Safeguarding Adults Review

YL
A Mother, a Daughter and a Granddaughter

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Introduction

YL the person

Throughout her life, YL lived mostly with her grandparents, a home YL chose as a child as the place where she preferred to live and where she continued to live as a young adult and mother to her own baby girl, until being placed in temporary accommodation in October 2019. YL's daughter continues to live with YL's grandmother in the same home now, the home she has lived in since she was born. During YL's pregnancy a safeguarding referral was made to Children's Services by a domestic abuse (DA) provider, relating to a domestic incident between YL and her partner, the father of YLs unborn baby. Both the Police and the DA provider were aware of the incident. The DA provider reported that YL had family support and had ended the relationship and police visited YL at her home and reported that there were no concerns. Children's services said that this incident was verbal and did not warrant an Unborn Baby Plan or safeguarding measures being initiated. YL and her partner did separate before YL gave birth.

Whilst YL's family life was at times complex, she maintained contact with her mum and siblings, who each had a presence in her life, albeit intermittently. The arrangement of YL living with her grandmother on a permanent basis was from around the age of 10, which Children's Services report was a private family arrangement, deemed not to be in need of a formalized care arrangement, given how close a grandmother is in terms of family relationships. Also child, mother and grandmother were each happy with this arrangement. This means that YL was never afforded the additional support that a looked after child or a Care Leaver is eligible for.

YL's grandmother described YL as an exceptionally pretty girl with a beautiful voice, a girl who also loved dancing. It was these personal qualities however that YL's grandmother said led to YL experiencing envy and bullying from peers as a young girl, culminating in YL needing to access the support of Child and Adolescent Mental Health Services (CAMHS) between the ages of 10 and 13. YL's grandmother also described how YL had had a difficult relationship with her stepfather, one of the reasons why YL asked to live with her grandmother as a permanent arrangement. YL's grandmother also shared how YL had a history of anxiety and self-harm and had struggled with her mental health and wellbeing, exacerbated by a reported rape in 2018. However YL did engage with a range of services and at times was very future oriented, right up to her death in January 2020, when she died by ligature at the temporary hotel accommodation she was living in. YL shared that she was at the top of the priority housing list just before she died.

YL was 21 when she died and her daughter was 2 years old.

Statutory Basis of Safeguarding Adult Reviews

Section 44 of the Care Act 2014 places a statutory requirement on the Portsmouth Safeguarding Adults Board (PSAB) to commission and learn from Safeguarding Adult Reviews (SARs) in specific circumstances. A SAR is defined in legislation as a review of a case involving an adult with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

1. there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
2. if the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect, or
3. the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Care and Support Statutory Guidance also states that SABs must arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. The Care Act also gives SABs the power to arrange a SAR in any other situations involving an adult in its area with needs for care and support.

Scope of SARs

SARs seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death, so that lessons can be learned and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organization to account, as other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council. A SAR is about identifying lessons to be learned across and for partnerships, in doing so they reflect realities of practice ("tell it like it is"). Each member of the SAB must co-operate in and contribute to the carrying out of a review in line with the Care Act (2014) and the Care and Support Statutory Guidance (2020).

Terms of Reference and Scope of this Safeguarding Adults Review

This case was considered by the Portsmouth Safeguarding Adult Board (PSAB) on 25 March 2020 and it was concluded that the above criteria for a mandatory safeguarding adult review had not been met. However the PSAB believed that it would be helpful to conduct a discretionary review as there were concerns that partner agencies could have worked together more effectively, thereby exercising its power to review any other case involving an adult in its area with needs for care and support.

The Portsmouth Safeguarding Adult Board (PSAB) SAR sub-group was responsible for defining clear terms of reference for this learning review and will submit findings and recommendations to the PSAB. The PSAB will have ultimate responsibility for agreeing any recommendations or actions identified as outcomes of this review.

The PSAB SAR sub-group identified that this review will focus on the following key areas of practice:

- How effective was partnership working.
- Were the appropriate assessments completed to identify need and to manage/mitigate known risks.
- Support provided to meet identified need
- Hearing the voice of the adult.
- Safeguarding

It is important to note that this review was produced just over a year after the death of YL, due to the impact of the Covid pandemic. Whilst this is not the preferred or normal timescale for reviews commissioned by the PSAB, this delay has provided an opportunity to be able to identify if and which elements of change have already been implemented as a result of the learning from YL's experience and of those caring for her.

This review will examine YL's care and support provision and consider whether partner agencies could have worked together more effectively. The timescale for this review is from June 2019 to January 11th 2020, the date of YL's death.

Monthly Summary of key points in full chronology

For a more comprehensive and detailed account of YL's story and experiences, please refer to the detailed and merged multiagency chronology or the monthly summary of key events.

June

1.1 At the beginning of June 2019, YL was admitted to hospital for a single overnight stay on the observation ward in the Emergency Department (ED). YL self-presented and disclosed attempted self-harm the day before using a ligature. YL was discharged to the care of the Crisis Resolution and Home Treatment Team (CRHT).

1.2 Throughout June YL engaged with CRHT well: they visited her on 12 occasions over 28 days. A range of strategies and interventions were introduced to YL to help her when she was feeling emotionally overwhelmed or when she experienced the desire to self-harm.

1.3 Throughout June a range of professionals completed assessments; this included a range of Mental Health professionals, a Job Retention Specialist and a Cognitive Behavioural Therapist (CBT) therapist who scored YL high on the post-traumatic stress disorder scale (PTSD) scale.

1.4 A range of risk assessments in relation to risk of self-harm and/or suicide, harm to others and risk to self from other behaviours were also completed, with YL's scores ranging from no risk to high risk, which was representative of Y'Ls mood which ranged from bright and improving to being acutely emotionally dysregulated. YL's emotional dysregulation presented as her inability to manage emotional responses typically, including sadness, anger, irritability and frustration.

1.5 YL's risk assessments reflected the fluctuating emotional dysregulation she was experiencing at differing points in time. However it would appear that there was no single practitioner designated with overall responsibility for leading on identifying, documenting and disseminating risk information to enable a multiagency approach to addressing risk.

1.6 One feature of YL's presentation was that she was intermittently hearing command voices, telling her to harm or kill herself. YL was worried about whether she could keep herself safe. Professionals viewed that YL saw her relationship with her daughter as a protective factor; this changed later in June, when YL said that it was no longer a protective factor.

1.7 During June, YL varied in her compliance with her medication and responded variably regarding suicidal thoughts and intent, with hearing voices seeming to correspond with acuity. YL's family reached out for help once in June during one of these acute episodes.

1.8 A care and contingency plan was co-produced, shared with YL and updated in June. It appears that this plan was not shared with wider multiagency teams or partners. Similarly, minutes and outcomes of multidisciplinary Team (MDT) meetings do not appear to have been shared with other key professionals.

1.9 MDT attendees were not documented in June and it is unclear who convened and/or led these meetings and who would be responsible for reviewing minutes and forwarding onto/determining who recipients would be of this information. Children's Services reported that they have no record of being invited to attend this meeting.

Risk Assessments and Review in June: In summary, the practitioner/s undertaking formal risk assessments in June included practitioners in the Emergency Department (ED) Mental Health Liaison Team (MHLT), Solent NHS Trust Crisis Resolution and Home Treatment Team (CRHT) and Cognitive Behavioural Therapists. Risk assessments in relation to YL's risk of self-harm were rated as High on two occasions, Medium on three and a rating of No Risk was recorded on a further three occasions. A CBT therapist rated YL as high on the PTSD scale.

On two occasions risk assessments also considered YL's risk to others and on both occasions YL was deemed not to present as a risk to others. It is notable however that YL had already articulated that she was no longer sure that her relationship with her daughter was a protective factor. This shift ought to have triggered a formal and documented exploration of the risk to YLs daughter, which it did not. Overall, risk assessment findings were variable and reflected how YL was presenting and her acuity at the time of their completion.

Additionally YL was formally reviewed once in June by the Adult Mental Health team (AMH) at The Orchards, as well as reviewed in three CRHT MDT meetings, formally convened to discuss and review YL's management and progress. Attendees were not recorded for these June MDT meetings. Formal Risk Review Questionnaires were completed on the 13th and 17th June, however it does not appear that there was a designated practitioner responsible or accountable for leading on and collating the overall risk findings and patterns for YL, in order to maintain and share a dynamic risk narrative with relevant multiagency partners involved in YL's care and the care of her daughter and family.

July

1.10 In July YL was admitted to hospital for 6 nights following an overdose of prescribed medication. YL also reported that she had felt suicidal whilst on holiday on the Isle of Wight in July, calling the local crisis service at the time which she said had helped her.

1.11 YL reported variable suicidal ideation, intent and planning in July, citing regret at her behaviour, fear at her impulsivity and worry that she could not keep herself safe. YL

highlighted she was unhappy with her discharge plans, saying she felt safer on the ward.

1.12 YL reported that she was still hearing voices, commanding she harm herself or also her family now. YL's relationship with her daughter was no longer being perceived of as a protective factor. At this time YL varied in her responses when she was asked if she used alcohol.

1.13 Children's Services were made aware in a safeguarding (MASH) referral in July by the ED team that YL had been admitted after taking an overdose and that she was accompanied to the hospital by her maternal grandmother and grandfather as well as YL's daughter.

1.14 The referral also stated that YL's grandparents were able to care for YL's daughter and that both YL and her daughter already lived with the grandparents, with YL's grandmother caring for YL's daughter whilst YL worked. No information was shared with Children's Services regarding YL hearing voices commanding her to harm her family.

1.15 Children's Services assessed the information relating to YL's admission as indicating a need for a Tier 2 response; therefore Think Family Mentors were tasked to make contact with YL's grandparents to ensure that they were able to care for YL's daughter.

1.16 There was a ward round on Monday 29th July at which it was agreed that a Care Programme Approach (CPA) meeting would be held pre-discharge. The CPA model describes the approach used in mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needed for people with complex care needs. This CPA meeting was attended by YL, YL's grandmother, a number of mental health practitioners and a benefits officer.

1.17 Support was offered and accepted by YL relating to the pressure she was experiencing from her employer regarding her plans and the timescale for her to return to work.

1.18 There is no record of any invitation being sent to Children's Services to attend either the ward round or the CPA meeting.

1.19 YL continued to access a range of professionals, interventions and services, whilst being placed on the waiting list for others. During admission YL's risk of harm to herself was rated as high, however there was no specific risk assessment by AMH evident in relation to YL's risk to others at this time. YL was subsequently discharged to the care of CRHT after a series of episodes of home leave to her grandmother's house where YL lived.

1.20 YL's family were becoming concerned about the risk YL may pose in their home as YL's daughter lived there too. Information regarding these concerns had been shared with both the adult and child MASH teams at the point of admission by professionals.

1.21 The MASH referral did state that YL lived with her daughter and that grandparents and

family were saying they could not have YL at home as they felt unable to keep YL safe. The family also expressed concerns about the impact on YL's daughter.

1.22 YL was noted to be planning a holiday to Tenerife after her discharge from hospital and was future oriented at the point she was discharged and looking forward to this break. No evidence of multiagency discharge planning was evident and therefore it is assumed that multiagency planning did not take place. YL was discharged back home to her grandmother's house to live with her daughter and grandparents again.

1.23 There was a CPA meeting on the day of discharge which was attended by YL, YL's grandmother, a number of mental health practitioners and a benefits officer. Again Children's Services were not invited to attend the CPA meeting and there is no evidence of the sharing of outcomes or minutes from these meetings or the sharing of risk information with Children's Services or with other relevant multiagency partners involved in YL's care or the care of YL's daughter.

Risk Assessments and Review in July: In summary, YL was assessed regarding risk of harm to self twice when she was rated as high and then low risk, no risk to others were noted during admission, however a referral to Child Safeguarding via MASH was made due to concerns about the potential risk to YL's daughter of both physical and mental harm. YL was also formally reviewed once in July during a ward round and once in a CPA meeting on the day of discharge. Solent NHS Trust formal Risk Review Questionnaires were completed on both the 25th and 30th July. Again it does not appear that there was a designated practitioner responsible or accountable for leading and collating overall risk findings and patterns for YL, in order to maintain and share the dynamic risk narrative with relevant multiagency partners involved in YL's care and the care of her daughter and family.

August

1.24 YL went to Tenerife as planned and on return YL disclosed to the CBT therapist that she had stopped taking her medicines whilst there and that she had engaged in further suicide attempts by ligature and drowning. Informal hospital admission followed as a result of these disclosures, the duration of this admission was 13 nights.

1.25 During admission YL disclosed alcohol use which was confirmed by YL's grandmother who disclosed more recent alcohol use too. Throughout her admission, YL's risk of self harm remained variable, ranging from low to high and YL cited suicidal ideation, intent and plans using ligature. Command voices persisted.

1.26 Safeguarding information was shared with both adult and child services again and YL's grandmother shared that YL had said that she no longer wanted her daughter, also citing disappointment with YL's minimal engagement with her daughter during home leave. No further assessment or escalation by Children Services was evident at this point.

1.27 YL continued to access and engage with a range of professionals and services. It is unclear if or how information regarding YL's repeat mental health admissions, risk assessment findings and care, treatment and discharge plans were being shared by and with wider multiagency partners involved in YL's care and the care and support of her daughter and family.

Risk Assessments and Review in August: In summary, YL was assessed regarding risk of harm to self in August once by CRHT before her admission and then repeatedly throughout her admission, by a range of mental health practitioners. YL's risk was deemed high on admission and then was deemed low just before discharge; with her risk to self from other behaviours (e.g. accidental death) being rated the same. Solent NHS Trust formal Risk Review Questionnaires were completed on the 2nd, the 23rd and the 31st August.

YL was also formally reviewed in relation to discharge plans in three ward meetings throughout her admission in August, however nobody other than YL, YL's family and mental health staff were present; that said attendee details were not recorded at all meetings, As before, it still does not appear that there was a designated practitioner responsible or accountable for leading and collating overall risk findings and patterns for YL, in order to continue to maintain and share a dynamic risk narrative with relevant partner agencies involved in the care of YL, YL's daughter and YL's wider family.

Again and despite recognized risk to YL's daughter, there does not seem to have been any inclusion of Children's Services in discharge planning. Referrals to both Child and Adult MASH teams were made in August by police and by the adult mental health team, due to concerns about the potential risk to YL's daughter of both physical and mental harm. No new Children's Services assessments were initiated at this point and so it does not appear that adult and child teams were working effectively and in an integrated way at this time, in order to safeguard and/or meet the needs of YL, YL's daughter and YL's family.

September

1.28 In September YL's mental health behaviours notably escalated, resulting in four presentations to ED due to acute episodes of emotional dysregulation, two of which resulted in hospital admission. A diagnosis of Emotionally Unstable Personality Disorder (EUPD) was made.

1.29 Multiple attempts at self-harm and or suicide occurred in September, with YL asserting there had been 15 of these in recent times. These self-harm and suicide behaviours included head banging, cutting, ligature attempts and running into moving traffic.

1.30 Family had needed to restrain YL on one occasion whilst in YL's grandmother's home in September (partially witnessed by YL's daughter). YL's grandmother had to call emergency services for help. YL's family expressed dissatisfaction with the effectiveness of YL's mental health care and asserted that they felt that emergency services were not always responsive either.

1.31 YL's Grandmother again reinforced that YL was saying that she had no feelings for her daughter and again reinforced her concern about the impact of YL's behaviours on YL's daughter and the wider family.

1.32 Multiple command voices were now being heard by YL and were now assigned genders. They continued to demand harm to or the death of YL, or consequences would be incurred for others, including YL's family. YL said she did not feel safe and could not trust herself.

1.33 YL's diagnosis of EUPD and the risk posed by the hospital environment was discussed with YL in relation to her EUPD diagnosis. YL disclosed at this point that she was trying to dissociate from friendships she had made on the ward previously, in order for her to try and focus on herself and her own recovery.

1.34 Despite both denials and disclosure of alcohol use, YL was advised that her EUPD related emotional dysregulation was notably impacted by alcohol use. YL accepted the offer of help with her alcohol use whilst she was an inpatient.

1.35 The mental health team continued to highlight the need for YL to take responsibility and be accountable for her behaviours, reinforcing that she was a capacitous adult who needed to consider and recognize the impact of her behaviours on her family.

1.36 The family remained unhappy with discharge plans and the overall effectiveness of mental health care and service provision. YL admitted that she was strategically using disguised compliance and still had suicidal ideation and intent all the time, but without plans.

1.37 YL maintained that despite knowing the risk of a false sense of safety in hospital, it was the only place she felt safe. Due to lack of documentation, the level of multiagency discharge planning and information sharing with key professionals was again unclear; therefore it was assumed that multiagency planning for discharge was not undertaken as with previous admissions.

Risk Assessments and Review in September: In summary, YL was assessed regarding risk of harm repeatedly, both as an inpatient and after discharge from hospital; this was by a range of mental health practitioners. YL's risk to herself ranged from no risk to high risk, with her risk to

others being rated as low by professionals. This view was not shared by YL herself or by her family, who expressed significant concern about the risk YL posed both to herself and to them as a family. Solent NHS Trust formal Risk Review Questionnaires were completed on the 24th and the 30th September. YL was also formally reviewed in relation to discharge plans in four MDT meetings in September; again these seem to be exclusively attended by YL, family and mental health staff, with attendee details again not being recorded on all occasions and no evidence being available of an invitation to or attendance by Children's Services at these MDT meetings.

This lack of multiagency discharge planning was now a significant omission given the risk to YL's daughter and potentially to other family members responsible for caring for YL's daughter.

Referrals to both Child and Adult MASH teams were made in September, but the impact and outcome of these is not apparent, despite the ongoing and persistent risk to YL's daughter of both physical and mental harm. What was also emerging very clearly now was the risk to both grandparents and it does not appear that adult safeguarding teams were responding to either YL herself as an adult with care and support needs, or recognizing/responding to evident carer vulnerability and need for adult safeguarding assessment within the family.

Despite escalating risk now being an ongoing and consistent feature, there is still no designated practitioner responsible or accountable for leading and collating overall risk findings and patterns for YL, or for sharing emergent risk information across health and social care teams (adult and child) and emergency response teams.

October

1.38 In October YL's condition notably deteriorated and YL was re-admitted for 8 nights again following a further acute episode of emotional dysregulation, requiring further restraint again by the family, again some of which was witnessed by YL's daughter.

1.39 At the point of this admission YL's grandmother called Children's Services Out of Hours service, reporting that YL was intoxicated and was not prioritizing her daughter’s needs, highlighting her concern for YL's daughter’s future.

1.40 This escalation by YL's grandmother did result in YL's daughter being opened to Children's Social Care for intervention. A Single Assessment was completed to identify family strengths, any unmet need and any support needed to ensure that YL's daughter had her needs consistently met in a safe and secure environment. The allocated Social Worker adopted the Lead Professional role for this assessment process.

1.41 The result of this assessment was a recommendation that YL's daughter remained open to Children's Services on a Child in Need plan and to ensure that the family engaged with

services specifically aimed at supporting them. It was also recommended that a meeting was held between all involved professionals and parents to establish a support plan. Who attended this meeting was not shared for the purpose of this review, however the resulting plan summary was:

- Work with YL to give her confidence to parent independently
- YL to contact professionals herself in relation to her mental health
- Work with YL around appropriate relationships and the impact on her daughter
- YL's mum and grandmother to explore private proceedings to help care for YL's daughter.
- Establish a safety plan with all family members to manage YL's care when YL is unwell or unavailable.

There is no evidence to support that this plan was widely shared across multiagency partners.

1.42 Children's Services worked towards the risk of harm to YL's daughter being managed by the family working together to identify safety plans that met YL's need for contact with her daughter and the rest of her family, ensuring that YL's daughter was kept safe from harm.

1.43 As all family members, including YL, engaged with Children's Services, who were confident that the family were able to ensure that YL's daughter was not put at risk of harm, Children's Services did not perceive a need to undertake a S47 investigation or work under Child Protection planning.

1.44 Children's Services now set conditions, however, that YL was only allowed supervised contact with her daughter and could not stay overnight at her grandmother's, to safeguard YL's daughter from exposure to YL's emotional dysregulation and behaviours. Children's Services said that this position could be reviewed as YL's mental health stabilized.

1.45 There were no restrictions made by Children's Services regarding the amount of time that YL could spend with her grandparents at their home, but it was agreed by the family that YL would always be supported when caring for her daughter and that she should not be alone with her.

1.46 These child contact arrangements meant that YL could no longer live, as she had since childhood, at her grandparents' home, as this could potentially result in her daughter being with her unsupervised.

1.47 In effect this meant that YL was now homeless.

1.48 YL did have a number of people she referred to as friends who she said that she could stay with; however as these friends were staying at the hotel commissioned by the local authority to provide temporary housing, these may possibly have been the friends YL

had met whilst an inpatient on the ward. YL's grandmother had already raised concerns about these new friendships and their influence on YL.

1.49 Children's Services also noted that YL had a friend that she could stay with, as well as that YL often stayed at her mother's home. They also noted that there was at least one occasion when YL's daughter went to stay with YL's mother for a sleepover, so that YL herself could return to her childhood home and stay with her grandparents.

1.50 The child contact conditions set by Children's services and the impact (actual and potential) on YL and her wider family were not discussed with adult mental health colleagues before being put in place. This was a missed opportunity to explore and fully understand the impact that the contact arrangements could have and therefore the impact and risk that they potentially posed.

1.51 Contact between YL and her daughter was reportedly discussed and agreed at an initial planning meeting and subsequent review meetings with Children's Services. YL and other maternal family engaged well in these meetings, as did the Housing team once the homelessness duty to refer was made in October. Notably, YL still did not have a Designated Lead Professional from adult mental health to attend these Children's Services planning and review meetings with her or on her behalf until a Care Coordinator (CCO) was allocated mid-October.

1.52 In October YL's assessments as an inpatient rated YL's risk to herself as ranging from low to high, with YL again stating that she felt variable in relation to her experience of suicidal ideation, intent and plans.

1.53 YL acknowledged during this admission that despite her compliance with the demands made by the voices she was hearing, the voices had not actually stopped. YL continued to question her ability to keep herself safe, however YL's belief in her ability to stay safe was reported as showing improvement in October.

1.54 As YL was now homeless, she was referred to the Housing Needs and Advice Service (HNAS), where the duty to assess was accepted and an interim offer of temporary accommodation was offered and accepted by YL, resulting in YL being placed with a local hotel provider.

1.55 Legal proceedings continued to progress in relation to YL's grandmother and the guardianship of YL's daughter. YL's Grandmother continued to formally express concerns about friendships and associations YL was making on the ward; however YL minimized these concerns.

1.56 The mental health team continued to reinforce YL's need to take responsibility and be accountable for her behaviours as a capacitous adult. They also reinforced that when YL

is experiencing emotional dysregulation, it is her responsibility to seek/access appropriate and timely help.

1.57 A number of CPA and MDT meetings were held, care and treatment and waiting times for therapy were reviewed, and YL continued to access support from a range of professionals and services, with daily recovery input starting, which included a focus on alcohol use.

1.58 Risk assessments continued to consider YL's risk of harm to herself through deliberate self-harm, as well as risk to self from other behaviours, such as impulsivity and accidental death.

1.59 Whilst risk to others appeared to be considered by adult mental health, reported findings are not recorded and shared. Paradoxically assessment of risk to others was less evident as YL's acuity and risk increased.

1.60 Conversely measures undertaken and stipulated by Children's Services to mitigate risk increased at this time, though these do appear to be undertaken almost in isolation and without discussion with wider multiagency teams. A CCO was allocated to support YL and engage in these meetings mid-October, who made contact with Children's Services.

1.61 At no time was a combined risk assessment and safety plan devised across and by partner agencies and YL collectively, therefore there was no evidence of multiagency shared understanding or coherent approach to risk management, for all parties to be aware of and work to.

1.62 MDT discharge planning was limited in its effectiveness as it was health staff and ward based, lacking multiagency input, usually being attended by health MDT members only.

1.63 Once residing at the hotel in October, YL reported that she found it a lonely and isolating place, but she continued to engage with her CCO once they had met. She reported medication compliance and attended daily recovery services.

1.64 YL also reported spending much of her daytimes at her grandmother's, which was in line with Children's Services conditions, as long as YL was supervised when her daughter was present and as long as no sleepovers were taking place whilst YL's daughter was in the house overnight too.

Risk Assessments and Review in October: In summary, YL was assessed regarding risk of self harm, mostly whilst she was an inpatient. YL's risk to herself was rated from none to medium, despite succeeding in two ligature attempts whilst on the Observation Ward in ED. The level of risk YL posed whilst on the Observation ward was escalated to senior management, who themselves escalated to senior staff in mental health services they were so concerned. However no bed was available on the mental health unit at the time, so YL was supported in the

interim with 1:1 care and medication to reduce her emotional dysregulation and risk to herself. By now YL and her family were deeply dissatisfied with previous discharge decisions, which they felt were too soon. YL's grandmother also expressed her concerns about the proximity of YL's hotel accommodation to a pub, again expressing concerns about relationships and friendships YL had formed with other inpatients and their influence on YL. YL's grandmother also stated that family suggested that YL stay with her mother whilst grandmother cared for all children at her house, however Children's Services were reported as not open to this as a solution.

Solent NHS Trust formal Risk Review Questionnaires were completed on the 4th and the 10th October and YL was formally reviewed to inform discharge plans in three MDT and two CPA meetings. These meetings continued to be exclusively attended by YL, family and mental health staff, with attendee details not being recorded on all occasions. With persistent and escalating risk, YL's level of complexity was such that a CCO was allocated, who would critically have oversight of and responsibility for sharing risk information across health and social care partners and emergency response teams. The overarching role of the CCO is to function as the professional who helps to develop a care plan and work in the community with other services to address a person's social care, housing, physical and mental health needs, as well as substance misuse; providing any other support a person may need.

Children's Services however were still not being included with discharge planning and it appeared that family were an established default mechanism for keeping Children's services updated in relation to YL's admissions and new risks to YL's daughter, as a result of YL's deteriorating mental health. Conversely, the Housing Needs and Advisory Service liaised well with Children's services once involved with YL, seeking to confirm on a number of occasions what the child contact arrangements were for YL and her daughter. However a key issue that remains unclear is whether Children's Services were fully aware and cognizant of the extent of the impact that the child contact arrangements were now having on YL's mental health, especially as they were perceived by YL as preventing her from “going home”. YL's feelings of isolation at the hotel are highly likely to have been amplified by this. This was also a very difficult situation for YL's grandmother, who felt that she had to choose between the granddaughter she had virtually brought up like her own daughter and her granddaughter's own child.

November

1.65 YL was admitted for a single overnight stay in November, following an overdose of prescribed medication. With this episode of self harm, YL stated that she answered a call from her mother on her mobile at the time of her overdose. YL was unclear why she had self-rescued in this way.

1.66 YL also disclosed to a third sector provider that she had also attempted suicide by ligature in November and evidence of self harm via cutting was also evident.

1.67 YL continued to assert that she only felt safe in the hospital, that she had suicidal intent, ideation and plans and was rated as being at medium risk for accidental death. She also continued to assert that she would make another attempt on her life if discharged.

1.68 YL remained homeless however and was returned to the hotel in November, with the HNAS team formally assessing YL's eligibility for accommodation under their duty to accommodate. Assessment deemed YL not to be in need of supported or residential accommodation. They therefore sought to support YL in securing a private solution.

1.69 YL disclosed in November that she had tried to reach out to both the Crisis Line and the CRHT team by telephone on two separate occasions, when she had felt emotionally dysregulated. YL reported that there had been no answer from both services at the time of calling each one. The CCO said they would follow this up and escalate internally.

1.70 YL also shared how she did not feel that her access to and uptake of the range of services aimed at supporting her mental health and recovery were really helping; however she remained future oriented, had new career plans and was making plans for the Christmas holiday period.

Risk Assessments and Review in November: In summary YL was recorded as formally assessed regarding her risk of harm to herself at the point of admission, the findings of which varied from her presentation to ED and then again at the point of discharge within 24 hours. This reflected the acuity and the swift resolution of her emotional dysregulation. These assessments rated YL as being at a medium risk overall of harm to self and at a medium risk overall for risk to self from other behaviours. A Solent NHS Trust Risk Review Questionnaire had been completed a week before her admission in November; this reflected the same level of risk as presented during the overnight hospital admission. There was no formal assessment of risk to others evident in information shared for this review.

In November YL's CCO began to liaise with Children's Services and with the Housing Team; however cohesive and real time information sharing across and by all agencies was not well established. In November, a third sector provider supporting YL, with whom she was engaging well, were advised by YL of some self-harm behaviours. These disclosures were not shared directly with adult mental health services at the time, as YL said that she would share this information when she attended her appointment with the adult mental health team later the same day. The third sector provider did escalate internally to their own safeguarding team; however the lack of formal sharing of this risk information with the adult mental health team at the time of disclosure was a missed opportunity to effectively safeguard YL.

Formal care proceedings by Children's Services progressed to legal consideration of a Special Guardianship Order (SGO). The CCO engaged with Children's Services to support YL and to stay informed, however the inclusion/involvement of Children's Services in adult mental health care and discharge planning was still very minimal and facilitated via the CCO.

December

1.71 December saw two further admissions for YL, one being overnight and one with a duration of three nights. These admissions were following self-harm by overdose, ligature, cutting and attempted drowning behaviours.

1.72 YL continued to vacillate in her mood and presentation, ranging from suicidal to positive and future oriented, with her risk to herself being rated as ranging from high risk to no risk, with her risk of accidental death continuing to be rated as medium.

1.73 YL stated that she had remained suicidal throughout recent times and never felt safe to be discharged, however YL denied suicidal intent or planning. YL continued to hear command voices demanding that she harm her family or risk consequences for herself. Formal assessment on the ward rated YL as high risk to others, however YL denied this.

1.74 In December the only information received by Children's Services relating to YL's mental health and potential risk to others was a Police report regarding an incident on the 21st December, when police had assisted an ambulance crew who were struggling to safely transport YL to hospital.

1.75 YL's daughter was living with YL's grandparents and so Children's Services perceived no risk of harm and therefore no new assessments were undertaken. Notably, risk information regarding the nature of YL's command voices was not shared with Children's Services by adult mental health, which was a missed opportunity to effectively safeguard both YL's daughter and other family members.

1.76 Use of alcohol continued to be a feature contributing to YL's episodes of significant emotional dysregulation, which on one occasion required that police cuffed and fast wrapped YL to safely restrain and transport YL to ED and to stop her from harming herself and others.

1.77 Key sources of stress identified by YL and her CCO included YL's pending new job due to start in the New Year, her need for housing, a new partner and progression of the SGO for her daughter's care to be legally transferred to YL's grandmother until she reaches the age of 18.

1.78 YL did on occasion show insight into the potential impact of her behaviours on family and notably did not visit her daughter on one occasion when she was feeling emotionally dysregulated. YL also reached out to services at other times of need on some occasions.

1.79 However YL failed to seek such support following an episode of self harm, which resulted in her partner calling an ambulance as YL had stopped answering his texts. YL made no attempt to self-rescue on this occasion.

1.80 Throughout December there were MDT and CPA meetings and contact with YL by key professionals in the community. It is unclear if and how minutes, care plans, changes to medication and the rapidly changing dynamic risk information was shared across the wider multiagency partnership and with key professionals involved in the care of YL, her daughter and her wider family. Evidence of this was lacking for this review.

1.81 YL was discharged to the hotel on Christmas Eve with CRHT follow up planned for Christmas Day, with Intensive Case Management (ICM) support being available if she required this. YL's CCO met with her on December 20th and was due to meet with YL again on January 8th, 19 days after they last met. Whilst this interval was in line with the agreed care plan, it could be argued that this interval was longer than ideal, given the emotional impact of legal child proceedings, a factor potentially amplified by Christmas.

1.82 YL was seen on Christmas Day but then was not present at the hotel as planned for two subsequent visits on the 27th and 28th December. A member of the CRHT team bumped into YLs grandmother when out shopping and asked how YL was. YL's grandmother said that she had not seen YL since Christmas Day, but was aware that YL had been out with friends drinking alcohol and that she believed YL had been using other substances too.

1.83 YL was however in her hotel room when visited on December 29th and stated that she had been spending time with family. YL was warm, pleasant, engaging and future oriented. The plan was discharge from CRHT and to see the CCO as planned on Jan 8th. It does not appear that the discrepancy between YL stating that she had been spending time with family and YL's grandmother stating they had not seen her was not opportunistically addressed at this point.

Risk Assessments and Review in December: In summary, YL was formally assessed regarding her risk of harm to herself at the points of admission. The risk rating at the point of YL's first presentation to ED and at the point of discharge within 24 hours following overnight admission, were consistent and indicated that YL posed a medium risk of harm to herself and of harm from other behaviours. Subsequently when admitted for 3 nights later in December, YL was rated as low risk of harm to self when first presenting in ED but rated as high risk upon admission to the ward, remaining at medium risk until and upon discharge. By now medium risk appeared to be the accepted level of tolerated risk for YL. This fluctuation in risk again arguably reflected the acuity and resolution phases of YL's emotional dysregulation.

Solent NHS Trust Risk Review Questionnaires were completed on the 21st, 24th and 29th of December, reflecting high risk of harm to self on the 21st, but only low on the 24th and 29th. These differ to other ward assessed risk which was medium and not low at discharge on the 24th December. The CCO proactively liaised with Children's Services and with the Housing

Team in December; however cohesive and real time information sharing across and by all agencies continued to be fragmented, with limited multiagency discharge planning still.

Formal care proceedings by Children's Services had progressed further, to possibly include permanent placement with YL's grandmother until YL's daughter was aged 18, which caused YL significant distress. The CCO again contacted Children's Services in support of YL and asked Children's Services to contact YL to explain in detail what was happening with YL's daughter, how this was progressing and what this meant for YL as a mother. It was agreed that the social worker would meet and speak with YL on December 27th. This meeting with Children's Services did not appear to take place.

January

1.84 YL's CCO telephoned her on January 7th to cancel their appointment the next day, due to sickness. The plan was that they would get back in touch when they were back at work and that YL would contact the ICM Team if needed in the interim.

1.85 On January 9th YL disclosed to her daughter's social worker and her grandmother that she had decided to discontinue her medication. This information was shared with the mental health team that same day by Children's Services and YL's grandmother.

1.86 On the 11th January YL's grandmother visited the hotel at nighttime as YL had not responded to her attempts at contact by telephone or text which was not normal for YL.

YL was tragically discovered dead in her room by YL's grandmother and the hotel receptionist due to ligature.

KEY LINES OF ENQUIRY

(aligned to Terms of Reference)

1. How effective was partnership working

When reviewing the information shared by partners submitted in their scoping documents and upon further discussion with some of these partners, what became evident is that a wide range of health and social care agencies were involved in the delivery of care for YL, along with the care and support provided by YL's family and the hotel sector. The main partners and agencies involved included:

- YL's Family
- Mental Health Teams – community and hospital
- Non-statutory commissioned mental health support services
- Hospital Emergency and Cardiology Departments
- Children's Services – Local Authority
- 0 – 19 Health Visiting Service
- Statutory Housing Needs and Advisory Service
- Non-statutory homelessness provider
- Hampshire Constabulary
- South Central Ambulance Service
- Hotel provider
- General Practitioner
- Health and Social Care safeguarding adult teams

The understanding and sharing of information emerged as a theme for all agencies, in a positive sense as well as when there was a lack of information sharing or when timeliness was a factor. These are summarized thematically below:

1.1 Understanding the diagnosis of EUPD

YL's presentation and experiences were complex, featuring rapidly changing dynamic risks. YL was formally diagnosed with Emotionally Unstable Personality Disorder (EUPD) during the period being reviewed. EUPD is a condition summarized in National Institute of Clinical Excellence (NICE) guidance (2009) as:

> *"characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour……..a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm……..Transient psychotic symptoms, including brief delusions and hallucinations, may also be present……. It is also associated*

with substantial impairment of social, psychological and occupational functioning and quality of life……..People with borderline personality disorder are particularly at risk of suicide" https://www.nice.org.uk/guidance/cg78/chapter/Introduction

YL presented with each of these EUPD characteristic and risks over time, some more frequently than others. An individual's narrative in the context of living with their EUPD is therefore key for families, carers and professionals, to support them in their understanding of that individual's EUPD behaviours, needs and risks. This understanding needs to be a shared and common one across all involved in providing care and support to the person living with EUPD, as EUPD and its complex presentations can easily be misunderstood and perceived of as psychosis. The difference between psychosis and EUPD is an important distinction for professionals to be clear about with service users and their families and carers: professionals need to be able to convey this difference meaningfully. Without understanding this difference, families and carers may perceive the care and treatment approach for the person with EUPD as inappropriate and inadequate, especially if they are perceiving that care and treatment through the lens of a person experiencing acute psychosis.

YL's family did question the effectiveness of YL's care and support, as did YL, particularly the effectiveness of mental health services and the care and treatment they offered. When speaking with the reviewer, YL's grandmother asked, "Why wasn't YL detained under The Mental Health Act and how could they say she wasn't a risk to anybody when she was throwing herself in front of a car…….she was clearly psychotic?" This exemplifies the ease with which people can conflate or confuse EUPD with psychosis and the distress that this misunderstanding can cause. Therefore agencies need to be sure that relevant teams are able to explain and reinforce the difference between psychosis and EUPD, with some teams also needing greater understanding and an ability to explain EUPD care and treatment approaches. NICE (2009) estimate that the UK prevalence of EUPD is around 1% of the UK population, therefore health and social care agencies need to ensure that relevant teams across their workforce are appropriately knowledgeable and skilled.

When health and social care staff can meaningfully explain EUPD to service users and their families and carers, this will promote consistency in understanding, which is essential to the support and management of a person living with EUPD. This level of understanding was not always evident with YL and her family, as was demonstrated in YL's grandmother's distress at the lack of detention due to what she perceived as psychotic symptoms. Improved and consistent understanding by those supporting people living with EUPD can potentially lead to improved effectiveness of care, both real and as perceived by service users, the families and their carers. However a notable word of caution advised by NICE (2009) is that "measuring the effectiveness of the range of therapies and interventions used with EUPD is fraught with

difficulty". This assertion by NICE remained unchanged in a national review and update of this guidance in 2018.

1.2 Timeliness and value of information sharing and escalation

A common and consistent understanding of EUPD would also support more effective partnership working, underpinned by a shared recognition of the essential need for the timely sharing of information across partners and individual agencies, particularly as the dynamic level of risk is ever changing for people living with this diagnosis. Information sharing agreements should be discussed with the purpose being explained to the service user, gaining consent where necessary and where the capacity to provide consent is present. There were a number of examples where information was not shared in a timely manner across partner agencies, which impacted on the effectiveness of partnership working and resulted in missed opportunities to safeguard YL.

For example, some hospital discharge summaries to the GP appeared to have been subject to delay; for a person with rapidly changing risk, the timeliness of these summaries is critical. One summary noted that YL was not a risk to herself or to others, denying suicidal intent or planning, which at the time of its writing was factually correct; however by the time the summary had been received by the GP the situation had changed significantly. Given the dynamic and rapid change potential in YL's presentation, such assurances are of limited value without mechanisms for keeping a GP and other key professionals informed and updated in real time.

Key to information sharing is the sharer's perception of the value of doing so. Both YL's family and some partner agencies questioned the role and value of escalating or sharing information at times. For example YL's family were aware that mental health services were not routinely sharing risk information with Children's Services, such as information regarding YL's command voices and YL's reducing engagement with her daughter. YL's grandmother became the sharer of that risk information, recognizing how key this was from a child safeguarding perspective. Similarly, when an agency tried to support YL to escalate her mental health concerns, they were advised that the reason for escalation did not meet that service's criteria and the agency supporting YL were advised to seek support elsewhere, resulting in a subsequent chain of redirections. When service users, their families and professionals begin to question the value of escalation and timely information sharing, choosing not to share in real time or at all, the scope to safeguard individuals becomes compromised.

Another example involves the Children's Services Single Assessment process, which was completed in October 2019. As a result of this assessment a planning meeting was held and a Child in Need plan devised to ensure that YL's daughter was safe and protected from harm. The plan was reviewed at meetings held every six weeks and family and professionals were invited to attend and contribute. Minutes were taken at these meetings and the plan was reviewed and updated. Meeting minutes containing the plan were distributed every six weeks. However it does not appear that until an adult mental health CCO was allocated that this important information was routinely and meaningfully shared with adult mental health services. Children's Services also reported that they do not routinely update GPs regarding care proceedings, so the GP would have been reliant upon YL and her understanding, which did not always seem to be accurate. Children's Services did report that Housing, Adult Mental Health and the Recovery Hub liaised with YL's daughter's Social Worker; however until the CCO was allocated, an integrated Family Approach was lacking that was inclusive of health partners.

There is a need to ensure that the role and functions of all agencies is clear for service users, families, carers and professionals, to ensure that appropriate information is shared and that advice and support is sought and accessible at the time it is needed, managing the needs and expectations of all parties sensitively. Indeed, discussion with providers regarding timely sharing of information highlighted that the complexity of the structure of the mental health service itself was experienced as a barrier to timely information sharing. Limited understanding about different services, what they offer and how they interface with each other, can prevent effective safeguarding and partnership working across service users, families, carers and professionals.

A partnership wide mechanism for partners to know of and understand each service's remit, staff roles, functions and criteria would go some way to resolving this. This could for example be readily achieved in a format suitable for many teams by developing a series of podcasts or by using other such forms of accessible media, supported by one to two page briefing type documents. A similar resource also needs to be developed for service users, their families and carers, which again could readily be achieved for example by developing an integrated website, where all agencies are represented and their information presented in a meaningful way. Such a multiagency project would benefit service users and could be supported and endorsed by both the PSAB and the PSCP.

1.3 Care planning

Throughout the period under review, there was limited evidence of co-production, updating and regular sharing of care plans with YL, YL's family, and other key multiagency professionals.

This was despite regular MDT, CPA and individual face to face meetings with professionals, YL and family members. This is not care planning as perceived and recommended by NICE for people living with EUPD:

"Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person). The care plan should:

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

https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#assessment-and-management-by-community-mental-health-services

Evidence shared for this review highlights events which should have resulted in YL undergoing further assessment and a review of her care and support, both in line with NICE guidance and with Trust Policy and Procedures. For example the NHS Trust's Clinical Risk Assessment & Management Policy and Procedure requires that risk assessments must be reviewed whenever there is a change in the service user's clinical presentation/circumstances, whenever there is admission to and discharge from an inpatient unit, or whenever a patient is transferred to another team/Trust. Updated information and care plans should then have been shared with the mental health MDT and with other key multiagency professionals involved in caring for YL, YL's daughter and her family.

This did not always take place and where it did, the reason for completion of the reviews was not always recorded in YL's notes. Ideally what would be helpful would be a standardized core risk assessment/care/safety plan template used across all partner agencies, which details the core essential information recommended by NICE as detailed above and which can be updated and version/date controlled by all partners, enabling them to then sharing electronically or digitally in real time. This standardized multiagency approach to information sharing is achieved with safeguarding MASH referrals, when a single referral forms is used by all agencies.

Therefore in principal a core risk assessment/care/safety plan template should potentially be achievable and agencies would benefit from collectively exploring the feasibility for this.

1.4 Discharge planning

Similar to the limited collaboration and sharing of care plans, there was limited evidence that summaries of meetings, key decisions and action plans from MDT and CPA meetings were shared with multiagency partners and key professionals involved in the care of YL, YL's daughter and YL's family. A number of partner agencies highlighted just how critical they believed the need for effective and timely multiagency discharge planning was. The lack of this multiagency discharge process was viewed as a significant risk, without which there could continue to be limited mechanisms to enable and support effective and safe hospital discharge for complex individuals like YL. Family should also be included in these discharge planning processes where consent is in place and family are willing, which was evident with YL and family inclusion was very much supported.

Short notice of discharge and lack of liaison and planning was also cited as a contributory factor in reducing the effectiveness of supporting people experiencing homelessness who are placed in temporary accommodation. For example, a number of days may be required for practitioners in the housing team to source optimal accommodation for individuals who present with complex behaviours and need, as YL did. Practitioners need this time to understand, plan and source suitable accommodation, this critical because temporary accommodation placements will break down when needs are poorly met.

With YL, the Housing Needs and Assessment Team (HNAS) acknowledged that the close proximity of a public house to YL's temporary accommodation was not ideal, but placing YL here was a result of limited temporary accommodation stock availability and the short notice given that YL was homeless and was going to be discharged imminently. The information shared for this review indicated that the first ward referral to HNAS whilst in line with the ward's duty to refer under the Homelessness Reduction Act (2017) was not made until the day before YL's planned discharge. What could not be determined was if this was simply short notice of discharge combined with a lack of multiagency discharge planning, or because this was the first point in time that the ward become aware of the child contact restrictions put in place by Children's Services, which meant that YL was effectively homeless. To minimize the risk that lack of discharge planning and late referrals create for people experiencing homelessness, multiagency partners need to ensure that their staff understand the critical need for timely and flexible discharge planning, inclusive of all relevant key professionals from across the multiagency partnership; as well as family members.

1.5 The impact of homelessness

As stated, it is key that once it becomes known there is a duty to refer due to homelessness, this referral needs to be made immediately to enable the sourcing of optimal housing. However, a question for agencies to consider is whether the homelessness status of a person is routinely assessed, documented and shared as appropriate at the point of contact with services. If a person is not readily identified as homeless, they may not be afforded the same safeguarding considerations, care and support as those who are known to be homeless.

YL's daughter was open to Children's Services under Child in Need planning, when a number of MASH referrals by professionals and risk escalation by YL's family in September and October 2019 resulted in Children's Services advising YL's family that further measures were needed to better safeguard YLs daughter. It was agreed that all contact between YL and her daughter would now be supervised and that YL could no longer sleep overnight at her grandmother's house if her daughter was also there. Given that YL's grandmother's house was home to both YL and her daughter, it was inevitable that YL's daughter would be there overnight, thus meaning that YL was now homeless. YL's grandmother therefore needed to ask YL to leave her home. Whilst this predicament was understood by YL, who was reported by her grandmother to recognize and support her grandmother in this incredibly difficult decision, this was still an extremely painful position for both YL and her grandmother to find themselves in. NICE guidance (2009) cited above highlights that people living with EUPD will present with and experience "fear of abandonment and rejection…… with a strong tendency towards suicidal thinking and self-harm". YL becoming homeless may have amplified such fears of abandonment.

Children's Services however believed that there were other family members that YL could stay with and so did not perceive YL as homeless. That said, the 'Homelessness code of guidance for local authorities (2018)' defines that a person is "to be considered homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them and which it would be reasonable for them to continue to live in". YL met these criteria and therefore was now homeless. Social Workers supported YL in accessing Housing Services. Children's Services did not raise a safeguarding alert with MASH as they believed that professionals from adult mental health and mental health recovery services were aware of the actions being taken in relation to child contact conditions with YL's daughter and would be more aware than Children's Services of any impact these may have on YL. The potential impact of these child contact conditions on YL were therefore not explored by Children's services with adult mental health colleagues prior to being stipulated and a safeguarding referral to adult MASH was not made, despite YL's resulting homelessness and vulnerability.

The adult MASH team reflected on the issue of homelessness and considered whether homelessness informed their perception of need for safeguarding, questioning whether they should have been made aware that YL was homeless when she was referred to them at this time. Adult MASH clarified that they are not routinely advised of someone's homelessness status. The adult MASH team recognized that when they do receive referrals from housing and homelessness services they do perceive that a person experiencing homelessness may possibly be more at risk of, or be experiencing abuse or neglect and therefore may possibly need additional support. The team agreed therefore that whilst being homeless did not on its own necessarily meet safeguarding thresholds, a person's homelessness status does function as an indicator of possible need for additional care and support. The adult MASH team thus concluded that a person's homelessness status is relevant information for all adult MASH referrals. Assurance should be sought that this is now routine practice for referring agencies.

1.6 Child and adult services and integrated working

The issue of homelessness clearly illustrates the need for multiagency partners to collectively consider, discuss and explore decision making, particularly in relation to child protection planning and the impact such decision making can have on associated adults with care and support needs. The commencement of care proceeding for YL's daughter was a significant and ongoing trigger for YL up until her death. Plans for legal guardianship of YL's daughter being awarded to YL's grandmother were supported by Children's Services and progressing well. YL was at times expressing how difficult she was finding this as well as beliefs that her grandmother was going to formally adopt her daughter. YL's CCO was invited to Child In Need meeting, however not all key professionals from adult services were regularly invited and updated such as the GP. Discussion with Children's Services clarified that it is not routine practice for the Local Authority (LA) to share care proceedings updates with GPs. YL's grandmother reported that YL had a very positive relationship with her GP and that they regularly spoke by telephone. If information had been formally shared with the GP, this insight may have helped to inform or focus support offered to YL.

YL expressed confusion and seemed to potentially have some level of misunderstanding regarding the scope and long term outcomes of care proceedings, including the level of access she would have to her daughter once the care order was formalized by the courts. A further source of confusion was that whilst YL was not allowed unsupervised contact with her own daughter and was not allowed to stay overnight at her grandmother's house if her daughter was also present; discharge arrangements from the hospital at Christmas included the option that YL could stay at her mother's house, where YL's half siblings lived, themselves children, albeit older in age.

When the issues of confusion were discussed with Children's Services as part of this review, it was clear that there were no orders which stated that YL could not see her daughter and that plans relating to YL not being left unsupervised with her daughter had been made by and with the family, including YL. Children's Services also stated that there were no known incidents of YL's half siblings being exposed to self-harm behaviours and that YL was never in a position where she would undertake a caring role for them, so there was no concern from Children's Services for YL's half siblings. Children's Services were clear that adult services would have been kept informed through the regular Child in Need meetings held for YL's daughter which were attended by professionals from Mental Health, Housing and the Recovery Hub.

Despite this, on 24th December 2019 a mental health nurse reportedly contacted Children's Services, stating that YL had advised adult mental health staff at the hospital that her daughter was being adopted. It was agreed that a social worker from Children's Services would meet with YL on December 27th to discuss the current child care proceedings, however this meeting does not appear to have happened. Children's Services confirmed that they did not liaise directly with the hospital adult mental health ward, citing that commonly the Social Worker for YL's daughter would be informed of hospital admissions by YL's grandparents or YL herself. This is not a robust mechanism for detailed and timely sharing of information that could be critical for safeguarding, and this arrangement also lacks robust governance. Children's Services did again reinforce that they invited YL's CCO to all meetings and that the CCO and Children's Services communicated between meetings; however as YL's daughter was living with YL's grandparents, Children's Services did not directly engage or communicate with the Queen Alexandra Hospital adult mental health unit in relation to YL.

This review has identified a significant need to clarify and understand the role and expectations of practitioners in both child and adult health and social care teams, in relation to their accountability for information sharing and for supporting parents in relation to understanding care proceedings. There is a need to strengthen the Family Approach.

1.7 Family structures

All families are unique and YL's family had a moderately complex history and family dynamics. Professionals and partner agencies need clarity regarding the structure of complex families from the outset, to effectively support families and to safeguard all parties as appropriate. Clarity of family structures needs to include explicit understanding of key roles such as who has parental responsibility for children, who has power of attorney for adults, and who service users have identified as their chosen next of kin. It is also important to establish agreements in relation to consent for information sharing, what information can be shared by whom and with

whom; this information needs to be established early and shared in a common multiagency care plan/safety plan document.

Good practice in Children's Services was described, who advised that they seek consent to share information routinely at the first meeting with parents and that without consent information will not be shared unless the case is subject to a statutory S47 safeguarding investigation. A plan is devised with the family and involved professionals and reviewed at meetings every six weeks. As already highlighted, this information is not routinely shared with the GP or with adult mental health teams. Unless a person meets the criteria for allocation of a CCO, then information will not be reliably shared across all agencies, especially health agencies.

Family structure information should be checked and updated regularly and all changes shared in real time via a shared multiagency care/safety plan.

Terms of Reference 1: How effective was partnership working?

Good practice examples

- Examples of timely information sharing and escalation included MASH referrals made by emergency services and PPN1 notification sharing with MASH by police.

- YL's grandmother shared information in a timely and transparent way with Children's Services and Mental Health teams, including concern about the impact of YL's behaviours on her daughter, suspected/known use of alcohol and other substances by YL and concern regarding the impact of friendships YL made with other service users.

- YL's family were regularly included in MDT and CPA meetings which also included discussion regarding discharge planning.

- The adult MASH team engaged in reflection on YL's referrals and concluded that a person's homelessness status is relevant information for all adult MASH referrals.

Overarching Areas for improvement

The PSAB and multiagency partnership would benefit from:

1. Examining the level of understanding across health and social care practitioners of EUPD and approaches to care and support; including how EUPD differs from psychosis.

2. Reviewing existing mechanisms for real time multiagency communication, specifically focusing on people with frequent and dynamic fluctuation of risk.

3. Developing a partnership wide mechanism for professionals and the public to understand service access criteria and remit and practitioner roles and functions.

4. Examining the feasibility to develop a core multiagency care/safety plan template, for use across all health and social care agencies, emergency services and by families too.

5. *Understanding local arrangements for discharge planning for adults and parents with care and support needs, specifically examining how a family approach is adopted.

6. Reviewing practices in relation to assessment of and the sharing of information regarding a person's homelessness status, to include the timeliness of referrals under the duty to refer and whether safeguarding referrals are made appropriately.

7. *Examining expectations of adult and child practitioners across health and social care, regarding responsibility for information sharing and supporting parents subject to child care proceedings; assessing the strength of integrated working/Family Approach.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

2. Were the appropriate assessments completed to identify need and to manage/mitigate known risks?

2.1 Assessment in Emergency Departments

YL was able to take herself to the ED or was taken there by family, friends or emergency services, following her episodes of self-harm and/or suicide. EDs are the main service provider for people who self-harm. ED staff therefore need to be competent in the assessment of risk and emotional, mental and physical state quickly; whilst trying to engage with and encourage the person in distress to stay in the department whilst a psychosocial assessment is organised. The ED department where YL was taken have clear assessment processes to enable this. All people who self-present to the ED or who are reviewed in the Community by Paramedics or other ambulance practitioners, due to an isolated acute Mental Health crisis or an acute Mental Health crisis complicated by a medical need (e.g. overdose), are conveyed directly to the ED.

All of these individuals undergo a risk assessment as part of their initial assessment, with staff having access to the use of two assessment checklists: The Mental Disturbance Primary Survey and the Self Risk Harm Assessment. These tools provide a risk score for the level of supervision a patient requires whilst in the ED and how urgently assessment by the Mental Health team and Senior ED staff should be sought. This approach to assessment reflects NICE self-harm guidance (2004) and quality standards (2013). The ED department where YL attended also has access to a mental health liaison team and the out of hours crisis team who support ED. The NHS Trust where YL usually presented or was conveyed to, undertook an internal investigation process, producing a Serious Incident Requiring Investigation (SIRI) report, which examined in detail the care of YL. This report focused predominantly on community and ward based mental health care provision, therefore assurance that assessment tools were used by ED with each of YL's attendances was not explicit in this report. The SIRI report was shared in full by the Trust for the purpose of this review, providing a wealth of information.

2.2 Access to urgent assessment within hospital

The Trust SIRI report examined compliance with NICE guidance regarding urgent assessment of risk in hospital, highlighting an incident when YL was admitted out of hours to the Observation ward in ED, yet was still able to engage in two ligature attempts. The ED team had escalated concerns regarding YL's acuity and the risk she posed; however the crisis team were not immediately available to assess. Sedation was required and temporary detention of YL under Section 5:4 of the Mental Health Act, given the level of acuity and risk to herself and others that she presented. Admission to the adult mental health unit was not possible until 24 hours later.

2.3 Variation in risk assessments

The Trust SIRI findings also indicated that risk assessments were not undertaken in line with Trust Policy and Procedures on a number of occasions. The undertaking and recording of findings of these assessments varied, with some practitioners reporting outcomes for all domains, including risk of self harm, risk of suicide, risk to self from other behaviours (e.g. accidental death) and risk to others, and other practitioners reporting on single domains only. Observed and documented behaviours did not always reflect the level of assessed and reported risk either. In the absence of assessment outcomes for each domain and the documented rationale underpinning these findings, it was difficult to identify whether disparity across assessments and risk ratings was due to assessor subjectivity, rapidly changing behaviours and risk, or whether it was due to significant variation in the understanding, interpretation and application of assessment tools in practice.

2.4 Sharing new risk information

There were a number of occasions when multiagency risk assessments or risk discussion could have taken place and didn't, which impacted upon the scope for risk management and risk mitigation. For example it became evident after YL died that she had not been collecting her medicines as prescribed and expected. It is important to understand how failure to collect prescribed medication is flagged and escalated to the prescriber, particularly when relating to complex individuals with care and support needs such as YL. Is this a responsibility for clinical prescribers or for commercial pharmacists? This failure to collect medicines does not appear to have been either noted or discussed as a risk in relation to YL.

A further example where a lack of risk discussion may have limited risk mitigation was when a third sector provider supporting YL stated that they had been unaware that YL was believed to have been using illicit substances whilst receiving their care and support. Whilst they acknowledged that they knew that YL had issues with alcohol, they reported that they were not aware of the extent of her alcohol issues or the impact on YL's behaviour and emotional dysregulation, only being made aware of the extent of both the alcohol and substance use by YL's grandmother after YL's death. On reflection and given some of the disclosures made to this service by YL, staff may have escalated differently had they been aware of this risk information. Similar to this the Housing Needs Advisory Service also experienced issues with limited information sharing. Whilst being provided with a risk overview for YL when first referred to them, the service reported that this risk information did not include detail about YL's most recent suicide attempts or the potential risk of her living in close proximity to a public house

serving alcohol, a specific concern raised by YL's grandmother in relation to the suitability of the hotel providing temporary accommodation.

A further example just before YL's death was when CRHT made a decision to discharge YL from their care after successfully making contact with her following two failed visits at the hotel. The plan was for YL's care to be transferred to the Recovery Team and her CCO. However there was no discussion with the Recovery Team or other relevant mental health team professionals in relation to the CRHT discharge/care transfer decision. YL had a clear pattern of escalating risk behaviours and at points in time when discharge of YL's care from one team to another was suggested or planned. In combination with YL's recent suicide behaviours, any decision for CRHT to discharge/transfer care needed robust discussion and risk assessment. Additionally, information had been shared with CRHT by YL's grandmother that YL had been using alcohol and illicit substances again, both known triggers for YL's emotional dysregulation and escalation of her risk behaviours; this factor also does not seem to have been considered as part of a robust risk assessment for discharge/care transfer. The Trust SIRI report did highlight the risk associated with this discharge/care transfer decision, acknowledging that the decision lacked appropriate consultation with other relevant team members, which was sub optimal.

If a multiagency care/safety plan is available and shared across multiagency partners in real time, responsively and as presentations/circumstances/risks change; the partnership's scope to recognise, escalate and mitigate risk collectively and cohesively could be enhanced, creating more scope for the partnership to be effective in its care delivery and its ability to effectively safeguard individuals.

Terms of Reference 2: Were the appropriate assessments completed to identify need and to manage/mitigate known risks?

Good practice examples

- When YL disclosed that she had decided to stop her medication without discussion, the social worker shared this intelligence immediately with mental health services on the day of the disclosure supported by YL's grandmother.

Overarching Areas for improvement

The PSAB and multiagency partnership would benefit from:

8. Seeking assurance that evidence based tools are routinely used to assess individuals who present to ED with an isolated acute Mental Health crisis or with an acute Mental Health crisis complicated by a medical need (e.g. overdose).

9. Seeking assurance that the relevant team is readily accessible to undertake urgent mental health assessments in ED or on the Observation ward in ED at the point of presentation, highlighting if, why and how often delay may be incurred.

10. Understanding how the Trust Risk Assessment Policy and Procedures could interface with and be assimilated with other risk assessments undertaken in mental health, to streamline and minimise the scope for multiple and disparate assessment ratings.

11. Understanding how the collection of scripts for individuals with additional care and support needs is routinely monitored and escalated when there is a failure to collect.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

3. Support provided to meet identified need

3.1 NICE recommendations for meeting the needs of people living with personality disorders

NICE (2009, 2018) recommend that before considering admission to an acute psychiatric inpatient unit, a person with a personality disorder should firstly be referred to a crisis resolution and home treatment team, as an alternative to admission, with people only being considered for admission to an acute psychiatric inpatient unit for:

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

NICE also recommend that when considering inpatient care, people need to be actively involved in the decision and:

- ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission
- agree the length and purpose of the admission in advance
- ensure that when, in extreme circumstances, compulsory treatment is used, management on a voluntary basis is resumed at the earliest opportunity.

Psychosocial interventions designed to help people with personality disorders cover a wide range of approaches, all of which are 'talking treatments' but which differ in intensity, complexity and method.

Overall the Adult Mental Health Team did try to work with and support YL in a manner which complied with NICE guidance recommendations. However as previously stated, it is critical that professionals, families and carers are supported in their understanding of EUPD as a mental health condition, as well as the recommended approaches to the treatment and care of people living with EUPD. Without this level of understanding, care and treatment can be perceived of as inadequate and bordering on neglectful. This was the perception of YL's family on a number of occasions, which reinforces this critical need to support families in their understanding from the point of diagnosis and on an ongoing basis, especially at times when they feel that care and treatment is ineffective. Families and carers are essential partners across the health and social care system, particularly for mental health provision; they are also fundamental to admission avoidance. The health and social care system therefore needs to value their role and to invest in their education and support.

3.2 Provision of needs based support and interventions

With each admission, YL's care needs were reported as assessed and detailed in a care plan, recorded as co-produced by and shared with YL on a number of occasions, but this was not routine practice as Trust policy required. Care planning goals focused on stabilizing YL's emotions, with the aim that her care could be transferred to the Recovery Team. Consideration of YL's physical health needs was also evident during a number of admissions. Whilst on the ward, YL was offered and accessed a range of ward based activities and groups, reportedly finding a number of these helpful. This offer was also available post discharge and YL was also invited to attend ward based activities as her needs increased, despite being discharged from hospital.

Whilst in the community, YL was on the waiting list for Dialectical Behaviours Therapy (DBT) and Emotional Coping Skills (ECS) therapy. YL also accessed other support services and employed a number of strategies and interventions to help manage her thoughts, emotions and behaviours. These included accessing support from CRHT, a Job Retention Specialist (JRS), alcohol support services, recovery college courses and the Wellbeing Centre. YL was also supported by the Housing Service and a Local Authority commissioned provider for homelessness. YL was seen by her daughter's social worker, had some contact with her health visitor and was supported by a CCO from late October. YL's grandmother also reported that YL had a supportive and positive relationship with her GP. The GP was not contacted directly as part of this review due to the demand Covid was exerting at the time on Primary Care and GPs; however scoping information was shared by them to contribute to the review.

In short YL was offered and accepted a wide range of services both as an inpatient and as a person living in the community, both whilst living with her grandmother and whilst residing in hotel temporary accommodation. One significant and paradoxical challenge that the involvement of this number of services poses however is the need to support and enable YL to be referred to and transferred into other services or to be discharged from them as YL's skills and abilities to deal with her emotions and daily life improved. EUPD is characterized by a fear of abandonment and rejection and what is evident upon compiling and reviewing YLs chronology in its entirety is that YL's emotional dysregulation symptoms and behaviours escalated at points in her journey where her care was to be transferred between teams or when some form of discharge or withdrawal was imminent. This paradox of meeting YL's needs whilst potentially triggering new risk did not seem to be recognized or considered by adult mental health practitioners, despite a correlating pattern of recurrent escalation. However hindsight and merged chronologies did make identification of emergent patterns easier to detect as part of this review. A live and shared multiagency care/safety plan could offer this insight more readily and earlier as all party information is presented, as with the combined chronology.

3.3 When needs were not met

There were occasions when YL's needs may not have been or were not met. For example YL attempted to contact services on a number of occasions in crisis and she could not get through or her calls were not followed up as she had been advised they would be. This inability to access services when needed was escalated to the NHS Trust; however the Trust SIRI report indicated that it was not possible to determine what the outcome of this escalation was. It would be helpful for the PSAB to understand the issue of missed and/or abandoned calls to crisis support services to quantify just how much of an issue this is.

Similarly some risk behaviours were escalated by YL to a third sector provider who did not escalate them at the time of disclosure, as they believed that YL would be sharing them later that day in a scheduled appointment with the mental health team. The provider understood the importance of sharing this information and they escalated this to their own safeguarding team internally; they also contacted YL later that day to ensure that she had shared this information with the mental health team and was safe. Notably however this was also the provider who had been redirected repeatedly when trying to support YL in escalating concerns previously, offering some validation to the potential impact of such negative experience on the perceived value of escalation.

Additionally, YL was not referred back to the JRS for advice and support once YL was expressing desire to work in the care sector, then specifically in the mental health sector of care and on nights. At this point in YL's recovery journey, this career choice may not have offered YL the best scope for success in her recovery journey and the shift patterns may have negatively impacted on established medication routines and thus risk behaviours. Re-referral for further JRS input was indicated but not offered.

YL's grandmother also shared information about YL's alcohol and drug use that was not taken account of fully and did not always inform new risk assessments or mitigation, a factor again identified in the Trust SIRI report. It could be argued that YL's alcohol use and its impact on her EUPD was identifiable as an emergent pattern earlier than was recognized, again a factor which would possibly be better recognized with a live and shared multiagency care/safety plan. There was also a notable and poignant reduction in the scope for services to meet YL's emotional needs and to safeguard her effectively, once free access to her childhood home and her grandmother was limited, ironically to safeguard YL's own daughter. The earlier allocation of a CCO may have offered greater and earlier opportunities to discuss understand and negotiate child contact arrangements with Children's Services; therefore a review of criteria for access to a CCO would be helpful.

Terms of Reference 3: Was support provided to meet identified need

Good practice examples

- Whilst care planning focused on stabilising YL's emotions, consideration of YL's physical health needs was also evident during a number of admissions.
- YL was offered access to a wide range of services in the community to support her in developing strategies to manage her emotions and risk behaviours
- YL was also invited to attend ward based activities as her needs increased, despite being discharged from hospital.
- A homelessness provider contacted YL to follow up and check that she had shared new risk information with the mental health team and to check that she was safe.

Overarching Areas for improvement

The PSAB and multiagency partnership would benefit from :

12. *Requiring the health and social care system to value the role of families and carers by investing more in education and support specific to their needs.
13. Seeking that health services audit and share current wait times for key psychological therapies such as Dialectical Behaviours Therapy and Emotional Coping Skills therapy, in order for the partnership to understand provision, alternative sources of support and to support dialogue regarding whether current commissioning of these therapies is fit for purpose.
14. Understanding the issue of missed and/or abandoned calls to crisis intervention services across health and social care, quantifying the extent and potential impact of this issue.
15. Understanding the criteria for allocation of a CCO, in order for the partnership to understand access and provision and to support dialogue regarding whether current commissioning of the CCO model is fit for purpose.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

4. Hearing the voice of the adult

4.1 YL's voice

4.1.1 I don't feel safe

YL was a capacitous adult, able to express her views, beliefs and wishes which she did, until a point where she admitted that she was employing disguised compliance as a strategy, having decided that her treatment and the involvement of adult mental health support was ineffective. YL repeatedly articulated that she feared she could not keep herself safe and that she was fearful of the risk she may pose to others as the result of the command voices she heard. YL was clear that she only felt safe in hospital. This false sense of safety from a hospital environment is a common and challenging conundrum for practitioners supporting people living with EUPD and is detailed well in the 2018 report: Safer Care for People with Personality Disorders. This report clearly highlights how hospitalization has little value for patients with Personality Disorders (PD) in crisis and may "negatively influence suicidal behaviours in some". It goes on further to state that those admitted may become "dependent on the locked hospital environment and be viewed as low risk by staff who sanction discharge when the patient is in fact still at high risk".

This was very much a feature of YL's experience and one which again can be difficult for families to understand too. For families they see the person they love at times of crisis being extremely emotionally dysregulated and at significantly high risk of self-harm, often engaging in acts of suicide. The distress and self-harm behaviours rapidly abate once their family member is in hospital, where they express feelings of safety and often then begin to express anxiety about the eventuality of leaving hospital. This brings relief and a sense of being in an appropriate and safe place for families too. However hospital is not always an optimal environment to meet a person living with EUPD's needs. Psychosocial interventions and therapies delivered in the community remain the approach most likely to succeed in the treatment and care of people living with EUPD. That said both the NICE technical review of (2018) and the initial NICE guidelines for the treatment and care of people living with PD (2009), along with the Safer Care for People with Personality Disorders Report (2018); highlight the difficulty with managing and supporting people living with PDs. Results echo each other in that findings indicate that mental health services struggle in managing patients with PDs, "with clinicians often skeptical about the clinical treatability of the disorder". This further reinforces the need to support families, carers and professionals in improving their understanding in relation to EUPD.

One of the risks of a hospital environment is the introduction of people living with EUPD to other people facing similar emotional dysregulation and also exhibiting a range of associated risk behaviours. Whilst this shared experience is usually a positive strategy for a number of health conditions, with Personality Disorders this conversely presents opportunities for the development of friendships and possibly intimate relationships, as was the case with YL, which may have a negative impact on a service user's recovery journey. Sharing common concerns and experiences through these friendships commonly serve to increase anxiety and thereby escalate behaviours, as well as create the opportunity to be exposed to new concepts and acquisition of new skills in self-harm. There is a risk that these friendships can also be exploitative and become all consuming, again as was the case with YL and as escalated by her grandmother too.

4.1.2 The need to safeguard my daughter versus the need to safeguard me

In undertaking this review, it did feel that the voice and the needs of YL seemed at times to be minimized or at times missed as a result of the need to safeguard YL's daughter. Whilst the need to safeguard YL's daughter is not in question, it was important to recognize the paradox that protecting YL's daughter increased Y'Ls risk. YL was asked to leave her grandmother's home and to return her key, YLs own home since childhood. This measure was to reduce YL's daughter's risk of exposure to YL's extreme emotional dysregulation, her self-harming behaviours and the potential risk for harm from YL when responding to command voices. This significant requirement of YL came at a time when YL had given up her education/training, needed to seek employment elsewhere and as she was trying to distance herself from service user friendships made on the ward. There was much scope at this time for increasing YL's fear and sense of abandonment.

It is important to recognize that YL had only just transitioned into adulthood herself and had now been placed into a hotel which she reported she experienced as a "horrible and lonely" place and where she felt isolated. It is however acknowledged that there was very little alternative temporary accommodation available to the housing team at the time, however the paramount need to safeguard YL's daughter did almost negate YL's voice and her own individual needs at times. Adult and Children's services would benefit from working together directly, earlier and in a more integrated way, adopting a more robust multiagency Family Approach. This needs to include discussion regarding additional safeguarding requirements for adults/parents who are homelessness and have additional vulnerabilities and how collectively, adults and child services will remain abreast of the safeguarding of all family members.

4.1.3 Helping me to gain employment

Employment was a key issue for YL, with YL switching career choices from working as a PE teacher to working in the care industry as a support worker on nights. Whilst aspiration and making such choices are usually key indicators of commitment and momentum in a person's recovery, YL's choice may have been over ambitious and possibly even unhelpful to her at the point in her recovery journey she was at. Whilst not seeking to deter or undermine the positive component of making such choices, it would have been helpful to understand YL's choices more comprehensively and for YL to be re-referred to the Job Retentions specialist. This practitioner would have helped YL to explore how she could embark on such a career in a phased and more supportive way, rather than simply taking on the role of a care worker on night duty in the mental health sector, with all the scope that this potentially offered to destabilize YL. It would be helpful to understand how much health and social care partners understand the role, function and referral criteria for this practitioner.

4.2 The voice of the family

Whilst YL's family, particularly her grandmother, were very much included in the care of YL with YL's consent, there were times when their views were in contrast and sometimes conflicted with the views of YL and/or the mental health team, for example when they felt that the onus was on them to push services to address issues such as YL's alcohol use. Another example was how YL's grandmother expressed concern regarding service user friendships which YL made whilst an inpatient, with YL minimizing these concerns; only to later identify her need to dissociate from these friendships due to the demands they made upon her, when she needed to focus on herself. It was also whilst socializing with these friends/service users that YL would engage in drinking alcohol, a behaviour that YL had been advised to avoid due to its impact on her EUPD and emotional dysregulation. YL's Grandmother's concerns were therefore to some extent validated; however as a capacitous adult, YL could and was supported in making her own choices. What was not evident however was any narrative which indicated if and how any time was taken to listen to and respond to YL's grandmother when she expressed these concerns; in recognition and response to how difficult this was for YL's grandmother herself. YL's grandmother also stated that she had not understood that YL was diagnosed with EUPD, instead she understood that she had been told that YL had psychotic tendencies and so would receive treatment for psychosis. This reinforces how critical it is to check family understanding and perceptions, as YL's grandmother was present at most clinical review meetings.

Throughout YL's time in temporary hotel accommodation, family members also expressed concerns that YL was unsupported in the hotel accommodation, citing the location and its proximity to a bar which YL found difficult to stay away from. The staff at the hotel had also

informed the family how they had been concerned about YL and so were making up excuses to go into her room in order to check YL was ok. YL's family asked the reviewer "how could they see YL was at risk and mental health services couldn't?" This is an issue which requires deeper understanding, particularly when considered in the context of the needs and vulnerabilities of homelessness, particularly when those people are also known to be living with mental health conditions that present with fluctuating risk, are subject to child care and/or child protection proceedings and are known to have substance and/or alcohol use issues. A hotel is not a home environment, so what additional measures are in place to support homeless individuals to live and recover in a hotel, and who is enabling them and their ability to cope in such an environment? The family as a whole found it really difficult to support YL effectively and in the way that they wanted to. YL's behaviours were such that she posed increasing risk and physical challenge for her grandparents and mother, culminating in not being allowed unconditional access to be in her family home. There is no evidence that a joint Adult and Children's services Family assessment was either considered or undertaken, which formally assessed the family structure as a whole unit, including half siblings and YL's mother and how it did and could function. Therefore multiagency partners were not all clear about the requirements of YL in relation to child contact arrangements and whether this was for all children including YL's half siblings. This again reinforces the importance of family structure information and how it should be updated regularly and changes shared in real time via a shared multiagency care/safety plan.

4.3 The voice of adult carers

This review repeatedly raises the question of who listens to the voice of the adult carers who support capacitous adults living with EUPD, as this is a challenging condition to live with and which exerts a significant impact on the day to day life of carers supporting individuals living with EUPD. This was explicitly evident with YL. In addition to trying to care for YL, YL's grandmother was also caring for and taking on legal guardianship for YL's two year old daughter, a significant additional demand for this lady and her husband. It was not possible to identify who listened to the emotional impact these adult carers experienced most days and who was accountable for responding to the stress this experience caused. Outside of attending meetings convened in relation to the person that they cared for, there was no evidence of the provision of a safe space which offered opportunity for advice and support centred on their needs. Children's services did state that following YL's death they continued to support YL's grandmother and her daughter until the end of March 2020. However, for YL's grandmother YL's death was like the loss of her own child, having raised YL since childhood. YL's grandmother did not feel effectively supported in relation to such a significant loss and in such tragic circumstances, or that her voice was ever really sought or heard.

4.4 The Voice of the Child

From the information shared for the purpose of this review the voice of the child was not evident and was indeed absent. Arguably this further evidences the limited Family Approach across and between adult and child services.

Terms of Reference 4: Hearing the voice of the adult

Good practice examples
• Nil noted
Overarching Areas for Improvement
The PSAB and multiagency partnership would benefit from: 16. *Seeking assurance of how Adult and Children's services effectively work together to avoid the safeguarding of children from overshadowing the need to safeguard adults too; establishing how adults and child services remain abreast of all family members. 17. *Seeking assurance in relation to the local model for joint Adult and Children's services Family assessments. 18. Understanding the role, function and referral criteria for the Job Retention Specialist. 19. Understanding how time is taken to listen to and respond to carers in their own right and how we ensure that these carers understand how to access this support. 20. Understanding how homeless individuals are supported to live in a hotel and are enabled to cope in an environment that lacks facilities for daily living such as cooking.
Items marked with an asterisk* could be jointly supported by the PSAB and PSCP Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

5. Safeguarding

5.1 Safeguarding – the case for an integrated Family Approach

YL was not identified as a person with care and support needs who was unable to protect herself due to her care and support needs, despite this increasingly being evident in the period under review. At the times when YL was emotionally dysregulated and when she was harming herself and engaging in suicide, YL was in need of safeguarding, as she also was when she became homeless. The challenge with safeguarding individuals living with EUPD is that the acute episodes during which they meet safeguarding thresholds will predominantly be both intermittent and short lived, with recovery and capacity often being regained swiftly and in a place of safety, be that home or hospital.

Whilst safeguarding referrals were made for both YL and YL's daughter, each in their own right; the need to safeguard YL's daughter was responded to more effectively than the need to safeguard YL. Adult safeguarding responses seemed to be focused on episodic management of acute emotional dysregulation, rather than on an emergent pattern of increasing risk and harm. Again, a live and shared multiagency care/safety plan could offer this insight more readily and earlier as all party information is presented, as afforded by the combined chronology.

There were also times when new risk assessments were indicated for YL's daughter as YL's behavioural risk became more frequent and as her command voices escalated to include harm to family and as YL articulated how her daughter was no longer a protective factor. These assessments did not appear to be undertaken as promptly as were indicated. For example the Single Assessment process for the family was not completed until October 2019, despite information regarding escalating risk being shared before then. That said, this may have been due to limited risk information sharing by Adult Mental Health Services, as well as reliance on YL and her family to share the risk information regarding escalating behaviours and hospital admissions. The limited implementation of an integrated Adult and Child Family Approach resulted in missed opportunities to safeguard all parties at an earlier stage.

5.2 Emergency Services

Emergency services and MASH did recognize and make a number of safeguarding referrals to MASH and/or share Police Public Protection Notices (PPN1s) with both adult and child teams. This safeguarding practice was less evident across mental health and ED services, though not entirely absent. YL's family did however identify that they did not always feel that emergency

services were as responsive as they had hoped when facing a crisis. This perception was shared with emergency services who reviewed their input and support for YL and her family.
The Ambulance Service clarified that if a person is known to be a regular user of their service, then the ambulance service will work with multiagency partners and collaboratively put a demand management plan in place to help inform their response to call outs. In the absence of such a plan, normal triage pathways would be utilized. YL did not have a demand management plan in place and therefore routine triage did ensue when called. On review of all calls made in relation to YL during the period under review, the ambulance service did respond and/or convey appropriately. The ambulance service also appreciated however the difficulty that understanding of responses may not always be in line with public expectations when facing a crisis at the time of calling.

The Police similarly reviewed their contacts with YL, also identifying that all responses were appropriate and also clarifying that they too establish high intensity user plans as agreed and negotiated with the multiagency teams. Police also highlighted that when they are called they have two priority considerations with every call: is there an identifiable need for safeguarding and is there a prosecutable offence. Police also importantly highlighted that their powers in call outs to people experiencing a mental health crisis are limited, with the seriousness of the situation informing the most appropriate response. This again can lead to some difficulty in public understanding of responses when facing a crisis at the time of calling. Irrespective of whether police attend a call, PPN1 notifications are shared with MASH by the police where appropriate, which are then responded to by MASH based on assessed need.

Police did reflect on this case and as alluded to earlier in this report, police emphasized the need for all agencies to have a better understanding of each other's roles, functions, scope and limitations, as well as the need for this understanding to be shared with the public.

5.3 The child as a protective factor

Failure to recognize and respond appropriately to changing parental perceptions regarding their children and the protective nature the parent/child relationship confers, have been highlighted in a number of national safeguarding children reviews, domestic homicide reviews and safeguarding adult reviews; with many outcomes tragically including filicide and homicide. It is important therefore that professionals understand that it is not merely the presence of a child in an adult's life per se that is the protective factor, but that it is the relationship that the adult has with that child and how they value this that can convey protection, in the form of positive experience and motivation. Once that experience and perceived value is significantly reduced

or lost, the child may no longer be a protective factor and may indeed become potentially at risk from the adult.

Changes in the relationship between YL and her daughter were escalated by her grandmother on a number of occasions, to both adult and child services and the mental health team, reporting that YL was distancing herself from her daughter and that she no longer perceived her relationship with her daughter as a protective factor. Whilst this was acknowledged by professionals on occasions in that it was noted, there was no evidence that this change in perception of YL's relationship with her daughter as a protective factor had triggered new risk assessments. This is a missed opportunity to safeguard YL's daughter, specifically in the context of the command voices YL was also hearing which demanded that YL harm her family. This combination should have been a red flag for all services and a new risk assessment was indicated. There is therefore a need to seek assurance that agencies understand the concept of children as a protective factor and how shifts in this perception may indicate changes in risk for those children.

Terms of Reference 5: Safeguarding

Good practice examples

- Reflection by police and ambulance was readily undertaken, comprehensive and included a clear willingness to identify areas for improvement and potential solutions.
- YL's grandmother was transparent in her sharing of concerns regarding the shift in perception for YL of her daughter as a protective factor.

Overarching Areas for improvement

The PSAB and multiagency partnership would benefit from :

21 *Seek assurance that agencies understand the concept of children as a protective factor and how shifts in this perception may indicate change in risk for those children.

22 *Improved understanding of the model and implementation of an integrated adult and child Family Approach to the safeguarding of complex families.

23 Supporting multiagency partners to collectively respond to the need for all agencies and the public to better understand each others' roles, functions, scope and limitations to respond at a time of crisis.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Emergent lines of enquiry not specified in Terms of Reference

Care and support of family

YL's grandmother was clearly the matriarch within her family, offering support to her daughter, her grandchildren and her great grandchildren, whilst responding to a situation in which she felt that she was required to choose between those family elements. This was incredibly difficult emotionally and YL's grandmother fulfilled all of these functions whilst still being in gainful employment herself. As alluded to earlier there is a need to consider and address the support of families and carers and to explore whether adult carers of people living with EUPD are being offered carers assessments and support aligned with the Care Act (2014).

Also notably and only after reading the final draft of this report, YL's grandmother considered how she had not been offered access to bereavement counselling, which she feels should have been part of the care and support offered her significant loss when YL died.

Commissioning temporary accommodation in the hotel sector

The commissioning of hotels and bed and breakfast accommodation for temporary housing is not new, however this is a growth area and one which has expanded in terms of its scope and use throughout the Covid pandemic. It should be welcomed as another option available to the temporary housing market, but not without careful consideration and good governance. Key issues and questions emerged throughout this review in relation to the commissioning and governance of hotel accommodation, which included:

- Is there adequate safeguarding expertise, input and oversight during the development of service specifications and service level agreements during the commissioning process?
- Who determines and monitors hotel provider compliance with contractual training requirements, specifically in relation to safeguarding adults and children, mental health and alcohol and substance misuse?
- When placing cohorts of individuals who are at risk and vulnerable due to mental health need in hotels, how does this differ in its prevention of creating a false sense of security offered by ward settings for groups of people living with EUPD and the risk posed for learning new risk behaviours? Who assesses and monitors this potential impact/risk?
- Why is basic risk information not shared with hotel staff when placing adults with care and support needs in the hotel? Consent for this can be gained from the capacitous

adults being placed there; giving the hotel some indication of who may require escalation should behaviour significantly change.

- What is the commissioner's duty of care to staff when there has been a serious incident such as a suicide attempt? After YL's death the support for the staff member who discovered YL with YL's grandmother was provided by the hotel itself, with no support being offered by mental health services or practitioners.
- The perception and understanding of risk and risk thresholds by hotel staff will not be the same as those of staff in the Adult Mental Health and social care services, so who is responsible for supporting hotel providers in their experience of accommodating people who may pose significant risk to or for hotel staff? Where is the training provision?
- What is the scope for a single point of access for hotel staff to escalate their concerns about individuals to?
- What is the scope for supervision provision at a general level for hotel staff who report that they regularly find themselves proactively and indirectly monitoring individuals they are concerned about, without necessarily understanding what it is they are intuitively responding to or the risk which may be presenting, including the risk to themselves?
- How can health and social care services be more responsive to these needs of hotel staff, particularly in relation to mental health concerns? The day to day support hotel staff offer can at times be similar to staff working in supported living settings, whereas supported living staff have access to supervision and support.
- Effective care and management plans for community based support provision need to be in place before discharge to hotel accommodation, for individuals living with EUPD; without this, housing team experience is such that their placement is likely to break down. Could/should these care plans be shared with hotel staff with consent?
- Parity of esteem is essential and required across both mental and physical health; however parity also needs to be inclusive of social care need. Only when such a holistic approach is adopted will recovery be optimized.

Provision of temporary accommodation needs to be more flexible and to be understood and assessed through a lens of development and support for all those experiencing homelessness, including young adults. YL identified just before she died that she wished to live in a shared house and that this was her preferred type of private accommodation, stating that she "wanted the company". The temporary housing market needs to develop to include accommodation in buildings that not only confer access to positive social living and social interaction, but also confer opportunities to develop life skills such as cooking and laundry. These facilities are not available in temporary hotel accommodation, making hotels impractical and expensive for homeless individuals as well as potentially overwhelming for young adults inexperienced in caring for themselves.

There is a critical need for health and social care systems to maintain a fine balance of both working in partnership and collaborating with the hotel sector, given the current and future scope for the hotel sector to meeting some of health and social care's accommodation demand. If we do not mutually respect what true partnership can offer, this market opportunity may be lost.

The scope of commissioned services and contract/quality monitoring

A commissioned third sector provider highlighted as part of this review that their caseload was high in relation to supporting people living with mental health challenges, with the level of risk they believed that this posed being high. On seeking further clarification, the provider shared that a rapid review in relation to this identified a 100% increase in service users being referred to them, identified as having needs relating to Mental Health as a significant component of their referral. They shared this with commissioners. The provider also highlighted that staff did not feel that mental health or Primary Care services were always responsive to their escalation of concerns regarding specific service users, with a common issue being faced being whether services viewed the person they were escalating as meeting their criteria or remit. This is a source of frustration as providers reach out to health agencies as the needs being escalated are clearly outside of their remit and sometimes their competence; therefore they need support. Contract and quality assurance monitoring processes need to remain abreast of such challenges faced by providers, for both for the safety of service users as well as the support and retention of market providers. As with the hotel accommodation sector, there is a need to maintain a fine balance of working in partnership and to respect what third sector providers offer.

YL's case has highlighted how a wide range of services were commissioned and provided to support YL with her experience of living with EUPD, in order to support her in meeting her health and social care needs. It is important that health and social care commissioners are clear about the scope and delivery of such a multitude of services and how they are expected and required to interface with each other and work collectively. The monitoring of compliance through the commissioning and quality assurance process is critical if standards are to be achieved and maintained and if service development and growth is to occur. However and importantly, when service demand and scope begins to show signs of extending beyond that which is commissioned, providers are responsible for escalating this and explicitly highlighting the risk to service users, risks in relation to safeguarding and risk for the workforce. The commissioner’s duty is to respond to this escalation in a timely manner, as the commissioner is

ultimately accountable for assurance that the commissioned service is both safe and fit for purpose.

Emergent lines of enquiry not specified in Terms of Reference

Good practice examples

- The hotel sector is supportive to health and social care in supporting the temporary accommodation of adults and families with complex needs and is happy to continue with appropriate support.
- Hotel staff intuitively recognised the need to check on YL based on behaviours and created viable reasons for doing so in the interest of knowing that she was safe.

Overarching areas for improvement

The PSAB and multiagency partnership would benefit from :

24 *Further understanding the scope of local housing options and the market availability of accommodation suitable for supporting people experiencing homelessness, to include younger adults with mental health conditions transitioning to both adulthood and independent living.

25 Need to review and ensure that the governance, support, supervision and information sharing arrangements for hotel providers are fit for purpose and enable them to provide safe accommodation.

26 *Consider the support needs of families and carers and whether adult carers of people living with EUPD are being offered carers assessments and support aligned with the Care Act (2014).

27. *Consider their offer of bereavement support.

28. Consider the commissioning and contract monitoring in relation to safeguarding and the quality assurance process for this. How is the PSAB gaining assurance from health and social care in relation to this?

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Was YL's death predictable or preventable?

YL was a young person on a journey of transition into her early adult life. YL was also a mum to her two year old daughter and a much loved member of a supportive and close family. YL's death was tragic and was not expected at the time it occurred.

There are relatively few studies in the UK which rigorously examine risk factors for suicide in young people with personality disorders or traits, however the wider evidence available and reported in the NICE guidance relating to Borderline Personality Disorders (2009), summarizes that young people with personality disorders who attempt suicide are likely to experience depression symptoms and to be more impulsive. They are also reported to be more likely to have experienced traumatic events and parental brutality, absence or divorce. These findings reflect a number of YL's own childhood experiences.

Statistics which provide some context to EUPD prevalence and death by suicide include:

- In 2017, the percentage of people aged 16 years and over screening positive in the UK for personality disorder ranged from 13.9% to 17.3%.
- In 2019, the year before YL's death; a total of 1,299 deaths were registered as suicide among females in England (5.2 per 100,000), an increase from the previous year and the highest since 2004 and significantly higher than 2016 and 2017.
- A study in America (Sack, 2015) reported that almost 1 in 4 people with a PD report suicide attempts, with suicide deaths ranging between 8-10%.

Whilst these statistics may indicate that YL's death by suicide was arguably a predictable possible outcome, it is not possible to confidently extrapolate that YL's death was both predictable and thereby preventable.

What has been possible however through undertaking this review, is the identification of when YL, YL's daughter and YL's family were well supported, but also where their care and experiences were sub-optimal and could have been improved. It is therefore incumbent upon the health and care system to learn from these identified findings and to implement change, so that other service users, their families and carers receive the best care and experience possible.

Although grief can be a normal part of loss and bereavement, those experiencing that grief are arguably likely to experience and cope with their loss less traumatically, when they know that their loved ones received optimal care and when they themselves were well supported.

Subsequent Improvement since and/or as a result of YL's experience of care

It is important to note that this review was produced just over a year after the death of YL, due to the impact of the Covid pandemic. Whilst this is not the preferred or normal timescale for reviews commissioned by the PSAB, this delay has provided an opportunity to be able to identify key changes which have already been implemented since and as a result of the learning from YL's experience and of those caring for her. It also provides an opportunity to outline the legacy of quality improvement and service developments underway.

Health – Solent NHS Trust

Improvements already undertaken

- The operation of the Trust's Clinical Risk assessment Policy in the mental health service has been reviewed so the service is assured that risk reviews are of a high quality and further training provided to teams where necessary
- The service has reviewed the discharge and transfer process of patients between different teams in mental health when risk behaviours still remain and the patient's level of engagement has deteriorated. Clinical Disengagement Procedures are to be added to Risk Policy and introduced and the Admission, Transfer and Discharge Policy is being re-introduced.
- The service has reviewed the format and recording of MDT meeting to ensure consistency. A standardized format has been agreed and implemented into SystmOne and leadership teams will conduct quarterly checks to ensure compliance with agreed standards.
- The service has reviewed communication and information provided to families to make them aware of Mental Health Act requirements and their right to request an assessment. Leaflets have been updated, include relevant information, are available to carers and carers will be contacted to ensure they are receiving information.
- An alert has been cascaded to remind staff that communication with agencies involved in care and support of patients should be kept up to date with relevant information being regularly shared.
- The new risk assessment policy includes a requirement for staff to be aware and compliant with the need to involve other agencies in the creation of risk management plans and to share plans with them at both inception and review.

- CRHT have reviewed the service description on Solent NHS Trust external website and have introduced a leaflet for patients and carers for the CRHT Team.
- The clinical pathway for the management of patients with a diagnosis of Emotionally Unstable Personality Disorder has been reviewed, to include a defined and evidence based rationale for intervention by CRHT, and the use of medication.

Further work ongoing or planned as part of continuing improvement

- There is a recruitment drive for Clinical Associate Psychologists underway with advertising already undertaken. This will increase capacity for the provision of therapeutic support.
- There will be review discussion pertaining to hospital discharge processes, with the aim of ensuring that ward discharges remain holistic in nature, avoid bee overly clinically focused and include social care needs assessment and consideration.
- Adult Mental Health Teams and Children's Services are mutually committed to work more closely with each other, to improve their information sharing and liaison processes; especially when crisis situations arise. This will be included as part of ongoing transformation work in adult mental health and across Children's Services.
- There is a recruitment drive already underway for Clinical Associate Psychologists, this will increase capacity for the provision of therapeutic support.

Arrangements for Shared Learning

Learning will be shared with relevant teams within the service and led by managers, with sharing including reflection on practice. All staff involved in YL's care will receive a copy of the SIRI and SAR report for their own reference and the report will be shared via the service clinical governance meeting.

Adult Social Care

Improvement already undertaken

- There are now two social workers at the Orchards, one at a senior level who has both the scope and ability to challenge decisions, including hospital discharge decisions. However these social workers will not be able to prevent the right for as person to leave before a social care assessment, if that person is not detained under the Mental Health Act or under a Deprivation of Liberty decision.

Further work ongoing or planned as part of continuing improvement

- In order to review and gain assurance that social care needs are comprehensively considered at the point of hospital discharge, Adult Social Care will review performance

against the Section 75 agreement and the associated delegation of duties relating to Care Act Assessments for inpatients.
- This will include reviewing how the quality of social care assessments is prioritised when inpatient areas are faced with pressure from high levels of admission and bed occupancy.
- Adult Social Care is exploring more in-reach models for the provision of social care and support for people placed in temporary housing, ensuring a more holistic approach to meet needs from day one after discharge.
- This work will be part of ongoing quality improvement in partnership working between Adult Social Care and the Housing Needs and Assessment Service.

Children's Services

Improvement already undertaken

- A family safeguarding service has been introduced which adopts a family approach to safeguarding and brings together both child teams when working with families.
- Improved links with adult mental health, adult social care and additional support teams is reported to have helped improve communication and integrated working across teams.

Further work ongoing or planned as part of continuing improvement

- A review of the Family Safeguarding service will take place to assess how it has improved links between child and adult services, specifically adult mental health services.
- Children's Services are looking at exploring their scope to provide a wrap-around response for those leaving private care arrangements.

Police

Improvements already undertaken

- Findings of this report have been shared with the with mental health lead in the service.

Further work ongoing or planned as part of continuing improvement

- Consideration is ongoing regarding how to raise awareness and understanding in relation to mental health conditions among frontline police officers.
- There is a drive to increase and improve liaison with adult mental health, resulting in more comprehensive sharing of information at the time of calls/referrals.
- This is to ensure that briefings shared with officers are more meaningful and help officers to improve their responses by being better informed.

Adult MASH and risk reflections/findings

Improvements already undertaken

Adult MASH was asked to consider YL's homelessness and their receipt and assessment of information regarding a person's homelessness status. The MASH team identified that they are not routinely advised of someone's homelessness status, but that when referrals are made by housing and homelessness services, it is usually because they are of the view that this person is at risk of, or experiencing abuse or neglect, and in need of additional support. Whilst the MASH team recognized that homelessness alone does not necessarily meet a safeguarding threshold, it does indicate possible needs for care and support and so is relevant information for any referral and therefore should be shared with them.

The MASH team also similarly reflected on how the team processes PPN1s if the referral does not meet the criteria for ASC involvement. It was identified that action or onward information sharing decisions are made based on the content of the PPN1, whether consent has been obtained and if not whether such action can be taken without the person's consent. They also highlighted that if the person is open to adult mental health services, the PPN1 will be shared with them for information and action; however MASH also acknowledged that despite YL being open to adult mental health, her PPN1 was not shared with AMH; a need for audit of PPN1 processes was therefore indicated. Adult MASH did however reinforce they do have points of contact for PPN1s within adult mental health, who then disseminate to relevant practitioners.

Housing Needs and Advisory Service and support for temporary hotel accommodation

Improvements already undertaken

- The Housing Needs and Advisory Service have increased their formal meetings with the hotel temporary accommodation provider, in order to be more supportive and to remain informed of challenges more effectively. They are exploring a single and responsive point of contact for hotel staff to liaise with to raise concerns.
- The Housing Needs and Advisory Service also now have homeless navigators based at the hospital and within the rough sleeping team, to help people navigate services and their journey.
- Health navigators from the team also work with the South Central Ambulance Service (SCAS)
- A social worker has also been appointed to the rough sleeping team, whose role will be to map journeys and highlight issues with the relevant services.

- The Housing Needs and Assessment Service also now have a development officer and a number of mental health first aiders.

Further work ongoing or planned as part of continuing improvement

- There are plans to deliver a campaign about the statutory duty to refer for homeless individual and the importance of early referral.
- The Housing Needs and Assessment Service have agreed to share their narrated presentation regarding the duty to refer across for use across all agencies, to help deliver this information consistently across all services.

Third Sector Provider

Improvements already undertaken

A third sector provider did not escalate risk information to Local Authority Adult Safeguarding services at the time it was disclosed, however they did escalate this information to their own safeguarding team internally in a timely manner. The internal safeguarding team was updated regularly over time, with a lack of response from the safeguarding team being understood and interpreted by front facing practitioners as indicating that there was no need for any further action or information over and above that which they had already undertaken or provided.

Upon reviewing practice in relation to YL, the provider uncovered that although staff communicated with their Safeguarding Lead on several occasions for support and advice, there was an issue with their internal safeguarding system software. Safeguarding concern updates were not filtering through to the Safeguarding Lead. This has now been rectified and on reflection the provider acknowledged that the advice and support from the Safeguarding Lead may have differed in light of the information that was regularly shared with them.
It is notable how commissioned homeless services provided very good support for YL.

Failure to collect regularly prescribed medicines

Improvements already undertaken

After YL's death, the family were informed by the pharmacist that YL had a number of prescriptions that she had not collected, an issue which has been recognized in serious case reviews at a national level. The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Designated Nurse workforce have escalated this issue regionally to NHS England who are responsible for commissioning pharmacy provision. There is no current national mechanism which is standardized in relation to this issue and which flags up to prescribers when regularly prescribed medicines are not collected. However the national network of Lead GPs for

Safeguarding is now leading on understanding this issue better and undertaking work to address this issue.

Commissioning and Transformation of Services

A number of issues were highlighted which require the attention of commissioners, especially as they progress the mental health framework and transformation agenda. These include:

- *Access to a Care Co-ordinator (CCO) in mental health*: it was recognised that a CCO was not allocated until a person's complexity level and need for support was very high. It was recognised that whilst this was a resource issue, it was also a matter of risk for health and social care commissioners, across adult and children's services, particularly as cohesive and timely information sharing was not as effective as it could have been until the CCO was allocated. Late access to a CCO support arguably resulted in safeguarding risk and potential/actual harm to both adult and child. It was also recognised that the CCO workforce needed improved understanding of the Care Act and how this interfaced with their role. There are currently plans to allocate people who are waiting for a CCO to the Intensive Case Management team, given significant vacancies in the CCO workforce; whilst this is welcome it is not a robust solution moving forward.

- *Service design and avoidance of hand off of care:* There were a number of occasions when care was unhelpfully handed from one team to another during a chain of attempts by YL to seek support, as it was felt that YL did not meet inclusion criteria for a series of teams. This was at a time of crisis and when YL needed a single and responsive point of access. As health and social care commissioners are still designing and transforming services, it is critical that services and inclusion criteria are co-designed to avoid this serial handover of care.

- *Abandoned calls or failure to call back – scope to quantify and assess risk*: on a number of occasions YL also reported that she had either abandoned a call in crisis due to a failure to get an answer at the time, or that she was advised that a clinician would call her back but then they didn't. It is incumbent upon commissioning organisations to understand and quality assure the capacity, demand and delivery of their crisis provision for populations at risk and for those who are vulnerable, without which commissioners cannot be confident that they as commissioners are compliant with their statutory safeguarding duties, not r that their providers are fulfilling theirs.

- *Waiting time for therapies:* Community services are universal services and provide for all, including those who are on a waiting list for therapy. Waiting times and access to therapies urgently needs to be understood as part of the review of the Community Mental Health Framework and redesign of services. YL was clearly and repeatedly linked

into and/or passed on to a number of disparate support services, and whilst her allocated CCO was trained in the therapy required by YL and for which she was on a waiting list for, the CCO role is not there to function as a formal therapist.

Throughout this time of accessing a range of different services, it was evident that YL was deteriorating and that her behaviour was escalating, yet still there was no access to the required therapy. Whilst therapeutic intervention wait times are recognised as a national problem, delays in access to therapy and the lived experience of those waiting, needs to be reviewed as a critical and urgent issue of high risk by commissioners. Plans to use apprentice Clinical Associate Psychologists (CAP) whilst an attempt to address this, are again not a robust long term solution.

- *Variation in assessment tools used*: Mental Health Services are delivered by a range of providers across a range of sectors and geographical locations. What became evident throughout this review was that each provider utilised different assessment process and procedures, as well as used different tools for the undertaking and reporting of this assessment activity. The result was fragmented and disparate mental health assessments which did not align and were therefore confusing and at times misleading. As part of the mental health framework development and the co-design of services, health and social care commissioners would benefit from to exploring the scope to commission services which utilise and share standardised evidence based risk assessment tools, which are thereby meaningful for all providers across the ICS. These assessments should also underpin shared and universal care/safety plan documents too.

Education and Training

What clearly emerged across all agencies and providers was the acute need for a better understanding of Emotionally Unstable Personality Disorder (EUPD) and other similar Personality Disorder (PD) conditions. There was also the need for a better understanding of the difference between acute psychosis and PD conditions and the different approaches to their treatment and care. Overall the following education and training outcomes were noted:

- Solent NHS Trust highlighted how everyone can access the recovery college for education and training, this includes a two hour course on a range of mental health topics, including personality disorder. Teams across both health and social care adult and child services will be signposted and encouraged top access these.
- The Housing Needs Assessment Service offer their team one and three day mental health first aider courses, which will be reviewed and will include EUPD moving forward. It was agreed that these training courses could potentially be offered more widely.

- The Housing Needs Assessment Service made a commitment to deliver a campaign and campaign briefing raising awareness and providing information in relation to the duty to refer under the Homelessness Reduction Act (2017).
- Portsmouth City Council offered a one day course for mental health first aider training and will review their training offer to ensure that this is still accessible.
- The Portsmouth Safeguarding Adult Board (PSAB) recognised the need to review the training offer in relation to the Family Approach toolkit.
- Adult social Care committed to ensuring access to mental health first aider training for all commissioned providers, specifically including hotel providers of temporary accommodation.
- Adult mental health and adult social care teams will share details of a range of mental health training opportunities available with Children's Services.
- Both adult and children's social care teams recognised the need to improve their understanding of the interface between the local care leaver offer and eligibility and Care Act duties, as young people transition into adult care and services.
- Children's services also recognised the need to better understand the Care Act and adult eligible needs, in order to better support parents.

Safeguarding

- It was recognised that the voice of the adult was overshadowed by a focus on child protection, not recognising that YL herself was only just into adulthood herself; therefore a coherent and clearly articulated understanding of what YL wanted was not evident.
- Career choices were not explored with YL effectively and YL's preferred choices may not have been in her best interests at some points.
- It is possible that YL may have been eligible for supported living or a short term placement rather than temporary housing, had eligible care needs been identified.

Portsmouth Safeguarding Adult Board (PSAB)

- PSAB committed to work with the Portsmouth Safeguarding Children Partnership (PSCP) to review, update and promote the Family Approach protocol and resources.
- PSAB will disseminate the good practice and the learning from this review.
- PSAB will distribute and promote the learning opportunities available as identified in the education and training section.
- Actions emerging from this review will be monitored within the PSAB Performance and Quality Assurance subgroup.

Abbreviations

AMH – Adult Mental Health	CAMHS– Child & Adolescent Mental Health Service
CBT – Cognitive behaviour Therapy	CIN – Child in Need
CPA – Care Programme Approach	CQC – Care Quality Commission
ECS – Emotional Coping Skills	EUPD – Emotionally Unstable Personality Disorder
CCO – Care Coordinator	DA – Domestic Abuse
CRHT – Crisis Resolution and Home Treatment	ED – Emergency Department
DBT – Dialectical behaviour Therapy	ICM – Intensive Case Management
GP – General Practitioner	LA – Local Authority
HNAS – Housing Needs and Advisory Service	MDT – Multidisciplinary Team
JRS – Job Retention Specialist	NICE – National Institute for Health & Care Excellence
MASH – Multiagency Safeguarding Hub	PPN – Public Protection Notice
MHLT – Mental Health Liaison Team	PTSD – Post Traumatic Stress Disorder
PD – Personality Disorder	SAB – Safeguarding Adult Board
PSAB – Portsmouth Safeguarding Adult Board	SCAS – South Central Ambulance Service
QAH – Queen Alexandra Hospital	SIRI – Serious incident requiring Investigation
SAR – Safeguarding Adults Review	S47 – Section 47 Investigation
SGO – Special Guardianship Order	
HIPS – Hampshire, Isle of Wight, Portsmouth and Southampton	

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Summary Table of Areas for Improvement (aligned to each Term of Reference)

How effective was partnership working?

The PSAB and multiagency partnership would benefit from:

- Examining the level of understanding across health and social care practitioners of EUPD and approaches to care and support; including how EUPD differs from psychosis.
- Reviewing existing mechanisms for real time multiagency communication, specifically focusing on people with frequent and dynamic fluctuation of risk.
- Developing a partnership wide mechanism for professionals and the public to understand service access criteria and remit and practitioner roles and functions.
- Examining the feasibility to develop a core multiagency care/safety plan template, for use across all health and social care agencies, emergency services and by families too.
- *Understanding local arrangements for discharge planning for adults and parents with care and support needs, specifically examining how a family approach is adopted.
- Reviewing practices in relation to assessment of and the sharing of information regarding a person's homelessness status, to include the timeliness of referrals under the duty to refer and whether safeguarding referrals are made appropriately.
- *Examining expectations of adult and child practitioners across health and social care, regarding responsibility for information sharing and supporting parents subject to child care proceedings; assessing the strength of integrated working/Family Approach.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP

Were the appropriate assessments completed to identify need and to manage/mitigate known risks?

The PSAB and multiagency partnership would benefit from:

- Seeking assurance that evidence based tools are routinely used to assess individuals who present to ED with an isolated acute Mental Health crisis or with an acute Mental Health crisis complicated by a medical need (e.g. overdose).

- Seeking assurance that the relevant team is readily accessible to undertake urgent mental health assessments in ED or on the Observation ward in ED at the point of presentation, highlighting if, why and how often delay may be incurred.

- Understanding how the Trust Risk Assessment Policy and Procedures could interface with and be assimilated with other risk assessments undertaken in mental health, to streamline and minimise the scope for multiple and disparate assessment ratings.

- Understanding how the collection of scripts for individuals with additional care and support needs is routinely monitored and escalated when there is a failure to collect.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP
Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Was support provided to meet identified need?

The PSAB and multiagency partnership would benefit from:

- *Requiring the health and social care system to value the role of families and carers by investing more in education and support specific to their needs.

- Seeking that health audit and share current wait times for key psychological therapies such as Dialectical Behaviours Therapy and Emotional Coping Skills therapy, in order for the partnership to understand provision, alternative sources of support and to support dialogue regarding whether current commissioning of these therapies is fit for purpose.

- Understanding the issue of missed and/or abandoned calls to crisis intervention services across health and social care, quantifying the extent and potential impact of this issue.

- Understanding the criteria for allocation of a CCO, in order for the partnership to understand access and provision and to support dialogue regarding whether current commissioning of the CCO model is fit for purpose.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP
Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Hearing the voice of the adult

The PSAB and multiagency partnership would benefit from:

- *Seeking assurance of how Adult and Children's services effectively work together to avoid the safeguarding of children from overshadowing the need to safeguard adults too; establishing how adults and child services remain abreast of all family members.

- *Seeking assurance in relation to the local model for joint Adult and Children's services Family assessments.

- Understanding the role, function and referral criteria for the Job Retention Specialist.

- Understanding how time is taken to listen to and respond to carers in their own right and how we ensure that these carers understand how to access this support.

- Understanding how homeless individuals are supported to live in a hotel and are enabled to cope in an environment that lacks facilities for daily living such as cooking.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP
Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Safeguarding

The PSAB and multiagency partnership would benefit from

- *Seek assurance that agencies understand the concept of children as a protective factor and how shifts in this perception may indicate change in risk for those children.

- *Improved understanding of the model and implementation of an integrated adult and child Family Approach to the safeguarding of complex families.

- Supporting a multiagency response to the need for all agencies and the public to better understanding each other's roles, functions, scope and limitations to respond in crisis.

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP
Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.

Emergent lines of enquiry not specified in Terms of Reference

The PSAB and multiagency partnership would benefit from:

- *Further understanding the scope of local housing options and the market availability of accommodation suitable for supporting people experiencing homelessness, to include younger adults with mental health conditions transitioning to both adulthood and independent living.

- Need to review and ensure that the governance, support, supervision and information sharing arrangements for hotel providers are fit for purpose and enable them to provide safe accommodation.

- *Consider the support needs of families and carers and whether adult carers of people living with EUPD are being offered carers assessments and support aligned with the Care Act (2014) and also consider their offer of bereavement support.

- Consider the commissioning and contract monitoring in relation to safeguarding and the quality assurance process for this. How is the PSAB gaining assurance from health and social care in relation to this?

Items marked with an asterisk* could be jointly supported by the PSAB and PSCP
Areas for improvement in preceding key lines of enquiry may be applicable to findings in this section.