Surrey Safeguarding Adults Board

A Serious Case Review in Respect of CC

Died 2009

Executive Summary

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1. Background

1.1 CC died in 2009 when he fell from a car park in Woking. He had sustained external trauma to his body as well as a self-inflicted injury to his upper chest. The Coroner gave the cause of death as suicide.

CC had a diagnosis of paranoid schizophrenia with secondary cannabis abuse and a personality disorder. He was on an enhanced level of Care Programme Approach at the time of his death. He was well known to SABP; to Woking Borough Council's housing department; to the police and to the probation service.

2. Purpose of Serious Case Review

2.1 The purpose of the Serious Case Review is to establish whether there are lessons to be learned from the circumstances of the case about the way in which professionals and agencies work separately and together to safeguard adults and to inform and improve practice by acting on the learning.

2.2 The Terms of Reference of this Serious Case Review are:

- To establish and analyse the chronology of events in relation to CC between January 2000 and his death in 2009
- To examine the adequacy of the collaboration and communication between all the agencies involved in the care of CC or in the provision of services to him between 2000 and 2009
- To examine the care and treatment provided including multidisciplinary decision making, risk assessments and risk management
- To examine the relevant policies and protocols in operation at the time including determining whether practice by all agencies was in accordance with national and local policy for safeguarding adults as set out in "No Secrets" (2000) and other safeguarding specific guidance.
- To identify the care and service delivery issues and the factors associated with these
- To prepare an independent overview report based on the findings and conclusions and make recommendations that can be implemented by the Surrey Safeguarding Adults Board.
- To ensure conclusions are evidenced
- To cascade any lessons learned to all agencies to improve practice.

3. Methodology

- Records were collected from all agencies that had significant involvement with CC for the period January 2000 to CC's death in 2009. These were collated into an integrated chronology.

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- Internal Management Reports (IMRs) were requested from agencies that had had significant involvement with CC. These were forthcoming from: Surrey probation service; Surrey police; Surrey & Borders Partnership NHS Foundation Trust; Woking Borough Council. Although requested IMRs were not received from: an independent GP (although CC's own GP provided a letter and chronology); from Surrey County Council, Adult Social Care (who provided minutes of three case conferences and answers to some specific questions); from an independent care provider.

- These documents were used to inform six serious case review panel meetings held between April and September 2010.

- Panel members were senior managers who had been nominated by their organisation to participate in the Serious Case Review. Their role was to analyse the information from the Internal Management Review.

- Additional records were requested from Surrey & Borders Partnership NHS Foundation Trust to substantiate references made in the chronology.

- IMR authors presented their reports to the panel. They answered questions and provided any clarification required.

- A meeting took place between the Chair of the panel, the SCR report writer and CC's brother and brother's partner both before and after the writing of the draft report. This provided further information from the perspective of a family member.

- Where issues were identified these were subject to further analysis with reference to relevant existing policies and literature as outlined in sections 9 and 10.

- The review report was submitted to the Surrey Safeguarding Adults Board in October 2010. Feedback from the Board was considered in producing the final report.

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4. Pen Picture of CC

4.1 CC was a white British male with a younger brother, a mother and father. The family lived in Woking.

4.2 CC's brother described him as *"a tall, large man who sometimes shaved his head and grew a beard. He wore the type of clothes worn by bikers. On first sight he might appear intimidating but on getting to know CC it would soon become apparent that his attitude and approach were more in keeping with the "peace and love" era of the 1970s."* To his family, CC was a "gentle giant" and once people got to know him, in general, they liked him. He was, his brother said, a roamer and "took off," without notice, for destinations in the south of England as well as France and Wales. CC's brother thought of CC as a man with a teenage mentality, "that of a 13 or 14 year old," and an underdeveloped sense of right and wrong. He had a strong family focus and their father was very closely involved in supporting CC up until his own death in October 2006. Their father spent "seven days a week doing things for CC". In some respects CC's brother regarded their family as a "private" family as they wanted to keep some of their difficulties quiet.

4.1 After 2000, CC was known to present a risk to vulnerable women. He was at risk from members of the communities in which he lived as well as being at risk of self harm (see 5.4).

5. Case Outline

5.1 The SCR considered the period January 2000 to the time of CC's death in 2009 during which time CC had contact with Surrey police; SABP; Surrey Probation Service; Woking Borough Council, a GP practice and Surrey County Council's adult social care department.

5.2 Key milestones and aspects of CCs life include:

- Sexual offences committed by CC in 2000
- A period spent subject to a Probation Order (in connection with the above offences) with conditions from 30 June 2000 to 9 July 2002

  The conditions attached to CC's three-year Probation Order are as follows:

- Live at a care home or elsewhere, as Probation saw fit, in consultation with medical staff
- Accept medical treatment as, and when, required by medical staff
- Give urine samples as requested
- A period spent in prison for breaching the conditions of the Probation Order from July 2002 to November 2002

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- A period spent living in a care home specialising in Mental Health issues for men. CC lived there between 2000 and 2004
- Between January 2004 and March 2006 CC resided in a tenancy provided by Woking Borough Council
- A period subject to RAMP/MAPPA processes: January 2004 to October 2006 (Risk Assessment and Management Planning Meetings: now since November 2005 under the MAPPA: Multi-agency Public Protection Arrangements)
- A year of instability in accommodation followed April 2006 to April 2007(with CC in a temporary tenancy, sleeping rough, staying with friends and staying at his mother's address)
- CC's father died November 2006
- A tenancy spanning April 2007 to his death in 2009
- A Community Order between July 2005 and January 2006 for *"driving a motorcycle while disqualified and driving without insurance"* with the requirement that CC must be supervised by the probation service for six months.
- CC's care is managed by probation at times (as shown here) but mainly through the Community Mental Health Team (CMHT) and between February 2004 and August 2005 through the Assertive Outreach Team (AOT).
- CC has frequent contact with the police with peaks and troughs of activity relating to the risks identified. There were three periods during which CC *did not* come to the notice of police: June 2002 to April 2003; April 2007 to July 2008; December 2008 to May 2009.
- CC was seen by the police and SABP five times in relation to self-harm between May 2009 and his death in 2009. On three of those occasions he was subject to a Police section 136 [1]and on two occasions he was not sectioned.
- CC committed suicide in the summer of 2009.

5.3 The following account details significant aspects of the chronology, in terms of reviewing the involvement of agencies with CC. Observations of the Panel regarding specific issues are highlighted in Section 5 in bold and times new roman font at the foot of each table/section. These are pertinent to conclusions and recommendations. The account captures the complexity of CC's situation and agencies responses to him. This is illustrated in tables 1-4.

5.4 Areas of risk in CC's life

[1] Mental Health act, 1983, section 136: The power for a police officer to take a person they have found in a public place, who appears in need of care or control, to a place of safety for assessment for up to 72 hours

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There were three key aspects relating to risk in CC's life. The following section deals with each:

- The risk CC posed to other vulnerable individuals and, in particular, to vulnerable women and children.
- The risk that CC might self harm or commit suicide.
- The risk to CC from others.

5.4.1 Risk to vulnerable women

5.4.1.1 There were initially three significant events which indicated CC's risk to vulnerable women and which constituted criminal offences. These occurred in January and February 2000 at a SABP acute adult mental health unit in northwest Surrey. These were two instances of sexual assault and one of rape. In respect of the latter CC "**was made the subject of a Probation Order for three years by xxx Court on 30/06/2000 for having sexual intercourse with a defective [under the 1956 Sexual Offences Act].**"

The Panel raised questions about risk assessment and risk management measures by the SABP acute adult mental health unit in northwest Surrey in response to each incident, There were a number of observations in IMRs about the way in which this unit appeared to handle the risk by a simple policy of excluding CC. It must be evidenced that the organisation (SABP) has, for all its inpatient units (including the specific unit in northwest Surrey) introduced measures to safeguard vulnerable women patients from harm from patients such as CC.

5.4.1.2 There were 27 episodes showing risk to vulnerable individuals. A sample of these is given below (as quotations from the chronology):

Table 1

April 2003	Call from a vulnerable female who complained of receiving unwanted phone calls from CC
February 2004	Call from female reporting that CC had moved in next door and for last month he had made various comments to her which made her concerned for her safety and welfare
May 2004	T/C from a neighbour. CC hangs around her front gate and whether deliberately or not he can be a little intimidating / harassing. Neighbour was a recovering alcoholic and her concerns about CC led to her relapsing recently
September 2004	Abusive to parents trying to get money, warned about this behaviour.
September 2005	Call from an elderly female reporting callers at address are constantly asking her for money. CC was one of many seen by the Police and verbally warned

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October 2005	(A multi-agency discussion) agreed to call for an Adult Protection Planning Meeting as a vulnerable adult had stayed at CC's flat for a number of days and subsequently detained under the MHA. No record was made of the nature of the concerns: of who the vulnerable adult was or why risks were perceived and there is no record of any meeting held subsequently
November 2005	CC said he tried to have sex with a female inpatient of mental health services but couldn't, they had both agreed to strip off
December 2005	Police wrote to CMHT to say that CC was harassing and threatening a woman Service User
July 2006	There were concerns that CC was being abusive towards his parents and demanding money from them. They have been advised to call 999
September 2006	Call received from father of vulnerable female reporting that his daughter had been visited by CC on three occasions and he had overstayed his welcome
November 2006	The police filed a Vulnerable Adult notice on CC's mother as it had been reported that CC was putting duress on his mother to supply money from his father's will
February 2007	Report from police that CC's mother was in her driveway and CC was shouting at her from inside

As far as the SCR panel is aware on only one occasion in May 2007 was there a referral into the Safeguarding Adults procedures and this was in respect of suspected abuse of CC's mother. There were 34 recorded occasions where CC posed a risk to others (children and adults) and 18 occasions where he was at risk from others in the period before the safeguarding meetings took place in 2007. There were clear references in the safeguarding meeting minutes of May to September 2007 regarding CC's risk to others and yet the meetings recorded no information on these.

5.4.2 CC involvement with/potential risk to children:

There were 8 episodes showing risk to children. These are given below (as quotations from the chronology):

Table 2

November 2001	CC wants to visit girlfriend in London. Asks about curfew. Told he must not babysit son aged 10-11

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November 2001	CC has been mixing with young people in Woking as young as 13 Children and others have been calling him "paedophile." CC has reported this to police
December 2001	Concerns about CC mixing with 12-13-year olds, denied and CC said he is taunted by them and reported this to the police
October 2005	Probation officer rang Care Co-ordinator to report that CC was letting children in school uniform in and driving a motorbike
November 2005	Probation officer rang Care Co-ordinator, to report CC driving motorcycle again today and having been seen letting children in his flat
December 2005	CC reported that had received an abusive phone call. He thought that it may have been made by some schoolgirls he had befriended and invited back to his flat to watch videos
January 2006	T/C from CC's neighbour – concerns – CC allowing youngsters into his flat regularly
February 2006	Home visit to give injection. School boy sitting in flat, when asked why CC said they were doing a fancy-dress cycle ride that afternoon

Although safeguarding is mentioned on one occasion, there was neither a referral to Children's Safeguarding nor a record of the names and details of the children concerned. There was a complete lack of recognition that safeguarding of children might be an issue.

5.4.3 Risk of self harm/suicide

There were 17 occasions of repetitive, deliberate self-harm and suicidal intentions. These are given below (as quotations from the chronology):

Table 3

February 2001	Hearing voices and wanting to jump at a train
May 2002	Claims to have been having suicidal thoughts; hearing voices telling him to jump out of a window
June 2002	CC feeling low and suicidal thoughts
July 2002	CC expressing suicidal ideas primarily to his father – distressed about pending court case

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February 2004	Letter received from neighbour of CC expressing concerns regarding his behaviour over last few weeks, she feels intimidated by his actions and scared that he will commit suicide as he has threatened to if she does not return his love
June 2004	CC presented at A&E. demanding admission and threatening to cut his throat if he was not admitted
September 2004	CC complained of anxiety and suicidal ideation
November 2005	CC's father, called into the office to say CC was in A&E wanting admission; he had cut his wrists superficially to get admitted. He feels CC is lonely and gets unsettled at nights
April 2006	CC was in another City and was detained on a sect 136 MHA after ringing an ambulance and saying he was afraid he might self harm
August 2006	999 call from a friend of CC stating that he had cut his wrists. Police attended and found CC with a small cut to his wrist but maintaining that he wanted to harm himself. He was sectioned under S136 MHA
July 2008	Call to Police from the ambulance service following the report of a man having slit his wrists and getting violent. Police attended and CC was sectioned. CC was found to have superficial cuts and was threatening further self-harm. He was sectioned by the police
May 2009	Call from CC sitting outside Woking Police Station stating that he was paranoid and was having suicidal thoughts. There was concern for the safety of CC. He was sectioned under S136 MHA and taken to the SABP acute adult mental health unit in northwest Surrey
May 2009	999 call from CC outside Guildford Railway Station to Police. He wanted to be sectioned and felt like throwing himself under a train. Concern for the safety of CC. He was sectioned by the police and taken to xxx Hospital
June 2009	CC rang the police from Guildford railway station and informed them that he was feeling suicidal and wanted to be sectioned.

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	When they arrived, CC said he had run out of medication and was feeling depressed and he said **"Feels like going under a car due to depression."** Police conveyed to xxx Hospital on a section 136. Presentation same as on 13.5.2009, admission was not deemed appropriate and CC was discharged back to care of CMHT
June 2009	999 call from CC stating that everything is getting on top of him. He has a knife and is suicidal. Officer decides that he is not suitable for sectioning as he feels that CC is getting himself sectioned to be seen more quickly at acute unit, northwest Surrey. (CC had been taken to hospital the day before by ambulance and had not been seen quickly enough and therefore walked out). He had decided that by calling the police he would be dealt with quicker and admitted this to the attending officer). CC left at home address. No injuries, no threat to self-harm, no knife found
June 2009	Call from passing motorist reporting a male with stab wounds. Informant called the ambulance initially. Police located CC lying on the pavement near to his house. He had a moderate amount of blood over his bare chest and a small puncture wound was seen. CC explained that he had inflicted the injury and nobody else was involved. CC stated that he had injured himself as nobody seemed to be taking his requests seriously to be sectioned. The police left CC in the care of staff at Hospital. He was assessed and discharged home. CMHT to follow up and assist in arranging respite care and review his mental state
June 2009	Call from a Contractor at a car park, Woking reporting that a male had jumped and landed on the mezzanine roof. Police and Ambulance attended. Unable to revive male identified as CC

The SCR panel found it significant that there were five incidents in six weeks in May-June 2009 when the Police responded to incidents around self-harm/suicide issues. On three of these occasions a Police Section 136 was applied. In any case there is a known high incidence of suicide in individuals with CC's diagnosis (10% suicide risk in those with paranoid schizophrenia). There was clearly a need for risk assessment and risk management within a longitudinal framework. This might have identified an escalation in risk of suicide.

5.4.4 Risk to CC from members of the Communities in which he lived

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CC reported 24 occasions when he was abused. A sample is given here:

Table 4

November 2001	Children and others have been calling him "paedophile" CC has reported this to police.
July 2004	Police attended a report that two males were kicking in CC's door. Two males were arrested
September 2004	Phone call from A&E. CC said two children called him names and he felt unsafe at home
November 2004	CC reported that he had been assaulted by another male (another Vulnerable Adult). He sustained pain and discomfort from being hit on the back of the head. Police attended and arrested CC's assailant. He claimed that CC owed him money and he had gone round to collect it
September 2005	CC mentions that teenagers have been throwing stones and asking him if he wanted to pay for sex. Told police wants to move out of area
December 2005	CC reported concerns about death threats from person from whom he had "borrowed" the van
December 2005	CC reported that he had received an abusive phone call. He thought that it may have been made by some school girls he had befriended and invited back to his flat to watch videos
February 2006	CC reported that his window had been smashed. Police attended and found that the incident had been witnessed by a neighbour who provided vague descriptions of the suspects
March 2006	CC rang the police to say his house had been trashed by friends he let in
March 2006	Interview with CC – wanted to hand in keys of his flat and relinquish tenancy. States is being bullied and burgled by 16-year-old
March 2006	CC called WBC to report that his flat had been damaged by youths and he is unable to live there as too scared to return
May 2007	CC reported that he was being harassed by someone by the name of who had caused him problems and made threats in the past. He felt angry and intimidated and does not know why he is being singled out

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September 2008	CC reported that he had been burgled twice in the last week. Police attended and saw CC. He complained that the lock to his door had been broken and his microwave oven had been stolen
December 2008	CC called the police to report that he had been burgled. Police attended and spoke to CC. His front door was damaged and the doorframe was split. CC could not state whether anything had been stolen. CC is noted as being lonely and unhappy

The SCR panel members noted that despite CC being a vulnerable adult and despite these episodes constituting abuse, on no occasion was the Safeguarding Adults procedure instigated. Agencies did not respond to the persistent nature of the harassment endured by CC by young people and adults.

6. Analysis and Lessons Learned: Issues and Themes Emerging from the Chronology and IMRs

6.1 CC's situation identifies a number of key areas of practice where lessons can be learned. The principal themes are:

- Risk assessment and risk management
- CC's accountability/responsibility for his actions
- The location of CC's care and support within mental health services
- Multi-agency cooperation and decision making
- Invoking safeguarding procedures
- Involvement with and focus on, the needs of CC's family

Points are illustrated by tables 5 & 6 identifying critical events/practice and the implications and challenges these raised for agencies and for CC.
In addition, section 6.6.2 captures perspectives (taken from records and IMRs) of individual agencies, which had a role in supporting CC.

6.2 There were positive elements of practice and evidence of good intentions to support CC. These included: the discretion of the police and probation to include CC in the RAMP/MAPPA meeting schedule; the police service's consistently proactive response to CC, particularly when he was threatening self harm in the last weeks of his life; particular professionals who undertook to engage with CC on a regular basis to assist with particular issues, e.g. a housing officer who undertook monthly monitoring visits to ensure that CC avoided Court action for non payment of rent; the probation officer who visited weekly in 2005-06 and instigated routine multi-agency monitoring ; and the decision to refer CC to the Assertive Outreach Team (AOT); Despite CC disengaging from mental health services, mental health professionals maintained contact with him and demonstrated a degree of tenacity in doing so. Woking Borough Council is taking action regarding the Car Park from which CC committed

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suicide as a preventive measure against further suicides. All of these measures did make, and will make, a tangible difference.

6.3 Risk assessment and risk management

6.3.1 Throughout the timeframe there are illustrations of risk assessment and risk management practices. Some of these examples are set out in Table 5:

Table 5

	Events	Practice Concerns/ Issue
February 2001	CC phoned for an ambulance at the Station because hearing voices and wanting to jump at a train	
March 2001	CPA meeting records that CC has remained stable in mood and spirits	CPA meeting not engaging with, or responding to, a significant suicide threat
June 2002	Probation breach report gives an assessment of a very high risk of re-offending	
January 2004	Police RAMP (Risk Assessment and Management Panel) meeting records "there was concern that CC had no concept of defined boundaries re women and drug misuse... It was felt therefore that he was a potential risk in the community"	
March 2004	Comprehensive clinical risk assessment by care coordinator SABP. Risk recorded as: risk of suicide: low; risk of self harm: low; risk of harm to others: medium; risk to children: low	Conspicuous absence of congruence across agencies as to assessment of level of risk
October 2005 to February 2006	There was one occasion on each of these five months when concern was	

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	expressed regarding CC letting children into his flat	
November 2005	Risk assessment by care coordinator refers to CC's risk to others in respect of allowing children into his flat. Response recorded is to "talk to CC to try to persuade CC not to allow children in his flat"	This appears naïve. CC is held responsible for modifying his behaviour when he has clearly indicated he does not understand the concerns of professionals
December 2005	CPA meeting cancelled	
January 2006	Professionals' network meeting does not refer to CC's risk to children.	Although the CPA of 27 October showed all professionals to be concerned about this issue there is no follow up
February 2006	Schoolboy in CC flat	Lack of consistent, timely and appropriate follow up on the events/ issues in respect of risk to children
May 2009	Call from CC sitting outside xxx Police Station stating that he was paranoid and was having suicidal thoughts. There was concern for the safety of CC. He was sectioned under S136 Mental Health Act and taken to the acute unit, northwest Surrey	
May 2009	SABP risk assessment. "all sections are rated as "0" or Low except for violence/aggression which is medium"	
On 2 occasions in May & June 2009	CC contacts police feeling suicidal at railway station. Police section 136	
June 2009	SABP risk assessment unchanged	Risk assessments disconnected from key events

6.3.2 There is a clear pattern of risk assessments and attempts to manage risks failing to engage with significant events in CC's life. Issues from one meeting or event were not re-visited and reviewed at the next meeting; there was neither consensus nor consistency regarding the

levels of risk identified and how these should be managed across the meetings convened by different agencies. There was an over reliance on CC to take responsibility for his own actions. There was a sense that staff compartmentalised incidents and looked at them in isolation rather than seeing the trend of escalation. There was a need for a longitudinal framework of risk assessment and risk management. There was also a tendency to look at risk in single dimensions, according to agencies own responsibilities, rather than considering the interaction of risk assessments and the risk management process over time.

6.4 CC accountability and responsibility for his actions

6.4.1 There were times in CC's life when he was given significant levels of responsibility (and accountability) by professionals. There were times too when CC was expected to make choices which appeared insensitive to his history and his circumstances. It does not appear that professionals considered CC's capacity for autonomy.

Table 6

Date	Event/Issue	Practice Issues/ Observations
Examples of CC displaying neither insight nor understanding regarding his offences		
January 2000	Inpatient Notes state "CC was found in bed with a female patient….CC said he thought her husband was dead so it was OK."	CC does not understand relationship boundaries
February 2000	"Arrested and charged with having sexual intercourse with a defective" "No remorse expressed for the offence"	Having sex with a woman with a learning disability suggests that CC was discerning in identifying vulnerable women His lack of insight into the level of deviance of his behaviour
CC being held responsible for managing his behaviour in relation to vulnerable adults and children		
November 2001	"CC to cease mixing with Children";	Giving CC responsibility to police his own associations with children and young

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		people appears unpromising given his inability to put boundaries in place
October 2005	CPA meeting at which concerns re children are raised with CC. "CC feels he is free to do what he likes and would not take on our concerns." However despite CC apparent lack of understanding of the issues the meeting notes record actions as: "Care co-ordinator to meet CC weekly until next CPA on 8 December to advise re risks of allowing children into his flat and meeting with vulnerable adults. CC to refrain from letting in children." CC in the notes is the responsible person for this action.	CC held responsible for modifying his behaviour and yet it is clear he does not understand the concerns of professionals There was a clear need for the giving of such accountability to CC to be associated with the assessed level of risk and with a clear mental capacity assessment in relation to the specific issues. There are clear examples of points where it might have reasonably been expected that a mental capacity assessment be triggered.
November 2005	SABP Risk Assessment. CC perceived as 'medium' risk of harm to others (i.e. vulnerable females and children). Action plan includes: "talk to CC and try to persuade CC not to allow children in his flat… and try to persuade CC not to mix with vulnerable clients"	CC was given responsibility for not mixing with children/vulnerable adults. There was no evidence that such a strategy or instructions had worked previously. There appeared little or no incentive for CC to comply. Reflecting on the consequences of behaviour appeared not to have been a primary governing factor in CC's life.
CC's "choice" re: independent living		

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May 2003	CC “wants to move to independent living”	It might have reasonably been expected that a mental capacity assessment be triggered.
September 2003	An Occupational Therapy report (SABP) sees sheltered/shared accommodation where support is available as the best option, but acknowledges that it is unlikely that CC will accept anything short of “complete independence”	Was CC capable of assessing and making decisions about where he was to live? Did he understand what those plans would involve? Professionals were themselves finding it difficult to assess and make decisions on this issue
November 2005	Case notes record: “CC would like to move into supported accommodation where he would have more company. However a few minutes later he said he prefers staying in his flat and he would try to attend…groups...”	How might professionals perceive and address such an apparent contradiction?
June 2006	CPA notes “CC has found new accommodation, he is happy there but feels he should be in shared accommodation”	Again a contradiction needs to be addressed

6.4.2 CC was unable to understand or to acknowledge personal boundaries. His own explanatory framework appeared to exclude consideration of the consequences of his actions for others. Set against this are the occasions when professionals appeared to believe that instructing CC not to let children into his flat and not to associate with vulnerable women would have the effect that he would stop doing so. CC’s history, and arguably his diagnoses, might have suggested otherwise i.e. that CC would be inattentive to mandates and instructions. Thus, the responses of services to considerable risk domains were seriously wanting. Much more assertive interventions were required.

6.4.3 CC’s “choice” to live independently was subject to fluctuations. The question arises as to how far CC understood the long-term implications of his decision. There needed to be greater professional support in

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exploring this more fully with him or supporting him to revisit the decision at intervals.

6.5 The location of CC's support within mental health services

6.5.1 The Community Mental Health Team (CMHT) managed CC for most of the period between January 2000 and his death in 2009. The Assertive Outreach Team (AOT) managed CC between 26 February 2004 and 18 August 2005.

6.5.2 The panel considered that the need for more intensive, focused and proactive input with CC, which is associated with the work of the Assertive Outreach Team (AOT) was evident. There should have been regular, clinical discussion regarding this option especially as, by his brother's account, CC was difficult for services to engage with in a consistent way. He was a "roamer" and would have been unlikely to co-operate with home visits.

6.5.3 The CPA was ineffective in identifying a downward spiral in CC's circumstances, which indicated that CC should have been referred back to the AOT (given that they would offer more intensive monitoring and support) and arguably, to forensic services.

Multi-agency collaboration/co-operation/decision making

6.6.1 CC's circumstances identify shortcomings in Multi-agency cooperation and decision making as key failings. There were processes led by individual agencies in which the other key agencies had involvement, but little indication of a shared commitment to manage and address key areas of risk highlighted in 5.4 in an integrated way.

6.6.2 Illustrations of Multiagency working issues in respect of Probation and the Police are given below as extracts from their respective IMRs

The Probation Service says in its IMR report of mental health professionals (in relation to the period of the probation order 2000 to 2002):

"their lack of appreciation of the interdependence of their treatment and care for CC with the authority and requirements of the court on which it was now based…Clear understanding could have been reached…about respective roles and responsibilities and contributions of each agency to the safe and effective management of CC. This should have included the relationship between treatment and the sanctions provided by the court…all these opportunities were missed and in most respects, the management of the Order appears never to have recovered."

The Police IMR also illustrates failings in relation to multi-agency working:

"In April 2004, following a CPA, CC was assessed to be a level 2 Potentially Dangerous Offender (PDO), a decision that was approved by the probation service…In principle, this was a good decision as even

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though CC's behaviour and offending had not met the criteria for automatic inclusion under this process it meant that at least there would be regular meetings where CC would be discussed particularly as he had already had a complaint of harassment…made against him by a female neighbour (Feb. 2004)"[2]

"There are no further minutes…for any further RAMP meetings until Nov 2005….it would appear... that CC had not been included on the meeting agenda when he should have been. So having gone through the process of registering CC as a PDO he was then over-looked and not considered again until Nov. 2005…

"The fact that CC was missed off the meeting agenda was due in the main to lack of ownership of the process by the various managers of the MAPPA procedures." The police acknowledge the period of transition from RAMP to MAPPA around 2004/5 and process and staff changes.

SABP in its IMR introduces points underlining the missed opportunities in multi-agency working in respect of CC:

"There was no clear audit trail of CC's status within MAPPA. It would be best practice where a user of the services is subject to MAPPA that this is clearly documented and the outcome of any relevant information is communicated to relevant services on a need to know basis. There is a current working arrangement where an operational lead links with the MAPPA process, which will improve communication and joint working."

"It is noted that on occasions some issues should have been raised with the police i.e. when there were accusations that CC was involved in the use and dealing of illicit drugs."

6.6.3 Key issues relating to multiagency working:

6.6.3.1 There is consensus that an established MAPPA process could have made a considerable difference in reducing the risks posed by CC. At the time the less developed MAPPA process was inadequate to the task. Despite the fact that the MAPPA process has now been refined, so that it would now always take into account diversity and issues of vulnerability such as risks to the individual from others and risk of suicide, significant questions still remain. For the MAPPA structure to be effective, it requires good practice both within and across agencies. That practice, in relation to a range of issues was found to be wanting.

6.6.3.2 The records in SABP lack clarity regarding CC's situation in respect of MAPPA. The crucial want of congruence between CPA and MAPPA risk assessments was not addressed. It is important that the MAPPA assessment, which is a vehicle for risk management is recorded and shared appropriately within Health. It is clear that as well as the more strategic links recommended by SABP via an operational lead it is necessary to consider how the CPA and MAPPA processes can more

[2] Surrey probation service had two distinct periods where it engaged with CC. CC was subject to a Probation Order with conditions (see 5.2) from 30.06.2000 to 09.07.2002 and then a Community Order under the supervision of the probation service from July 2005 to January 2006

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effectively communicate in individual circumstances and in day to day practice by formally linking these in one risk assessment.

6.6.3.3 The issue of CC being missed from RAMP/MAPPA agendas is indicative of an approach, which is process-led, rather than one governed by agencies assessing and monitoring risk and requesting meetings to address events and changes in levels of risk. It is difficult to fathom that none of the agencies involved noticed CC's absence from the agendas given the range of 12 events in the intervening period, which highlighted risks to his parents, to vulnerable women and to children. Even had CC been "on the agenda" it is not clear how agencies would have responded to these incidents.

6.6.3.4 There are clear issues about formal routes for agencies holding each other to account when things are not happening, as they should. A broad strategic approach relating to challenge needs to go hand in hand with a climate in which mutual challenge in the course of day to day practice is also embraced as a positive contribution to improving practice. In respect of CC it is clear that the processes for challenge were not being used. This issue around the need for mutual challenge within the safeguarding partnership is also underlined in the SCR into the death of Baby Peter*.

6.6.3.5 In the last few weeks of CC's life there were clear indications that he might take his own life, the Police were repeatedly reporting these issues and taking action. How could they escalate their concerns about CC given that NHS responses were proving ineffective in impacting upon the level of risk? Risk assessment and risk management processes agreed across agencies might facilitate such a challenge.

6.6.3.6 The effectiveness of the police form (formerly form 39/24) known as a "vulnerable adult coming to notice form"[3] relies on circulating it to other agencies. Arguably it should not simply replace valuable face to face or telephone contact between the police and other agencies. This needs to be addressed.

6.6.3.7 CC's circumstances have confirmed that the volume of police "vulnerable adult coming to notice" forms coming into the SABP service, their prioritisation and communication about them within, as well as outside the organisation, require attention. A clear system for triaging these is essential. A recent review has resulted in some improvement measures this needs to be sustained and built upon.

6.6.3.8 SABP staff should always consider the possibility of reporting to the police circumstances, which constitute criminal activities involving service users. This must be considered against a framework of risk assessment (risk to self and others) and in line with the Data Protection Act 1998, which refers to the sharing of information being permissible in the "vital interests of the data subject" or "in the public interest".

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[3] *39/24 is a police referral form alerting agencies that a vulnerable adult has come to police notice. This is now known as a "vulnerable adult coming to police notice" form. Formerly known as a form 39/24

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6.6.4. Multi-agency working issues in relation to Housing

There was considerable concern amongst members of the SCR Panel that an individual could potentially have a serious mental health and forensic history and pose a threat to the Community but that Housing might know little or nothing about this. When an individual applies to Housing for accommodation in order to secure a tenancy, it is up to that individual to self declare information regarding their mental health. There is little evidence in housing records that the extent of CC's support needs were known.

Housing received CC's CPA notes in September 2004 but there is no record regarding their role or any actions in relation to this. This is an example of minimalist multi-agency "involvement," but not of services engaging with each other's information and acting collaboratively to address areas of risk / concern. Housing would not in general attend a CPA meeting unless invited to do so. Mental Health professionals must invite key players such as Housing to CPA meetings.

6.7 Safeguarding Adults from Abuse

6.7.1 Following three incidents of abuse towards vulnerable women in an inpatient unit there were 27 occasions identified when CC presented a risk of abuse to other adults (5.4 Table 1). On only one occasion were the Safeguarding Adults procedures invoked (in respect of concerns about the possible abuse of CC's mother). There were also eight occasions when there were safeguarding concerns in respect of children.

6.7.2 There were 24 occasions when members of the communities in which he lived potentially abused CC. Nowhere is this acknowledged as the possible abuse of a vulnerable adult. The escalation of abuse endured by CC between December 2005 and March 2006 caused such distress to CC that he wanted to (and indeed did) give up his tenancy.

6.7.3 The safeguarding process needs to give confidence that it will add value to the assessment of risk if agencies refer into the procedures.

When a referral was made into adult social care safeguarding procedures in respect of CC's mother there is evidence in the minutes of the assessment of risk and the adult protection plan failing to include/address all areas of risk. Some important issues are not acted upon and the safeguarding process is arguably concluded prematurely pending any further issues arising (based on the fact that CC's mother said that she did not want anything done on the issues identified). For example the minutes of the case conference on 24th September 2007 refer to a withdrawal of money from CC's mother's bank account. The possibility of financial abuse is not listed in the safeguarding adults plan of that meeting. Risk from CC to other vulnerable adults is noted in minutes but not followed up. At its best the safeguarding procedures can add real value to a holistic consideration of all of the risks to all of the vulnerable adults involved. In this case the safeguarding meetings, despite preliminary information being available, did not seek out further

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information, which would have identified the range of safeguarding incidents in which CC played a part.

6.7.4 The SABP acknowledged that its work should have been consistent with the Surrey Multi agency Safeguarding Adults procedures. Although notifications were received "**there is limited evidence that they were considered under the safeguarding process...Furthermore CC's own vulnerabilities do not appear to have been focused on through this process…Safeguarding issues were raised at various times throughout the time that CC engaged in psychiatric services, but there has been a lack of ownership by the teams involved in ensuring that these issues were followed up."** SABP adds that it has now invested training and time and a dedicated post to explore safeguarding and assist in adhering to responsibilities. An important aspect in SABP's efforts to address the safeguarding issues raised by CC's situation will be to address the erroneous assumption that as the protection of adults is built into the CPA process safeguarding is unnecessary. This is an assumption, which is widespread in mental health settings and not confined to SABP.

6.7.5 The police considered in their IMR where their responsibilities lay under Surrey Safeguarding Adults Multi agency Procedures. They set out the core business of the police Vulnerable Adults Unit in respect of abuse of vulnerable adults as to:

"Investigate allegations of abuse of vulnerable people committed by persons caring for a VA or in a position of trust/responsibility in relation to a VA. CC did not fall into the criteria."

6.7.6 The probation service does not refer at all to safeguarding in their scrutiny of CC's circumstances.

6.7.7 There is a range of issues relating to safeguarding illustrated by responses to CC. These need to be addressed:

- There were many occasions when safeguarding procedures should have been triggered. This needs to be addressed by making clear links with other processes such as MAPPA and the CPA. Perhaps prompts in those processes to consider a safeguarding framework, as an option would assist.
- Nearly all agencies (bar probation) state that they have policies and procedures and training in place regarding safeguarding vulnerable adults. Given that so many incidents in CC's life were not referred into safeguarding, measures must be put in place to ensure that the learning from training is transferred into practice and further, that this is audited across agencies. The Safeguarding Board should ensure that policies across agencies are up to date and robust.
- None of the agencies, under the safeguarding adults procedures, addressed the fact that CC was being harassed and targeted by people in his community. The kind of harassment and abuse CC experienced is widely documented in the safeguarding adults literature and experience elsewhere indicates that it requires urgent

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attention. (see for example Serious Case Review reports relating to: Steven Hoskin; Fiona Pilkington*). In Surrey, as in other local authority areas, It will be necessary to ensure that definitions of vulnerability and abuse within safeguarding policies incorporate individuals subject to significant harassment. There is growing evidence that in a range of such circumstances the police and other agencies have hesitated to get involved. A hate crime cross-government action plan* was published in 2009 to begin to address these issues.

- The Panel questioned whether or not safeguarding might be “outgunned” with someone as dangerous as CC i.e. is there a hierarchy of intervention enabling MAPPA to deal with dangerous offenders and safeguarding to deal with those who do not meet the MAPPA criteria? This should not be the case. Safeguarding is a broad “umbrella” and must involve itself with dangerous offenders who are also vulnerable. This prevents a system where the more dangerous an individual is the less integrated becomes the response. Integration means meeting together as agencies and marrying interventions in all facets of risk management and monitoring. Safeguarding as a process is capable of achieving this.
- The safeguarding meetings regarding CC’s mother were a missed opportunity insofar as they should have identified mother *and son* as vulnerable adults as well as other vulnerable adults and children to whom CC presented a risk. Safeguarding procedures should have been triggered in respect of these.
- There needs to be an understanding across all agencies that the Local Authority has the lead coordinating role in safeguarding so that all safeguarding concerns should be reported to adult social care. This needs to happen alongside for example an alert to the police of a criminal offence.

6.8 Focus on CC’s family: their needs and the information they held

Insights into CC’s world were available from family members but the potential for engaging with this was largely untapped.

6.8.1 In a letter to the Housing Department after CC died and in an interview with members of the SCR Panel CC’s brother observed that for CC, having his own place was not ideal. He needed care and attention and people around him all the time. The practical tasks were difficult but the situation he found himself in regarding other people was the bigger issue. CC associated with people who took advantage of him and an example was given of when CC’s door was broken down and intruders had written graffiti in his home.

6.8.2 CC’s father attended most CPA meetings and on numerous occasions reported concerns for CC or for others in-between formal meetings. There is little in the notes or in CPA records to indicate any significant and sustained follow up on the information and concerns expressed by CC’s father

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6.8.3 SCR panel meetings drew attention to the clear knowledge of stresses within the family, which should have been brought more thoroughly into the assessments and risk management plans. There was no real impression of a real understanding of CC's father's place in his life: the dependency that existed and the effect his dying would have on CC.

7 Conclusions

7.1 CC was vulnerable and he posed a significant risk to others. As highlighted in 5.4 there were: 27 incidents where he posed a direct risk to other adults; 8 incidents where he was a potential risk to children; 24 instances where he was vulnerable at the hands of others and there were 17 occasions of repetitive, deliberate self harm and suicidal intentions. He moved out of a care home to his own tenancy, a move that should have been subject to a clear risk assessment with a clear risk management plan. It should have triggered too a mental capacity assessment in respect of CC's ability to make this specific decision.

7.2 At no point was a holistic risk management plan formulated where all agencies had an understanding of, and took responsibility for, all aspects of the risks. Even single agency attempts at risk assessment and risk management fell short in serving CC, his family and the women and young people with whom he associated. The Safeguarding Adults procedures were considered as a framework for addressing the risks only once during the ten-year period analysed. There was as little awareness of the need to refer into the safeguarding children process as to that for safeguarding adults.

7.3 There is consensus that an established MAPPA process could have made a considerable difference in reducing the risks posed by CC. At the time the less developed MAPPA process was inadequate to the task. The MAPPA system as it is now would mean that now a lead agency would be required to be identified and that lead agency would be responsible for coordinating risk assessment and risk management. The question would remain however as to how the management of risk of self-harm/suicide and the risk to CC from members of the community would have been achieved. Despite the fact that the MAPPA process has now been refined, so that it would now always take into account diversity and issues of vulnerability such as risks to the individual from others and risk of suicide, significant questions still remain. For the MAPPA structure to be effective, it requires good practice both within and across agencies. That practice, in relation to a range of issues was found to be wanting. These issues include: single agency risk assessments carried out in isolation; lack of timely and appropriate sharing of risk assessments and information; lack of response to significant events and their likely impact on risk assessment and risk management; responses to CC and his family. These aspects of practice must work well for MAPPA to be effective.

7.4 Perhaps services became over familiar with CC and the frequency of contact and the level of familiarity eroded their alertness to his needs and

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to the significance of events in his life. This is alluded to in the SABP Serious Untoward Incident report: "…over familiarity with a service user's needs may cause practitioners to overlook the deeper issues". This begs the question as to whether, in such chronic situations where the recorded level of risk over an extended period does not change, an independent review should be triggered with a fresh analysis of the risk. Supervision also has a crucial part to play in the oversight of such complex people.

7.5 There was no evidence of professionals accepting that if CC were under pressure in one domain, this may impact upon others e.g. as the cumulative picture of CC's harassment and abuse by people in his community gathered pace, what were the potential impacts on his risk to others or his risk of self-harm? Likewise, if there was a risk of losing his tenancy, the likely impact deserved consideration.

7.6 CC's responses to the offences he committed in 2000 gave a clear picture that he had neither insight into the consequences of his behaviour nor any understanding of boundaries. He did not believe that his behaviour was wrong. Despite this, professionals often expected CC to take full responsibility for his actions, which was implausible.

7.7 CC was a "roamer" and given to disengaging from services. Taking into account his biography and diagnoses it is remarkable that a CMHT was supporting CC when the need for a more assertive approach was so amply demonstrated. Further referrals into the Assertive Outreach Team were clearly necessary. If there had been a clear referral route into the AOT this may have altered the outcome.

7.8 There were a number of precursors and warnings leading up to CC taking his own life. In addition there is a known high incidence of suicide in individuals with CC's diagnosis (10% suicide risk in those with paranoid schizophrenia). There was clearly a need for risk assessment and risk management within a longitudinal framework. This might have identified an escalation in risk of suicide. The SABP CPA Risk Assessment and Risk Management Procedure (June 2007)* makes it clear that *" longitudinal issues i.e. past events that increase the likelihood of risks" should be brought into the assessment."*

7.9 There were clear issues relating to policies and protocols. These included: lack of adequate policies to safeguard patients in SABP inpatient units; inattention to existing risk assessment and risk management policies; inadequate risk policies and protocols; inattention to safeguarding policies and protocols; inconsistency in safeguarding policy across agencies. Attention to these policy issues and the underpinning training is pivotal in learning the lessons from CCs situation.

7.10 That there was no real harnessing of the contributions and insights of CC's father and brother was an important factor. His father's

contributions in and around CPA meetings and critically, his brother's insight that although practical tasks were difficult for CC, of far greater

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significance was “the situation he found himself in regarding other people”.

7.11 All agencies to whom CC was known are committed to addressing shortcomings in practice and at a strategic level both individually and collectively.

8 Recommendations

An asterisk (*) alongside six of the following recommendations indicates that similar or related recommendations have been made regarding two further Serious Case Reviews in Surrey (see Appendix 2), which are just being completed.

8.1 Risk assessment

Risk assessment is at the heart of services’ failings in CC’s circumstances. CC’s support has confirmed the dangers inherent in relying on an array of risk assessments and risk management plans, which are neither mutually informative nor compatible. Further, inattention to revising risk assessments in the light of new information/events and CC’s changing behaviour and circumstances was a significant flaw. There was a specific failure in this respect to trigger referral of CC into the AOT. There is a need to ensure that risk policies are in place to address these issues; that these are underpinned by learning and that the learning is audited and evidenced.

Recommendation 1

(*)8.1.1 In situations where health, social care, housing and criminal justice personnel are involved there must be a single comprehensive and holistic risk assessment including attention to longitudinal risk issues which is subject to timetabled multi-agency review according to the level of risk with a lead professional /key worker responsible for co-ordination

Recommendation 2

(*)8.1.2 Agencies should review their risk assessment and risk management policies and processes and include the requirement for holistic and longitudinal assessment in the light of lessons arising from this SCR.

Including reference to recommendation 1 (above) and including a link to this SCR in respect of CC. Policies and processes must prompt professionals to include service users, their families and informal networks in assessing and managing the risks.

Recommendation 3

8.1.3 Implementing and revising multiagency training in risk assessment and risk management.

Learning needs to focus on real and live cases including the case of CC

Recommendation 4

8.1.4 Renewing approaches to supervision with a focus on current cases to facilitate the effective assessment and management of risk and to ensure learning from training is transferred into practice

Recommendation 5

8.1.5 Undertake regular case audits as pivotal in ensuring learning is transferred into practice.

8.2 Safeguarding

Most agencies in Surrey have policies and procedures and training regarding safeguarding adults. Despite this agencies were unclear about when to invoke these. Similarly, there were failures in terms of children's safeguarding. The Adults' and Children's Safeguarding Boards should ensure that procedures and training of lead agencies and sectors reflect CC's experience of flawed multi-agency working.

Recommendation 6

8.2.1 Updates to the Safeguarding Adults Surrey Multiagency Procedures (2008) should reference harassment and hate crime.

Recommendation 7

(*)8.2.2 All agencies must put measures in place to ensure that the content of the safeguarding policy and procedures and training in safeguarding is being transferred into practice. This to include: supervision requirements; case audit; regular learning in the workplace based on real cases (just as in respect of risk work as in recommendation 3&4).

Recommendation 8

8.2.3 The Surrey Safeguarding Adults Board to ensure governance of recommendation 7 through the training strategy group.

Recommendation 9

8.2.4 Surrey and Borders Partnership NHS Foundation Trust must provide assurance that the protection of vulnerable adults from abuse is clearly built into the CPA process. If not it must take immediate steps to provide assurance that this is underway. This needs to be part of a broader action to address the assumption that as the protection of adults is built into the CPA process safeguarding is unnecessary. This is an erroneous assumption, which is widespread in mental health settings and not confined to SABP.

Recommendation 10

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(*)8.2.5 The Surrey Safeguarding Adults Board works with the Safeguarding Children Board and MAPPA Board on the need to share responsibility and learning in terms of engendering a holistic and inclusive approach to safeguarding.

Recommendation 11

(*)8.2.6 An acknowledgment of and real engagement in safeguarding must be achieved across agencies especially in respect of sectors with diverse membership such as housing and independent sector providers. The Board should review its Terms or Reference and requirements of member agencies.

8.3 Empowering service users and their families and informal networks

CC was given significant responsibility in terms of making choices and modifying his behaviour.

Although CC's father and brother had valuable insights into CC's world there was no sustained follow-up on the concerns expressed by his father or any proactive attempt to gather information from his brother.

Recommendation 12

8.3.1 A mental capacity assessment and risk assessment should inform judgements regarding a service user's ability to assume responsibility for decision-making with the potential to impact on the lives of others. The necessary level of support and direction must be offered in accordance with these assessments and in the process of the assessments. This recommendation applies to all agencies and must be underpinned by relevant training

Recommendation 13

(*)8.3.2 The insights and information available from families and informal networks must be central to care planning processes and risk assessment and risk management processes. The offers of Carers' assessments even when these are declined, should be accompanied with respect for their expertise. It is vital to embed their unique understanding of their relative, as well as their concerns, in practice and in particular in risk assessment, risk management and care planning processes.

8.4 Actions

Recommendation 14

8.4.1 Mutual challenge amongst partners on the Safeguarding Adults Board

This SCR highlights occasions when agencies experienced unease about a partner agency's decision-making or assessment. This manifested as an array of assessments and decisions, which did not merit the description of "multiagency". This is an important feature in the analysis of what went wrong. Had agencies confronted their unease this

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may have had a positive impact. Effective multiagency risk assessment is at its best a transparent process making explicit the decision making processes professionals have relied on and exposing conflict and hidden agendas. This challenge needs to take place at a strategic level as well as in the development of a culture where mutual challenge at practice level is embraced as positive.

Recommendation 15

8.4.2 **The Safeguarding Adults' Board; MAPPA Board and Safeguarding Children's Boards should model the respectful challenge expected of professionals engaged in difficult and complex casework. The process of holding each other to account is not just about seeking clarity, it is important to take action to ensure that problems do not grow in magnitude and urgency.** Action should include that opportunities for challenge must be a regular explicit feature on agendas of strategic Board meetings and in CPA and safeguarding meetings.

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