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HEALTH & SOCIAL CARE CONSULTING

Joint Safeguarding Adult Review and Independent Mental Health Homicide Investigation, Ms G and Mr Q in Greenwich

November 2022

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting healthcare providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our draft report has been written in line with the Terms of Reference for the joint Safeguarding Adult Review and Mental Health Homicide Investigation into the care and treatment of Ms G and Mr Q. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and NHS Improvement and Royal Borough of Greenwich Safeguarding (RBG) Adults Board. It cannot be used or published without their permission.

Niche Health & Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

1 Executive summary 5
 Homicide 5
 Background 5
 Conclusions 6
 Recommendations 10
2 Independent investigation 14
 Homicide 14
 The review process 14
 Approach to the review 15
 Contact with the perpetrator 15
 Contact with families 16
 Evidence and interviews 16
 Structure of the report 18
3 Summary chronologies and background 20
 Mr Q 20
 Ms G 22
4 Mental health care and treatment 31
 Care planning 31
 Risk assessment and risk management 39
 Medicines management 44
 Family engagement 48
 ICMP West 52
 Ms G's mental capacity 54
5 Other agencies 57
 Metropolitan Police Service (MPS) 57
 London Ambulance Service (LAS) 64
 Lewisham & Greenwich NHS Trust 68
 GP services/primary care 72
 Bridge Support 78

Royal Borough of Greenwich – appointeeship 82
Royal Borough of Greenwich – housing 85
6 Ms G's care and treatment in 2013 97
March 2013 97
Appointeeship and other financial arrangements 102
7 Internal investigations 104
Mr Q internal investigation 104
Ms G Trust internal investigation 107
Trust's progress with action plans 112
8 Safeguarding 116
Safeguarding Adult Board (SAB) 116
Safeguarding Adults Reviews (SAR) 116
Royal Borough of Greenwich (RBG) safeguarding 117
Referrals sent to RBG 117
Support provided by RBG 120
Oversight and assurance 121
Adult safeguarding on behalf of RBG 121
9 Summary findings 133
Oxleas NHS Foundation Trust 133
MPS 134
LAS 135
Lewisham and Greenwich NHS Trust 135
Primary care 135
Bridge Support 136
Royal Borough of Greenwich (RBG) 136
10 Conclusions and recommendations 138
Recommendations 140
Appendix A – Terms of reference for independent investigation 144
Appendix B – Extension to terms of reference 148
Appendix C – Documents reviewed 149
Appendix D – Professionals involved 153

Appendix E – Tabular timeline of Ms G's care and agency contact, March–September 2013 154
Appendix F – Niche Investigation Assurance Framework: internal investigation reports 171
Appendix G – Oxleas received safeguarding referrals for Ms G 179

1 Executive summary

1.1 This Safeguarding Adults Review (SAR) and Independent Mental Health Homicide Investigation (joint review) examines the circumstances surrounding the homicide of Ms G in South London in June 2018 and the care and treatment of Ms G and Mr Q by the NHS, local authority and other agencies. Ms G was a tenant in the same house as Mr Q. Discussions between the Royal Borough of Greenwich (RBG) Safeguarding Adults Board (SAB) and NHS England and NHS Improvement concluded a joint review would meet the requirements of the SAR and Independent Mental Health Homicide Investigation.

1.2 A joint review panel was chaired by RBG SAB and NHS England and NHS Improvement. Niche Health and Social Care Consulting (Niche) were commissioned to carry out the joint review. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.3 We would like to express our condolences to all the parties affected by this incident.

1.4 The victim's family have requested that she be referred to as Ms G in the report.

1.5 In September 2021, NHS England and NHS Improvement and the RBG SAB commissioned an extension to the joint review to include two additions to the terms of reference to include an examination of elements of Ms G's care and treatment in 2013. The review was expanded in this way at the request of Ms G's family who identified several concerns about her care that preceded the original review time frame of 2015 to 2018.

Homicide

1.6 In June 2018, it was reported that Ms G had died following a fatal incident where she was assaulted in the shared house where she lived. The alleged perpetrator, Mr Q, who also lived in the house, was charged with murder.

1.7 Mr Q was convicted of murder and sentenced to life imprisonment in December 2018.

Background

1.8 Both Ms G and Mr Q were receiving care from Oxleas NHS Foundation Trust ('the Trust' hereafter) Mental Health Services.

1.9 Ms G was 56 years old when she was killed. She had been a client of Mental Health Services since 1991. She had been under the care of the Trust since 2006 when she moved to supported accommodation in Greenwich.

1.10 Ms G was cared for under the Care Programme Approach (CPA) by the Greenwich West Intensive Care Management for Psychosis (ICMP) multidisciplinary team who work with clients with a diagnosis of long-term psychotic illness. Ms G's diagnosis was paranoid schizophrenia and she was known to act erratically, frequently contacting the emergency services and attending her GP practice without notice. She often complained to her GP that she was experiencing pain in her abdomen and legs and was concerned that stitches from a historical operation remained in situ (they did not). English was not her first language, and service providers sometimes struggled to understand the nature of her concerns. She regularly made allegations against those she lived with but emergency services, particularly the police, could not find evidence to substantiate her allegations.

1.11 Mr Q, a 50-year-old white male, had been known to Mental Health Services for over 20 years. Mr Q had a diagnosis of paranoid schizophrenia and a past history of personality disorder. Mr Q was under CPA with the Greenwich West ICMP team.

1.12 Mr Q and Ms G were both under the care of the same Care Coordinator(s) and Associate Specialist[1] in the ICMP. Both were usually considered low risk, categorised by the Trust Zoning Policy as being in the 'green' zone, though at times Ms G would be moved to the higher risk 'amber' zone. They were both in receipt of support services offered by Bridge Support (also known as 'Bridge'), a charity that supported mental health service users in the community, though Ms G engaged considerably less with the service than Mr Q. Bridge Support is funded by an RBG block contract to provide community support. Mr Q and Ms G both had their finances managed by the RBG Financial Protection and Appointee (FPA) team; Mr Q in particular was known to regularly request large sums of money.

1.13 Ms G and Mr Q resided in a privately rented property managed by a landlord. Ms G had lived there since 2005 when the property was part of a supported housing scheme. The supported housing scheme ended in 2013 and Ms G remained in the property on a shorthold tenancy. Mr Q moved into the property in 2015. From 2017, a private cleaning company, arranged by the Trust via RBG and funded by the residents, cleaned the communal areas of the property.

1.14 The household was stable for a number of years with Ms G and Mr Q sharing with two other tenants. However, in the eight months prior to the homicide one tenant died unexpectedly and one was transferred to hospital. As a result, Ms G and Mr Q were the only tenants at the property from March 2018 to the date of the homicide.

Conclusions

1.15 Mr Q and Ms G were both recipients of ICMP services, they were under CPA, received depot medication[2] and had the same Care Coordinator and Psychiatrist (Associate Specialist). They lived in the same shared accommodation, were recipients of Bridge support services, had their finances managed by the local authority and were registered at the same GP practice. In many respects, their lives shared several parallels, but in reality, their cases were very different.

1.16 Mr Q's engagement with Trust services was limited to receiving his depot medication. He missed his last three CPA appointments and consistently reported no concerns to his Care Coordinator. Trust staff did not demonstrate professional curiosity towards Mr Q, despite him missing his CPA appointments and his frequent requests for relatively large sums of money via the appointeeship. Equally, when there were changes in the living arrangements at the house which culminated in Mr Q and Ms G being the only residents, there is no evidence that their Care Coordinator considered this a matter for concern.

1.17 There was no long-term plan for Mr Q, who predominantly remained on the ICMP caseload for his depot medication. Mr Q might have met the criteria for step down services but for his depot medication requirements. There is no shared care agreement between the Trust and primary care services for the administration of depot medication or clozapine.[3] There are roughly 100 patients on the ICMP caseload who cannot be discharged from Trust services due to depot or clozapine requirements.

1.18 Conversely, Ms G regularly utilised Trust, acute, Metropolitan Police Service (MPS), London Ambulance Service (LAS), primary care and A&E services, particularly in 2015. Ms G had several physical health complaints for which she frequently contacted services, often without notice, and at times more than once in the same day. She sometimes made allegations about the people she lived with. Ms G's behaviour could be erratic. In June 2018 her neighbours

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[1] Associate Specialist: A medical professional who has developed skills/expertise in a specific field e.g., psychiatry. They are not trainees or consultants. https://www.rcpsych.ac.uk/members/support-for-specialty-doctors/who-are-sas-doctors

[2] Depot medication is medication given by injection which is slowly released in the body over a number of weeks.

[3] Clozapine: an antipsychotic medication used to treat schizophrenia. https://bnf.nice.org.uk/drug/clozapine.html

complained to the police and the ICMP that she was bothering them, though this did not prompt her care coordinator to discuss the living arrangements in the house with her.

1.19 We identified gaps in practice across all agencies, though some to a greater degree than others. In particular, we identified significant gaps in practice at the Trust pertaining to adherence to policy, specifically CPA, risk assessment and management, care planning, capacity assessments and record keeping.

1.20 We identified that RBG holds a largely administrative role for safeguarding adults. RBG was clear to us that it delegated its safeguarding responsibilities to the Trust under a Section 75 Agreement (NHS Act 2006), but we found little evidence of monitoring or quality assurance on the part of RBG who were largely reliant on Trust reporting systems. Of concern, we identified an attrition in the number of safeguarding reports received by RBG in comparison to those it shared with the Trust.

1.21 We note none of the agencies responded in a consistent manner to Ms G's repeat allegations of abuse, frequent contact with services and erratic behaviour. There were opportunities between 2015 and 2018 when we would have expected the agencies to have undertaken a multi-agency response to work with Ms G to manage her behaviour, but these did not come to fruition. Instead, we identified agencies operating in silos and in some instances, reluctant to engage with other agencies because they believed Ms G's behaviour would not change (e.g., primary care). The exception to this was the MPS, who did communicate safeguarding concerns to RBG and the Trust, however, there were inconsistencies in their approach and management of contact with Ms G.

1.22 Crucial to Ms G's case was a failure by all the agencies involved to consistently recognise and respond to her repeated allegations. They did not implement appropriate safeguarding processes or develop a multi-agency response. We identified substantial gaps in safeguarding practices across all agencies, in terms of recognising and responding to allegations, quality assurance and monitoring.

1.23 We identified significant missed opportunities for safeguarding activity in relation to Ms G and to a lesser extent, Mr Q. In instances when safeguarding was used, there was limited adherence to the six principles of safeguarding.

1.24 We set out below a high-level summary of our findings. Please refer to the main body of the report for the full detail.

Oxleas NHS Foundation Trust

- ICMP staff did not adhere to Trust policy in relation to CPA, care planning, risk assessment and risk management, and accommodation monitoring for Mr Q or Ms G.
- Ms G's medication was unchanged and there is no evidence of a documented review by ICMP between 2015 and 2018.
- ICMP staff did not involve the families of Mr Q or Ms G in the CPA process, care planning, risk assessment or risk management.
- ICMP staff did not formally review Ms G's mental capacity between 2015 and 2018 despite several occasions when it should have been considered in response to her actions and decisions.
- ICMP staff were taking steps to move Ms G from the house in 2015 because her accommodation was deemed unsuitable, but she declined to move, and staff considered she had capacity to make this decision.
- ICMP staff did not recognise and respond to the changes in Mr Q and Ms G's housing arrangements between late 2017 and early 2018.

- There are approximately 100 patients on the ICMP caseload who cannot be considered for step down services because of their medication requirements. This has implications for service delivery.
- The ICMP is under immense pressure to provide care as a result of high caseloads, staff sickness and ongoing vacancies.

Trust Internal investigations

- The Trust internal investigations were undertaken in line with Trust policy and national guidance. However, whilst the findings of both investigations were reasonable, they lacked depth and did not set out the detail of any underpinning analysis.
- Trust investigators sought to involve the families of Mr Q and Ms G in their internal investigations at the outset of their work, but this was not sustained and there is no evidence Mr Q's family received the final report(s). Ms G's family received the final reports but there is no evidence they were shared via a formal process – we do not know when or how they received the reports.
- The Trust has provided limited evidence of the progression of the action plans in response to Mr Q's or Ms G's respective internal investigations.

Metropolitan Police Service (MPS)

- Ms G regularly contacted the MPS between 2015 and 2018. She did not meet the MPS threshold for a frequent caller.
- There were gaps in the MPS management of and engagement with Ms G, and not all her contact with her was handled in keeping with expected practice. However, there were some examples of good practice on the part of individual officers, appropriately identifying and escalating safeguarding concerns.

London Ambulance Service (LAS)

- Ms G met the LAS criteria for a frequent caller in 2015, under the Frequent and Vexatious Users Policy, but this was not triggered and implemented.
- There were gaps in the LAS identification of, and referrals in response to, Ms G's vulnerabilities.
- LAS has implemented several changes in relation to working with, and identifying vulnerable individuals, in the form of a revised structure, increased training and supervision, but there is no evidence that these changes have been embedded or tested.

Lewisham and Greenwich NHS Trust

- Lewisham and Greenwich NHS Trust supported a substantial amount of Ms G's physical health care. It communicated appointments, findings and test results in a timely manner to Ms G's GP.
- Acute staff documented in the notes that they were aware Ms G benefited from the use of an interpreter, but arrangements were not consistently put in place for her.
- Ms G frequently attended A&E in 2015 and she was usually discharged to her GP with pain relief medication.
- A&E staff acknowledged that Ms G had mental health problems, and recognised safeguarding and welfare concerns. These were communicated primarily to her GP, but

also to mental health services a small number of times; however, there is no evidence the agencies followed up.

Primary care

- Ms G was prescribed temazepam[4] by her GP, on a long-term basis, which is not in keeping with best practice guidance.
- Primary care services did not communicate Ms G's frequent contact to the ICMP, rather it sought to manage her attendance 'in house'.
- Primary care services did not consider Ms G's repeat allegations of abuse and that her medication was being stolen to be safeguarding concerns, instead they were understood to be delusions.
- Primary care did not trigger a multi-agency review in response to Ms G's allegations or behaviour, rather it sought assurance from her landlord and care team.
- There is no service level agreement (SLA) between primary care and Trust mental health services in relation to the administration of depot medication and clozapine.

Bridge Support

- Bridge Support provided support services to Mr Q and Ms G, as agreed with them and their care coordinators.
- Bridge Support identified one safeguarding concern each for Mr Q and Ms G, but these were not escalated beyond initial contact with partner agencies.

Royal Borough of Greenwich (RBG)

- Ms G's RBG sheltered housing assessment could not be completed in October 2017 because she declined to engage. The outcome of the assessment was not formally communicated to the Trust and another assessment was not arranged.
- The RBG Finance Protection and Appointee team did not act on safeguarding concerns about Mr Q identified informally by Bridge Support.
- The RBG Finance Protection and Appointee team placed too much emphasis on the role of mental health staff in identifying and responding to safeguarding concerns.
- RBG delegates adult safeguarding functions to the Trust under a Section 75 Agreement, maintaining an assurance and oversight role only.
- RBG placed too much emphasis on the delegation of its safeguarding responsibilities to the Trust.
- RBG was unable to provide substantive evidence of monitoring and quality assuring safeguarding processes, despite its responsibility to monitor Care Act 2014 functions delegated under a Section 75 Agreement.

Ms G's care and treatment in 2013

- Ms G suffered a broken leg in March 2013. She reported she had been assaulted by one or more males at the property she shared with them.

[4] Temazepam: A benzodiazepine used to treat insomnia. https://bnf.nice.org.uk/drug/temazepam.html

- Ms G's allegations of assault were initially taken seriously by health and social care professionals who held a safeguarding adult conference and agreed a number of actions and investigations to be undertaken in response to the incident.
- However, over the period of five months, those actions and investigations (and others that were subsequently agreed) were not taken forward, and the case was closed by the MPS after they interviewed Ms G in August 2013.
- Ms G returned to the property unsupported in July 2013 despite the initial agreement by health and social care professionals in March 2013 that she should not return to the property.
- No arrangements were in place to support Ms G when she returned to the property in July 2013, her bedroom remained on the first floor, despite her reduced mobility and an earlier suggestion that she would be relocated to the ground floor if she did not change property.
- Trust staff undertook a home visit to review Ms G in September 2013, over nine weeks after she had returned home.

Ms G's appointeeship details in 2013

- Ms G's family requested responsibility of her finances in May 2013. The FPA team and the Trust were initially supportive of this suggestion, but Ms G's Care Coordinator later advised that Ms G wished for the FPA team to retain responsibility of her finances.
- There is no evidence Ms G's mental capacity was formally assessed as part of the decision-making process of who should manage her finances. The FPA team shared the relevant paperwork with the Trust, but there is no evidence this was completed or returned.
- There is no evidence the matter was formally resolved and communicated to Ms G's family, instead the appointeeship remained with the FPA team in 2013 by default.

Recommendations

1.25 This Joint review has made 23 recommendations.

Recommendation 1: The Trust must improve ICMP care planning so that care plans are written and updated in line with Trust policy and include longer term goals, and adopt a biopsychosocial approach, incorporating the wider needs of the service user, beyond immediate day to day living.

Recommendation 2: The Trust must review its assurance and monitoring programme for risk assessment and management plans to include clear quality indicators against the Trust policy and expected standards using learning from this investigation.

Recommendation 3: The Trust should update its Zoning Policy to reflect the immediate interventions staff should take in response to a service user changing zones. This should include the timeliness of key interventions, which staff should be involved in, and details of ongoing monitoring including frequency and leads for escalations or reporting any issues found in practice.

Recommendation 4: The Trust must support regular monitoring and assurance of mental capacity assessments in multidisciplinary teams. In instances where mental capacity is questioned, there must be a record of the final decision whether to undertake a capacity assessment and the underpinning rationale for this in keeping with best practice guidance. A regular audit programme to support this should be established.

Recommendation 5: The Trust must ensure there are clear standards and criteria within relevant policies to guide staff on the routine monitoring of patient property when the person lacks mental capacity.

Recommendation 6: The Trust must develop a system to identify service users who live in shared accommodation. Underpinning this should be an ongoing process for sharing proportionate risk information about these individuals between internal and external services involved.

Recommendation 7: The Trust should review its management of repeat safeguarding referrals and concerns. This should include a review of policy and training materials to ensure repeat referrals and allegations are incorporated into Trust policy and guidance.

Recommendation 8: The Royal Borough of Greenwich (RBG) Safeguarding Adult Board should facilitate a peer review of adult safeguarding practice at the Trust, which includes quality assurance audits of randomly selected cases and a programme of planned audits going forward.

Recommendation 9: The Trust must provide assurance that involvement of service users' families is considered when planning care. This should include documenting any contact, and recording instances when the decision has been taken not to involve a family, or they have declined to engage.

Recommendation 10: The Trust must ensure any engagement with families during its internal investigation process is documented. This should include instances when the family declines to be involved and whether the final report has been shared.

Recommendation 11: The Trust needs to review the ICMP caseload with a view to evaluating the care pathway of service users whose treatment is based on long-term medication requirements (e.g., depot), to ensure service users are on the appropriate care pathway.

Recommendation 12: The Trust should assure itself that it has fulfilled the requirements of the Mr Q and Ms G action plans from the internal investigations, with a view to providing commissioners and the families involved with evidence-based, completed action plans within three months of receipt of this report.

Recommendation 13: The Metropolitan Police Service (MPS) should review the learning from this investigation to update its programme of safeguarding awareness and policy within 6 months of receiving this report.

Recommendation 14: The MPS and partner agencies should undertake a system review of how MERLIN Adult Come to Notice (ACN) reports are managed and responded to. The MPS should undertake a programme of regular review of MERLIN ACN reports to ensure they are being completed in line with MPS policy.

Recommendation 15: The RBG Safeguarding Adult Board should recommend that partner agencies expand the local children's safeguarding MASH to include adult referrals. Mental health specialism should be part of this MASH. Partner agencies should report back to the Safeguarding Adult Board within three months of receipt of this report.

Recommendation 16: The London Ambulance Service (LAS) must evidence an assurance programme that takes into consideration:

- when to make a safeguarding referral;
- how LAS works with other agencies in relation to safeguarding;
- monitoring of safeguarding practice; and
- embedding of recent changes (e.g., structure, increased training and supervision).

Recommendation 17: The GP Practice, within six months of this report, should provide assurance that any existing patients with long-term prescription of benzodiazepines have been reviewed and documented in line with NICE guidance. This should include introducing a method for future identification and review of new patients.

Recommendation 18: The GP practice should provide assurance that it has taken steps to support staff in understanding and applying its policies in relation to assessing mental capacity and adult safeguarding, and introduce a regular monitoring approach to make sure staff are consistently applying the principles of the policies.

Recommendation 19: The Clinical Commissioning Group[5] should clearly set out in a policy or procedure the expectations for GP practices in taking a proactive approach in triggering, requesting and/or engaging in multi-agency reviews in instances where there is clear evidence that service users are behaving erratically, over attending practices, excessively using services, or engaging several agencies.

Recommendation 20: The RBG Finance Protection and Appointee (FPA) Team should clarify and agree a process for identifying, managing and resolving safeguarding concerns brought to its attention by partner agencies. The policy should be updated to reflect this.

Recommendation 21: RBG sheltered housing services must develop a system and set out expectations for staff to formally communicate and document the outcome of housing assessments and agree next steps with partner agencies. This should include regular monitoring to support implementation and improvements.

[5] and successor Integrated Care System.

Recommendation 22: RBG, within six months, should lead a full review of how safeguarding and welfare referrals are received and managed to assure itself of the effectiveness of adult safeguarding activity carried out on its behalf. This should include consideration of referrals from external agencies, and the handover process between RBG and the Trust.

Recommendation 23: All agencies must use the findings from this investigation within safeguarding training for staff. All agencies must ensure staff are familiar with the requirements of, and their responsibilities under, the London Multi-Agency Adult Safeguarding Policy and Procedures.

2 Independent investigation

Homicide

2.1 In June 2018, it was reported that Ms G had died following a fatal incident when she was assaulted in the shared house where she lived. The team were informed and the alleged perpetrator (Mr Q), who also lived in the house, was charged with murder.

2.2 Mr Q was convicted of murder and sentenced to life imprisonment in December 2018.

The review process

2.3 This section outlines the process undertaken by the joint Safeguarding Adults Review (SAR) and Independent Mental Health Homicide Investigation into the care and treatment of Ms G and Mr Q. The purpose of the joint review is to identify if there were opportunities to intervene, which may have prevented the death of Ms G, and to identify if there are any lessons to be learned which could improve practice.

2.4 The circumstances of the homicide met the requirements for an independent investigation into mental health homicides as outlined in the NHS England Serious Incident framework (2015).[6] NHS England and NHS Improvement (London) along with Royal Borough of Greenwich (RBG) Safeguarding Adult Board (SAB) agreed to hold a joint independent review, as it was acknowledged that the objectives and process would be similar. The review will be referred to as the 'joint review'.

2.5 The independent investigation follows the NHS England Serious Incident framework (March 2015) and Department of Health guidance on Article 2 of the Human Rights Act (1998), the investigation of serious incidents in mental health services, and the Care Act[7] in conducting a SAR.[8]

2.6 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

2.7 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

2.8 SARs seek to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission (CQC), the Nursing and Midwifery Council, the Health and Care Professions Council, Social Work England and the General Medical Council.[9]

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[6] Serious Incident Framework, 2015, NHS England. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

[7] Safeguarding Adults Reviews (SARs), Section 44, Care Act 2014. https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted#:~:text=44Safeguarding%20adults%20reviews&text=(b)the%20SAB%20knows%20or%20suspects%20that%20the%20adult%20has,meeting%20any%20of%20those%20needs

[8] Safeguarding Adults Reviews (SARs) under the Care Act. https://www.scie.org.uk/safeguarding/adults/reviews/care-act#learning

[9] Care and support statutory guidance, Section 14.168, August 2017. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2.9 The independent Mental Health Homicide Investigation and SAR panel was chaired by RBG SAB and NHS England and NHS Improvement.

2.10 Kathryn Hyde-Bales and Mary Smith are the joint authors of the review. Expert clinical advice was provided by Dr Mark Potter. Dr Carol Rooney, Associate Director, Niche, chaired the review.

2.11 The report was peer reviewed by Elizabeth Donovan, Senior Consultant, Niche, and internal quality oversight was provided by Nick Moor, Partner Niche.

2.12 Legal review was carried out by Weightmans LLP for NHS England, and legal review for the RBG SAB was carried out by Cornerstone Barristers.

2.13 The investigation team will be referred to in the first-person plural in the report.

2.14 The investigation comprised a review of documents and a series of interviews, with reference to the National Patient Safety Agency (NPSA) [10] guidance and SAR report writing guidance. The terms of reference were agreed in July 2020 and can be seen in Appendix A.

2.15 Additions to the terms of reference were agreed by NHS England and RBG SAB in September 2021 and can be seen in Appendix B.

2.16 We would like to offer our deepest sympathies to Ms G's family for their loss.

Approach to the review

2.17 The process began formally in July 2020 with an initiation meeting which was jointly chaired by NHS England and NHS Improvement and RBG. The meeting involved the SAB, NHS England and NHS Improvement and other agencies who had the most contact with Ms G and Mr Q, prior to the death of Ms G.

2.18 There were significant delays during the review due to the Covid-19 pandemic and the pressure this placed on all health and social care services from March 2020 onwards. The draft report addressing the original terms of reference was completed in June 2021.

2.19 NHS England and NHS Improvement and RBG SAB issued an extension to the terms of reference in September 2021. We commenced this phase of work the same month. Please see 'Contact with families' for more information (paragraphs 2.23-2.28).

2.20 The narrative and analysis in this report refers to 2015 to 2018 unless otherwise indicated (e.g., 2013).

Contact with the perpetrator

2.21 NHS England contacted Mr Q in March 2021 (he had not received previous correspondence) informing him about the review. We wrote to Mr Q in April 2021 inviting him to take part in the review. We were informed by Mr Q's mother in early June 2021 that he did not wish to engage at that time.

2.22 We wrote to Mr Q towards the end of the investigation to share the draft report with him. He did not respond to our contact.

[10] The NPSA closed in 2012 and is now part of NHS Improvement.

Contact with families

Mr Q's family

2.23 NHS England wrote to Mr Q's family at the outset of the review to inform them of our work. Further contact was delayed due to the Covid-19 pandemic, but we spoke with Mr Q's mother in March 2021. We submitted regular updates to Mr Q's mother by email and phone from March 2021 onwards. We shared the final report with Mr Q's mother for her review and comment.

Ms G's family

2.24 The family of Ms G were contacted by NHS England[11] in October 2019. They initially indicated they did not wish to be involved in the review but submitted a list of questions via their solicitor in October 2019 and wrote directly to NHS England and NHS Improvement in July 2020. NHS England and NHS Improvement sent Ms G's family an update about the joint review in March 2021 at which point they indicated they would like to be involved in the review.

2.25 We spoke to Ms G's family in April and June 2021. They told us they had significant concerns about their mother's care between 2015 and 2018, but they considered 2013 to be the point at which things started to go wrong for their mother. They told us that they felt our investigation would be largely flawed if we did not consider the events of 2013. We relayed their views to NHS England and NHS Improvement and the RBG SAB and asked that they decide whether the scope of our investigation be broadened to consider the family's 2013 concerns.

2.26 Following discussions with Ms G's family, NHS England and NHS Improvement and RBG SAB agreed in September 2021 that the terms of reference would be expanded to include two points pertaining to Ms G's care and treatment in 2013. Specifically:

- *"To review the decisions taken for immediate care after Ms G sustained a broken leg and her subsequent placement.*
- *To review the assessments and decisions made regarding appointeeship and any purchasing of private health insurance".*

2.27 We wrote to Ms G's family in September 2021 to confirm we would be undertaking the additional elements of the review. The additions to the terms of reference do not extend to Mr Q's care and treatment.

2.28 We shared the final report with Ms G's family for their review and comment.

Evidence and interviews

2.29 A list of all documents referenced can be seen in Appendix C.

2.30 The draft report was shared with the services who contributed information to the investigation. This provided an opportunity for those agencies that had contributed significant pieces of information, and those whom we interviewed, to review and comment on the content.

2.31 The agencies participating in this review were:

- Bridge Mental Health
- Lewisham and Greenwich NHS Trust
- London Ambulance Service (LAS)

[11] NHS England became NHS England and NHS Improvement in 2020.

- Metropolitan Police Service (MPS)
- Ms G and Mr Q's GP practice
- NHS South East London Clinical Commissioning Group (CCG)
- Oxleas NHS Foundation Trust
- Health and Adult Services, Royal Borough of Greenwich (RBG)

2.32 We have used information from Ms G and Mr Q's clinical records provided by the Trust, Lewisham and Greenwich NHS Trust, Bridge Support and the GP practice they were both registered at, social care records from RBG and other agencies listed. We have received Individual Management Reports (IMRs) from the Trust, RBG, LAS, Bridge Support, MPS and NHS South East London Clinical Commissioning Group (CCG) submitted on behalf of the GP practice.

2.33 As part of our review, we interviewed the following staff.

Oxleas NHS Foundation Trust:

- Consultant Psychiatrist, Greenwich Intensive Care Management for Psychosis team (ICMP)
- Associate Specialist, ICMP
- Care Coordinator 3, ICMP
- Care Coordinator 4, ICMP
- Two members of the Mr Q internal investigation panel
- Chair of the Ms G internal investigation panel
- Service Director, Adult Mental Health Services
- Associate Director, Adult Mental Health Services
- Quality Lead, ICMP (Sept 2019 – Oct 2020)
- Service Lead, ICMP
- Head of Social Care, Greenwich directorate
- Trust Lead Safeguarding Adults & Prevent

2.34 In addition to the above interviews, we held a focus group with five front line staff from the ICMP.

2.35 Other agency interviewees:

- GP1, GP practice
- Chief Executive, Bridge Support
- Service Manager, Community Services, Bridge Support
- Review Team Officer and IMR review author, MPS
- Frequent Caller Lead (South), LAS

- Deputy Head of Safeguarding and Corporate Mental Capacity Act 2005 (MCA)[12] Lead, LAS
- Head of Adult Safeguarding, RBG
- Service Manager, Commissioning, RBG
- Manager, Financial Protection & Appointee team, RBG
- Senior Assistant Director for Operations and Partnerships, RBG.

2.36 We also spoke with the Greenwich SE-CU[13] Multi-Agency Safeguarding Hub (MASH) and Abuse and Neglect of Adults Single Point of Contact (ANVA SPOC) and submitted questions in writing for which we received answers.

2.37 The MPS Family Liaison Officer (FLO) who liaised with Ms G's family provided information to us in writing.

2.38 Where interviews were recorded, these were transcribed and returned to the interviewees for corrections and signature to verify as an accurate record of the interviews.[14]

2.39 We would like to thank all interviewees for their time and contribution to the investigation.

2.40 Agencies were asked to give chronological accounts of their contact with Ms G and Mr Q prior to the homicide. Where there was no involvement or no significant involvement, agencies advised accordingly. In line with the terms of reference, this report has reviewed the care, treatment and services provided by the NHS, the local authority and other relevant agencies from January 2015 until the offence in June 2018.

2.41 All responded with information indicating some level of involvement with either Ms G, Mr Q, or both individuals, and completed an IMR.

2.42 We contacted Lewisham and Greenwich NHS Trust after the joint review had started. They were not involved in start-up discussions, it was only during a review of Ms G's GP records that it became apparent we also needed her acute records. Lewisham and Greenwich NHS Trust was not asked to provide an IMR, we asked for Ms G's acute notes only (Mr Q had not used their services).

Structure of the report

2.43 Section three provides Ms G and Mr Q's chronology of care and background.

2.44 Section four sets out the details of the care and treatment provided to Ms G and Mr Q. We have provided an anonymised summary of those staff involved in Ms G and Mr Q's care and treatment for ease of reference for the reader. These can be found at Appendix D.

2.45 Section five considers the involvement of the other agencies (MPS, LAS, Lewisham and Greenwich NHS Trust, primary care and RBG) in Ms G and Mr Q's care.

2.46 Section six provides a review of Ms G's care after she suffered a broken leg in March 2013. It also considers the details of her appointeeship.

[12] Mental Capacity Act (2005): https://www.legislation.gov.uk/ukpga/2005/9/contents

[13] South East Control Unit.

[14] One RBG interviewee did not engage in the sign off process and we were unable to share their transcript with them.

2.47 Section seven provides a review of the internal investigation and reports on progress made in addressing the organisational and operational matters identified.

2.48 Section eight provides a review of safeguarding practices in the borough, the role of RBG and the safeguarding of Ms G.

2.49 Section nine examines the issues arising from the care and treatment provided to Ms G and Mr Q and includes comment and analysis.

2.50 Section 10 sets out our conclusions and recommendations.

3 Summary chronologies and background

Mr Q

3.1 Mr Q, a white British male, was 50 years old at the time of the incident. He had a diagnosis of paranoid schizophrenia and was a long-standing user of Trust services. He was under the Care Programme Approach (CPA), had an allocated Care Coordinator and received depot medication every three weeks. Mr Q and Ms G had the same Care Coordinator. Mr Q was in the green zone[15] between 2015 and 2018 (detail about zoning can be seen under 'ICMP West', please see paragraph 4.127 for more information).

3.2 Mr Q moved to supported accommodation shared with Ms G and two other residents in early 2015. This was initially provided by Royal Borough of Greenwich (RBG) but latterly was a shorthold tenancy managed by a private landlord. Mr Q did not work and had few documented interests but was noted to be sociable and regularly saw friends. He was a smoker and drinker. His finances were managed by the RBG appointeeship because of historical concerns about his money management and risk of exploitation.

3.3 Mr Q had some inpatient admissions, the last of which was in 2004. Since then, his care had been managed in the community.[16] Mr Q had historic risks associated with drug and alcohol use and reducing his alcohol intake was discussed at pre-CPA reviews.

3.4 Mr Q typically did not engage with Trust services beyond the receipt of his depot medication (detail of Mr Q's medications can be seen under 'Medicines management', please see paragraph 4.81) at the Trust and in relation to financial requests for the appointeeship. Eight CPA reviews took place between 2015 and 2018, of which he attended three, the last of which was in December 2016. Mr Q had told his Care Coordinator that he was unable to attend CPA appointments booked on a Monday because he was seeing his mother, but these appointments were not rescheduled.

3.5 Mr Q's Care Coordinators changed in September 2015 and October 2017. These individuals also became Ms G's Care Coordinators.

3.6 Mr Q was in monthly contact with his Bridge Support Worker, who supported him to collect his money from the local authority. They also routinely met for a walk and coffee, subject to Mr Q's availability. Mr Q's Support Worker had helped him enrol on to a cookery course in 2016, but generally Mr Q did not seek support or therapeutic intervention beyond that previously set out.

3.7 Mr Q had a good relationship with his landlord, but the Trust and Bridge staff documented concerns in relation to his landlord's informal involvement in his finances (e.g., arranging holidays and Mr Q's requests for large sums of money).

3.8 Mr Q did not use other health services other than annual health checks with his GP.

3.9 Mr Q's care plan did not change between 2015 and 2018, and there were few significant events during this period, though of note between 2016 and 2017:

- Mr Q's father died in early 2016.
- Mr Q's last risk assessment was completed in May 2017. His risk to others and risk of violence/aggression was documented as low.

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[15] Zoning: The Trust operates a traffic light system of red, amber and green zones to denote service user risk. Service users in the green zone are considered stable with few/low risk. Green zone services users should be seen by Trust staff once/twice a month.

[16] This joint review has not examined Mr Q's admission history because it is out of scope.

- A safeguarding alert was raised in July 2017 regarding the cleanliness of the communal areas of the property Mr Q lived in (a cleaning package was subsequently put in place, funded by the residents).
- Mr Q often requested large sums of money (e.g., £300 for an Xbox in July 2017, £250 to pay for a birthday meal in September 2017, and £250 to buy funeral flowers in November 2017).
- A resident in the shared house died in late 2017.
- Bridge staff raised a possible safeguarding concern in November 2017 about Mr Q's landlord with the RBG FPA team but there is no evidence this was formalised or investigated.

2018

3.10 In the months preceding the incident Mr Q saw his Care Coordinator and Support Worker as agreed. Early in March 2018 another resident was transferred to hospital. Mr Q and Ms G became the only residents in the house. Mr Q's Support Worker noted and informed him on 14 April 2018 that his depot was overdue (23 March). Mr Q attended his next depot appointment on 20 April 2018. Mr Q did not attend his CPA review on 30 April 2018. There is no evidence in the notes this was raised with him by the Intensive Care Management for Psychosis (ICMP) team.

3.11 Mr Q attended the ICMP team office on 1 June 2018 for his depot medication. He received 100mg of flupentixol[17] every two weeks.[18] He told his Care Coordinator he was going to Brighton for a week's holiday.

3.12 Mr Q last saw his Care Coordinator on 15 June 2018[19] for his depot medication. They discussed that Mr Q's landlord had informed Mr Q he would have to move out of the property because he could no longer afford to run it with only two residents. Mr Q indicated to the Care Coordinator that he was not concerned because he knew his Bridge Support Worker would help him find alternative accommodation.

3.13 Mr Q saw his Bridge Support Worker on 20 June 2018. They discussed that Mr Q had received agreement from the FPA team that he could have £1,400[20] to buy a recliner. Mr Q told his Support Worker that his trip to Brighton had been cut short due to a disagreement with a friend though they had since reconciled. Mr Q told his Support Worker that his landlord had told him he would need to move to a new house as he could no longer rent the property to Mr Q and Ms G. The Support Worker recorded in his notes that Mr Q had taken the news well. No concerns were identified.

3.14 The Support Worker emailed Mr Q's Care Coordinator on 20 June 2018 to confirm that Mr Q needed to move house. He set out the steps he would undertake to support Mr Q with this process. Mr Q's Support Worker suggested that a professionals meeting be arranged to plan what support Mr Q would need going forward.

3.15 Mr Q was arrested on suspicion of murder in June 2018. Police reports following Mr Q's arrest indicated his accommodation was in a poor condition and littered with empty alcohol cans.

[17] Flupentixol: An antipsychotic drug administered intramuscularly. https://bnf.nice.org.uk/drug/flupentixol-decanoate.html

[18] Mr Q was a recipient of depot medication throughout the period of review.

[19] The Care Coordinator recorded this appointment in the progress notes on 25 June 2018 as a 'late entry'.

[20] Correspondence between Bridge Support and Financial Protection and Appointeeship team in November 2017 said the recliner cost £600.

3.16 Mr Q was charged with murder on 25 June 2018.

Ms G

3.17 Ms G was a 56-year-old woman, originally from India. She was a practising Hindu. She moved to England in 1985 and first engaged with Mental Health Services in 1991. Her first language was Hindi, although she also spoke Punjabi, and some English. Ms G had been a service user at the Trust since 2006. She had a diagnosis of paranoid schizophrenia and was under the CPA with an allocated Care Coordinator. Her care plan included depot medication every three weeks and six-monthly CPA reviews. Ms G had two adult children with whom she had some contact.

3.18 Ms G lived in a shared house in the area from 2005 that was originally provided as part of the Caring Landlord scheme. She remained a resident at the house when commissioning arrangements changed, culminating in her holding a shorthold tenancy at the property with a private landlord. Mr Q became a resident at the house in 2015. Ms G's finances were managed by the local authority Financial Protection and Appointeeship team.

3.19 Ms G had several physical health conditions which included:

- Hepatitis C
- Knee osteoarthritis
- Cirrhosis of the liver
- Type 2 diabetes
- Degeneration of the lumber spine
- Osteoporosis
- Asthma

2013

3.20 In keeping with the additions to the terms of reference agreed in September 2021, we provide further information about two points pertaining to Ms G's care in 2013: when her leg was broken in March 2013, and details of her appointeeship.

Incident in March 2013

3.21 In March 2013, Ms G was the only female living at the property with three male residents. At some point during the day on 17 March 2013, Ms G suffered a broken leg. She called an ambulance at 3.53pm which attended the property at 4.20pm. Ms G was subsequently transferred by ambulance to Queen Elizabeth Hospital (QEH), Lewisham and Greenwich NHS Trust. She remained at QEH for 10 days, after which she was transferred to Kings College Hospital (KCH) for specialist treatment on 27 March 2013. Ms G stayed at KCH for a month, until 27 April 2013, when she was transferred back to QEH.

3.22 Ms G was based at QEH for nearly a month, after which she was discharged from QEH to the Bevan Unit, a Trust rehabilitation unit, on 24 May 2013. She was on the unit for six weeks, until 2 July 2013, when she was discharged home.

3.23 We have compiled a tabular chronology detailing the events that occurred after Ms G suffered a broken leg at home on 17 March 2013. This can be seen in Appendix E. The tabular chronology covers Ms G's care from 17 March 2013 until 6 September 2013 – the first time she was seen at home by the team Specialty Doctor and Care Coordinator 1 after her

discharge home in July 2013.[21] It does not provide the detail of Ms G's care and treatment after this point, or during any part of 2014.

Details of Ms G's appointeeship in 2013

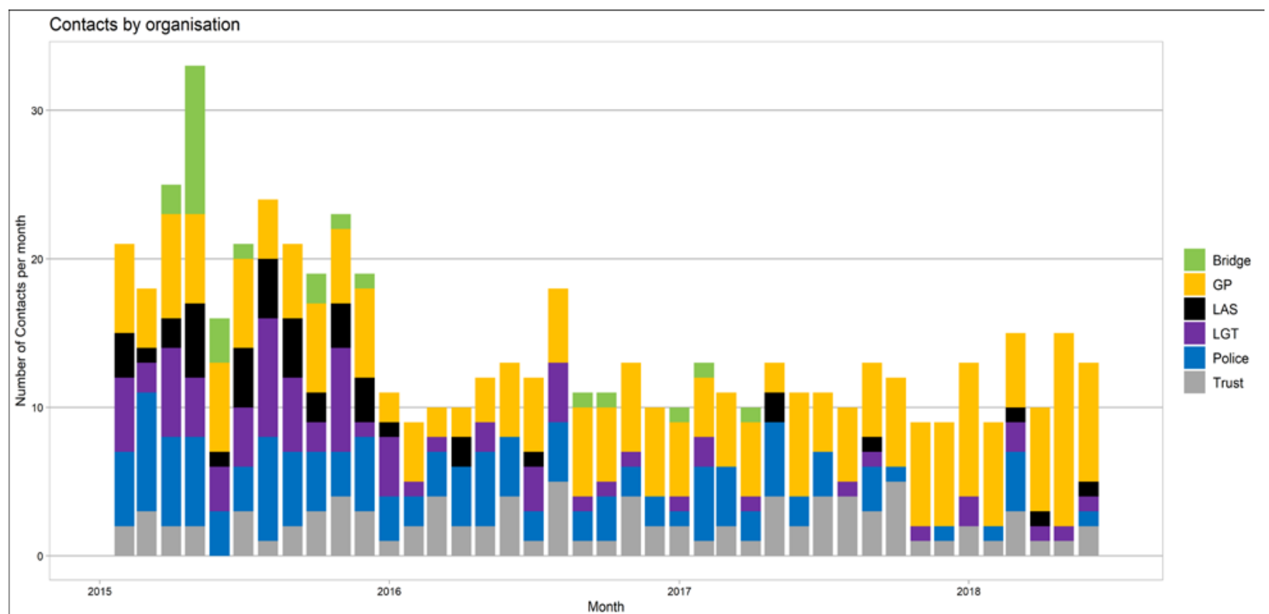
3.24 Ms G's appointeeship was in place in 2013. We have reviewed the local authority notes and have been unable to establish when the appointeeship began, although there is evidence to suggest it was in 2008.

3.25 There is evidence in the notes that Ms G's family asked the FPA team if the family could assume responsibility for Ms G's finances in May 2013, but the matter was not resolved and the FPA team continued to manage Ms G's finances by default. We discuss this further in section 6.

2015 – 2018

3.26 Ms G was well known to health and emergency services. She made extensive contact with agencies between 2015 and 2018, the frequency of which is detailed in the chart below.

Chart 1: Ms G's contact with all agencies between 2015 and 2018



3.27 The extensive nature of Ms G's contact with health and emergency services was such that to provide full detail in a chronology would be disproportionate to the rest of this report. From the chart we note that Ms G generally made at least 10 contacts a month with statutory and support services. In 2015 Ms G was in contact with all services, but this reduced over time. By 2018, Ms G was predominantly in contact with her GP, making less contact with the Trust, MPS and LAS. She ceased contact with Bridge Support in 2017. We set out below what we consider to be the key incidents from 2015 until her death in June 2018. We have not detailed every contact Ms G made to other agencies throughout this period.

2015

3.28 In late 2014 and early 2015, ICMP staff were taking steps to move Ms G from her residence which they did not consider to be suitable for her.

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[21] The team Specialty Doctor was originally scheduled to see Ms G on 19 July 2013, but no one else was available to attend the meeting, therefore it was cancelled.

3.29 Ms G attended a CPA review on 6 January 2015. She was seen with an interpreter and her Support Worker from Sanctuary.[22] The ICMP Specialty Doctor led the CPA review. Ms G was noted to be difficult to engage during the meeting. It was recorded in the notes that she could be abusive towards care workers during her appointments. She was described as still experiencing delusional thoughts that people were doing things to her. Ms G declined to discuss her accommodation arrangements and the option of moving. She left the meeting without warning. It was noted that she "*appeared*" to have the capacity to make decisions about her accommodation, but a formal capacity review was not documented. Ms G's medication was unchanged, and another CPA review was scheduled for six months' time.

3.30 A professionals meeting for Ms G took place on 29 January 2015 to discuss potential changes to her accommodation and care package. The meeting was attended by representatives from the Trust, Bridge Support and local authority commissioning staff. It was agreed that Ms G needed to move out of her existing accommodation which was not suitable for her needs. Ms G was noted to need self-contained, ground floor accommodation, and that she needed medium support services.[23] The meeting agreed a series of actions to address Ms G's care and accommodation needs.

3.31 Care Coordinator 2 undertook a home visit with Ms G's Bridge Support Worker and an interpreter on 25 February 2015 with the intention of taking Ms G to view the flat they wanted her to move to. Ms G declined to view the flat.

3.32 Care Coordinator 2 completed a universal mental health pathway risk assessment for RBG on 3 March 2015 (it is unclear when the assessment took place because Ms G was not seen on 3 March 2015 – there is no entry in the notes for this day). It documented a number of current risks including that Ms G was "*expressing beliefs that she is being harmed by other residents/support workers and has been contacting the police on numerous occasions*". This was also recorded as a historic risk. It was also documented that Ms G's lack of engagement with financial management was a risk, and she continued to contact emergency services "*inappropriately*" despite being asked not to.

3.33 Care Coordinator 2 undertook a home visit with Ms G's Support Worker on 5 March 2015. Ms G was taken to view her new property which she indicated she liked but she would not say whether she was prepared to move. Care Coordinator 2 subsequently contacted Ms G's landlord to advise him that the viewing had taken place. The landlord confirmed he had told Ms G that she needed to move out. Care Coordinator 2 recorded in the notes "*…* [Ms G] *is now the only female in the house and the fact that he* [unknown] *likes being half naked in the house, it is increasingly looking like an inappropriate accommodation… will be best she moves quickly*".

3.34 Ms G called the police several times during March and May 2015, often making reference to being beaten by men in the property. Police could not find any evidence of assault when they attended.

3.35 Care Coordinator 2 undertook a home visit with a Bridge Support Worker on 28 April to assess whether Ms G needed intensive support. Ms G's Support Worker spoke the same language as Ms G and was able to act as an interpreter. Ms G requested that someone cook and clean for her. She was unhappy when told this was not a service Bridge Support offered and left the meeting although she later returned.

[22] Sanctuary was the support service in place before Bridge Support was awarded the contract. We did not engage Sanctuary in this review because this was the only occasion that they saw Ms G before Bridge Support assumed responsibility for providing support services.

[23] The notes do set out the detail of medium support services, but reference is made to accommodation therefore we assume the discussion pertained to placing Ms G in accommodation that provided support services (e.g., a warden).

3.36 Ms G's Support Worker emailed Care Coordinator 2 on 27 May 2015 to advise that Ms G was not engaging in her support during the sessions.

3.37 Care Coordinator 2 spoke to GP1, Ms G's GP, on 5 June 2015 about taking part in a multi-agency meeting about Ms G. GP1 said he did not object to the meeting but did not think the practice could add much. GP1 said the practice was aware of Ms G's presentation but there was little they could do if she continued to contact the police and ambulance service. GP1 said the matter would be discussed at the next GP meeting and the surgery would get back to Care Coordinator 2.

3.38 Ms G contacted the police on 8, 17 and 24 June 2015 to report that three individuals, one of whom was Mr Q (first name only), had assaulted her. Police could not find evidence of assault although they filed a MERLIN[24] report after the last two attendances.

3.39 Bridge staff agreed with Care Coordinator 2 in July 2015 that they would stop her support sessions because she was not engaging but they would remain available 'on demand'.

3.40 Ms G called the police on 14 August 2015 to report she had been attacked by males at the address. The police attended Ms G's home, but she appeared puzzled when they arrived, saying she had called the police for her X-ray results. The police documented that they contacted Ms G's Care Coordinator[25] who advised she suffered from delusions. The police completed a MERLIN report.

3.41 Care Coordinator 3 became Ms G's (and Mr Q's) Care Coordinator in September 2015.

3.42 A CPA review took place on 7 December 2015. Care Coordinator 3, the ICMP Associate Specialist and two representatives from Bridge Support attended. Ms G was present and supported by a Hindi interpreter. It was noted that Ms G's mental health was generally settled, though she remained anxious at times, and continued to experience physical health concerns. Ms G described her mood as "*ok*" and said she believed the other residents came into her room with hammers and knives and intended to kill her, but she was saved by God. Ms G also reported auditory hallucinations but was unable to explain them. The CPA review concluded Ms G's treatment plan should continue, her medication should not change and that Bridge Support would continue to support Ms G's attendance at medical appointments.

3.43 Ms G called the police on 13 December 2015 to report she had been assaulted by three individuals, one of whom was Mr Q (first name only). The attending officers concluded that because Ms G was making a repeat allegation and had no visible injuries, that she was delusional. They submitted a MERLIN report.

2016

3.44 Ms G attended the Heights (ICMP base) for her depot medication on 12 January 2016. She received 200mg of flupentixol every three weeks (further detail of Ms G's medication can be seen under 'Medicines management', paragraph 4.88).[26] She asked Care Coordinator 3 if it would be possible to have some "*respite*" accommodation. She agreed to look into applying for new accommodation.

3.45 Ms G attended a police station on 26 January 2016. Whilst on site she dialled 999 to report she was being assaulted by a man called [Mr Q's first name] at her hostel. It is not clear why she had attended the police station; if it was for the same or an unrelated matter. She was told to report the assault at the station office. The police checked to see whether Ms G had

[24] MERLIN: Metropolitan Police Service (MPS) database used to record details of safeguarding concerns pertaining to children and vulnerable adults (via Adult Come to Notice (ACN)).

[25] It is unclear in the Trust notes who the Police spoke to.

[26] Ms G received depot medication throughout the period of review.

reported the assault at the station; she had not, therefore they attended her home. When the police arrived at her home, Ms G told the officers she had a bad back and leg. She had no recollections of speaking to a police operator or of an assault.

3.46 Ms G called the police on 5 March 2016 to report that three residents including Mr Q (first name only) assaulted her in the night and hurt her leg. The police attended and she reiterated she had been assaulted by two residents including Mr Q (first name only), but she did not know how it had happened because her bedroom door had been locked all night. The police could not see any injuries on Ms G. They spoke to the other residents who said Ms G frequently made false allegations. The police concluded an offence had not occurred and recorded the incident on MERLIN.

3.47 Ms G called the police on 9 March 2016. She said she had been attacked by men who lived in the house. The police attended and a male answered the door wearing soiled underwear. The police spoke to Ms G who asked one of the officers if she was her mother and if they knew the time of her next hospital appointment. Ms G told the officers she had not been assaulted and had no injuries, though her leg hurt due to an old injury. The police completed a MERLIN report.

3.48 Ms G called the police on 22 May 2016 to say a man called [Mr Q's first name] had a knife and had injured her. The police attended, but she later denied making the allegation. She told the officers her leg was hurting. The officers assessed that Ms G was delusional, but no support staff were available over the weekend to help her. The police completed a MERLIN report.

3.49 A CPA review took place with the ICMP Associate Specialist on 2 June 2016 (Care Coordinator 3 was unable to attend). The Associate Specialist recorded in the notes that it was difficult to assess Ms G because her Interpreter was late, arriving at the end of the appointment, and her Support Worker did not attend. Ms G was noted to continue to experience leg and back pain and had a hospital appointment booked the following week. Ms G presented as well and appeared to be stable. No changes were made to her care plan, and she was to remain on enhanced care.

3.50 Ms G attended the Heights on 23 June 2016 and said she was still experiencing pain in her legs. She said a resident had been "*horrible to me*" but would not expand further. Care Coordinator 3 discussed Ms G moving to a new house with her and she said she would think about it.

3.51 Ms G attended the Heights on 27 June 2016 for her depot medication. She told Care Coordinator 3 "*the resident is beating her*" but was unable to expand further. Care Coordinator 3 recorded in the notes that she had reassured Ms G and told her to report this to her landlord.

3.52 A CPA meeting with Ms G took place on 7 November 2016. The ICMP Associate Specialist and Care Coordinator 3 attended. Ms G was accompanied by a Punjabi interpreter. Ms G said her mood was "*ok*" although it was recorded in the notes that "[Ms G] *continues to believe other residents are beating her up whilst she is asleep*". Ms G also reported auditory hallucinations but was unable to explain them. No changes were made to Ms G's medication, and she was to remain on enhanced care.

3.53 Ms G was seen by GP2 on 23 December 2016. She asked for temazepam saying that "[Mr Q's first name] *Uncle*" had stolen it. She was issued with seven tablets.

3.54 Ms G was seen by GP2 on 29 December 2016. Ms G requested more medication, including temazepam, which she said "[Mr Q's first name] *Uncle*" had stolen again. GP2 issued Ms G's latest prescription but advised her she must keep it safe.

2017

3.55 Ms G called the police on 15 February 2017 (it is unclear if this was before or after her hospital appointment). She said she had had an operation on her leg and the stiches were still in situ. She said "*Uncle* [redacted] *and Uncle* [redacted]", who lived in the same house as her, hit her daily and had hit her in the stomach that day. The operator noted Ms G was a frequent caller and decided attendance was not needed.

3.56 Ms G called the police on 25 February 2017. She said [Mr Q's first name] lived in a room at the property and was harassing her to marry him. She said he had threatened her with a hammer. She also said he had paid someone to kill her, but God has protected her. The operator decided police attendance was not required but asked Ms G to attend the police station to file a report. The operator noted Ms G was a frequent caller.

3.57 Ms G called the police on 31 March 2017. She said she had been hit by [Mr Q's first name] with a hammer, and was in a detention house without police, doctors or nurses. She said [Mr Q's first name] prepared her food. Ms G said she had pain in her legs and had lived in the house of 15 years. The police attended Ms G's home, but she did not repeat the allegations and had no visible injuries. The police completed a MERLIN report.

3.58 Ms G called the police in a confused state on 21 April 2017, saying uncles had hit her with a hammer. The police attended Ms G's house. Ms G did not repeat the allegations and had no visible injuries but said she had been told to call the police when she needed transport to hospital.

3.59 A CPA review took place on 4 May 2017 with the ICMP Associate Specialist and Care Coordinator 3. Ms G attended with an interpreter. They discussed exploring alternative accommodation with Ms G, but she did not wish to move from her current address (where she had been resident for 10 years). The ICMP Associate Specialist wrote in the notes that Ms G continued to believe other residents were beating her with a hammer when she slept, and that she continued to experience auditory hallucinations but could not explain them. There was no change to Ms G's treatment plan.

3.60 Ms G called the police on 20 May 2017, requesting an ambulance. She said she had been hit by two men she named (one of whom was Mr Q's first name) who hit her daily. The police and London Ambulance Service (LAS) attended her home, but Ms G had no injuries and did not repeat the allegations. The police completed a MERLIN report.

3.61 London care (cleaning services) raised a safeguarding concern about the cleanliness of the communal areas in Ms G's building on 7 June 2017.

3.62 Care Coordinator 3 undertook a home visit on 27 June 2017. She noted the bathroom needed cleaning. She later met with her manager (on 3 July 2017) to discuss Ms G's accommodation and raise concerns about the environment. A professionals meeting took place on 10 July 2017 to discuss the condition of the property. It was attended by representative from the Trust, RBG and London Care. It was agreed a safeguarding alert should be raised, and Ms G spoken to about moving to accommodation that offered more support. Care Coordinator 3 submitted a Safeguarding Part 1 report on 13 July as an action from the professionals meeting and in response to safeguarding concerns raised by the cleaning company. Care Coordinator 3 contacted the Financial Protection and Appointeeship team on 14 July to advise that a safeguarding alert had been raised, and to ask for information about Ms G's contribution – under the private landlord scheme – towards service charges and any payments for support in place.

3.63 Care Coordinator 3 submitted an interim care package application to RBG for a cleaning service for Ms G on 19 July 2017. She completed a sheltered housing referral and submitted Ms G's Freedom Pass[27] application the same day.

3.64 Ms G was taken to A&E at QEH the night of 25 September 2017 after being found asleep and difficult to rouse in a cafe. She presented with confusion and hyperglycaemia. She did not complain of specific symptoms but said a man living in her accommodation hits her and is trying to kill her. Ms G was referred for a psychiatric assessment but left the department before a member of the Psychiatric Liaison service could see her. She did not answer calls to her mobile or landline. It was recorded in the notes that Ms G's Care Coordinator would be informed and asked to follow up.

3.65 Care Coordinator 3 phoned Ms G on the morning of 26 September 2017. Ms G said she was ok and agreed to a home visit. Care Coordinator 3 subsequently saw Ms G at home. Ms G talked about pain in her legs and her visit to hospital but did not report any other concerns.

3.66 Care Coordinator 3 moved teams on 13 October 2017. Care Coordinator 3 told us she sent a handover note to the Team Manager but could not recall the date. It said Ms G received depot medication every three weeks and a sheltered housing assessment was scheduled to take place on 19 October 2017.

3.67 The local authority attempted to undertake a sheltered housing assessment with Ms G and an interpreter on 19 October 2017. However, Ms G did not want to engage, and the assessment was stopped. Ms G told the Assessment Officer that she wanted to move to a property run by the Asra Housing Association, which did not come under the scope of sheltered housing. The Assessment Officer informed her she would need to submit a direct application to the Housing Association or through nomination via RBG Choice Based Lettings, neither of which required a sheltered housing assessment. The Assessment Officer sent an email to Bridge Support on 20 October 2017 detailing the meeting with Ms G and advising that Ms G could apply directly to the housing scheme.

3.68 The Assessment Officer advised us in email that she later spoke to either Bridge Support or Ms G's Care Coordinator, but she could not remember who, or which agency had initiated the call. None of the agencies had a record of the conversation. The Assessment Officer told us she had informed either Bridge Support or the Care Coordinator that if Ms G would like sheltered housing, a joint visit would be the best course of action. The Assessment Officer put the assessment on hold.

3.69 The assessment was not discussed during Ms G's CPA on 19 October 2017. We have been unable to ascertain which meeting took place first. The ICMP Associate Specialist documented that Ms G said she was ok although "*... continues to believe other residents are beating her with a hammer when she is asleep*". No changes were made to her care plan.

3.70 Ms G was introduced to Care Coordinator 4 as her new Care Coordinator on 31 October 2017 (Care Coordinator 4 also became Mr Q's Care Coordinator).

3.71 Ms G called the police on 11 December 2017. She said her son was trying to take her away although the details obtained via an interpreter were confused. The police attended Ms G's home where they identified a safeguarding alert. The police completed a MERLIN report.

3.72 Bridge Support emailed Care Coordinator 4 on 12 December 2017 asking him to confirm he was Ms G's new Care Coordinator, he replied the same day.

[27] Freedom pass: London concessionary travel scheme, providing free travel for those aged 65 and over, or who have a disability.

2018

3.73 Ms G had 40 GP appointments and attended A&E twice between 1 January 2018 and the incident.

3.74 Ms G called and hung up on the police twice on 23 February 2018. Her calls were traced, and she was called back three[28] times by an operator who confirmed no offence had occurred.

3.75 Ms G called the police on 3 March 2018. She said she had been assaulted during the night by "*Uncle* [redacted] *and Uncle* [Mr Q's first name]" and was suffering stomach pain. The police attended Ms G's address. She did not repeat the allegations but said she wanted to go to hospital. The police contacted LAS who subsequently attended the address. LAS staff found Ms G difficult to engage, speaking a mix of English and Hindi. They examined Ms G, who appeared to be experiencing pain, though staff concluded she did not need to go to hospital. LAS staff contacted 111 who confirmed they would pass on the information to Ms G's GP.

3.76 Ms G called the police on 11 March 2018. She said she was being threatened by her brother and mother-in-law, and that she was hit daily by her uncles. The police attended Ms G's address where they ascertained an offence had not been committed. The police completed a MERLIN report.

3.77 Ms G called the police on 15 March 2018. She reported, via Hindi interpreter, that her uncle had stolen her phone. She said her uncle lived in a separate room on the premises. Ms G was noted to sound confused. The police attended Ms G's home where she made no reference to a theft. The police reviewed her care package which said she suffered from delusions and paranoia. The police completed a MERLIN report.

3.78 Care Coordinator 4 undertook a pre-CPA[29] review with Ms G on 19 March 2018. Ms G did not have an interpreter. It was recorded in the notes that Ms G was "*happy at her current resident* [sic]". No changes were made to her care plan.

3.79 GP3 saw Ms G on 3 April 2018. GP3 noted Ms G's history of chronic hepatitis C and mental health problems. Ms G appeared to be more tired than usual. GP3 queried in the notes whether Ms G's health was declining.

3.80 GP3 subsequently spoke to Ms G's carer[30] who confirmed she appeared quieter, was sleeping more and was more confused than usual. GP3 discussed Ms G's history with an Ambulatory Care Consultant, who advised that Ms G should attend A&E given she had possible encephalopathic symptoms.

3.81 Following the call, GP3 called LAS requesting an ambulance attend Ms G's address. Ms G was reported to be confused, experiencing increased lethargy and abdominal pain. Ms G initially refused to go to hospital and her clinical observations were documented within normal parameters. However, GP3 was concerned Ms G had deteriorated quite rapidly, and she was taken to hospital.

3.82 Ms G did not attend a scheduled CPA review on 12 April 2018.[31]

[28] The operator made three attempts to contact Ms G; Ms G was spoken to on the third call.

[29] The progress notes document this meeting as a CPA review but the Trust internal investigations set out that it was a 'pre-CPA' review (a formal CPA review took place on April 2018).

[30] The name of this individual was not recorded in the notes.

[31] The notes do not indicate why another CPA review was scheduled so soon after the 19 March CPA review undertake by Care Coordinator 4.

3.83 Ms G was discharged from hospital on 12 April 2018. She attended her GP practice the next day to report pain in her buttocks. Ms G attended the Heights on 17 April and 15 May 2018 for her depot medication. No concerns were identified.

3.84 Ms G was seen by GP4 on 16 May 2018. GP4 found Ms G difficult to understand. She said her son was being harassed by his neighbours. GP4 advised that she speak to her son's care home or the police.

3.85 Ms G attended her GP surgery on 4 June 2018. She attended a further four days in a row with different physical health complaints, seeing four different GPs up to 8 June 2018.

3.86 Ms G's neighbour contacted the ICMP on 6 June 2018 to report that Ms G had been behaving bizarrely. The neighbour said Ms G frequently stood in their driveway and shouted at them. Ms G had been seen speaking to herself and yelling at people on the road. The neighbour had contacted the police, but they had reportedly said they could not do anything because Ms G had not acted violently.

3.87 Care Coordinator 4 undertook a joint visit with another member of the ICMP team to see Ms G on 6 June 2018. They discussed the neighbours' allegations which Ms G denied. Ms G said her brother lived at the address in question and that she had been sending him letters but had not received a reply. Ms G was informed her brother did not live at the address and her behaviour was worrying the neighbours. Care Coordinator 4 wrote in the notes that Ms G did not appear to be processing the conversation but agreed not to attend the address again. Ms G accepted her depot medication (the notes do not say why this was administered at home). Her risk was recorded as "*risk of harm from others due to current presentation, she poses vulnerability to herself*".

3.88 A zoning meeting[32] took place on 8 June 2018 (details about zoning meetings can be seen under 'ICMP West', paragraph 4.127). The complaints from Ms G's neighbour were discussed. It was agreed Care Coordinator 4 and the ICMP Associate Specialist would consider whether there was alternative accommodation available for Ms G. Care Coordinator 4 was to arrange to discuss the matter with Ms G via an interpreter. The notes do not say if Ms G was moved from the green zone to the amber zone.

3.89 Another zoning meeting took place on 12 June 2018. It was agreed a crisis appointment should be arranged with Ms G who remained in the amber zone. It is not clear from the notes when Ms G was placed in the amber zone (it was recorded on 6 April 2018 that she was in the green zone). A crisis appointment was booked to take place on 21 June 2018.

3.90 Care Coordinator 4 saw Ms G at home on 13 June. Ms G said she was ok and had been sleeping well. Ms G was told a crisis appointment had been booked for her on 21 June. She was given a copy of the appointment letter.

3.91 Ms G continued to be listed as amber at zoning meetings held on 15 and 21 June 2018.

3.92 Ms G did not attend the crisis meeting with the ICMP Associate Specialist on 21 June 2018. Care Coordinator 4 was on annual leave, but the Associate Specialist wrote in the notes that Care Coordinator 4 would follow up with Ms G.

3.93 It was reported at the zoning meeting on 22 June 2018 that Ms G had not attended the crisis appointment.

3.94 The police contacted the team on 23 June 2018 to advise Ms G had died under suspicious circumstances.

[32] Zoning meetings are held twice a week to discuss service user risk, specifically those in the amber or red zone. The Trust Operational Policy says zoning meetings should take place three times a week, but we note it is under review at the time of writing.

4 Mental health care and treatment

4.1 In this section we have reviewed the care and treatment provided to both individuals by the Mental Health team between 2015 and 2018 under these headings:

- Care planning
- Risk assessment and management
- Medicines management
- Bridge Support
- Family engagement
- Intensive Care Management for Psychosis (ICMP) West
- Ms G's capacity

4.2 There are specific sections in the report focused on the input of London Ambulance Service (LAS), Metropolitan Police Service (MPS), Acute and Primary Care, Housing and Royal Borough of Greenwich (RBG).

4.3 We were told during the investigation that RBG delegates its mental health functions to the Trust for Adult Social Care under an unsigned Section 75 agreement[33] (NHS Act 2006, [34] Section 31 Health Act 1999).[35] The Trust is responsible for the management and supervision of RBG Social Care staff working under the Trust. We were subsequently told by RBG during its review of this report that between 2015 to 2018, there was not an unsigned Section 75 in place, rather there was a signed Section 31 by custom and practice and an implied Section 75 agreement.

4.4 RBG and South East London Clinical Commissioning Group (CCG, formerly NHS Greenwich CCG) are responsible for funding decisions and escalating matters of concern, complaints or queries.

4.5 The Trust does not hold a care package budget, for example for cleaning services; this has been under RBG remit since 2008.

Care planning

4.6 The Care Coordination Association (2016) *Writing Good Care Plans: A Good Practice Guide* (2016)[36] sets out several factors involved in care planning which include:

- *"A systematic review of the needs of the person.*
- *Exploring and discussing choices: to help work out what's the most important, and the implications of different choices.*
- *Goal setting: what do we want to achieve and by whom.*

[33] Section 75 Agreement (NHS Act 2006): https://www.legislation.gov.uk/ukpga/2006/41/section/75

[34] Section 31 Health Act: https://www.legislation.gov.uk/ukpga/1999/8/notes/division/5/1/28

[35] The Trust and RBG are taking steps to formalise the Section 75 Agreement, though at the time of writing did not have a time frame for completion.

[36] Writing good care plans handbook: http://www.cpaa.org.uk/writing-good-care-plans-handbook.html

- *Action planning: what are we going to do, who is responsible, and when will it be reviewed?*
- *Safety: how do we make care as safe as possible?*
- *Support: for someone to manage their own health as much as possible."*

4.7 The guidance says a care plan should be a written plan of action to meet an individual's health and social care needs, including aims, actions and responsibilities.

4.8 NICE guidance (2014)[37] says *"People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider".*

4.9 The Trust Assessment and Care Planning including Care Programme Approach (CPA) Policy (2012) for all Oxleas service users describes CPA as the approach to "*… assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services that have complex needs*". The policy sets out what recipients of CPA should expect which includes:

- *"A comprehensive multidisciplinary, multi-agency assessment covering the full range of needs & risks with use of interpreting and translation services where required.*
- *Support from a Care Coordinator.*
- *Comprehensive formal written care plan: including risk and safety/contingency/crisis plan and in line with national best practice guidance.*
- *Ongoing review, formal multidisciplinary, multi-agency review 6 monthly.*
- *Increased need for advocacy support".*

4.10 A formal review of the care plan should take place every six months with service users on CPA. The policy advises it is good practice for there to be a minimum of fortnightly contact between a Care Coordinator and a service user on CPA. All service users under CPA should have a crisis plan.

4.11 The Trust Care Planning Policy (2016) says personalised care planning *"… enables individuals to be involved collaboratively in planning their care, addressing their full range of needs and supporting them to self-manage"*. The policy sets out seven principles of care planning which include recognising individual strengths and goals, agreeing treatment options, and empowering individuals to self-manage. The seventh principle is *"Developing a plan and where possible agreeing the goals, outcomes and review dates of the treatment options and the care being delivered"*.

4.12 The policy sets out 13 rules for effective personalised care planning which notes *"The care plan is the core document for care delivery for each service user and is supported by the assessment tools. The information contained within it must ensure that holistic, safe and effective care is provided"*. The rules say the care plan must be in a language the service user understands and record *"… agreed goals, communication needs and reasonable adjustments, interventions including risk management plans, the service users and or their family/support networks view and an agreed review date"*. The care plan is noted to be a live document that should be regularly reviewed.

[37] NICE guidance: https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#promoting-recovery-and-possible-future-care-2

Mr Q CPA and care planning

4.13 Mr Q was under CPA and had a Care Coordinator. His last care plan was completed by Care Coordinator 3 on 15 May 2017. The care plan focused on Mr Q continuing to receive depot medication and taking his oral medication (procyclidine 10mg twice a day and zopiclone 7.5mg at night). The care plan set out interventions in relation to Mr Q:

- Complying with the conditions of his lease.
- To give up smoking, drink less alcohol, not take drugs, and lose weight.
- Managing his finances via his Care Coordinator and the Financial Protection and Appointeeship team.
- Continuing to see his family regularly.

4.14 Mr Q had a crisis and contingency plan that detailed his relapse indicators/warning signs and what Mr Q should do if he was in crisis e.g., in working hours contact the ICMP.

4.15 Mr Q's care plan addressed his day-to-day living requirements e.g., financial management, but did not explore his long-term plans or goals. The plan was not holistic and failed to consider Mr Q's broader needs (e.g., social and psychological). For example, it is documented in notes from Bridge Support that Mr Q's Support Worker had encouraged him to consider attending a cookery course, and that he seemed keen, but his care plan did not reflect any consideration of further learning or attending courses. The care plan did not explore with Mr Q his social network, activities, or plans beyond the immediacy of his daily living.

4.16 Equally, it was documented in the notes that Mr Q had a strong relationship with his mother whom he saw regularly, but there is no evidence she was ever invited to contribute to the care planning process between 2015 and 2018. It is possible that Mr Q's mother could have had insight about Mr Q that might have contributed to the care planning process. Mr Q may also have been more engaged in the process had his mother been an active participant. There are no guarantees in relation to this last point but in the first instance, best practice (and in keeping with Trust policy) would have been to invite Mr Q's mother to his CPA meetings (subject to Mr Q's agreement).

4.17 There is no evidence Care Coordinator 4 updated Mr Q's care plan in response to significant events e.g., the death of a tenant at the house – the tenant was anecdotally described as a "*stabilising*" factor – and the transfer to hospital of another, resulting in Mr Q and Ms G being the only residents in the property. Mr Q was told in June 2018 that he would need to find alternative accommodation.

4.18 Mr Q's attendance at his CPA reviews was variable. He missed his last three CPA reviews, scheduled every six months in keeping with Trust policy. Mr Q did tell his Care Coordinator(s) that he could not attend on Mondays when the appointments were usually held (it was noted in his care plan that he typically visited his mother on Sundays and Mondays). Mr Q asked that a CPA review in June 2016 be rescheduled and gave advance notice in May 2017 that he would not be available to attend the appointment but, in both instances, there is no documented evidence that Trust staff explored rescheduling. Mr Q attended three CPA reviews in the three years prior to the incident.

Table 1: Mr Q's CPA attendance 2015–2018

Date of CPA review	Mr Q attendance
30/04/2018	DNA[38]
09/11/2017	DNA
15/05/2017	DNA[39]
01/12/2016	Yes
27/06/2016	DNA[40]
18/01/2016	DNA[41]
06/08/2015	Yes
19/02/2015	Yes

4.19 We asked Care Coordinator 3 and Care Coordinator 4 about Mr Q's level of engagement in the care planning process. Care Coordinator 3 told us that Mr Q did attend some of his CPA reviews and she had occasionally spoken to his mother by phone. She said she also liaised with his Support Worker at Bridge Support. Care Coordinator 3 said Mr Q was engaged when she worked with him, he attended appointments and agreed to occasional home visits. She did not have concerns about him.

4.20 Care Coordinator 4 told us that Mr Q was independent, and their engagement rarely extended beyond his depot appointments. He said it was a challenge to get Mr Q to engage in the CPA process because he felt everything was fine and therefore meetings were not warranted. We asked whether consideration was given to rescheduling Mr Q's CPA appointments, but Care Coordinator 4 told us Mr Q was quite fixed in terms of his availability, and the team's availability (e.g., the Associate Specialist) was also a factor; we were given no indication rescheduling was considered by Care Coordinator 4 or the ICMP Associate Specialist.

4.21 The ICMP Associate Specialist told us it was the responsibility of the Care Coordinator to schedule CPA meetings. Whilst we accept this is Trust policy, we would have expected the ICMP Associate Specialist to have spoken to Mr Q's Care Coordinator about Mr Q's failure to attend three consecutive CPA reviews, with a view to arranging an appointment that he could attend.

4.22 The Trust internal investigation highlighted several concerns in relation to Mr Q's CPA management which included:

- Mr Q had not attended a CPA since December 2016.
- There was no evidence a pre-CPA review had been undertaken with Mr Q in the 18 months prior to the incident.
- Other professionals and Mr Q's family were not invited to the CPA reviews.
- There was no evidence of liaison with Mr Q's GP in relation to his medication.
- CPA records were of a poor quality and were inaccurate (e.g., Mr Q's GP was listed as an attendee on 30 April 2018, but this was not correct). The GP was also listed as contributing to Mr Q's CPA reviews but there is no evidence of this in the notes).

[38] DNA: Did Not Attend.

[39] It was documented in the notes on 26 April 2017 that Mr Q would be unable to attend the CPA review on 15 May 2017.

[40] Mr Q and Care Coordinator 3 did not attend the CPA review, but a documented CPA review was completed by Care Coordinator 3 in the morning.

[41] Mr Q was in the building but declined to attend the review.

- There was no evidence that attempts were made to reschedule CPA meetings or to explore with Mr Q his reluctance to attend.

4.23 We agree with the Trust internal report findings. In addition, we note that there are entries headed 'CPA Review' in the notes, completed by Care Coordinator 4 on 30 April 2018 and 9 November 2017 that suggest a CPA review did take place. These meetings are recorded as taking place shortly before the Associate Specialist's entries in the notes which documented that Mr Q did not attend his CPA review. In both instances Mr Q and Care Coordinator 4 are recorded as being present. In addition, on 9 November 2017, the ICMP Associate Specialist is also listed as an attendee, and on 30 April 2018, Mr Q's GP is listed as having attended. As previously noted, the GP attendance was inaccurate and Mr Q did not attend the meeting.

Finding: Mr Q's care plan had not been updated since May 2017. His care plan addressed the immediate concerns of his day-to-day living but did not consider long-term goals or action planning; it did not involve his family and was not written in line with Trust policy or best practice.

Medication review

4.24 We asked the ICMP Associate Specialist if there had been a long-term plan for Mr Q given his lack of engagement. He told us the plan had been that Mr Q remain on the ICMP caseload who would continue to administer his depot medication. We were advised that depot medication is rarely administered in a primary care setting in the area and that the responsibility falls to Mental Health Services. As a result, Mr Q would remain on the ICMP caseload. We discuss this further under 'Medicines management' (paragraphs 4.81-4.87).

Ms G CPA and care planning

4.25 Ms G was under enhanced CPA and had a Care Coordinator. Her care plan was reviewed every six months, and she was usually supported by an interpreter as per Trust policy. Ms G had eight CPA reviews scheduled between January 2015 and June 2018. She attended six appointments and missed two, the reasons for which were not documented.

Table 2: Ms G's CPA attendance 2015–2018

Date of CPA review	Ms G attendance
12/04/2018	DNA[42]
19/10/2017	Yes
04/05/2017	Yes
07/11/2016	Yes
02/06/2016	Yes[43]
07/12/2015	Yes
09/06/2015	DNA
06/01/2015	Yes

[42] Ms G was discharged from hospital after an acute inpatient admission on 12 April 2018.

[43] Interpreter arrived late and missed meeting.

4.26 We could not find a recent care plan for Ms G. We have been provided with care plans dated back to 2008. There is scant information in them about the nature and outcome of the review undertaken, and there are few reviews. The care plans which were 'open' in June 2018 are detailed below:

7 November 2016 – Problem and Need Type: Language: open

"*Punjabi*[44] *is* [Ms G's] *mother tongue.* [Ms G] *is able to communicate in English Language, but sometimes needs an interpreter when discussing difficult and sensitive matters.*"

There was no documented review of this care plan.

5 October 2017 – Problem and Need Type: Accommodation

"[Ms G] *currently lives with others in private renting accommodation in Greenwich. The goals* [sic] *was for* [Ms G] *to move to more suitable accommodation to meet her needs. The client view was: 'I am happy here but wanted to move'".*

There was no documented review of this care plan.

2 December 2008 – Problem and Need Type: Finances

"[Ms G's] *money is currently been* [sic] *managed by the appointeeship scheme. She attends the Woolwich Centre two times a week for her money. Mondays and Wednesdays. On Monday's* [Ms G] *receives £50.00 and Wednesday's £40.00*

This was updated on 5 October 2017 to: support [Ms G] *with her finances, a weekly allowance of £90.00."*

4 May 2017 – Problem and Need Type: Mental health

"[Ms G] *is diagnosed as having Paranoid Schizophrenia for which takes prescribed medication (listed)*

The goal was listed as for [Ms G] *to remain well, the intervention was for the ICMP West team to encourage* [Ms G] *to take her medication daily, Consultant Psychiatrist to review* [Ms G]*'s mental state and treatment plan, at her CPA Review Meeting every 4–6 months, Care Coordinator to see* [Ms G] *3 weekly, following appointment at Depot Clinic, to monitor her mental state and provide practical support, Care Coordinator to monitor any side effects from medication, Care Coordinator to provide* [Ms G] *with psychoeducation about her condition and treatment. The client view was: 'I take my medication'".*

This care plan had been reviewed since its initial start in 2013 but had not been reviewed since May 2017.

11 March 2010 – Problem and Need Type: Physical health

"[Ms G] *is non-insulin dependent diabetic and Hepatitis C*

Diabetes controlled with metformin 500mg bd

[Ms G] *to test her blood sugar level daily.*

She has been diagnosed with asthma and has been prescribed a pump for use.

[Ms G] *has 'Brittle Bones' and has regular Vitamin D injections, due to not being exposed to enough sunlight. She also has six monthly appointment with 'Bone Specialist'.*

[44] It is recorded elsewhere in the notes that Ms G needed a Hindi interpreter.

[Ms G] *suffers from back pains (osteoporosis) and has been attending the pain clinic once a week at her GP surgery."*

This plan was updated on 4 May 2017, but the interventions were unchanged.

4.27 There is very limited evidence the CPA reviews prompted exploration of Ms G's care plan with her; the notes of the meeting were largely similar from one meeting to the next. Each CPA review concluded with the plan:

- no change to medication;
- to remain on enhanced care;
- Care Coordinator to continue to support Ms G; and
- next CPA in six months unless a medical review was needed sooner.

4.28 The wording of the mental state examination paragraph completed by the ICMP Associate Specialist was almost the same in four of the five CPA reviews undertaken. The exception was the CPA review undertaken in June 2016 when Ms G's interpreter missed the appointment which therefore meant a full CPA meeting did not take place.

4.29 The Trust internal investigation was critical of Ms G's care plan, describing it as "*not adequate*". The internal investigation noted the care plan was not updated to reflect significant events (e.g., when Ms G's neighbours complained she was bothering them in June 2018 and when a safeguarding referral was raised in July 2017). Trust policy sets out that any changes to a service user's lifestyle should be reflected in their care plan and risk assessment.

4.30 We agreed with the Trust's assessment that Ms G's care plan was inadequate. However, in addition to not being updated to reflect significant events, the care plan was narrow in scope and provided no long-term planning or goal setting for Ms G. Factors we would expect the care plan to consider and include are:

- Ms G's frequent contact with other services (e.g., the MPS and her GP) and whether steps could be taken to mitigate this, ideally working with other agencies to manage her contact.
- Her continuous expression of bizarre beliefs. There is no evidence to suggest that the psychoeducation referred to in May 2017 took place. Equally there is no evidence of any exploration of the origins of these beliefs, or psychological interventions to help her manage them.
- Ms G's mobility issues. In 2015 Care Coordinator 2 was looking at ground floor accommodation for Ms G but this was not taken further, and there is no evidence in the notes to indicate Ms G's living environment was considered again in the context of her mobility issues.
- Ms G's physical health. She had Type 2 diabetes[45], hepatitis C, degeneration of the lumbar spine, labyrinthitis, cirrhosis of the liver, osteoporosis and she was asthmatic.
- The nature of Ms G's daily life. It was noted she did not engage in activities but there is no information to suggest her daily routine was discussed with her.
- Input from support services (e.g., Bridge Support and cleaning services).
- Ms G's support or social network. There is nothing in the notes to indicate whether Ms G had a social network. She was seen weekly by her son, but historically her relationship

[45] Ms G experienced a hyperglycaemic episode in McDonalds in September 2017 and had to be taken by ambulance to A&E.

with her children had been variable. There is no evidence Ms G's children were invited to attend or contribute to her CPA reviews.

- Ms G's cultural needs. Ms G was originally from India and her first language was not English, it was not known whether she was routinely active in religious observance (there is some evidence in the notes that she did sometimes attend temple), or whether she had access to any social support through her local community.
- Ms G was hospitalised for medical reasons in April 2018. Her care plan was not reviewed in response to her hospital discharge.
- Her capacity to make decisions about her housing situation.

4.31 It was routinely documented in the CPA meeting notes (including prior to 2015) that Ms G experienced delusions that residents at her house were beating her with a hammer and that she experienced auditory hallucinations. She also raised this with her care coordinators and GP on many occasions. We asked the ICMP Associate Specialist about Ms G's delusions and what, if any steps had been taken to address these. He told us her delusions were long-standing but she had respectful relationships with the other tenants in the house (e.g., she referred to them with the noun uncle). He clarified that she did not say anyone was abusing her, rather that she was hit with hammers in the night. However, she had no obvious injuries in the morning. The Associate Specialist said there was no evidence she was being abused rather that her thinking had remained unchanged for a long time. The Associate Specialist described Ms G's delusions as ongoing and said they did not need review or urgent attention.

4.32 There is no evidence in the notes that Ms G's care coordinators or the ICMP Associate Specialist explored Ms G's concerns with her, or that steps were taken to try to address them (e.g., Cognitive Behavioural Therapy). There is no way of knowing if interventions would have been successful, or if Ms G would have engaged with them, but good practice would have been to explore (and document in the notes) these options with her.

4.33 We asked the ICMP Associate Specialist whether there were any long-term plans for Ms G. He told us the plan was to continue to review Ms G in CPA meetings, ensure she had her depot medication, and to liaise with her GP and other supporting agencies as required. We identified very little change in the nature of the CPA reviews between 2015 and 2018.

4.34 Ms G's crisis, relapse and contingency plan was last updated by Care Coordinator 3 on 4 May 2017. They detailed what Ms G should do in case of emergency and her relapse indicators/early warning signs. We do not know the extent to which Ms G was able to read English. Her notes indicate she often spoke a mix of Hindi or Punjabi and that English was not her dominant language. There is no evidence Ms G was provided with any documentation in a language or format that suited her needs (as recommended in Trust policy). The ICMP Associate Specialist told us Ms G was reasonably settled during the last CPA review she attended, which was in October 2017. He told us that when she had become unsettled (in June 2018) steps had been taken to arrange a crisis meeting with her, to discuss her medication and consider the dose, but unfortunately the meeting did not happen.

4.35 Care Coordinator 4's entries for each of their meetings from November 2017 to May 2018 was: "*she appeared stable in her mental state and calm in behaviour, she reported good sleep and good dietary intake. No concerns was* [sic] *raised by* [Ms G]".

4.36 The medical entries completed by the ICMP Associate Specialist for the CPA reviews between November 2016 and October 2017 varied only slightly in wording. There are no medical entries for March and April 2018; for one of these the doctor was not present, and Ms G did not attend in April 2018 (she was discharged from hospital the day of the CPA review).

Finding: Ms G's care plan was limited to ensuring she received her depot medication. The care plan lacked breadth and did not consider her mental and physical health,

capacity, cultural needs, housing, social networks and/or her relationships with her family. Ms G's care plan did not contain future planning and was not updated in response to events or changes in her behaviour. It was not updated in line with the CPA Policy expectation of "*Ongoing review, formal multidisciplinary, multi-agency review 6 monthly*".

Finding: There is no evidence CPA reviews were a dynamic, engaged process designed to work with Ms G, rather they followed the same pattern with little variation between 2015 and 2018. The entries made by Care Coordinator 4 and the Associate Specialist for meetings and CPA reviews in 2017 and 2018 suggest that there was a 'copy and paste' approach to the note entries.

Risk assessment and risk management

4.37 The Healthcare Quality Improvement Partnership (HQIP, 2018)[46] says a good risk assessment combines "*consideration of psychological (e.g., current mental health) and social factors (e.g., relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people.*"

4.38 A comprehensive risk assessment will take into consideration the patient's needs, history, social and psychological factors, and any negative behaviours (e.g., drug use).

4.39 Risk management planning is defined as a cycle that begins with risk assessment and risk formulation, which in turn leads to a risk management plan subject to monitoring and review.

4.40 The Department of Health (2009)[47] identifies 16 best practice points for effective risk management which include:

"… a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions be taken by practitioners and the service user in response to crisis"; and

"Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach."

4.41 Best practice in managing risk is based upon clinical information and structured clinical judgement. It involves the practitioner making a judgement about risk based on combining:

- an assessment of clearly defined factors derived from research (historical risk factors);
- clinical experience and knowledge of the service user, including any carer's experience; and
- the service user's own view of their experience.

4.42 The Trust Clinical Risk Assessment and Management Policy for Mental Health and Learning Disabilities Services (2016)[48] sets out the Department of Health description of risk assessment and management as:

[46] HQIP partnership: https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf

[47] Department of Health (2009) Best Practice in Managing Risk: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

[48] The Trust policy was issued in 2009 and reviewed in 2016. Three changes to the policy were documented in 2016 (e.g., removal of London Probation Service definition of risk assessment), none of which alter the overall content therefore we have referred to the 2016

"*making decisions based on knowledge of research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement*".[49]

4.43 The policy defines risk factors in terms of dynamic and static factors; factors which do change and those that do not change, respectively. The Trust uses the structured clinical approach to risk (e.g., clinical experience and knowledge of the service user, the service user's views and those of other professionals). The policy sets out four questions staff should ask as part of their assessment of risk:

- What can go wrong?
- How bad?
- How often?
- Is there a need for action?

4.44 The policy states the essential components of risk assessment and management "*include engagement, good history taking, and formulation risk*". Risk assessment and formulation should reflect a number of factors which include:

- *"Summarise dynamic and static risk factors, and protective factors;*
- *Try to give an idea of how much impact individual risk factors have and what the precipitating event that has increased risk now is;*
- *When possible, involve family members and care network; and if not involved a clear rationale is documented;*
- *When possible, include multi-agencies in risk assessment and management if multi-agencies are involved;*
- *Take into consideration mental capacity."*

4.45 Risk should be assessed for a variety of reasons including as part of routine assessment, following an incident, and in response to any significant changes. Engagement with service users is fundamental to risk management. Risk assessments and management plans should be recorded on RiO.[50]

4.46 The policy says "*Fundamental to risk management is engagement with service users, and a focus on finding out what they would want to prioritise in terms of making their mental health stable… when service users may not have the capacity to engage in prioritising risks, their families, carers or supporters should be involved in helping the multidisciplinary team make those decisions. If a service users* [sic] *doesn't engage with the risk assessment and care plan, clinical teams should have a clear escalation plan*".

4.47 Service users should also have a crisis and contingency plan as part of their risk management. Risk assessment should be reviewed at every contact where a risk has been raised, and as part of the CPA process.

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policy because barring the aforementioned three edits, it was the policy in place throughout the period of care being examined. The policy was reviewed again in November 2018.

[49] Department of Health (2009) Best Practice in Managing Risk: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

[50] Trust electronic clinical record system.

4.48 Clinical teams are responsible for quality monitoring and must audit five risk assessment and care plans each month.

Mr Q's risk assessment and risk management

4.49 Mr Q's last risk assessment was undertaken by Care Coordinator 3 on 15 May 2017.[51] A full risk assessment was not completed but the summary described Mr Q's risk to others as low. His risk of violence/aggression was also recorded as low. Mr Q's risk to others was consistently recorded as low from 2012 onwards (it is not considered prior to this). The Trust Clinical Risk Assessment and Management Policy for Mental Health and Learning Disabilities Services does not quantify low, medium or high risk or set out indicators for these categories.

4.50 The risk assessment provides a history of Mr Q's assessments and there is evidence it was updated in 2015 and 2016, but the 2017 assessment lacked detail. There is no evidence "*risk formulation including triggers, immediacy, protective factors and influencing factors*" or "*other risk behaviours and issues*" were explored with Mr Q. Mr Q had historically engaged in risky behaviour (e.g., self-harm, drinking alcohol to excess and drug taking) but there is no evidence this, or other risk factors, were considered with Mr Q as part of the 2017 risk assessment. Equally, historically it was noted he had been considered vulnerable to financial exploitation, but this had not been explored with Mr Q since 2016 despite him regularly requesting relatively large sums of money (e.g., up to £1,400[52] to buy a chair).

4.51 The risk assessment was not updated in response to changes in Mr Q's life which included the death of a resident in 2017 who had been considered a "*stabilising*" factor in the house, and the transfer of another resident to hospital in early 2018, which resulted in him moving out. This resulted in Mr Q and Ms G being the only remaining residents in the house. Care Coordinator 4 told us that he deliberately did not discuss Mr Q's living arrangements with him, in the context of Ms G, because he did not want to breach patient confidentiality. We discuss Mr Q and Ms G's living arrangements in 'Royal Borough of Greenwich – housing' (paragraphs 5.229-5.325).

4.52 Patient confidentiality could have been maintained whilst still discussing Mr Q's living arrangements and whether he had any concerns. Mr Q's Care Coordinator would have been aware there were several occasions in which Ms G's behaviour could have had a disruptive impact on the house (e.g., her unwelcome contact with neighbours in 2018); it would have been appropriate to explore house dynamics with Mr Q, without needing to disclose information about Ms G.

4.53 Mr Q's risk was considered as part of his CPA reviews but as previously noted, he did not attend most CPA meetings and there is little detail in the notes. No concerns were identified by the health professionals during the CPA reviews.

4.54 The Trust internal report concluded the risk assessment completed on 15 May 2017 "*does not provide a comprehensive or detailed formulation of* [Mr Q's] *risk*". We agree with this assessment.

4.55 Mr Q did not have a comprehensive risk assessment or management plan in place at the time of the incident. His risk assessment was not updated in response to significant events and there is little evidence of professional curiosity on the part of the ICMP, rather they accepted there were no concerns without adequately exploring this with him. Care Coordinator 4 told us he deliberately avoided discussing Mr Q's living arrangements and his relationship with Ms G in case Mr Q perceived it as a conflict of interest.

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[51] This is the same day a CPA review was held for Mr Q which he did not attend. There is no evidence in the notes he was present for the risk assessment.

[52] Subsequent correspondence suggests the chair would cost £600.

Finding: Mr Q did not have a comprehensive risk assessment or management plan in place at the time of the incident.

Ms G's risk assessment and risk management

4.56 Ms G's most recent risk assessment was completed by Care Coordinator 3 on 5 October 2017. Her risk rating was low; the risk assessment does not include indicators for this categorisation of risk.

4.57 Evidence was identified of Ms G being at risk of:

- Financial abuse
- Unlawful restrictions (e.g., locks on doors and physical restraints)
- Accidental harm outside the home
- Falls
- Unsafe use of medication

4.58 Evidence was identified of Ms G representing a risk to:

- Children[53]
- Violence/aggression/abuse to other clients
- Violence/aggression/abuse to staff

4.59 There was also evidence of Ms G's risk behaviours including:

- Damage to property
- Incidents involving the police
- Phone calls

4.60 Ms G's risk assessment did not categorise the above in terms of low, medium or high risk, instead "*yes*" is marked next to each point. The above were long-standing elements of Ms G's risk assessment. However, there is no evidence in the notes that her risk assessment was updated in response to events, changes in her behaviour, or contact from other agencies.

4.61 We set out below examples where, in keeping with Trust policy, Ms G's risk assessment should have been reviewed:

- Her neighbours complained to the police about Ms G's behaviour in June 2018. A crisis meeting was booked in response, but Ms G's risk assessment was not updated.
- Changes in her living arrangements following the death of a resident and the relapse of another in late 2017 and early 2018, respectively.
- Receipt of MERLIN reports. The notes indicate that the ICMP did not receive all the MERLIN reports submitted to RBG, but there is evidence of five[54] occasions in which MERLIN reports were received. Ms G's risk assessment was updated twice in response to the reports (22 October 2016 and 4 May 2017).

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[53] The risk assessment does not detail the nature of the risk to children.

[54] MERLIN reports were received on 20/06/2016, 20/10/2016, 11/11/2016, 11/04/2017 and 15/12/2017.

- A report was received from the Bracton Centre[55] on 1 May 2015 to advise that the police had called to say Ms G was making 'nonsense' calls 10–15 times a day,[56] reporting that her flat had been burgled.
- The police called on 16 April 2015 to advise that Ms G had reported someone was going into her bedroom and stealing things.

4.62 There is no evidence that Ms G's family were contacted as part of her risk assessment or management; and the reason for this was not documented. Ms G's son collected her money for her as part of the appointeeship arrangements therefore his contact details were available to the team. Equally, there is no evidence other agencies were engaged as part of her risk management despite her frequent contact. Both actions would have been in accordance with the Trust policy.

4.63 There is evidence in the notes that Ms G's care coordinators did sometimes raise concerns with her. For example, Care Coordinator 3 documented on 18 April 2017 "*Discuss* [sic] *her recent contact to police* [but] *she did not say much*".

4.64 However, Ms G's risk assessment was not updated. Equally, Care Coordinator 4 recorded in the notes on 8 June 2018 after visiting Ms G at home, "*Risk of harm from others due to current presentation, she poses vulnerability to herself*". Care Coordinator 4 did not expand on this point or explain why Ms G was a "*vulnerability to herself*". A crisis meeting was booked for Ms G later in the month, but again, her risk management plan was not updated in the interim. This is not in adherence with Trust policy. We discuss this further under 'Amber zone' (paragraph 4.67).

4.65 Ms G did not have a comprehensive risk assessment or management plan in place at the time of the incident. Ms G's care coordinators did not update risk documentation in response to changes in her behaviour or significant events, which was in breach of Trust policy. They did not involve Ms G's family or other agencies in their risk assessment and management of Ms G.

4.66 However, we note the above cannot happen in isolation and broader contributory factors must be taken into consideration. We discuss these under the ICMP section.

Finding: Ms G did not have a comprehensive risk assessment or management plan in place at the time of the incident.

Amber zone

4.67 Ms G's neighbours complained to the police and Care Coordinator 4 on 6 June 2018 that she was bothering them. Care Coordinator 4 undertook a joint home visit with another member of the ICMP the same day to see Ms G. They raised the neighbours' concerns with Ms G, who denied she had been bothering them, rather she was visiting her brother who lived at the address (he did not). Care Coordinator 4 wrote in the notes "*It appears* [Ms G] *wasn't processing the conversation* [we were] *having with her, however she acknowledged that she will not go to the address…*"

4.68 Ms G was placed in the amber zone in early[57] June 2018 following these complaints from her neighbours to the police. The plan documented that Care Coordinator 4 and the ICMP

[55] The Bracton Centre provides inpatient forensic mental health services. It is not documented in the notes why the police contacted the Bracton Centre about Ms G.

[56] The MPS chronology provided for this review indicates that Ms G was calling the police regularly in 2015, but not 10 to 15 times a day.

[57] The notes do not say when Ms G was placed in the amber zone, but we believe it happened on 8 June 2018.

Associate Specialist would "think *about an alternative accommodation*" for Ms G, and that Care Coordinator 4 would book an appointment with Ms G and an interpreter to discuss this.

4.69 It was agreed at the zoning meeting on 12 June that Care Coordinator 4 should book a crisis appointment for Ms G with the ICMP Associate Specialist. The crisis meeting was booked that day, to take place on 21 June 2018, two weeks after the neighbours complained. The plan also said Bridge Support would monitor the situation and make contact (the notes do not say who they would contact).

4.70 There is no evidence Bridge Support was contacted in relation to the incident.

4.71 Care Coordinator 4 undertook a home visit on 13 June 2018, roughly five days after she was placed in the amber zone. He noted Ms G reported she was ok. He informed Ms G a crisis meeting was booked for 21 June 2018.

4.72 The Trust zoning sets out a number of key interventions to be undertaken with service users in the amber zone. These include:

- "*Mental State Examination (MSE) monitoring*
- *Support and develop insight self-management*
- *Information and medication choices, side effects and concordance therapy*
- *Targeted lifestyle support*
- *Daily living skills and home management*".

4.73 The Trust Zoning Policy does not say how or when key interventions should be implemented. There is no narrative in relation to what staff should do when a service user changes zones (e.g., within how many days they should be seen and by who). The exception to this is that the policy says the team should work collaboratively to develop a management plan when a service user is placed in the red zone. However, it does not provide detail of what the management plan should consider.

4.74 There was no process for Care Coordinator 4 to refer to in response to Ms G being moved from the green zone to the amber zone. The progress notes do not suggest any of the above interventions were explored with Ms G.

4.75 We agree a crisis meeting was needed, but we do not consider its scheduling two weeks after the incident, to be sufficiently timely. Such a meeting should have taken place sooner.

4.76 We cannot comment on why the meeting was booked over two weeks after the neighbours complained and if it was due to staff capacity or availability.

Finding: The ICMP response to Ms G being moved to the amber zone in June 2018 was not sufficiently proactive.

Medicines management

4.77 The Royal College of Psychiatrists[58] describes depot medication as that given by injection which is slowly released in the body over a number of weeks. The Royal College says there are positives and negatives to depot, most notably, the positives being depot medication is taken monthly as opposed to daily oral medication, thereby placing less demand on a service user's time, reducing the chance of forgetting to take medication, and likely improving compliance. Depot medication and oral medication can be the same medication; it is the

[58] Royal College of Psychiatrists: https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/depot-medication

method of administration that is different, although achieving an equivalent dose is not always easy.

4.78 British National Formulary (BNF) guidance recommends that patients on long-term antipsychotics should have annual health reviews which monitor blood count, urea and electrolytes and liver function. The patient's weight, blood lipids and fasting glucose levels should also be checked annually.

4.79 The Trust has an Administration of Medicines Policy (2014) which provides guidance about the administration of depot medication.

4.80 Mr Q and Ms G were both long-term recipients of depot medication. They were also prescribed additional medication.

Mr Q's medication

4.81 Mr Q was prescribed the following medication between 2015 and 2018:

- Flupentixol 100mg (fortnightly)
- Procyclidine[59] 10mg (twice a day)
- Zopiclone[60] 7.5mg
- Loperamide[61] 4mg
- Salbutamol[62] inhaler

4.82 The ICMP Associate Specialist told us he reviewed Mr Q's medication as part of his CPA reviews (which Mr Q typically did not attend). Clinic letters were shared with Mr Q's GP after each review (i.e., twice a year). We consider this to be at the limit of reasonable information sharing with Mr Q's GP, although it must be noted there were no changes to his medication, and the Trust does not set out minimum standards for frequency of contact with a patient's GP.

4.83 Staff completed Glasgow Antipsychotic Side Effect Scale (GASS)[63] forms as part of Mr Q's CPA reviews in February and August 2015 and in June 2016, but this practice did not continue thereafter.

4.84 Staff arranged for Mr Q to have routine blood tests, and his medication was monitored at his depot clinic where his mental state and any side effects were recorded in the notes. However, it is difficult to assess the extent of this monitoring given a number of the entries were the same: "*He appeared stable in his mental state and reported no concerns*". Similarly, although Mr Q's medication was documented in his CPA reviews, there is no evidence this was explored with him, largely due to his limited attendance. Mr Q's GP monitored his asthma medication.

4.85 We discussed Mr Q's medication management with the ICMP Consultant Psychiatrist and the Associate Specialist, specifically in the context of his limited engagement with Trust services

[59] Procyclidine: Medication used to treat the side effects caused by antipsychotic medication. https://bnf.nice.org.uk/drug/procyclidine-hydrochloride.html

[60] Zopiclone: A non-benzodiazepine used to treat insomnia. https://bnf.nice.org.uk/drug/zopiclone.html

[61] Loperamide: Used to treat diarrhoea. https://bnf.nice.org.uk/drug/loperamide-hydrochloride.html

[62] Salbutamol is used to relieve symptoms of asthma and chronic obstructive pulmonary disease. https://www.nhs.uk/medicines/salbutamol-inhaler/

[63] The Glasgow Antipsychotic Side Effect Scale (GASS) is a self-reporting questionnaire aimed at identifying the side effects of antipsychotic medication. https://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/

beyond depot medication. Part of the ICMP team remit is to facilitate a step down service for patients in the community. However, both told us it was difficult to discharge patients from the team caseload if they received depot medication because there was no shared care agreement with primary services for them to manage the administration of depot medication. This has implications for the team's capacity. We were told local GPs refuse to administer depot medication in the community. Consequently, a patient in receipt of depot must stay on the ICMP caseload. We were told that the ICMP had approximately 40–50 patients in receipt of depot who were stable and could potentially be discharged from the team caseload if primary care assumed responsibility for their depot management. Mr Q potentially met the criteria for being on a step down pathway but this could not be considered because of his depot medication.

4.86 We have not considered whether Mr Q would have been discharged from Trust services, but we note his lack of engagement with services and what was considered to be 'stable' mental health, which suggests he would have warranted consideration, had medication management not been a fundamental factor.

4.87 However, this should not detract from the reality that ICMP staff had not undertaken a comprehensive assessment of Mr Q's care and treatment needs between 2015 and 2018.

Finding: Mr Q's medication was monitored in line with expected practice with the exception of timely GASS monitoring.

Finding: There were approximately 50 patients on the ICMP caseload who could not be considered for step down services because the Trust was responsible for the administration of their depot medication. Mr Q was part of this group.

Ms G's medication

4.88 Ms G received medication for her physical and mental health needs. We set out below details of the medication she received:

- Flupentixol 200mg (every three weeks)
- Escitalopram[64] 10mg (in the morning)
- Procyclidine 5mgs (three times daily)
- Temazepam[65] 10mgs (every night)
- Metformin 500mgs, 2 in the morning and 1 at night
- Folic acid 400mcgs (once daily)
- Adcal-D3[66] (twice daily)
- Ferrous fumarate[67] 210mgs (twice daily)
- Omeprazole[68] gastro-resistant 20mgs (once daily)

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[64] Escitalopram: An antidepressant. https://bnf.nice.org.uk/drug/escitalopram.html

[65] Temazepam: A benzodiazepine used to treat insomnia. https://bnf.nice.org.uk/drug/temazepam.html

[66] Adcal-D3: chewable calcium and vitamin D3 tablets. https://www.medicines.org.uk/emc/product/4723/pil#gref

[67] Ferrous fumarate: Medication used to treat iron deficiency and anaemia. https://bnf.nice.org.uk/drug/ferrous-fumarate.html

[68] Omeprazole: Medication used to treat acid reflux.

4.89 There were few changes made to Ms G's medication between 2015 and 2018. Her depot and antidepressant medication did not change. Ms G was given a dosette box to help her manage her medication. ICMP staff monitored her medication via her depot clinics, documenting her mental state and any side effects. Blood tests were undertaken in 2016 and 2017 as part of the monitoring process. There is no evidence in the notes that GASS forms were completed as part of the monitoring process.

4.90 Staff had no concerns in relation to Ms G's compliance with her depot medication which she routinely received – she rarely missed depot appointments.

4.91 Ms G was taking temazepam and pain relief medication (e.g., co-codamol and paracetamol prescribed by her GP) on a long-term basis. In July, November and December 2016, there were occasions when Ms G told her GP that her temazepam had been taken or she had lost her prescription. The GP practice usually issued a shorter prescription in response. Ms G's GP practice had considered reducing the temazepam dose in May 2017, but it concluded that this would likely increase her attendance to the practice.

4.92 Temazepam is a benzodiazepine used to treat sleeping problems (e.g., insomnia). Temazepam is a controlled drug[69] usually prescribed for up to four weeks; guidance advises against prolonged use (e.g., risk of addiction, rebound insomnia) and to use with caution in patients with mild to moderate liver impairment.

4.93 The GP notes do not set out why Ms G was on temazepam on a long-term basis. We asked the GP practice if it had a policy for prescribing benzodiazepines but at the time of writing it had not replied to our query. It would have been best practice to have gradually weaned Ms G off the temazepam, although this may have been difficult to implement. There is no evidence in the GP notes that this was discussed with her. It should be noted that Ms G's dosage was never increased. The need to increase the dosage is common in instances of long-term benzodiazepine use as an individual's tolerance to the medication increases.

4.94 Ms G continued to experience psychotic residual symptoms whilst taking antipsychotic medication (e.g., hallucinations). We asked the ICMP Associate Specialist if consideration had been given to changing Ms G's medication to mitigate these, but he said it was unlikely such a change would have made a difference. He said Ms G had experienced hallucinations for years and it was likely clinicians had considered other medication in the past but with little success. There is no evidence in Ms G's CPA reviews that her medication was discussed with her or was subject to a broader review.

4.95 It would have been best practice to have considered changing Ms G's medication, possibly to a newer, second-generation antipsychotic,[70] though there is no guarantee this would have alleviated her residual symptoms. Similarly, any change in medication could have had a destabilising effect on Ms G. However, on balance, we would have expected to have seen evidence in the notes, particularly at her CPA reviews, of Ms G's medication being considered in the context of a possible change, even if it was concluded this was an inappropriate course of action.

Finding: Ms G's medication was generally monitored in line with expected practice.

Finding: Ms G's long-term prescription of temazepam was not in keeping with best practice guidance. There is no evidence in Ms G's notes that this was considered or explored in depth by the GP practice except during one practice meeting when it was concluded that reducing her prescription would likely increase her attendance to the practice. Ms G's GP notes do not document whether the clinicians considered Ms G's

[69] https://www.nice.org.uk/guidance/ng46/ifp/chapter/information-for-people-using-and-looking-after-controlled-medicines

[70] https://cks.nice.org.uk/topics/psychosis-schizophrenia/prescribing-information/available-antipsychotics/

physical health, particularly her liver function, in the context of her long-term temazepam prescription.

Finding: It would have been best practice for Ms G's long-term antipsychotic medication to have been reviewed by the ICMP Associate Specialist in the context of trying to manage her residual symptoms, even if ultimately her medication remained unchanged.

Family engagement

4.96 There is extensive guidance available about the role of families and carers in service user's care. NICE guidance on service user experience in adult mental health (2011) advises:

"Discuss with the person using mental health services if and how they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once… if the person using mental health services wants their family or carers to be involved, encourage this involvement and:

- *Negotiate between the service user and their family or carers about confidentiality and sharing of information on an ongoing basis*
- *Explain how families or carers can help support the service user and help with treatment plans*
- *Ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the service user and their family or carers."*[71]

4.97 NICE guidance on Psychosis and schizophrenia in adults (2014) recommends:

"Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user… this can be started either during the acute phase or later, including inpatient settings"[72]

4.98 The Trust CPA Policy (2016) sets out an expectation that Trust staff will actively engage with service user's carers, family and social support networks:

"*All clinicians are therefore required to identify the service user's family/support network, build relationships with those identified and include them as far as is possible in all aspects of the service user's care plan.*"

4.99 The Trust Clinical Risk Assessment and Management Policy for Mental Health and Learning Disabilities Services (2016) says families, where possible, should be involved in risk assessment and formulation. In instances where they are not involved, a clear rational should be documented in the service user's notes.

Involvement in care and care planning

Mr Q family involvement in care and care planning

4.100 We spoke to Mr Q's mother about her contact with the Trust whilst he was a service user. She told us that some contact had been made by Trust staff early in his care and that she had

[71] NICE clinical guidance [CG136]: https://www.nice.org.uk/guidance/cg136/chapter/1-Guidance

[72] NICE clinical guidance [CG178]: https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

attended a CPA review. However, she found the CPA review unhelpful because Trust staff talked over her and used a lot of medical terms.

4.101 The Trust internal investigation found that Mr Q's family (specifically his mother) was not invited to attend his CPA reviews in the last two years of his care. There is no evidence in the notes his mother was contacted either in relation to Mr Q's CPA reviews or for any other reason during this period.

4.102 Mr Q's mother told us she struggled to get hold of his care coordinators. She said she was always told his Care Coordinator was unavailable for several reasons including annual leave, training or they were off sick. Mr Q's mother told us she felt his Care Coordinator changed too often and he had no continuity of care.

4.103 Conversely, Mr Q's mother told us she felt his Bridge Support Worker was "*absolutely brilliant*" and supported Mr Q. The Support Worker continued to contact her to check she was ok after the incident.

4.104 Mr Q's mother told us she regularly saw Mr Q on Sundays, but less so on Mondays (and he tended not to stay over on Sunday nights). Trust staff were aware that Mr Q was in regular contact with his mother. That he was visiting his mother was given as a reason why he would not attend CPA reviews on a Monday. However, there is no evidence staff sought to verify this with Mr Q's mother.

4.105 There is no evidence Trust staff took steps to engage with Mr Q's mother in relation to his care. This was not in keeping with Trust policy and was a missed opportunity for staff to develop their understanding of Mr Q. In particular, we would have expected his care coordinators to have contacted Mr Q's mother in relation to:

- His regular requests for money, sometimes to buy his mother flowers and pay for holidays for her. Confirmation should have been sought that he was spending his money as advised.
- The death of his father in January 2016.
- His failure to attend CPA reviews because he was seeing her on Mondays and was therefore unable to attend. Trust staff should have confirmed this with Mr Q's mother.
- His general wellbeing, particularly following changes in the house dynamics. Mr Q's mother told us that he had repeatedly complained to her about Ms G for approximately 18 months prior to the incident and that he struggled with her erratic behaviour. This included being woken by emergency services in the middle of the night responding to Ms G's 999 calls. Mr Q's mother said he had asked his Care Coordinator that one of them be relocated (this is not documented in the notes).

4.106 Engagement with Mr Q's mother would have facilitated the development of his care plan and potentially encouraged his attendance to CPA reviews.

Ms G family involvement in care and care planning

4.107 Ms G had adult children with whom she was in contact. Her son collected her money as part of the appointeeship arrangement.

4.108 However, there is no evidence in the notes that Trust staff engaged with Ms G's family during her care other than in relation to her son collecting her money. There is evidence Ms G's family had contacted the Trust in the past to raise concerns about her care and welfare (e.g., 2013), but there is no evidence Trust staff sought to engage with the family between 2015 and 2018. The family were not invited to attend or contribute to her CPA reviews. Ms G's behaviour was at times erratic, and we would have expected the ICMP to have sought contact with her family in relation to several issues which included:

- Her decision not to move to another property in 2015.
- Her repeated contact with emergency services, particularly in 2015.
- The poor level of cleanliness in the property communal areas in June 2017.
- Her decision to not engage in the sheltered housing assessment in October 2017.
- Her wish to move to supported housing specifically for Asian residents in October 2017. The local authority had advised this was beyond its remit therefore Ms G would have needed help to progress her application.
- Complaints from her neighbours that she was bothering them. The complaints were made to the police in June 2018.

4.109 Had ICMP staff sought to engage Ms G's family it is possible they may have been able to facilitate exploration of the above issues in more depth with Ms G. We have no way of knowing whether Ms G would have engaged further with Trust services and the local authority, but nonetheless, ICMP staff should have considered involvement of Ms G's family in her care and management.

Finding: ICMP staff did not involve the families of Mr Q or Ms G in their care planning, risk assessment and risk management, despite having access to both family. This was a missed opportunity to work with both of the families to develop a better understanding of each service user, develop comprehensive care plans and risk management plans, and provide more effective support to Ms G and Mr Q.

Trust internal investigation, duty of candour and being open

4.110 Duty of candour (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20)[73] sets out the legal duties of healthcare providers to inform individuals affected by an unexpected or unintended incident which has caused harm about what has happened and why. It includes the families of service users (who were regarded as the 'relevant person').

4.111 Following the death of Ms G and the arrest of Mr Q, the Trust, in accordance with the above regulation, would be expected to have contacted both service user's families. The Trust Incident Management Policy (2018) reiterates that duty of candour should be implemented in response to a serious incident and the service user and/or family should be offered a meeting.

4.112 The Trust has a Duty of Candour and Being Open Policy (2017)[74] which sets out the statutory requirements of duty of candour. The policy details 10 principles of being open which include the principles of acknowledgement, truthfulness and apology.

Mr Q's family

4.113 The Trust internal investigation report states the Chair of the panel and a panel member contacted Mr Q's mother to ask if she would like to be involved in the investigation. The report says she declined due to personal reasons but raised two concerns which are set out and commented on in the report. The investigation panel members told us they thought the panel Chair (who has since left the Trust) had spoken to Mr Q's mother but were unable to confirm this, and whether the draft report had been shared with her.

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[73] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

[74] The policy was scheduled for review in May 2019.

4.114 Mr Q's mother told us that the Trust Chief Executive contacted her twice shortly after the incident in 2018 and advised her that an internal investigation would be undertaken. However, she said was not contacted by the Trust investigators and she did not receive a copy of the final report. We have not seen evidence of any written correspondence from the Trust to Mr Q's mother about the internal investigation findings.

Ms G's family

4.115 The Trust sent Ms G's family a Duty of Candour letter on 23 July 2018. The Trust internal investigation report says that initial contact was made with Ms G's family, but they declined to be involved in the investigation. The internal investigation Chair told us that the family had reservations about her chairing the investigation because she worked in the ICMP and they felt she was too close to the case. The Trust offered a panel member to act as a liaison with the family, but the family declined. The family confirmed that they considered the Trust internal investigation to lack impartiality.

4.116 We have not seen any other written correspondence to Ms G's family. We are aware that they were given a copy of the report, however, we have been unable to establish when.

4.117 The Trust has since revised its investigation model, utilising a central team, which mitigates the risk of services investigating themselves. The internal investigation Chair told us that the investigation was probably undertaken too soon after Ms G's death, though we note the requirements of the Serious Incident Framework that an investigation be completed within 60 days of the incident.

4.118 Ms G's family submitted several points/questions to this review via NHS England. However, some pertained to Ms G's care in 2013, and were therefore out of scope for this review (except points that could be addressed by the extended terms of reference covering Ms G's care in 2013. Please refer to section 6, Ms G's care and treatment in 2013, for further information). We specify below their questions pertaining to the period between 2015 and 2018.

"*A reference appears in the existing* [internal] *Oxleas Report into the death of* [Ms G]*. The CCO documents 'a risk of harm from other (sic) due to her current presentation' dated 6 June 2018, some 17 days before the incident. The meaning and import of this reference is at present unclear.*

There is reference in the above report to an overall inadequacy in the deceased's care plan and risk assessment. The family believe that this aspect of the care and treatment of the deceased should be scrutinised in full with especial reference to the potential risk presented to the deceased by others, and any specific risk recorded or suspected".

4.119 We have undertaken a review of Ms G's care plan, risk assessment and risk management earlier in the main body of the report.

"*The family are seeking a specific response to their concern as to why the deceased's reference to sheltered housing was not progressed in 2017*".

4.120 We have provided detail pertaining to Ms G's sheltered housing assessment in October 2017 in the main body of the report. Please refer to 'Royal Borough of Greenwich – housing' for more information (paragraphs 5.229-5.325).

"*The specific relevance of concerns expressed in the* [internal] *Report overstated deficiencies in the care and treatment of the perpetrator* [Mr Q]*, to the monitoring and management of his relations with the deceased whilst there were only the two of them resident at the address*".

4.121 We discuss the housing arrangements for Ms G and Mr Q in under 'Royal Borough of Greenwich – housing' (paragraphs 5.229-5.325). This considers the appropriateness of Ms

G's placement at the property including when the numbers within the house began to reduce in 2017, culminating in Ms G and Mr Q being the only residents.

Finding: The Trust implemented duty of candour in response to the death of Ms G, contacting her family and that of Mr Q. However, we have not seen evidence either family were provided with written information about the internal investigation process, other than when referenced in the Duty of Candour letter to Ms G's family.

Finding: The families of Mr Q and Ms G had limited involvement in the Trust internal investigations. The family of Mr Q did not receive the final investigation report.

Finding: Ms G's family declined to be involved in the Trust internal investigation because they did not consider the internal investigation process had an appropriate level of impartiality from the ICMP.

ICMP West

4.122 We have identified gaps in practice in relation to care planning, risk assessment and management. However, these cannot be considered as stand-alone issues, but rather must be taken in the context of the broader ICMP and the demands on the team.

4.123 In 2015 the ICMP service was reconfigured from three Psychosis teams, and an Assertive Outreach team, to two (East and West) Psychosis teams. Assertive Outreach was absorbed into the two Psychosis teams. The medical component for the team reduced from eight to four doctors.

4.124 The Trust ICMP Operational Policy (2016)[75] describes the pathway as:

"*… a flexible service to all adults within the psychosis clusters who currently require secondary community mental health care in the locality.*

The service is comprised of two functions:

1. Intensive Case Management (ICM) involving a multidisciplinary team approach under CPA arrangements (i.e., 'step up').

2. A 'step down' function: This phase of care is focused on developing self-management skills, recovery planning and social inclusion. It results in a Well Being Plan which supports future transfer back to Primary Care".

4.125 The model is intended that service users can move between the two functions according to their needs.

4.126 ICMP West has approximately 500 patients on its caseload, of whom around 300 are on CPA. The remaining 200 patients are non-CPA, of which roughly 100 are primarily on the ICMP caseload for medication management (administration of depot and clozapine). We discuss this further under 'Medicines management' (paragraphs 4.77-4.95).

[75] The policy is listed as 'under review'.

Zoning

4.127 We were told approximately 80% of CPA patients were in the green zone, 5% in amber and 15% in red. Details of the Trust zoning criteria as set out in its Zoning Policy (undated) is detailed below.

Table 3: Trust zoning criteria

Zone	Red	Amber	Green
Criteria	• High level of risk to self • High level of risk to others • Signs or symptoms that indicate relapse • Pregnant or children being part of delusional system or unable to put needs of children first • Require immediate action to prevent hospital admission • Assessment under the Mental Health Act • Not engaging/out of contact with service • Current inpatient • Just been discharged from hospital with high level of risk or need	• Symptoms and predisposing factors to indicate pending relapse • Significant risk factors and approaching a crisis • Mentally unwell • Fluctuating level of risk • Significant social dysfunction • Active intervention required • Just been discharged from hospital medium level of risk or need • Acute physical health problems adversely effecting mental health and causing destabilisation of condition • Poor engagement	• Working collaboratively with the team in achieving care plan objectives and outcomes • Monitoring of care plan and pre-agreed interventions only • Practical or targeted intervention required • Maintaining supportive therapeutic alliance • Stable with few current concerns/risks at present • Preparing to move on from the team

4.128 Zoning meetings are held twice a week[76] to discuss those in the red or amber zone.

Service demands

4.129 The ICMP West staff we interviewed indicated it was difficult to provide the quality of care they aspired to due to the demands on the service. Care Coordinator caseloads were described as high, with staff each managing between 25 and 30 cases, and in some instances more (e.g., 34). The ICMP was described as "*over capacity*" with high levels of staff sickness. The ICMP Consultant Psychiatrist told us that staff retention was a challenge and that at the time of writing roughly half of posts were unfilled. He echoed the general view of staff we spoke to that staff sickness was an issue. We were told that at the time of the incident in 2018, the team was routinely reliant on agency staff because it could not fill substantive posts; something which continues to be a problem in present day.

4.130 We were told a key implication of agency use was the negative impact this had on care coordinators building up relationships with their caseload; the frequent turnover of agency staff means it is difficult for a trusting relationship to be developed.

4.131 Care Coordinator 4 was an agency nurse. He told us he had a caseload of 30 patients, for which he was given a target of contacting three to four patients a day, though this could be by phone or a depot appointment. He told us substantive staff were provided with iPads to document their contacts in the community, but agency staff were not given these, and he was

[76] The 2016 ICMP Operational Policy says zoning meetings should occur three times a week, though we note the policy is 'under review'.

expected to return to the main office to document contacts which took more time. He told us the demands of the role meant that this could not always be done on the same day, but sometimes took place a couple of days later. We were unable to substantiate whether agency staff are given contact targets. Trust staff we spoke with did not know of such targets.

4.132 We held a focus group with five ICMP staff who told us role of the ICMP was not clearly defined and they assumed a lot of delegated responsibility from the local authority.[77] This included monitoring and reviewing residential placements.

4.133 The focus group told us it was difficult to discharge patients from the team caseload because of factors like depot medication. We were told it was felt the demands on the team were unlikely to change when considering the growing local population.

4.134 The Trust provided a Community Mental Health team (CMHT) action plan that was reviewed in July 2020. This is outside of the scope of our review (2015–2018), but we note the identified areas for improvement (some of which were documented as completed) included a number related to care coordination:

- The ability of care coordinators to manage a safeguarding alert.
- Care coordinators not regularly undertaking visits to see service users.
- Staff turnover leading to periods when service users do not have a Care Coordinator.
- Poor attendance at training.
- Variation in quality of care coordination.

Finding: The ICMP has approximately 100 patients on its caseload that cannot be considered for discharge because of their medication needs (e.g., depot and clozapine).

Finding: The ICMP caseload, coupled with high sickness levels and vacancies mean the team is under immense pressure to provide care, which staff find difficult to deliver to the expected standard.

Finding: Care coordination continues to be a challenge for the Trust in terms of quality and staff turnover.

We have written a recommendation about working with primary care, please refer to the main recommendations for the detail.

Ms G's mental capacity

4.135 Guidance regarding the assessment of capacity is provided in the Mental Capacity Act 2005 Code of Practice 2007[78] which gives information and guidance about how the Act works in practice.

4.136 People may lack capacity to make some decisions for themselves but will have capacity to make other decisions. It is also the case that a person who lacks capacity to make a decision for themselves at a certain time may be able to make that decision at a later date. A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.

4.137 When assessing capacity to make more complex or serious decisions there may be a need for a more thorough assessment (perhaps by involving a doctor or other professional expert).

[77] RBG social workers are provided through a block contract to the Trust.

[78] Mental Capacity Act and Code of Practice. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Significant, one-off decisions (such as moving house) will require different considerations from day-to-day decisions about a person's care and welfare. However, the same general principals should apply to each decision.

4.138 Capacity should be assessed when:

- A person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision.
- Somebody else says they are concerned about the person's capacity.
- It has already been shown that they lack capacity to make other decisions in their life.

4.139 It is good practice for professionals to carry out a proper assessment of a person's capacity to make a particular decision and to record the findings in the relevant professional record.

4.140 An assessment of a person's capacity to consent or agree to the provision of services will be part of the care planning process and should be included in the relevant documentation. It should follow the process specified in section 2 and 3 of the MCA (2005).[79] [80]

4.141 Trust staff identified in 2014 and 2015 that Ms G's accommodation was not appropriate for her needs. However, Ms G refused to engage in discussions about moving. There is one recorded attempt to assess her capacity in December 2014. Ms G's capacity was discussed at her CPA review on 6 January 2015. The Specialty Doctor recorded in the notes that Ms G "*appeared*" to have capacity to choose where she lived but this might need to be reviewed in the future if her mental state changed. We found no evidence of this being supported by a mental capacity assessment.

4.142 Ms G refused to engage in both the assessment and discussion, and no further attempts were made to assess her capacity.

4.143 Ms G's mental capacity was not formally assessed between 2015 and 2018 despite sufficient evidence of concerns about her capacity during this time to indicate an assessment might have been required. For example:

- The RBG Financial Protection and Appointee team were Ms G's appointees, and whilst it is recognised that all capacity assessments are decision specific, her inability to manage her finances may have indicated that she lacked capacity to make other significant decisions.
- Ms G made numerous calls to emergency services about her accommodation and regarding other residents between 2015 and 2018. Police officers and paramedics reported on several occasions that Ms G appeared to be "*confused*". A number of these concerns were shared with the Trust.
- Ms G regularly attended A&E and on at least one occasion, 26 September 2017, concerns regarding her mental state and safety were shared with the Trust.
- The Sheltered Housing Officer identified that Ms G could not compete an "*effective assessment*" for sheltered accommodation (19 October 2017).
- Care Coordinator 4 recorded on 6 November 2017 that "[Ms G] *wasn't able to make meaningful conversation with me. CCO couldn't understand what* [Ms G] *was saying*".

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[79] Section 2 MCA (2005): https://www.legislation.gov.uk/ukpga/2005/9/section/2

[80] Section 3 MCA (2005): https://www.legislation.gov.uk/ukpga/2005/9/section/3

4.144 It is our view that members of the ICMP placed too much reliance on the January 2015 assessment that Ms G had capacity despite a formal assessment not taking place.

4.145 If the team had concerns about Ms G's capacity in relation to her decision to remain at the property, a formal assessment of capacity should have been undertaken and documented.

4.146 Consequently, it appears that Ms G's refusals to engage in discussions about her property were considered in the context that she had full capacity to make these decisions.

4.147 Best practice would indicate that Ms G should have had a full mental capacity assessment regarding her accommodation, and this should have been recorded on RiO.

4.148 Given Ms G's capacity was not formally assessed regarding a move, it is not possible to comment on whether she had full capacity to engage in the process and make decisions about her accommodation. However, it is clear that the efforts to engage Ms G were limited and she was not afforded "*all practicable help*" to make this decision.

Finding: Ms G's capacity was not subject to formal assessment or review by ICMP staff between 2015 and 2018. There were several occasions when it would have been expected practice for professionals to have undertaken mental capacity assessments in response to changes in her behaviour and incidents, in particular her decision to not move house in 2015 despite the property being deemed unsuitable for her needs.

5 Other agencies

5.1 This section reviews the input from other agencies to Ms G and Mr Q.

5.2 The agencies concerned are:

- Metropolitan Police Service (MPS)
- London Ambulance Service (LAS)
- Lewisham and Greenwich NHS Trust (acute services)
- GP services/primary care
- Bridge Support
- Royal Borough of Greenwich (RBG) – Housing and Appointeeship.

Metropolitan Police Service (MPS)

5.3 Mr Q was historically known to MPS, but he had not had contact with them for several years before the incident in June 2018. Consequently, the MPS did not submit an IMR and had no comment to make pertaining to Mr Q, as part of this review. The MPS submitted an IMR for Ms G.

5.4 Ms G was known to the MPS during the time frame of this review. Ms G made 126 calls to the MPS between January 2015 and June 2018. In some instances, an interpreter was available to support the call. Please refer to the table below for detail of how the police responded to the 126 calls.

Table 4: Detail of MPS response to Ms G calls

Sum of Frequency	**Action Taken**		
Reason For Call	**MERLIN ACN report**	**NFA**	**Total**
Closed with NFA		**73**	**73**
No police attendance		73	73
Direct allegation of crime	**22**	**26**	**48**
No police attendance		14	14
Police attendance	22[81]	12	34
Welfare check	**2**	**3**	**5**
Police attendance	2	3	5
Total	**23**	**102**	**126**

[81] One Crime Report Information System (CRIS) report was also submitted alongside a MERLIN ACN report

5.5 The nature of Ms G's calls to the MPS varied. As noted above, there were 48 occasions in which she made allegations of assault (14 of which named people), in response to which the MPS attended her address 34 times. However, in most instances when the MPS did attend, Ms G could not remember why she had either called the police or asked for medical assistance. In a small number of instances, Ms G would repeat her allegation of assault, but the attending officers regarded these allegations as delusional and did not record a crime report. One Crime Report Information System (CRIS) report was created in response to the 48 allegations made by Ms G.

5.6 Ms G did not make specific allegations in her other 78 calls to the MPS. Instead, she either asked for medical assistance, called and hung up, or was documented in the notes to be at times "*rambling*" incoherently. The MPS closed 73 of the calls without further action. The MPS undertook welfare checks for the remaining five calls, two of which resulted in MERLIN reports.

MERLIN

5.7 MERLIN reports are used to highlight concerns to the appropriate local authority when attending officers have concerns about people who may be adults at risk. This could be as a victim, a witness, a suspect or a member of the public. Officers have an operational toolkit[82] – the vulnerability assessment framework (VAF) – that guides assessment in five domain areas. A MERLIN report is indicated if there are concerns in three or more areas.

5.8 MPS guidance introduced in 2013 advised a MERLIN report must be created for vulnerable adults who come to the notice of the police (ACN). The guidance (and current toolkit) lists five criteria to consider when assessing an individual's vulnerability:

- Physical
- Emotional/psychological
- Sexual
- Acts of omission/neglect
- Financial

5.9 Officers must also consider whether there is a risk of harm to the individual or another person.

5.10 MERLIN is the mechanism by which MPS staff should identify someone who is vulnerable and refer them to partner agencies.

5.11 In total, 24 MERLIN reports were submitted to RBG between 2015 and 2018.

5.12 Ms G made varying numbers of call to the MPS/999 between 2015 and 2018. We provide a breakdown of the numbers by year in the table overleaf.

[82] Operational toolkit: https://www.londonscb.gov.uk/wp-content/uploads/2016/04/MASH-Research-Tool-Kit-V-9.pdf

Table 5: Calls made by Ms G to the MPS 2015 - 2018

Year	Call to MPS/999	Number of MERLIN reports
2015	61	9
2016	35	9
2017	25	3
2018	5	3
Total	**126**	**24**

5.13 Ms G made five calls to the MPS in 2018. She made one in January and four in March 2018. In her last call to the MPS, Ms G alleged she had been hit with a hammer by two people, one of whom she named as Mr Q (first name only). The interpreter supporting the call advised that Ms G sounded confused. MPS staff decided the police were not needed, rather it was a matter for the LAS, who were contacted.

MPS policy

Frequent callers to MPS

5.14 The MPS has two policies to address repeat calling but these were not in place at the time of Ms G's contact:

- Service Delivery Manager (SDM) BT Blocking guidance (2018)
- Hate Crime Reporting

5.15 We were advised that the number of calls Ms G made between 2015 and 2018 would not meet the threshold for her to be considered a frequent caller under current policy. The guidance does not give a specific number of calls to constitute a frequent caller but says as assessment should be based on the frequency, persistence and content of calls. The guidance gives examples which include 25 times in the past hour and 116 times in the last month. Ms G's calls were not on this scale.

5.16 The MPS does not have a policy that covers callers who have mental health problems. We were advised that the MPS assess callers on an individual call basis and since November 2018 a THRIVE+ assessment[83] is undertaken. THRIVE+ is the MPS risk assessment model. The MPS has a duty of care to respond to callers identified as vulnerable, and where appropriate, refer them via the MERLIN system.

Vulnerable Adults Policy

5.17 There is extensive guidance available to MPS staff about engaging with vulnerable adults. The MPS Vulnerability and Adults at Risk Policy (2016) provides "*... guidelines and accountability for the identification, recording, protection of and investigation of vulnerability and adults at risk*". The policy directs staff to use the VAF to assess whether individuals may be vulnerable or at risk.

5.18 The VAF sets out five factors to consider: appearance, behaviour, communication capacity, danger and environment circumstances; and asks officers/staff to consider whether there are three or more of these factors which are unusual or cause for concern.

[83] THRIVE+ is an assessment tool designed to help call operators identify how best to respond to a victim; Threat, Harm, Risk, Investigation, Vulnerability, Engagement, + prevention and intervention.

Reporting a crime

5.19 Home Office National Crime Recording Standards (NCRS) advise allegations in which an individual is named should be recorded as a crime.

MPS response to Ms G

5.20 The MPS IMR described the police response to Ms G's allegations as inconsistent, noting significant variation in the way individual officers dealt with Ms G's concerns and identified her needs and vulnerabilities.

5.21 Ms G made numerous calls to the MPS between 2015 and 2018 but she did not meet the threshold to be considered a frequent caller (we were advised that the volume of calls made by Ms G would be considered low in comparison to other callers).

Crime Report Information System (CRIS)

5.22 Only one of Ms G's allegations was recorded as a crime report (on 13 May 2015). Ms G reported to police that "*two males went into her room and stole £15. She saw them leaving and then noticed the money was missing*".

5.23 The CRIS was later closed, the outcome was recorded as "*matter resolved undetected*" and the outcome report was sent to RBG. The independent review (IMR V6.0) completed by MPS indicates that there were other occasions when Ms G repeated her allegations and a CRIS report would have been indicated. We cannot say that this would have led to further investigations of these allegations as crimes or resulted in a review of Ms G's accommodation or care plans.

No Further Action (NFA)

5.24 The MPS closed 73 of the calls without further action.

5.25 There were instances when Ms G made allegations but police officers were not allocated. On 24 March 2015, the call handler linked the call to previous episodes and determined NFA was required. On 28 June 2016 the call handler relied on the interpreter's view that Ms G was a frequent caller and that the nature of her emergency was unclear, and the operator closed the call NFA.

5.26 There were instances when it would have been helpful to assign a unit to Ms G's address to gain further information about her allegation rather than for the operator to close the call. For example, Ms G called the MPS on 24 March 2015, alleging that a man, whom she named, was bothering her. There were no units available, and the operator linked Ms G's call to previous calls and closed it. Similarly, Ms G called the MPS on 28 June 2016 to report "*Uncle* [redacted – same name as that given on 24 March 2015] *and* [Mr Q's first name]" were beating her. The interpreter facilitating the call told the police operator that Ms G was a frequent caller, and the nature of her emergency was unclear; the operator closed the call.

MERLIN (ACN)

5.27 In total 24 MERLIN ACN reports were generated during 2015–2018 and passed to RBG. It is unclear why officers did not generate a MERLIN ACN following each attendance. There were 16 occasions, predominantly in 2015 and 2016, when the police attended Ms G's address – which housed vulnerable adults – but did not complete a MERLIN report to share with other agencies. It is MPS policy that a MERLIN report should be generated in any instance where an individual is considered vulnerable; officers should have completed a MERLIN report after each attendance to Ms G's address because it housed vulnerable adults.

5.28 The independent management review undertaken by MPS recognised this inconsistency in approach, highlighting that the use of MERLIN ACN is good practice in information sharing when attending a place housing vulnerable adults or adults at risk of abuse.

5.29 We were unable to review any MERLIN ACN reports due to the MPS system purging old records. We were able to see summaries of the reports as stored in electronic case records or on the MPS IMR. The reports generally shared information regarding Ms G as a vulnerable adult. We noted four instances when officers also identified a need for a review of care and one instance where the officers identified and shared information about Ms G not taking her medication. In one instance the MERLIN ACN report summary indicates that the officers concerned took the time to consider all elements of the VAF and recorded their findings in each area.

5.30 The MERLIN ACN reports were shared with RBG as the responsible local authority who passed them to the Trust to complete welfare and/or safeguarding activity on their behalf. The IMR recognises that there were missed opportunities to share information and concerns when officers failed to record reports on the MERLIN ACN system. The IMR makes recommendations regarding an audit of MERLIN (dip testing) to ensure officers are completing the reports appropriately and at appropriate times.

5.31 The MPS IMR identified examples of good practice undertaken by individual officers seeking to identify Ms G's needs and vulnerabilities. For example, Ms G called the MPS on 24 November 2016 to report she was being mistreated by her carers. Officers attended Ms G's address, but she denied she had made the call. The MPS submitted a MERLIN report highlighting that Ms G's care plan did not seem appropriate and needed to be reviewed. Identifying and communicating Ms G's needs to other agencies was good practice.

Multi-Agency Safeguarding Hub (MASH)[84]

5.32 The ability to share information in a timely and effective manner to facilitate joint decision-making is a key component of adult safeguarding. Multi-agency safeguarding hubs are designed to facilitate information sharing and decision-making. Hubs are often co-located, and members include staff from the local authority, health agencies and the police. At the time of the incident, and to date, there was not an adult MASH; however, there is a children's MASH in operation.

5.33 During 2015–18 MPS were members of a children's MASH where adult MERLIN ACN reports were shared. Representatives at this children's MASH told us that during this time frame there was a system of review and governance for all MERLIN ACN reports generated. They also informed us that there was a clear escalation system when individuals had multiple contacts with agencies.

5.34 This process was confirmed within the MPS IMR:

"*The police MASH team have throughout this review carried out full 5 year background checks, documented them, and appropriately shared information with the adult social care team. In addition recent changes to the MERLIN system now produce the document in the colour of their risk grading (Blue/Green/Amber/Red), to further highlight potential concerns.*"

5.35 The MPS chronology specifically identifies that on one occasion (24 November 2016) the concerns were shared with the MASH who reviewed the case, highlighted the repeated contacts and passed the information to RBG with a recommendation that the care provider (identified as ARK) was also informed. We found no further information regarding this and no evidence that the request was followed up.

[84] Multi-agency Safeguarding Hub: https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/collaborative-working-and-partnership/multi-agency-safeguarding-hubs.asp

Changes in practice

5.36 The MPS IMR advised there have been a number of changes since the incident in June 2018. The Metropolitan Police's Command and Control (MetCC) structure has evolved to service the new Business Command Unit (BCU) model that came into effect at the end of 2018. Safeguarding is now under the strategic leadership of a Detective Superintendent, including the investigation and support functions. A Crises Assessment team, composed of a Police Constable and Mental Health Nurse is now available to assist officers with South East (SE) BCU related concerns.

5.37 There was also a roll out of safeguarding awareness training and a campaign in 2018. Attending officers now have tablets and are able to complete MERLIN reports on site which are then transferred to the CRIS – a quicker response than during Ms G's case.

5.38 We were told that THRIVE+ was successfully introduced to MetCC in 2018 and has since been rolled out across the MPS.

5.39 In view of the changes in MPS practice, the MPS IMR did not make recommendations pertaining to individual practice, rather recommendations centred on using the circumstances of Ms G's case to remind staff of their roles and responsibilities in relation to compliance with NCRS and completing MERLIN reports. It was recommended that the MetCC Senior Leadership team undertake dip sampling in relation to the management of calls from vulnerable individuals and MERLIN reports, to ensure both are managed and completed in line with MPS policy.

5.40 The changes in MPS reporting concerns practice may help the Trust to identify patterns of reporting and/or issues pertaining to specific service users.

Finding: Ms G regularly contacted the MPS between 2015 and 2018. There was no Frequent Caller Policy in place at the time of Ms G's contact, but the volume of her calls would not meet the thresholds of the current MPS Frequent Caller Policy.

Finding: The MPS IMR identified gaps in its management and engagement with Ms G, but specified a number of changes in structure and process which it is anticipated will serve to mitigate similar omissions in the future.

MPS safeguarding of Ms G

5.41 We have detailed above the MPS response to Ms G's contact. We consider this below in the context of safeguarding practice.

Good practice

5.42 On 24 occasions police officers shared their concerns regarding Ms G with RBG. On at least four of these occasions, officers considered Ms G's wider care needs and made recommendations that a review of her care was required, and on two occasions noted that her accommodation may have been inappropriate. On one other occasion an officer identified that Ms G was non-compliant with her diabetes medication and shared this information appropriately.

5.43 During 2016 Ms G had repeated contact with the police and it appears this was appropriately referred for review to the MASH. The MASH appropriately referred this on to RBG.

Concerns

5.44 The IMR published by the MPS indicated inconsistencies in how they responded to Ms G. This inconsistency ran throughout her contact with MPS. The IMR makes recommendations regarding reinforcing adult safeguarding awareness and policy across the force. We endorse these recommendations.

5.45 We did not see the MERLIN ACN reports. It would have been useful to review these to determine whether the VAF had been applied in each case. The IMR recognised the inconsistencies in reporting and also in recording the MERLIN ACN reports. We endorse the recommendation of a regular review (dip test) of these MERLIN ACN reports.

5.46 We have been informed that the Safeguarding Adult Board (SAB) has also requested a review of the system response to MERLIN ACN reports. We would also endorse a wider system review of how MERLIN ACN reports are responded to.

5.47 There was one instance of MASH reviewing Ms G's repeated contact with MPS. However, we are unclear whether Mental Health Services are full partners in the hub and would recommend that this position is reviewed.

5.48 Our recommendations below reflect those of the MPS IMR.

Finding: There are examples of the MPS appropriately considering Ms G's safeguarding when responding to call outs and acting accordingly. This included occasions when they identified her mental health should be subject to review, that she might not be compliant with medication, and that her accommodation was inappropriate. On one occasion the MPS made an appropriate referral for review by the MASH which was subsequently referred to RBG.

Finding: The MPS IMR identified inconsistencies in its approach to Ms G's contact and that not all contacts were managed appropriately or in keeping with expected practice.

Post-incident

5.49 The terms of reference for the review include consideration of the MPS' engagement with the families of Mr Q and Ms G after the incident in June 2018.

5.50 The MPS advised that Ms G's family – as the family of the victim – would have been offered a Family Liaison Officer (FLO) as standard practice. We were advised similar support would not be offered to a suspect's family (e.g., Mr Q's family) who would usually only be contacted for background information.

5.51 We contacted the FLO who liaised with Ms G's family. The FLO advised they were in contact and provided support to Ms G's family throughout the criminal investigation, after which they referred Ms G's family to the Homicide Service Victim Support (HSVS). The HSVS in turn signposted Ms G's family to Hundred Families, an organisation that works with families who have been impacted by mental health homicides.[85]

5.52 The FLO advised that the family accepted their support and that of the HSVS. The FLO also provided the details of the Trust Incident Lead with whom they also had contact.

5.53 We asked Ms G's family if they had any comment about the support provided by the MPS. They told us most of their support and contact was from their FLO and Victim Support, whom they spoke positively about.

Finding: The MPS provided support to Ms G's family during the criminal investigation and trial. They provided the family with details of additional support agencies.

Finding: In keeping with MPS practice, the MPS did not engage with Mr Q's family beyond investigative purposes. This is in keeping with MPS practice.

[85] Hundred Families: http://www.hundredfamilies.org/

London Ambulance Service (LAS)

5.54 Mr Q was not known to LAS. Consequently, the LAS did not submit an IMR and had no comment to make pertaining to Mr Q as part of this review.

5.55 Ms G contacted LAS 44 times between January 2015 and June 2018. This contact was either made directly by phone, or as a result of a referral from another service (e.g., MPS).

5.56 The majority of these contacts, 35 – including 32 phone calls made by Ms G – were in 2015. Ms G made four calls in 2016, three in 2017, and two in 2018.

5.57 An interpreter was available on some occasions to support the calls via LanguageLine Solutions.[86]

Calls to LAS and responses

5.58 In 2015 the calls made by Ms G were predominantly for back pain, abdominal pain and allegations of assault. LAS also referred to calls for "*mental health episodes*" but it is not clear what this meant. Of the 32 calls Ms G made in 2015, she was taken to Queen Elizabeth Hospital (QEH) by ambulance on 18 occasions, and to University Hospital Lewisham (UHL) on one occasion. She was not conveyed on 13 occasions, for various reasons including: she took herself to A&E, police cancellation, conveyance was not needed, she denied requesting an ambulance, she was referred to NHS 111, ambulance was not needed, or Ms G had gone out and declined all aid.

5.59 Ms G made four calls in 2016.

5.60 On 8 January 2016 a 999 call was made reporting that Ms G had stitches in her leg from an operation and they were hurting, and that she suffered with kidney problems. She was in bed when the ambulance arrived and complained of pain in her lower leg, but no other symptoms. Her spoken English was difficult to understand but it was understood she had previously had an operation and subsequently had pain in her leg. She was conveyed to A&E at UHL.

5.61 On 19 and 20 April 2016 two 999 calls were made:

- For stitches in her foot. Advice was given to call NHS 111 for advice, and it was deemed an ambulance was not necessary.
- A 999 call for stomach and back pain. No ambulance was sent after contact between MPS and LAS, and Ms G was advised to call NHS 111.

5.62 Ms G made a 999 call on 20 July 2016, in which she reported severe back, chest and stomach pain and painful stitches in her leg. On examination by LAS staff she was found to have very high blood glucose levels and pain in her abdomen and lower back. She was conveyed to A&E at QEH.

5.63 Three calls were made about Ms G in 2017 (e.g., the police requested an ambulance for Ms G on 2 September 2017).

5.64 On 13 May 2017 Ms G called 999 and reported bleeding, but she also said it had stopped. A LanguageLine interpreter was engaged but Ms G kept hanging up. LAS called back and Ms G said an ambulance was no longer required.

5.65 On 20 May 2017 a GP ring back was requested after an NHS 111 call.

[86] LanguageLine Solutions is a telephone interpreting service which is available 24 hours a day, 365 days a year. https://www.languageline.com/uk/interpretation/telephone-interpretation

5.66 On 2 September 2017 a 999 call was received from MPS. It was reported that they had concerns for Ms G who would not give them straight answers apart from she had a broken backside and wanted an ambulance, she would not answer any other questions, and kept clearing the line. An ambulance was dispatched, on their arrival the ambulance staff documented that Ms G had chronic back and leg pain. Ms G met them at the door, fully alert. On examination she looked alert, was moving well, but her blood pressure was elevated and her blood glucose high. Following the ambulance staff assessment it was deemed that conveyance to hospital was not appropriate. The ambulance staff made an out-of-hours GP referral for the raised blood pressure. The GP confirmed a follow up on the Monday. Ms G was left at home with the advice to ring back if her condition worsened.

5.67 In 2018 two calls were made to LAS.

5.68 The police called the LAS on 3 March 2018, reporting that Ms G had stomach pains. LAS attended Ms G's address. Upon arrival, the ambulance staff documented that Ms G told them another resident had called the police on her behalf because she was in pain. The LAS staff documented in the notes that Ms G's pain appeared to be an ongoing issue, as opposed to new. Ms G was reportedly difficult to engage, ignoring questions and speaking in a mix of Hindi and English, but she made it clear to them that she did not want to go to hospital.

5.69 Following the LAS staff assessment it was deemed that conveyance to hospital was not needed. LAS staff contacted NHS 111 who confirmed they would pass on the information to her GP. Ms G was left at home with the advice to ring NHS 111 if she experienced any more pain that day.

5.70 On 3 April 2018 a 999 call was made by a GP requesting an ambulance attend Ms G's address.[87] It was reported that she was confused, had increased lethargy and abdominal pain. LAS staff documented that Ms G initially refused hospital. She was well known to the GP surgery and visited often, this day she was seen by a GP who was concerned that she had deteriorated quite rapidly. She was sleeping more, was lethargic and very confused at times. All clinical observations were within normal parameters. Following the LAS staff assessment and as per the GP's request Ms G was taken to QEH where a handover of care was provided to the hospital staff.

LAS policy

5.71 The LAS has a frequent caller unit, divided into North and South London. The South London unit manages information from across the boroughs, identifying people who call the LAS frequently. In early 2021 there were between 600 and 700 people calling frequently.

5.72 The Policy & Procedure of the Management of Frequent and Vexatious Callers (v2) (2010) defines a frequent caller as:

"… an individual or establishment to which emergency calls have been placed regularly for 3 months or more, and where the quantity of calls is considered to have a significant impact on LAS resources."

5.73 The policy goes on to say the definition is not definitive, and individual circumstances should be taken into consideration. We were advised that the number of calls Ms G made after 2015 would not meet the threshold for her to be considered a frequent caller.

5.74 The LAS approach to frequent callers is to request that a multi-agency meeting is called to discuss intervention and action plans. The LAS does not host these meetings, but often prompts GPs or other health services to arrange and plan. Individuals may have an agreed

[87] The GP had spoken to an Ambulatory Care Consultant who advised that Ms G should attend A&E.

multi-agency plan developed, which would then be used as a guiding brief if an ambulance is called. Plans are developed using the framework of Coordinate My Care (CMC).[88]

5.75 CMC was originally used for long-term physical health conditions, but usage for long-term mental health conditions is gradually becoming more common.

5.76 There is a Mental Health team within the LAS, which is funded to provide direct mental health support to the control room and in a response car. There is a project called Serenity Integrated Mentoring (SIM)[89] which has developed a model of working across emergency services in London[90] to provide intensive support for vulnerable and complex individuals.

5.77 LAS has also been a partner in specific projects focussing on particular areas of need such as reducing ED attendances for frequent attenders with mental health issues, and local ED Forums are also attended by mental health Trusts.

LAS response to Ms G

5.78 The LAS IMR noted that efforts were made to assist communication with Ms G through LanguageLine and consideration was given to Ms G's needs to access emergency services and English not being her first language.

5.79 Where appropriate, in order to manage her presenting needs, the emergency call centre and/or ambulance staff either signposted to other services, such as NHS 111 or the GP, or conveyed her to hospital for further assessment.

5.80 Although the IMR noted that there were at least two occasions when a safeguarding referral should have been made, there were no recommendations.

Changes since the incident

5.81 LAS told us that there is a new governance and training post in place, and there is a plan to focus on how they learn from serious incidents (SIs) and incidents. They will also carry out audits of referrals.

5.82 LAS staff now have access to a tablet on site to make electronic records and referrals. Crew can also check electronically to see if the person has a CMC in place.

5.83 There are also safeguarding specialists in each sector who review SIs, incidents and good practice, and there is now a structure to enable feedback and reflection with teams and the staff involved.

5.84 LAS has a governance structure in place for safeguarding, with a Safeguarding Assurance Group (SAG) that meets quarterly to monitor the Trust's safeguarding activity and provide assurance on safeguarding practice.

5.85 SAG reports to the Quality Oversight Group (QOG) bimonthly, providing assurance and raising issues for escalation to the Quality Assurance Committee (QAC). QAC is the Trust assurance committee that feeds into the Trust Board. QAC is chaired by a Non-Executive Director. LAS Safeguarding reports to commissioners via the NHS North West London CCG Designated Nurse/professionals and the Clinical Quality Review Group.

5.86 These reports contain safeguarding assurance for all areas of the Trust.

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[88] Coordinate My Care is an NHS service that coordinates urgent care for patients. It starts with the patients filling in an online advance care planning questionnaire called MyCMC. https://www.coordinatemycare.co.uk/

[89] Serenity Integrated Mentoring: https://healthinnovationnetwork.com/projects/nhs-innovation-accelerator-serenity-integrated-mentoring-sim-model/

[90] https://healthinnovationnetwork.com/wp-content/uploads/2020/12/HIN-SIM-2pp-Summary-WEB-1.pdf

Finding: Ms G contacted the LAS sporadically between 2015 and 2018. She did not call frequently after 2015, though there was ongoing information sharing between LAS and MPS about their individual experiences of contact with her.

Finding: The LAS IMR identified some gaps in identifying vulnerabilities and making appropriate referrals for Ms G. We have been provided with evidence of changes in structure, increased training and supervision, but there is no indication of how the effects may be measured.

Ms G safeguarding

5.87 LAS Safeguarding Adults in Need of Care and Support Policy (v4.3, 2019) sets out the 2015 safeguarding duties which apply to any adult in need who:

- has need for care and support (whether or not the local authority is meeting any of those needs); AND
- is experiencing, or at risk of abuse or neglect; AND
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

5.88 Guidance is provided to LAS staff, who must, where safe, discuss safeguarding concerns with the adult in need, obtain their view of what they would like to happen as a result of raising a concern and ensure consent is obtained to raise the concern.

5.89 The NHS intercollegiate document (2019)[91] describes the level of safeguarding training that should be provided for ambulance crew. This has been changed from level 2 to level 3 at LAS and was delivered in 2020/21. The emphasis of this training is on professional curiosity, having difficult conversations and making assessments and referrals.

5.90 We were told that the number of calls Ms G made after 2015 would not meet the threshold for her to be considered a frequent caller (now called High Intensity User). "*A frequent caller to the ambulance service is defined nationally by the Ambulance Frequent Caller National Network as an adult (18 years +) who makes five or more emergency calls in a month, or 12 or more emergency calls in three months from a private dwelling.*" (LAS IMR)

5.91 However, the LAS Policy and Procedure for the Management of Frequent and Vexatious Users (2010) is less rigid and the policy identifies a frequent user as an individual placing emergency calls regularly for 3 months or more, and where the quantity of calls is considered to have a significant impact on LAS resources. Under this policy Ms G may have met the frequent user definition during 2015 and may have been referred to the Patient Centred Action team. This team uses a multi-agency approach towards intervention and care planning.

Opportunities for adult safeguarding – allegations of abuse

5.92 During four emergency calls Ms G made direct allegations regarding physical abuse and one call where she alleged she was being prevented from leaving her home to attend the temple.

- Ms G reported on 5 September 2015 that two male residents were preventing her from leaving the property to attend temple.

[91] ROAN information sheet 36: Intercollegiate document on safeguarding guidance, 2019 revision. https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/intercollegiate-document-on-safeguarding-guidance/

- Ms G reported on 14 August 2015 that "*someone*" was threatening to kill her and that she was hurt as "*clients*[92] *kept hitting her, stating her attackers used sticks and knives*".
- Ms G reported on 23 July 2015 that her hip was broken and that she believed that her helper was the one who broke her bone.
- Ms G said on 16 May 2015 she had been assaulted by three female carers and that her assailants "*cut her body and drink her blood*".
- Ms G said on 7 February 2015 that her cleaner was "*hunting*" her.

5.93 The chronology provided by LAS indicates that one of these calls (16 May 2015) resulted in a safeguarding alert being sent to RBG by LAS staff. We found no further record of the LAS report on the RBG case recording system or in the Trust case notes.

5.94 We found no evidence that the other incidents were referred as adult safeguarding concerns.

5.95 Good practice would have been to refer these incidents as adult safeguarding concerns.

Finding: The LAS did not consistently respond to Ms G's statements that she was being prevented from leaving her home or her allegations of abuse. This was not in keeping with safeguarding practice.

Lewisham & Greenwich NHS Trust

5.96 Mr Q was not experiencing any physical health conditions that required ongoing treatment. As a result, this section of the report relates to Ms G only.

5.97 Ms G had several physical health conditions for which she received treatment which included:

- Hepatitis C
- Knee osteoarthritis
- Cirrhosis of the liver
- Type 2 diabetes
- Degeneration of the lumber spine
- Osteoporosis
- Asthma

5.98 Ms G received most specialist treatment at Lewisham and Greenwich NHS Trust, with a small number of appointments at Kings College Hospital (KCH) NHS Foundation Trust. She regularly attended Gastroenterology and Rheumatology clinics at Lewisham and Greenwich NHS Trust.

5.99 Lewisham and Greenwich NHS Trust shared clinic appointment letters, outcomes and test results with Ms G's GP in a timely manner, usually within a couple of weeks.

5.100 There is evidence of Lewisham and Greenwich NHS Trust staff working to support Ms G's treatment. For example, in a letter to Ms G's GP in August 2016, a Clinical Nurse Specialist detailed Ms G's medication and advised that she had provided additional instructions,

[92] It is unclear what is meant by 'clients' but Ms G requested an ambulance attend her address, therefore it is likely she was referring to other residents.

including her phone number, to the Pharmacist to ensure Ms G's medication was provided to her in a dosette box.

5.101 Equally, clinical staff acknowledged in correspondence with the GP that it was difficult to communicate with Ms G without a Hindi interpreter, although formal arrangements were not in place. For example, she was seen with an interpreter at a Gastroenterology clinic on 27 March 2018, and the clinic letter indicated an interpreter would be present at the next review, but one was not present at the clinic on 14 June 2018. However, the Rheumatology clinic correspondence to the GP did not indicate the use of an interpreter for Ms G's appointments.

5.102 Treating staff should have clarified with Ms G the extent of her understanding of the information they were sharing with her. Had they had any doubts, they should have engaged an interpreter on her behalf.

5.103 There was a lack of a formalised decision by clinical staff about whether Ms G required an interpreter to support her when making decisions about her physical health care. It was largely left to staff judgement. As a result, Ms G consented to procedures without an interpreter in September 2015; the interpreter form on the consent form was not completed. There is no evidence that staff sought to discuss this with her GP or Mental Health Services.

5.104 Ms G received inpatient treatment at QEH for 10 days in April 2018. She had deteriorated in the preceding days and when her GP consulted an Ambulatory Care Consultant, he was advised she should attend A&E given the recent decline in her physical health and the concern that she might have encephalopathic symptoms.

5.105 Ms G was discharged from QEH on 12 April 2018. Her diagnosis at discharge was hepatic encephalopathy. Ms G attended her GP practice the next day and the GP noted she did not have a discharge summary and the GP practice had not received one either. However, there is evidence the GP practice subsequently received a discharge summary.

5.106 The staff at QEH were aware that Ms G would benefit from a Hindi speaker at her appointments. They informed her GP on 26 July 2018 that an appointment had been booked for her with a consultant who spoke Hindi. This was to ensure that Ms G understood the importance of having an MRI scan. Regrettably, staff were unaware that Ms G had died the previous month.

Finding: Lewisham and Greenwich NHS Trust provided acute care to Ms G. The Trust communicated appointments, findings and test results in a timely manner to Ms G's GP.

Finding: Staff treating Ms G were aware she had limited English and benefited from the presence of an interpreter, but there is no evidence this was formally put into practice, and there was variable use of a translation service by those treating her.

A&E attendance

5.107 Lewisham and Greenwich NHS Trust is an acute Trust. Mental health A&E liaison is provided at two Trust sites, University Hospital Lewisham (UHL) and Queen Elizabeth Hospital (QEH), by South London and Maudsley NHS Foundation Trust and the Trust respectively. The purpose of the Mental Health Liaison Service is to provide support to individuals experiencing mental health problems who are in crisis. The Trust information leaflet for service users says, "*We will assess your needs, circumstances and the reasons for your current difficulties and together we will identify the best way to help you*". The liaison team is composed of a psychiatrist, nurses and support workers. The service is available 24 hours a day, throughout the year.

5.108 Ms G attended A&E 47 times between 2015 and 2018. She usually attended QEH A&E, either by ambulance or as a self-referral. The nature of Ms G's complaints varied, though they often

centred on back and leg pain. She was typically discharged with pain relief medication or advised to speak to her GP. Ms G's attendance gradually decreased over time (this coincided with reduced contact with LAS): she attended A&E 39 times in 2015, six times in 2016, and once in 2017 and 2018.

5.109 The A&E notes indicated that staff sometimes found it difficult to communicate with Ms G, although some were able to speak to her in Hindi and Punjabi and occasionally an interpreter was engaged, although the use of an interpreter was inconsistent. The notes document that some staff had concerns pertaining to Ms G's mental health. There were examples in May, July and September 2015 when staff queried whether Ms G had mental health issues. The A&E letter sent to Ms G's GP on 29 July 2015 queried whether she had underlying psychiatric issues and asked that the GP investigate. The author of the letter asked the GP to arrange a meeting to discuss Ms G's health concerns with a view to reducing her A&E attendance.[93] A similar request was made to Ms G's GP on 7 August 2015; A&E staff asked the GP to investigate Ms G's mental health.[94] We discuss this further under 'GP services/primary care' (paragraph 5.141).

5.110 However, despite A&E staff identifying concerns pertaining to Ms G's mental health, there is no evidence that the hospital-based Mental Health Liaison team was ever contacted about Ms G. The Trust told us that A&E liaison staff would record any information about a service user on RiO and there is no evidence in Ms G's notes of her being assessed by the A&E Mental Health Liaison team.

5.111 Ms G was taken by ambulance to A&E on 25 September 2017 after being found difficult to rouse in a local cafe. The A&E notes say a history was taken in Hindi but do not document whether the assessing member of staff spoke Hindi or if an interpreter was used. The plan was documented as "*Referred to psych as no medical cause found for current state*". However, Ms G left the hospital before the assessment took place. No further information was shared with Ms G's GP though there is evidence details of the A&E referral were recorded in the Trust on 26 September 2017. There is no evidence in the notes Trust that staff subsequently discussed the episode with Ms G.

Finding: Ms G regularly attended A&E in 2015, after which her contact reduced substantially. Her complaints often related to pain in her legs or back and she was typically discharged to the care of her GP with pain relief medication.

Finding: A&E staff were mindful that Ms G might have mental health issues and referred her twice to the A&E Mental Health Liaison team. On the second occasion Ms G left the department before an assessment could take place.

Finding: There were additional occasions when it would have been reasonable to have considered referring Ms G to the Mental Health Liaison team; it would have provided an opportunity to facilitate a wider discussion with mental health professionals, including the Intensive Care Management for Psychosis (ICMP), about Ms G's care and management.

Finding: A&E staff communicated their concerns about Ms G's mental health to her GP, asking that they discuss this with her.

[93] The letter was logged by the GP practice but there is no evidence in the notes that it was discussed with Ms G.

[94] The summary points in the A&E entry are very similar to those recorded on 29 July 2015, including typos.

Safeguarding Ms G

5.112 Lewisham and Greenwich NHS Trust has a Safeguarding Adults at Risk Policy and Procedure (2016).[95] The policy reflects the requirements of the Care Act 2014 and London Multi-Agency Adult Safeguarding Policy and Procedures.[96]

5.113 The Trust policy details the criteria staff should consider when assessing if an individual is at risk. It specifies types of adults who may be considered at risk including:

- "*An older person.*
- *A person with a physical or learning or a sensory impairment.*
- *Someone with mental health needs including dementia or a personality disorder.*
- *A person with a long-term health condition*".

5.114 The policy says other factors including a lack of support networks, inappropriate accommodation, social isolation or financial circumstances would also increase an individual's vulnerability.

5.115 Ms G attended QEH A&E on 17 November 2015 where a doctor recorded in her notes "*Doctor noted Ms G lived in a hostel with three men*".

5.116 We cannot now say why the doctor recorded this, however, we note patient living arrangements are often documented as part of the patient history. It would have been good practice for the doctor to pass any concerns on that they had regarding this.

Examples of good practice

5.117 We identified examples where QEH A&E staff identified possible safeguarding or adult welfare concerns. They were all passed to either Ms G's GP or Mental Health Services. We found no evidence that the concerns were addressed or taken any further.

5.118 On several occasions A&E staff – at QEH and UHL – identified Ms G may have had mental health issues. The notes indicate that two of these occasions resulted in a referral at QEH to the Mental Health Liaison team and Psychiatry, although there were no notes on the RiO case note system on the outcome of the referrals.

5.119 On six occasions letters were sent to Ms G's GP suggesting a review of care. These requests were not followed up by her GP.

5.120 There was one occasion, on 3 March 2015, when QEH A&E staff specifically identified that Ms G required an interpreter.

5.121 On 25 September 2017 QEH A&E staff identified safeguarding concerns and they contacted her home to discuss these (it is not clear from the notes who they spoke with, other than that the individual was male). Staff referred her to Psychiatry/A&E Mental Health Liaison and informed her GP. We found a related record on Ms G's RiO case notes, but the concerns were not taken any further or managed under safeguarding. The concerns (*'reports that a man living in the same accommodation as her gives people 20 million pounds and hits her and wants to kill her'*) warranted a referral under Section 42 of the Care Act. This did not happen.

5.122 On 22 November 2015 a QEH A&E doctor referred to and had a discussion with Liaison Psychiatry about Ms G. A CMHT follow up was arranged although it is unclear from the notes

[95] We asked the Trust to provide the policy in place at the time of Ms G's attendance.

[96] London Multi-Agency Adult Safeguarding Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2015/02/Pan-London-Updated-August-2016.pdf

whether follow up happened as part of routine care or was arranged specifically to discuss A&E attendance, as it is not recorded in the notes.

5.123 QEH A&E staff informed Ms G on two occasions in 2015 that her use of emergency services was inappropriate. On both occasions a letter was sent to her GP. This issue was not taken any further.

5.124 In March 2015, a member of QEH A&E nursing staff discussed Ms G's care with her landlord (identified as her carer). The landlord reported "*poor engagement and self-care*". The nurse requested a review by her GP. This was not followed up by the GP or passed to the Trust. It is unclear why the landlord was identified as her carer.

Finding: QEH A&E staff recognised safeguarding and welfare concerns about Ms G, passing these on to her GP or mental health services, but there is no evidence these were acted upon by either agency or that QEH followed up with a referral under Section 42 of the Care Act 2014.

GP services/primary care

5.125 Mr Q and Ms G were both registered at the same GP practice in Greenwich. The practice has approximately 16,000 registered patients.

Mr Q GP services

5.126 Mr Q registered at the GP practice in June 2009. His medical history includes asthma, borderline personality disorder and paranoid schizophrenia. Mr Q's appointments at the practice between 2015 and June 2018 were primarily for the ongoing review of his asthma; he attended the practice five times over this period. His last appointment was on 16 May 2018 for a medication review and asthma monitoring.

5.127 The Trust copied the GP practice into appointment letters inviting Mr Q to his Care Programme Approach (CPA) reviews and the subsequent outcomes (clinic letters). The GP practice was not invited to attend Mr Q's CPA reviews. There is limited correspondence between the ICMP and The GP practice regarding Mr Q, though Mr Q's CPA records say the practice "*contributed*" to each of his CPA reviews.

5.128 The ICMP sent feedback forms to the GP practice in February 2015 and November 2016 as part of its preparation for Mr Q's CPA reviews. The GP practice submitted a completed feedback form in November 2016. It reported there were no significant changes to Mr Q's health, but it would be helpful if his blood pressure was checked (in view of his age) and that he be given advice about stopping smoking. The practice advised the ICMP it could not comment on Mr Q's compliance with medication because he had not been seen since December 2014.

5.129 The above were the only examples we could find of the GP practice being asked to contribute to Mr Q's CPA review process.

5.130 There is evidence that historically (e.g., in 2012 and 2013) Mr Q's care plan was shared with the practice, but there is no evidence this occurred between 2015 and the incident.

5.131 Mr Q's Responsible Clinician wrote to the GP practice, after the incident in October 2018 asking for detail of his physical and mental health history. The GP practice provided this information the same month and advised there had been no concerns in relation to Mr Q's mental health. There is no evidence in the notes that the GP practice contacted Mr Q's family after the incident to offer support.

Finding: The GP practice was aware that Mr Q was on CPA and received the outcomes of his CPA reviews. There is evidence the ICMP sometimes asked the GP practice to

contribute to the CPA review process, and that the practice submitted feedback at least once. However, this was not requested by the ICMP on a routine basis. The ICMP did not actively involve The GP practice in Mr Q's care planning and monitoring.

Shared care agreements

5.132 NHS England describes Shared Care Prescribing Guidelines as "… *local policies to enable General Practitioners to accept responsibility for the prescribing and monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service.*"[97]

5.133 The ICMP service is comprised of two functions:

- Intensive Case Management (ICM)
- Step down function

5.134 Mr Q engaged with the ICMP to receive his depot medication. However, his engagement with the service did not extend beyond this, and he rarely attended his CPA reviews (he missed the last three CPA reviews prior to the incident).

5.135 We spoke to the ICMP Associate Specialist and the ICMP Clinical Lead and asked them what the long-term plan was for Mr Q. They told us their expectation would have been for Mr Q to be 'stepped down' from the service to the care of his GP. However, there is no shared care agreement in place between the Trust and the local GPs for the administration of depot. This has resulted in a number of patients remaining on the ICMP caseload, primarily to manage their depot medication.

Finding: There are no shared care agreements between the Trust and primary care in relation to the administration and management of depot medication.

Ms G GP services

5.136 Ms G registered at the GP practice in April 2006. She suffered from several physical and mental health complaints:

- Paranoid schizophrenia
- Type 2 diabetes
- Knee osteoarthritis
- Osteoporosis
- Hepatitis C
- Cirrhosis of the liver
- Degeneration of the lumbar spine
- Asthma

5.137 Ms G attended the GP practice frequently between 2015 and 2018 – it was the agency that she contacted the most. There were also a small number of telephone consultations each year though these generally were recorded as a failed contact (e.g., Ms G did not answer the call). We set out overleaf the number of times Ms G attended the GP practice for scheduled or emergency appointments.

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[97] Shared care prescribing guidelines: https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

Table 6: Ms G's attendance to her GP practice between 2015 and 2018

Year	Number of attendances
2018 (Jan–Jun)	49
2017	62
2016	51
2015	67
Total	**229**

5.138 Ms G would often attend the practice emergency clinic rather than schedule an appointment. She was also known to enter consultation rooms without warning, asking to be seen. Practice staff raised this with her several times, asking that she book appointments, but she continued to attend the emergency clinic without notice.

5.139 Ms G was referred to several secondary care clinics including Chest, Gynaecology, Pain, Musculoskeletal and a Bone Density Unit. However, she did not always attend these appointments and was discharged from some clinics.

5.140 Ms G was under the care of several specialist services including:

- Oxleas NHS Foundation Trust for her mental health condition.
- Lewisham and Greenwich NHS Trust Rheumatology Clinic and Bone Densitometry Unit for her osteoporosis.
- Lewisham and Greenwich NHS Trust Gastroenterology Clinic for management of her hepatitis C.
- Kings College Hospital NHS Foundation Trust Knee Unit following a fracture and subsequent surgery.[98]
- South East London Diabetic Eye Screening.

5.141 Ms G often complained of experiencing pain in her lower back, leg and knee. She frequently raised concerns that stitches from a historic operation remained in her leg and would ask that they be removed.

5.142 Ms G regularly attended QEH A&E complaining of pain in her lower back and legs. Discharge letters were sent to Ms G's GP after each attendance. There were a small number of occasions, particularly in 2015, when A&E staff queried whether Ms G had mental health issues. A&E staff asked Ms G's GP on 29 July and 7 August 2015 to investigate Ms G's mental health concerns. In July 2015 they asked the GP to arrange a meeting with Ms G to discuss her health concerns with a view to reducing her A&E attendance. The GP practice advised us they do not always receive secondary care correspondence. However, there is evidence these letters were received, but there is no evidence they led to follow-up action by the Practice. The notes do indicate Ms G was spoken to on 10 August 2015 about her frequent attendance and use of emergency appointments, but our understanding is this related to her attendance at the Practice rather than A&E.

[98] Ms G had previously received treatment at KCH in 2013 for treatment when she suffered a broken leg. Her referral in 2015 pertained to knee pain.

Analysis of primary care services engagement/involvement with Ms G

5.143 The CCG IMR notes there was significant variation in the sensitivity by which the GPs engaged with Ms G, acknowledged her complaints and investigated accordingly. Some GPs were described as dismissing Ms G's complaints too readily and expressing clear frustration at her frequent attendance and use of emergency appointments.

5.144 We agree that the tone of the GP notes varies by author and suggests some of the GPs were frustrated by Ms G's erratic attendance and engagement.

5.145 We spoke to GP1, a partner at the practice, about Ms G's attendance. He told us that her attendance was typically unscheduled and difficult to manage. He said communication with Ms G could be challenging due to the language barrier. In instances where an appointment was scheduled, the practice was able to book an interpreter for Ms G, but she generally attended without warning. However, GP1 added that on the occasions when an interpreter was used, the conversations were still confusing and difficult to follow.

5.146 The GP practice does not have a policy for dealing with frequent attendance. GP1 told us that he did not think agreeing a schedule of attendance with Ms G would have worked because of her mental illness and it was likely she would fail to attend scheduled appointments. GP1 told us Ms G was often discussed at clinical meetings, where the overriding view was that the practice was limited in what it could do to mitigate her repeated attendance.

5.147 Ms G regularly attended the practice to request pain relief medication and was prescribed a variety of medication between 2015 and 2018 e.g., paracetamol, co-codamol and temazepam. In late 2016 Ms G reported four instances where her temazepam was lost or stolen and she asked for more medication:

- Ms G requested more temazepam on 29 December 2016 because "[Mr Q's first name] *Uncle*" had stolen it.
- Ms G requested more temazepam on 23 December 2016 because "[Mr Q's first name] *Uncle*" had stolen it.
- Ms G requested more temazepam on 25 November 2016, reporting she thought her previous medication had been taken by "*someone*".
- Ms G advised she had lost her temazepam on 11 November 2016.

5.148 On each occasion Ms G was issued with another prescription of temazepam (seven tablets) and reminded of the importance of keeping her medication safe. The GP practice advised they prescribed seven tablets each time to reduce the possibility of misuse.

5.149 We have previously discussed Ms G's temazepam prescription under 'Medicines management' (paragraphs 4.91-4.93). Ms G's use of temazepam was discussed at a practice meeting in April 2017. It was agreed it would be futile to try and reduce Ms G's temazepam prescription as this would likely increase her attendance at the Practice. Ms G's notes do not indicate whether the discussion considered the implications of her prescription on her physical health, specifically her liver function.

5.150 There is also no evidence whether the safeguarding nature of Ms G's complaint about her medication being taken by other residents was considered; there is no evidence in her notes that safeguarding was considered, or that her allegations were explored with her.

5.151 Though the clinical notes suggest some of the GPs at the practice were frustrated by Ms G's engagement, there are examples in the notes of clinicians trying to work with Ms G. For example, Ms G was seen by GP5 on 28 September 2016, who documented in the notes that the best means of addressing Ms G's ongoing concerns that stiches had been left in her leg would be to arrange a therapeutic ultrasound. GP5 booked an ultrasound for Ms G. Other GPs

at the practice subsequently used reference to the ultrasound scan to reassure Ms G that there were no stitches left in her leg.

5.152 Equally, in early April 2018, GP3 noted that Ms G appeared more tired and lethargic than normal. He subsequently contacted Ms G's carer[99] the same day who said Ms G seemed to have declined recently. GP3 then "*bleeped*" the Medical Specialist Registrar (SpR) and spoke to an Ambulatory Care Consultant. They agreed Ms G should be admitted given her history of possible encephalopathic symptoms and other possible causes of her decline. GP3 liaised with Ms G's 'carer' and arranged for an ambulance to take Ms G to hospital where she was admitted until 12 April 2018. GP3 was proactive and sought appropriate advice in relation to Ms G's health, facilitating her admission to hospital.

5.153 We note Ms G's attendance at the GP practice was escalating in 2018, having attended 49 times in the first six months (she had attended 62 times the previous year). There is no evidence in the notes that practitioners explored this escalation with her or the ICMP. There is no evidence Ms G's physical health needs were raised with the ICMP.

5.154 There is no evidence the GP practice contacted Ms G's family after her death to offer support.

Communication with ICMP

5.155 The ICMP sent the GP practice clinic letters following Ms G's CPA reviews. However, there is little evidence of communication between the two agencies beyond this, and the GP practice was not invited to attend CPA reviews. The ICMP asked The GP practice to attend a professionals meeting about Ms G in June 2015, to which GP1 documented in the notes that he did not object to the meeting but did "*not anticipate much/any benefit from such a meeting given the patient's mental health and communication issues*". GP1 told Ms G's Care Coordinator that he would discuss it at the practice meeting the following week and get back to her. The GP practice told us there is no contractual provision for GPs to attend such meetings, and they need to consider the resource implications in terms of taking staff away from their clinical duties.

5.156 There is no evidence in the GP notes of this being discussed further and a professionals meeting did not take place. There is no further evidence of a dialogue between the ICMP and the GP practice, about Ms G despite her frequent attendance and use of emergency appointments.

5.157 Whilst we appreciate that it was difficult to manage Ms G's attendance at the GP practice, it may have been helpful to have engaged in a dialogue with the ICMP, to ensure the team was aware of the extent to which Ms G attended. There is evidence that Ms G told her care coordinators that she visited her GP regularly but there is nothing to suggest they were aware of the volume or unpredictable nature of her visits. GP1 told us the practice discussed Ms G at practice meetings and sought to manage this internally. However, the GP practice received notifications from the local A&E departments and was aware in 2015 that she was attending frequently, which given her frequent attendance to the GP practice, should have been raised with the Mental Health team.

5.158 We would have expected this, coupled with her frequent attendance to the practice, to have prompted a discussion with the ICMP about approaches to working with Ms G. GP1 told us he did not think agreeing a management plan for Ms G with the ICMP would have been effective because Ms G would probably not have adhered to it and would have continued to attend the practice. However, we still consider it would have been helpful for the practice to have contacted Ms G's Care Coordinator with a view to exploring means of managing her attendance.

[99] Ms G did not have a carer but her funded care package included a cleaning service. It is unclear who the GP spoke to.

5.159 There are no mental health link workers or liaison services between the Trust and local GP practices. Consequently, there are limited means by which primary care can engage with the Trust.

5.160 CPA reviews would have been the primary mechanism to gain input from the GP practice. The practice submitted a feedback form in January 2015, noting that Ms G attended the practice on a weekly basis, but otherwise we did not see evidence of a dialogue between the ICMP and The GP practice about Ms G (e.g., we did not see evidence that the GP practice was routinely invited to attend or contribute to CPA reviews).

5.161 The primary care IMR recommended "*GPs to take a more proactive approach in triggering or requesting multi-agency meetings or similar where there is clear evidence the patients are testing boundaries across several agencies*". We endorse this recommendation and agree The GP practice should have been more proactive in engaging with other services about Ms G. However, we note the practice does not have a policy for managing frequent or unpredictable attendance and as such there is no guidance as to when other agencies should be contacted.

Finding: The GP practice did not engage with the ICMP about Ms G's frequent attendance, seeking instead to manage her frequent attendance internally.

Primary care safeguarding

5.162 Ms G's GP practice has an Adult Safeguarding Policy in place (dated September 2016) that indicates where a doctor identifies adult safeguarding concerns due consideration should be given to referring the concerns on. Possible referral points include:

- Social Services Mental Health team
- Police
- CCG lead
- CQC if a member of staff is suspected of abuse to patients.

Missed opportunities for adult safeguarding

Medication

5.163 We have detailed above four instances in late 2016 when Ms G reported her medication (temazepam) as lost or stolen and asked for more medication.

5.164 Adult safeguarding statutory guidance defines 'misuse of medication' as physical abuse. It appears that the attending GPs did not consider the potential safeguarding nature of these allegations, they did not discuss them with Ms G and they did not report them further.

5.165 Three of these occasions indicate that Ms G's medication had been allegedly taken from her, possibly indicating she was vulnerable to abuse.

5.166 Good practice would have been to initiate a safeguarding adult concern.

Repeated allegations

5.167 During her time with the practice Ms G also made allegations of abuse by other residents:

- Complaints of being "*pushed*" by another resident.
- Further complaints of assaults by residents over a period of time.

- One of Ms G's delusional beliefs was that other residents were coming into her room at night to stab or kill her, and that Jesus was protecting her.

5.168 It appears that Ms G's GP practice held the view that these allegations were delusional in nature and the concerns were not referred as adult safeguarding concerns. The GP took assurances from the ICMP and Ms G's landlord about her safety.

5.169 Good practice would have been to initiate an initial safeguarding adult concern.

Multi-agency meeting

5.170 In June 2015 Ms G's GP was asked to attend a multi-agency meeting to discuss her repeated use of emergency services. We have noted that the GP informed Ms G's Care Coordinator they did not object to the meeting, but they did not believe there was merit in attending.

5.171 Good practice would have been for the GP practice to support a multi-agency meeting. This would have enabled consideration of all aspects of Ms G's care including any concerns relating to adult safeguarding.

Capacity

5.172 Ms G presented to her GP practice on numerous occasions often seeking emergency appointments. The attending GPs often recorded concerns regarding effective communication, and even when interpreters were present, they recorded that they found Ms G difficult to communicate with.

5.173 These concerns did not trigger any consideration of whether practice staff had an accurate understanding of Ms G's capacity, and whether she was able to make decisions about her care and treatment.

5.174 Good practice would have been to consider Ms G's capacity in the light of concerns about effective communication and Ms G's persistent allegations regarding abuse in her accommodation.

Finding: The GP practice did not identify safeguarding concerns about Ms G, despite her making repeat allegations of abuse and that her medication had been taken. The practice considered her assertions to be delusions and took assurance about Ms G's safety from Ms G's landlord and the ICMP.

Bridge Support

5.175 Bridge Support is a charity that provides support services to mental health service users in the RBG. These services include 24-hour hostel services, medium support services and flexible community support services, which vary from one to 20 hours a week per client (which can be reduced according to need). At the time of writing, Bridge Support provided support to roughly 150 clients, though this number varies, depending on need.

5.176 Mr Q and Ms G were recipients of the flexible community support services commissioned by RBG. Bridge Support submitted an IMR to us as part of the review process.

Mr Q

5.177 Mr Q received flexible support from Bridge Support between December 2014[100] and June 2015 at which point he decided he did not wish to engage with the weekly service. However, this later changed, and he was introduced to a new Support Worker in March 2016. This individual remained his Support Worker until the incident in June 2018. They met on a

[100] Bridge Support first offered support in December 2014 when it won the contract to provide community support in Greenwich.

fortnightly basis, usually for a walk or coffee, with the option of Mr Q increasing contact as required e.g., when needed to liaise with the Financial Protection team on Mr Q's behalf. Mr Q's Support Worker helped him enrol in a cookery class at the Recovery College in September 2016. He told us Mr Q was happy with his life and generally was not seeking further opportunities. Their engagement was primarily limited to catch-ups and supporting Mr Q to collect his money.

5.178 Bridge Support was not in regular contact with Mr Q's mother between 2015 and 2018 but she told us his Support Worker contacted her after the incident. She told us he was supportive and helpful.

Engagement with the Trust about Mr Q

5.179 Mr Q's Support Worker told us that engagement with the Trust about Mr Q was variable. He told us he had a good relationship with Care Coordinator 3, whom he described as "*proactive*" and who made regular contact with the Support Worker by phone and email, whereas engagement from Care Coordinator 4 was limited. He considered Care Coordinator 4's focus to be predominantly on administering Mr Q's depot. We asked Mr Q's Support Worker whether he spoke to Care Coordinator 4 about his relationship with Mr Q. He told us he did not, but this is something he would now do.

5.180 Mr Q's Support Worker told us Mr Q was clear with both care coordinators that he could not attend CPAs on a Monday because this was when he saw his mother. However, no steps were taken to reschedule this to a more convenient time for him. As a result, Mr Q did not generally attend his CPAs, and consequently, neither did his Support Worker, who had informed the Associate Specialist and Mr Q's Care Coordinator(s) that he would only attend the CPA reviews (and pre-CPA reviews) if Mr Q was present. Mr Q did not attend his last three CPA reviews prior to the incident.

Management of Mr Q's finances

5.181 A key part of Mr Q's Support Worker's role was to ensure Mr Q collected his money safely from the Woolwich Centre or Council Office. Historically, there had been an incident when Mr Q had lost a large sum of money, therefore Care Coordinator 3 had asked the Support Worker to support Mr Q's financial collections.

5.182 We were told that Bridge Support did not typically have a role in assessing Mr Q's financial requests but did have concerns about the involvement of Mr Q's landlord in his purchases and holiday arrangements. As a result, they intervened in November 2017 when Mr Q made a request for a large sum of money to buy a recliner. Bridge Support liaised with the Appointee team who agreed Mr Q's landlord did not need to be involved in the purchase. The Appointee team advised there was no need for Mr Q's landlord to submit requests for money or to speak on Mr Q's behalf.

5.183 We asked whether these concerns were escalated to Care Coordinator 4 (who had assumed the role around the same time) and we were told they were not, but it was common knowledge there were concerns about the role of the landlord.

5.184 There is evidence Bridge Support intended to raise a safeguarding concern about the landlord in November 2017, but there is no evidence this was taken forwards (discussed further below).

Ms G

5.185 Ms G first received support from Bridge Support in May 2015. She initially received weekly support, but it was agreed with her Care Coordinator in December 2015 that this should be reduced, because Ms G was not engaging with the service. Contact was restarted in July 2016 when it was agreed with Ms G and her Care Coordinator that Bridge Support would

support her to attend medical appointments and provide additional help as required; for example, a member of the team attended a sheltered housing assessment for Ms G in October 2017. However, Ms G preferred to engage with her Care Coordinator and Bridge Support had limited contacted with her, rarely seeing her in person. Ms G's Support Worker between May 2015 and November 2017 (when she left) spoke and understood Hindi, although Ms G rarely wished to engage beyond minimal conversation.

5.186 In December 2017 Bridge Support was informed that Ms G's Care Coordinator had changed, after which they received no further requests for support. Bridge Support was not informed in June 2018 that Ms G had been moved to the amber zone.

5.187 Bridge Support was not in contact with Ms G's family between 2015 and 2018 or after her death. However, there is no evidence in the notes to suggest that the family sought engagement or there was an expectation from the Trust or other agencies that they would make contact.

Engagement with the Trust about Ms G

5.188 The Trust provided Bridge Support with a copy of Ms G's risk assessment before they started working with her (in 2014) but otherwise updates and information about Ms G was primarily received via her Care Coordinator. Bridge Support was informed by Ms G's Care Coordinator when her CPA reviews were taking place, but they were not invited to attend, and did not receive copies of the meeting notes. Despite this, Bridge Support described the working relationship and flow of information from Care Coordinator 3 to her Support Worker as "*good*".

5.189 Bridge Support staff were not asked to accompany to Ms G to any appointments from late 2017 and rarely saw her.

Finding: Bridge support provided support to Ms G and Mr Q as agreed with them and their care coordinators.

Finding: There was no formal information sharing in place between Bridge Support and the Trust with regards to either service user, though Care Coordinator 3 took steps to keep Bridge Support informed on an ad hoc basis. Communication from the Trust to Bridge Support reduced in November 2017 which coincided with the change in Care Coordinator.

Post June 2018

5.190 Bridge Support did not conduct its own investigation into the events leading to the incident in June 2018 but engaged with the Trust as part of its internal investigations. Bridge Support provided information, timelines and data to the Trust as part of this process.

5.191 Mr Q's Support Worker contacted Mr Q's mother after the incident and provided support to her; she spoke highly of Mr Q's Support Worker. Bridge Support was not in contact with Ms G's family between 2015 and 2018, or after the incident in June 2018.

5.192 In addition, since the incident in June 2018, Bridge Support has planned and implemented joint sessions with the Trust community teams to agree more effective ways of working. This included training, agreeing the principles and practices of inter-agency communication, supervision of Bridge Support staff and a psychological debrief after Ms G's death.

5.193 Bridge Support told us that there is now better information sharing with the Trust including:

- An information sharing protocol.
- Monthly sharing of CPA dates and Care Coordinator/ Bridge Support Worker details.
- Quarterly provider meetings attended by the Trust and Bridge Support Team Managers, and two providers in the Greenwich Mental Health Pathway.

- Bridge Support attend weekly Trust bed management meetings.
- The Trust has created a Service Improvement Lead post with a view to developing Trust care coordinators' understanding of pathway services.
- New dedicated posts at Bridge Support, a Quality and Compliance Manager and a Learning and Development role to improve both quality and training (as of 1 October 2020).

5.194 Bridge Support IMR highlighted that improving communication between agencies was an ongoing process:

"*There is a Trust and borough-wide recognition that communication between agencies in terms of organisational, structural or caseload changes will need to be communicated in a more timely way and with absolute clarity and in way that people outside that agency will be able to understand and act on immediately.*"

Safeguarding

5.195 Bridge Support shared four policy documents (all dated October 2015 with a review date on October 2016) details of which are shown below.

Table 7: Bridge safeguarding policies

Document name	Introduction – quoted from document
Safeguarding Recognising and Responding to Abuse Guidance	*'This guidance covers how to recognise and what to do when you think an adult with care and support needs is experiencing, or is at risk of, abuse and neglect and who, because of their care and support needs, is unable to protect themselves from abuse or neglect'*
Safeguarding Policy	*'This Safeguarding policy also incorporates Bridge Mental Health's Adult Protection Policy and extends it to include prevention and broader safeguarding measures'*
Adult Protection Policy	*'The following Policy & Procedure Guidelines are based on and in line with the relevant London Borough of origin for the client that is receiving the service. Bridge Mental Health is committed to adhere to the Adult Protection Policy and Procedure Document and in the event of an allegation of abuse will refer to these policies during revision of in-house policies, procedures and training'*
Adult Protection Procedure	The document has no introduction and appears to be a practice guide covering 'Responsibilities of People Discovering Abuse'. Document includes guidance on alerting / referring / investigating / making decisions and monitoring

5.196 These policies and procedures cover different aspects of adult safeguarding and if read in isolation may lead to limited guidance for staff. The four policies do not adequately signpost to each other (e.g., corresponding guidance) and there is no guidance directing the reader to read all four policies.

Mr Q safeguarding

5.197 During November 2017 Bridge Support raised a concern regarding the purchase of a reclining chair for £600[101] that was being arranged by Mr Q's landlord. Bridge Support raised this with the FPA team who confirmed that all future requests for purchases should be made through Mr Q's Care team (e.g., Mr Q's care coordinator) and not the landlord to avoid any misunderstandings. Bridge Support expressed several concerns to the FPA team regarding

[101] It was documented in Bridge Support notes on 20 June 2018 that Mr Q would receive £1,400 for the recliner chair.

the landlord's involvement in Mr Q's finances although they do not appear to have been shared with the Care Coordinator. It was around this time that the Care Coordinator changed.

5.198 Bridge Support informed the FPA team they would raise a safeguarding concern. Bridge Support Adult Protection Procedure is clear that any allegation of abuse should first be discussed with a line manager and the individual involved to determine whether a referral under adult safeguarding is required and then if appropriate referred to the care management team in the locality. There is no evidence a referral was made.

5.199 The FPA team subsequently agreed funds in June 2018.

Ms G safeguarding

5.200 Whilst Bridge Support had limited involvement in Ms G's care there is evidence that in December 2016 a Support Worker contacted Care Coordinator 3 to discuss concerns regarding Ms G's landlord: "*Can we arrange a visit to Ms G's on Friday either between 9.30–11am or 2pm–5pm we have professionals meeting about (Landlord) and his conduct with the clients so we like visit the property to check the accommodation before the professionals meeting on Monday.*"

5.201 We found no further information regarding this meeting and no adult safeguarding concerns were raised regarding the landlord.

Finding: Bridge Support staff identified safeguarding concerns in relation to Mr Q and Ms G (one each) but there is no evidence these were escalated beyond initial contact with other agencies.

Royal Borough of Greenwich – appointeeship

5.202 Ms G and Mr Q both had their finances managed through RBG's FPA team. The FPA Policy states that the FPA team "*acts as Corporate Appointee and Court appointed Property & Affairs Deputy for those service users who are deemed to lack the capacity to manage their own finances*". This policy is not dated or version controlled, however the accompanying procedures were variously dated as issued from 2013 to 2016 and appear to have been current at the time of the incident.

5.203 Prior to the RBG team undertaking an appointee or deputy role the Trust care team (e.g., a psychiatrist) are instructed to provide an assessment of capacity on a COP3[102] form and a record of the best interest (BI) decision made on the Mental Capacity Act 2005 (MCA) FACE form (a COP3 form is required when the application is going to the Court of Protection). We requested and reviewed the completed COP3 forms for Ms G and Mr Q. These were completed in line with FPA policy. We also requested copies of the FACE forms but did not receive these.

5.204 Once an individual's finances are under the control of the FPA team they are allocated a weekly personal allowance. If they require additional funds for ad hoc expenses this request is made through their Care Manager, Social Worker or Care Coordinator if they have one.

5.205 The role of the FPA team appears to be mainly administrative and Trust staff (e.g., the care coordinators) are expected to monitor any requests for additional funds, and to be alert to the risks of financial vulnerability or potential abuse. If an individual does not have active Care team involved the FPA team reviews expenditure on an annual basis as a minimum.

[102] This is a report on someone's capacity to make decisions. https://www.gov.uk/government/publications/make-a-report-on-someones-capacity-to-make-decisions-form-cop3

5.206 Both Ms G and Mr Q had ICMP involvement, and both requested additional funds beyond their weekly allowance on a regular basis. We reviewed the case records to identify whether there were any safeguarding concerns and, if so, how they were managed.

Mr Q appointeeship

5.207 Mr Q received a weekly allowance and was supported in collecting this by his Support Worker from Bridge Support. Mr Q had lost a large sum in 2015 and there were concerns regarding his vulnerability with money. Mr Q often requested additional large sums of money for purchases, and these were requested from the FPA team by his Care Coordinator. Most were approved without question. The amounts requested do appear excessive in some cases (e.g., £250 for funeral flowers on 3 November 2017) and a curious Care Coordinator may have questioned whether the money was being spent as indicated, especially given Mr Q's past history of financial vulnerability. Mr Q's mother told us she had been contacted by Mr Q's Care Coordinator (she did not specify which care coordinator), when he had requested a large amount of money or made a number of requests, but she could not recall the detail or frequency of these contacts.

5.208 Mr Q identified his financial vulnerability on his care plan of 15 October 2017. "*My finances are being managed by the Financial Protection and Appointee team at Woolwich Centre due to my vulnerability and inability to manage my finances*."

5.209 Bridge Support raised a concern via email to the FPA team in November 2017 regarding the purchase of a reclining chair for £600[103] that was being arranged by Mr Q's landlord. Bridge Support raised this concern with the FPA team, and it was agreed that all future requests for purchases should be made through the Care team (e.g., care coordinators) and not the landlord to "*avoid any misunderstandings*". Bridge Support expressed concerns to the FPA team regarding the landlord's involvement in Mr Q's finances. These concerns do not appear to have been shared with the Care Coordinator.

5.210 It was around this time that the Care Coordinator changed. Bridge Support informed the FPA team they would raise a safeguarding concern. However, we have seen no evidence that this was progressed.

Ms G appointeeship

5.211 Ms G received a weekly allowance. Her son initially collected this twice a week, but for ease and convenience and at her son's request this moved to once a week in March 2016. In addition to this weekly allowance Ms G requested additional amounts, usually for gifts for her children or to celebrate festivals. The amounts varied and were always signed off by the Care Coordinator. There were no concerns raised regarding Ms G's weekly allowance or additional requests however Ms G did make several allegations that her money was being stolen. There is no evidence her allegations were investigated.

Capacity assessments

5.212 We requested but were not given the MCA FACE[104] assessment forms for Ms G or Mr Q. Therefore, we were unable to confirm that a mental capacity assessment took place before they were placed under the appointee system.

Family involvement

5.213 The FPA policy indicates that the team would only take on the role of appointee or deputy when other avenues of support had been exhausted. "*Due consideration should be given to a*

[103] The FPA team later agreed a sum of £1,400 for the chair in June 2018.

[104] FACE: Functional Analysis of Care Environment

service users family or friends managing their finances prior to a referral being made, with the referral being taken on by the FPA team in a safeguarding situation or as a last resort."

5.214 Ms G's family provided us with correspondence (sent by registered post) that they sent to the FPA team in 2013, asking that Ms G's daughter be appointed as her deputy for finances. They told us that the FPA team did not respond to this request or their follow-up letter. We note this correspondence is out of scope, but it does evidence a history of Ms G's family having sought to be involved in her financial management. Whilst the FPA team did not have the authority to make Ms G's daughter the deputy, it should have helped her, or at least directed her, to submit her request via the Court of Protection.

5.215 We did not find any evidence that Ms G's family had been consulted, but this was to be expected, given RBG became her appointee outside the time frame of this review. However, had the MCA FACE form been made available to us we may have identified whether Ms G's family had been consulted at the time.

5.216 The policy clearly indicates that records on this form should "*address why family members or friends are unable to manage*".

5.217 The MCA FACE form was not shared with us.

Review and oversight

5.218 When acting as appointee or deputy the FPA team carry out administrative functions relating to an individual's finances. The team rely on 'care professionals' to monitor and support people to manage their own finances. If an individual does not have a 'care professional' involved the FPA policy states that "*each service user will be reviewed on an annual basis by a Royal Greenwich reviewing team, if they do not have regular contact with a Care Team. Any outcomes of the review will be fed back to the FPA team as necessary.*"

5.219 Finances are considered as part of an individual's CPA and any irregularities or vulnerabilities should be highlighted. We found no evidence that this happened for either Ms G or Mr Q.

5.220 There is no evidence that the FPA team received a review for either Mr Q or Ms G from the Trust.

5.221 There is no evidence the FPA team ever queried the financial requests submitted to them on behalf of Mr Q or Ms G.

Financial abuse

5.222 The Bridge Support Worker identified two adult safeguarding concerns: that Mr Q was being unduly influenced to purchase an expensive chair by his landlord and a more nebulous concern regarding the landlord's 'behaviour' and not always following protocol. The email read "*We're concerned about the landlord's behaviour and will raise a safeguarding issue. As discussed on the phone.* [Mr Q's] *landlord doesn't always follow protocol and we don't entirely trust him.*"

5.223 Bridge Support clearly identified two areas of adult safeguarding concern and they informed the FPA worker that they would raise a safeguarding alert. This is clearly recorded on RBG's Framework-I.[105]

5.224 Regardless of the actions of Bridge Support, when abuse is identified we would expect the FPA team to ensure the safeguarding concern had been raised.

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[105] RBG electronic records.

5.225 We found no evidence that Bridge Support staff made this safeguarding referral or shared their concerns with the ICMP (e.g., care coordinator).

5.226 This example highlights how important it is that everyone is aware of their adult safeguarding responsibilities. In particular, all local authority staff working with or for adults who may be vulnerable to abuse should be clear regarding their adult safeguarding duties.

5.227 Neither the FPA policy nor procedure document informs finance officers what to do if financial abuse is suspected. This should be amended. The FPA team clearly have a responsibility to address safeguarding concerns if they are brought to their attention.

Finding: The RBG FPA team has no formal structure in place to monitor the appropriateness of requests to release money to service users.

Finding: The RBG FPA team did not respond to, or follow up, safeguarding concerns brought to its attention by Bridge Support.

Finding: The RBG FPA team places too much emphasis on the role of mental health in identifying and managing safeguarding concerns, despite its own responsibilities towards service users who use Mental Health Services.

5.228 Ms G's appointeeship was in place in 2013. Please refer to Section 6 for more information.

Royal Borough of Greenwich – housing

5.229 Mr Q and Ms G lived in shared accommodation, in a residential house. They had private bedrooms with access to the communal living area and bathroom.

5.230 Ms G had lived in the house since 2005, and Mr Q since early 2015. Historically, there had been two other residents living in the house, but at the time of the incident Ms G and Mr Q had been the only residents in the house for approximately three months. The house was to be sold and both had been asked to seek alternative accommodation.

Caring Landlord scheme

5.231 The accommodation was originally provided by RBG under the Caring Landlord scheme for Greenwich (also known as the Supported Landlord scheme). The scheme provided housing to mental health service users, for which the landlord's role extended beyond property maintenance to providing basic support for tenants and undertaking welfare checks.

5.232 The commissioning of supported housing changed during the time Ms G lived in the house:

- Community Options subcontracted the private landlord to provide support to residents between 2005 and 2011 (the Caring Landlord scheme).
- Community Options managed the contract between 2011 and 2013.
- Community Options lost the contract and ended the Caring Landlord scheme in December 2014. Commissioners set up new supported housing arrangements, predominantly via private landlords.
- New models of Medium Support and Accommodation (8am to 8pm) and a floating support service were introduced at the beginning of 2015. Bridge Support and Sanctuary provided these services.

5.233 There was no Caring Landlord scheme in place after December 2014. Ms G and Mr Q chose to stay in the house as private tenants with shorthold tenancy agreements when the scheme ended. RBG was not responsible for commissioning privately rented accommodation. The

Trust was responsible for ensuring privately rented accommodation met service user needs and for the ongoing monitoring of its appropriateness.

5.234 The landlord did not have any formal/commissioned responsibilities towards Mr Q or Ms G, though the notes indicate he was involved in their lives. He made holiday arrangements for Mr Q and sometimes liaised with health services about Ms G (e.g., with her GP).

5.235 The RBG Housing team told us that there was a Pathway Implementation Needs Group (PING) that considered individual placements after the Caring Landlord scheme ended, with a view to assessing whether individuals were in appropriate accommodation. We asked if Ms G had been referred to this group and we were told it was believed she had not, but this was unconfirmed.[106]

Section 75 agreement

5.236 During our investigation and in interviews with senior Trust and RBG staff we were informed RBG delegated its mental health functions to the Trust for Adult Social Care under an unsigned Section 75 agreement. This includes Adult Safeguarding functions under the Care Act 2014. The Trust is responsible for the management and supervision of RBG social care staff working in the ICMP under the Trust. We were subsequently told by RBG during its review of this report that between 2015 to 2018, there was not an unsigned Section 75 in place, rather there was a signed Section 31 by custom and practice and an implied Section 75 agreement. The current position is RBG has an unsigned Section 75 Memorandum of Understanding (2021/22) in place.

5.237 RBG and South East London CCG (formerly NHS Greenwich CCG) are responsible for funding decisions and escalating matters of concern, complaints or queries.

5.238 The Trust does not hold a care package budget, for example, cleaning services; this has been under RBG since 2008.

Mr Q housing

5.239 Mr Q lived at the property from 2015 until the incident in 2018. He indicated to Trust staff and his Support Worker that he was happy in the house. Mr Q was informed in June 2018 that he would need to seek alternative accommodation because the property was to be sold. He was reportedly unconcerned about this as he was confident his Support Worker would help him find alternative accommodation.

5.240 We have seen no evidence that Mr Q's needs were formally assessed by his Care Coordinator to ensure his placement at the property was appropriate and would meet his needs.

5.241 London Care (the cleaning company) raised a safeguarding alert in early June 2017 and concerns about the cleanliness of the communal areas in the house. Following the agreed partnership working arrangements, the concern was managed within the Trust. The concern was raised for all residents at the property and managed as one enquiry by the same care coordinator.

5.242 The Trust's Safeguarding Policy at the time contained a flow chart (page 29) detailing actions to be taken in Greenwich when raising a safeguarding concern with indicative timescales. This activity is divided into four processes: raising a concern (within 48 hours), enquiry (within 5-days), case conference and safeguarding planning (within 4 weeks), and finally review.

5.243 We discuss the effectiveness of the safeguarding activity here.

[106] We were provided with a copy of the PING strategy meeting minutes notes for 5 April 2016, which made no reference to Ms G.

5.244 The alleged abuse (neglect and acts of omission) was recorded beyond the 48-hour timeframe and the form does not indicate a reason for the delay. This is outside of expected practice.

5.245 As the alleged abuse occurred in shared accommodation, the commissioners, the local authority adult safeguarding team and the care coordinators responsible for supporting other adults at the property were all informed. This was in line with policy and expected practice.

5.246 The enquiry states that a home visit, a professionals meeting, and a strategy discussion all took place. Records show that residents involved were afforded the opportunity for their views to be recorded and a safeguarding plan was developed within the stated timeframe and indicates that a review of the placement would take place for each resident. The concerns were also shared with the landlord who stated he would address them. This was all in line with policy and expected practice.

5.247 The professionals meeting took place on 10 July 2017 and detailed substantial concerns about the conditions of the property which was noted to be *"… in a poor condition, with infestation and very poorly maintained communal areas. The poor condition of the property and environment negatively impacts on the wellbeing of each of the 4 service users living there".* It was noted that the meeting attendees (predominantly from the Trust, but also RBG and London Care) were not clear about the financial arrangements in the house e.g., who was paying for utilities. The care coordinators for the residents (e.g., Care Coordinator 3) were tasked with resolving this issue, either by speaking to the residents or by contacting the FPA team.

5.248 The final outcome of the safeguarding was recorded as 'action taken and risk remains' and the safeguarding concern was recorded as 'inconclusive'.

5.249 Overall, the immediate concerns about the cleanliness of the property appear to have been identified and risks mitigated with the referral for a weekly cleaning service. The effectiveness of the plan cannot be determined however as there was no formal review to determine whether the deficits with the accommodation had been rectified.

5.250 When Care Coordinator 3 saw Mr Q at home she did document observations about the cleanliness of the property in the notes. For example, in August 2017 she checked Mr Q's bedroom and the communal areas. However, following the change in Care Coordinator, monitoring of the property's cleanliness stopped. Care Coordinator 4 undertook a home visit in November 2017 but otherwise saw Mr Q at the ICMP offices.

5.251 We believe the impact of this safeguarding was limited, and following Care Coordinator 3's departure, the state of the accommodation was not monitored. Alongside this, the safeguarding failed to identify whether the Landlord provided other shared properties for mental health service users and whether this should have resulted in a wider review, and there was no evidence that the placements of the residents were formally reviewed as per the agreed plan.

5.252 Following this safeguarding, Mr Q's Support Worker told us that Mr Q was reluctant to show people his room and did not facilitate access. Despite Mr Q's reluctance, it was the responsibility of his Care Coordinator to monitor the cleanliness and suitability of his accommodation, particularly given the property was not subject to formal monitoring by RBG.

5.253 There is no evidence of professional curiosity on the part of the ICMP team or attempts to see Mr Q in his home setting, despite the safeguarding alert in 2017. Trust CPA Policy says staff should consider service user's housing as part of their assessments, but Care Coordinator 4 typically took Mr Q's view that he was "*fine*", at face value. The police reported after Mr Q's arrest that his room was largely unkept, with extensive rubbish on the floor and evidence he was sleeping in a chair. Had Care Coordinator 4 sought to check Mr Q's accommodation this would likely have prompted broader discussion about his wellbeing.

5.254 Trust CPA Policy (2012)[107] says staff should "*… assess the adequacy of housing provision and where appropriate assessments, including risk, should be shared with local housing agencies.*"

5.255 We would have expected Mr Q's Care Coordinator to have checked the cleanliness of his accommodation. Had Mr Q indicated reluctance to facilitate access, this should have been a trigger to prompt further inquiry, potentially working with Mr Q's Support Worker to see his room and undertake regular monitoring.

Finding: A safeguarding alert was raised in July 2017 about the cleanliness of the property Mr Q and Ms G lived in. The initial safeguarding activity developed a clear action plan, however there is no evidence ICMP staff followed this plan or monitored the condition of the property, or Mr Q's room, following the change in Care Coordinator in October 2017. In keeping with Trust policy, Mr Q's Care Coordinator had a responsibility to monitor Mr Q's housing provision. We attribute the lack of monitoring predominantly to an acceptance of Mr Q's view that he was "*fine*", and a lack of professional curiosity.

Ms G's mental capacity and concerns about her accommodation in early 2015

5.256 Ms G had lived at the property since 2005. Historically, there had been concerns as to the appropriateness of Ms G's placement in the house and Care Coordinator 2 had been undertaking arrangements for Ms G to move in late 2014.

5.257 After the change in tenancy in 2014 Ms G was identified as being in the wrong type of accommodation. It was decided that she required ground floor accommodation in a self-contained property with a 'medium support service'. Following the agreed commissioning process shared with us, Ms G's accommodation should have been reviewed at this time and if there had been concerns about Ms G's capacity a formal decision specific assessment of mental capacity should have been undertaken. There is evidence that a capacity assessment was attempted. There is no evidence however that a formal capacity assessment was ever completed.

5.258 The outcome of a home visit on 23 December 2014[108] was reported by Care Coordinator 2 to the RBG assistant commissioner (mental health) on 2 January 2015 **(our emphasis):**

"*T/C to* [redacted] – *Assistant Commissioner to discuss issues with* [Ms G's] *move on. She was informed* ***another MCA was attempted but walked out on myself and the psychiatrist.*** *The fact that her landlord had informed her she does not have to move out of the property remains a worry, it was suggested* [Ms G] *is seen again and a statement is obtained from her regarding this as it is contrary to what the landlord agreed during the professionals meeting the last time. This will be arranged as soon as possible with an interpreter present*'.

5.259 There is no evidence that further attempts were made, or that a formal capacity assessment regarding accommodation ever took place beyond this one attempt, although the topic of moving accommodation was raised with Ms G during her CPA review on 6 January 2015. Ms G's capacity to make decisions about her accommodation had been assessed by the ICMP Specialty Doctor during the review. He wrote in the notes:

[107] The policy expired in June 2017, but the Trust's next CPA policy was issued in February 2018, therefore we have referred to the older version in the context of assessments made in 2017.

[108] December 2014 is beyond review scope, but findings formed the basis of actions agreed in early 2015.

"*The conclusion is that despite that she has residual symptoms; it appears that she has capacity to decide to stay at her accommodation. As her mental state may change in the future, her capacity may be* [sic] *change accordingly*".

5.260 It is unclear what evidence was used to make this decision. This record is not a formal assessment of capacity although it appears to have been taken as such.

5.261 The Trust Mental Capacity Act 2005 Policy (2012)[109] and the Mental Capacity Act (MCA) 2005 are clear that for complex or major decisions a more formal assessment of capacity must be undertaken and recorded.

5.262 The MCA sets out a two-stage test of capacity (Sections 2 and 3 of the MCA):

- Is the person unable to make a decision, and
- Is the inability to make a decision because of an impairment of the mind or brain?

5.263 The MCA says a person is unable to make a decision if they cannot:

- understand the information relevant to a decision;
- retain that information;
- use or weigh up that information as part of the process of making the decision.

5.264 Following the CPA review on 6 January 2015, a professionals meeting took place on 29 January 2015 with representatives from RBG (commissioning), Housing, the Trust and Bridge Support in attendance.

5.265 The following points were agreed:

- "[Ms G] *needs to move from her current accommodation as it is not suitable for her needs.*
- *She requires ground floor accommodation, although her true range of mobility is not known.*
- *She requires a self-contained property.*
- *She requires a Medium Support Service".*

5.266 The following actions were planned:

- "[Trust/Bridge/commissioning staff] *will go and view Flat B,* [road name redacted] *on 05/02/15.*
- *If property is suitable, a viewing will be arranged for [Ms G] (Landlord will be notified as a courtesy).*
- *If* [Ms G] *likes the property, she will be offered a place there, with the following in place:*
- *A support contract with Sanctuary, stating that she must engage with the service.*
- *An interim care package can be put in which will provide support to [Ms G] around cleaning and cooking.*
- *The interim care package will be phased out over a period of time, so that [Ms G] officially starts to take responsibility for maintaining her environment".*

[109] The policy was reviewed in 2016. The next review was scheduled for June 2019.

5.267 It was further agreed that if Ms G rejected the property and did not agree to any of the above provisions:

- "[Ms G] *will have her support transferred over from Sanctuary to ISS*[110] *(Bridge).*
- *Bridge will provide assertive support to Ms G, with the aim of increasing her engagement.*
- *Ground floor properties in Medium Support will be explored.*
- *If no Medium Support options, spot-purchased or ISS & accommodation options will be considered".*

5.268 This plan gives no indication of how Ms G was to be supported to engage in making these decisions and it seems that when she refused to engage in the process the plans for moving stalled. We found no evidence that Ms G's reluctance or unwillingness or inability to engage was explored further.

5.269 Ms G did not wish to move from the property but there is evidence in the notes that Care Coordinator 2 continued to discuss this with Ms G and sought to identify alternative accommodation should she change her mind. It was recorded in the notes on 11 February 2015: "*… (CCO) informed* [Ms G] *about viewing a new accommodation soon but* [Ms G] *refused to respond*".

5.270 It was documented in the notes on 25 February 2015: "*Sanctuary staff to contact* [initials redacted] *– acting CCO if* [Ms G] *suddenly agree* [sic] *to view the flat for an urgent arrangement to be put in place.*"

5.271 Care Coordinator 2 completed a universal mental health pathway risk assessment on 3 March 2015, as part of the housing assessment process. The assessment identified a number of risks which should have been used to inform Ms G's placement, but there is no evidence this was taken forward jointly with RBG.

5.272 RBG also provided a 'Referral for Greenwich Mental Health Support Services' submitted by Sanctuary Supported Living to RBG Intensive Support Services. The form is undated, but we believe it was completed as part of the above assessment work in 2015 (the form refers to an event in December 2014 which leads us to conclude it was completed after this time).

5.273 It was documented by the Sanctuary Supported Living referrer (role not recorded) that Ms G lacked capacity, but they were unable to provide specific detail of a Mental Capacity Assessment:

"*Attempts to carry out mental capacity assessment have been unsuccessful as* [Ms G] *refuses to engage. Her finances are managed by an Appointeeship and she is under Court of Protection suggesting lack of financial capacity. She has capacity about where she wants to move, medication and daily living*"*.*

5.274 We have not identified evidence of capacity assessments being completed in relation to Ms G's decision of where she lived, medication or daily living.

5.275 Three recommendations were made in relation to Ms G's housing:

"*1. Ground floor – because of reduced mobility due to her leg fracture over a year ago and back pains…*

2. Self-contained flat – because she struggles to do well in shared accommodation…

[110] ISS: Intensive Support Service

3. Concierge Service – as she frequently calls the police and emergency services at any time of day or night and it is possible that she may go out at night on occasions (it is not clear the frequency of this)."

5.276 There is no evidence RBG Housing explored the above with Care Coordinator 2 or Ms G, beyond what we have previously set out. When Ms G declined to move, the matter was not taken further.

5.277 RBG provided a consent form for the Mental Health Pathway Services, signed by Ms G on 13 March 2015 but there was no supporting capacity assessment.

5.278 Care Coordinator 2 continued to explore alternative accommodation options for Ms G in March 2015, though there is no evidence her capacity was reviewed again as part of this process. Care Coordinator 2 documented in the notes on 5 March that she did not consider Ms G's accommodation to be suitable: "*…* [Ms G] *is now the only female in the house… it is increasingly looking like an inappropriate accommodation for* [Ms G] *and will be best she moves quickly*".

5.279 Care Coordinator 2 did not progress the issue of accommodation after March 2015, and Ms G had a change of Care Coordinator in October 2015. We have not seen evidence that Ms G's accommodation, specifically historic concerns, was included in a handover (though we note Care Coordinator 3 was not originally allocated as Ms G's Care Coordinator. Another individual was allocated in July 2015, but they ultimately did not fulfil the role).[111]

5.280 Ms G informed Care Coordinator 3 in August 2016 that she would like to move to a new house. We also identified five episodes between January 2016 and September 2016 where Ms G mentioned or requested respite care.[112]

5.281 Taken alongside the repeated allegations made at this time by Ms G this cluster of requests for respite may have indicated further underlying issues with Ms G's accommodation. The episodes were recorded in Trust notes but not progressed and did not feature in any safeguarding discussions.

Finding: ICMP staff were taking steps in early 2015 to move Ms G from what they considered to be unsuitable accommodation. Professionals were in agreement she would benefit from ground floor accommodation and support services. However, Ms G declined to move, and she was considered by professionals to have capacity, though a formal assessment was not undertaken. Consequently, there was no recourse for staff to move Ms G against her will, though her mental capacity was not assessed again as part of this process. The matter was not progressed after March 2015; the reason why is not documented in the notes.

5.282 We have previously made a recommendation in relation to the ICMP's adherence to CPA and care planning.

5.283 We have previously made a recommendation in relation to the Trust's monitoring of capacity.

Ms G's request to change accommodation in 2016

5.284 Ms G told Care Coordinator 3 on 30 August 2016 that she wanted to move to a new house. The following month she told Care Coordinator 3 she would like more information about taking a respite break. It is documented in the November pre-CPA notes that Care Coordinator 3 discussed Ms G's accommodation with her. She wrote in the notes on 1 November 2016:

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[111] It was recorded in the notes in July 2015 that the new Care Coordinator would undertake a joint home visit with Care Coordinator 2 as part of the handover process, but he/she did not attend. There is no information in the notes as to why this did not happen, and it was not until October 2015 that Care Coordinator 3 became Ms G's Care Coordinator.

[112] 12 January 2016, 26 July 2016, 8 August 2016, 30 August 2016 and 20 September 2016.

"*Discuss* [sic] *of exploring alternative accommodation she does not wish to move from current address*".

5.285 Ms G's CPA review took place on 7 November 2016. The notes do not detail a discussion about Ms G's accommodation, but Care Coordinator 3 recorded in the notes "*To explore Asra housing"*.

5.286 There is no evidence that this action was followed up.

Safeguarding alert in July 2017

5.287 London Care (cleaning service) raised a safeguarding alert on 7 June 2017 regarding the cleanliness of the house communal areas. Care Coordinator 3 submitted a safeguarding concern in response to this and the 10 July professionals meeting, on 13 July 2017 (as detailed and discussed above re Mr Q housing, paragraphs 5.241-5.243).

5.288 The professionals meeting on 10 July 2017 identified extensive concerns about the condition of the property and the environment. It was noted that none of the meeting attendees (predominantly from the Trust, but also RBG and London Care) were clear about the financial arrangements in the house e.g., who was paying for utilities. The care coordinators for the residents (e.g., Care Coordinator 3) were tasked with resolving this issue, either by speaking to the residents or by contacting the FPA team.

5.289 Ms G was informed on 11 July 2017 that a safeguarding referral would be made. She indicated that she did not have any concerns about the property and was happy to stay there, although she reiterated her request for a respite break. A care package was put in place which provided a cleaning service for the communal areas.

5.290 It was agreed at the professionals meeting that the ICMP manager and care coordinators (including Care Coordinator 3) would have a follow-up meeting on 17 July 2017 to discuss progress with the agreed actions. There is no information in the progress notes as to whether this took place.

5.291 Care Coordinator 3 continued to monitor and document the cleanliness of the property. There is no evidence in the notes to suggest Care Coordinator 4 continued to monitor the condition of the property.

RBG sheltered housing assessment in October 2017

5.292 It was suggested at the professionals meeting on 10 July 2017 that Ms G might benefit from moving to supportive accommodation. Sheltered Housing and Asra housing were discussed as options. It was agreed Care Coordinator 3 would discuss these options with Ms G, with a view to making a referral to the RBG Sheltered Housing team.

5.293 Care Coordinator 3 submitted an application to RBG on 17 July 2017 for Ms G to be placed in sheltered housing. Ms G's care plan and risk assessment were provided as part of the referral.

5.294 Ms G was told about the referral the same day; she said she wished to move in the future. Care Coordinator 3 documented in the referral that Ms G struggled with stairs and her current placement was located on the first floor. She added that Ms G had indicated she would feel safe and less vulnerable if placed in RBG sheltered housing.

5.295 The RBG Assessment Officer for Sheltered Housing emailed Care Coordinator 3 on 5 October to confirm she would be undertaking an assessment with Ms G on 18 October 2017. She asked for copies of Ms G's care plan and risk assessment. Care Coordinator 3 forwarded the email to Bridge Support the same day, asking that they support Ms G during the appointment at her home.

5.296 Care Coordinator 3 emailed Bridge Support on 13 October to advise she was changing roles and would no longer be Ms G's Care Coordinator. She sent the Sheltered Housing Assessment Officer Ms G's care plan and risk assessment the same day in preparation for Ms G's housing assessment. There is evidence that Care Coordinator 3 included Ms G's sheltered housing assessment in her internal handover note[113] but we have been unable to confirm who the recipients of the email were or when it was sent. Care Coordinator 3 told us she sent it to the Team Manager but could not give more detail.

5.297 The Assessment Officer attempted to undertake an assessment with Ms G at home with an interpreter on 19 October 2017 (a day later than originally set out in the email of 5 October 2017). A member of Bridge Support had attended Ms G's property on 18 October for Ms G's assessment. There is no evidence they were advised Ms G's appointment was the next day. The Assessment Officer had booked an interpreter for 19 October therefore we consider the date recorded in the 5 October email to be an error.

5.298 The Assessment Officer sent an update to Bridge Support staff on 20 October. She advised that she had been unable to complete the assessment the previous day because Ms G would not engage but she did indicate there were two choices of property, both of which were managed by the Asra Housing Association. The Assessment Officer advised Bridge Support that Ms G could apply directly to the scheme.

5.299 The sheltered housing request was put on hold though there was no evidence in the Trust progress notes that the Trust was informed of the outcome of the assessment. The Assessment Officer told us she spoke to someone from Bridge Support or Ms G's Care Coordinator – but had not made a record of the call and could not remember who she had spoken to. The Assessment Officer told us she put the case on hold and awaited contact from the Trust.

5.300 Care Coordinator 4 confirmed he joined the ICMP in October 2017 but could not remember the exact date. He did not meet Ms G until the end of the month; therefore, it is unclear who the Assessment Officer spoke to at the Trust after the assessment.

5.301 This referral to sheltered housing was the last time alternative accommodation was documented as being discussed with Ms G and was not followed up by Trust or local authority staff.

Finding: A RBG sheltered housing assessment was initiated on 19 October but could not be completed due to Ms G's lack of engagement. The local authority shared Ms G's housing preferences with Bridge Support but there is no formal record of communicating this to the Trust.

Finding: There is no evidence Care Coordinator 4 or other members of the ICMP were made aware of the assessment outcome or the expectation that they would follow up with the RBG Assessment Officer if they wanted to arrange another housing assessment or discuss Ms G's other options. This was a missed opportunity to agree a plan with Ms G to support her to move out of the property.

Change in residents at Mr Q and Ms G's house

5.302 Historically, there had been two other male residents living in the house with Mr Q and Ms G. However, in the latter part of 2017 and early part of 2018 one resident passed away and another had to be transferred to hospital. This left Mr Q and Ms G living alone at the property.

5.303 We would have expected to see evidence in the notes that Ms G was spoken to regularly about her living arrangements to make sure she was happy to live with three men. There is

[113] We have been unable to identify Trust expectations in relation to the detail and sharing of handover information to staff within the same team. The Trust CPA and care planning policies do not set out policy/process in relation to handover.

extensive evidence in the notes that she made allegations against individuals in the house yet there is no evidence this was explored with her, either by the Trust or primary care. We asked the ICMP Associate Specialist about Ms G's allegations, who told us he was not concerned because she used the word 'Uncle' in reference to her housemates and was very respectful of them. He told us her allegations were delusions. We discuss this further in section 8 'Safeguarding'.

5.304 We asked Care Coordinator 4 whether he discussed the change in living arrangements in 2017 and 2018 with either Ms G or Mr Q. He told us he made a point of not discussing their living arrangements with them as he did not want to breach confidentiality. However, it would have been good practice to have had these discussions with them without the need to breach confidentiality, with a view to checking both were happy with the arrangements. In particular, Ms G should have been asked if she felt safe living with just Mr Q.

5.305 Equally, given the sometimes erratic nature of Ms G's behaviour, Mr Q should have been spoken to in the context of whether it was bothering him. For example, the ICMP were sometimes informed by the police that they had responded to emergency calls made by Ms G at the address, and the neighbour's made complaints in April 2018. There is no evidence in the notes to suggest Mr Q told his care coordinators or Bridge staff that he was frustrated or bothered by Ms G – something reiterated to us by Bridge Support – but after the incident in June 2018 his mother told Trust investigators and later ourselves that he strongly disliked Ms G.

Finding: Care Coordinator 4 deliberately did not speak to Mr Q and Ms G about their relationship in the house. However, it would have been good practice to ask about living arrangements, particularly in response to events like police contact and neighbour complaints, without breaching patient confidentiality. This was a missed opportunity to explore the dynamic between the two and to potentially identify any concerns pertaining to the living arrangements.

Safeguarding – accommodation

5.306 Ms G made repeated allegations about her fellow residents. Had they been followed up within a safeguarding framework they may have led to a wider multi-professional review of her care needs and accommodation.

5.307 As a minimum, the repeated allegations should have indicated to her care team (e.g., care coordinator) that her care plan and risk assessment needed reviewing. Good practice would have also indicated that a multi-agency safeguarding process may have supported staff when responding to repeated allegations of the same nature. The London Multi-Agency Adult Safeguarding Policy and Procedures say:[114]

"*Where there are patterns of similar concerns being raised by the same adult within a short time period, a risk assessment and risk management plan should be developed and a local process agreed for responding to further concerns of the same nature for the same adult. All organisations are responsible for recording and noting where there are such situations and may be asked to contribute to a multi-agency response*".

5.308 Notes on RiO on 5 June 2015 indicate that Care Coordinator 2 was attempting to arrange a multi-professional meeting. Care Coordinator 2 stopped being Ms G's Care Coordinator shortly after and there is no evidence a meeting took place. Care Coordinator 3 did not formally become Ms G's Care Coordinator until later in the year; during this gap, the role was covered by other staff.

[114] London Multi-Agency Adult Safeguarding Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2015/02/Pan-London-Updated-August-2016.pdf

5.309 In addition, Ms G requested respite on at least five occasions during 2017. Care Coordinator 3 referred her for a sheltered accommodation assessment, but this was not followed up because of a further change of Care Coordinator in October 2017.

5.310 There were no records indicating why Ms G was requesting respite.

5.311 Good practice would have been to explore with Ms G why she wished to have respite and to explore this alongside her wider concerns regarding her accommodation.

Safeguarding – cultural issues

5.312 One of the concerns about the appropriateness of Ms G's accommodation was that Ms G was a single Asian woman, who from 2015, was the only woman living in the shared accommodation.

5.313 Furthermore, English was not her first language. Whilst services had engaged interpreters to support communication with her, no consideration was given to the impact that English not being her first language might have on her relationships in the household.

5.314 There is no evidence her cultural or communication needs were considered as part of her care plan.

Safeguarding – male walking round 'half naked'

5.315 During the home visit on 5 March 2015, it was identified that a new male resident in the house liked to walk around 'half naked'. This should have been raised as a safeguarding concern and an enquiry should have been undertaken.

5.316 Had this been flagged as an area of concern it may have been linked to a visit made by police on 9 March 2016 in response to Ms G calling to report she had been attacked by male residents. The door was answered by a male wearing soiled underwear.

5.317 However, neither incident was raised as a safeguarding concern.

5.318 In addition, Ms G made four repeat allegations between January and March 2015, and one in February 2017, that "*males wanted to marry her*". The first four are close to the visit on 5 March 2015 and should have elicited a safeguarding concern.

5.319 As a minimum, good practice would have been for Ms G's Care team to explore these issues with her to understand why she was describing these experiences.

Safeguarding – landlord

5.320 During the telephone call between Care Coordinator 2 and the RBG commissioner (mental health) in January 2015 a comment was made that "her *landlord had informed her she does not have to move out of the property remains a worry*".

5.321 This conversation identified concerns that Ms G was being unduly influenced to stay in the house by her landlord. This was significant given Ms G's clear reluctance to discuss moving and concerns about the appropriateness of her accommodation. Her Care team recognised her landlord might have been influencing her to stay in the property. There was a discussion with the landlord on 12 January 2015 but following his reassurances of acting in Ms G's best interests, the concern about undue influence did not lead to any further action and was not considered within the safeguarding framework.

5.322 It is of note that concern about the landlord's behaviour and influence was also identified in relation to having influence over Mr Q's finances. This was the same landlord.

5.323 Good practice would have seen a safeguarding concern being raised and shared. This would have enabled an assessment of the appropriateness of the landlord's interactions and influence with his residents.

5.324 This incident further highlights the lack of information sharing by the care teams supporting each resident.

5.325 Even when the Care Coordinator for two residents was the same person the cases were never reviewed as a whole to see how the dynamics of the house were affecting each resident.

Finding: All agencies involved in Ms G's care failed to consistently recognise and respond to Ms G's repeat allegations, and failed to develop a multi-agency response, as advised by the London Multi-Agency Adult Safeguarding Policy and Procedures.

6 Ms G's care and treatment in 2013

6.1 In this section we consider the actions undertaken by all agencies in response to Ms G suffering a broken leg in March 2013. We also detail the arrangements in place regarding her appointeeship and if she had private medical insurance.

March 2013

6.2 Ms G sustained a broken leg in March 2013. At the time, and in the months that followed, she stated she had been assaulted by at least one male resident who lived in the same property as her. The terms of reference require that we detail the events after the incident on 17 March 2013; they do not extend to analysing the response of the agencies involved, and whether this was in line with expected practice.

6.3 We set out below details of agreed actions and whether there is evidence these were undertaken. Please note the Trust was only able to provide us with Ms G's progress notes for 2013. These are the only records we have been able to refer to in relation to the Trust's contact with Ms G in 2013. Please refer to Appendix E for the full tabular timeline of events between March and September 2013.

Table 8: Key events between March and September 2013

Date	Agreed action	Evidence provided/action taken
20/03/13	Care Coordinator 1 to complete a safeguarding referral.	Safeguarding referral submitted on 22 March 2013.
21/03/13	Care Coordinator 1 to complete an incident report.	No evidence of incident report.
21/03/2013	Care Coordinator 1 to interview Ms G in hospital with a hospital interpreter about the events of 17 March 2013.	The ward was unable to arrange an interpreter. Care Coordinator 1 proceeded without an interpreter.
22/03/13	The Trust East Recovery team[115] to proceed with investigation under safeguarding procedures.	No evidence of formal investigation.
22/03/13	Care Coordinator 1 informed the Community Options Supported Lodging Scheme Manager that a safeguarding conference was to take place on 25 March 2013.	Safeguarding conference held with the Trust, Community Options and the Caring Landlord on 25 March 2013.
25/03/13	Agreed at Safeguarding conference: • Ms G's care plan would be reviewed prior to her discharge from hospital. • Community Options to explore alternative accommodation arrangements (e.g., ground floor) for Ms G. • Review in four weeks.	No evidence Ms G's care plan was reviewed, with her or separately, prior evidence alternative to discharge from the Bevan Unit in July 2013. No documented accommodation options were shared with the Trust. No evidence the plan was reviewed four weeks later.
02/04/13	Documented at zoning meeting that Ms G would be seen by Trust staff the next day.	No evidence Ms G was seen in hospital by Trust staff the next day (3 March 2013).

[115] The East Recovery team later became part of the ICMP.

Date	Agreed action	Evidence provided/action taken
10/04/2013	Discussed at zoning meeting; Care Coordinator 1 to speak to Ms G about her future accommodation.	Care Coordinator 1 spoke to Ms G (without an interpreter) at Kings College Hospital (KCH) on 25 April 2013. Ms G indicated she wanted to return home. Care Coordinator 1 spoke to Ms G on 30 May 2013. Ms G said she wanted to return to the property. However, a member of the Bevan Unit told Care Coordinator 1 that Ms G had said she did not want to return to the property. Care Coordinator 1 spoke to Ms G on 21 June 2013. Ms G said she wanted to return to the property.
24/04/2013	GP6 contacted the Recovery East team (and later Ms G's Landlord) to let them know the practice had safeguarding concerns about Ms G. GP6 was told a member of the team would call back.	Care Coordinator 1 contacted the GP practice to confirm Ms G was assaulted by another resident who has been detained under the MHA and would not be returning to the property.[116]
25/04/2013	KCH Discharge Coordinator to liaise with Occupational Therapy to arrange a functional assessment of Ms G with an interpreter present.	Hospital notes indicate an assessment was undertaken (outcome not recorded), though there is no evidence this was shared with Care Coordinator 1.
25/04/2013	Care Coordinator 1 to contact Community Options and the Caring Landlord to discuss Ms G's accommodation.	No evidence in the notes of any discussion about Ms G's accommodation.
03/05/2013	Queen Elizabeth Hospital (QEH) Physiotherapist notes say the Caring Landlord was contacted about Ms G's accommodation who advised they were in the process of relocating Ms G's room to the ground floor of the property.	Ms G's room was not changed to the ground floor. When she returned to the property, it was to her original bedroom on the first floor.
07/05/2013	The Metropolitan Police Service (MPS) spoke to Care Coordinator 1 about the whereabouts of the alleged assailant. Care Coordinator 1 advised the alleged assailant was soon to be discharged and might return to the property. The MPS asked if Ms G would be willing to be interviewed via the 'Achieving Best Evidence' approach. Care Coordinator 1 was to discuss with Community Options staff and the Caring Landlord.	No evidence in the notes that the MPS interview approach was discussed with the Caring Landlord or Community Options staff.
10/05/2013	It is documented at an East Recovery team meeting that Ms G's family were	There is no evidence steps were taken to make the property

[116] This information was originally shared with the practice by Ms G's landlord. The GP noted that Care Coordinator 1 confirmed what the landlord had said to be correct.

Date	Agreed action	Evidence provided/action taken
	concerned that she wished to return to the property, and they queried whether she had capacity to make this decision. It is noted that Community Options intend to bring in more female residents.	predominantly female. Ms G remained the only female at the property.
10/05/2013	Another member of the Trust East Recovery team who knew Ms G's family emailed them to relay that the team intended for Ms G to return to the property and the team considered she had capacity to make this decision. It is further stated that the property was to have only female residents with the exception of an elderly male who was considered to be "*harmless*".	As above. No evidence a capacity assessment was undertaken by Trust staff.
16/05/2013	Ms G's family wrote to the East Recovery team Manager (part of ongoing communication) stating their concerns about Ms G and accepting an offer of a meeting.	Notes indicate Care Coordinator 1 was to meet with Ms G's family sometime after 20 May 2013.
20/05/2013	Royal Borough of Greenwich (RBG) staff undertook a ward visit to see Ms G following a referral for intermediate care. It was difficult to establish Ms G's wishes because of the language barrier. Discharge planning was subsequently discussed between RBG and Care Coordinator 1. Care Coordinator 1 was to see Ms G with an interpreter on 24 May 2013 to undertake a capacity assessment and to agree with Ms G what she would like to do about her accommodation.	No evidence Care Coordinator 1 saw Ms G on 24 May 2013. Ms G was transferred to the Bevan Unit on 24 May 2013.
24/05/2013	Documented at East Recovery team meeting that Ms G would have a capacity assessment that day in relation to her accommodation.	No evidence a capacity assessment was undertaken on 24 May 2013. Ms G was transferred to the Bevan Unit the same day.
18/06/2013	Care Coordinator 1 informed Bevan Unit administrative staff that she would be overseeing Ms G's discharge planning. It was documented she was waiting for details of an access visit and the Physiotherapist's recommendations.	No details of an access visit or Physiotherapist recommendations documented in the notes as part of discharge planning; no evidence of formal discharge planning. Later documented in the notes (10 July 2013) that Care Coordinator 1 was unhappy with the Bevan Unit because they had not assessed Ms G's property in advance of her discharge from the unit.
26/06/2013	Care Coordinator 1 to liaise with Community Options about further Occupational Therapy and Physiotherapy assessments Ms G may need.	No evidence in the notes of contact with Community Options in relation to Ms G returning to the property or any assessments required in relation to this.

Date	Agreed action	Evidence provided/action taken
02/07/2013	Ms G was discharged from the Bevan unit to her home.	
16/07/2013	Care Coordinator 1 cancelled Ms G's GP appointment because the team Specialty Doctor would see her that day.	The home visit did not take place on 16 July 2013. The team Specialty Doctor was scheduled to undertake a home visit on 19 Jul 2013, but this was cancelled because a second member of staff was unavailable.
24/07/2013	A member of Community Options contacted the East Recovery team to ask if Ms G had had a capacity assessment. They said Ms G should not have returned to the property but should instead have been relocated to a care home.	No evidence of a capacity assessment.
08/08/2013	Care Coordinator 1 spoke to Ms G who complained of leg pain. Care Coordinator 1 told Ms G she would attempt a home visit the next day.	No evidence a home visit was undertaken by Care Coordinator 1 on 09/08/2013. However, a Community Psychiatric Nurse (CPN) did attend the property to administer Ms G's depot medication.
13/08/2013	The Trust Joint Emergency team (JET) contacted Care Coordinator 1 to say Ms G had been attending A&E. Care Coordinator 1 advised she would see Ms G at home to put a support plan in place.	Care Coordinator 1 saw Ms G at home on 6 September 2013.

6.4 The above details several instances when actions were agreed by various agencies, though predominantly by the Trust, and where we have not seen evidence to confirm they were implemented. Crucially, early discussions about finding alternative accommodation for Ms G appear to have been overridden by her wish to return to the property, despite her family having concerns about whether she had capacity to make this decision, and conflicting messages about her wishes (see 6.5 below). Equally the option of moving Ms G to a ground floor bedroom at the same property was not implemented.

6.5 The notes indicate mixed messages about whether Ms G wished to return to the property – in March 2013 it was understood by Care Coordinator 1 that Ms G did not want to return to the property (something Care Coordinator 1 relayed to the police on 22 March 2013). In late May Ms G told Bevan Unit staff (via a Healthcare Assistant (HCA) acting as an interpreter) that she was too scared to return to the property. This was reported to Care Coordinator 1 when she visited Ms G on 30 May 2013. Ms G subsequently said she wanted to return to the property. She repeated this when Care Coordinator 1 visited her again on 21 June 2013. However, both meetings took place without an interpreter, and there is no evidence a capacity assessment was undertaken in relation to Ms G's decision to return to the property, despite this being documented as an action at a team meeting on 24 May 2013.

6.6 The notes clearly document that Ms G benefited from an interpreter, but with the exception of the police, there is no evidence staff made arrangements for an interpreter to be present in advance of seeing Ms G. For example, RBG staff saw Ms G in hospital on 20 May 2013 to discuss discharge planning. It was documented that it was difficult to ascertain where Ms G wished to go, because of the language barrier; there is no evidence an interpreter was booked in advance of the meeting.

6.7 There is little evidence in the notes that the Trust, Community Options or the Caring Landlord worked together in advance of Ms G's discharge from the Bevan Unit on 2 July 2013. Care Coordinator 1 completed a funding approval form the day Ms G was discharged from the Bevan Unit, requesting additional support for her. However, there is no evidence any preparation was made in relation to the property, be it locating her on the ground floor or refurbishing her room to accommodate her reduced mobility: Ms G returned to her unchanged bedroom on the first floor. Other agencies raised concerns with Care Coordinator 1 about the suitability of the property after Ms G had returned e.g., Ms G's Support Worker, a Physiotherapist from QEH and a member of staff from Community Options.

6.8 We also note a lack of timeliness in some of the agencies' responses to the concerns identified. We detail examples below.

- KCH staff informed the MPS that Ms G has been transferred to QEH and was fit for interview on 8 April 2013; the MPS interviewed her over four months later with an interpreter, on 15 August 2013.[117] The investigation was dropped shortly thereafter due to inconsistencies in Ms G's account of events.
- Care Coordinator 1 saw Ms G at KCH on 25 April 2013, over a month after she saw her at QEH.
- Ms G was discharged home on 2 July 2013. Care Coordinator 1 telephoned Ms G on 4 July 2013 to check on her. Ms G was first seen by Trust staff on 5 July 2013, when a CPN attended the property to administer her depot medication.
- The team Specialty Doctor was originally scheduled to see Ms G at home on 19 July 2013, but a second member of staff was not available to attend, therefore the meeting was cancelled. Ms G was not seen at home for review by the team until over seven weeks after the original appointment, when the Specialty Doctor and Care Coordinator 1 undertook a home visit on 6 September 2013.

6.9 The notes indicate Ms G's allegations of assault were initially taken seriously by health and social care staff, and safeguarding proceedings were initiated. A member of staff at QEH confirmed Ms G's injuries were consistent with her account of events. However, there is no evidence this was followed up or that a safeguarding investigation was undertaken. Ms G was not interviewed by the MPS until 15 August 2013, nearly five months after the incident (she was identified as fit for interview on 8 April 2013). The MPS closed the case on 27 August 2013 because Ms G gave conflicting information about the alleged assailant.

6.10 We identified several instances when actions were not implemented or there was a lack of timely response by the agencies involved in Ms G's care after her leg was broken on 17 March 2013. The safeguarding conference held on 25 March 2013 identified that Ms G should not return to the property and that alternative accommodation should be considered; if Ms G wished to return, consideration should be given to moving her to the ground floor. There is no evidence these plans were adequately explored or implemented. Ms G returned to the same room at the property unsupported on 2 July 2013.

Finding: Ms G's allegations of assault were initially taken seriously by health and social care professionals. However, actions and investigations agreed by the agencies were not implemented, and the MPS did not interview Ms G until 15 August 2013, shortly after which they closed their investigation.

Finding: It was agreed at a safeguarding conference on 25 March 2013 that Ms G should not return to the property if the alleged assailant continued to live there, but if she wished to return she should be relocated to the ground floor. However, she returned

[117] The MPS did attend QEH on 22 March 2013 to speak to Ms G but told us they were unable to "*communicate with her*".

unsupported on 2 July 2013 with no changes to her living arrangements, despite the concerns of her family that she did not have the capacity to make this decision.

Finding: No arrangements were in place to support Ms G when she returned to the property on 2 July 2013.

Appointeeship and other financial arrangements

6.11 Ms G's appointeeship was in place in 2013. We have been unable to establish when the appointeeship began, although using the records available, there is some evidence that suggests this was in 2008.

6.12 In 2013, her family sought to assume deputyship for Ms G's finances, because of their concerns about Ms G's ability to manage her money and collect it safety. They wrote to the manager of the Financial Protection and Appointee (FPA) team on:

- 8 May 2013
- 1 October 2013

6.13 The case notes indicate the FPA team received the letters (sent by recorded delivery) and were aware Ms G's daughter wanted to assume responsibility of Ms G's finances in August 2013 (there is no reference to the correspondence prior to this). The FPA team shared the letter with Care Coordinator 1 by email on 12 August 2013; they asked whether she had any objections to the family assuming responsibility of Ms G's finances. Care Coordinator 1 replied by email on 18 September 2013 indicating she had no objections to Ms G's daughter assuming deputyship. Consequently, on 20 September the team emailed a partially completed but undated COP3 Assessment of Capacity to Care Coordinator 1, asking that it be completed by Ms G's GP or Consultant Psychiatrist. There is no evidence this was progressed.

6.14 The FPA team sent a follow-up email to Care Coordinator 1 in October 2013, following receipt of the second letter from Ms G's family, asking for a response to their original request. Care Coordinator 1 replied by email saying she had discussed the matter with Ms G via an interpreter, and Ms G had said that she wanted the local authority to continue to manage her finances.

6.15 It is recorded in the notes that Ms G's daughter telephoned the manager of the FPA team on 15 November 2013. The manager of the FPA team told Ms G's daughter that Care Coordinator 1 had said that Ms G wanted the local authority to continue to manage her finances. Ms G's daughter challenged this, and consequently the manager of the FPA emailed Care Coordinator 1 asking her to contact Ms G's daughter with a view to resolving the matter.

6.16 There is no evidence in the notes that the Trust or FPA team arranged a capacity assessment to establish whether Ms G had capacity to decide who should manage her finances and/or whether her daughter should have assumed deputyship. Ultimately, it is the Court of Protection who would have made the decision regarding deputyship, but the FPA team should have supported Ms G's family to submit their request. There is no evidence in the notes that the FPA team liaised with Ms G's family again in 2013 in relation to her finances.

6.17 Ms G's family told us they were concerned she had private health insurance, and they could not establish why this had been put in place, or by who. We have been unable to identify any evidence to suggest Ms G had private health insurance in 2013.

Finding: There is no evidence the FPA team or Trust proactively communicated with Ms G's family in 2013 about their request to assume responsibility of Ms G's finances.

Finding: There is no evidence Ms G's capacity was formally assessed as part of the decision-making process of who should manage her finances. The FPA team shared

the relevant paperwork with the Trust, but there is no evidence this was completed or returned.

Finding: There is no evidence the matter was formally resolved with Ms G's family, rather the appointeeship remained with the FPA in 2013 by default, through lack of action.

Finding: We found no evidence to suggest Ms G had private medical insurance in 2013.

7 Internal investigations

7.1 The NHS England Serious Incident framework (SiF) (2015) does not give an explicit definition of a serious incident (SI), rather, it says the classification should be judgement based. It gives examples which include:

"[a] *homicide by a person in receipt of mental health care within the recent past*"

7.2 There are seven principles to SI management which include being open and transparent, objective, proportionate, timely and responsive. The SiF says:

"*Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again*".

7.3 The framework says a systems-based methodology – typically known as root cause analysis (RCA) – should be adopted to identify:

- "*The problems (the what?);*
- *The contributory factors that led to the problems (the how?) taking into account the environmental and human factors and*
- *The fundamental issues/root causes (the why?) that need to be addressed*'.

7.4 The SiF says that when more than one organisation has been involved in a patient's care all parties should – where possible – take steps to undertake a single investigation.

7.5 The Trust Incident Reporting and Management Policy and Procedure was issued in August 2018. The policy is underpinned by reference to Department of Health and Social Care (DHSC), Care Quality Commission (CQC), NHS England and National Quality Board (NQB) guidance. It sets out the roles and responsibilities of staff in relation to reporting and investigating incidents. The policy advises investigators to adopt a systematic approach (e.g., RCA) to their investigations. It places emphasis on "*… identifying weaknesses in systems and/or processes and to understand what went wrong and why*". It says that investigations must be completed in line with the SiF and submitted to the Clinical Commissioning Group (CCG) for approval within 60 days.

7.6 The policy details the investigation process for all serious incidents, the approach to gathering and mapping information, undertaking analysis, and setting out recommendations in response to findings. It specifies the requirements for the investigation report including details of duty of candour; evidence of the methodology used; and details of the engagement, support and involvement of patients/victims and their families in the investigation process.

7.7 The Trust undertook two internal investigations in response to the death of Ms G in June 2018, looking at the care and treatment of Mr Q and Ms G, separately. Bridge Support contributed to the Trust investigations, providing information and data. We set out below our assessment of each investigation. We discuss our analysis below.

Mr Q internal investigation

Mr Q internal investigation approach

7.8 The Trust internal investigation panel was composed of six staff:

- Director of Therapies and Consultant Clinical Psychologist (Chair)
- Staff Governor
- Non-Executive Director

- Virtual Risk and Family Liaison Nurse (South West London and St George's Mental Health NHS Trust)
- Consultant Psychiatrist
- Incident Manager (Patient Safety team)

7.9 The terms of reference set out eight areas for review. Seven of these were the same as the terms of reference for the Ms G internal investigation, the exception was a review of Mr Q's forensic risks. The terms of reference were to consider:

- *"The appropriateness of [Mr Q] being placed on the Care Programme Approach (CPA), whether he was offered care in line with trust policy and the quality of the pre CPA and CPA reviews.*
- *The quality of the risk assessment and care plans.*
- *The quality of the communication and liaison between Oxleas and external agencies (including Bridge and the housing provider).*
- *Whether the trust's safeguarding adults policy was fully complied with.*
- *Whether any forensic risks and risk to self and others, previously recorded in the Windip records, were transferred to Tio when Rio was introduced.*
- *The cultural, equality and diversity factors in relation to his care and treatment.*
- *The matters raised by family members.*
- [The panel will also] *Review the support offered to staff on the day of the incident and in the following days"*

7.10 The time frame for the internal investigation was the two years of Mr Q's care prior to the incident, though the tabular timeline sets out the preceding 13 months of his care. The investigation began on 17 July 2018 and was completed on 28 September 2018.

7.11 Interviews were conducted with five Trust staff, Mr Q's Bridge Support Worker and his landlord. The Trust Chief Executive contacted Mr Q's mother after the incident. The internal report says that the internal investigation Chair and a panel member subsequently made contact to invite Mr Q's mother to meet with them. The report says Mr Q's mother was unable to meet but set out two concerns in relation to Mr Q's care and treatment. The investigators maintained contact with Mr Q's mother during the investigation; the report says it would be shared with her upon completion.

7.12 In contrast to details included in the report, Mr Q's mother told us that she had been contacted twice by the Trust Chief Executive but otherwise had had no contact with the Trust since the incident. She told us she had been informed an internal investigation was to be undertaken but she was not contacted by the investigators and had not received a copy of the final report.

7.13 During its review of this report, the Trust reinforced the contact detailed in paragraph 7.11, that Mr Q's mother was contacted twice during its investigation. It provided a file note of a conversation between a member of the investigation panel and Mr Q's mother, dated 18 July 2018 (the author of the file note is not listed). We were not given a file note for the second conversation that took place a couple of weeks later. There is no evidence the final report was shared with Mr Q's mother.

7.14 Investigators did not contact Ms G's family as part of their Mr Q investigation, but a separate investigation into her care and treatment was undertaken by a different Trust team.

7.15 The report is composed of Mr Q's admission history, a chronology of care and a summary of findings against the terms of reference.

Mr Q Internal investigation findings

7.16 The internal report seeks to address the terms of reference, but the scope could have been broader. For example, the report makes little comment about the appropriateness of Mr Q's living arrangements or his relationship with Ms G. His mother informed investigators that he strongly disliked Ms G, but Mr Q's Care Coordinator was unaware of this and there is no evidence the Intensive Care Management for Psychosis (ICMP) staff explored their living arrangements despite them both being on the team caseload (and concerns being raised separately about Ms G's behaviour by the London Ambulance Service (LAS), the Metropolitan Police Service (MPS), and most recently a neighbour).

7.17 Members of the investigation panel told us that they did discuss broader issues pertaining to Mr Q's care and treatment (e.g., housing arrangements) and the panel Chair liaised with the Ms G investigation team, but this was not detailed in the internal report. However, they agreed that the report did not set out the 'whys' underpinning their findings.

7.18 The internal report identified gaps in Mr Q's care and treatment. The summary findings are set out under each term of reference. The investigation identified gaps in practice in relation to the Care Programme Approach (CPA), care planning and risk assessment. The report is clear there were gaps in practice, but it does not consistently set out the expectation of Trust policy and procedure (i.e., what *should* have happened). Equally, the report does not explore the underpinning factors in relation to these points (e.g., staff factors: case load, capacity, sickness etc.), though it does note the wider demands on the team in its consideration of zoning.

7.19 As a result of the summary nature of the findings, the report lacks detail of its analysis or how conclusions were reached. For example, in relation to whether the Trust's Safeguarding Policy was fully complied with, the report says, "*The panel heard that this matter* [2017 safeguarding incident] *was satisfactorily investigated and resolved*". There is no evidence the investigators independently tested this assessment or how they were provided with assurance.[118] The requirements of the policy are not included and there is no detail of actions undertaken at the time. Equally, Mr Q's risk assessments were reviewed but Trust policy was not referenced as part of the panel's analysis.

7.20 The investigation did not identify a root cause for the incident, which is often the case, but furthermore it does not identify care and service delivery problems, or contributory factors (as per RCA methodology).

7.21 The report concludes the incident was not predictable or preventable – it sets out its analysis in relation to this.

7.22 Further detail of our assessment of the Trust internal investigation can be seen in Appendix F.

Mr Q Internal report recommendations

7.23 The Trust internal report made three recommendations. We provide comments below each one.

"*1. The CPA policy was not followed as would have been expected. All staff within mental* [health] *teams where patients are on CPA must read and review the CPA policy and ensure that they are compliant. This must include the involvement of the wider social network."*

[118] As part of a review of this report, the Trust provided use with an email between the internal investigators and the Safeguarding Adults team about the 2017 safeguarding concern.

7.24 We agree all staff should be familiar and comply with the Trust CPA Policy, but we consider the above to be expected practice. The internal investigation did not explore whether there were broader barriers to policy adherence (e.g., staff factors) therefore it is unlikely the above recommendation would serve to mitigate the issue from recurring.

"*2. The panel recommends that the processes for monitoring patients in the 'green' zone must provide assurance that the patients continue to be appropriately placed in the 'green' zone.*"

7.25 The internal report identified several occasions when Mr Q's placement in the green zone should have been reviewed. However, the report also identified a lack of opportunity for staff to discuss green zone service users due to time limits during zoning meetings, and similarly, during supervision. Therefore, it is not so much the zoning process that is the issue, but the opportunity and mechanism that would trigger discussion about patients in the green zone. It may have been helpful to suggest a recommendation aimed at generating protected time to reviewing green zone service users.

"*3. All conclusions of clinical discussion are to be recorded within the primary clinical record, RiO.*"

7.26 As with the first recommendation, we consider this to be expected practice. It may have been helpful to focus the recommendation on quality assurance with a view to ensuring that staff are not only keeping RiO records up to date, but that they are clear and comprehensive.

Finding: The Trust internal report into the care and treatment of Mr Q was completed in line with Trust policy and national guidance. However, though the summary findings are reasonable, the report does not include the analysis used to reach its conclusions and there is limited benchmarking. The investigation lacks depth. The report is largely missing the 'why' underpinning omissions in practice e.g., why weren't Mr Q's care plans and risk assessments completed in line with Trust policy? Equally, its assessment that the Safeguarding Policy was adhered to is based on interview evidence as opposed to independent testing.

Finding: The terms of reference provided a clear scope for investigation, though these could have been extended to consider Mr Q's living arrangements, his relationship with Ms G and the long-term ICMP plan for Mr Q, who beyond receiving depot medication, was not engaging with the service, and had missed his last three CPA meetings.

Finding: The report recommendations primarily set out expected practice as opposed to actions to improve practice.

Ms G Trust internal investigation

7.27 The internal investigation team of four was composed of:

- Consultant Psychologist (Chair)
- Locality Manager for Greenwich East
- Consultant Psychiatrist
- Associate Director of Nursing

7.28 The report identified its approach as a single incident investigation, designed to identify care and service delivery problems, and contributory factors and root causes. Its approach was to gather information via written documentation and staff interviews. The report does not list what information was reviewed during the investigation.

7.29 The terms of reference set out eight areas of review. These were the same as those for the Mr Q investigation with the exception that there was no review of forensic risk. The terms of reference had the addition of undertaking a Structured Judgement Review into Ms G's death.

7.30 The team undertook interviews with the ICMP Associate Specialist, Ms G's two care coordinators and the ICMP Team Manager. A telephone interview was conducted with Ms G's landlord.

7.31 The Trust Chief Executive wrote to Ms G's family in July 2018. The investigation team contacted the family the same month, offering to arrange a meeting, which the family declined.

7.32 The internal investigation report provides a chronology of Ms G's care from 4 May 2017 until the incident. The chronology includes a section for 'Comments/issues identified'. The investigators identified a number of occasions in the chronology when Ms G's care plan and risk assessment were not updated in response to events (e.g., receipt of MERLIN reports and Ms G being found confused and hyperglycaemic in McDonalds in September 2017).

7.33 The Trust report says that an RCA investigation was undertaken. A root cause would be the earliest point at which a service intervention could have prevented the incident, and that is generally seen as the most significant contributory factor. However, whilst there is a chronology and timeline, we did not find evidence of an RCA methodology e.g., fishbone diagram, the contributory factor framework to identify contributory factors, or the five 'whys'. RCA tools would have facilitated the analysis and understanding of any fundamental system issues associated with the findings. We discuss the internal investigation findings below (paragraphs 7.36-7.42).

7.34 The report concludes with a Structured Judgement Review (SJR). Undertaking an SJR was part of the terms of reference. Typically, an SJR is a case note review that leads to a full investigation as opposed to being carried out at the end of an investigation. Whilst it was good practice to consider avoidability, it would have been helpful to explain the reason for including the SJR and the underpinning analysis that led to the conclusion there was "*at least slight evidence the death* [of Ms G] *may have been avoidable*". This is not consistent with the care delivery problems (CDPs) or assessment against predictability and preventability. We asked the internal investigation Chair what the rationale was for including an SJR in the terms of reference, but she told us she has not been involved in this decision.

7.35 The internal investigation was submitted to commissioners on 16 November 2018.

Ms G Internal investigation findings

7.36 The internal investigation set out its findings under each element of the terms of reference. It identified three CDPs and corresponding contributory factors (though these are not labelled in the context of 'staff', 'task' or 'patient' factors). We agree with the report findings, but the CDPs and contributory factors do not detail the 'why' underpinning some of the findings. For example, the report is clear that Trust policy was not adhered to in relation to keeping Ms G's care plans and risk assessments up to date but does not say whether this was explored with Ms G's care coordinators and if an explanation was offered. There is no exploration of team vacancies, agency use and individual caseload and if this was impacting the ability of staff to keep documentation current. We discussed this with the internal investigation Chair who told us she did not consider these to be factors pertinent to the case, it was more a case that clinicians at the time missed the broader context of Ms G's living arrangements e.g., that the household dynamics had changed and culminated in her living alone with Mr Q.

7.37 Similarly, the report identifies there was no documented follow up regarding Ms G's referral to sheltered accommodation, attributing this as an oversight by the clinical team, but it does not provide detail of Trust handover expectations and whether these were adhered to by Ms G's care coordinators (and if not, why not). The internal investigation Chair provided us with evidence that there had been a handover by email, but this was not reflected in the internal

report. The report makes no comment as to whether there should be broader oversight to ensure policy and practice is adhered to e.g., monitored by the Team Manager.

7.38 The scope of the Trust internal investigation is relatively narrow and provides no comment about Ms G's repeated contact with the emergency services and her GP. The terms of reference included reviewing the quality of communication and liaison between the Trust and external agencies, but the report focused on engagement with Ms G's landlord. There is evidence in Ms G's notes that the MPS and LAS contacted the Trust to raise concerns about Ms G's repeated contact with them, but the internal investigation makes no comment on how this was managed, or whether a professionals meeting should have been arranged.

7.39 The report makes little comment in relation the whether the Trust's Safeguarding Adult Policy was fully adhered to, rather it describes the three occasions safeguarding referrals were made. There is no assessment about whether practice was conducted in line with Trust policy. The report makes no comment about Ms G's capacity and whether this should have been subject to review, particularly in the context of her decision not to move house when the opportunity arose.

7.40 The report makes no comment on Ms G's physical health needs and whether her care plan adequately reflected these. The report notes Ms G's care plan was not updated in response to Ms G being found in a hyperglycaemic state in McDonalds but does not explore her broader health issues and the Trust's role in helping her manage these, and whether her accommodation was appropriate in this context (e.g., osteopetrosis, degeneration of the spine, cirrhosis, knee osteoarthritis, asthma and hepatitis C).

7.41 The SJR concludes the incident would have been less likely to have occurred if Ms G had been given the option and had agreed to move to supported housing. We agree it is reasonable to assume the incident in 2018 would not have happened had Ms G moved in 2017, but there is no evidence a risk assessment was undertaken, or any consideration given to the appropriateness of Ms G staying in the house with one other resident – Mr Q.

7.42 The SJR conclusion does not correspond with the assessment that Ms G's death was neither predictable nor preventable. We consider the latter assessment reasonable in the context of the information that was available to Trust staff at the time.

Ms G Internal report tone

7.43 The internal report Chair was part of the ICMP and was consequently leading an investigation into her own service and interviewing her peers. We consider that the findings of the internal report whilst reasonable were relatively light touch and did not highlight the serious nature of some of the omissions in care. For example, the report concludes "… *the care plan and risk assessment for* [Ms G] *were not adequate*". However, the report does not say Ms G's care plan had not been updated since May 2017 and that her CPA reviews predominantly contained the same narrative (e.g., the text was cut and paste from one review to the next). We raised this with the internal investigation Chair who said she had perhaps been too close to the team to reasonably challenge her peers. She described the case as possibly "*compromised*" by her involvement with the ICMP but noted there was no investigative alternative at the time.

7.44 The internal report Chair told us that Ms G's family had been unhappy about her involvement because she worked in the ICMP which is why the Associate Director of Nursing was involved in the case (as a panel member) and liaised with the family, who ultimately declined involvement in the investigation. We were informed that the Trust has since moved to a central investigative model, managed by a central investigative team who draw on clinical expertise as required.

7.45 Further detail of our assessment of the Trust internal investigation can be seen in Appendix F.

Finding: The Trust internal investigation into Ms G's care and treatment was conducted in line with Trust and national policy; though it is not clear whether the report findings were shared with Ms G's family as part of the investigation process. The investigation findings were reasonable and in some but not all instances, were underpinned by Trust policy. However, the terms of reference were not fully addressed (e.g., communication with other agencies), and the scope of the Trust investigation should have been expanded to consider Ms G's living arrangements and the broader management of Ms G's physical and mental health needs, particularly in relation to working with other agencies.

Finding: The tone of the report does not adequately reflect the gravity of the gaps in care identified, in part due to the service essentially investigating itself, and the challenge this created in terms of undertaking a robust inquiry into the practice of colleagues.

Ms G Internal report recommendations

7.46 The Trust internal report made three recommendations. The recommendations are included twice in the internal report. The wording varies slightly between the two examples; therefore we have set out those listed under 'Recommendations' at the beginning of the report as opposed to those listed under 'CDPs/Contributory Factors/ Systems/ Recommendations'. We asked the Trust internal Chair why there was a slight variation in the wording of the report recommendations, but she was unable to provide an explanation. We set out comment below each recommendation.

"*1. All staff within mental* [health] *teams where patients are on CPA must read and review the CPA policy and ensure that they are compliant. The team must put in place an improvement plan for the management of all patients on CPA so that all team members routinely consider and document the wider social circumstances, key relationship changes or other events within the patient's accommodation, and the impact of these on the patient. These changes must be fully reflected in the care plan, and in appropriate, risk assessment.*"

"*A thorough review of the robustness of care planning and risk assessment practice within the team to be undertaken. This needs to include clarification of the responsibilities of the team manager, the senior clinical staff and care coordinators*".

7.47 We agree with the Trust internal report findings that there were gaps in the quality of risk assessment and care planning. The above recommendation would go some way to mitigate this but because the Trust investigation did not explore staff factors in more depth (e.g., caseload) it is not possible to know if the recommendation will wholly address the gap in practice.

"*2. The team must document the handover of a CCO's* [Care Coordinator's] *caseload from one Care Coordinator to another.*

Team member to clearly document handovers from one Care Coordinator to another in RiO".

7.48 The Trust internal report did not set out expected practice in relation to handover, e.g., Trust policy. We consider the above recommendation to be expected practice. The recommendation would ensure handovers are documented but would not ensure the quality and detail of handovers. Crucially, in Ms G's case, her referral to Sheltered Housing was not followed up by her new Care Coordinator; documenting it would have been the first step to ensuring this was picked up by her new Care Coordinator, but involving a third party (e.g., the Team Manager) would have provided a failsafe to ensure such information had been noted and followed up. We are aware that Ms G's departing Care Coordinator did send a brief handover email to staff but we have been unable to establish who received this email and when.

"*3. As per Trust policy, the team must monitor and record on RiO, the outcomes of all safeguarding adult referrals to provide assurance that investigations and subsequent actions are completed.*

Team to monitor and record on RiO the outcomes of safeguarding adult referrals to provide assurance that referrals and investigations are completed'.

7.49 We agree with this recommendation though we note it relates to practice in 2018. Given the time that has passed, it would have been helpful to add an element of audit to this recommendation, to check whether current practice is undertaken in line with Trust policy.

7.50 The Trust recommendations do serve to partially mitigate the findings of the internal investigation but do not sufficiently address what we consider to be key issues pertaining to Ms G's care and treatment, specifically:

- Her repeated contact with other agencies.
- Her extensive physical care needs.
- The lack of professional curiosity in relation to Ms G's frequent allegations.
- The lack of a long-term plan for Ms G.
- The lack of consideration to safeguarding.
- The lack of consideration of Ms G's housing arrangements, particularly when living alone with Mr Q, and her requests for respite.
- The lack of consideration of any cultural issues – Ms G was an Asian practising Hindu living alone with a white male who drank heavily.
- The lack of central management of her care.

Finding: The recommendations partially mitigate the internal investigation findings, but do not sufficiently extend to the key issues pertaining to Ms G's care and treatment.

Analysis of both internal investigation reports

7.51 We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency (NPSA),[119] the NHS England SIF[120] and the NQB Guidance on Learning from Deaths.[121] We also reviewed the Trust's policy for completing SI investigations to understand the local guidance to which investigators would refer.

7.52 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA (or root cause analysis and Action, hence 'RCA Squared')[122] which discusses how to get the best out

[119] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services.

[120] NHS England (2015) Serious Incident Framework Supporting learning to prevent recurrence. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

[121] National Quality Board (2017) National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

[122] National Patient Safety Foundation (2016) RCA^2 Improving Root Cause Analyses and Actions to Prevent Harm. Published by Institute of Healthcare Improvement, United States of America.

of RCA investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

7.53 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust e.g., lack of patient/staff involvement;
- inappropriate use of SI process e.g., doing too many, overly superficial investigations;
- misaligned oversight/assurance process e.g., too much focus on process related statistics rather than quality;
- lack of time/expertise e.g., clinicians with little training in investigations trying to do them in their spare time; and
- inconsistent use of evidence-based investigation methodology e.g., too much focus on fact finding, but not enough on analysing why it happened.

7.54 We evaluated the guidance available and constructed 25 standards for assessing the quality of SI reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice. We have developed these into our own '**credibility, thoroughness and impact**' framework.

7.55 Detail of our assessment of both internal investigations using these standards can be seen in Appendix F. Our findings are summarised in the table below.

Table 9: Trust internal investigations findings summary

	Ms G internal investigation	Mr Q internal investigation
Standard met	12	9
Standard partially met	11	9
Standard not met	2	7

Trust's progress with action plans

7.56 The Trust Incident Reporting and Management Policy and Procedure (2018) says the SI team is responsible for drafting the internal investigation action plan, in collaboration with the directorate. The directorate is responsible for the implementation, delivery and financial implications of the action plan. Actions must be uploaded to the incident reporting system, Datix, and assigned to a responsible person who hold responsibility for the implementation and monitoring of the action. The Trust Board is responsible for agreeing the action plan and time frame for completion. The SI team lead is responsible for submitting progress reports to the SI Performance and Assurance Group

7.57 The Trust completed two SI reports, one for Mr Q and one for Ms G. Each internal report made three recommendations. We asked the Trust to provide us with the corresponding action plan for each report.

7.58 The Trust gave us a Serious Incident Action Plan for Mr Q dated 16 October 2018. The Mr Q action plan said a taskforce had been developed, led by the Deputy Chief Executive and supported by the Medical Director and Director of Nursing, to oversee the implementation of the action plan.

Mr Q Trust internal investigation action plan

"*Recommendation 1: A thorough review of the robustness of care planning and risk assessment practice within the team to be undertaken. This needs to include clarification of the responsibilities of the Team Manager, the Senior Clinical Staff and Care Coordinators.*"

7.59 The Deputy Chief Executive was assigned the action with a deadline of February 2019, though the action plan also said "*The Taskforce will oversight this review*". The Trust said evidence of action implementation would be through the embedding of the local induction programme and awayday programme. The Trust provided an induction checklist dated November 2018, "*awayday action points*" dated October 2018, and an agenda for the March 2019 awayday. The Trust also provided minutes from the ICMP awayday dated 8 March 2019. The action plan says, "*Taskforce Meetings have taken place with relevant Locality and senior staff on 28/11/2018, 16th Jan 2019, 27th Feb 2019*".

7.60 We have reviewed the documents provided by the Trust in relation to this action, none of which provide detail in undertaking a "*thorough review of the robustness of care planning and risk assessment practice within the team*". The induction checklist sets out a list of items to be covered over a four-week induction period; CPA is listed in week two. Risk assessment is not listed. The March awayday action points do not refer to care planning or risk assessment. We have not seen evidence of a review of practice or detail pertaining to the clarification of roles.

7.61 We would have expected evidence in relation to assessing the quality of risk assessments and care planning (e.g., case note audits – at the outset and after a period of change in practice to assess any improvement), evidence of expected standards and Trust policy being shared with staff (e.g., meeting minutes and communication of Trust policy), and communication of the role responsibilities in relation to risk assessment and care planning (e.g., details of training sessions including attendance, emails, meeting minutes, staff briefing).

7.62 The evidence embedded within the Trust action plan provides no assurance the action has been started.

"*Recommendation 2: The panel recommends that the processes for monitoring patients in the 'Green' zone must provide assurance that the patients continue to be appropriately placed in the 'Green' zone.*"

7.63 The ICMP Team Manager was assigned the action with a January 2019 completion date. The action detailed was to undertake "*monthly audits of HCPs'* [Healthcare Professionals'] *caseloads, specifically focussing on green zone patients and review care plans to ensure compliance*". The action plan further details that green patients should be reviewed in supervision and relevant documentation recorded on RiO. All care coordinators were to detail green zone criteria and discussions at the pathway meetings in progress notes. The action plan set out anticipated evidence to be:

- Audits.
- Random Care Coordinator caseload audits (bimonthly, undertaken by the Team Manager).
- Team meeting minutes to reflect discussion and awareness.
- Evidence of discussion of green zone patients under CPA at the weekly pathway review meeting.
- Random supervision notes audits.

7.64 The Trust action plan detailed progress as "*Online audits via Oxleas audit tool. Results discusses* [sic] *team meeting*". We were not provided with evidence of audits of either case notes or supervision.

7.65 We were given anonymised 'Move on' meeting minutes dated 15 March 2019. These minutes detail discussions around the step down/discharge of patients. The minutes included details of the step down criteria.

7.66 We were given the Greenwich West ICMP team meeting minutes for 12 February 2019. The agenda included zoning discussions and evidence that at least one patient in the green zone was discussed ("*XX – green, possible discharge at CPA*"). We have seen additional meeting notes (October 2018, November 2018 and February 2019) that detail 'zoning' as an agenda item, but it is not clear from the minutes the extent to which patients in the green zone were discussed.

7.67 The Trust has provided evidence that green zone patients are discussed in meetings though, based on the notes, the nature and structure of these discussions is not clear (we acknowledge internal meetings notes are not typically written with an external audience in mind). We have not been provided with clarity about the process for monitoring patients in the green zone and ongoing monitoring.

"*Recommendation 3: All conclusions of clinical discussion are to be recorded within the primary clinical record, RiO.*"

7.68 The action was assigned to the Team Manager with a completion date of the end of November 2018. The action set out in the action plan was "*Team manager to inform staff that all clinical discussions that take place in team meetings, huddles and zoning will be recorded* [in] *the patients RiO progress notes so that clear plans are visible*". It added that care package support should also be documented in the notes.

7.69 The Trust provided one page of an anonymised care plan, minutes of a zoning meeting (February 2019) and a "*3rd section feedback entry in RiO progress notes*". However, we have been unable to triangulate the evidence provided to track whether the discussions at the team meeting and recorded in the care plan are recorded in RiO for the relevant patients.

7.70 The Trust has provided limited evidence of clinical discussions being documented in RiO. Possible evidence of this would have been to provision of team meeting minutes, highlighting relevant (anonymised) discussions about service users and the associated RiO notes that reflected the team discussion.

7.71 We have limited assurance that all conclusions of clinical discussions are recorded in RiO.

Finding: The evidence submitted in the Mr Q internal action plan provides little assurance that the actions have been comprehensively implemented or embedded in practice.

Ms G Trust internal investigation action plan

7.72 The Serious Incident Action Plan for Ms G had three recommendations. Each recommendation had a lead (e.g., Deputy Chief Executive) and a completion date.

"*Recommendation 1: A thorough review of the robustness of care planning and risk assessment practice within the team to be undertaken. This needs to include clarification of the responsibilities of the Team Manager, the senior clinical staff and care coordinators.*"

7.73 The Deputy Chief Executive was assigned the action with a deadline of February 2019, though the action plan also said, "*The Taskforce will oversight this review*". The Trust update says care plan and risk assessment audits will take place on a monthly basis as part of supervision and will be discussed in team meetings.

7.74 However, the evidence attached to the action plan is the same as that listed for the Mr Q action plan: an induction checklist and awayday notes. Please see above our comments in relation to our expectations of evidencing progress.

"*Recommendation 2: Team members to clearly document handovers from one Care Coordinator to another in RiO.*"

7.75 The Associate Director was assigned the action with a completion date of February 2019. Evidence of progress with the action was the local induction checklist and awaydays notes. The action plan referenced the monthly audits detailed in relation to Recommendation 1.

7.76 "*Caseload update/summaries/transfers/allocation*" is included in weeks 3 and 4 of the induction checklist. Handover/transfer of care within the team is not recorded in the ICMP awayday notes for March or October 2019.

7.77 We agree transfer of care should be part of staff induction, but the Trust has not provided any examples of handover notes or audits of handover notes. Consequently, we are unable to comment on whether ICMP staff are providing clearly documented handovers to their colleagues.

"*Recommendation 3: Team to monitor and record on RiO the outcomes of safeguarding referrals to provide assurance that referrals and investigations are completed.*"

7.78 The Associate Director and Head of Social Care were assigned the action with a completion date of December 2018. Evidence of progress is the same as those listed for Recommendations 1 and 2; awayday notes and the induction checklist. The action plan says the Head of Safeguarding will review iFox with the team on a monthly basis to monitor safeguarding investigations to ensure they are completed.

7.79 Safeguarding is not listed in the ICMP induction checklist or the awayday notes. The Trust has not provided evidence of monitoring or recording on RiO the outcomes of safeguarding referrals.

7.80 There is no evidence of monitoring safeguarding investigations and ensuring they have been completed either in the form of iFox reports or team minutes evidencing discussions.

Finding: The evidence submitted in the Ms G internal action plan provides no assurance that the actions have been implemented or embedded in practice.

8 Safeguarding

Safeguarding Adult Board (SAB)

8.1 Each local authority must set up a SAB. The Care Act 2014 says that there should be three core members: the local authority, CCGs and police. The overarching purpose of an SAB "*is to assure itself that local safeguarding arrangements and partners are effective in helping and protecting adults at risk of abuse and neglect*."[123]

8.2 SABs have three core duties. They must:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria for these.

Safeguarding Adults Reviews (SAR)

8.3 The Care Act 2014 states that SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

8.4 SARs should reflect the six safeguarding principles (empowerment, prevention, proportionality, protection, partnership and accountability) and the following should be applied to all reviews:

- *"There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.*
- *The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.*
- *Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.*
- *Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.*
- *Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively".*[124]

8.5 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. The overall

[123] Safeguarding Adults Boards: https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/role-and-duties.asp

[124] Care Act (2014) statutory guidance: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

purpose of a SAR is to promote learning and improve practice, not to re-investigate or to apportion blame. The overall objectives include establishing:

- Lessons that can be learned from how professionals and their agencies work together.
- The effectiveness of safeguarding procedures.
- Learning and good practice issues.
- How to improve local inter-agency practice.
- Service improvement or development needs for one or more service or agency.

Royal Borough of Greenwich (RBG) safeguarding

8.6 In this section we detail RBG's Adult Safeguarding Duties under the Care Act 2014, and as delegated to the Trust under a Section 75 Agreement (we were later informed the delegation authority was in place due to locally agreed custom and practice indicated from a previously signed Section 31 Agreement).

8.7 Adult safeguarding is a statutory responsibility for local authorities and partner agencies under the Care Act 2014. Within RBG adult mental health and social care services operate under a commissioning arrangement with the Trust. This commissioning arrangement is defined within an (unsigned) Section 75 agreement under the Health and Social Care Act 2012. This agreement replaced the previously agreed Section 31 of the Health Act 1999. All partners have identified the need to have the Section 75 signed off and they recognise that this is long overdue. The local commissioners told us that "*a current project is completing a version to be signed off and follows two further major projects to get this completed*".

8.8 We did not review the Section 75, but we understand that the agreement covers adult safeguarding enquiries.

8.9 Whilst a Section 75 partnership agreement allows for an NHS Trust to undertake local authority statutory duties, the Care Act 2014 (Care and Support) statutory guidance identifies that:

'..the local authority would still remain legally responsible for its functions when they are carried out via partnership arrangements, as with delegated functions'. [125]

8.10 As part of RBG's safeguarding delegation, senior staff from the local authority are seconded into the Trust. These include Service Manager for Social Care, Heads of Social Care and AMHPs. These staff are in post to provide support, oversight and assurance of safeguarding, alongside other mental health social care functions.

8.11 The Trust has a quarterly Safeguarding Committee, which oversees the work of the safeguarding children and the safeguarding adults agenda. The Committee reports through the Trust board and then onto the SAB. The Safeguarding Committee is a sub-group of the Performance and Quality Assurance Committee which reports to the Trust Board.

Referrals sent to RBG

8.12 As the responsible local authority for adult safeguarding in Greenwich, RBG will receive referrals or welfare concerns for any adult in their area. This includes adults whose support needs may relate to their mental health. These referrals or welfare concerns can be made in person, by email, telephone or letter or through specific organisational processes such as

[125] Department of Health and Social care guidance (2021). Chapter 18 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

those of the emergency services (London Multi-Agency Adult Safeguarding Policy and Procedures).

8.13 In London, the Metropolitan Police Service (MPS) use a welfare and safeguarding alert system called MERLIN Adult Come to Notice (ACN) for reporting concerns for adults they come into contact with.

8.14 The London Ambulance Service (LAS) use an adult safeguarding form (LA280) to report safeguarding adult concerns to the local authority (Safeguarding Adults in Need Policy V4.3 appendix one). Guidance for staff states "*if you have concerns about the adult and believe they are suffering or likely to suffer abuse or neglect then you should share the information with the local authority and/or the police if you believe or suspect that a crime has been committed*" and "*This is raised with EBS* [Emergency Bed Service] *either via the phone or on a safeguarding adult concern form (LA280 appendix one)*".

8.15 Both MERLIN ACN reports and LAS safeguarding adult forms are passed to a contact referral team at RBG called the Contact Assessment team (CAT). Once received these referrals are scanned onto a case note recording system called Framework-I. For an adult with care and support needs relating to their mental health these referrals are then passed to the mental health Trust.

8.16 We were also informed that adult safeguarding concerns for people open to Trust services sometimes get sent directly to the relevant team rather than to RBG. These referrals are not logged with RBG.

Referrals to RBG for Mr Q

8.17 We found no referrals from MPS or LAS to RBG for Mr Q during the time frame.

Referrals to RBG for Ms G

8.18 The LAS chronology indicates that paramedics attending Ms G's home on 16 May 2016 "*submitted a safeguarding concern to the local authority*" (CAD 2421).

8.19 Notes on Framework-I for 16 May 2016 state "*16MAY16 refers to client calling LAS out saying she has been stabbed – client is resident in MH Supported housing*".

8.20 The MPS sent a total of 24 MERLIN reports. In 14 of the 18 loaded MERLIN ACN logged episodes there was a delay between the date of the report and the date it was entered onto Framework-I (see Table 10). It is unclear where the delay occurred (whether from receipt of the report or the report being logged onto the system) although seven of the Framework-I records indicate the report was received on the date recorded on the system.

8.21 It is unclear what happened to a further six MERLIN ACN reports that are shown on the MPS chronology as they do not appear on the RBG system. We were unable to establish with RBG why there was a discrepancy between the numbers of MERLIN ACN reports reported by MPS and the numbers recorded on Framework-I. We were informed that this would be explored further. We were also informed that a full review into how MERLIN ACN reports are responded to is underway as part of the work of the Greenwich SAB.

Table 10: MERLIN ACN reports received and logged

Date of record	Report dated	Days Diff.	Action taken by RBG
15/03/18	--		*Email forwarded to East Mental Health (MH) team to follow up and assess situation*
12/03/18	11/03/18	*1*	*Passed to MH team to action as necessary*
11/12/17	11/12/17		*Redirected to MH team by email and uploaded in documents*
25/07/17	24/07/17	*1*	*MERLIN report passed to NHS Oxleas to follow up*
25/05/17	20/05/17	*5*	*Logged and passed to MH team*

03/04/17	31/03/17	*3*	*MERLIN report uploaded into documents and referred to MH services to follow up as necessary*
29/11/16	24/11/16	*5*	*Passed to MH team for follow up/necessary action. No Further Action (NFA) from CAT*
08/11/16	06/11/16	*2*	*Passed to MH team for follow up. NFA from CAT*
24/10/16	22/10/16	*2*	*MERLIN report uploaded into documents and referred to MH services to follow up as necessary*
16/06/16	14/06/16	*2*	*MERLIN report uploaded into documents and referred to MH services to follow up as necessary*
23/05/16	22/05/16	*1*	*MERLIN report uploaded into documents and referred to MH services to follow up as necessary*
03/12/15	02/12/15	*1*	*Information passed to* [Care Coordinator 3] *@ the heights via email*
20/08/15	14/08/15	*6*	*Logged and passed to MH services for follow up. NFA from CAT*
16/05/15	16/05/15		***No detail re where this MERLIN went***
17/04/15	13/04/15	*4*	*The report relates to a skeleton crime report – logged and faxed to allocated worker –* [Care Coordinator 1] *at The Heights*
01/04/15	--		*Information logged and faxed to allocated MH worker,* [Care Coordinator 1] *at The Heights*
30/03/15	28/03/15	*2*	*Fax send to the Heights*
16/03/15	11/03/15	*5*	*Faxing to allocated worker at the Heights*

Safeguarding episodes recorded on Framework-I for Mr Q

8.22 There is one adult safeguarding episode for Mr Q recorded on Framework-I on 30 August 2017. The date indicates that this related to the safeguarding enquiry completed by the Trust in July 2017 although Framework-I records do not provide sufficient detail to confirm this. The entry directs any queries regarding the safeguarding to the Trust.

8.23 The RBG chronology also identified two further entries (26 March 2018 and 28 March 2018) but we could not find any other reference to these safeguarding forms on the RBG Framework-I notes provided or the Trust case notes. The chronology states Safeguarding Adults Investigation Part 2 & Part 3 were completed by Mental Health services. We found no records of these forms.

Safeguarding episodes recorded on Framework-I for Ms G

8.24 There is one adult safeguarding episode for Ms G recorded on Framework-I on 31 August 2017. The date indicates that this related to the safeguarding enquiry completed by the Trust in July 2017 although Framework-I records do not provide sufficient detail to confirm this.

Mr Q – information sharing with the Trust

8.25 There is no record on Framework-I of any referrals for Mr Q being passed *to* the Trust by RBG during the time frame (the referral in August 2017 was *from* the Trust to RBG).

Ms G – information sharing with the Trust

8.26 We found evidence on Framework-I that following the locally agreed protocol 18 MERLIN ACN reports were shared with the Trust. Once the reports were shared RBG's involvement ended.

Finding: There is no record RBG followed up any of the safeguarding concerns shared with them about Ms G or asked to see the outcomes of any enquiries made, on their behalf. There is no evidence RBG, or the Trust provided feedback to the referring agency about how these concerns were addressed.

Support provided by RBG

8.27 We asked Trust and RBG staff what support RBG provided to the Trust to enable them to complete adult safeguarding activity on their behalf. The Trust's Head of Social Care, Trust Lead for Safeguarding Adults and Prevent, RBG's Head of Adult Safeguarding, and the Assistant Director of Operations and Partnerships identified the following (our comments follow each point):

- Trust staff can access the Trust Safeguarding Adult Manager (SAM) and training for enquiry officers.

8.28 We did not review the training materials therefore we cannot comment as to the standard of the training. However, it is good practice to have joint local authority and Trust training.

- Front line practitioners have access to legal advice as necessary.

8.29 It is good practice that RGB staff seconded to the Trust have access to legal advice. Further good practice would be for the RBG Legal team to formalise a process whereby seconded staff can talk through complex cases and obtain advice on legal options e.g., Court of Protection assessments.

8.30 RBG may wish to consider whether it extends the availability of legal advice to the Trust 'high risk' panel with a view to developing/improving staff understanding of the legalities around safeguarding.

- Trust staff can access the Safeguarding Adults and Deprivation of Liberty Safeguards (DoLS) team for advice and support for complex cases – "*the team is a scrutiny and advisory team in relation to adult safeguarding ... It considers the quality of safeguarding work through audits and from performance data provided by the Strategy and Performance team and supports managers to support frontline staff to improve practice.*" (RBG Safeguarding Policy).

8.31 We have not sought data from RBG to clarify how regularly the team is contacted by Trust staff for advice. The RBG Safeguarding Adults and DoLS team does not audit Trust managed safeguarding referrals only RBG cases, consequently it does not have full oversight of the volume and quality of referrals. Good practice would extend the team's remit to auditing cases managed by the Trust.

- RBG does not provide safeguarding supervision to individual practitioners and managers. RBG second senior practitioner and management grade staff into the Trust to provide supervision. The Trust confirmed that they provide managerial supervision and that safeguarding forms part of that discussion.

8.32 Good practice would be for safeguarding supervision to be treated as a separate entity to managerial supervision. This would provide staff with an opportunity to reflect on their practice and consider how they identify and manage safeguarding concerns.

- RBG has a Principal Social Worker (PSW). The Trust is in the process of appointing a Lead Social Worker whose role will be to support the local authority's statutory duties including adult safeguarding. The role was not in place during 2015–18.

8.33 PSWs are now recommended under statute. Statutory guidance states that the local authority should "*have in place a designated* principal social worker *in adult care and support. Local authorities should make arrangements to have a qualified and registered social work professional practice lead in place*".[126]

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[126] PSW statutory guidance: https://www.gov.uk/government/publications/principal-social-workers-in-adult-services-roles-and-responsibilities

- RBG is a member of the Trust Safeguarding Adult Committee although their attendance is limited.

8.34 We were told that RBG did not attend the Safeguarding Adult Committee. The two sets of committee minutes we reviewed noted RBG's apologies (the meeting minutes are shared with RBG). The Trust Lead for Safeguarding Adults and Prevent told us the Trust monitored itself but if a safeguarding concern arose, a three-way meeting would take place between the Trust Lead for Safeguarding and Prevent, the Trust Head of Social Care, and RBG's Head of Adult Safeguarding.

8.35 We were told the RBG Head of Safeguarding received reports from the committee.

8.36 Good practice would be for a jointly owned RBG and Trust Safeguarding Adult Committee whose remit extends to reviewing the quality of practice and sample cases and having oversight of the Trust's response to referrals (including MERLIN ACN reports).

- RBG seconded staff attend the Trust's High Risk Panel for complex cases.

8.37 Please see paragraphs 8.29-8.30. It would be good practice for feedback from this meeting to be shared with the broader RBG Adult Safeguarding team. We consider it would be good practice for RBG's legal team to formalise their support to RBG seconded staff.

Oversight and assurance

8.38 We asked the Trust and RBG how safeguarding adult enquiry outcomes are reported and what the assurance processes are between the two organisations. We were informed that the Trust reports all outcomes of safeguarding enquiries to RBG for inclusion within the Adult Social Care Outcomes Framework (ASCOF)[127] reporting and they also provide a thematic review of safeguarding enquiries quarterly within the joint Section 75 meeting.

8.39 The Trust shared examples of the quarterly report and the data used within the ASCOF. Neither format provides detail of the individual outcomes either of welfare concerns, Care Act referrals or adult safeguarding enquiries. The data provided is generic and used for trend and thematic analysis.

8.40 Once a concern or referral is shared with the Trust it appears that there is no effective method for RGB to assure itself that the concerns have been addressed or that delegated adult safeguarding functions have been effectively carried out.

8.41 Overall, we found RBG's involvement with the concerns raised regarding Ms G to be minimal and as they stated within their IMR report "*largely administrative*".

Adult safeguarding on behalf of RBG

8.42 We were told the Section 75 agreement allows for the Trust to undertake RBG's statutory duties in relation to adult safeguarding. The overall responsibility however for ensuring the effectiveness of adult safeguarding practice remains with the local authority. We did not have access to the Section 75 Agreement to consider the assurance mechanisms in place, however RBG told us it obtains its assurance through records of the Trust Safeguarding Adult Committee, the Trust Safeguarding Annual report, and via Trust reporting to the SAB.

8.43 Throughout this review we have found missed opportunities when an adult safeguarding response would have been appropriate.

[127] The Adult Social Care Outcomes Framework (ASCOF) is a tool that measures how well care and support services achieve the outcomes that matter most to people. The measures are grouped into four domains, which are typically reviewed in terms of movement over time.

8.44 For Mr Q where we identified that the RBG Finance team failed to follow up on the allegation regarding adult safeguarding concerns relating to possible undue influence by his landlord regarding how he spent his money.

8.45 For Ms G with the repeated allegations she made about her accommodation and her fellow residents.

8.46 We know that RBG had been made aware of these concerns, through the email to the Financial Protection and Appointee (FPA) team (for Mr Q) or through a minimum of 18 police MERLIN ACN reports (for Ms G).

8.47 We recognise that RBG followed the locally agreed policy for Ms G and passed the police MERLIN ACN reports to the Trust. However, we later found that none of the allegations were addressed within a safeguarding framework. RBG would not have been aware of this. There was no evidence that RBG sought assurances regarding the referrals they sent across. There was no evidence that RBG sought assurance that either welfare concerns or adult safeguarding concerns had been appropriately addressed.

8.48 RBG receives quarterly reports from the Trust's Safeguarding Adult Committee, detailing a range of trends and themes with performance assurance indicators that include staff training statistics and the number of completed Section 42 enquiries.[128]

8.49 However, we found no evidence that RBG sought to follow up on individual concerns, or that they received feedback on concerns and referrals passed to the Trust. We found no evidence that RBG followed up to see if concerns of abuse were being addressed within a safeguarding framework and whilst we found examples of an enquiry outcome form being passed from the Trust, we were informed that RBG no longer requires these. We found no evidence that RBG actively sought assurances on the effectiveness of adult safeguarding practice within the Trust.

8.50 We do not believe RBG fully understood how concerns about welfare or adult safeguarding were being managed by the Trust between 2015 and 2018. Leading from this, RBG staff were clear in their discussions with us that their role was predominantly administrative.

8.51 We have been informed that there is an improvement plan in place, but our discussions with RBG indicate this had not been implemented by Autumn 2021 and oversight has not improved yet.

Additional risks within referral and handover process

8.52 Delays in reporting: We identified discrepancies between dates referrals were made and dates they were recorded onto the system (although it was unclear where this delay occurred). Delays in receiving and acting on adult safeguarding concerns can potentially increase risks to the adult(s) and should be minimised wherever possible.

8.53 Missing referrals: We identified discrepancies between the reported numbers of concerns and actual recorded concerns, including five missing MERLIN ACN reports and one missing LAS report.

8.54 We have been informed that the Adult Safeguarding Board has requested a review into how MERLIN ACN reports are received and responded to. We would welcome this.

Finding: RBG did not actively engage in the safeguarding of Ms G. Its involvement and response to safeguarding concerns was administrative. There is no evidence RBG

[128] Section 42 enquiry: the statutory requirement that a local authority undertake enquiries in response to safeguarding concerns. https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

sought assurance the concerns had been appropriately followed up to ensure the welfare of Ms G.

Finding: RBG's oversight of adult safeguarding at the Trust is dependent upon the Trust's reporting systems.

The Trust safeguarding processes

Referral process

8.55 We have previously noted that within the RBG all adult mental health and social care services are delivered under Section 31 by custom and practice and an implied Section 75 partnership agreement by the Trust within integrated health and social care teams. Services provided include undertaking adult safeguarding duties for adults who have care and support needs relating to their mental health.

Adult safeguarding concerns shared by RBG

8.56 RBG is the responsible local authority for adult safeguarding in Greenwich and they therefore receive all adult safeguarding concerns for the area. This includes referrals from other services and members of the public, which can be made in person, by email, telephone or letter or through specific organisational processes such as those of the emergency services (e.g., LAS).

8.57 When the safeguarding concern relates to an adult with mental health needs these are directed to the Trust.

8.58 We reviewed Trust and RBG safeguarding procedures to understand the referral/handover process. Neither procedure gave details of how referrals are shared, indications of expected timescales or how referrals are tracked and recorded. RBG told us any concern or referral they receive is initially screened and recorded onto the electronic record system (Framework-I). If it is decided that the concern or referral is for an adult with mental health needs, then the Contact Assessment team (CAT) at RBG forward the details (via email) to the Trust Primary Care Plus (PCP) team.

Primary Care Plus (PCP) team management of initial concerns

8.59 The agreed procedure is that all initial safeguarding concerns forwarded by RBG are sent to the Trust's locality PCP team. The operating procedure for this team indicates that they are a single point of access for all referrals from primary care, completing assessments "*in line with the Care Act*" and are able to provide a "*rapid response*" for same day urgent referrals. The policy states that any adult safeguarding concerns would be dealt with under the Trust Safeguarding Adults Guidance.

8.60 We were also informed that if the PCP team receive a MERLIN ACN concern, they use a specific screening tool. The tool is not part of the operating procedure. This tool indicates that for an individual open to a team (i.e., on a team caseload) the MERLIN ACN report should be "*scanned into RiO and forwarded to that team*". Where a MERLIN ACN refers to an individual not open to a team the report should be "*scanned into RiO and passed to a team manager or consultant to review*". In both cases a team manager or consultant should:[129]

Review MERLIN and grade the response:

[129] *Greenwich West PCP MERLIN screening and booking checklist, 28 September 2015*

- *For information only, no further action needed*
- *Send 14-day opt-in letter to service user*
- *Book tele-triage*
- *Other*

Adult safeguarding concerns identified by Trust staff

8.61 Trust staff may also identify adult safeguarding concerns during the course of their activities, for which they have two choices:

1) Refer the adult safeguarding concern to RBG. This option would be for concerns relating to adults not open to Mental Health Services (i.e., not on the Trust caseload), or where the team managing the adult's care was not able to complete adult safeguarding activity. The adult teams within RBG manage these referrals/concerns.

2) Refer and manage the adult safeguarding concern within a Trust integrated Health and Social Care team. The concerns are not shared with RBG at this stage. The team would follow the Trust Adult Safeguarding Guidance.

8.62 The process for deciding the above is shown in the flowchart in the Trust Adult Safeguarding Guidance (version 2 issued 2016). In accordance with this guidance, any safeguarding concerns generated by Trust staff pertaining to Trust service users would be managed within the service. This was confirmed during our interviews.

Joint safeguarding concern

8.63 One adult safeguarding concern was generated internally by Trust staff during 2017 that related to Ms G and Mr Q's accommodation. This concern was taken to the Trust by a care provider, resulted in an enquiry and was managed by the ICMP. The outcome was reported to RBG and the form was recorded on Framework-I. The referral and associated enquiry have been discussed above (paragraph 5.240).

8.64 We were told this practice no longer happens and RBG no longer require updates on individual safeguarding outcomes.

Mr Q

8.65 There were no safeguarding concerns sent to RBG for Mr Q during the time frame of review. However, a Support Worker from Bridge Support did raise a concern via email to the FPA team at RBG on 13 November 2017, regarding the landlord's involvement in Mr Q's finances. There is no evidence the concerns about the landlord were shared with the Care Coordinator in the Trust. Bridge Support informed the FPA team that they would raise a safeguarding concern. We found no record that this safeguarding concern had been raised or dealt with.

Ms G

8.66 Between 2015–2018, 24 adult safeguarding concerns, or concerns for welfare for Ms G were shared with RBG. These concerns were sent by MPS as MERLIN ACN reports. We have identified from Framework-I that 18 of these reports were passed to the Trust. Summaries of these referrals received by the Trust can be seen in Appendix G. We discuss the Trust response to these referrals below.

Concerns identified by the Trust

8.67 The Trust was also aware from their own contact with Ms G that she often made repeated allegations. In addition to allegations of abuse by other residents, Ms G made allegations of

abuse by care staff, theft of money and medication and being subjected to controlling behaviour. Ms G's care plan and Care Programme Approach (CPA) reviews recorded that her allegations were all part of her delusional belief system. The risk section of Ms G's CPA recorded "*frequent contact to police that she alleged been* [sic] *beaten up by other residents in the house.*"

8.68 We found no references to the other allegations on Ms G's care plans or any indication that they were seen as separate incidents.

8.69 Alongside Ms G's allegations of abuse, we identified instances when she requested a change in her accommodation. Ms G asked to move accommodation in August 2016, and on five separate occasions between January 2016 and September 2016 she mentioned or requested respite care. In addition, when her accommodation was discussed with her in July 2017 as part of the one safeguarding enquiry carried out by the Trust Ms G, she again asked for "*respite*".

8.70 We found no evidence that anyone explored the issue of why Ms G was seeking respite care, despite the overwhelming evidence that the ICMP had identified her accommodation as unsuitable as far back as 2015. This is particularly evidenced during a home visit by Care Coordinator 2 and Ms G's Support Worker in March 2015. On entering the property, they identified that a new male resident in the shared property liked to walk around "*semi-naked*":

05/03/15 "*H/V ... We were let into the building by a man – new, presumed to have moved in from the landlord's other house, dressed only in an under pant… As it was reported that Ms G is now the only female in the house and the fact that (he) likes being half naked in the house, it is increasingly looking like an inappropriate accommodation for Ms G and will be best she moves quickly.*"

8.71 Although the concerns were identified they were never raised as a safeguarding concern or discussed with Ms G to understand her views and feelings.

8.72 The above incident is of note because almost 12 months later, the MPS reported a similar occurrence through their MERLIN system:

09/03/16 – From MPS chronology (RG/2464 RG/2781 16PAC059613) Ms G "*Calls police to state she has been attacked by males who reside in the house. Police attend and a male answered the door wearing soiled pants…*"

8.73 The MPS record that this MERLIN was shared with RBG, but we found no evidence of it on Framework-I and no associated record on RiO.

8.74 This would have been an opportunity for the agencies to have discussed the appropriateness of Ms G's accommodation, but it was lost to follow-up.

Summary and analysis of adult safeguarding passed to the Trust

8.75 We identified 21 instances between 2015 and 2018 when concerns relating to Ms G were passed formally to the Trust. The reports surrounding a significant number of these concerns also referenced Ms G's ability to engage with staff. There were concerns raised about her understanding, her difficulty with communication (even with interpreters supporting her) and that often Ms G was described as confused.

8.76 A variety of agencies raised these concerns which included direct allegations of abuse, as well as concerns for Ms G's welfare. Several of these concerns were raised following an incident when Ms G made an allegation of abuse but then denied this, retracted the allegation or simply failed to mention it again. In these instances the allegations were reported alongside a wider concern for Ms G's welfare. These reports on occasion also suggested a review of Ms G's care plan or support network. Other concerns were raised following instances when Ms G repeated an allegation of abuse and the agencies passed the allegation on as a safeguarding

concern, again usually alongside a concern for welfare. In addition, we have identified numerous instances when Ms G herself raised concerns directly with the ICMP (e.g., her care coordinator).

8.77 We believe in the majority of these instances a safeguarding adult response would have been appropriate. However, it appears that these concerns were not addressed. It also appears that the majority of Ms G's allegations were labelled as delusional beliefs, and no distinction was made between the different types of allegations.

8.78 We have identified several factors that appear to have influenced decision-making around these concerns. These factors should be viewed alongside other findings identified throughout this review around information sharing, care planning, handover of care and risk management.

Ms G's allegations – attributed to delusional beliefs

8.79 The allegations made by Ms G were not all the same, but they all received the same response – being labelled as part of her delusional belief system and not taken any further. This response did not allow for any distinction between the allegations even when later evidence identified elements that could have been true (i.e., when Ms G lost her money and purse). In addition, Ms G was making repeated allegations in the context of changing circumstances. We do not feel Ms G's changing circumstances were considered within the safeguarding decision-making process.

8.80 Good practice would have been to explore Ms G's repeated allegations within a safeguarding framework. For example, an enquiry into allegations of abuse by other residents would have enabled an exploration of the allegations and if found to be unsubstantiated a plan could have been put in place to support Ms G with what appeared to have been very distressing thoughts and images. This approach would also have enabled the team to review the plan each time a further allegation of abuse was made and determine whether it was a new allegation or a repeated one and to discuss them with Ms G.

8.81 Good practice would also have been to review Ms G's allegations within the context of her circumstances of the time. This approach would have enabled factors, including those following, to be taken account of and if appropriate included in a safeguarding plan. For example:

- Changes in tenancy and make up of residents within the shared house.
- Related gender and cultural issues within the house.
- Communication difficulties for Ms G.
- The language barriers between residents as well as for care staff.
- Previous reports that said Ms G had "*mothered*" other residents and had previously been described by some as "*annoying*".
- Ms G's past history of domestic abuse.
- Ms G having previously made serious allegations regarding abuse in her accommodation (e.g., in 2013). The MPS closed its investigation into these allegations, but Ms G continued to repeat concerns that she had been subjected to an assault resulting in a broken leg.
- The mental state of Ms G and other residents at the time of the allegations.

Ms G's repeat allegations

8.82 We found that the impact of Ms G's repeated allegations about services and other residents in the home was not explored, recognised or appreciated.

8.83 We found that even though Ms G made repeated allegations about her fellow residents abusing her this was not explored by the ICMP staff with her. We also know that the other residents were aware of these allegations from the reports received from the police. We do not know how these allegations impacted upon the relationships within the house.

8.84 We are aware that Ms G and Mr Q shared the same Care Coordinator several times in their separate care journeys. We did not find any exploration or curiosity in the case notes of how relationships within the house were going and their care discussions appeared to have been kept separate deliberately.

8.85 Good practice would have seen Ms G's repeated allegations explored within an adult safeguarding framework. This would have enabled a full exploration of what Ms G was saying, why she was saying it and how it impacted upon her relationships with others.

8.86 Given the nature of the allegations Ms G's Care Coordinator would have been justified in seeking the views of the other residents, either directly or through their care coordinators as part of a risk management and safeguarding planning process.

Ms G's accommodation (concerns)

8.87 Concerns relating to Ms G's accommodation were never fully explored by the Trust or RBG. There were several incidents that could have prompted the whole Care team (e.g., Trust, RBG, Housing) to address the issue of Ms G's accommodation. In late 2014, early 2015, it was identified that Ms G was not in appropriate accommodation, yet they developed and maintained the view that Ms G had full capacity regarding her choice of accommodation. This belief continued despite multiple incidents when Ms G was described as "*confused, vague, hard to understand and incoherent*" by services she came into contact with.

8.88 In addition, Ms G asked to move on at least one occasion, and also asked or mentioned wanting respite care. Whilst these requests may not initially highlight a safeguarding concern, if taken alongside her allegations about her fellow residents they did present an opportunity for her care coordinator to explore her feelings about her accommodation.

8.89 Good practice would have been to address all the concerns about Ms G's accommodation within a safeguarding framework, addressing issues of capacity as part of a systematic enquiry.

Lack of awareness of what constituted safeguarding

8.90 We found just one instance when a concern raised with the Trust was progressed to a safeguarding adult enquiry. This concern related to the state of the accommodation for Ms G (and Mr Q) and had been formally raised by a care agency.

8.91 However, we also found other examples, separate from Ms G's repeated allegations of abuse, when a safeguarding approach would have been appropriate.

8.92 Examples of concerns reported by Ms G include:

- Allegations that people wished to marry her.
- Loss of property and possible theft.
- Repeated physical assaults by other residents.
- Abuse by carers.
- Concern Ms G was being controlled or coerced.

8.93 Examples of concerns identified by Trust staff included:

- A male “*walking half naked*” round the house.
- Concern about the landlord’s influence over Ms G’s decisions to stay in the house.

8.94 It is probable that because Ms G made allegations of abuse that were discounted as delusional, any concern she raised was subsequently dismissed. However, we are unsure why the very evident safeguarding concerns identified by other agencies were also dismissed.

8.95 Good practice would have been to initiate a safeguarding adult concern for each reported incident and then determine whether a fuller enquiry was warranted. This would have enabled the links between concerns to be identified (particularly around the landlord and the suitability of Ms G’s accommodation).

Concerns viewed in isolation

8.96 Each concern raised by Ms G was viewed by Trust staff in isolation. There was a failure to consider a preventative or multi-agency safeguarding approach after early 2015.

8.97 Ms G had repeated contacts with various agencies but failed to trigger the ‘frequent contact’ policies across these services. However, Ms G was open to the Trust under CPA, an approach that depends upon multi-professional and multi-agency care planning in relation to assessed need.

8.98 Good practice would have been for the Trust team to recognise there was a need for an adult safeguarding preventative approach and then to arrange a multi-agency meeting to explore all the issues and concerns identified.

8.99 We did find a reference that indicated Care Coordinator 2 was planning a multi-agency meeting (although not under the safeguarding umbrella) to address Ms G’s repeated use of emergency services in 2015. However, if this meeting happened, the outcome and any subsequent plan does not appear to have been recorded in case notes.

System issues

8.100 In addition to the above practice issues, we identified issues within the system of adult safeguarding which we set out below.

Referral and screening system

8.101 We have identified a particular concern regarding how concerns are shared with the Trust, and once shared, how they are screened.

8.102 We identified six instances when MPS identified they had shared MERLIN reports, but the report was not recorded on the RBG system. We also identified one instance when LAS identified they had shared a safeguarding report, but the report was not recorded on the RBG system.

8.103 We do not know where these referrals went, and we cannot say they were received by the Trust. This is a significant risk.

8.104 We did identify from the RBG system that they had sent 18[130] MERLIN reports to the Trust, but we only found six instances in Trust case notes that indicated a police report had been received. From these we only identified one instance where the case note indicated that a MERLIN report had been screened using the designated MERLIN toolkit.

[130] RBG’s Senior Assistant Director for Operations and Partnerships later told us RBG had received 30 reports from the MPS. We advised him RBG’s IMR identified 12 reports. At the time of writing we had not received clarification for the discrepancy.

8.105 We also identified that when reports were recorded on the Trust system there were delays of many days before the concerns were discussed.

8.106 From our interviews we determined that reports of ‘welfare’ concerns are treated outside of the adult safeguarding system and that they are not all screened by a SAM. We recognise that not all reports received from the emergency services or other agencies will indicate a safeguarding concern. However, it seems that the agreed system for emergency services sharing adult safeguarding concerns with the responsible local authority has had layers added. These layers potentially mean concerns may not be immediately or correctly identified as adult safeguarding concerns and as such may not be appropriately responded to.

8.107 We believe this is a risk for the whole system and requires further review.

8.108 We were informed that a review of how the system receives and actions MPS MERLIN reports has been requested as part of the SAB work plan. We were told this would include the development of data analysis reports for MERLIN reports and that there would be a monthly safeguarding report to show any multiple MPS contacts. We were informed the Head of Safeguarding will be responsible for monitoring the report and the Safeguarding team will check cases in instances where there have been multiple MPS contacts, with a view to highlighting these to Trust teams as appropriate.

8.109 We would welcome this review and recommend that the system for receiving concerns at RBG and transferring them to the Trust is included within the terms of reference.

Finding: We identified an attrition of safeguarding referrals received by RBG compared to those it shared with the Trust.

Oversight for adult safeguarding

8.110 We have addressed the issue of oversight of adult safeguarding by RBG in a previous section and will not repeat our findings here.

8.111 We are aware that the Trust has made changes relating to adult safeguarding practice since this incident. We have been told that adult safeguarding training is widely available for care coordinators and that each team now has a SAM on site. We welcome this but would sound the cautionary note to ensure the SAM views all concerns, including those sent across from RBG.

8.112 The Trust have also improved their reporting data and are now using a new system called iFox to track and monitor referrals and outcomes. These reports are shared with RBG. We have seen examples of these reports including the quarterly audits to identify themes and trends. We were told that the findings from these audits are shared at the safeguarding committee and with the SAB. This is a good first step but more needs to be done. For example, the audits do not examine the quality of safeguarding adult practice in the Trust, they do not offer any assurances regarding how the six safeguarding principles are being applied or how teams are striving to achieve making safeguarding personal. We are aware that the Trust has now appointed a Lead Social Worker whose role will be to develop assurances in these areas and to develop an improvement plan and we welcome this initiative.

8.113 In addition, since this incident the Trust informed us that they have developed a High Risk Panel where care coordinators can present cases and receive advice on risk management, including discussing referrals for adult safeguarding. This is to be commended, but we have little assurance Ms G would have met the threshold for referral, or whether her Care Coordinator would have identified the need for her referral to the panel. Ms G remained at risk level green throughout the majority of her care until just before her death. Her numerous allegations were consistently dismissed, and any additional concerns were not recognised as adult safeguarding concerns.

8.114 Throughout this review we found an overwhelming lack of adult safeguarding awareness in the notes by Trust staff. Despite numerous referrals and signals that Ms G was vulnerable in her accommodation no actions were taken.

8.115 We also identified a general lack of safeguarding awareness by staff, and this appeared to be pervasive throughout the organisation. This lack of awareness also highlighted a lack of the professional curiosity necessary to protect adults who may be at risk of abuse or who are presenting as vulnerable.

8.116 We believe if the Trust is to ensure all adult safeguarding concerns are identified and acted on, there is more work to be done. This should include further work in supporting staff to recognise what constitutes a safeguarding concern and how to support individuals when they make repeated allegations.

8.117 More work needs to be done to support the Trust as they complete adult safeguarding work on behalf of RBG. We do not make recommendations about how this should be actioned because that is for the Trust and RBG to negotiate. However, actions could include additional and separate safeguarding supervision for all care coordinators, safeguarding forums between the organisations and joint adult safeguarding training or awareness sessions.

8.118 The Trust must develop a deeper understanding of adult safeguarding and its role in protecting vulnerable adults, if future incidents similar to what happen to Ms G, are to be avoided.

Finding: All agencies repeatedly failed to recognise safeguarding concerns in relation to Ms G's repeat allegations and her accommodation. Her allegations were typically considered to be delusional beliefs and were not explored further by staff.

Summary of the six principles of safeguarding

8.119 The six principles of safeguarding[131] were introduced by the Department of Health in 2011. The principles are embedded in the Care Act and apply to all health and social care settings. The principles place emphasis on preventing risk of harm, raising awareness and supporting individuals to make informed decisions. We have explored safeguarding practice in detail throughout this report; in this section detail our summary of the agencies' adherence to the six principles in the context of Ms G and Mr Q's care.

Ms G

Empowerment (People being supported and encouraged to make their own decisions and informed consent)

8.120 During the safeguarding enquiry in July 2017, Ms G's views were sought (alongside other residents) in relation to the state of the accommodation, although her subsequent request for respite was not followed up.

8.121 In addition, throughout this review we have found numerous occasions when Ms G told various agencies that she was unhappy in her accommodation and she made repeated allegations about other residents, care staff, and her landlord. We found no evidence that these allegations were considered under an adult safeguarding framework, or that staff sought to support Ms G to consider her options, to determine whether she had capacity regarding her accommodation choices or to support her in her decision making.

[131] Six principles of safeguarding: https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

Finding: Ms G's views did not form part of a safeguarding response in all but one occasion. Ms G was not empowered in her decision making about her care and support needs.

Prevention (It is better to take action before harm occurs)

8.122 Throughout the period of review Ms G made numerous and varied allegations of abuse, and on occasion appeared distressed by these. These were not acted on. These were missed opportunities for all the agencies involved with Ms G to develop a preventative multi-agency approach with Ms G, to support and consider the appropriateness of her living environment and to manage her ongoing levels of distress.

8.123 These missed opportunities included:

- Allegations that people wished to marry her
- Loss of property and possible theft
- Repeated physical assaults by other residents
- Abuse by carers
- Concern Ms G was being controlled or coerced
- A male "walking half naked" in the house
- Concern about the landlord's influence over Ms G's decision to stay in the house.

Finding: Agencies involved in Ms G's care did not consider the role of prevention as part of a planned safeguarding response. There were missed opportunities throughout for a multi-agency approach to prevention.

Proportionality (The least intrusive response appropraite to the risk presented)

8.124 This review identified numerous occasions when a safeguarding response would have been appropriate, particularly a multi-agency approach, to manage Ms G's repeat allegations. This did not happen.

8.125 When a formal safeguarding alert around the accommodation was received in July 2017 the response was proportionate, although the safeguarding actions failed to provide the necessary review to ensure the accommodation remained suitable, and so ultimately were ineffective for Ms G.

Finding: The lack of a safeguarding response was disproportionate given the number of allegations made by Mrs G.

Protection (Support and representation for those in greatest need)

8.126 Various agencies identified Ms G as in need of protection, most notably MPS and the LAS, although their responses were not always consistent. When Ms G attended A&E staff again recognised that Ms G presented with welfare concerns. Further, both the Trust and her GP recognised that Ms G required a level of support; however, this was provided in the context of her mental illness and her allegations of abuse were typically considered to be delusional beliefs.

Finding: Despite all agencies recognising at various times that Ms G required a level of support, or care review, this recognition was not consistent or joined up.

Partnership (Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse)

8.127 Ms G lived in shared accommodation. Ms G made allegations about other residents within this accommodation and her community. These allegations were not followed up and opportunities were missed to understand Ms G's views about living in the accommodation as a single Asian female whose first language was not English, or how she was managing overall within a supported accommodation environment.

Finding: Agencies involved in supporting Ms G did not consider her wider community as part of any safeguarding response.

Accountability (Accountability and transparency in safeguarding practice)

8.128 Ms G was known to multiple agencies. Her care was coordinated by the Trust, who was responsible for acting on any safeguarding concerns raised, and RBG, as part of their oversight and assurance role, were responsible for the quality and effectiveness of this safeguarding response.

8.129 Ms G's repeated allegations were seen in the context of mental illness and delusions and the agencies involved did not consider her care needs within the safeguarding framework or consider the principles of safeguarding, particularly empowerment, prevention, and protection.

Finding: Despite the extensive contacts and multiple agencies involved in Ms G's case, she did not receive an accountable or transparent safeguarding response.

Mr Q

8.130 We were unable to consider the safeguarding of Mr Q in the context of all six principles of safeguarding, due to the limited activity. However, we have considered Mr Q's safeguarding in the context of empowerment, proportionality and partnership.

Empowerment

8.131 During the safeguarding enquiry in July 2017, Mr Q's views were sought (alongside other residents) in relation to the state of the accommodation.

Finding: Mr's Q's views were considered as part of the safeguarding response in July 2017.

Proportionality

8.132 As noted above, a formal safeguarding alert around the accommodation was received in July 2017 and the response was proportionate. However, the safeguarding actions failed to provide the necessary review to ensure the accommodation remained suitable, and so ultimately were ineffective for Mr Q.

Finding: The safeguarding response to the accommodation in 2017 was proportionate but ineffective.

Partnership

8.133 Mr Q was based in the community and lived in shared accommodation, but there is no evidence of joined up working between agencies, despite Mr Q and Ms G sharing the same care coordinator, utilising similar services and that Ms G had made allegations about other residents in the house. Opportunities were missed by the agencies involved to gather and share information in response to these allegations.

8.134 Similarly, when the Bridge identified concerns in relation to Mr Q's finances, whilst these were initially raised with the local authority, they were not taken forward, or shared with the Trust.

Finding: There was no partnership working in relation to Mr Q's living arrangements or concerns about his finances.

9 Summary findings

9.1 Ms G and Mr Q were both recipients of Trust services, under the Care Programme Approach (CPA) and had the same Care Coordinator and Psychiatrist. They lived in the same house, had their finances managed by the RBG Financial Protection and Appointee (FPA) team, had the same GP, and engaged (to differing degrees) with Bridge Support. To a large extent, their lives shared a number of parallels, but that is where the similarities ended.

9.2 Ms G was a frequent user of Trust, acute and primary care services. She regularly contacted the Metropolitan Police Service (MPS) and London Ambulance Service (LAS) between 2015 and 2018, though this had diminished in the latter part of 2017 and early 2018. Ms G attended her GP practice, often without an appointment, over 200 times between 2015 and 2018.

9.3 Conversely, Mr Q's engagement with Trust services amounted to receiving his depot medication. He did not engage in the CPA process and missed his last three CPA reviews prior to the incident in June 2018. His engagement with Bridge Support services was predominantly administrative or social as opposed to therapeutic. He had no contact with the other agencies involved in this review, except his GP who he saw annually for health reviews.

9.4 Ms G and Mr Q were at opposite ends of the spectrum of engagement with the Trust and other services.

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9.5 We identified substantial gaps in practice pertaining to the CPA process, care planning, risk assessment and risk management, and adult safeguarding; none of which were undertaken in line with Trust policy or national guidance, including the Care Act 2014.

9.6 Ms G and Mr Q were both primarily managed through the administration of depot medication. Intensive Care Management for Psychosis (ICMP) professionals, particularly in the latter part of 2017 and early 2018, showed little professional curiosity towards either individual in the context of attempting to engage Mr Q in the CPA process, or working with Ms G to explore her behaviour or delusions. Ms G's Care Coordinator was largely accepting of her behaviour and felt there was little to be done to manage her repeated contact with other services (e.g., her GP). However, we note this was a common theme across all agencies, particularly primary care, who indicated there was a sense little could be done to address Ms G's behaviour. The ICMP Associate Specialist who undertook Ms G's CPA reviews considered her delusions to be long-term and unlikely to change; there is no evidence he sought to explore these or her behaviours with her between 2015 and 2018. The notes of Ms G's CPA meetings changed little across the three years and in some instances were likely copied and pasted from one meeting to the next. There were similar examples of little change to her progress notes documenting her depot appointments.

9.7 Trust staff and other agencies may have been correct that Ms G's behaviour was unlikely to change, but there is no documented evidence in the Trust notes to indicate that the ICMP sought to explore these points with Ms G or work with her to see if a different approach or medication might have helped her. Instead, there was no long-term plan for Ms G; her care plan was largely unchanged between 2015 and 2018, and we were left with a sense of acceptance by staff that Ms G would not change.

9.8 We also note there was little consideration to Ms G's physical health needs, for which she received several ongoing treatments and medication, and the impact this might have on her mental health and wellbeing. The notes indicate Ms G's son contacted the ICMP in relation to her finances but there is no evidence the team ever sought to engage her son – or Ms G's daughter – in her care, either as part of the CPA process or more informally.

9.9 However, whilst we note there were gaps in the care and treatment of Ms G and Mr Q, these should be considered within the broader context of the demands on the ICMP. We were repeatedly told the ICMP has historically struggled – and continues to do so – with high sickness, vacancies and agency use. Care Coordinator 4 was agency staff, who advised he had contact targets to meet, and could not always keep up with the demands of the role e.g., record keeping. Consequently, whilst the gaps in practice must be addressed, high Care Coordinator caseloads, coupled with high sickness and vacancies, mean it will likely continue to be a challenge for the ICMP to provide care and treatment at an expected standard.

9.10 Equally, the expectations of partner agencies, and in some instances, other Trust staff, that the Care Coordinator is central to all aspects of a service user's management is unrealistic without support. The Care Coordinator role is indeed central, but reliant on manageable caseloads, information sharing by partnership agencies and the engagement of these agencies in the management of individuals like Ms G.

9.11 We were told the ICMP has roughly 100 patients on its caseload whom it would seek to step down from the service if they were not recipients of depot or clozapine. Mr Q was one of these patients and he would have been considered for the step down service had he not been a recipient of depot medication which had to be administered by the Trust. The lack of a shared care agreement with primary care means the Trust continues to assume responsibility for these patients, placing extra demand on Trust/ICMP resource, despite the argument they could be managed in the community under primary care.

9.12 We accept that subsequent findings pertaining to Mr Q after the incident, for example the extent of his drinking and his alleged dislike of Ms G, indicate the team did not have a comprehensive understanding of his mental health. As noted in paragraph 9.5, poor CPA and care planning, and inadequate risk assessment and management meant staff did not have a comprehensive understanding of Mr Q's mental health needs. Had they had a better understanding of Mr Q and successfully engaged him in the CPA process, it is likely he would have been some way off being considered for step down but a long-term plan could have been formulated. Instead, Mr Q's need for depot medication meant he was unlikely to be discharged from the ICMP caseload unless depot practices in the area changed.

MPS

9.13 Mr Q was not known to the MPS during the period of review.

9.14 Ms G regularly called the MPS between 2015 and 2018, though the frequency of her calls reduced over time. Whilst there was not a Frequent Caller Policy in place during the period of Ms G's contact, she would still not be considered a frequent caller under current policy. Consequently, there was little guidance available to staff in terms of escalating a response to Ms G's repeated contact, and her calls instead continued to be managed on an individual basis.

9.15 We identified examples of good practice on the part of MPS officers who took into consideration Ms G's wider care needs, noted her accommodation might not be appropriate, and that a review of her care was needed. However, the MPS IMR also identified inconsistencies in how they responded to Ms G.

9.16 Ms G's frequent contact did not trigger the MPS frequent contact policy. This meant staff attempted to manage her on an individual basis and outside of an agreed approach/process. This would still be the case today which is why the MPS should seek to assure itself as a priority that staff are consistently recognising and responding to frequent callers who fall below its contact threshold.

LAS

9.17 The LAS IMR makes several recommendations which we endorse about reinforcing safeguarding awareness and policy across the force.

9.18 Ms G frequently contacted the LAS in 2015, after which her contact was limited. As with the MPS, her contact did not meet the LAS criteria of a frequent caller, therefore her actions in 2015 did not trigger an escalation process. The LAS responded inconsistently to Ms G's allegations that she was being prevented from leaving home and was being abused. The LAS IMR identified gaps in expected safeguarding practice. We were advised changes had been made with a view to improving practice, however, we understand these are yet to be tested.

9.19 As was the case for the MPS, Ms G's frequent contact did not trigger the LAS frequent policy, nor would she do so today. The LAS needs to assure itself that its staff recognise and respond to individuals who make frequent contact but fall below its contact threshold.

Lewisham and Greenwich NHS Trust

9.20 Ms G routinely used acute services to address her extensive physical health concerns. Clinical care was provided in line with expected practice, and we noted examples of healthcare professionals seeking to support her to understand her treatment (e.g., they engaged interpreters).

9.21 Ms G regularly attended Lewisham and Greenwich A&E in 2015, either as a self-referral, or when taken by ambulance. She was typically discharged to her GP, sometimes with pain relief medication, but otherwise with no further action. A&E staff communicated these attendances to Ms G's GP and on a small number of occasions raised concerns in relation to her mental health. There is little evidence this information was shared by her GP with Trust services

9.22 A&E staff sought to involve Mental Health Liaison on two occasions but there were further occasions when it would have been helpful to have engaged Liaison services with a view to discussing Ms G's frequent attendance and mental health.

Primary care

9.23 Much like the other agencies, Mr Q's engagement with his GP was limited to annual health checks. Conversely, as previously noted, Ms G was a regular presence at the practice.

9.24 We identified elements of good practice on the part of individual GPs responding to Ms G's concerns and behaviour, but also a sense of exasperation on the part of others. The practice never sought to proactively engage with other agencies to address Ms G's repeat attendance. The practice appeared reluctant to engage when the opportunity arose in 2015, advising that whilst they would attend a professionals meeting, they thought little could be done to manage Ms G.

9.25 However, the GP practice had no long-term plan for Ms G, other than continuing to ask her to book appointments and not attend unannounced. Ms G's long-term temazepam prescription further emphasises this approach; it is not good practice to prescribe benzodiazepines on a long-term basis, but the practice was of the view that reducing it would only serve to increase her attendance.

9.26 Equally, the GP practice did not recognise the significance of Ms G's repeat allegations, attributing them to her mental health, rather than implementing appropriate safeguarding responses.

9.27 There is no evidence that consideration was given to working with other agencies, particularly the Trust, in relation to Ms G's mental health to develop a plan to manage her behaviour and support her wellbeing.

Bridge Support

9.28 Bridge Support is the only agency that had consistent communication with Mr Q. Mr Q did not seek a therapeutic relationship, but there is evidence of him regularly engaging with his Support Worker and rearranging meetings when he was no longer available. Equally, his Support Worker adapted to Mr Q's schedule and provided support when needed e.g., helping him to collect his money. Mr Q's mother spoke highly of his Support Worker.

9.29 Bridge Support had little contact with Ms G, who generally declined their support services, but they did respond to other agencies' requests to provide support e.g., help Ms G attend a medical appointment. Equally, when Ms G did engage with Bridge Support, they sought to provide a Support Worker who spoke Hindi.

9.30 We consider Bridge Support staff worked with Mr Q and Ms G to the extent that was requested of them by other agencies. The exception to this was escalating safeguarding concerns pertaining to their landlord, though we note the concerns were informally raised with RBG who in turn did not follow up.

9.31 The Bridge Support IMR identified gaps in communication from the Trust and the two agencies have since developed an information sharing agreement to mitigate this.

Royal Borough of Greenwich (RBG)

9.32 Throughout the review, RBG was clear that it delegated its safeguarding responsibilities to the Trust. The manner in which it described its role led us to conclude the local authority assumes an administrative role in the context of safeguarding. Responsibility for safeguarding ultimately falls to RBG under the Care Act 2014, and even when delegated under a partnership Section 75 Agreement, the legal responsibility for assuring the effectiveness of safeguarding functions remains with RBG.

9.33 However, we found little evidence that RBG sought assurances from the Trust regarding the quality of adult safeguarding practice. We found no evidence that RBG proactively engaged with the Trust in considering the quality of referrals, whether these referrals were acted upon or to support and facilitate the identification of at-risk individuals. We found no evidence that RBG sought the outcomes of any enquiries or referrals and no evidence that feedback was provided to individuals or agencies raising concerns or referrals. Alongside this lack of assurance, we found discrepancies in the number of concerns received, reported and transferred between RBG and the Trust. There was no system of oversight for this process during 2018 and we have not been made aware of any significant improvements in this area to date.

9.34 To use Mr Q as an example, we were given little evidence of professional curiosity about requests to the FPA team for large sums of money. The team had managed Mr Q's finances for many years due to historical concerns that he was vulnerable to financial exploitation. Mr Q regularly requested large sums of money via Bridge Support or his Care Coordinator yet there is little documented in the notes to suggest ICMP staff challenged him about his finances to ensure he was not being exploited. Mr Q's mother told us she was sometimes contacted by Trust staff about his finances, but this was not recorded in the notes, and there is no evidence of any discussion with Mr Q about his spending.

9.35 There is no evidence the FPA team ever reviewed either Mr Q or Ms G's long-standing appointeeship arrangements because they were under the care of the Mental Health team (which meant there was an expectation that the Care Coordinator would review annually and

feedback). Had they not been under the care of Mental Health Services, the FPA team would have been required to review Mr Q and Ms G's appointeeship arrangements annually.

9.36 RBG's oversight of adult safeguarding was and continues to be minimal, passive, and crucially, heavily dependent on the Trust's reporting systems.

10 Conclusions and recommendations

10.1 The narrative of this report is dominated by the care, treatment and safeguarding of Ms G. We have detailed at length her extensive contact with each agency and the varying quality of their responses in relation to her allegations of abuse, frequent contact and erratic behaviour.

10.2 Conversely, our review of Mr Q's care and treatment has largely centred on the role of the Trust with input from Bridge Support and Royal Borough of Greenwich (RBG). We have noted the gaps in the Intensive Care Management for Psychosis (ICMP) team adherence to policy, particularly from 2017 onwards, though we acknowledge the demands placed on staff and the realities of how much they can do to fulfil their roles, against a backdrop of high caseloads, vacancies and staff sickness.

10.3 Despite this, Mr Q's consistent reluctance to engage in the Care Programme Approach (CPA) process should have been addressed and steps taken with him to develop a long-term plan for his management. Mr Q's mother told us she had little contact from the ICMP between 2015 and 2018 despite Mr Q telling ICMP staff he could not attend his CPA appointments because he was seeing his mother. Mr Q regularly mentioned his mother to ICMP staff yet there is no evidence they sought to engage her in his care and treatment.

10.4 ICMP were largely accepting of Mr Q's sentiment that he was "*fine*" (communicated during his depot appointments) and there was no evidence of professional curiosity in relation to his daily life or accommodation. Mr Q's CPA appointments were never rescheduled despite him – and Bridge Support staff – being clear that he was not available on Mondays. We consider this further illustrates the ICMP acceptance that Mr Q would continue to be on the team caseload because of his medication needs, but there was little they needed to do provided he continued to accept his depot medication.

10.5 Similarly, there is no evidence the RBG FPA team sought to actively monitor Mr Q's appointeeship arrangements, despite being historically identified as an adult at risk of financial exploitation and the concerns identified by Bridge Support regarding the influence of Mr Q's landlord. The RBG staff we spoke to told us that in instances of individuals under Mental Health Services, the Trust was responsible for identifying any concerns (despite the local authority acting as appointee for Mr Q's finances). There is little evidence Trust staff were monitoring Mr Q's finances.

10.6 This level of acceptance on the part of the ICMP meant they did not recognise or explore significant events with Mr Q which included the Metropolitan Police Service (MPS) regularly attending the property in response to Ms G's phone calls, a resident dying, Mr Q and Ms G being the only residents in the house, and Ms G being placed in the amber zone following complaints from neighbours about her behaviour.

10.7 Had the ICMP sought to engage with Mr Q about these matters, we cannot say if it would have prompted Mr Q's engagement, but this should not have dissuaded staff who had a duty under CPA Policy to consider Mr Q's broader health and social care needs.

10.8 Situational factors mean the ICMP will continue to encounter challenges in relation to high caseloads and vacancies, but we note staff identified approximately 100 individuals who are on the team's caseload primarily for the administration of clozapine and depot medication. Mr Q would likely have been on the step down pathway had it not been for his depot medication which had to be administered by Trust services. We do not comment on the appropriateness of the step down approach for Mr Q, or his possible engagement, but prescribing practices in the borough – then and now – meant this was never an option.

10.9 In the case of Ms G, we note each agency, barring Bridge Support with whom she had minimal contact, gave little sense there was anything that could proactively be done to address Ms G's repeated contact and erratic behaviour. Instead, each agency continued to

work in a silo, seeking to manage her as individual agencies. There were few instances of the agencies, other than the MPS, communicating with each other about Ms G. This blinkered approach towards Ms G and the fact she did not trigger agency thresholds for what constituted frequent contact meant the ICMP was unaware of the scale of Ms G's behaviour.

10.10 We have no way of knowing if things could have been different for Ms G, but we consider there were fundamental points between 2015 and 2018 when more could have been done for her had agencies sought to work together to help her. In particular, we note:

- Trust staff's lack of consideration about Ms G's mental capacity in response to her refusal to move house in 2015. This was despite the accommodation being considered unsuitable for her and staff already being aware of her lack of capacity to manage her finances, alongside cited concerns about her experiencing confusion.
- The lack of consideration by ICMP staff to arrange another professionals meeting after June 2015 (which did not take place) in response to Ms G's repeat allegations and frequent engagement with emergency services.
- The lack of timely action by Trust staff to explore other housing options for Ms G in August 2016 and 2017 when she asked to move, in parallel with her having made several requests for respite between 2015 and 2018.
- The lack of formal communication from RBG to the Trust following the incomplete sheltered housing assessment in October 2017, explaining that the Trust would need to rearrange another assessment, and/or support Ms G to complete her application to her preferred housing scheme because the scheme was not supported by RBG.
- Trust and other agencies failure to recognise and consider Ms G's repeated allegations that she was being assaulted and had money and medication stolen by other residents.
- The overreliance placed on the role of the Trust by RBG in carrying out the adult safeguarding function without effective assurance processes being in place and despite its own responsibilities under the Care Act.
- The lack of formal, consistent communication between agencies – particularly to the Trust – to identify the extent to which Ms G was contacting them.
- The failure by Trust staff to recognise the significance of the changing dynamics in the household and the resultant impact of Ms G and Mr Q being the only residents in the house.
- The failure by all agencies to recognise the extent of Ms G's erratic behaviour and that a coordinated agency response – beyond the Trust – was needed to work with her to help her.

10.11 We identified significant gaps in agency safeguarding practices. RBG is clear that it discharges its safeguarding responsibilities to the Trust under a Section 75 Agreement and considers its role to be largely administrative. However, we note RBG retains a legal responsibility for Care Act 2014 functions carried out on its behalf and that currently the local authority can offer little assurance in terms of monitoring and quality assurance practice of safeguarding referrals. RBG has advised it is undertaking scoping work to develop its assurance processes and we would urge the local authority to expediate these as a priority.

10.12 We have little assurance that the care and treatment of Mr Q and Ms G, or the safeguarding of Ms G, would be different today. To note:

- The ICMP continues to experience high caseloads, staff sickness and vacancies.

- Ms G would not trigger present day London Ambulance Service (LAS) and MPS frequent contact policies.
- Primary care gave little indication they would manage Ms G differently.
- RBG is not robustly quality assuring safeguarding referrals.
- All agencies identified steps to improve practice and policy, but these remain in their infancy and largely untested.

10.13 At the heart of concerns pertaining to Ms G was the lack of communication and engagement across agencies, a failure to understand the safeguarding concerns, and in particular the need for RBG to own its statutory responsibility for safeguarding. Until agencies adopt a proactive approach towards working together to identify individuals at risk, are clear about what constitutes a safeguarding concern and how these should be managed, and consider multi-agency working to be the norm as opposed to the exception, we have little assurance that Ms G would be treated differently today.

10.14 It is of note that we identified similar concerns for the period of care we looked at in 2013 after Ms G suffered a broken leg. Whilst professionals involved in Ms G's care initially identified actions in response to the incident, most were not implemented, and those that were, were not always done so effectively. For example, Ms G was routinely seen without an interpreter, despite the language barrier being a known complication in communications with her. Similarly, the MPS interviewed Ms G four months after they were advised she was fit for interview; they closed the case shortly thereafter due to inconsistencies in Ms G's account of events.

10.15 Ms G's family raised concerns about her accommodation, support and financial management in 2013, yet these were not addressed by the relevant agencies. The Trust offered the family assurances that there would be changes to Ms G's accommodation, but these did not materialise. Similarly, when Ms G's family sought to assume responsibility of her finances, RBG and the Trust did not take the necessary steps to establish, in the first instance, whether Ms G had the mental capacity to decide who should manage her finances. The FPA team did not formally respond to the family's approach or to their further correspondence. As a result, the FPA team maintained the appointeeship by default.

10.16 There were numerous opportunities between March and September 2013 when Ms G's care needs could have been assessed and addressed, but these were missed and ultimately Ms G returned to the property which was unsuited to her needs, unsupported and with no management plan in place. She was not seen in person by her Care Coordinator or the team Doctor for over nine weeks.

Recommendations

10.17 The recommendations detailed in this report place emphasis on assurance and strengthening processes. We have noted a number of agencies have, or intend to, undertake improvement work, particularly in relation to safeguarding. Taking into account the time that has passed since Ms G's death, we endorse this improvement work, and encourage those at the outset of it, particularly RBG, to develop a timetable that will expedite the process.

10.18 Equally, we note the ongoing demands the ICMP and Trust experience, and that whilst we set out recommendations with a view to improving and quality assuring practice, these factors will continue to challenge the Trust and impact its ability to deliver care and treatment in line with best practice.

Recommendation 1: The Trust must improve care planning so that care plans are written and updated in line with Trust policy and include longer term goals, and adopt a biopsychosocial approach, incorporating the wider needs of the service user, beyond immediate day to day living.

Recommendation 2: The Trust must review its assurance and monitoring programme for risk assessment and management plans to include clear quality indicators against the Trust policy and expected standards using learning from this investigation.

Recommendation 3: The Trust should update its Zoning Policy to reflect the immediate interventions staff should take in response to a service user changing zones. This should include the timeliness of key interventions, which staff should be involved in, and details of ongoing monitoring including frequency and leads for escalations or reporting any issues found in practice.

Recommendation 4: The Trust must support regular monitoring and assurance of mental capacity assessments in multidisciplinary teams. In instances where mental capacity is questioned, there must be a record of the final decision whether to undertake a capacity assessment and the underpinning rationale for this in keeping with best practice guidance. A regular audit programme to support this should be established.

Recommendation 5: The Trust must ensure there are clear standards and criteria within relevant policies to guide staff on the routine monitoring of patient property when the person lacks mental capacity.

Recommendation 6: The Trust must develop a system to identify service users who live in shared accommodation. Underpinning this should be an ongoing process for sharing proportionate risk information amongst internal and external services involved.

Recommendation 7: The Trust should review its management of repeat safeguarding referrals and concerns. This should include a review of policy and training materials to ensure repeat referrals and allegations are incorporated into Trust policy and guidance.

Recommendation 8: The Royal Borough of Greenwich (RBG) Safeguarding Adult Board should facilitate a peer review of adult safeguarding practice at the Trust, which includes quality assurance audits of randomly selected cases and a programme of planned audits going forward.

Recommendation 9: The Trust must provide assurance that involvement of service user's families is considered when planning care. This should include documenting any contact, and recording instances when the decision has been taken not to involve a family, or they have declined to engage.

Recommendation 10: The Trust must ensure any engagement with families during its internal investigation process is documented. This should include instances when the family declines to be involved and whether the final report has been shared.

Recommendation 11: The Trust needs to review the ICMP caseload with a view to evaluating the care pathway of service users whose treatment is based on long-term medication requirements (e.g., depot).

Recommendation 12: The Trust should assure itself that it has fulfilled the requirements of the Mr Q and Ms G action plans from the internal investigations, with a view to providing commissioners and the families involved with evidence-based, completed action plans within three months of receipt of this report.

Recommendation 13: The Metropolitan Police Service (MPS) should review the learning from this investigation to update its programme of safeguarding awareness and policy within 6 months of receiving this report.

Recommendation 14: The MPS and partner agencies should undertake a system review of how MERLIN Adult Come to Notice (ACN) reports are managed and responded to. The MPS should undertake a programme of regular review of MERLIN ACN reports to ensure they are being completed in line with MPS policy.

Recommendation 15: The RBG Safeguarding Adult Board should recommend that partner agencies expand the local children's safeguarding MASH to include adult referrals. Mental health specialism should be part of this MASH. Partner agencies should report back to the Safeguarding Adult Board within three months of receipt of this report.

Recommendation 16: The London Ambulance Service (LAS) must evidence an assurance programme that takes into consideration:

- when to make a safeguarding referral;
- how LAS works with other agencies in relation to safeguarding;
- monitoring of safeguarding practice; and
- embedding of recent changes (e.g., structure, increased training and supervision).

Recommendation 17: The GP practice, within six months of this report, should provide assurance that any existing patients with long-term prescription of benzodiazepines have been reviewed and documented in line with NICE guidance. This should include introducing a method for future identification and review of new patients.

Recommendation 18: The GP Practice should provide assurance that it has taken steps to support staff in understanding and applying its policies in relation to assessing mental capacity and adult safeguarding, and introduce a regular

monitoring approach to make sure staff are consistently applying the principles of the policies.

Recommendation 19: The Clinical Commissioning Group[132] should clearly set out in a policy or procedure the expectations for GP practices in taking a proactive approach in triggering, requesting and/or engaging in multi-agency reviews in instances where there is clear evidence that service users are behaving erratically, over attending practices, excessively using services, or engaging several agencies.

Recommendation 20: The RBG Finance Protection and Appointee (FPA) Team should clarify and agree a process for identifying, managing and resolving safeguarding concerns brought to its attention by partner agencies. The policy should be updated to reflect this.

Recommendation 21: RBG sheltered housing services must develop a system and set out expectations for staff to formally communicate and document the outcome of housing assessments and agree next steps with partner agencies. This should include regular monitoring to support implementation and improvements.

Recommendation 22: RBG, within six months, should lead a full review of how safeguarding and welfare referrals are received and managed to assure itself of the effectiveness of adult safeguarding activity carried out on its behalf. This should include consideration of referrals from external agencies, and the handover process between RBG and the Trust.

Recommendation 23: All agencies must use the findings from this investigation within safeguarding training for staff. All agencies must ensure staff are familiar with the requirements of, and their responsibilities under, the London Multi-Agency Adult Safeguarding Policy and Procedures.

[132] and successor Integrated Care System.

Appendix A – Terms of reference for independent investigation

Brief summary of concerns that triggered this SAR/Mental Health Independent Investigation

Ms G was a 58-year-old woman living in supported living accommodation run by a voluntary organisation. She was receiving home meals and appointeeship managed by the Council and a Community Psychiatric Nurse from Oxleas was involved in monitoring her mental health. It is understood that Ms G regularly made 999 calls to the Police. Lewisham and Greenwich NHS Trust were also involved regarding Ms G physical health. Ms G was killed in 2018 by Mr Q the other person living in the accommodation. He was subsequently convicted of murder and given a life prison sentence.

The Safeguarding Adults Board Evaluation Sub-Group considered that this case met the criteria for a Safeguarding Adults Review on 2 April 2019. The SAB Chair agreed with this recommendation on 3 April 2019. Subsequently, after discussion with NHS England it was decided that a joint Safeguarding Adults Review and NHS England Independent investigation would be undertaken.

Purpose of investigation

To identify whether there were any gaps or deficiencies in the care and treatment of Ms G and Mr Q and the care, treatment and safeguarding of Ms G and Mr Q.

To identify areas of best practice, opportunities for learning across organisations and areas where improvements to local services and inter-agency working might be required which could help prevent similar incidents from occurring.

Specifically:

- Review Oxleas and Bridge internal investigations and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that Oxleas and Bridge has made in implementing both action plans.
- Review the care, treatment and services provided by the NHS, the local authority, London Ambulance Service and other relevant agencies to both Ms G and Mr Q with specific attention to interagency working and safeguarding in relation to Ms G and Mr Q.
- Review whether local Safeguarding Adults policies and procedures were properly followed. The investigation should specifically address the six principles of safeguarding in relation to Ms G and Mr Q (empowerment, prevention, proportionality, protection, partnership and accountability).
- Review Mr Q's risk assessments and risk management plans to ascertain if they adequately incorporated historic risks with specific attention to the risk of Ms G or others. To specifically address whether any safeguarding concerns were identified or should have been identified.
- To review the effectiveness of the safeguarding referrals made for both Ms G and Mr Q.
- To review Ms G's contact and actions taken by London Ambulance Service to identify if there is any wider learning for emergency services.
- Review the effectiveness of care planning for Ms G and Mr Q including family involvement.
- Review contact and support provided from the police, GP, Oxleas and the Bridge to both families following the incident.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Methodology

The investigation will be carried out by Niche Health and Social Care consulting who are deemed sufficiently skilled and experienced to undertake this review. Niche have produced a project plan which details the methodology which comprises of a mix of desktop review and field work

Family involvement

The investigation process will involve Ms G and Mr Q's families as fully as is considered appropriate, in liaison with the Metropolitan Police), Victim Support and other support organisations.

Clinical input

The investigation process and final report should involve an independent psychiatrist in an advisory role.

Outputs

- A succinct, clear and relevant chronology of events for both Ms G and Mr Q leading up to the incident which should help to identify any problems in the delivery of care.
- A summary of the incident and any Court decision (e.g., sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome
- Provide a written report to NHS England and Royal Greenwich Safeguarding Adults Board that includes measurable and sustainable recommendations.
- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and the family.
- In addition to the final report the investigation team are required to produce a learning lessons document, that is easy to read and follow that can be distributed to across Health and Social care for wider learning.
- Meetings with both families to seek their involvement in influencing the terms of reference.
- Meeting with Mr Q to seek his involvement in influencing the terms of reference.
- An Independent panel will meet to include statutory stakeholders to consider progress and any potential barriers (this will be the Royal Greenwich Safeguarding Adults Board panel with additional membership and will be jointly chaired with NHS England)
- Monthly updates where required, to be shared with stakeholders including the family
- A concise and easy to follow presentation for the family
- At the end of the investigation share the report with the Trust and meet the family to explain the findings of the investigation
- A final presentation of the report to NHS England, Royal Greenwich Safeguarding Adults Board, the Mental Health Trust Board and NHS South East London Clinical Commissioning Group.
- A follow up assurance review, six - twelve months after the report has been published, to independently assure NHS England and Royal Greenwich Safeguarding Adults Board that the report's recommendations have been fully implemented. The investigators should produce a short report for NHS England and the family and this may be made public.
- Assist NHS England and Royal Greenwich Safeguarding Adults Board in undertaking a post investigation evaluation

Timescale

The starting point for the investigation will be 2015 to date of incident, when both parties started living together.

The joint investigation/review process will start when the investigators receive all the clinical records, and the investigation should be completed within nine months thereafter.

Timescales may be required to change due to the current national Coronavirus pandemic in adherence with government advice and any impact on services. The investigation must comply with the Coronavirus Act 2020.

Disclosure and confidentiality

All communication regarding this joint investigation/review that contains personal and/or sensitive information must be sent securely using the secure email addresses provided.

Please contact [redacted] or [redacted] with any queries as to how to securely contact another panel member. Requirements in respect of the General Data Protection Regulation 2016/679 implemented on 25 May 2018 will be adhered to throughout the process and legal advice will be sought regarding this matter prior to completion of the report.

Confidentiality should be maintained by all Royal Greenwich Safeguarding Adults Board members and organisations involved in this joint investigation/review, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective joint investigation/review to be completed in the public interest, in line with the NHS England Serious Incident Framework (2015), Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All Royal Greenwich Safeguarding Adults Board members and organisations involved in this joint investigation/review commit to co-operate in and contribute to this work, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, NHS England and the Royal Greenwich Safeguarding Adults Board may use its powers under Section 45 of the Care Act to obtain the relevant information.

The investigators/reviewers may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/guidance, or meet with review participants. Individuals will be granted anonymity within the report.

Communications and media strategy

Communications advice will be provided, and the communications approach managed by NHS England and the Royal Borough of Greenwich communications department. All media queries will be referred to NHS England/Royal Borough of Greenwich, unless criminal proceedings are ensuing in which case all media queries will be referred to the Metropolitan Police Service.

The final anonymised report will be published in line with NHS England requirements and on the Royal Greenwich Safeguarding Adults Board website.

Legal advice

Legal advice will be sought by NHS England and the Royal Greenwich Safeguarding Adults Board to ensure the process and final report complies with legal requirements and safeguards all parties.

Funding and resourcing

This joint investigation/review will be funded by NHS England and Royal Greenwich Safeguarding Adults Board.

Review of Terms of Reference

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the joint investigation/review progresses but must be approved by the joint chairs of the panel. These terms of reference were approved at the Joint Investigation/Review Panel Meeting on 30th July 2020.

Appendix B – Extension to terms of reference

NHS England and NHS Improvement and Royal Borough of Greenwich (RBG) Safeguarding Adults Board (SAB) requested the following additions to the terms of reference in September 2021:

- To review the decisions taken for immediate care after Ms G sustained a broken leg and her subsequent placement.
- To review the assessments and decisions made regarding Ms G's appointeeship and any purchasing of private health insurance.

Appendix C – Documents reviewed

Documents reviewed – Oxleas NHS Foundation Trust	
Greenwich Community Mental Health team (CMHT) actions summary, 27/07/2020	Greenwich Intensive Care Management for Psychosis (ICMP) Performance Quality Monitoring Snapshot
Mr Q action plan progress & evidence, 21/03/2019	Mr Q Care and Planning and Risk assessment documentation
CMHT action plan review & actions summary	Greenwich ICMP Performance Quality Monitoring Snapshot
Contact Assessment team (CAT) Operational Policy, 12/12/2019	Serenity Integrated Mentoring (SIM) Documents
Structure Chart – Adult Mental Health (AMH) & Community Organisation Chart (inc. Mental Health Division), 24/03/2021	Clinical Risk Assessment Policy, Jan 2016 & Nov 2018
Care Programme Approach (CPA) for Oxleas service users	Care Planning Policy, Oct 2016 & Mar 2018
ICMP Operational Policy (Locality Adult Mental Health Service), Apr 2016	Medicines Policy, Jan 2019 & Jul 2019
Incident Management Policy, Apr 2020	Carers & Support Networks Strategy, May 2019
Safeguarding Adults Guidance, Sep 2018	Department of Health Mental Health Act (MHA) 1983 Code of Practice, 2015
Guidance for staff on safeguarding adults processes, Sep 2012	Mental Capacity Act (MCA) Policy, Feb 2019
Medical Treatment under the Mental Health Act (MHA) 1983, Nov 2015 & May 2018	DNA Protocol
Co-occurring mental health and alcohol and/or drug use conditions (COMHAD) Policy for Care Treatment, Jul 2019	Patients Money Policies, 2015 & 2018
Zoning Policy	Care Planning Policy, Oct 2016 & Mar 2018
Administration of Medicines Policy, Aug 2014	Greenwich ICMP team Structure, Sep 2020
Dual Diagnosis – Policy for the Care Treatment, Jun 2013 & Dec 2015	Local AMH Operational Policy, Apr 2016
Information Sharing Protocol –Bridge Support	Safeguarding Adults Guidance
Mental Health Pathway – Housing & Support Options, Oct 2018	Bexley Care Navigation Leaflet
AWOL Policy	CPA Policy
Clinical Risk Policy	Incident Management Policy, Feb 2017
FOO 1750 Oxleas Structure Chart (each division)	Older Adults CMHT Operational Policy
Safe & Therapeutic Observation, Dec 2016	Safeguarding Adults Guidance
Operational Policy – Greenwich ICMP	Committee Minutes, 2020–21
Caseload Zoning Tool	GMH-HRP Flowchart & Terms of Reference, Oct 2019
Safeguarding Committee – SGA Audits, 2020–21	PCP MERLN screening checklist
HRP Referral from Appendix 1 and 2	2017 RiO Forms – Mr Q & Ms G

Q3 2020–21 Documentation	Duty of Candour and Being Open Policy 2017
Care Programme Approach (CPA) for all Oxleas Service Users, Dec 2018	Mr Q Combined RiO Records to Jun 2018
Mr Q – Progress Notes, 2018–20	Ms G awayday PowerPoint, Oct 2018
Ms G Combined RiO Records	Ms G Combined WinDIP archived folders
Ms G ICMP awayday notes, Mar 2019	Ms G induction checklist
Ms G Safeguarding Adults Corporate team – feedback on action, Jan 2020	Trust internal investigations (Ms G and Mr Q)
Root Cause Analysis Report – Ms G	Care Coordinator handover email
Trust action plans (Ms G and Mr Q)	Redacted family contact notes, 18/07/2018
Tunnel Avenue action plan, 05/11/2014	Tunnel Avenue meeting notes, 05/11/2014
Tunnel Avenue Professionals Meeting minutes 12/12/2016	Greenwich Oxleas/housing provider partnership forum agenda, 20/01/2022
Tunnel Avenue Professionals Meeting minutes 10/07/2017	Greenwich Oxleas/housing provider partnership forum meeting minutes, 18 November 2021
Heads together summary	Greenwich Oxleas/housing provider partnership forum meeting minutes, 20 January 2022
Heads Together Workbook, 23/02/2022	ICMP care plan data, 01/02/2022
Duty of Candour letter, 23/07/2018	Safeguarding email, July 2018
Transfer of care within Oxleas and externally Policy 2012	Provider forum minutes, 18 November 2021
Provider forum minutes, 20 January 2022	Risk assessment and care plans monthly audit report February 2022

Documents reviewed – Lewisham and Greenwich NHS Trust	
Clinic Letters	Clinical notes 2015–18
Safeguarding Adults at Risk Policy and Procedure, 2016	QEH ward notes, Mar 2013
Ms G's clinical notes, Mar–April 2013	QEH orthopaedic fracture notes, Mar 2013
Queen Elizabeth Hospital (QEH) nursing notes and assessments, 2013	ED and clinic notes, Mar 2013

Documents reviewed – London Ambulance Service (LAS)	
Estate Consolidation Phase 2 – Service 5 Sector Map v4, 20/04/20	Policy and Procedure for the Management of Frequent and Vexatious Users
Safeguarding team Structure, 2021	Safeguarding Adults in Need of Care and Support policies
Safeguarding Governance Arrangements	Safeguarding feedback form, Aug 2020
Adult Safeguarding: Roles and Competencies for Health Care Staff, Aug 2018	IMR Documentation
Safeguarding team Structure	LAS Chronology Documents
Call log 17.03.2013	CAD referral 17.03.13

Documents reviewed – Metropolitan Police Service (MPS)	
Appendix of summary information	Service Delivery Manager (SDM) Blocking Guidance

Chronology – Suri transmission – 999 Calls?	MPS Vulnerability and Adults at Risk Policy statement and Equality Impact Assessment, 17/05/16
MPS Vulnerability and the Protection of Adults at Risk Policy, Dec 2014	News – MERLIN System Enhancements, 05/04/13
SAR IMR Suri	Safeguarding Adults at Risk Policy
Multi Agency Safeguarding Hub (MASH) response to queries, Apr 2021	Timeline of contact with Ms G and other agencies re the incident in March 2013

Documents reviewed – GP	
IMR Ms G	IMR Mr Q
Chronology – Ms G	Chronology – Mr Q
Consent Protocol	GDPR Fair Processing & Privacy Notice
Safeguarding (Vulnerable) Adults Policy	NHS England – Letter Request for access to medical records
Safeguarding Adult Review – Ms G and Mr Q	Mr Q – Medical Records
Ms G – Medical Records (inc. 2013)	Consent Protocol

Documents reviewed – Royal Borough of Greenwich (RGB) (local authority)	
Choice and Control Carers' Policy, Jan 2013	Deprivation of Liberty Safeguards (DoLS): Policy and Procedures
Financial Assessment Review, 02/10/2015	Financial Protection and Appointee (FPA) Procedure Document
Adults & Older Peoples Services Carers Policy, 2015	RBG Safeguarding Adults Procedures, Nov 2017
Managing Service Users Finances Policy	Individual Management Report (IMR) Documentation
RBG Carers Policy, May 2015	COP3 assessments (Mr Q & Ms G)
Statement of government policy on adult safeguarding, 2011	Ms G case notes, 2013
COP1 and COP1a (Ms G)	LAS referral, 18/03/2013
LAS referral, 19/03/2013	LAS fax confirmation, 18/11/2013
Safeguarding referral LAS, 19/03/2013	Referral to intermediate care service, 2013
Community Assessment and Rehabilitation team's referral, 05/07/2013	Funding approval form, 03/07/2013

Documents reviewed – Royal Borough of Greenwich (Housing)	
Supported Lodgings Scheme (Greenwich)	Chronology documents
IMR Documents	Ms G consent form
Pathway Implementation Needs Group (PING) Strategy notes, 5 Aug 2016	Universal mental health risk assessment form (Ms G)
Greenwich University mental health pathway form (Ms G)	Sheltered housing assessment notes, Oct 2017

Documents reviewed – The Bridge	
Adult Protection Policy, Oct 2015 & Oct 2019	Adult Protection Procedure, Oct 2015

Bridge Support chronology documents	Bridge Support response to Mr Q & Ms G from Niche Consult
Oxleas –Bridge Support Information Sharing Agreement	Safeguarding – Recognising & Responding to Abuse Guidance, 2015 & 2019
Safeguarding Policy, Oct 2015 & Oct 2019	Information Sharing Protocol
IMR documents	

Documents reviewed – Ms G's family	
Correspondence with the Trust	Correspondence with the FPA team
Photographs taken in hospital of Ms G's injuries after she broke her leg in March 2013	Ms G transaction history, Jan 2017–August 2018
Photographs of Ms G's accommodation taken after her death.	

Appendix D – Professionals involved

Pseudonym	Role and organisation
Specialty Doctor	Specialty Doctor, ICMP, Oxleas NHS Foundation Trust
Consultant Psychiatrist	Consultant Psychiatrist, ICMP, Oxleas NHS Foundation Trust
Associate Specialist	Associate Specialist, ICMP, Oxleas NHS Foundation Trust
Care Coordinator 1	Care Coordinator, East Recovery team, Oxleas NHS Foundation Trust
Care Coordinator 2	Care Coordinator, ICMP, Oxleas NHS Foundation Trust
Care Coordinator 3	Care Coordinator, ICMP, Oxleas NHS Foundation Trust
Care Coordinator 4	Care Coordinator, ICMP, Oxleas NHS Foundation Trust
GP1	GP, GP Practice, Greenwich
GP2	GP, GP practice, Greenwich
GP3	GP, GP practice, Greenwich
GP4	GP, GP practice, Greenwich
GP5	GP, GP practice, Greenwich
GP6	GP, GP practice, Greenwich
GP7	GP, GP practice, Greenwich
Support Worker	Support Worker, Bridge Support

Appendix E – Tabular timeline of Ms G's care and agency contact, March–September 2013

Date	Time logged	Agency	Event
17/03/2013	15:53	Ms G	Ms G called London Ambulance Service (LAS) to report she had fallen, and a bone was protruding from her foot. The call concluded at 16:06.
17/03/2013	16:20	LAS ambulance	LAS arrived at Ms G's address. The attending LAS staff documented Ms G had sustained a fracture to her left tibia and fibula.[133] It was unclear when this had happened, but Ms G told them she had been hit by a male resident who sat on her leg and broke it. Ms G said she was scared of this man.
17/03/2013	16:57	LAS Single Responder	LAS Single Responder[134] arrived at Ms G's address.
17/03/2013	17:44	A&E	Ms G is transported by ambulance and admitted to Queen Elizabeth Hospital (QEH) A&E.
17/03/2013		QEH	Orthopaedic Senior House Officer (SHO) review. Noted Ms G said another person had jumped on her left leg; SHO documents that the alleged assault needs investigating.
17/03/2013	18:44	QEH	Section 2 Notification – Protection of Vulnerable Adults (POVA). Alleged assault by clients at residential home.
17/03/2013	19:00	QEH	Noted another resident jumped on Ms G's lower left leg. Staff tried calling Caring Landlord to get more information but no answer.
18/03/2013		QEH/Royal Borough of Greenwich (RBG)	Q&E staff contacted Safeguarding to raise concerns in relation to Ms G who presented at A&E with injuries she says were the result of another resident assaulting her.
18/03/2013	12:45	Oxleas	Care Coordinator 1 is contacted by the manager of the (Oxleas) Joint Assessment and Emergency team who informed her that Ms G had been admitted to hospital the day before, reporting she had been attacked by other residents at her address. Hospital staff were unwilling to discharge Ms G to her home. It was agreed Care Coordinator 1 would contact the Ward to obtain more information with a view to raising a safeguarding alert.
18/03/2013	17:15	QEH/Oxleas	Care Coordinator 1 contacted the QEH Ward who confirmed Ms G had been admitted due to an "*apparent fall*" and has sustained serious fractures to her tibia and fibula. Ward staff advised Ms G would not be fit for discharge for some time. Care Coordinator 1 told the Ward staff that Ms G was known to Mental Health Services and took antipsychotic medication.

[133] Tibia and fibula: lower leg bones. The tibia is the larger of the two bones, more commonly known as the shin bone. The fibula is the smaller, anterior bone.

[134] Single Responder: https://www.londonambulance.nhs.uk/calling-us/who-will-treat-you/single-responder/

Date	Time logged	Agency	Event
18/03/2013	17:30	Oxleas/ Community Options	Care Coordinator 1 contacted Community Options to advise that the Mental Health team had been contacted by the Joint Assessment and Emergency team. The Community Options member of staff said they would inform Ms G's Caring Landlord of the recent events.
18/03/2013	17:37	Oxleas	Care Coordinator 1 contacted Ms G's son to tell him his mother had been admitted to hospital.
18/03/2013		QEH	Ms G is transferred from A&E to an inpatient ward (Ward 6).
19/03/2013	11:25	QEH	Transferred from Ward 6 to Ward 17. It is documented she had been assaulted by a "*housemate*".
19/03/2013	12:50	LAS/RBG	LAS staff submit a Referral of a Vulnerable Adult/Child to the RBG Emergency Bed Service.[135] The referral detailed concerns that Ms G had been subject to physical abuse and concerns about the home environment.[136]
19/03/2013		Orthopaedic Multidisciplinary team (MDT) (QEH)	Agreed Ms G should be transferred to Orthopaedics at Kings College Hospital (KCH). Ms G was to be seen at the KCH Fracture Clinic (no clinic date).
19/03/2013	14:38	QEH	Referral to integrated care service Hospital Integrated Discharge team (HID). Reason for admission documented as alleged assault by client at residential home.
20/03/2013	AM	Oxleas	It was documented at the team zoning meeting that Ms G had been admitted to hospital due to being attacked. Care Coordinator 1 to complete a safeguarding referral.
20/03/2013	14:30	QEH/ Oxleas	Care Coordinator 1 spoke to the Orthopaedic Ward Sister, advising that Ms G was known to Mental Health Services and they would need to speak to her in relation to safeguarding concerns she had raised. The Ward Sister reported that Ms G had an open fracture to her leg and that Ms G had said someone from the home had stamped on it. The Ward Sister advised that the nature of the injury was consistent with Ms G's allegation. During the call, Care Coordinator 1 also spoke to the Ward Pharmacist to advise Ms G's depot medication was due that day. The Pharmacist confirmed they would order the medication for Ms G.
20/03/2013	16:04	Oxleas	Care Coordinator 1 contacted Ms G's daughter to tell her what had happened to Ms G.
20/03/2013	16:04	Oxleas	Care Coordinator 1 contacted the Metropolitan Police Service (MPS) who advised they could not take direction from her because Ms G's son and daughter had already contacted the police.

[135] The notes indicate RBG sent a copy of the referral to Care Coordinator 1 on 18 March 2013. The referral was completed on 17 March 2013 by LAS but the cover fax sheet is dated (and time stamped) 19 March 2013.

[136] The referral form is a tick box form: further accompanying detail is not provided.

Date	Time logged	Agency	Event
20/03/2013		KCH	Ms G seen at Kings College Fracture Clinic; she is to be transferred to KCH once a bed becomes available. Clinic note by Sister says: "*fractured left tibia, sustained in Residential home by resident*".
21/03/2013	AM [137]	Oxleas	Care Coordinator 1 visited Ms G in hospital to discuss her allegations. Ward staff had been unable to arrange an interpreter in advance of Care Coordinator 1 attending, therefore the conversation took place without an interpreter. Ms G told Care Coordinator 1 that the incident occurred in the house kitchen at around 17:00 (day not given). Ms G provided a description of the alleged assailant and details of the attack. Ms G told Care Coordinator 1 that she called an ambulance after the attacker left the kitchen. During her discussion with Care Coordinator 1, Ms G referred to the individual using male and female pronouns. She advised that they lived in the room next to her and they were "*big and tall*". Nursing staff examined Ms G's shoulders and back and confirmed she had bruising at the top of her right arm and bruising on the left arm (which was consistent with her account).
21/03/2013	13:40	Oxleas	Care Coordinator 1 informed the Recovery East Team Manager about her discussion with Ms G. They agreed she should tell the police about the discussion and contact Ms G's Caring Landlord with a view to obtaining more details about the other residents at the property. Care Coordinator 1 was to complete an incident report. A strategy meeting was scheduled to take place the next day.
21/03/2013	13:55	Oxleas/MP	Care Coordinator 1 contacted the MPS to report what Ms G had told her about the alleged incident. The operator advised that the MPS would contact Care Coordinator 1 because they had originally intended to speak to Ms G when she was discharged from hospital. Care Coordinator 1 told the operator that the alleged perpetrator lived at the property, and it was not appropriate for Ms G to return to the address.
21/03/2013	15:00	Oxleas/Caring Landlord	Care Coordinator 1 contacted Ms G's Caring Landlord to ask if there had been any concerns at the address. The landlord said everyone in the house was quiet and there had been no incidents. The landlord provided the details of three other residents living at the property, all of whom were known to Trust services.
22/03/2013	11:30	MPS/Oxleas	The MPS contacted Care Coordinator 1 asking for details about the incident, Ms G's mental health, and the other residents at the property. The Police Constable (PC) indicated he would pass on the information to the

[137] Recorded on RiO at 13:28.

Date	Time logged	Agency	Event
			Investigating Officer. He advised the MPS intended to interview Ms G when she was discharged home. Care Coordinator 1 told the PC it would not be appropriate for Ms G to return to the property because the alleged assailant lived there, and Ms G had expressed a wish not to return.
22/03/2013		MPS	MPS attend QEH to speak to Ms G but were unable to communicate with her (no further information available).
22/03/2013	12:25	Oxleas/ Community Options	Care Coordinator 1 spoke to the Supported Lodging Scheme Manager. She advised an investigation would be undertaken and a safeguarding conference was to take place on 25/03/2013.
22/03/2013	12:25	Oxleas	Care Coordinator 1 spoke to the care coordinators for two of the residents (one of whom was the alleged assailant) to advise a safeguarding alert had been raised.
22/03/2013	16:00	QEH	"*Plan – seen*[138] *by police this morning, son & daughter around to help interpret*" [unclear who signed notes].
22/03/2013	16:17	Oxleas	Care Coordinator 1 contacted a member of the Early Intervention team who is the third resident's Care Coordinator, to advise a safeguarding alert had been raised.
22/03/2013		MPS	Ms G's daughter informed the MPS that her mother has been assaulted by another member of the supported accommodation. Ms G is alleged to have been punched in the face and her leg was stamped on. Description and name provided [same name as that submitted in Oxleas safeguarding referral on 22/03/2013 – see below]. Alleged perpetrator has been reportedly sectioned under the Mental Health Act (MHA).
22/03/2013	20:40	Oxleas/RBG	Care Coordinator 1 submitted a safeguarding referral to RBG. Noted: "*According to ambulance crew* [Ms G] *alleged that the man downstairs has sat on her leg, breaking it. She apparently seemed scared and changes her story often…* [Ms G] *has indicated that she does not wish to return to the accommodation…. Description given is possibly* [redacted]"*.* Documented incident was reported to the police on 19/03/2013. Proceed to investigation under safeguarding procedures.
25/03/2013	10:00	QEH	Orthopaedic Ward round documented Ms G was still waiting for a bed at KCH.
25/03/2013	12:00	Safeguarding Conference – Oxleas,	1. Agreed Ms G should not stay at the property with the alleged perpetrator. Noted Ms G had done well at the property for a number of years, and Care

[138] The MPS told us that they did attend QEH on 22 March 2013 but were unable to "*communicate with her*".

Date	Time logged	Agency	Event
		Community Options and Caring Landlord	Coordinator 1 would seek her views about moving. Possible option of moving Ms G to the ground floor whilst she recovered was discussed. Community Options to look into alternative accommodation should Ms G wish to move. Ms G's care plan to be reviewed prior to her discharge from hospital. 2. Immediate risk from alleged perpetrator deemed to be low because Ms G was in hospital, and he had been admitted to Mental Health hospital. 3. The police were planning to interview Ms G when she was discharged from hospital. 4. Community Options Lead to arrange a meeting with Ms G's family to discuss the incident. 5. Care Coordinator 1 was to inform the alleged perpetrator's Care Coordinator of the meeting actions. Caring Landlord and other care coordinators to be asked to check with other residents whether they had any concerns. 6. Review in 4 weeks.
27/03/2013	Evening	QEH/KCH	Ms G transferred to KCH. Arrived at 21:00.
27/03/2013	23:22	KCH	Ms G was referred from QEH without notes, a referral letter, or handover (X-rays received shortly after). Admitted to QEH 12 days previously after alleged assault at home. Assaulting person kicked her and stood on her left leg. Ms G unable to give a clear description of events.
27/03/2013	11:52	Oxleas	Zoning meeting: blue.[139]
28/03/2013	PM	KCH	Underwent surgery – Left tibia plateau and left ORIF[140] distal tibial fracture
29/03/2013	07:21	KCH	Member of nursing staff called by Recovery team to collect Ms G. Nursing staff advised she had read all the notes and would await Ms G being reviewed by the Anaesthetist. The nursing staff recorded in the notes she had made a safeguarding referral as "*not particularly impressed by how the her* [sic] *'assault' by another resident seems to be given less attention and already informed she will need repartriation* [sic]. *She is a vulnerable adult after all. I have already d/w* [discussed with] *my concerns with the NIC* [Nurse in Charge]." Information re safeguarding referral recorded again in the notes at 01:06 on 30/03/2013.
02/04/2013	AM	Oxleas	Zoning meeting: blue. Incident downgraded to level 3.

[139] The Trust Zoning Policy (undated) we have refers to green, amber and red zones; not blue. We have received no explanation as to what constitutes the blue zone.

[140] Open reduction and internal fixation.

Date	Time logged	Agency	Event
			Noted Miss G will be seen the next day [staff name not listed]
02/04/2013	10:11	KCH	Orthopaedic Ward round. Ms G to be repatriated to QEH.
02/04/2013	10:57	KCH	Learning Disability alert received from the ward. Noted Ms G had transferred from QEH. Stated: "[Ms G] *Had allegedly sustained injuries during a fight with another resident. Events leading to injury not clear. Patient is known to have learning disabilities*". Noted the alert had been forwarded to the Community Learning Disability team – and KCH needs to know who her next of kin (NoK) is and the supported accommodation contact (because they need to be invited to Ms G's discharge planning).
02/04/2013	13:24	KCH	Health passport filled in as per learning disability protocol. Ms G awaiting repatriation to QEH; staff intend to discuss this with Ms G's son who is scheduled to visit.
02/04/2013	16:44	KCH	Nursing staff spoke to Ms G's son who advised Ms G's Social Worker was Care Coordinator 1. Contact details provided. Ms G's son confirmed she was assaulted by another resident and the incident had been reported to the police who were investigating.
02/04/2013		MPS	MPS liaise with Ms G's family and KCH regarding her fitness to be interviewed.
02/04/2013		MPS/Oxleas	MPS liaise with Oxleas Staff Nurse who is concerned the alleged perpetrator is not fit for interview.
02/04/2013		RBG	Safeguarding alert received.
03/04/2013	13:44	KCH	Physio/Occupational Therapist (OT) noted difficulties engaging Ms G – queried whether Ms G's son and Learning Disability team should be contacted to undertake a joint session.
03/04/2013	14:59	KCH	OT contacted Ms G's daughter for her history and to arrange a joint session. Ms G's daughter gave consent Ms G's supported accommodation to be contacted to provide further care/ability details. Ms G's daughter said the family were unhappy with the care their mother has received at her home. Joint session with Ms G's son booked for 01/07/13.
04/04/2013	16:49	KCH	Earlier afternoon Physio/OT session with Ms G and her son postponed because her son was delayed attending the appointment. When Ms G's son arrived, he spoke to the OT and they agreed to reschedule, though he voiced his doubts as to whether Ms G would respond to the joint session.
07/04/2013	14:55	KCH	Staff Nurse advised Ms G to bring her own escitalopram because the hospital did not stock the same version. Noted the team and/or Pharmacist needed to call Care Coordinator 1 because Ms G did not think she had received her regular medication and had missed a depot

Date	Time logged	Agency	Event
			injection (note to team/Pharmacist highlighted in Ms G's notes).
08/04/2013		MPS/KCH	MPS liaise with KCH who advised that Ms G had completed emergency treatment and was to be transferred back to QEH. Noted that Ms G was fit for interview.
10/04/2013	10:24	KHC	Orthopaedic Ward round. Ms G complained of pain over her right posterior rib cage; says she fell at home. Reassured pain is likely muscular.
10/04/2013	11:10	Oxleas	Ms G discussed at zoning meeting, category blue. Ms G remains on a ward at KCH. Noted the KCH Safeguarding Lead had called to get more information about Ms G who was not being cooperative on the ward. Ms G was to be transferred back to QEH and Care Coordinator 1 was to speak to her about future accommodation.
12/04/2013	10:27	KHC	Orthopaedic Ward round. Ms G complained of pain over her right posterior rib. Last chest X-ray reviewed; no fractures. No falls reported since last chest X-ray.
13/04/2013		Ms G's family	Letter sent by Ms G's daughter to the Manager of the East Recovery team, detailing her concerns in relation to Ms G's wellbeing, physical health and accommodation.
16/04/2013	00:00	KCH	Transferred to another ward at midnight.
17/04/2013	09:49	KCH	Decision taken by Physio team to no longer provide input to Ms G because she will not engage; noted she is unlikely to progress until she starts doing the exercises as advised. Ms G's left leg was meant to be non-weight bearing (NWB) but she continued to put her weight on it. Ongoing wait to repatriate Ms G to QEH.
18/04/2013	01:45	KCH	Ms G complained of pain in her right side, but said it was not chest pain. Chest X-ray to be arranged.
18/04/2013	09:06	KCH	Orthopaedic Ward round. Bony prominence noted on left lower rib region – impression: rib fracture. Chest X-ray booked.
19/04/2013	10:37	KCH	Orthopaedic Ward round. Chest X-ray reviewed – no rib fractures.
24/04/2013	12:21	GP/Adult Safeguarding team[141]	GP6 advised the administrator of the Adult Safeguarding team that the practice has safeguarding concerns regarding Ms G. Administrator advises he will check whether Ms G is under their care and let the practice know.
24/04/2013	16:16	GP/Caring Landlord	GP6 spoke to the Caring Landlord who advised Ms G has been under the Safeguarding team at Oxleas for the

[141] GP notes refer to "*adult safeguarding team*" but we consider this to be the Locality team given there is also reference to Care Coordinator 1.

Date	Time logged	Agency	Event
			past three years. The resident who caused Ms G's injuries had been sectioned and would not be returning to the property. Ms G remained in hospital. MPS investigating.
24/04/2013	16:16	GP/ Oxleas	GP6 spoke to Care Coordinator 1 who confirmed information provided by the Caring Landlord.
24/04/2013	16:22	KCH	Nursing staff received call from Care Coordinator 1 who advised she would be visiting Ms G and would welcome OT input re their assessment for Ms G's care. Care Coordinator 1 said Ms G should be receiving depot medication and this had been given to a Staff Nurse when Ms G was on a previous ward.
25/04/2013	15:30	Oxleas	Care Coordinator 1 visited Ms G at KCH. Junior Sister advised that Ms G had not been cooperating with OTs or adhering to their advice (e.g., not to put weight on her left leg). Ms G was not independently mobile, and it was unclear the extent to which this would influence her care package requirements. Care Coordinator 1 discussed Ms G's discharge (home or to QEH) with the Discharge Coordinator; advised they would need more information about her Activity of Daily Living (ADL) functioning which should be done with a Punjabi interpreter present. Ms G expressed a wish to return home. Care Coordinator 1 told Ms G that her children did not want her to do this, but Ms G continued to indicate she wished to return to the property. Ms G was told the alleged perpetrator was not in the property. Plan: • Ms G to be transferred back to QEH. • Discharge Coordinator to liaise with OT to carry out functional assessment (with interpreter present). • Care Coordinator 1 to contact Community Options and Landlord re supported accommodation. • Ms G requested £40 to be collected week commencing 29/4 (Ms G's son, who collects the money, to be informed with a view to giving it to his mother at KCH).
25/04/2013	16:05	KCH/Oxleas	Entry from Care Coordinator 1 in the KCH notes: documented Ms G would like to return home. Police investigation into alleged assault ongoing; perpetrator is no longer at the house and is unlikely to return. [Similar plan to above recorded at 15:30 documented].
27/04/2013	17:30	QEH	Ms G transferred from KCH back to QEH. Documented Ms G required treatment following an assault at her home. Recorded in the notes that she has a full cast on her left leg.
30/04/2013		MPS/QEH	QEH Staff Nurse unsure about Ms G's fitness to be interviewed.

Date	Time logged	Agency	Event
01/05/2013		QEH	Orthopaedic review. Ms G asked to see the SHO because she was hearing voices, panicking and had chest pain. The SHO provided assurance and booked an ECG.
02/05/2013	13:30	Oxleas	Care Programme Approach (CPA) review – Ms G not present. To be rebooked.
02/05/2013	20:13	QEH	Orthopaedic review: Ms G needs rehabilitation and physio but is fit for discharge. Care package needs to be sorted.
02/05/2013		Oxleas	Letter from Oxleas Specialty Doctor to GP re CPA review. Advised Ms G did not attend the meeting (reason not given). Asks the GP to continue Ms G's medications as detailed.
02/05/2013		Oxleas	The manager of the East Recovery team wrote to Ms G's family (original letter not seen).
03/05/2013	11:00	QEH	Physio notes. Physio spoke to Caring Landlord who said they are in the process of relocating Ms G's room to the ground floor.
03/05/2013	12:55	Oxleas/ Community Options	Community Options advised they have been informed Ms G is to be discharged home and "*she is not happy with the plan*" [unclear if this means the Community Options member of staff or Ms G].
03/05/2013	12:55	Oxleas	Member of team contacts QEH. Initial confusion as to which ward Ms G is based on, but once resolved ward staff advise the plan is to discharge Ms G on 07/05/2013. Ward staff said a functional assessment had been completed and the OT was liaising with the Caring Landlord.
03/05/2013	12:55	Oxleas	Member of team updates Community Options on the above, who in turn indicate they will be contacting the ward.
07/05/2013 [142]		QEH	Orthopaedic Ward round. Ms G awaiting discharge plan and input from social services.
07/05/2013	11:30	Oxleas	Care Coordinator 1 contacted the MPS to advise the alleged perpetrator was to be discharged from the mental health ward within the next few days (police seeking to undertake an interview).
07/05/2013	12:45	Oxleas	Police contacted Care Coordinator 1 querying where alleged perpetrator will be discharged; Care Coordinator 1 indicated this may be the shared property. Ms G has also indicated she wished to return to the property. Police asked that the alleged perpetrator, upon discharge, be taken to the local police station to be interviewed under caution. Care Coordinator 1 said a responsible adult may need to be present. Police asked whether Ms G could be interviewed via method known as 'Achieving Best Evidence' which would involve

[142] Handwritten notes dated 07/04/13 – presumed to be an error because notes at top and bottom of page are dated May 2013.

Date	Time logged	Agency	Event
			interviewing her by video at home rather than taking a formal statement. Care Coordinator 1 said she would need to discuss with Community Options and Caring Landlord. Plan: Care Coordinator 1 to liaise with alleged perpetrator's Care Coordinator and QEH re Ms G's discharge.
07/05/2013	16:42	Oxleas	Care Coordinator 1 called the QEH Discharge Coordinator. No other details.
08/05/2013	10:38	Oxleas	Zoning meeting: red. Care Coordinator absent, therefore another member of staff to check Ms G's discharge date and details of OT assessment.
08/05/2013		QEH	Orthopaedic awaiting feedback from Care Coordinator 1 on 09/05/2013 re "*urgent interim* [illegible] *(discharge)*".
09/05/2013	15:51	Oxleas	Care Coordinator 1 called Early Intervention team (no other details).
10/05/2013	10:58	Oxleas	Team meeting. Ms G's family are concerned she wants to return to the property and have queried whether she has the capacity to make this decision. Property was mixed gender but Community Options plan to bring in more females (leaving one male).
10/05/2013	15:15	Oxleas	A Care Coordinator from the East Recovery team who knew Ms G's family emailed them to say that he had relayed the family's concerns to Care Coordinator 1 and the team. He advised that the team intended for Ms G to return to the property because this was what she wanted, and the team considered she had capacity to make this decision. He wrote that he had advised the team to consider this last point "*very carefully*". He added that he had been told the property was to be female only with the exception of an elderly gentleman who was considered "*harmless*"; "*The perpetrator of the assault will definitely not be there*". The email indicated that the author was aware the family had tried to arrange a meeting with the Team Manager, but he was on leave.
16/05/2013		Ms G's family	Ms G's daughter wrote to the manager of the East Recovery team. The communication was in reply to a letter sent by the manager on 2 May 2013 (original letter not seen), which referred to what Ms G's daughter felt were issues that were still outstanding. The letter also referred to the offer of a meeting, which was accepted. Ms G's daughter asked that appropriate staff be at the meeting to address her concerns in relation to: • Where Ms G would reside after she was discharged from hospital and that the accommodation would be appropriate for her needs. • That Ms G's daughter assume responsibility for her finances.

Date	Time logged	Agency	Event
			• Detail of Trust policy in relation to the placement of female patients. • Details of the team's monitoring and record keeping about Ms G's accommodation.
20/05/2013		RBG	Ward visit: discharge planning following referral for intermediate care. Language barrier meant it was difficult to clarify with Ms G whether she wanted to return to her house or participate in bed-based intermediate care.
20/05/2013		RBG/Oxleas	Discharge planning discussed with Care Coordinator 1 who was due to meet with Ms G's family later in the week. The family had concerns about Ms G returning to the house. Noted that Care Coordinator 1 was to see Ms G that Friday (24/05/2013) with an interpreter with a view to determining what Ms G would like to do.
21/05/2013		RBG	Discharge Coordinator asked that the family meeting be brought forward so Ms G could be discharged sooner. Ms G is noted to be medically fit and the alleged perpetrator no longer resides at the property, therefore there was no reason why Ms G could return home.
22/05/2013	10:09	Oxleas	Zoning meeting: red. Ms G has been referred to interim care at the Bevan Unit because she will require further support. Care Coordinator 1 to continue liaising with the ward. Ms G scheduled to have a capacity assessment on Friday (24/05/2013).
23/05/2013	13:02	Family	Ms G's family contacted Care Coordinator 1 to ask when a family meeting would be arranged; Care Coordinator 1 advised that week.
24/05/2013	11:43	Oxleas	Team meeting. Ms G to have a capacity assessment that day in relation to her accommodation. Soon to be transferred to Bevan Unit but unclear where she will go thereafter. Family meeting arranged for next Tuesday to discuss her care needs and accommodation.
24/05/2013		HID (QEH)	Ms G signs a consent form to be transferred to intermediate care at the Bevan Unit.
24/05/2013		HID (QEH)	Identify needs form completed by nursing and physio staff.
24/05/2013		Greenwich Social Services (QEH)/St Marks (local GP)	Fax from QEH to local GP advise that Ms G was being admitted to the Bevan Unit that evening; requests that they accept care for her for the duration of her stay. Transfer letter of intermediate care provided. Details: reason for admission, past and present medical history, current medication, allergies, recent investigations, results and any resultant action.
24/05/2013		Greenwich social services (QEH)/Bevan Unit	HID faxed Ms G's paperwork to the Bevan Unit. The cover note said St Mark's (local GP) had been sent a copy of the transfer letter and GP cover had been requested for the duration of Ms G's stay.
24/05/2013		Oxleas	Ms G admitted to the Bevan Unit.

Date	Time logged	Agency	Event
29/05/2013	08:50	Oxleas	Ms G seen by OT for initial interview but she became agitated and started to speak Hindi very fast. Ms G asked that her son be contacted.
29/05/2013	14:45	Oxleas	Healthcare Assistant (HCA) acts as an interpreter for OT. Ms G asked that they speak Punjabi. Ms G gives detail of her life and needs before the incident. She reports she was attacked by two men in the house who wanted her food. She now feels too scared to return to the property. HCA advised OT that some of the discussion was muddled and did not always make sense.
30/05/2013	14:40	Oxleas/RBG	Care Coordinator 1 met with member of Financial Protection and Appointeeship team to collect £40 for Ms G.
30/05/2013	15:41	Oxleas	Care Coordinator 1 visited Ms G at the Bevan Unit. A member of staff advised that Ms G had said she did not want to return to the property. Care Coordinator 1 discussed Ms G's accommodation with her; she indicated she wanted to return to the property (notes do not indicate whether an interpreter was present).
04/06/2013		MPS	Detective Inspector requests further action from the internal MPS team because basic steps are taking too long.
06/06/2013	15:31	Pharmacy	Noted Ms G was admitted to the Bevan Unit with her medication changed from escitalopram 10mg to citalopram 20mg. Citalopram was continued on the unit.
07/06/2013	12:43	Community Nursing	Community Nursing team called Ms G's GP to confirm her medication.
07/06/2013	16:00	Bevan Unit	Email sent from Pharmacist to Mental Health team to confirm whether Ms G received her depot on 23/05/2013.
10/06/2013	14:10	Community Nursing	Call to District Nurse about Ms G's depot medication. Awaiting call back.
12/06/2013		Community Nursing	District nurse attended the Bevan Unit to give Ms G her depot medication.
18/06/2013	05:55	Bevan Unit/MPS	Ms G called the MPS to say she wanted to go to KCH. MPS asked to speak to ward staff who provided information. No Further Action (NFA).
18/06/2013	10:56	Bevan Unit/Oxleas	Ward admin rang Care Coordinator 1 who advised she would be completing all discharge planning for Ms G because she in under enhanced care with their team. Care Coordinator 1 said she was waiting for an access visit and the detail of the Physiotherapist's recommendations for Ms G. Discharged planned for 02/07/2013.
21/06/2013	16:29	Bevan Unit/Oxleas	Care Coordinator 1 visited Ms G. Ms G indicated that she wanted to return to the property. Care Coordinator 1 explained they were looking into what support she

Date	Time logged	Agency	Event
			would need when she returned. Ms G indicated she had recently seen a Support Worker. Care Coordinator 1 spoke to a Physiotherapist who agreed to provide an update about Ms G's functional assessment and liaise with the OT regarding a broader assessment of needed. Care Coordinator 1 was to liaise with Community Options about this.
28/06/2013	21:02	Oxleas	Ms G refused to let her son be told about the multidisciplinary meeting (MDM) (no additional information about the MDM).
02/07/2013		MPS	Alleged perpetrator interviewed in secure accommodation: denied offence.
02/07/2013	13:33	Oxleas	Care Coordinator 1 called the Bevan Unit who advised Ms G was to be discharged that day.
02/07/2013	15:00	Bevan Unit	Ms G left the unit and returned to her place of residence. Discharge letter faxed to Ms G's GP.
02/07/2013		Oxleas/RBG	Funding approval form completed by Care Coordinator 1, requesting additional support for Ms G: weekly support (Mondays, Wednesdays, Thursdays and Saturdays) with shopping, laundry and collecting her money. Requested to start 03/07/13 and be reviewed three months later. Support provider: Ark Home Health Care Ltd. Supporting statement says "… *treated for fractures and injuries sustained from an incident at her home… requires urgent practical support to enable her to maintain her independence when she returns home. Without this she will be at risk of falls and deterioration of her physical wellbeing…* [Ms G] *resides on the first floor of a shared accommodation and is using a zimmer frame and walking stick as she recovered. She* [is] *not fully bearing her weight as yet and requires support with domestic tasks and moving significantly heavy objects.*" [The supporting statement makes no reference to Ms G's left leg being in a cast].
03/07/2013	09:50	Oxleas	Rehab Assistant visited Ms G at home to take her a new frame, but no one answered the door. Following calls to Care Coordinator 1 and the Caring Landlord, she is given the key safe number.
03/07/2013	11:01	Oxleas	Zoning meeting: green. Noted Ms G was discharged home the day before and an urgent care package was put in place. Noted she would need ongoing support in relation to her leg injury.
04/07/2013	18:47	Oxleas	Care Coordinator 1 called Ms G to ask about her leg. Ms G reported she was in pain and asked for some money. Care Coordinator 1 advised a Community Psychiatric Nurse (CPN) would visit Ms G in the morning to administer her depot. Recorded in the notes that staff should contact Community Options or the

Date	Time logged	Agency	Event
			Caring Landlord if they had difficulties accessing the property (because of Ms G's mobility issues).
05/07/2013	08:55	Oxleas	A CPN visited Ms G to administer her depot medication. Ms G appeared well.
05/07/2013		GP	GP7 reviewed Ms G. Notes the practice did not receive a discharge letter from KCH or QEH (intends to chase).
05/07/2013		Oxleas (Bevan Unit)	Bevan Unit sent referral form to Community Assessment and Rehabilitation teams (CART). Requests Ms G be given support to progress to load-bearing on her left leg, managing stairs and improved mobility.
08/07/2013	14:15	Oxleas	A Support, Time and Recovery (STR) worker contacted the team to advise Ms G had said she has no money to buy food. The STR was advised to speak to Care Coordinator 1 or one of the carers at the property.
08/07/2013		A&E (UHL)	Ms G attended A&E complaining of problems with her leg plaster.
10/07/2013	16:00	Oxleas	Physiotherapist contacted Care Coordinator 1 to advise that Ms G would need help to attend clinic appointments. Care Coordinator 1 said she was not happy with the discharge from the Bevan Unit as they had not undertaken a home visit to check whether Ms G could manage the stairs. Ms G was struggling to access the kitchen downstairs. The Physio advised Ms G be given a flask and/or bottled water to reduce her use of the stairs whilst her leg remained in a cast. Physiotherapist advised Ms G would only be considered "*urgent*" by the team once her cast had been removed – asked Care Coordinator 1 to keep them informed.
11/07/2013		A&E	Leg pain (unclear which hospital Ms G attended).
13/07/2013		Support Worker	Email sent to Care Coordinator 1 and Community Options outlining concerns in relation to Ms G's wellbeing. Ms G had advised that her carer had not been to visit, and she did not have food. Support Worker advised "*… From my observation I feel that* [Ms G] [the] *majority of the time is not capable of making the right decision for herself for basic things. I suggest that this should be observed and looked into…* [Ms G] *struggles to understand the risk of going up and down the stairs and I fear that she will fall down them or injure herself more…*"
14/07/2013		A&E (QEH)	Leg pain.
15/07/2013	17:19	Oxleas/GP	Care Coordinator 1 spoke to GP7. Care Coordinator 1 outlined the concerns of Ms G's family and the Support Worker in relation to her cognition and ability to remember tasks designed to help her leg heal. GP appointment made.
15/07/2013	17:19	Oxleas/Family	Care Coordinator 1 called Ms G's daughter to advise that a GP appointment had been made for Ms G the next day. Ms G's daughter was unable to attend but

Date	Time logged	Agency	Event
			indicated her brother could. Ms G's daughter asked who would pay for Ms G's taxi as Ms G and her son did not have any money. No response documented.
16/07/2013	09:46	Oxleas/GP	Care Coordinator 1 contacted the GP practice to cancel Ms G's appointment with GP7 that morning. Advised that the Psychiatrist will undertake an assessment of Ms G at home; a letter will follow assessment.
16/07/2013	12:00	Oxleas/ Community Options	STR contacted Care Coordinator 1 to advise Ms G was mobilising appropriately up and down the stairs. Care Coordinator 1 said Ms G's family were concerned Ms G was not able to remember tasks (e.g., how to use the stairs properly) due to possible cognitive deterioration.
19/07/2013	13:44	Oxleas	Home visit by team Specialty Doctor cancelled because no one was available to accompany him. Team left a message on Ms G's mobile. Admin staff contacted the interpreter service to check whether one had been booked for the visit (and therefore needed to be cancelled) – an interpreter had not been booked.
19/07/2013	16:19	Oxleas/ARK/ Community Options/Family	Various contacts about the concern that Ms G had little money or enough food to last her the weekend. Subsequently enquiries indicated her appointeeship funds had not been reinstated. Ms G's son asked a member of the team to speak a carer who knew Ms G (but was not her carer). The carer confirmed Ms G did not have much food and was hungry. The carer was concerned other residents were eating Ms G's food.
24/07/2013		A&E (QEH)	Plaster problem.
24/07/2013	12:38	Oxleas/ Community Options	Community Options contacted the team to ask if a capacity assessment had been undertaken for Ms G. Advised a Support Worker had been in contact to say Ms G was not safe within the house and cannot go out. Advised Ms G should not have returned to the property but to a care home. Team advised there is no record of a capacity assessment, but this would be followed up with her Care Coordinator when she returned from leave on Monday [29/07/2013].
01/08/2013		A&E (QEH)	Lower back pain.
02/08/2013	18:17	Oxleas	Ms G has not attended the depot clinic since 26/07/13. Care Coordinator 1 and Psychiatrist informed.
05/08/2013	15:13	Oxleas	Care Coordinator 1 telephoned Ms G who reported ongoing leg pain. Ms G struggled to understand the conversation. Care Coordinator 1 noted she would attempt a home visit the next day [did not take place but a CPN attended to administer depot to Ms G].
09/08/2013		A&E (QEH)	Leg pain.
13/08/2013		A&E (QEH)	Plaster problem.

Date	Time logged	Agency	Event
13/08/2013		Oxleas/QEH	QEH Consultant asks Joint Emergency team (JET) to review Ms G who was having problems coping with daily living – no change in her physical presentation.
13/08/2013		Oxleas/QEH	Joint assessment undertaken by JET and A&E (OT and Assessment Officer). Language barrier impeded assessment – staff queried whether Ms G was experiencing auditory hallucinations. JET contacted Care Coordinator 1 who advised she was unaware of Ms G's repeated attendance to A&E. Care Coordinator 1 advised she would see Ms G at home[143] to put a support plan in place for her. Ms G discharged.
15/08/2013		A&E (UHL)	Back pain.
15/08/2013		MPS	Ms G interviewed by the MPS at home with an interpreter, appropriate adult and her son present. Ms G provided information that appears to contradict what she has said earlier (in terms of race and name). The interpreter advised that Ms G was side-tracked throughout the interview, discussing different issues.
16/08/2013		A&E (QEH)	General aches and pain.
19/08/2013		GP	GP7 saw Ms G who reported that six to seven weeks ago she was kicked by three men who broke her left leg. MPS aware. GP7 documented that Ms G was still living at the property because she said she felt safe there. Noted she is attending A&E frequently because of back and leg problems.
23/08/2013	11:09	Oxleas	Team meeting. Reported by Community Options that Ms G is leaving the house at night despite her leg still being in a cast. Ms G has no memory of this when asked; team to arrange a memory assessment.
27/08/2013		A&E (QEH)	Leg pain.
27/08/2013		MPS	Investigation closed because Officer in Charge has concerns about Ms G's differing descriptions of the suspects.
28/08/2013		GP	Home visit by GP1. Ms G complained of a broken back and no balance. Able to stand and sit unaided. Leg still in cast. Reassurance given.
29/08/2013	10:43	Oxleas	Ms G had not attended the depot clinic. Care Coordinator 1 and Psychiatrist informed.
03/09/2013	16:34	Oxleas	GP7 saw Ms G who was complaining of back and stomach pain. GP7 noted a recent A&E report which said Ms G had a laceration on her back. Ms G denied she had fallen or been hit although she seemed to admit to being scratched at home.
05/09/2013		A&E (UHL)	Lower back pain.

[143] No entry in the Trust RiO notes for this date. Next entry by Care Coordinator 1 was 29 August 2013 – telephone call.

Date	Time logged	Agency	Event
06/09/2013	13:40	Oxleas	Home visit by team Specialty Doctor and Care Coordinator 1 with interpreter. Impression that Ms G had memory problems, but they were not severe. Plan for Ms G to have a diabetic review, and Care Coordinator 1 to clarify "*things*" with the Support Worker.

Appendix F – Niche Investigation Assurance Framework: internal investigation reports

Ms G

Rating	Description	Number
Green	Standards met	12
Amber	Standards partially met	11
Red	Standards not met	2

Standard		Niche commentary	Rating
	Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident.	The Trust investigation was Level 2[144] – comprehensive. This is in keeping with NHS England Serious Incident framework (SiF) guidance. The scope and level of the investigation was appropriate for the investigation.	Green
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	The terms of reference covered the care and treatment of Ms G, Trust staff adherence to policy and liaison with other agencies. The terms of reference did not set a time frame, but the report chronology details May 2017 until the incident in June 2018. The internal investigation Chair was unable to say why this time frame had been chosen.	Amber
1.3	The person leading the investigation has skills and training in investigations.	The Trust report does not detail the investigative training or experience of the internal team though the Chair informed us she had undertaken root cause analysis (RCA) training and that this was a Trust requirement at the time for anyone chairing an internal investigation.	Green
1.4	Investigations are completed within 60 working days.	The investigation was completed in November 2018 but did not include a start date, so it is unknown whether the investigation was completed in 60 days.	Red
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report is written in plain English and provides a description of the investigation. There are minor spacing typos in the report. The title of the report 'GS lost her life as the result of an assault that occurred in the shared house where she resided' is inappropriate.	Green
1.6	Staff have been supported following the incident.	A debrief session was arranged for staff in July 2018, facilitated by a Consultant Psychotherapist. The report does not say whether her care coordinators were offered separate additional support.	Green

[144] The Trust internal investigation for Mr Q references the Ms G internal investigation, saying it is a level 4 RCA as per the NHS England SiF. There are three levels of investigation in the SiF: concise internal, comprehensive internal and independent.

Standard		Niche commentary
	Theme 2: Thoroughness	
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	The report provides a summary of the incident that culminated in the death of Ms G.
2.2	The terms of reference for the investigation should be included.	The terms of reference are in the main report.
2.3	The methodology for the investigation is described, that includes use of root cause analysis (RCA) tools, review of all appropriate documentation and interviews with all relevant people.	The report is headed a "*root cause analysis report*" but provides limited information about its methodology or the evidence reviewed. A chronology is available, but the report does not set out the nature of its analysis to support its findings e.g., fish bone diagram or the five whys.
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	The Trust Chief Executive contacted the family of Ms G in July 2018. An investigation panel member contacted the family the same month to arrange a meeting. The family declined to meet. There is no evidence they were told what the investigation process would entail. The internal investigation Chair told us that the family was unhappy with her involvement because she worked in the Intensive Care Management for Psychosis (ICMP) team. She also felt that the investigation was undertaken perhaps too soon after Ms G's death.
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	Ms G's family declined to meet the internal investigation Chair, but we do not know if they were invited, then or later, to submit questions as part of the investigation process. The internal investigation Chair told us the family felt she was too close to the service to undertake the investigation.
2.6	A summary of the patient's relevant history and the process of care should be included.	The internal report provides a concise summary of Ms G's mental health history following her move to England in 1985.
2.7	A chronology or tabular timeline of the event is included.	A tabular timeline is included in the main body of the report.
2.8	The report describes how RCA tools have been used to arrive at the findings.	The report contains a section called "*investigation type, process and methods used*" which includes "*gathering information via written documentation and staff interview and incident mapping*". The report does not include standard RCA tools such as fishbone diagram or the five whys.
2.9	Care and service delivery problems are identified (including if what was identified were actually care delivery problems	Three CDPs were identified.

Standard		Niche commentary
	(CDPs) or service delivery problems (SDPs)).	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	The report sets out four contributory factors in conjunction with the CDPs. However, these are not identified in the context of patient, staff, task factors etc.
2.11	Root cause or root causes are described.	The investigation did not identify a root cause for the incident. It can be the case that a root cause is not identified. We agree with the investigation findings in relation to adherence to Care Programme Approach (CPA), particularly, care planning and risk assessment. However, as noted above, we consider the report should have been more critical of practice, and there were further factors in Ms G's care that should have been taken into consideration.
2.12	Lessons learned are described.	The report does not contain a lessons learned section but does make three recommendations in relation to practice.
2.13	There should be no obvious areas of incongruence.	The report says that after March 2013 there were no further incidents reported about or by Ms G until her death. However, we note there are entries documented in the progress notes and Ms G's CPA review in which she alleged she was being hurt. For example, it is recorded in May 2017 that she "*… continues to believe other residents are beating her with a hammer when she is asleep*". The same allegation had been documented in her December 2015 and November 2016 CPA reviews.
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The report has helpfully set out its findings under each term of reference. However, we do not consider the terms of reference have been fully met as set out in the main body of our report (e.g., communication and liaison with external agencies and adherence to safeguarding policy).
	Theme 3: Lead to a change in practice – impact	
3.1	The terms of reference covered the right issues.	The terms of reference focused on the appropriateness of Ms G's care, risk assessments and care planning. They also included communication with external agencies, adherence to safeguarding policy and allowed for family concerns. We agree these covered the right issues though consider it would have been helpful to also place focus on Ms G's living arrangements; specifically, that her and Mr Q were living alone in accommodation which was largely unmonitored.
3.2	The report examined what happened, why it happened	The report provides an account of what happened to Ms G, in terms of her care and treatment, but does not set out the *why*. For example, it notes practice

Standard		Niche commentary	
	(including human factors) and how to prevent a reoccurrence.	was not undertaken in line with Trust policy but does not say why. There is no detail as to whether either of Ms G's care coordinators were spoken to about their workloads, caseload management, wider demands in the team and/or if they were able to give an account for the gaps in practice. Consequently, the recommendations would partially but not completely mitigate a recurrence in omissions.	
3.3	Recommendations relate to the findings and specify and change in practice.	The recommendations relate to the report findings. However as explained previously we do not consider that the report fully explored all issues associated with Ms G's care and treatment and therefore the recommendations would not serve to entirely mitigate similar omissions in practice.	
3.4	Recommendations are written in full, so they can be read alone.	The report recommendations are written in full and can be read alone.	
3.5	Recommendations are measurable and outcome focused.	The recommendations are measurable and outcome focused.	

Mr Q

Rating	Description	Number
Green	Standards met	9
Amber	Standards partially met	9
Red	Standards not met	7

Standard		Niche commentary	Rating
	Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident.	An RCA investigation was undertaken but the report does not say at what level. However, given the detail and approach, we assume like the Ms G internal investigation, it was Level 2 (comprehensive).	Green
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	The internal investigation had eight terms of reference, examining the care and treatment of Mr Q. The level of investigation is not described, though as noted above, we consider the RCA to be Level 2. The time frame for review was the two years of care Mr Q received prior to the incident. However, the tabular chronology details the last year (not two) of Mr Q's engagement with services.	Green
1.3	The person leading the investigation has skills and training in investigations.	The internal report does not detail the training or investigative experience of the inquiry panel, though we note the Chair of the internal investigation for Ms G told us investigation chairs had to be RCA trained.	Amber
1.4	Investigations are completed within 60 working days.	The investigation began on 17 July 2018 and was completed on 28 September 2018. Using this time frame, the report was completed within 60 working days. However, the report front cover is dated 22 October 2018. This time frame exceeds 60 working days.	Red
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report is written in plain English and provides a description of the incident.	Green
1.6	Staff have been supported following the incident.	The terms of reference include considering the support offered to staff after the incident. The panel was of the view that staff were receiving the support they needed.	Green
	Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	The report includes details of the incident.	Green
2.2	The terms of reference for the investigation should be included.	The terms of reference are included in the main body of the report.	Green

Standard		Niche commentary
2.3	The methodology for the investigation is described, that includes use of root cause analysis (RCA) tools, review of all appropriate documentation and interviews with all relevant people.	The report sets out its RCA process and detail of the records it reviewed. It does not provide detail of RCA tools e.g., fishbone diagram or the five whys.
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	The report says Mr Q's mother was contacted by the investigation team as part of its review. She declined to meet but submitted two concerns. However, Mr Q's mother told us that whilst she had been informed by the Trust Chief Executive that an investigation would take place, she was not contacted by the Trust investigators. Ms G's family were not contacted by the investigation team though a separate investigation into her care was undertaken.
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	Mr Q's mother submitted two concerns to the investigation. However, Mr Q's mother told us she only spoke to the Trust Chief Executive shortly after the incident and did not submit concerns or questions to the internal investigators because they did not make contact.
2.6	A summary of the patient's relevant history and the process of care should be included.	The report contains details of Mr Q's inpatient admission history (between 2004 and 2009) and his contact with services between May 2017 and June 2018.
2.7	A chronology or tabular timeline of the event is included.	The tabular timeline details Mr Q's care between May 2017 and June 2018. The chronology does not include an entry for 15 June 2018, the last time Mr Q saw his Care Coordinator. We assume this is because the Care Coordinator added it as a late entry to the notes on 25 June 2018 after being made aware of the incident.
2.8	The report describes how RCA tools have been used to arrive at the findings.	The report does not set out the RCA tools or analysis used to reach its findings.
2.9	Care and service delivery problems are identified (including if what was identified were actually care delivery problems (CDPs) or service delivery problems (SDPs)).	The report does not identify care or service delivery problems.
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	The report does not identify contributory factors.

Standard		Niche commentary	
2.11	Root cause or root causes are described.	The investigation did not identify a root cause to the incident – as can be the case – and did not set out the underpinning analysis of this conclusion.	
2.12	Lessons learned are described.	The investigation did not describe any lessons learned.	
2.13	There should be no obvious areas of incongruence.	The investigation introduction says it will consider the two years of Mr Q's care prior to the incident but the tabular timeline sets out the preceding 13 months. There is one reference to Mr Q's care in 2016. Mr Q's mother told us she was not contacted by the Trust investigators; this is in direct conflict with the report. The chronology does not include Mr Q's last depot appointment on 15 June 2018. We assume this may have been missed because the Care Coordinator added it as a late entry to the notes after the incident had been reported.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The terms of reference have been addressed in the summary findings, but the report does not set out its underpinning analysis of the investigation. Of note, the investigation concluded the Trust Safeguarding Policy had been adhered to, based on hearing the matter had been "*satisfactorily investigated and resolved*". There is no evidence of independent testing of this assessment.	
	Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues.	The terms of reference identified several issues to consider pertaining to Mr Q's care and treatment. We consider these to be reasonable, but the scope of the investigation should have been widened to consider Mr Q's living arrangements, his relationship with Ms G, and the ICMP's long-term plan for him given he had missed his last three CPA reviews.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	The report provides a tabular timeline of Mr Q's care and treatment. It identifies a number of gaps in practice (e.g., lack of adherence to Trust policy) but it does not include the *why*. For example, the report identifies that Mr Q's Care Coordinator was not completing his care plan in line with expected practice, but there is no evidence this was explored in terms of staff factors (e.g., capacity, sickness, caseload and supervision). In the absence of the underpinning why, we do not consider the investigation findings would serve to mitigate a similar incident from happening.	
3.3	Recommendations relate to the findings and specify and change in practice.	The internal investigation made three recommendations, all of which relate to the report findings. However, two are expected practice rather	

Standard		Niche commentary	
		than recommendations e.g., "*All staff within mental* [health] *teams where patients are on CPA must read and review the CPA Policy and ensure that they are compliant*". The recommendations do not specify actions in relation to achieving assurance.	
3.4	Recommendations are written in full, so they can be read alone.	The recommendations are written in full and can be read alone.	
3.5	Recommendations are measurable and outcome focused.	One of the recommendations is outcome focused and measurable; "*All conclusions of clinical discussion are to be recorded within the primary clinical record, RiO*". However, we consider this recommendation to be expected practice.	

Appendix G – Oxleas received safeguarding referrals for Ms G

Chronology of concerns sent to the Trust by RBG

- 11/03/2018 (12/03/2018) & 15/03/2018

Two reports in March 2018 identified concerns that Ms G *"sounded confused, difficult to understand, vacant and living in her own world*". One police officer recorded that they thought her care package was "*meeting her medical needs*" yet another on a different day suggested "*it may be best suited that the subjects care is reconsidered as she may benefit from 24hour care*".

There is no record in Trust case notes (RiO) that these MERLINs were received, recorded or the concerns followed up.

- 11/12/2017

The Metropolitan Police Service (MPS) recorded that Ms G "*stated her son is trying to take her away – details through interpreter who states the caller is very confused… Safeguarding issue identified*".

15/12/2017 related RiO record An administrator recorded they uploaded a MERLIN and sent an email to inform the Care Coordinator. There is no further information regarding the episode and no record the safeguarding concerns were followed up.

- 24/07/2017 (25/07/2017); 20/05/2017 (25/05/2017) & 31/03/2017 (03/04/2017)

From March to July 2017, three MERLIN reports detailed various concerns including a request for help with her landlord, non-compliance with diabetic medication and a concern that a male (initial G) hit her with a hammer.

11/04/2017 related RiO record An administrator recorded they uploaded a MERLIN, a pre-assessment checklist, and sent an email to inform both the Care Coordinator and Doctor. This record indicates the Primary Care Plus (PCP) team screened the report and forwarded it to the team as per policy. 18/04/2017 related RiO record Care Coordinator 3 recorded "*discuss her recent contact to police she did not say much*". The reference to a discussion with Ms G on 18/04/2017 about her recent contact with the police may relate to this MERLIN, but this contact was seven days after the Trust record, and 15 days after the Royal Borough of Greenwich (RBG) recorded they had shared it with the Trust. We found no evidence that any of the concerns from the three MERLINs were taken any further or that any of the safeguarding concerns were addressed.

- 24/11/2016 (29/11/2016) & 06/11/2016 (08/11/2016)

During these contacts Ms G reported being mistreated by carers and MPS officers wrote "*the current care plan for Ms G would not seem appropriate and should be reviewed*". Ms G was described as "*confused, incoherent, and hard to understand even through language line*" and officers "*noted there is a list of contact numbers by the phone in the premises, at the top of which is 999*" and they tried to contact support services but had no reply "*as weekend*". These reports also record that the Multi Agency Safeguarding Hub (MASH) team completed research highlighting Ms G's contacts and requested that RBG share details with her support service (identified as ARK by MASH).

11/11/2016 related RiO record An administrator recorded they uploaded a MERLIN. There is no evidence that any of the concerns were followed up or that the Care team considered that Ms G required a review of her care or that the MERLIN prompted the team to consider how Ms G accessed support at weekends and out of hours. There was no recorded contact with MASH.

- 22/10/2016 (24/10/2016)

A report in October identified Ms G as "*suffering from MH issues*" and asked for "*consideration regarding staffing at the weekends as Ms G needed extra support*".

The Core assessment review on RiO notes – 22/10/2016: [Ms G] contacted the police MERLIN report uploaded on RiO. There is no evidence this was taken any further.

- 14/06/2016 (16/06/2016) & 22/05/2016 (23/05/2016)

Two MERLIN reports received between May and June 2016.
We could not find any details of the concerns shared.

20/06/2016 related RiO record A Trust administrator recorded they uploaded a MERLIN and informed the Care Coordinator. It is unclear which MERLIN report this refers to. A case note three days later indicates that a concern may have been discussed with Ms G on 23/06/2016 but due to lack of further detail we could not be sure. Case note stated "*She said the resident has been 'horrible to me' and when asked to explained* [sic] *she did not say much*". There was no evidence of any further follow up.

- 02/12/2015 (03/12/2015)

A report in December 2015 stated Ms G had called police saying "*im* [sic] *being hit with a stick*". LanguageLine was used to support Ms G but she was described as "*rambling*". Ms G reported that males in the house wanted her to marry them, or for her to be their mother. She reported being assaulted and that someone had taken her medication. Police officers ran checks and contacted care workers (no further detail available) before completing their report. The information was shared with Care Coordinator 3.

03/12/2015 related RiO record Case notes detail "*Received phone call fro* [sic] *social services that* [Ms G] *contacted the police and will forward the paper work*". Later that same day a further case note records "*Received police report from social services.*" This was also recorded onto the pre-Care Programme Approach (CPA) record of this date and noted under RISKS: "*Frequent contact to police that she alleged been beaten up by other residents in the house*". Despite being recorded on CPA documentation no further action was taken to address the risks or concerns.

- 14/08/2015 (20/08/2015)

This MERLIN stated Ms G called police to report being assaulted and told police that the attackers were still "*on scene*". On arrival police determined no attack, stating that Ms G "*suffers with mental health issues resulting in her making calls to the emergency services making false allegations.*"

14/08/2015 related RiO record

"*Telephone call from police, Greenwich, who had attended to Ms G's home after a call in which she stated that she had been assaulted. Police did not find any evidence of this when they visited Ms G. I informed them there is a history of contacting police with similar allegations. Ms G informed the police she had stomach pain but did not appear to be in any distress. I suggested that she could be advised to contact/attend her GP surgery regarding this.*"

No further evidence that Ms G's care was considered to be appropriate for review or that Ms G's contact with services may require a different approach.

- 16/05/2015; 13/04/2015 (17/04/2015); 01/04/2015; 28/03/2015 (30/03/2015); 11/03/2015 (16/03/2015)

Five MERLINs were received between March and May 2015.

The MERLIN dated 16/05/2015 indicates that both MPS and the London Ambulance Service (LAS) attended because Ms G reported she had been stabbed. On arrival Ms G was found to be safe and well, but concerns were identified, and the MERLIN report concluded: "*The location is a home for people with mental health problems – No staff members stay at the location*" and the report recommends that "*it may be worth social services or a mental health team assessing Ms G*".

We found no evidence of the LAS report.

01/05/2015 Related RiO record

Case note states "*Call received from the Bracton centre reporting that, a call came through from the police control room that Ms G has being making nonsense call non-stop, up to 10–15 times a day reporting that her flat has been burgled. She was looked up on Rio and I find out she belongs to the East Recovery team, I called her mobile number but no response from her, to advise her to get in contact with her CCO*".

No further evidence this was taken any further or that Ms G was contacted.

The MERLIN dated 13/04/2015 references a crime report (CRIS). Ms G had reported the theft of £15 from her room by two males. The police attempted to take the crime report forward but struggled to contact Ms G following the first visit. The police contacted the Mental Health team to check Ms G had been seen before closing the crime.

16/04/2015 related RiO record

"*Received a call from the police reporting that Ms G called the police reporting that someone has been in her bedroom stealing things. CAD number 921-13.4.15. Police will contact the heights for more information*".

This case note is dated three days after the MPS report and a day before it is recorded on Framework-I. We found no further evidence that Ms G was contacted, that her care was reviewed, or that any safeguarding concerns regarding financial vulnerability were considered.

The second report in April stated Ms G alleged assault and that her landlord clapped whilst this happened. We did not find any associated RiO records or evidence the concerns they described were addressed.

We did identify one further case note two weeks after the last of these MERLIN reports on 05/06/2015 that suggests the Care team (e.g., Care Coordinator 2) were attempting to arrange a multi-professional meeting regarding Ms G's repeat attendance and were seeking GP attendance. "*T/C received from GK from Ms G's GP practice in response to my earlier call to them to discuss her. He informed they are aware of her presentation everywhere and does not think there is much input they can put in place as she will continue to contact the police and ambulance as she wants. He was informed a meeting will be arranged and his views will be put forward.*"

We found no further evidence that this meeting happened.

The two reports in March detail further allegations made by Ms G. These reports record MPS concerns about her confusion "*she kept repeating her self and made reference to no assault* [sic]*",* and identify clear vulnerabilities "*suffers from some sort of mental health issue.*"

We found no evidence that these two reports were recorded onto RiO or that the concerns shared were explored or taken any further.

In addition to the concerns sent by the police we identified two instances when acute staff in A&E contacted the Mental Health Services with concerns about Ms G, and one instance when a Support Worker from Bridge Support highlighted concerns relating to Ms G's landlord.

A&E

- 22/11/2015

Ms G attended A&E "*Asking for stitches to be taken out. Requesting X-rays, cast and dressings. Discussion with Liaison psychiatry. Noted Ms G has chronic schizophrenia with persistent delusions of requiring health leading to recurrent attendances. Taxi organised by psychiatry team. CMHT* [Community Mental Health team] *follow-up arranged. Doctor contacted MH* liaison".

Related RiO records

RiO documents that Ms G and her son had telephone contact with Care Coordinator 3 around this date but none of these identified any concerns or addressed the issues shared by the A&E Doctor. In addition, the pre-CPA and CPA meetings around this time (03/12/2015) did not address these concerns and the care plan recorded "*what worked well – engagement with community team and attending for a depot*" and there were "*Nil Unmet needs*" identified.

- 25/09/2017

Records from A&E stated Ms G *"... reports that a man living in the same accommodation as her gives people 20 million pounds and hits her and wants to kill her. NoK* [next of kin]/*care home (same number) contacted – unable to give much information about how* [Ms G] *has been recently. Referred to psychiatry as no medical cause for current* state." It appears A&E staff also contacted Ms G's accommodation, but it is unclear whom they spoke to.

26/09/2017 related RiO record

Ms G's Care Coordinator completed a home visit on this date and did discuss the hospital visit the day before. They did not identify any concerns and the record does not indicate if the safeguarding concerns were addressed with Ms G.

Bridge Support

We identified one case note on 06/12/2016 recording an email from the Support team at Bridge Support to Ms G's Care Coordinator "*Can we arrange a visit to Ms G's on Friday either between 9.30–11am or 2pm–5pm we have professionals meeting about* [Landlord] *and his conduct with the clients so we* [would] *like visit the property to check the accommodation before the professionals meeting on Monday.*"

This case note indicates there are safeguarding concerns related to the landlord's conduct with residents, however we found no further records of this meeting.

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

Read more about us at: **www.nicheconsult.co.uk**

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