but it was thought that an inpatient admission would not assist him. A review by Cambridgeshire County Council concludes that they failed to meet Mr A's needs and his risk assessment and care plan were not effective. The same review questions whether the setting was appropriate accommodation for Mr A and that he would have benefited from a different setting with a more detailed care and support plan to meet his needs.

It is difficult for this review to assess whether the response of the crisis team on the day of the murder was appropriate or whether there should have been a more immediate response. This area will be analysed in more details in the Mental Health Homicide Review. What is clear is that Miss Y was not made aware of the potential threat to her where there was a clear duty and opportunity to do so.

10 Recommendations

Recommendation 1

Cambridgeshire and Peterborough NHS Foundation Trust and Sanctuary should ensure, and be able to demonstrate, that their care plans and risk assessments are current, person centred, with the voice of the subject represented and contain all relevant information. This should be evidenced by way of internal audit activity.

Recommendation 2

Cambridgeshire and Peterborough NHS Foundation Trust should reassure the Cambridgeshire and Peterborough Safeguarding Adults Board that they meet the requirement for Care Act compliant assessments, Care and Support Plans and Reviews to ensure legal compliance where there are clear social care needs within the terms of the Section 75 agreement.

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Recommendation 6

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appropriately recorded and the factors are reflected in a coherent risk management plan. This should include reporting appropriate incidents to the police.

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Recommendation 9

Sanctuary should review their policy on critical incidents to ensure that there is clear guidance on recording incidents, identifying and managing risk, and management oversight. This should include reporting appropriate incidents to the police.

Recommendation 10

Cambridgeshire and Peterborough NHS Foundation Trust and Sanctuary should assure the Cambridgeshire and Peterborough Safeguarding Adults Board that their staff are aware of and comply with safeguarding adult policy and procedures.

Recommendation 11

Cambridgeshire and Peterborough NHS Foundation Trust should ensure that where support is identified for a learning disability that the person is assessed, and appropriate support follows.

Recommendation 12

Sanctuary should ensure that they have robust management oversight to ensure that the necessary support is provided to service users and this is appropriately reflected in records and that where there are concerns regarding the ability of staff to meet a service users' needs they are addressed and where necessary escalated.

Recommendation 13

The Cambridgeshire County Council Commissioning and Contract Management Service should ensure that there are measures in place to provide assurance and oversight that all relevant aspects of the commissioned service are met.

Recommendation 14

The Cambridgeshire and Peterborough Safeguarding Adults Board should consider what further can be done to support professionals to deal with self-neglect.

Recommendation 15

All agencies involved in the care and support of adults should consider whether the support of an advocate is required to not only ensure they have a voice but to facilitate and maximise their involvement in a whole range of adult Care and Support processes.

Recommendation 16

The Cambridgeshire and Peterborough Safeguarding Adults Board should share the recommendations of this review with other care providers.

This report has referenced a s42 enquiry undertaken by CPFT and a review undertaken by Cambridgeshire County Council. This review is also aware of a Serious Incident Investigation Report completed by CPFT and the referenced NHS England Mental Health Homicide investigation.

The Cambridgeshire and Peterborough Safeguarding Adults Board should be assured that actions identified in these reports are being progressed.

11 Appendix A – Terms of Reference

Safeguarding Adults Review (SAR) Terms of Reference

In respect of Miss Y

Family: Miss Y's mother and sister

BACKGROUND

Miss Y lived in supported living occupied by persons with mental health vulnerabilities. Miss Y suffered with anxiety, depression.

The accommodation comprises of sixteen flats all occupied by adults with mental health vulnerabilities and who are all believed to have care and support needs.

On 27th November 2019 Miss Y was strangled and hit by another resident and died as a result. The other resident has a Mental Health diagnosis of 'depressive episode and schizophrenia'.

A man has been arrested and the police investigation is ongoing.

Time period to be covered by the review:

1st January 2018 to 27th November 2019

If the author recognises events that they consider relevant or potentially relevant to this review that fall outside of the dates above, they are asked to highlight in their report.

AGENCIES INVOLVED IN THE CARE AND SUPPORT OF Miss Y

- **ASC – CCC**
- **CPFT**
- **GP**
- **Sanctuary Supported Living**
- **Metropolitan Thames Valley Housing**

Areas to be considered:

1) Were there any early indicators that the perpetrator could cause harm, and if so, were the correct steps taken to prevent harm?

2) Was Miss Y sufficiently safeguarded, did professionals share information adequately to ensure she was kept safe?
3) How were risk and protective factors identified, assessed and managed?
4) What actions were taken by practitioners and agencies to ensure that concerns were shared appropriately, and within the available frameworks, to attempt to mitigate any risk?
5) Are there any areas of good practice?
6) Does the learning and improvement from this case resonate with other pertinent local (and national) case reviews?
7) What recommended improvements can be made by local partners in adult safeguarding policy, procedures and practice in relation to this case?

The review will also seek to identify any early learning from the review and whether there has already been organisational remedial action taken or whether the issue remains unresolved. The review will also consider if the principles of Making Safeguarding Personal were applied when professionals worked with Miss Y.

PANEL MEMBERS

- ASC – CCC
- CPFT
- GP
- Sanctuary Supported Living
- Metropolitan Thames Valley Housing
- Police
- Head of Service, Cambs & P'boro Safeguarding Partnership Boards

METHOD

The review will seek to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time and avoid the use of hindsight. The methodology will reflect a systematic approach, drawing on the requirement to consider strategic and organisational learning and improvement, as well as learning from practice at the frontline.

CHRONOLOGY and IMRs

- ASC – CCC
- CPFT
- GP

- Sanctuary Supported Living
- Metropolitan Thames Valley Housing
- Police

TEMPLATE FOR AGENCY REPORTS

As provided – contains generic questions to be considered under each heading.

FAMILY or OTHER SIGNIFICANT PERSONS MEETING

The review will seek to include the views of the family and/or other significant persons as appropriate.

Parallel Processes:

There is an ongoing police investigation – this may impact on how witnesses can be involved in the review – **all agencies must check with the police before interviewing staff.**

The Coroner's inquest is suspended pending further information from the police investigation.

NHS England are monitoring but until the internal investigation has been completed won't make a decision as to whether or not to commission an independent investigation. What they have seen so far would indicate this case meets the criteria.