Safeguarding Adults Review for Hillingdon Safeguarding Adults Board

AA and BB

Report prepared by
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Contents

Executive Summary

This report explores the care and treatment provided to two co-tenants, BB and AA, who shared a house for seven months and received 'floating support' from an independent provider organisation until AA stabbed BB to death in the house in November 2015.

BB only received support from the provider organisation and was not receiving any services from either the local authority or the mental health trust. AA, however, had been known to the mental health trust for two and a half years, and had been admitted to psychiatric hospital twice during that time, the first admission lasting 19 months. He was subject to the Care Programme Approach (CPA) and had a care coordinator from the community mental health team throughout that time.

BB was allocated her tenancy at the house in autumn 2014 and moved in during December of that year. The referral for accommodation was made through a housing support officer, and she had not received a formal social care assessment of need. AA was allocated the other tenancy in February 2015 and moved in at the end of March. Despite AA's CPA status and admissions to hospital, no full psycho-social assessment was completed throughout his period under the care of the service. There was no CPA assessment completed throughout this time, and no CPA care plan during his time in the community. All the care plans in the patient notes relate to times when AA was an inpatient.

Although the two co-tenants appeared to get on well during the first few weeks, difficulties between them became evident just five weeks after AA moved in. These remained a feature of their lives at the house throughout the following six months. These difficulties were mainly demonstrated through AA's complaints that BB was overbearing; that she stole his food; and that she locked him out of the house by putting the inside latch on the door.

There were also complaints from both BB (dating from before AA moved in) and from AA that the heating and hot water frequently did not work. AA claimed that BB was controlling the heating and hot water, but the veracity of this allegation was never established. The problem, and AA's concerns were exacerbated by the fact that the boiler was located in a cupboard in BB's bedroom, which made it particularly difficult for engineers to examine the boiler and identify and fix the problems.

Neither AA nor BB engaged with their respective support workers, or (in AA's case) his care coordinator. BB was frequently not in, or did not answer the door for her key work session, and AA either did not answer the door, or was staying with his mother or father due to his dissatisfaction with living at the house. AA's relationships with his support worker and care coordinator was difficult and he showed frequent hostility to them. This hostility focused on the problems he was experiencing in the house with the heating and hot water, and his allegations against BB.

Matters came to a head for AA in summer 2015 when he was informally admitted to psychiatric hospital after stabbing himself in the leg. He stated that he wanted to be admitted to hospital and to move out of the house, and he told a liaison psychiatric nurse that it could have been BB who he had used the knife on. The Home Treatment Team felt unable to provide support for AA at home because of the risk he posed to his co-tenant.

At this time both AA's allocated workers changed. His support worker changed shortly before his admission to hospital, but the new support worker had not had an opportunity to meet him before his admission. His care coordinator changed during his admission. A new

care coordinator was not allocated until the day of his discharge. Both changes were made because of the hostility AA was showing towards the respective workers.

AA remained in hospital for a little over three weeks, and was discharged without any formal planning after being found with another patient on the ward smoking cannabis. There had been discussions between AA's first care coordinator and the support worker whether it was feasible for AA to return to the house, but there appears to have been no alternative accommodation immediately available, and there is no record of any formal investigations or applications to transfer AA to a different property. The sudden discharge following the cannabis incident prevented any possible further exploration of this and AA returned to the house.

There was no further discussion of a move of accommodation following the discharge and the allocation of a new care coordinator. There was slightly better engagement with the support workers with both BB and AA during September. AA did not, however, attend any of his outpatient appointments.

There were a variety of significant events in relation to AA during October. He complained that an acquaintance, of whom he was frightened and intimidated, had taken over £1,000 of his benefit money; he received two letters from the landlord informing him he was over £1,000 in rent arrears and must make arrangements to pay off the debt; he was again locked out of the house and spent the night in a corridor outside his father's flat; and he was found by his care coordinator to be keeping a large kitchen knife on the floor in his bedroom. He explained that it was for his own protection, but did not elaborate on what he was protecting himself from.

AA was reluctant for the police to become involved in the loss of his benefits money, and the care coordinator sought advice from the borough safeguarding team. Further discussion with AA was recommended to gain consent, but this did not happen. There was also some suggestion that AA was putting himself at risk by undertaking risky behaviour purchasing illegal drugs, thus making it more difficult for him to keep safe.

AA was not seen during November up to the date of the incident, but BB met with her support worker two or three days before the incident and complained that AA had locked her out of her room. She also showed the support worker a dent in her bedroom door which she alleged AA had made. AA later stated that he had caused the damage to her door with a fire extinguisher. This was the last time that BB was seen before the incident.

Both care coordinator and support worker had expressed concerns for their safety at times when AA was angry and agitated, but other than during the AA's second admission to hospital, there was no explicit exploration of the possible risks to BB from AA, despite the ongoing antipathy between them.

Safeguarding Adults Reviews (SARs)

National Requirements

Under section 44 of the Care Act 2014:

1) [A] SAB [Safeguarding Adults Board] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
    a. there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
    b. condition 1 or 2 is met.
2) Condition 1 is met if—
    a. the adult has died, and
    b. the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
3) Condition 2 is met if—
    a. the adult is still alive, and
    b. the SAB knows or suspects that the adult has experienced serious abuse or neglect.
4) [A] SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
    a. identifying the lessons to be learnt from the adult's case, and
    b. applying those lessons to future cases.

The following principles apply 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

Introduction and methodology

This Safeguarding Adults Review (SAR) concerns the care and support and treatment of two individuals (AA and BB) who shared a tenancy in Hillingdon and who both received 'floating support' from an independent support provider. Both individuals were vulnerable due to mental health difficulties, although had differing levels of input from the secondary mental health service

AA stabbed BB to death on 10 or 11 November 2015 at their accommodation, and has subsequently been detained in secure hospital care under the auspices of the Mental Health Act 1983.

Hillingdon Safeguarding Adults Board (SAB) determined that the threshold for a statutory SAR has been met and commissioned the reviewer in January 2017.

The various agencies involved with AA and BB prepared a chronology of their contacts with them, dating back in the case of AA to 2002 at the earliest. An integrated chronology was developed from the individual agency chronologies. A decision was taken at the first panel meeting not to involve the Youth Offending Service in the panel membership, due to their early involvement which ended before AA's first contact with secondary mental health services.

The following agencies (local authority, provider organisation, police, social housing landlord, clinical commissioning group, acute hospital, GP surgery) prepared individual management reports. The mental health trust has prepared its own report which has now completed the process of sign-off through the trust.

A narrative was developed to describe the key events involving all agencies, with brief information regarding AA's and BB's background, but concentrating primarily on the period from 2013, when AA first came into contact with the secondary mental health services.

The chronology in relation to BB begins in 2011, but focuses on the period leading up to her allocation to the property in late 2014 to her death in November 2015.

The reviewer visited AA in the hospital where he is currently detained, and attempted to contact AA's mother and father. He was able to have a brief telephone conversation with AA's father, but was unable to speak to AA's mother.

The reviewer contacted BB's son and communicated with him by email, but has been unable to speak to him regarding his thoughts about the incident, or the review.

A SAR is not intended to apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately to improve the safeguarding and wellbeing of adults at risk in the future.

Glossary of terms

AMHP	Approved Mental Health Professional
ARCH	Addiction, Recovery, Community Hillingdon service
CCO1/CCO2	Care coordinator 1 and care coordinator 2
CMHT	Community Mental Health Team
CNWL	Central and North West London NHS Foundation Trust
CPA	Care Programme Approach
EIS	Early Intervention in Psychosis service
HTT	Home Treatment Team
LAS	London Ambulance Service
Merlin	"**M**issing p**ER**sons and other **L**inked **IN**dices" Police method of recording and notification of missing persons, children and vulnerable adults.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SW1/SW2	Support worker 1 and support worker 2

Terms of reference

SUBJECT: Two adult service users placed at the same address

EVENTS: November 2015

This is a serious adult review regarding a fatal stabbing of a female adult service user by a male adult service user in shared accommodation. The review has been commissioned on the basis that relevant lessons can be learned that will assist adult services in their decision making.

PURPOSE OF THE REVIEW

The purpose of the review is to improve services and assist in preventing similar events.

> - The fundamental purpose of Safeguarding Adult Reviews (SAR's) is reviewing the multi-agency service response to a vulnerable adult in order to learn lessons for the future and ensure improvements are implemented. They will make sure that the Hillingdon Safeguarding Adults Board (SAB) gets the full picture of what went wrong, so that all organisations involved can improve their practice and services.
>
> *LB Hillingdon guidance for Multi-Agency Safeguarding Adults Review of Serious Cases* (July 2016)

SCOPE OF THE REVIEW

The time period to be covered is from 2011 to the date of the incident in November 2015.

The following people are to be invited to contribute to the review.

- Central and North West London NHS Foundation Trust (CNWL)
- LB Hillingdon adult social care service
- Hestia
- Hillingdon Hospital Trust
- Hillingdon Clinical Commissioning Group
- Police
- Youth Offending Service
- Family Members

CNWL has already commissioned a report, which will inform the review, and the lead reviewer will draw information from this report.

The review is to be conducted on the assumption that the events that happened and the actions of the senior management team are not untypical of events and reactions that could occur on other occasions.

ISSUES TO BE EXAMINED

- The care and support provided to AA and BB
- The decisions relating to allocation of housing for AA and BB
- The management of the respective tenancies of AA and BB and their relationship
- How health and social care professionals and agencies worked together in relation to both AA and BB
- How local and national policies were followed and their impact on the management of the care and support provided to AA and BB

It is expected that other themes will emerge during the process of review and these will be addressed by the lead reviewer in his overview report.

REVIEWER AND ADMINISTRATION

Steve Chamberlain has been independently appointed as lead reviewer. He has been involved with a number of SAR's & SCR's. The review is to be managed by the serious adult review panel. The administration process will be managed by the Business and Quality Assurance Manager of the SAB.

A STATEMENT OF GOOD PRACTICE

The approach taken within this review should be proportionate: led by individuals who are independent of the case; with relevant professionals fully involved and able to contribute their perspectives without fear of blame; family (and others) invited to contribute.

CRIMINAL (AND OTHER) PROCEEDINGS

The offender in this case has been convicted of manslaughter on the grounds of diminished responsibility. He was detained under Section 37 of the Mental Health Act 1983 with a restriction in place under Section 41.

TIMESCALE

Plan to complete review by end of August 2017

BB's background and history of service contact

This information has been obtained from the mental health trust's panel of inquiry report. I had some email correspondence with BB's son during the process of this review but I was not able to meet with him.

BB was born in July 1965. She was originally from Derby, the younger of two siblings. Her mother continues to live in that area and her father died in 2002. BB developed epilepsy around the age of eight or nine years, although it did not progress beyond petit-mal seizures.

BB met her husband at the age of 16 or 17 years, and married at the age of 19, having a son and a daughter born in 1985 and 1987 respectively. The family lived initially in Burton, and moved in 1991 to Lincoln where BB's husband was working.

BB's epilepsy developed and in the early 1990's she was having multiple seizures. None of the treatment offered worked to stabilise her condition.

In 1995, BB met her husband's uncle, with whom she went on to have a relationship. He died around 2010.

It is not clear how and when BB moved to the West London area, but in 2008 she was living in Hayes. Her son made contact with her at that time. In 2013, BB was living in temporary accommodation in Uxbridge, from where she was rehoused into the house where the incident occurred.

The first record of involvement with social services dates from May 2011. Two contacts with Hillingdon Adult Social Care during spring and summer 2011 focused on minor issues: a dentist's appointment and a fault with a fridge/freezer. It was reported that BB had a key worker with Look Ahead Housing and Care at the time.

In December 2011, BB's son contacted Hillingdon Adult Social Care, asking for details as he had not spoken to her for two years. He was advised to write to the council, so the letter could be forwarded to BB. There was a follow-up to this approximately one year later, in December 2012. BB wrote to the council, referring to her estranged son trying to contact her. It was not clear what, if anything, BB was requesting, and as there was no contact number given, a letter was sent asking her to contact Social Care Direct. BB did not respond to this.

In the early hours of 5 February 2012, BB was brought into Uxbridge Police Station by a member of the public, having been found "wandering around" in Uxbridge. BB was described as confused and in need of care. BB had stated that she suffers from seizures and becomes confused after a seizure. She was taken to Hillingdon Hospital A&E and detained under section 2 Mental Health Act for assessment. She remained in hospital for approximately three weeks, being discharged on 29 February.

BB was described in the discharge summary as extremely agitated, elated in mood and sexually disinhibited. She did not receive any drug treatment while in hospital and the diagnosis for the admission was recorded as manic episode; acute stress reaction. BB was assisted to obtain housing through the local authority in preparation for her discharge.

BB was referred to Hillingdon's Independent Living Support Scheme by the local authority Housing Options Team in April 2013 and was allocated a support worker. This did not

involve any input from adult social services or any formal assessment of need under the NHS and Community Care Act 1990.

BB was admitted to the psychiatric ward a second time on 25 April 2014. This time she was admitted informally (without compulsion) after presenting to A&E and remained in hospital for two weeks, being discharged on 7 May. She again received no psychotropic medication during her inpatient episode and none was prescribed on discharge. She was prescribed medication for her seizures. The diagnosis on discharge was recorded as epilepsy and adjustment disorder.

It is noted in her discharge summary that BB had been living in temporary accommodation for the past two years, since her last discharge from hospital, and that she had no electricity or heating in her home. She stated that this was because she could not be trusted to use saucepans due to her blackouts.

> **Comment: The lack of heating and hot water was a significant feature in the difficulties experienced by both BB and AA when sharing their accommodation. The cause of the problems was never clearly established.**
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> **Comment: The location of the boiler in BB's bedroom was a significant obstacle to effective maintenance and repairs, due to the difficulty in obtaining access to the bedroom when BB was present. The support provider raised this with the landlords, but were told that it did not need to be moved.**

A telephone call was received from the London Ambulance Service on Saturday 2 August 2014 following BB having a seizure in Ruislip. BB did not want to go to hospital. The paramedic was concerned that she was not registered with a GP.

The Independent Living Support Scheme support worker referred BB to Hillingdon's Supported Accommodation Panel in October 2014. The referral identified "high need" requiring possible long term support for a variety of activities of daily living. No risks to others was identified. Risks to BB involved vulnerability, self-neglect, threats of suicide, poor living skills and poor engagement. Her diagnosis was recorded on the referral as "manic adjustment disorder with mixed disturbance of emotions and conduct".

Following the panel meeting, BB was referred to, and accepted by Hestia's Visiting Support Service and she was allocated accommodation at Ivybridge Close.

> **Comment: no assessment of social care need was undertaken with BB, despite being assessed as having high need and requiring floating support.**

BB moved into Ivybridge Close on 15 December 2014 and was allocated a support worker by Hestia. He arranged weekly sessions at her home on a Friday afternoon. This support worker remained BB's key worker until the incident which led to her death.

The records show that the Hestia support worker found it very difficult to engage with BB, as she did not respond to his visits. She was either not at home when he visited, or did not answer the door. During the first two months of 2015, the support worker visited nine times but saw her just once. At one point, he asked the police to undertake a 'welfare check' as BB had not been seen. They forced entry and found BB in the flat and safe. Over the period of BB's tenancy, she was present for only one in three of the scheduled key work sessions.

The problem with the boiler, which was located in BB's room, was first identified before AA moved into the house. It was recorded that there was no heating or hot water in the house

on BB's moving-in day, on 15 December 2014. The central heating was reported to be fixed on 23 January 2015 and access was needed to BB's room for repairs to the boiler on 6 March 2015. BB further reported that there was no heating or hot water on 18 March. BB was still complaining about the faulty boiler in May and June.

It is recorded that BB's support worker informed her on 13 March that there would be a new tenant (AA) moving into the house.

> **Comment: BB's support worker later stated that she had been consulted, although there is no contemporaneous record of any consultation with BB regarding the identity of the new tenant or any views she may have expressed.**

BB met AA for the first time on 18 March 2015. During March, BB appears to have engaged more with her support worker. This was possibly linked to rent arrears caused by a problem with her Housing Benefit, and the need to sign relevant claim forms.

Hestia consulted with Notting Hill Housing Trust (the landlord) with a view to considering moving BB to a different house, where another female tenant was living. This was before any indication of problems in the relationship between BB and AA, and appears to reflect a general attempt to maintain single-sex accommodation, although this was not a formal policy.

There is no evidence in the chronology to suggest that BB was formally consulted regarding a possible move, although Hestia reports that the key worker raised the possibility with BB and she was not particularly interested in moving.

> **Comment: This expressed reluctance to move can be seen as an understandable reaction, as BB had only recently moved into this accommodation four months previously.**

Difficulties in the relationship between BB and AA started to emerge in May 2015. A meeting took place on 11 May involving both key workers and AA's care coordinator. BB was present but AA was not. BB was informed that she should not be telling her co-tenant how to live, and that they both had equal rights in the accommodation.

During the following three months, there was little contact with BB. What contact there was tended to focus on the boiler and access to her room for repairs. A face-to-face review took place on 8 August 2015, but there is no record of the details or what was discussed.

BB fell on 27 August and broke her ankle. She was treated in hospital and a reablement package was established. This was a limited service as BB was assessed as being independent with most activities, despite her injury. Meals on Wheels was set up for her. The reablement service found it difficult to engage with BB as she was not in for many of their visits.

On 10 September, BB complained to her co-tenant's support worker that he had entered her room to steal money. However, BB did not answer the door when her support worker visited to discuss it, and the following day it was not mentioned in the records of the keywork session.

On 8 October, BB met with AA's support worker following her movement of her bed into the living room of the house. A Notting Hill Housing Group housing officer was also present. BB was told by the support worker that the living room was a communal space, that she could

not keep it to herself and that she must allow AA access to it. BB was assisted to return the bed to her bedroom.

At this meeting BB asked for the boiler to be moved out of her bedroom, but the housing officer replied that it was safe there and could not be moved. There was a discussion about carbon monoxide safety, so it appears that this was the reason why BB wanted the boiler moved.

On 9 November, BB met with her support worker, and complained that AA had locked her out of her room. BB was locked out of her room, and none of the keys he had for the property were able to unlock the door. The support worker also identified that there was a dent in BB's door, which BB claimed that AA had caused. The support worker contacted the housing officer to request an emergency repair.

> **Comment: There is evidence of increasing problems between BB and AA, and a suggestion that AA had been violent towards BB's door. The support worker made an appropriate call to enable BB to regain access to her accommodation, but did not inform any of AA's care team about this escalation in violence.**

This is the last contact with BB before the events of 10/11 November 2015.

AA's early history

The main information the reviewer obtained regarding AA's early history comes from a psychiatric report produced in preparation for the criminal case. The information given by AA to the psychiatrist was broadly supported by his mother's statement.

AA was placed in care on several occasions as a child, spending time with foster parents on at least two occasions. He moved back to live with his mother between these episodes. AA lived in a children's home for one year to 18 months when he was about 15 years old, before moving back to live with his mother. He continued to live with his mother until his admission to hospital for the first time.

AA came into contact with the criminal justice system in August 2010, when he was 17 years old. He was made subject of a six-month referral order in the youth court for assaulting a police officer with intent to resist arrest in January 2010. During this period AA was assessed as having a medium risk of re-offending, and medium risk of serious harm to others.

During the course of the contact with the Youth Offending Service, AA attended Hillingdon Hospital A&E in December 2010 following an alleged assault. He had apparently been punched and kicked in the face, and his nose looked swollen. He left the department before being seen by a doctor.

In January 2011, an Emergency Referral Order Panel was held due to AA's failure to attend required appointments. AA's mother did not attend as she said AA had been aggressive towards her. She had told AA she would call the police if he was aggressive towards her again. The panel took no action at that stage regarding AA's non-attendance. At that time the risk assessments of re-offending and serious harm were reviewed, and remained at medium for both.

In March 2011, AA was referred back to the Youth Court due to ongoing failure to attend appointments, and the Referral Order was extended for three months. About the same time, the social worker visited his home and found that AA had locked his mother in the family home and taken both sets of keys. The following day he smashed his mother's phone.

A 'mental health assessment' was undertaken in the Youth Offending Scheme by a mental health worker. It recorded that the major issue was excessive and long-standing use of cannabis. AA's thinking was described as paranoid when using cannabis, but he described himself as depressed. He identified having little or no motivation to do things that he previously enjoyed.

> **Comment: The status of the mental health professional who undertook this assessment is not clear. There is no comment on consideration of further mental health input.**

The social worker stated that AA's mother would not report the violence he exhibited towards her. AA's case was closed to social work on his 18th birthday (13 April 2011). However, the extended referral order continued until June 2011, and the notes confirm that AA continued to be seen until it ended at the end of June. The final risk assessment in June 2011 placed AA's risk of re-offending at medium and risk of serious harm to others as medium. AA had received a conditional offer of a course at Uxbridge College, but a month later his mother stated that he had not attended.

It is noted that the police also arrested AA for a charge of common assault on his mother in March 2013. There is no record of this elsewhere in AA's notes, and the case was later discontinued by the Crown Prosecution Service.

> **Comment: There is a history of violence from AA towards his mother during his late adolescent and early adult years, which is never formalised and as a result never picked up in later assessments.**

First contacts with mental health service

AA was admitted to Hillingdon Hospital twice in May 2013 following reported seizures. It is recorded on both occasions that he was uncooperative and aggressive. Following both admissions, AA was discharged within a day or two. During the admissions, a referral was made to psychiatric liaison services for an opinion whether the seizures were alcohol-related. He was not seen by that service.

He was referred to Addiction, Recovery, Community, Hillingdon service (ARCH). AA did not contact ARCH and they closed the case after three weeks.

A referral was made on Friday 2 August 2013 to CMHT North for AA from the consultant psychiatrist of AA's mother, who was reported to be an inpatient at the time. The referral stated that Hillingdon Safeguarding Team were involved. It was recorded that AA's mother reported that he had physically assaulted her in the past and that on at least one occasion recently she had woken and found him in bed with her. She denied any kind of sexual assault, however.

The CMHT referrals meeting on Tuesday 6 August states urgent assessment for Monday 19 August.

> **Comment: The reviewer was informed that a standard appointment at that time would have taken approximately five weeks, therefore an appointment after two weeks would have been considered a priority.**

However, AA was seen in Hillingdon A&E on Friday 9 August after calling an ambulance. The London Ambulance Service (LAS) patient report suggests AA was living alone, as his mother was in hospital at the time. AA was denying any mental health issues. The LAS report stated that AA "has no capacity".

> **Comment: The LAS statement regarding capacity does not state what decision AA lacks capacity to make, as is required by the Mental Capacity Act. If, as appears likely, the decision is capacity to consent to transport to A&E, then the record should state that, with some evidence to support this initial assessment.**

An initial assessment of AA's mental health was carried out. The provisional care plan suggested that AA should have a drug urine screen and await medical clearance. If there was no organic cause of his delusions, there should be an urgent referral to the mental health team and consideration of input from the Home Treatment Team. A referral to the Early Intervention in Psychosis team (EIS) was also indicated. AA could not be found in the department for approximately two hours in the early evening, but he was seen later. AA said he did not want to wait to see a doctor, so transport was arranged to take him home.

> **Comment: There is no recording of what, if any action was taken when AA could not be found in the A&E department. It is not clear what, if any referrals were made, or whether AA accepted a drug urine screen.**

On Monday 12 August, it was agreed after discussion with the consultant psychiatrist, that the duty social worker would contact AA urgently, but there was no up-to-date phone number. The police were contacted on Friday 16 August to make a welfare check. The police reported they had visited but there was no-one home.

AA did not attend for his appointment on Monday 19 August and the team was unable to contact him on his mobile phone. A decision was made to make an emergency domiciliary visit with the approved mental health professional (AMHP). A Mental Health Act assessment was undertaken and AA was admitted to the mental health unit on section 2 Mental Health Act on Wednesday 21 August 2013.

> **Comment: Efforts were made to see AA before the planned appointment date but they were not successful. Once AA was seen his mental ill health was recognised and he was admitted to hospital the following day.**

Hospital admission and first inpatient episode

AA remained in hospital detained on section 2 and the consultant psychiatrist made a recommendation for further detention on section 3. An AMHP met with AA but the application for s3 was not made. AA remained an informal inpatient on the ward.

> **Comment: the AMHP record indicates that AA was able and prepared to remain on the ward informally, and had capacity to consent to that arrangement. Further detention was therefore not required.**

At a ward round on 16 September, a discussion took place regarding AA's possible discharge destination. While AA stated that he wanted to return to his mother's home, the consultant suggested that his mother may sometimes be scared of him, giving an example of AA getting into bed with her in the middle of the night.

> **Comment: Both AA and his mother were patients of the mental health service, and there is historical and recent evidence of violence and other inappropriate behaviour by AA towards his mother. This was discussed in ward rounds and recorded in the notes, but subsequent risk assessments only referred to an 'altercation' between AA and his mother, which AA denied.**

AA was referred to both the Early Intervention Service (EIS) and to the inpatient rehabilitation unit. He was assessed for the latter unit in early October. In the intervening period the notes state he was cooperating with his treatment plan on the ward, going out at times and there were no concerns raised.

During the subsequent nine weeks, AA remained an informal inpatient on the ward. Repeated nursing reports state he "continues to leave the ward whilst cooperative and compliant with treatment plan on the ward". He saw the dual diagnosis lead worker five times.

AA was transferred to the inpatient rehabilitation unit on 9 December 2013.

Whilst at the rehabilitation unit, AA engaged in various activities, assessments and therapeutic sessions. On 9 January 2014, AA reported that he had been robbed by two men who stole £50 and his mobile phone. The police visited him at the unit the following day and took a statement. He was unable to identify his assailants and the case was closed.

During the following 15 months, AA remained at the rehabilitation unit. He saw the dual diagnosis worker, employment worker and occupational therapist at various times. Discharge and accommodation options were mentioned during August and September 2014, including a plan to invite AA's care coordinator to the ward, but there is no evidence of this happening. On 23 September 2014 it is noted in the records that 'needs assessment to be done'. On 14 October, the ward notes record that '[care coordinator] to complete core assessment for the panel'.

A CPA review took place on 6 January 2015 and AA's case was presented to the accommodation panel on 30 January.

> **Comment: Despite AA being an inpatient on the rehabilitation ward for 15 months, neither a full psycho-social assessment was undertaken, nor a NHS and Community Care Act needs assessment. This would have been an important element in identifying his needs and the support required when he was discharged. It would also have informed his overall risk assessment.**

Referral to supported accommodation and allocation of accommodation

AA's case was presented to the Hillingdon Accommodation and Floating Support Adult Mental Health Panel at the end of January 2015, and the panel agreed for the floating support provider to assess AA for a "group home – 2 people and with an additional visiting support package". The diagnosis was recorded as paranoid schizophrenia, adding that AA was subject to CPA and (incorrectly) section 117. Cannabis use was noted on the referral form, adding that AA required support around cooking, paperwork, finance, accessing other agencies, daily structure, motivation, medication, accessing ETE [education, training and employment]. The risk field included completed filled tick-boxes for physical and verbal aggression, and vulnerability/neglect in the past (not recent). The field entitled 'further details if required' contained no further information regarding the physical or verbal aggression.

> **Comment: The field in the risk section for 'further details if required' contained no mention of the nature of the aggression or any analysis of triggers.**

An initial assessment for the visiting support service was undertaken on 12 February by a senior support worker from the care provider organisation. The assessment included risk of violence to self and others but there was no comment on this element. The outcome of the assessment was that AA was accepted onto the visiting support service.

The following week, the provider confirmed that AA was accepted to receive the floating support service, and that the landlord had agreed to allocate the tenancy to him. The email stated that AA is aware that a female tenant is currently occupying one of the rooms, and that AA does not have any issue with the idea of sharing a property with a female. The records state that the other tenant was to be advised of this by her support worker

> **Comment: There is no record of any consideration of possible risks of allocating AA to this accommodation with an older female. AA was asked his views, but there are no records that the other tenant was consulted prior to the decision being made. The reviewer notes during Hestia's exploration of the circumstances of the case, that BB's support worker stated that BB had been consulted on this matter.**

It was reported that AA was excited about the prospect of moving into this accommodation and arrangements continued to prepare for this move during the following month.

The final ward round took place on 24 March 2015, with a plan for discharge on Monday 30 March. The plan stated "if there is any sign of relapses, [care coordinator] to make referral to Home Treatment Team." An entry from the EIS team included a statement "EIS to provide ongoing support".

Discharge from inpatient rehabilitation unit

AA was discharged on Monday 30 March 2015. The 7-day follow-up contact was made with AA on 2 April at his new accommodation, and the support worker reported that things were going well.

The discharge summary was completed by a junior doctor (Core Trainee 2). The forensic history relies on AA's self-reports and the care plan focuses mainly on medical issues (medication, dermatitis and GP to review bloods). The non-medical plan involves setting up a standing order to pay his rent and to inform the Job Centre to activate his Personal Independence Payment (PIP)

> **Comment: The discharge summary is six pages long but much of the content comprises historical facts (mental state on admission, details of ward rounds in February and November 2014. The care plan is extremely limited and not consolidated within the summary. There is no risk assessment within the summary.**

AA's care coordinator (CCO1) undertook a care review on 10 April, shortly after his discharge. It was noted that AA had recently been discharged following a 1½ year admission. AA was advised to reduce and stop use of cannabis and also advised about controlled drinking and risk of relapse to alcohol dependence.

During the first two weeks of April, AA expressed satisfaction with his new accommodation, and also made positive comments about his co-tenant.

AA's support worker (SW1) undertook an assessment with him on 28 April. It is recorded that this was in line with Hestia's procedure. The assessment highlighted some concerns with cannabis use leading to lack of self-care. It is recorded that AA was identified as willing to reduce his cannabis use.

During the first week of May, AA made two complaints about his co-tenant [BB]. He told SW1 that she had an overbearing attitude and two days later told him that she locked him out and controlled the heating and hot water. AA told SW1 that he was not happy living at the property. SW1 informed CCO1 of these issues.

> **Comment: This is the first indication of difficulties in the relationship between the two tenants. It is just five weeks after AA moved in.**

CCO1 and support workers of both tenants attended the property on 11 May after inviting both AA and BB to a meeting. However, AA did not attend and BB informed the professionals that he had not been at the property for days. CCO1 discovered that AA had been staying with his mother.

Both support workers informed BB that it was unacceptable to tell her co-tenant how to live, and that they had equal rights at the property.

During the following three months until his admission to hospital, AA was very seldom seen by either CCO1 or SW1. The notes from the provider and the mental health trust record frequent attempts to meet with or telephone AA, but he was seen by his care team on only three occasions in 12 weeks (once by CCO1, once by SW1 and he was seen once jointly). He also missed his outpatient appointments. CCO1 had two additional telephone conversations with him.

Comment: Both care coordinator and support worker made repeated and frequent attempts to keep in touch with AA, by visiting and telephone. They also kept in regular contact with each other, and there were frequent attempts to address the problems with the heating and hot water through liaison with the landlord.

Of those contacts, both meetings between AA and his support worker featured hostility from AA. Shortly after AA's first complaints, SW1 and CCO1 arranged a 'house meeting' with both tenants, which took place on 18 May. Although both tenants were in the house, they did not let the professionals into the property and the support worker had to gain entrance with his own keys. CCO1 reported that AA "kicked off" and was verbally abusive through his room door. He told them that he did not want to see them and that he would kill them. It was recorded that it was because he was angry about the lack of heating and hot water.

Following this visit, CCO1 contacted the AMHP service to discuss her concerns and to consider a Mental Health Act assessment. This resulted in a discussion about arranging a police-escorted visit, and AA being moved from the 'amber zone' to 'red zone' in the EIS zoning meeting.

Comment: The EIS zoning system (green/amber/red) indicated differential levels of concern for a person's mental health. It is understood that the zoning system is now service-wide, but at that time it was restricted to the EIS team. See separate section below regarding zoning.

Comment: There were significant concerns about AA's mental health, and sufficient concerns about his responses for the care coordinator to consider asking the police to escort professionals on their next visit. However, there was no consideration of risk to the other tenant in the house.

AA was next seen on 1 June, by CCO1 and a mental health nurse, in the company of his mother and aunty. AA's mother had agreed to visit with the professionals and she facilitated the meeting with them.

The meeting concluded that AA's issues were related to persistent hot water and heating problems, and that AA agreed to attend the Pembroke Centre every day. The AMHP service was informed that a Mental Health Act assessment was not required, and at the next EIS zoning meeting, AA was moved from 'red zone' to 'amber zone'. The rationale for this appears to be that AA had been seen by the care coordinator and 'agreed to cooperate with the treatment plan'.

An email was sent to the support provider and the landlord "regarding the situation in the house, repairs to be done and situation with [AA's] housemate and to look at taking steps to move things forward".

Comment: AA's mother assisted in ensuring he attended this meeting. The meeting appears to have been a positive one in which AA was able to raise issues which were concerning him and agreed to a plan of increased support. The situation with the other tenant was discussed and there was a plan to take steps to attempt to deal with the issues.

Comment: The decision to move AA from red to amber zone appears to have been made on the basis that he had been seen by his care coordinator (for the first time in four weeks, and facilitated by his mother), and verbally agreed to cooperate

with the treatment plan. There was no evidence to support the fact that he would start to engage with the care coordinator and/or the support worker.

During this period, the professionals were aware of the difficulties between the two tenants. At one point CCO1 informed SW1 that AA was staying with his mother due to issues with the co-tenant.

CCO1 spoke to AA on the telephone on 3 July, during which he claimed that BB has been turning the water off at certain times. He told CCO1 that he wanted to move out and was planning to do it in a couple of weeks.

The third face-to-face contact took place on 9 July when SW1 visited AA and was let into the flat by the other tenant. The report states that AA was verbally abusive to SW1 and told him to leave, swore at him and suggested that SW1 had 'made [him] sign to live in this dump'. SW1 left to avoid inflaming the situation and informed CCO1. SW1 also expressed to CCO1 reservations about continuing to be AA's support worker and suggested a change of personnel. CCO1 agreed to this.

The following week, SW1 made a decision to telephone AA rather than visit face-to-face because of AA's recent outburst, but AA did not answer the phone. A new support worker (SW2) was allocated to AA's case in mid-July.

Comment: The incident with AA was not reported internally, and the manager of the service reported that the support worker transferred the case because he was moving to another part of the service. Therefore, the information about AA's aggressive behaviour was lost to the support service.

Comment: It is notable that SW1 chose to telephone AA rather than to visit him face-to-face following his outburst the previous week. There is no evidence that consideration was given to the safety or welfare of BB in the context of AA's aggressive behaviour.

AA was not seen in the following three weeks, despite numerous attempts to contact him by CCO1 and SW2, and enlisting the assistance of AA's mother and father. During this time, neither his mother nor his father was able to contact him and his benefits were suspended due to failure to submit a sick certificate. The EIS team maintained AA on 'amber zone' throughout this time.

Second hospital admission

Apart from a brief, hostile encounter with SW1 on 9 July, AA had not been seen by any of his care team since 1 June. On 31 July, AA was picked up by the police after stabbing himself in the leg on the street. He was taken to Hillingdon Hospital A&E in the early hours with a wound to his right leg.

AA initially stated that the wound was inflicted by a friend, but he later told the investigating police officer that he had inflicted it himself and wanted to return to the mental health unit to get away from BB. He said she had been eating his food, locking him out of the house and refusing to let him use items in the house.

When the police officer spoke to BB she told him they had been arguing all day, that they did not get along and that they should not be housed together. A 'Merlin' report of this event (which would have been passed to adult social care) was not created.

AA told the A&E staff that he wanted to be admitted to hospital as he was not coping, having ongoing problems with money and his flat-mate. Following treatment in A&E, AA was seen by a liaison psychiatric nurse. He told the nurse of a turbulent relationship with his flatmate and alleged that she had been stealing from him as well as being racially abusive. The nurse recorded that "'[AA] says that the knife could have easily been aimed at his roommate."

Consideration was given to Home Treatment Team (HTT) involvement as an alternative to admission but this was felt inappropriate as the "HTT cannot guarantee safety due to risk of knife stabbing and hostility towards his female roommate".

AA was admitted informally to the mental health unit. On clerking in, it was recorded that he has delusions about his flatmate stealing food, making racist comments and stealing hot water. It includes the risks of knife stabbing and hostility towards his female housemate, and that there was a history of aggression towards his mother.

> **Comment: AA reached a crisis point at the end of July 2015 in relation to his accommodation and his relationship with BB. AA harmed himself by stabbing and requested admission to hospital, telling the police, A&E staff and the liaison psychiatric nurse about the degree of difficulties he was experiencing. He revealed to the psychiatric nurse that one option, which he did not pursue on this occasion, was to harm his co-tenant with the knife, rather than himself. The dynamic risk assessment leading to his admission to hospital identified that it was not safe for him to remain in the community due to risk of harm to himself or his co-tenant.**
>
> **Comment: On admission, the assumption made by the admitting doctor was that his complaints against his co-tenant were delusional in nature, and not based in reality. The history of aggression by AA against his mother was picked up.**

AA was an informal patient at The Riverside Unit for a little over three weeks. A conversation took place between CCO1 and SW2 on 5 August, regarding whether AA should return to the house on discharge because of BB's contribution to his breakdown. CCO1 stated that AA may have to return to the house if she was unable to find alternative accommodation before he was discharged. This conversation is recorded in the support provider notes but there is no record of it in the mental health trust notes.

Comment: The discussion whether AA should return to the house on discharge focused on AA's mental vulnerability, and did not consider the risk to BB, in the light of the recent incident and AA's comments.

Comment: The statement by the care coordinator that AA may have to return to the house if no alternative was found suggests that positive action would be taken to attempt to identify alternative accommodation.

AA visited his disabled sister at her supported accommodation while in hospital. He allegedly assaulted her and according to the police report punched her several times before being restrained and removed from the premises. The police attended the ward to arrest AA but he was not there at the time. The case was passed to the Community Safety Unit.

No further action was taken for a week before an acting detective inspector instructed that AA should be arrested at the earliest opportunity. However, no further progress was made on the case until after AA had been arrested for the murder of BB.

Two reasons were given for the failure to progress this investigation. Firstly that there was no means of contacting AA once he had left the mental health unit, and separately that AA was unfit for interview (recorded in September 2015).

Comment: The failure to progress this investigation in a timely manner meant that the full details of the alleged assault may not have been available to inform the risk assessment for AA. It was not difficult to establish AA's whereabouts after he left the mental health ward, as he continued to live at his permanent address. The fact that AA was a mental health inpatient does not necessarily mean he was unfit for interview, and in any case, AA had been discharged three weeks before this note was written.

CCO1 visited AA on the ward on 13 August. CCO1 recorded that he ignored her and that he was shouting and swearing. CCO1 recorded that she would talk to her team about getting AA a new care coordinator as he was refusing to engage with her and believed she was controlling his money. CCO1 repeated her concern that AA returning to the property would not be sustainable in the long term and told SW2 that AA would remain in hospital until she had spoken to the psychiatrist about his accommodation.

AA attended four ward rounds during the final week of his inpatient episode (17, 18, 21 and 24 August).

It was noted on 17 August that the care worker (sic) [CCO1] was expressing concerns regarding his level of risk to others as he mentioned to her previously 'it could have been [his housemate] that I stabbed'. She was concerned about potential continued delusional beliefs concerning his flat mate and that she was specifically concerned about his potential return to his previous housing for that reason. The meeting also noted his recent aggressive episode towards his sister.

On 18 August, AA's difficult relationship with BB was explored, including his view that she stole food from him. He stated that he felt violent feelings towards BB, commenting that he had felt like hitting her in the past, but added that he would not have done it. He denied feeling that he wanted to stab BB because he said "it wouldn't feel right. I would worry about getting arrested." The alleged assault on his sister was again referred to in the ward

round, but described as a “scuffle”, rather than the multiple punches as described in the police record.

At the ward round on 21 August, AA repeated his unhappiness about living at his accommodation and that he did not want to return there on discharge. He repeated his concerns about BB’s behaviour which was causing him particular difficulties. The recorded risks included “potential violence to others given history of assault to sister.”

CCO1 wrote to SW2 on 21 August to inform him that AA remained in hospital and asking if the provider could explore alternative accommodation. She added that his case would be transferred to a different care coordinator. A separate decision was made on the ward to discharge AA from hospital if he was suspected of smoking or providing cannabis to others.

That day and the following day AA was found in his bedroom on the ward smoking cannabis. The police were called, and it is not clear what action, if any was taken.

At the final ward round on 24 August, the decision was made to discharge AA from hospital. This confirmed the plan made at the previous ward round, and the reason given in the notes is consistent with that plan. The risk events in the ward round notes refer to AA’s admission due to stabbing self; can be hostile towards housemate; cannabis use and has been non-compliant with medication in the past.

> **Comment: AA’s aggressive behaviour and the potential risk to others, including BB, was identified throughout this inpatient episode. The care coordinator is quoted as being especially concerned about the risk to BB if he was discharged back to the house. While there was discussion about the desirability of alternative accommodation, there is no record of active attempts to explore the option of AA moving to a different address. At the ward round in which AA’s discharge was confirmed, the degree of concern about his risk of violence to others was considerably less pronounced than at the previous ward rounds in the week before.**

Second discharge from hospital

AA was discharged home on Monday 24 August. The ward telephoned CCO1 at lunchtime to inform her of the discharge. CCO1 and the provider were informed and he was referred to the Home Treatment Team, with a view to the HTT visiting on alternate days.

> **Comment: AA's care coordinator was not present at the ward round at which the decision was taken to discharge AA in the event of him being found smoking cannabis. There is no evidence of this plan being passed to the care coordinator. Following being found smoking cannabis, there is no evidence of planning for the discharge, despite the fact that the discharge did not take effect until after the weekend. There is no record of any communication with AA's care coordinator before the time of discharge, at lunchtime on 24 August.**

The EIS allocated a new care coordinator to AA's case (CCO2). The EIS re-zoned AA to 'red zone' at the meeting following his discharge. That meeting also commented "Has a tenancy but investigating alternative tenancy because he does not want to return to his property."

> **Comment: There is no evidence of active investigations taking place regarding alternative accommodation.**

The HTT unsuccessfully attempted to visit AA twice on the day after his discharge and once the following morning. Following the third abortive attempt to visit, the HTT discharged AA back to the EIS. CCO2 noted her unhappiness about this and asked the HTT to reconsider their decision, in the context of concerns about his risk and that he was not taking medication.

AA returned home during the afternoon shortly after the decision to discharge him from HTT. He was asking for the HTT to visit, but the team responded that he had been discharged and should make contact with EIS.

> **Comment: Given the considerable difficulties in engaging with AA over the previous six months, it was unfortunate that the HTT did not respond more positively to the news that he was asking for contact.**

During the three weeks following AA's discharge from hospital, the care professionals were able to keep in slightly more contact with him, seeing him just once (jointly) but having telephone contact six times. He also had a session with an occupational therapist during the week following his discharge, with one of the actions recorded as "…to be moved to a studio flat on the rehab unit as soon as one becomes available." There is no further information regarding this plan, or any reference to it in future notes.

> **Comment: in the joint meeting with the care coordinator and support worker, AA's difficulties with BB were discussed, but the main action points related to his medication compliance, drug use and financial issues. There was no further mention of efforts to move him to alternative accommodation.**

AA was placed in the 'red zone' at the EIS zoning meeting following his discharge, but at some point was moved to the 'amber zone' after approximately two weeks. It is not clear from the records on which date this move was decided, or the reasons for it. At the end of September, AA was moved to 'green zone' with a statement 'doing well'.

> **Comment: There is no evidence in the notes to support the statement that AA was 'doing well', and he had not been seen for over two weeks.**

There was relatively more contact with AA by CCO2 during October 2015. He was seen three times and there was also a telephone contact. On two occasions, AA's mother or father helped to facilitate the face-to-face meeting, and CCO2 was in telephone contact with AA's father several times during the month. AA missed his outpatient appointment during the month.

There were several significant developments affecting AA during October.

AA reported that someone had borrowed money from him. AA stated that he was afraid of this person and did not want to report it. SW2 suggested that this should trigger a safeguarding concern, and CCO2 commented that it would be difficult to safeguard AA as he engaged in dangerous drug dealing activities with potentially dangerous people.

This was raised with the safeguarding team for advice two weeks later. It was not clear whether AA had given consent to make the referral so CCO2 agreed to check this with AA.

> **Comment: There is no further mention in the records of any discussion regarding this issue.**

AA had fallen into significant rent arrears, totalling over £1,000 and two letters were sent to him from the landlord instructing that he should pay off the arrears or agree a regular payment plan.

BB moved a folding bed into the shared space of the living room and was using it as a bedroom. This was identified on a visit by SW2 and a housing officer, and BB was told that she could not use the communal space for herself. She was helped to take the bed back into her bedroom.

On a visit by CCO2 and a student nurse on 5 October, AA was found to be keeping a large kitchen knife on his bedroom floor. When challenged, he replied that he was keeping it for him to feel safe, and "just in case" as he always feels on edge. The day after this visit on 6 October, SW2 completed a risk/needs assessment with AA, stating "no risk of violence or aggression assessed."

On the following visit by CCO2 and the student nurse on 22 October, AA admitted to still having the knife in his bedroom, saying that he needed it for protection. This was nine days before the incident and the last face-to-face contact with AA.

> **Comment: There is no record of any further analysis of the possible increased risk created by AA's actions, and no evidence that the support provider had been informed about the knife in AA's room.**

The final contact with AA took place on 29 October, when SW2 visited him at home. AA's mother had told SW2 that AA had again been locked out of the house by BB, and had been forced to sleep in a corridor outside his father's flat. AA's mother asked about him moving out because BB was "taking over". His mother encouraged him to be present for the meeting, and told him that SW2 would be moving him out of the property. SW2 recorded that she did not make that promise but advised AA should come to the office the next day to discuss his concerns about the house share and his experiences with his co-tenant.

SW2 contacted AA the following day to inform him that the meeting was cancelled and he should not come to the office. No reason was given.

It is not clear exactly when AA killed BB. The police reports suggest it was between 10 and 11 November. AA attended Hillingdon A&E department twice during the night of 10/11 November, asking for admission to hospital. AA stated that he had lost his keys to his accommodation. On both occasions, he was assessed as not needing admission to psychiatric ward and when he was given this information he became angry and abusive and left the department.

AA told his father on 11 November that he had stabbed BB. AA's father went with him to AA's home address and assisted him to effect entry but did not enter himself. He then informed SW2 to tell her what his son had said. SW2 attended the property, found BB and contacted the ambulance service and the police.

Comments by AA to the forensic psychiatrist while on remand

The reviewer has had an opportunity to read the two psychiatric reports to the court, in preparation for the trial.

AA was able to provide detailed information from his own point of view to one of the forensic psychiatrists, and while some of that information is unclear and contradictory, there are elements which are consistent with the chronology which has been prepared by the agencies involved.

The reviewer visited AA in Three Bridges Medium Secure Unit but he was not forthcoming regarding his care and relationship with BB. This provides a more detailed picture of AA's views, and it is therefore suggested that it is important to include in the review.

AA discussed his relationship with an acquaintance (CC) who had left some of his belongings in AA's room, and came to remove them shortly before the incident in which BB was stabbed. AA described how he was scared of CC who was controlling and threatening. AA stated that he had been staying with him for an unspecified time and that CC had also taken over £1,000 of backdated benefit payment from him.

AA reported to SW2 on 8 October in the presence of his father, that a person he knew had borrowed money off him, and that he was afraid of him and did not want it to be reported. SW2 passed this to her manager and to CCO2.

CC corroborated the fact in his statement to the police that he had left his belongings in AA's room, and returned to collect them shortly before the stabbing incident.

In relation to the damage to BB's bedroom door, noted on 9 November by BB's support worker and BB claimed that AA had caused it, AA stated that he had bashed her door with a fire extinguisher.

When discussing the problems he experienced with BB, AA repeated the concerns he had raised previously, that she had locked him out of the accommodation, causing him to sleep outside or go to his father's home; that she had stolen his food. He stated that he had told his support worker, and in his view, more should have been done.

AA described his motivation for stabbing himself in the leg and asking for admission to hospital on 31 July 2015 so he would be given new accommodation because he could not cope with living with BB any more.

Housing allocation decision-making

Decisions regarding the allocation of supported housing for people with mental health needs were, in 2015, taken by a panel chaired by an officer of the housing department.

The support at this particular property is called 'floating support' as there are no support workers based at the property, and they visit for a certain number of hours each week. The residents live in the property as independent tenants. The support provider is a different organisation to the landlord of the property.

The support workers are employees of the support provider organisation, whose role is to ensure that the individuals with whom they are working are getting the appropriate level of support, as agreed with the social worker or care coordinator. The housing officer is an employee of the landlord, whose role it is to ensure that the tenancy is maintained and to respond to any issues regarding the fabric of the building.

The assessment for suitability of floating support is taken by the support provider, while the landlord assesses the individual's ability to afford the rent. It is usual that an assessment by the support provider that the individual is suitable to receive floating support will lead to an offer of a tenancy by the landlord.

BB was referred to the mental health accommodation panel in October 2014 and moved into the accommodation in December of that year. No needs assessment was completed in preparation for her presentation to the mental health accommodation and floating support panel, and there is limited documentation to clarify how her needs were established when she was considered at the panel.

BB's risks are described on the referral form as relating to vulnerability and neglect. She had in fact been detained on section 2 of the Mental Health Act in 2012 and had a further informal psychiatric admission in 2014, but this was not included in the referral information. The referral was made by the Housing outreach team and BB was not currently open to either the mental health or adult social care services when she moved into the property.

AA was referred to the mental health accommodation panel in January 2015. The referral suggested that AA would be suitable for a group home or semi-independent accommodation with floating support at least three times per week at the beginning. AA was offered the tenancy after an assessment of suitability for floating support was undertaken during February and he was found suitable to receive floating support. The support to be provided from his discharge from hospital was once per week.

There is no record of discussions or decision-making regarding the different provision of support (once per week) compared to the assessed need (at least three times per week).

AA was informed that there was one other resident who was female, and it is reported that he said that he did not have any issues with that. There are records that BB would be advised by her support worker of this allocation. In March 2015 it was recorded that BB's support worker informed her of the new tenant moving into the premises in the near future. There are no records of consultation with BB regarding her views on a male co-tenant moving into the accommodation.

At the time of AA's allocation to the property, it has been confirmed that this property was the only void available for him. The allocation was therefore made solely on the existence of a vacancy, with no consideration of whether or not the two individuals would be compatible.

While there was discussion at the accommodation panel regarding the suitability of each individual to benefit from floating support, there was no consideration of the impact on existing tenants of new arrivals. While this may be less critical in properties with staffing on-site, where there is no staffing and just two individuals living together, it is suggested that it is important to consider issues of compatibility and possible conflict between the two individuals.

However, the issue of a mixed gender house was raised within the floating support provider organisation. Within one week of AA moving into the house, the team manager for the floating support service emailed the housing officer to propose moving BB into a void in another property which where another female tenant was living. The proposal was to maintain single-sex occupancy in the properties which it was believed would enable better tenancy management. The housing officer responded that there were rent arrears for one of the female tenants, and no further exploration could be made until this had been resolved.

No further discussion took place regarding this option, despite the increasing problems between AA and BB as the year progressed.

This property is one of three properties where two people share a house without any on-site support. It was confirmed at the SAR panel that the properties are still being used in that way with floating support, which is provided from another provider which took over the contract in 2016.

Learning points:

- **Decisions on allocation of accommodation where support is included (whether floating or based at the accommodation) should be made following consideration of a full social needs assessment in addition to other assessments.**
- **Careful consideration should always be given to the gender and age mix in accommodation reserved for people with mental ill health, particularly when there is no on-site support.**
- **The continuing use of shared accommodation for individuals with no on-site support should be reconsidered, with particular consideration given to the compatibility of the residents, and any risk issues which could compromise the health and safety of the residents.**

Ongoing difficulties with the accommodation and hostility between the co-tenants

AA started to express concern about his relationship with BB within five weeks of moving into the property. He was discharged from hospital on 30th March 2015 and on 5th May, AA commented to his support worker that he experienced BB to have an "overbearing attitude". Two days later, AA complained that BB controlled the heating and hot water. He told his support worker that he was not happy living at the property.

Problems with the heating and hot water predated AA's arrival at the property and became a significant focus of conflict and tension between the co-tenants. When BB moved into the property in December, it is recorded that the landlord was informed that there was no heating or hot water. During January 2015, it was reported that there had been no heating or hot water for three weeks, although a plumber had been sent out to fix it.

During the time that AA was living at the accommodation, he accused BB of controlling the heating and hot water, and preventing him from accessing it at times. This was never established, although the boiler was located in BB's room. It was reported to the accommodation panel that there had been similar issues in BB's previous accommodation. AA's comments were at times described by the care team as delusional in nature.

AA's angry response to the care coordinator and the support worker in May was linked to the lack of heating and hot water. This led to discussion regarding a possible Mental Health Act assessment, but can alternatively be seen as a frustrated response to a significant problem for AA's day-to-day life. When AA was next seen two weeks later it was acknowledged that his issues were related to persistent hot water and heating issues, and he agreed to cooperate with his treatment plan.

During June, it appears that AA stayed with his mother for at least two weeks due to issues with his co-tenant, which led to him not being seen by any of his care team. During June and July, AA was hardly seen, but on the one day that he saw his support worker, he swore at him and used words to the effect "you made me sign up to live in this dump".

It appears that AA was already a man who did not easily engage with services. However, his excitement at obtaining independent accommodation rapidly changed to frustration and anger at the significant difficulties he encountered in the property. Whether the problems with the heating and hot water were caused by BB or were a fault in the system, AA believed that his co-tenant was responsible for much of the difficulties. When the reviewer visited AA in hospital as part of this review, he continued to suspect that BB had caused many of these difficulties, although he agreed that he could not be certain.

The fact that the boiler was located in BB's bedroom was problematic for two reasons. Because BB also did not engage with her support worker and did not comply with requests to be present for appointments, many attempts to fix the boiler failed due to the workmen being unable to gain access to the boiler in BB's room.

In addition, if BB was instrumental in any of the problems with the heating and hot water (which cannot now be established), the fact that the boiler was located in her bedroom would make it straightforward for her to control these services, as AA suspected and claimed, and make it difficult to prevent this from happening.

Learning points:

- **It is important that major services such as boilers and key utilities should be located in common areas and protected from the possibility of being tampered with as far as is practicable. Locating them in common areas will also allow easy access when maintenance and repairs are needed.**
- **Where it is evident that there are serious conflicts between tenants, a formal reassessment of the status of both (or all) tenants should be held to identify how to address the issues**

Needs and risk assessments

As BB was not in receipt of mental health services, she was not subject to the Care Programme Approach (CPA) and did not have a care coordinator.

However, there is evidence that BB was eligible for a social care needs assessment and was receiving significant support, in the form of floating support. If she had received a needs assessment, her needs would have been clearly established, with a care plan, and from April 2015 (after the enactment of the Care Act 2014) the local authority would have been required to provide a personal budget alongside a care and support plan.

Under both legislative schemes, the existence of social care-funded provision would require regular reviews of the care in order to determine whether the plan was working, and whether it should be reduced, maintained or increased. It would also give the service user the opportunity to give their views on the care being provided.

At no time during AA's contact with mental health services was a full psychosocial needs assessment completed with him. There is reference in ward round notes during summer 2014 that a needs assessment should be completed. This was linked to the preparation for presentation to the accommodation panel.

AA was subject to CPA throughout his period of contact with mental health services, and a key element of his care and support involved social care support, in the form of floating support from the provider organisation. The local authority delegates the social care assessment and care management process to the trust through a partnership agreement, and therefore service users with social care needs should be receiving the assessment and care planning that they are entitled to, under the NHS and Community Care Act 1990 up to 1 April 2015, and since that time under the Care Act 2014.

During the course of the contact with AA, there were numerous risk assessments undertaken by the care coordinators and inpatient staff, some of which were formally recorded on risk assessment documentation and some, following discussion in meetings, were recorded in the notes. The majority of references to risk sit within the mental health notes, as would be expected, as the primary care and support was being provided by that service.

There is a history of violence and aggression dating back to before AA's first contact with mental health services. He was convicted of assault on a police officer at the age of 17, which led to his involvement with the Youth Offending Service, and there is also reference to AA being violent to his mother, although this was never formalised and it was recorded that his mother would not report the violence.

The first formal risk assessment completed by the mental health trust referred to an "altercation" with his mother, which he denied, but it is not clear where this information originated. The initial referral to the mental health service originated from AA's mother's treating psychiatrist, who advised that the borough safeguarding team were aware of these issues.

Risk assessment documentation was completed and updated while AA was an inpatient and during his stay at the inpatient rehabilitation ward. This repeated the alleged 'altercation' with his mother, which he denied, and focused on substance use and self-neglect.

AA's mental health risk assessment was updated by the care coordinator in preparation for his presentation to the supported accommodation panel and included the same information as mentioned above. The referral form to the supported accommodation panel included a risk assessment which allowed for different risks to be indicated as 'none', 'past' and 'recent', through a check-box. Both physical aggression and verbal aggression were ticked as 'past' but there was no reference to what that entailed in the text area beneath the check-boxes.

The support provider undertook their own risk assessment as part of the overall assessment of AA's suitability for the visiting support service. Risks of substance misuse and misuse of prescribed medication were identified. No risk of violence to self or others was identified.

Further discussion of the accommodation allocation process is found in a separate section above.

AA's risk assessment was reviewed following the incident in May 2015 in which he was verbally abusive to the care coordinator and support worker. The risk assessment records that he was shouting at them and threatening to kill them. The workers left the property due to risk as he would not calm down. It is relevant here that the context is recorded that AA was having increasingly paranoid thoughts towards others. AA had started to report problems with BB since the beginning of that month. The care coordinator was appropriately concerned regarding the implications of AA's presentation and a Mental Health Act assessment was considered. The care coordinator discussed with the team and AMHP, attempted to consult with AA's mother and made repeated attempts to see AA.

However, AA was not seen until 1 June, two weeks later, when his mother assisted in facilitating a meeting. During that time, although AA's complaints were against BB, there is no evidence that consideration was given of any risk towards BB from AA.

AA's second admission to hospital at the end of July 2015 followed an episode of self-harm in which he initially claimed he had been stabbed by another person, but later admitted that he had stabbed himself in the leg. The record of admission to the ward states that there is a turbulent relationship with his roommate (sic), and adds that AA commented that the knife could easily have been aimed at her. The Home Treatment Team felt that they could not manage AA safely in the community due to the risk of stabbing and AA's hostility to his co-tenant. The potential risks to BB were clearly identified at this time.

This additional risk continued to be discussed during AA's inpatient stay, with a ward round noting that AA's care worker expressed concerns regarding his level of risk to others as he mentioned to her previously 'it could have been [BB] that I stabbed".

During AA's inpatient episode, he attended his sister's supported accommodation and an incident took place which led to the police being called. It was reported that he assaulted his sister by punching her several times. AA was not arrested or questioned for this alleged offence, and while it was recorded in the notes, there was no opportunity to examine the nature of this incident in detail, nor provide the victim with appropriate support. The incident did not feature in the final mental health risk assessment completed in October 2015.

The final risk assessment focused on AA's vulnerability to exploitation by others, and while there were references throughout the assessment of the possibility of violence, these were not consolidated.

The assessment states that AA was keeping a knife in his bedroom, which he stated was for his protection after having his benefit money stolen. The difficulties in the relationship with his co-tenant were mentioned in the context of his disengagement from services.

The final risk assessment update from the provider service was completed the day after the mental health risk assessment, in early October. There appears to have generally been regular and frequent communication between the care coordinators and the support workers, but on this occasion, the support worker had not been told about the fact that AA was keeping a knife in his room. It recorded that no risk of violence or aggression was identified.

The mental health risk assessment form focuses on actual events, and does not appear to provide for any concerns for future risk based on those events. There appears to be limited analysis of dynamic risk factors in the assessment.

While it is important to be aware of the risks of wisdom in hindsight, it is apparent that throughout the time that AA was sharing accommodation with BB, there were a variety of incidents and episodes which led professionals to be concerned regarding the possibility of violence by AA towards others.

At times, staff felt obliged to withdraw from the building due to his threats and his hostility. Following the change of care coordinator, the team were concerned for the safety of the worker who had been replaced, due to his reported paranoid thoughts about her. However, there was very little consideration of risks to BB from AA during the period of their co-tenancy. This was raised explicitly during AA's final hospital admission, but on discharge it was mentioned as no more than hostility to her and there was no consideration of risks to her safety.

The combination of AA's comments on his last admission that the knife he used to harm himself could have been aimed at BB, and the fact that he took to keeping a kitchen knife in his bedroom, can with the benefit of hindsight be seen to be a very concerning development in the way AA was responding to the difficulties he was facing with his tenancy.

Learning points

- **Individuals with significant social care needs should be offered an assessment of their social needs in line with the requirements of the Care Act 2014. Where the person's needs indicate the provision of a service, an assessment of needs, eligibility and care and support plan must be completed.**
- **The risk assessments did not at any point consider risks to BB from AA, despite the increasing tension between the co-tenants, the concern for the safety of the workers at times, and the incidents of aggression during the summer of 2015.**
- **Risk assessments need to be a combination of longer term risks and dynamic (changing and potential) risks, as far as can be identified.**

Changes of staffing and handover processes

During the period in which AA was living at his tenancy, there were a number of changes within the staff whose responsibility it was to maintain contact with him and provide support to him. While there were significantly fewer staff involved in providing care to BB, during that period there were not the same number of changes in relation to people seeing her.

The two major changes in staffing allocated to AA both took place around the period in which he was admitted to hospital for the second time, following a crisis which appears to have been prompted by problems in his relationship with BB. The care coordinator and support worker had been discussing the suitability of AA's continued tenancy in that property and the possibility of alternatives, even though there was no evidence of actual moves to attempt to identify alternative accommodation. However, these discussions did not continue following AA's discharge, when there were new staff involved with his care and support.

It is widely considered to be favourable for service users to have continuity of care. A wide range of papers have been published regarding this aspect in relation to a range of client types, including those people with significant mental health needs[1]. It has been argued that it allows for consistency in response, improved engagement and development of effective working relationships, maintenance of good historical information and the ability to use longitudinal information to inform ongoing work with the individual.

However, it is inevitable in any service that staff will change, and this will happen for a variety of reasons. In the case of AA, the changes in staffing were caused not by the professionals moving roles or jobs, but as a result of AA's own reaction to them.

In the case of AA's first support worker (SW1), they met on a number of occasions during the first six weeks of AA's tenancy, but during the following three months, there were only two contacts, both of which were characterised by hostility and verbal abuse by AA towards SW1. SW1 continued to attempt to make contact with AA throughout this time, both by telephone and visiting the property.

On the second occasion in which AA was abusive and hostile to the support worker, SW1 communicated with AA's care coordinator that AA appears to blame him for the problems with the accommodation and suggested it may be appropriate to change support worker. While it is recorded in the Hestia notes that this conversation took place, and the care coordinator agreed, the official reason given for the handover was that SW1 moved to another service and left the team. The new support worker was allocated in late July and was unable to make contact with AA before his admission to hospital, despite making efforts to do so.

So, despite efforts to engage with AA, SW1 was not able to establish a consistent working relationship with him due to the limited contact he had with him throughout the period in which he was allocated as his support worker. It would be overstating the engagement to suggest that their relationship had broken down when the decision was taken to change support worker, as it had not had an opportunity to develop to any extent.

[1] Providing continuity of care for people with severe mental illness – a narrative review. Crawford MJ, et al. Social Psychiatry and Psychiatric Epidemiology, Apr 2004

AA's care coordinator (CCO1) had similar difficulties in keeping in regular contact with AA, despite frequent attempts to do so, both by telephone and home visits. The contact dropped off at the same time as that with the support worker. CCO1 had face-to-face contact with him in total only four times following his discharge from hospital in March until she was replaced as care coordinator while AA was in hospital in August, and she did not see AA (other than in passing on the ward) after 5 May. During that time she had one telephone conversation with him.

The change of care coordinator was made during AA's inpatient episode in August 2015. He refused to engage with CCO1 when she visited him on the ward, and made statements to the ward staff that he believed she was controlling his benefit money. AA stated that he did not want to work with her and asked for a change of worker. This was agreed and a new care coordinator (CCO2) was allocated on his discharge.

AA was not fully engaged with his care team following his first discharge from hospital. His attendance at scheduled meetings during the first month of his new tenancy was patchy. However, the complete disengagement from both support worker and care coordinator coincided with the time that AA first raised concerns about his accommodation, notably the heating and hot water, and also his complaints about his co-tenant, who he alleged was over-bearing and locked him out of the property at times. There is no clear evidence that there is a direct relationship between these two developments, but AA's angry outbursts towards the staff were focused on his perceived difficulties in his accommodation.

At the time of AA's admission to hospital, CCO1 discussed with the new support worker (SW2) whether the property was the right place for AA to return on discharge because she identified the difficulties in his relationship with the co-tenant as contributing to the deterioration in his mental health. She spoke of the possible need for AA to return to the property if she could not find alternative accommodation before his discharge. This indicated a view that a move of accommodation may benefit AA's mental health and an intention to actively seek alternative accommodation.

This view was reinforced in the notes of a ward round one week before AA's discharge in which reference was made that CCO1 was concerned that AA may have continued delusional beliefs concerning his flat mate, and that she was specifically concerned about his potential return to the property for that reason.

However, during late August, it was agreed that CCO1 would cease to act as AA's care coordinator, and at the same time AA was discharged from the ward after being found using cannabis on the ward and supplying it to others. A decision was made to allocate CCO2 on 24 August, and the comment in the team notes made no reference to AA being discharged from hospital, so it is assumed that the team were unaware of the plan for discharge later that day.

The discussions around exploring alternative accommodation were not maintained with the new care coordinator, and there was less focus on the difficulties in the relationship with BB. Most of the focus was on AA managing his day-to-day life. It cannot be clearly established in this case, but certainly changes of key professionals creates a risk of discontinuity in planning, unless clear and explicit handovers take place in which the main tasks in hand are passed on to the new professional.

Learning points

- **Changes in key professionals must include a comprehensive handover of information, to minimise the likelihood of discontinuity of planning or care. This should ideally be provided through a written summary of work undertaken and work in progress.**

Inter-agency and inter-professional communication

BB did not have any contact with secondary mental health services after May 2014, and her contact with the local authority adult social care service was limited to specific issues, such as her recovery from a broken ankle. Therefore the only worker involved with BB's case was her support worker.

As BB was not in receipt of mental health services, she was not subject to the Care Programme Approach (CPA) and did not have a care coordinator.

As mentioned above, in the section 'needs and risk assessments', BB was in receipt of floating support, and her needs suggested she was eligible for a needs assessment and care plan. From April 2015, The Care Act 2014 placed additional duties on the local authority in relation to care and support planning.

A Care Act care plan would have required involvement of a social care professional from the local authority, at least at each review, but as this did not happen, the support provider was working alone in attempting to provide support to BB.

AA: Communication between care coordinators and support workers

There appears from the chronology and the records that the care coordinators and support workers kept in regular and frequent contact during the time that they were working with AA. This was in the context of considerable ongoing difficulties in maintaining contact with AA experienced by both care coordinators and support workers.

However, there were significant issues during summer and autumn of 2015 where information was not shared, particularly in relation to events which contributed to AA's ongoing risk assessment. CCO1 informed SW2 of AA's admission to hospital shortly after the admission and CCO1 arranged to visit AA when she returned from annual leave.

The professionals kept in contact during August, during which time they explicitly discussed whether AA should continue to live in the property, due to the difficult relationship between himself and BB. However, AA's comment to the psychiatric nurse on admission to hospital on 31 July, that the knife (used to harm himself) could have easily been aimed at his co-tenant, does not appear to have been shared with SW2 or the support provider organisation.

While in hospital, AA allegedly assaulted his sister when visiting her at her home, and there was also reference during ward rounds to AA's comments on admission regarding the possibility of him stabbing BB rather than himself. Neither of these pieces of information appear to have been shared with SW2 or the provider organisation, and therefore were not included in further consideration of whether AA should return to the property on discharge.

Following AA's discharge from hospital, CCO2 quickly introduced herself to SW2 and a meeting was held with AA involving CCO2, SW2 and a senior support worker. This was recorded as a positive meeting with plans made for the future, but there was no further consideration of exploring alternative accommodation for AA.

In October, AA was visited twice by CCO2, accompanied by a student nurse, and was found to be keeping a large kitchen knife in his bedroom. This was discussed with AA both times, and he explained that he was keeping it with him to feel safe, and "just in case". It was first

identified at the same time as AA told CCO1 that someone had taken his benefit money from him, and AA described this person as "controlling".

When SW2 telephoned CCO2 three days later, CCO2 informed SW2 of the issue regarding the money, but did not mention the existence of the knife. SW2 had completed a review of AA's risk assessment on 6 October and had identified no risk of violence or aggression. The opportunity to discuss the increased risk posed by this development was therefore missed.

AA: Communication between teams within the mental health service during AA's second admission

There were numerous ward rounds recorded, in which AA's progress was discussed. The risk to AA's co-tenant was explicitly discussed on a number of occasions, as was the potential risk to CCO1, due to AA's allegations that she was controlling his money.

However, running parallel to this was the concern on the ward of AA smoking cannabis and bringing it onto the ward to give to, or deal to other patients. At the ward round on Friday 21 August, a decision was made to discharge AA if he was suspected to be smoking or providing cannabis to others. CCO1 was not present at this ward round and there is no evidence that she was informed of this decision by the ward.

The decision to discharge AA was made in relation to the need to maintain a suitable environment on the ward and to minimise the use of illicit drugs amongst the inpatients. In the context of the general running of the ward, this is an understandable and reasonable decision. However, there was no consideration and discussion of the significant risk issues which led to AA's admission and which had been discussed explicitly in the ward rounds during the previous three weeks.

There was no communication with AA's care coordinator and no planning for his discharge. The discussions regarding AA's accommodation at the point of admission focused on whether he had a key, rather than any other questions about the suitability of his return to that property.

It was an unfortunate coincidence that this happened at the same time that a decision had been made to change AA's care coordinator. Although the decision had been made to reallocate AA's case, no one had been identified. However, a new care coordinator was rapidly allocated by EIS when they were informed of the discharge.

The Home Treatment Team discharged AA from their caseload after failing to see him on two occasions. This was despite CCO2 asking that they review that decision following AA's contact with her later that afternoon. It is suggested that this was an unnecessarily rapid discharge and that further discussion could have taken place with CCO2, and more flexibility shown by the HTT.

Learning points:

- **Careful consideration should be given to sharing of risk information with provider services, to ensure the appropriate balance between confidentiality and effective risk management.**
- **Communication between inpatient services and community teams in relation to discharge from hospital should enable planning to take place prior to discharge. Planning should follow CPA procedures.**

Safeguarding practice

At the time that AA informed CCO2 of his difficulties with another individual, who he alleged had taken his benefit money from him, this was not initially considered to be a safeguarding issue. The need to raise it as a safeguarding concern was suggested by SW2 when she was informed.

The records suggest that CCO2 questioned the point of a safeguarding referral, due to AA's behaviour involving illicit drug use. There was a significant delay before any discussion took place with the borough safeguarding team and when the safeguarding team advised that further exploration was needed in relation to AA's consent to proceed further, no further action was taken to explore this.

It is notable in the interview between AA and the forensic psychiatrist in preparation of the court report, AA talks of this person who he describes as controlling and threatening. AA was scared of him and he alleged that he took over £1,000 of benefits from him. Many of these statements corroborate comments made at the time by AA or his mother.

In addition, this person was also keeping his belongings in AA's room for an unspecified length of time, and AA stated to an interviewing psychiatrist how it was causing him further stress and anxiety.

Safeguarding responses are particularly difficult in relation to vulnerable individuals who are possibly experiencing abuse or exploitation, but have capacity to make decisions regarding their lives and are stating that they do not want any action to be taken. However, safeguarding procedures are designed to attempt to address these situations and create a space for professionals to work with individuals to explore ways in which they can be protected.

It is important for professionals to be aware that all service users may be vulnerable to abuse and exploitation, including those individuals who participate in risky and illegal behaviour.

Learning points:

- **Staff should be aware of safeguarding policies and procedures, and ensure timely advice is sought where safeguarding issues may be occurring.**

Zoning protocol and practice

At the time of the incident, the EIS service was operating a 'zoning' system for its patients. At this time the process only applied to the local EIS service with a written protocol dated July 2012. The reviewer was informed that there is now a trust-wide zoning policy which has a different set of guidelines.

The EIS zoning procedure worked on a four-colour scheme, mainly using the traffic lights system with an additional colour for patients who were in hospital. Zoning decisions were made following discussions at the regular team 'zoning meetings'.

The Red Zone

This zone is for clients "currently at risk, or in crisis". This was for clients who were experiencing relapse, or had stopped their medication, or who had disengaged from the team. It would also include clients who had a variety of complex social needs which were placing them under stress, with the accompanying risk of relapse of their psychosis.

Team professionals should be attempting to see clients in the red zone at least every week and a thorough assessment of their mental state should be carried out.

The Amber Zone

This zone includes clients who continue to present with high levels of need but are not presenting high risk factors. An example given is a client who is unwell but continues to attend appointments, someone with serious social needs but is managing them well.

The team should attempt to have direct contact with clients in the amber zone every two weeks to reassess their mental state. Direct contact can include reliable and corroborated evidence from the client's close family.

The Green Zone

This zone includes clients who are stable in their mental state, are well and managing their medical prescription, for instance. They may be working and have good support networks.

The care coordinator should be aiming to see clients in the green zone at least once per month. Direct contact can include telephone contact, but should always include a review of the client's mental state.

The Blue Zone

This zone is for clients who are in hospital or other institution, and are considered to be in a 'safe place' with another clinical team managing their immediate care.

The protocol includes guidance on moving between zones. There are a variety of indicators for moving a client to a 'higher' zone, including disengagement, relapse and change in circumstances. Guidance on moving a client to a 'lower' zone states that it should take place following a team discussion, should be based on assessment and should have a clear rationale.

AA's 'zoning' history while living in the shared accommodation

There are numerous references to the EIS zoning meeting in AA's notes during the seven months AA was living in the shared house. The first reference to zoning followed his verbally aggressive outburst to his support worker in May, when he was moved from Amber to Red zone. This is consistent with the protocol which suggests that there was concern that AA

could be relapsing or in crisis. A Mental Health Act assessment was being considered at this time.

AA remained in 'red zone' for approximately two weeks, and was moved down to 'amber' after he had been seen by his care coordinator and had verbally agreed to cooperate with his treatment plan.

AA remained on 'amber' until his admission to hospital at the end of July, although he had almost fully disengaged with the service, only being seen once in eight weeks. That one contact was with SW1 and AA was verbally abusive to him, leading to a conversation that SW1 should cease to work with AA. The zoning protocol suggests that a move to 'red zone' was indicated during this period.

When AA was admitted to hospital at the end of July, he was appropriately moved to 'blue zone' for the duration of his hospital admission. His discharge was unplanned and caused by his continued use of cannabis on the ward, and he was placed in 'red zone' on discharge. He remained in red zone for approximately two weeks with daily reviews while he was not engaging. The records are not clear when he was moved to 'amber zone' but it was confirmed that he "remained on amber" on 14 September. The analysis at the Zoning Meeting was that AA was "seen last week, taking medication, engaging with [care coordinator]".

On 28 September, the EIS meeting noted that AA was 'rezoned to green" with a comment "doing well". There was no further analysis of the reasoning behind this rezoning, and AA had not been seen by either the care coordinator or his support worker in the two weeks since the previous zoning meeting record two weeks previously.

There is no further record of zoning leading up to the incident, so it is assumed that he remained in 'green zone' throughout that time.

It is suggested that the re-zoning to green at the end of September was precipitate and was not in accordance with the service protocol. In reality, contact with AA during October was more frequent than at any time since April, so the fact that AA was in the 'green zone' did not reduce the contact from his care coordinator. However, it could have created a false sense of security within the team that his social situation was stable and without problems.

As described above, AA experienced several significant stressors during October, including having money taken off him by someone he said that he was afraid of; receiving letters from his landlord regarding major rent arrears; and having ongoing problems with his co-tenant over access to the common areas in the house. He had taken to keeping a kitchen knife in his bedroom because of concerns for his safety. It is suggested that these stressors indicated that AA should at least have been rezoned to 'amber' during this period, which would have led to a more thorough consideration of his mental state and circumstances.

Learning points:

- **Zoning processes and procedures should be followed, with clear rationale for decision-making recorded in the notes**

Conclusion

The review has attempted to avoid hindsight bias which "over-simplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour before the fact"[2]

The review has identified a number of themes which impacted on the care and support provided to mainly AA, but also to BB. These factors impacted on the decision-making and planning for their care and support.

It is suggested that no one single factor in isolation influenced the outcome, but their interaction with each other was significant. When separating each theme for the purpose of this review, it has been difficult avoid referring to others which overlap but have their own discrete issues and need for analysis.

The decision to house AA in the same property as BB was made based solely on the availability of vacant accommodation, and no consideration was given to the suitability of the two tenants to share a property. This was particularly relevant as there was no on-site support and the individuals, both with significant social needs would only receive one visit each per week of floating support.

Problems in the relationship between AA and BB started to become evident just five weeks after AA moved into the property. Professionals found it very difficult to engage either individual in the regular support sessions. This appears to be a long-term issue for BB, but there is no previous history of community mental health support for AA. However, it appears that the problems in the house at least exacerbated the difficulties the professionals found in keeping in regular contact with AA, as he spent time with his mother and with his father, as a result of the issues he was experiencing at the house.

Discussions took place between professionals regarding the suitability of AA continuing to live at the property, and returning to the property following his second hospital admission. There were no simple alternatives as there were no vacancies immediately available at other properties. However, there was no planning for a future move and exploration of possible alternatives.

Neither BB nor AA received social care needs assessments, despite receiving a significant level of support as part of their care package. AA was also subject to the Care Programme Approach, but there were no CPA care plans completed for him which reflected his care and support in the community. The only CPA care plans were completed as an inpatient.

Several risk assessments were completed and updated for AA. The community risk assessments focussed mainly on risks of self-harm or exploitation. The risk assessments during AA's second admission to hospital included the alleged assault on his sister and the potential risk to his co-tenant. However, these were not included in the final risk assessment completed in the community in October 2015.

Throughout the time when professionals were attempting to see AA and he reacted with verbal abuse and aggression, there were explicit references to concern for the safety of the

[2] Woods, D el al (2010), *Behind Human Error* (quoted in The Munro Review of Child Protection: Final Report. DfE 2011

professionals, but at no time was BB's safety considered, either in day-to-day recording or in the formal risk assessments undertaken in the community.

The zoning protocol was, and continues to be used in order to identify those service users who need increased levels of care and support due to their mental state and social circumstances. At the time of the events, it was restricted to the EIS but it is now used service-wide. Decisions were made to change AA's 'zone' without any clear rationale, and in some cases in conflict with the protocol's guidance.

AA's second admission to hospital provided a key opportunity to explore in detail the factors which had led to this crisis. It was particularly unfortunate that both AA's support worker and his care coordinator changed at approximately the same time, which coincided with this hospital admission. There had been discussions regarding the suitability of AA continuing to live at this property, and AA was making clear statements that he wanted to live elsewhere on discharge.

The shortage of suitable housing accommodation is well-known, and there was no simple solution to finding alternative accommodation. However, the clear and explicit statements that moves should be made to find alternative accommodation for AA appeared to be lost on his discharge from hospital.

This was further complicated by the sudden discharge from hospital prompted by AA's continued use of cannabis on the ward, and providing it to other patients. Issues relating to the overall management of the ward were in acute tension with the need to plan AA's discharge in the context of the risks identified during his inpatient stay. There was no discharge planning and little information to the community team in preparation for his discharge.

An opportunity to explore AA's vulnerability to financial exploitation and possible intimidation was missed when no safeguarding concern was raised regarding his statement about another person taking a large amount of his benefits money from him. Some of the statements made suggest that AA's illicit drug use made him less likely to be amenable to safeguarding, due to the sort of people he was likely to associate with. There is no guarantee that AA would have cooperated with work to help safeguard him from others, but an opportunity to provide that support was missed by failing to follow this up in a timely manner using the safeguarding procedures.

Appendix I: Documents provided for the review

Hestia Care, Support and Support Planning: Lack of engagement policy: 14/08/12

Hestia Care, Support and Support Planning: Operational handbook: 14/08/12

Discharge summary (BB) (for inpatient episode ending 29/02/12): 01/11/12

Independent Living Support Service (ILS) referral (BB): 16/04/13

Needs/risk assessment and support plan (BB): 01/05/13

Email from Mill House Assessment and Brief Treatment team to ILS (BB): 24/06/13

Letter from Mill House Assessment and Brief Treatment team to ILS (BB): 15/07/13

Needs/risk assessment and support plan (BB): 14/08/13

Baseline assessment form (inpatient rehabilitation unit) (AA): 03/10/13

Support plan closure letter from ILS to BB: 27/11/13

ILS client closure assessment form (BB): 05/12/13

CNWL care and support plan (AA): 14/01/14

Discharge summary (BB) (for inpatient episode ending 07/05/14): 23/06/14

Hillingdon Accommodation and Floating Support Panel minutes (BB): 31/10/14

Referral to Hillingdon Accommodation and Floating Support panel (BB): Oct 14

Hillingdon Accommodation and Floating Support Panel minutes (AA, BB): 31/01/15

Referral to Hillingdon Accommodation and Floating Support panel (AA): Jan 15

Hillingdon Accommodation and Floating Support Panel minutes (AA): 27/02/15

Discharge summary (AA) (for inpatient episode ending 30/03/15): undated

H&H EIS proposed protocol: Protocol for using the “Zoning System” for targeted interventions (reviewed May 2015)

Hestia floating support service risk assessment (BB): 07/09/15

Hestia floating support service recovery star document (AA): 06/10/15

Hestia floating support service risk assessment (AA): 06/10/15

Hestia floating support service incident report: 11/11/15

Discharge summary (AA) (for inpatient episode ending 24/08/15): 12/11/15

Psychiatric report (AA): 31/10/16

Psychiatric report (AA): 28/11/16

Hayes Town Medical Centre GP summary (AA): printed 02/05/17

Individual Management Review Report prepared by Belmont Medical Centre

Individual Management Review Report prepared by Hayes Town Medical Centre

Individual Management Review Report prepared by Hestia floating support provider service

Individual Management Review Reports prepared by Hillingdon Hospital (for AA and BB)

Individual Management Review Report prepared by Notting Hill Housing Group (for AA and BB)

Individual Management Review Report prepared by London Borough of Hillingdon

Individual Management Review Report prepared by the Metropolitan Police

Chronology of events

Biography of the reviewer

Steve Chamberlain is a consultant, trainer and independent social worker, having left local authority employment in July 2014. He is a registered social worker, having qualified in 1983 and was a practising Approved Social Worker (AMHP from 2007) from 1987 to 2013.

Steve started his career as a generic social worker, including child protection work. From 1990, he specialised in adult social work and mental health. He has managed locality adult services, an acute hospital social work team and a multi-disciplinary community mental health team. He was social care lead for mental health and AMHP lead for an inner London borough from 2001 to 2013. During 2013/14 he managed an inner London adult assessment and care management service.

Steve was Mental Capacity Act lead for his borough until 2008, preparing for implementation and writing policies and procedures for the local authority. He was seconded to the Department of Health from 2008 to 2011 as London implementation lead for MCA/DoLS. He trained as a Best Interests Assessor in 2009 and continues to practice in this role. In his most recent post he was DoLS signatory for the supervisory body.

He has delivered training to uni and multi-disciplinary audiences since 1998, mainly related to mental health and mental capacity. This has been both freelance and as part of his employed roles. Steve was a panel member in two serious case reviews following the deaths of children at the hands of their parents where mental ill health was a factor.

Since leaving local authority employment, he has undertaken reviews of three local authority AMHP services and one mental health social work service. He has co-written learning materials for adult social workers on the Mental Capacity Act, published by DH, and was involved in re-writing the Royal College of Psychiatry DoLS e-learning for medical assessors.

Steve was a member of The College of Social Work until its closure and is a member of the BASW mental health Practice, Policy and Education Group (PPEG). He has been chair of the national AMHP leads network since 2011.