LONDON BOROUGH OF CAMDEN SAFEGUARDING ADULTS PARTNERSHIP BOARD

SAFEGUARDING ADULT REVIEW MARK

2022

Review Report by Patrick Hopkinson

Contents

Mark SAR Camden

Executive Summary

This Safeguarding Adults Review (SAR) was commissioned by Camden Safeguarding Adults Partnership Board (CSAPB) in June 2020 following a referral by Camden Police, after they had been called to a block of flats to find Mark deceased.

Mark was 24 years old when he was found dead by his uncle in the stairway of the flats in which he lived on 7th May 2020. Mark had stabbed himself in the throat with a pair of scissors.

Little is known about Mark's interests, ambitions and his likes and dislikes. Contact with his family was attempted during the process of this review but was unsuccessful and professional records focused on their work with him and the difficulties he faced.

Mark had a history of contact with the police and a childhood of physical and sexual abuse and neglect. These highly traumatic childhood experiences continued to affect Mark, who self-harmed, experienced violence as a young adult from gangs, peers and his family and used drugs. Mark had been in intermittent contact with children's service since he was 8 years old and remained in intermittent contact with general practice and mental health services for the rest of his life. During the last three months of his life, Mark does not appear to have been in contact with any services or agencies.

The agencies involved with Mark were:

Camden Police
Camden and Islington NHS Foundation Trust Personality Disorder Service and the Complex Depression, Anxiety and Trauma Team.
Ampthill GP Practice
Tavistock and Portman Foundation Trust/ The Hive/ Catch 22
Camden Council Adult Social Services and the Integrated Youth Support Service.

This SAR used a hybrid methodology. Agencies submitted chronologies of their contacts with Mark and a practitioner learning event was held to gain insight into the experiences of the practitioners who worked with Mark or made decisions about him. Legal, academic and practice research and guidance were analysed to develop an analytical framework within which the practice of the agencies involved with Mark could be understood. This framework included:

- Links between childhood sexual and physical abuse and trauma and the experience in adulthood of mental health problems, excessive use of drugs and/ or alcohol, self-neglect and chaotic and abusive personal relationships.

- Links between a history of trauma and struggling to engage with services.

- Research on depression, suicide and younger people; emotionally unstable personality disorder and suicide; and the guidance published by the Royal College of Psychiatrists on self-harm and suicide in adults.

- Decisional and executive mental capacity and the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) and on mental capacity.

- The Mental Capacity Act and section 42 of the Care Act 2014.

The main **findings** are summarised below and can be found in full in the analysis and final sections of the report.

Despite Mark coming to the attention of the police and being referred through Camden's Multi-Agency Safeguarding Hub (MASH), no safeguarding concerns were raised, and no safeguarding enquiries or interventions were made. Instead, since Mark was known to be in contact with mental health services, the MASH passed on any concerns raised about him directly to mental health services and did not screen them. This approach is frequently used to manage demand but may inadvertently mean that opportunities for using adult safeguarding approaches are missed. These approaches can include identifying the need to review how cases are progressing or to spot escalating patterns and to coordinate multi-agency interventions.

The risk of Mark's suicide was not fully understood. Assessments did not fully capture the risk that Mark might kill himself. Nor did they, or any risk management plans, consider Mark's background, history of self-harm and emotional instability as suicide risks. Further consideration of these factors might have influenced the outcome of the risk assessments so that they went beyond an assessment of Mark's immediate presentation. Risk management plans would have required more frequent contact with Mark than took place and would not have been effective if services had been struggling to engage with Mark. Some form of more assertive intervention was needed but there were no events which might have precipitated this.

The other option would have been to formulate the risk management plans with Mark's family or friends but services have little involvement with them. There may have been a reticence by professionals to work with Mark's family because of concerns about confidentiality and Mark's lack of consent for his family to be contacted. The "Information sharing and suicide prevention consensus statement" (Department of Health (DoH), 2014) sets out the circumstances in which concerns about suicide can and should be shared even in situations where permission to do so has not been given by the person at risk.

There was little inter-agency coordination and opportunities for joint working were not always taken. Agencies closed cases due to Mark's non-engagement. This is a regular feature in other SARs, to the extent that case closure due to non-engagement could be considered to be a risk indicator in itself.

There does not appear to have been consideration of a single agency taking the lead on assessing and managing Mark. There is a need to help people like Mark to develop trust in services.

Mark's last two GP appointments were with locum doctors. If Mark had met one GP more regularly, with whom he had developed a feeling of trust, this might have enabled him to talk more openly about how he was feeling.

There is an opportunity to build on the joint work already taking place in Camden on transitional safeguarding.

The **recommendations** from this SAR are summarised below and can be found in full in the final section of this report.

- Seek assurance that safeguarding processes are used as a means for identifying the need to review how cases are progressing, to spot escalating patterns and to coordinate multi-agency interventions.

- Agree a multi-agency risk management and escalation process for people who disengage from services and are assessed to be at risk.

- Identify how GP appointments for people who are hard to engage, and are considered to be at risk, can be made more consistently with a specific GP.

- Commission training to understand trauma and its impact and on how to work with people who are hard to engage.

- Promote the Royal College of Psychiatrists' report Self-Harm and Suicide in Adults, and the DoH's "Information sharing and suicide prevention consensus statement".

- Continue the work on creating Core Teams and include suicide risk identification and prevention; working with people transitioning to adulthood and voluntary and community organisations with the Core Team approach

- Audit of the use of multi-agency information sharing protocols to determine whether they promote effective joint working, cooperation, sharing information and prevention when working with people at risk of suicide and to the extent to which they include voluntary and community organisations and families.

- Review and revise the mental health service processes so that the need for safeguarding enquiries in addition to mental health interventions is recognised.

- Audit risk assessment and management processes for suicide across all agencies, including the creation and oversight of suicide Safety Plans.

- Consider the development of a Suicide Prevention Strategy in Camden with partnership with the Camden Public Health service.

SAFEGUARDING ADULT REVIEW – MARK

1. INTRODUCTION

1.1 Mark was 24 years old when he was found dead by his uncle in the stairway of the flats in which he lived on 7th May 2020. Mark had stabbed himself in the throat with a pair of scissors.

1.2 Little is known about Mark's interests, ambitions and his likes and dislikes. Contact with his family was attempted during the process of this review but was unsuccessful and professional records focused on their work with him and the difficulties he faced.

1.3 Mark had a history of contact with the police and a childhood of physical and sexual abuse and neglect. These highly traumatic childhood experiences continued to affect Mark who self-harmed, experienced violence as a young adult from gangs, peers and his family and used drugs. Mark had been in intermittent contact with children's service since he was 8 years old and remained in intermittent contact with general practice and mental health services for the rest of his life. During the last three months of his life, Mark does not appear to have been in contact with any services or agencies.

2. SAFEGUARDING ADULT REVIEWS

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Camden Safeguarding Adults Partnership Board (CSAPB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Camden Safeguarding Adults Partnership Board the power to commission a SAR into any other case:

'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) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

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).

…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.

2.2 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-final-.pdf

2.3 SARs are about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4 This case was referred to the CSAPB on 18/06/2020 for their consideration of a Safeguarding Adult Review by Camden Police.

2.5 The CSAPB delegates these decisions to the Safeguarding Adults Review subgroup who assessed the case on the 24/06/2020, where it was decided that the criteria under s44 of the Care Act had been met and that the care and support received by Mark prior to his death should be reviewed.

2.6 All CSAPB members and organisations involved in this SAR, and all SAR subgroup panel members, agreed to work to these aims and underpinning principles. The following team and organisations contributed to the SAR:

2.7 Complex Depression, Anxiety and Trauma (CDAT) team – Camden and Islington NHS Trust

2.8 Personality Disorder Service -Camden & Islington NHS Foundation Trust

2.9 Catch 22/ Tavistock and Portman Foundation Trust

2.10 Mark's GP Practice

2.11 Integrated Youth Support Service – Camden Council

2.12 Adult Social Services – Camden Council

2.13 Metropolitan Police

2.14 A SAR panel was formed of representatives from these organisations and teams and agreed terms of reference to guide the review. The terms of reference focused the review on:

2.15 The practitioner and intra-and inter-organisational understanding of, and systems for assessing and monitoring, suicide and self-harm risk in Mark's case and more generally in young adults with mental health needs and /or who have been children in need.

2.16 Information sharing and communication and any barriers to these.

2.17 Practitioner understanding of Inter-agency working, including eligibility, function, powers and any barriers.

2.18 Practitioner awareness, interpretation and understanding of relevant legislation and how to implement this in practice.

2.19 Practitioner awareness, interpretation and understanding of multi-agency risk management forums and processes and any barriers to access.

2.20 SAR Panel members provided chronologies and reflective Individual Management Reviews of their involvement with Mark and answered specific questions and provided additional information as required. A chronology was also provided by Camden Housing Services.

2.21 A Multi-Agency Practitioner Learning Event was held, attended by staff who had worked directly with Mark or had led decision making about him, to assist in understanding the approaches taken and the challenges faced by practitioners.

2.22 The Safeguarding Adults Review was led by Patrick Hopkinson who is an Independent Consultant in Adult Safeguarding and who had no previous involvement with this case and no connection with the agencies that worked with Mark.

2.23 Contact with family

2.24 The CSAPB and the review writer tried to contact Mark's aunt and uncle by telephone and by letter to involve them in this review but received no reply. It was discovered that Mark's aunt had died before this review began. Continued attempts to contact Mark's uncle received no reply. Consequently, little is known about Mark apart from the information contained about him in the records of his contact with services and obtained from practitioners during the Multi-Agency Practitioner Learning Event.

2.25 Parallel Review Processes

2.26 A Coroner's Inquest following the death of Mark was concluded on 29th September 2020. The medical cause of Mark's death recorded as an incised stab wound to the neck. HM Coroner made a determination that Mark had died by suicide from a self-inflicted cut to the neck with a pair of scissors.

3 BRIEF SUMMARY OF CHRONLOGY AND CONCERNS

3.1 Mark's early life

3.2 Mark had been in contact with services for the majority of his life, a life which was defined by trauma, abuse and dysfunctional personal relationships. Later, Mark would disclose to the Clinical Team Lead at the HIVE/ Catch-22, "*the trauma of a rape he suffered as a child, calling for his mum to help him, but she was too high on drugs to intervene. He reported being consumed with shame and rage and ruminated on exacting his revenge on one of the perpetrators of his sexual abuse. He witnessed and experienced ongoing violence as a child. He continued to experience violence as a young adult from gangs, peers and family, he disclosed being kidnapped by gang members and tortured in a warehouse with an iron*".

3.3 Before the age of 18 years old, Mark had been in contact with children's services. Between the ages of 8 and 12 years old, Mark attended the Junior Youth Inclusion Project (JYIP). The aim of this project was to prevent the most at-risk children from entering the criminal justice system and to provide a safe place with positive activities. Mark's attendance at the JYIP was intermittent, however. Mark had to move for his and his family's safety, to protect them from his father when he was released from prison. Mark's brother was also in prison and at the age of 8 years old, Mark had said that he feared that he would go to prison too.

3.4 After this, Mark was in contact with the FWD Drug and Alcohol Services for Young People in Camden (also known as Forward Young Persons Substance Misuse Team) which is a multi-agency team offering advice and support services including medical and mental health assessment to young people whose lives are affected by the use or misuse of drugs or alcohol.

3.5 Mark was supported by the FWD in January 2013 when he was 17 years old. Mark attended seven sessions with the case worker at FWD and one workshop but was discharged from the service on 28th April 2014 due to lack of engagement with the service and because he had moved back to his mother's house (which was in a different London borough. There is no evidence that a referral was made on Mark's behalf to a similar service in this London Borough).

3.6 From the age of 18 years old, Mark was in contact with several teams. These were:

3.7 Catch 22's The Hive is a free mental health and wellbeing service that supports young people aged 16 to 24 in Camden. It is based at Camden and supports young people with mental health needs, personal development, health and wellbeing, sexual health, employment and education, substance misuse and

accessing other services if appropriate. The Hive offers one-to-one work, a social hub and a sexual health clinic.

3.8 The Camden and Islington Personality Disorder Service (PDS) (Camden and Islington NHS Foundation Trust) provides a service to people who have significant difficulties in their daily lives, regulation of their emotions and maintenance of personal relationships. It aims to support people to build a picture of a life they want to live, a plan of how they can move towards this, and an awareness of the barriers that may get in the way. People who use the service must have an established diagnosis of personality disorder or meet the diagnostic criteria for a personality disorder.

3.9 The Complex Depression, Anxiety and Trauma Service (CDAT) (Camden and Islington NHS Foundation Trust) works with people with complex needs. The CDAT carries out assessments and develops individual treatment plans. Treatment may involve individual or group therapy sessions. The CDAT also offers information and advice about mental health needs and medication and support to help access employment and education.

3.10 The South Camden Crisis Resolution Team (SCCRT) (part of Camden and Islington NHS Foundation Trust) provides a rapid assessment of mental health and if necessary, the home treatment team provides an alternative to acute hospital admission.

3.11 Team Around the Practice is part of Mental Health Camden and is aimed at people with mental health needs who are not receiving support in secondary care services. Team Around the Practice offers psychotherapy sessions and link-working to community resources. Referrals to the service are made by GPs.

3.12 In January 2015, when Mark was 19 years old, he was referred to the CDAT (Complex Depression, Anxiety and Trauma Service) by the Mental Health Liaison Team (a specialist mental health team which assesses and treats people with mental health needs in general hospitals) at University College London Hospital following an incident of self-harm.

3.13 On 4th March 2015 a parenting worker (organisation not specified) contacted a transitions psychologist member of the CDAT about regular text messages they had received from Mark about his level of distress. These specifically concerned how Mark's distress related to his feelings about his family. Mark's mother had reported that Mark had spoken about thoughts of suicide and about his fear that he might seriously hurt her mother and his father because he was feeling very angry with them. Mark's mother was also worried about Mark's potential risk to other people.

3.14 Mark remained open to the CDAT until April 2015 during which time there were discussions about the best way to meet his needs and of the services which would be most suitable for him. Mark's engagement with the CDAT had been intermittent.

3.15 The CDAT referred Mark to the South Camden Crisis Team (SCCRT) on 4th March 2015. Mark was assessed, appeared ambivalent about the team's input and was discharged on 13th March 2015 due to non-engagement and safety concerns following his response to unannounced visits from SCCRT members. Mark was discharged from CDAT to his GP on 9th April 2015.

3.16 On 3rd June 2015 Mark contacted Camden Housing Services to say that he had left the hostel he has been staying in due to his mental health problems and was now staying with friends. On 19th June 2015, Mark contacted Camden Housing Services to say that he has been stabbed in the legs two or three days ago in a gang related incident and was staying with his aunt and uncle. Mark was asked to provide supporting documentation.

3.17 Mark renewed contact with the FWD case worker in July 2015, and shortly afterwards FWD received a referral from Mark's GP.

3.18 On 21st August 2015, Mark contacted Camden Housing Services again to say that he had been kidnapped a few days previously after attending a squat rave near the o2 arena. He had not reported this to the police and had escaped. Mark said that he would kill himself if he did not get help and if he stayed in Camden he would be killed. Mark denied being involved in a gang. Mark was offered assistance with housing but said that he would make his own arrangements outside Camden and was advised that since he was fleeing violence he could contact the local authority in the area he had gone to.

3.19 On 16th September Mark contacted Camden Housing Services and was told that since he could not stay in Camden, the Camden housing pathways were not suitable for him. Mark did not respond to efforts to contact him after this.

3.20 Mark did not attend either of the two FWD appointments arranged for him, on 14th August 2015 and on 2nd October 2015. Mark said that he did not want to engage because he had not received support with obtaining housing. FWD consequently discharged Mark on 2nd October 2015.

3.21 Mark contacted the police on 6th November 2015, stating that he wanted to harm himself, had a knife and was going to stab people (Mark subsequently denied this). The police took Mark to UCHL. Mark said that he did not want to kill himself (and would have chosen more lethal means if he had intended to do so) but was unhappy with his life because he had no job, no family and nowhere to live. Mark was to be admitted with self-inflicted lacerations on his arm but discharged himself. UCHL fed back the need to reassess Mark to his GP.

3.22 On 14th December 2015, CDAT reviewed Mark's notes which suggested a likely diagnosis of Emotionally Unstable Personality Disorder with a history of repeated self-harm. Consequently, CDAT referred Mark to the Personality Disorder Service (PDS), which accepted Mark for an assessment and placed him on its waiting list on 7th January 2016. 20th May 2016 Mark was invited to an appointment by letter on 10th June 2016. The PDS is not a crisis service and its functions do not include the management of self-harm. Mark was

offered an appointment because of his vulnerability and the complexity of his needs. This would appear to be a very long time to wait for therapeutic input especially for someone who self-harmed.

3.23 On 22nd January 2016, the police attended UCHL since Mark had said that he was suicidal and was threatening people. Mark said that he had mental health problems and wanted to be sectioned.

3.24 The PDS discharged Mark on 27th June 2016 without having seen him since he had missed two previous appointments. The discharge letter to the GP advised that Mark be referred to the Hive and a similar letter to Mark encouraged him to approach the Hive directly. Mark's GP then referred Mark to the Hive.

3.25 On 24th February 2017, Mark was referral again to the PDS following contact from a counselling psychologist in the Team Around the Practice (TAP).

3.26 On 17th March 2017, the TAP referred Mark again to the PDS, describing a, "*Picture of impulsive behaviour, emotional instability, active self-harm/ suicidal thoughts, very strained relationships within family from an early age. It was noted that Mark had been able to engage with assessment process at TAP as surgery was close by to where he lived, and it felt safer not having to go too far*".

3.27 The Hive became involved with Mark from 3rd May 2017, and on 21st June 2017, Mark was assessed by the PDS. This initial assessment was the only face to face contact between PDS and Mark. The meeting was also attended by a youth worker from the Hive. Mark was described as keen to get help but anxious about the assessment process. Mark explained that he was a target for several people in Camden. He had been kidnapped and tortured the year before.

3.28 Mark spoke of chronic and cumulative childhood trauma, parental domestic violence, maternal heroin addiction and childhood sexual abuse within the context of an unboundaried and criminal family. Mark was, however, now living with his aunt and uncle, whom he described as supportive. Mark said that due to their age he was now caring for them. Mark's main goals, and his request for help, was with finding somewhere to live, accessing education and finding employment.

3.29 Mark said that he would kill his childhood abuser when he found him and that he was prepared to go to prison for this. Mark does not know the person's name or where he lived and said that he was not making attempts to find out (question of how serious).

3.30 Mark's diagnostic formulation was mixed personality disorder with anti-social, narcissistic and emotionally unstable traits. Mark described symptoms of post-traumatic stress disorder (hypervigilance, avoidance) as a result of previous assaults.

3.31 Mark was allocated for care coordination in the PDS to help with social care, social inclusion, basic distress tolerance and emotional regulation

3.32 Mark was able to access the PDS duty service for support but was still on the waiting list for PDS care coordination on 4th December 2017. Consequently, Mark was offered interim support. Mark had obtained and left a full-time job and had bought a houseboat with his brother. Mark, however, refused to meet the PDS again since he found the first meeting very difficult.

3.33 Multiple attempts to contact Mark after this were unsuccessful and on 5th March 2018 Mark was discharged from the Hive and on 10th April 2018 from the PDS.

3.34 On 22nd April 2018 Mark was in police custody after being arrested and charged with carrying and offensive weapon). He disclosed that he was experiencing mental health difficulties as a result of child sex offences committed against him. Mark was unwilling to support a criminal investigation at this stage but needed help. Mark was referred to the Forensic Mental Health Team at Highbury Corner, who spoke with him on 23rd April 2018. At Mark's request the Forensic Mental Health practitioner contacted Mark's GP prior to a GP appointment Mark had apparently booked for the following week. Mark wanted a referral for support with sexual abuse and access to talking therapies. According to the GP, Mark did not have an appointment booked, so subsequently booked one on Mark's behalf. Mark did not attend.

3.35 On 26th April 2018, Mark contacted Camden Housing Services for help to find a hostel. Mark said that he was sleeping rough. Mark was referred to the single homeless team and on 20th August 2018 told them that he was living in his car, after having been asked to leave by his family. Mark was referred to the YMCA but was asked to leave on 2nd January 2019 since in response to the behaviour of another person there he had threatened their partner. Mark explained by telephone to Camden Housing Services that due to his background of abuse he should not be placed with other people and said that he "should just jump of a bridge". Mark was asked to seek medical help and to provide medical evidence of his needs to support further referrals for accommodation. Mark ended telephone call and did not respond to further telephone calls and emails but did renew contact on 14th January 2019 by telephone. Mark said that he had delivered the requested medical documentation, was told that this had not been received and was asked to provide information supporting his housing claim.

3.36 On 17th January 2019, Mark was referred back to the PDS by his GP. The PDS contacted the GP the same day asking whether Mark had agreed to this referral. The PDS also sent Marks GP its referral form, which the GP was asked to complete and to confirm that Mark was motivated to engage. This referral was closed on 5th February 2019 by the PDS since no reply has been received from the GP and there remained concerns that Mark would not engage with the PDS.

3.37 Mark contacted Camden Housing Services again on 8th February 2019 and was told that a letter had been received from his GP and on 4th March 2019

was asked to provide contact details for his keyworker at the Hive to assist in completing a referral form for housing. Contact after this was irregular, with Mark not accepting telephone calls but occasionally telephone calling to complain about the service he was receiving.

3.38 Mark re-engaged with the Hive on 5th May 2019 and his case was reopened and he was reallocated his previous worker.

3.39 On 13th May 2019, Mark told his GP that he sometimes thought about deliberate self-harm but had no plans to act on it. Mark was advised to take the anti-depressant mirtazapine regularly rather than erratically and to tell his GP if his thoughts of self-harm increased.

3.40 On 7th June 2019, Camden Housing Service agreed with the HIVE to try to contact Mark directly to fill in the referral form since Mark was not in regular contact with the HIVE.

3.41 On 1st July 2019, Mark notified the HIVE that he had moved to Surrey (whether or not Mark was on his own and, more precisely, where he was, was not stated by Mark, despite further attempts to contact him).

3.42 On 27th July 2019, Camden Homeless Services closed Mark's case due to lack of contact.

3.43 On 19th August 2019 Mark told his GP that he was living with his aunt and uncle in Camden. He was currently deliberately self-harming and had no suicidal thoughts. Mark said that he was not working or drinking alcohol at the time. He was taking double mirtazapine at times to help him sleep and was therefore running out of medication.

3.44 Between 29th August and 6th September 2019 Mark contacted Camden Homeless Services by telephone and email six times (four times on 6th September) asking that the be called back. Mark was left a voicemail message that on 27th July 2019 his case had been closed and he was asked to resubmit a homelessness application if he required further assistance. This was the last contact of Camden Homeless Services with Mark.

3.45 On 27th September 2019 the HIVE closed Mark's case after a long period of disengagement.

3.46 On 5th February 2020 the PDS notified Mark's GP that it had closed Mark's case.

3.47 After two non-attended appointments in November and January, Mark was last seen by a GP on 26th February 2020 for a medication review. Mark was to continuing take the anti-depressant mirtazapine. This also appears to have been the last contact that Mark had with any services. Mark may still have been living with his aunt and uncle at this time.

3.48 On 7th May 2020, Mark's uncle called the police to the block of flats in which Mark lived. The police found the deceased body of Mark laying in the stairway. He was covered in blood and had what appeared to be a stab wound to the front of his throat. Nearby was found a pair of scissors, also covered in blood. The Coroner's Inquest concluded on 29th September 2020 that Mark's death was the result of suicide.

4 THE EVIDENCE BASE FOR THE REVIEW

4.1 The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "*Type of Reviews*" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as following:

4.2 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with someone in Mark's situation: experiencing significant and ongoing life trauma, mental health difficulties and self-harm and not intermittently engaging with services.

4.7 Evidence from research

4.8 Adverse childhood experiences and the impact of trauma

4.9 There are strong evidential, as well as logical and intuitive, links between child sexual abuse, physical abuse and trauma and the experience in adulthood of mental health problems, excessive use of drugs and/ or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). These traumatic events in childhood are often referred to as adverse childhood experiences (ACE) (Felitti et al, 1998).

4.10 ACEs include growing up in a household with someone who is depressed, mentally ill, a substance abuser or has been incarcerated in the criminal justice system; exposure to child maltreatment or domestic violence and losing a

parent through divorce, separation or death (WHO, 2012). It is quite clear that Mark had survived very considerable adverse childhood experiences, including rape, neglect, growing up in a household where there was substance abuse, domestic violence and in which his father was frequently in prison. Mark's brother had also imprisoned. Mark feared that he would go to prison too.

4.11 Exposure to such ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence. Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. From what is known of Mark's background and life, he faced multiple ACEs, which were highly likely to have had a cumulative impact upon him. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013).

4.12 There is also considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them: Mark was in irregular contact with multiple agencies, which struggled to engage with him.

4.13 **Depression, suicide and younger people.**

4.14 Mark was being treated in general practice for depression. Mark had been in contact with the Complex Depression and Anxiety Team in 2015 and had discussed depression and the value of mirtazapine (an antidepressant which is also effective in the treatment of depression and anxiety) with a GP in 2019. Mark appears to have continued to take mirtazapine since April 2019. On 26th February 2020, the GP notes under the heading of Depression Interim Review state that "Mirtazapine helps with sleep and mood, (Mark) wants to continue. Restarted January 2019. Medication review updates". Mark's repeat medication for Mirtazapine was issued during this appointment

4.15 The majority of people who have depression do not die by suicide but having major depression does increase suicide risk compared to people without depression. Longitudinal studies have found that two percent of people who have ever been treated for depression in an outpatient setting will die by suicide (for people treated in an inpatient hospital setting, the rate of death by suicide is twice as high).

4.16 Given that at least 96% of people with depression do not die by suicide, an alternative way of considering suicide risk and depression is to examine the lives of people who have died by suicide and to identify the proportion who were depressed. From this perspective, it is estimated that 60 percent of people who died by suicide had a mood disorder (for example depression or bipolar disorder).

4.17 Whilst suicide occurs more often in older rather than younger people, there is evidence that younger people (defined in the research as up the age of 20 years old) are vulnerable to developing mental health problems due to several

changes and transitions in their lives. These include building their own identity, developing self-esteem, acquiring increasing independence and responsibility, and building new intimate relationships. Such situations can lead to feelings of helplessness, insecurity, stress, and a sense of losing control (Patton et al 2016). There is evidence that Mark experienced these struggles

4.18 There is increasing neurological evidence, which adds to the established psychological research foundation, that the brains of young adults undergo significant changes through adolescence and into young adulthood. These are not completed until approximately the age of 25 years old (Giedd et al, 2004). This mid-twenties mental maturation is further complicated and even delayed by the experience of mental health problems and the underlying life trauma associated with these (Davis and Vander Stoep, 1997).

4.19 According to Casey et al, 2008), there are differences in "executive information processing" between "immature and maturing brains" (i.e. those generally possessed by people under the age of 25 years old) and "mature" brains (i.e., those possessed by people aged 25 years and over who have not experienced life trauma and have not developed mental health problems). These include reduced representational knowledge (of rules, conventions and social and cultural norms); reduced operational processing skills (planning ahead, being organised and the ability to connect intentions and goals with the actions necessary to implement and achieve them) and reduced self-regulation (the ability to resist distractions, impulses and to generally resist behaving in unhelpful and unproductive ways).

4.20 Mark was 24 years old when he killed himself and so it is unlikely that, especially given the impact of his early life experience and his development of mental health problems, his brain and consequent executive skills had matured. These less well-developed executive skills may have negatively impacted on Mark's ability to comply with appointments and therapeutic interventions. There is evidence that when he did not have far to travel or when less effort was required he found engagement with services to be easier.

4.21 Significantly in Mark's case, younger people who kill themselves often have a substance abuse disorder (whilst there does not appear to have been a formal diagnosis of this, Mark was reported to be using cannabis, which he also associated with feelings of paranoia).

4.22 **Borderline/ Emotionally Unstable Personality Disorder and suicide**

4.23 Mark does not appear to have been formally diagnosed with Borderline/ Emotionally Unstable Personality Disorder (BPD/ EUPD), but this appears to have been suspected, hence his referrals to the PDS. Practitioners identified that the formal diagnosis of BPD/ EUPD takes time and that it is better clinically to respond to the presentation of symptoms rather than wait for a formal diagnosis to be made. In addition, practitioners found that sometimes a diagnosis of a personality disorder was refuted by clients and that it was often more helpful not to medicalise their life and experiences. A BPD/ EUPD

diagnosis does not necessarily capture and convey the complexity of each person's lives.

4.24 The significance of BPD/ EUPD, however, is that it is associated with unstable mood, impulsive behaviour and unstable interpersonal relationships, all of which appear to have been present in Mark's life. For example, the referral to mental health services on 11th January 2019 by Mark's GP, stated that, Mark, *"…has a difficult and traumatic history of childhood abuse. He has been involved with the criminal justice system. He has a pattern of behaviour that may suggest lack of empathy, disregard of others, impulsivity and a lack of awareness of consequences. He occasionally uses cannabis. He has recently become homeless. I believe he has antisocial PD and am worried that he is spirally into a vicious cycle*".

4.25 This is important since BPD/ EUPD is associated with suicide. Up to 10% of people with BPD/ EUPD die by suicide (Paris, 2019), which potentially makes the presence of indicators of BPD/ EUPD more predictive of suicide than indicators of depression are.

4.26 The research also highlights a positive association between impulsivity and difficulties with emotion regulation and suicidal acts, particularly for younger people (Bilsen, 2018)**.** Finally, and particularly for younger people, the move from contemplation of suicide to suicide attempts and then to completed suicide can occur suddenly (Apter and Wasserman, 2006). A significant factor in moving from depression to suicide is the contemplation of suicide (Bilsen, 2018). A significant factor in moving from contemplating to actually attempting suicide is the availability of lethal means (Milner, et al, 2017). Mark's reports and witnessed acts of self-harm and of suicidal thoughts appear to have declined from 2019 onwards, but the research evidence suggests that this does not necessarily mean that the risk of suicide has reduced.

4.27 In summary, whilst the experience of depression is not a strong predictor of death by suicide, it is a factor in the majority of suicides. This makes the clinical task of identifying those people with depression who may kill themselves both difficult and essential. This is particularly important in the context of a review of 70 major studies which found that 60% of people who died by suicide had denied having suicidal thoughts (McHugh et al, 2019).

4.28 Based on this research, it is likely that Mark's background placed him at increased risk of attempted suicide and that he had researched and obtained the means to take his own life.

4.29 **Evidence from guidance**

4.30 The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, a year after the events described in this Safeguarding Adults Review, sets out a number of "Risk factors and red flag warning signs". The report states that "*A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time. This*

imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan". This report was published after the time period covered by this safeguarding adults review, but it still provides a useful framework for understanding the risk factors and warning signs in Mark's life. The risk factors and "red flags" are divided into a number of themes and are as follows:

4.31 **Demographic and social**

- Perception of lack of social support, living alone, no confidants
- Males (may not disclose extent of distress or suicidal thoughts)
- Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)
- LGBT
- Ethnic minority group.

4.32 Mark was male and had experienced physical and sexual abuse and neglect. At his first meeting with the CDAT following a self-harm attempt in January 2015 when he was 19 years old, Mark said that the have been feeling "crazy" for years and described symptoms of emotional instability and angry outbursts (verbal) towards his girlfriend of the past 10 months. Mark said that his sleep was disturbed by nightmares, vivid dreams and flashbacks about the domestic violence and trauma he had experienced and witnessed as a child, and for which his father was eventually sent to prison when Mark was 6 years old. Mark was also frequently unemployed, appears to have been homeless at times and may have lacked social support.

4.33 **Personal background**

- Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship
- Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)
- Use of suicide-promoting websites or social media
- Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

4.34 There were also a number of risk factors and "red flags" present in Mark's personal background. These were "Substance misuse"; Mark was known by the mental health services that he was in contact with to be using cannabis. It is unclear, and does not appeared to have been explored, whether or not Mark's use of drugs was, "precipitated by a recent loss of relationship" just before his death but relationship difficulties were a persistent feature in Mark's life. It is uncertain, but arguably likely that Mark had made "Use of suicide-promoting websites or social media" but again this does not appear to have been explored in Mark's contact with services before his death. Mark had "Access to lethal means" in the form of kitchen knives. The only factor that was not present appears to have been "Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers,

favourite celebrity)". However, Camden Housing Services identified that prior to Mark's death, a friend of Mark's had died from Covid-19.

4.35 These risk factors should also be considered in the context of the evidence on depression, suicide and younger people and on suicide and adoption. From this perspective, it would seem that there were multiple factors

4.36 **Clinical factors in history**

- Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
- Mental illness, especially recent relapse or discharge from in-patient mental health care
- Disengagement from mental health services
- Impulsivity or diagnosis of personality disorder
- Long-term medical conditions; recent discharge from a general hospital; pain.

4.37 Mark had an extended history of suicide attempts and self-harm. Mark told a mental health liaison nurse following his arrest in February 2015 that he had been self-harming since he was 14 years old, starting with making superficial cuts to his arms. Mark had also tried to hang himself twice but had miscalculated the length of rope required. Mark had also taken an overdose but denied any suicidal intent.

4.38 Mark had also referred in February 2015 to previous paranoia associated with cannabis use.

4.39 **Mental state examination and suicidal thoughts**

- High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden')
- Sense of being trapped / unable to escape (sense of entrapment) and/or a strong sense of shame
- Suicidal ideas becoming worse
- Suicidal ideas with a well-formed plan and/or preparation
- Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).
- Suicidal ideas with a well-formed plan and/or preparation.

4.40 Mark's contacts with services in the last months of his life were too infrequent to establish whether or not any of these factors were present. Given what is known about the rapidity with which suicidal intention can turn into suicidal acts, especially for younger people and particularly for younger people who have experienced traumatic events to the extent that Mark had, there may not have been many warning signs.

4.41 Consequently, there is evidence that Mark was at risk of suicide and that he presented a number of the risk factors and red flags identified in the Royal

College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults.

4.42 These risk factors and red flags were specifically formulated for use in primary care settings. The report cautions that risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The presence of red flag warning signs indicates that someone may be particularly at risk of suicide. Neither risk factors nor red flag warning signs can or should, however, be used to predict or rule out an individual suicide attempt*."

4.43 The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

4.44 The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

4.45 It is important that Safety Plans are co-created with patients and encourage communication with family and friends.

4.46 **Decisional and Executive Mental Capacity**

4.47 The Mental Capacity Act sets out the process for assessing and determining whether or not someone with an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" is able to make a specific decision at a specific time. Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

4.48 There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance

is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

4.49 Are significantly slower and less accurate at problem solving when it involves planning ahead.

4.50 Persisted with riskier behaviours for longer and were less responsive to negative outcomes.

4.51 Were no different when identifying what the likely outcome of an event would be.

4.52 As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

4.53 Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments. There is no evidence that Mark's mental capacity was explored. He had an extensive history of trauma which, set also against a background of what is known of the rate at which brains and cognitive functioning matures, may have impacted upon how he understood, retained, used and weighed information and communicated decisions.

4.54 **Housing and homelessness**

4.55 There is substantial, as well as intuitive, evidence that the well-being of individuals and of families is substantially affected when the need for satisfactory housing is not met. According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, satisfactory housing consists of: legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc.); cultural adequacy; and affordability. It would appear that the places that Mark stayed in rarely met these criteria. Despite often having a roof over his head, Mark experienced frequent housing insecurity and moved regularly.

4.56 In terms of addressing homelessness, the Homelessness Reduction Act 2017 requires that local authorities must offer early intervention and prevention to avoid homelessness, must assess housing need, offer advice and information, work with other agencies and develop personalised housing plans. Mark was in intermittent contact with housing services but often appeared to live with family members without any form of security or stability. He was for example, living in a hostel in 2015, with his brother on a boat in 2017, sleeping in car in 2018 and then living in a YMCA in 2019 and later living with his aunt and uncle. On 1st July 2019, Mark told a Hive worker that he had moved from London to Surrey and had been street homeless for seven months. Mark did, however, appear to be in more stable accommodation in the last period of his life.

4.57 There is a strong interrelationship between mental health and homeless, such that housing can be considered to be “foundational” to good mental health and wellbeing (Padgett, 2020). Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their chaotic and dangerous behaviours are unlikely to be successful.

4.58 Housing is also included in the Wellbeing Principle, set out in section 1 of the Care Act 2014, and the provision of suitable accommodation should be considered when making decisions about care and support needs (Ch.15 of the Care Act statutory guidance). Meeting a housing need, however, does not mean that care needs are met (s.23, Care Act 2014).

4.59 Consequently, there is a significant relationship between housing and the effective support of people who face the same challenges and exclusions as Mark did. There is also a legal framework in which this relationship can be explored and needs can be met.

4.60 **The wider context**

4.61 It is generally well known that both social care and health care in the UK have faced years of financial constraints and cuts to funding since 2010 (if readers are still in any doubt about this, then an internet search using terms such as “austerity and social care” or “austerity and health care” will reveal a wealth of resources that do not need to be reproduced in this report).

4.62 Austerity has impacted on practice, particularly in social care, to the extent that decisions about who should receive services, and what the extent of those services should be, are influenced by financial limitations well as need (for example, Olaison et al, 2018). Data for England in 2018/19 (Kings Fund, 2019) showed that whilst requests for social care services had increased by 6%, the actual number of people who received formal care packages had decreased by 2%.

4.63 Whilst there was no direct evidence that resource restrictions impacted on the decisions taken by the professionals working with Mark, practitioners reflected on the under-resourced and disjointed nature of services.

4.64 Although there was no direct evidence of discrimination in the approaches to Mark there is wider evidence that men are three times more likely to kill themselves than are women and that suicide is the most frequent cause of death for men below the age of 45 years old (Simms et al, 2019). There is also a growing literature on the difficulties faced by men (Baker et al 2015) and on preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson. 2011). There are also gender differences in risk of suicide in depression. Whereas seven percent of men with a lifetime history of depression will die by suicide, only one percent of women with a lifetime history of depression will die by suicide. Mark faced multiple inequalities including adverse childhood experiences, contact with the criminal justice system, mental health needs and homelessness. These are

likely to have impacted on his contact and engagement with services and on perceptions of what Mark and services could expect from each other.

5 ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the ways in which the organisations worked with Mark and understood and responded to the needs and challenges that he presented.

5.2 **Recognition of the impact of adverse childhood experiences**

5.3 As predicted by the evidence of the impact of adverse childhood experiences. Mark experienced relationship difficulties and violence in adulthood.

5.4 Practitioners considered that Mark's childhood experiences of domestic abuse predisposed him to behave in an abusive and violent way in adult relationships. For example, the police intervened in Mark's angry, and allegedly violent, altercations with, including an alleged threat to kill, his girlfriend.

5.5 Mark also had fairly extensive contact with the police on suspicion of drug offences, thefts from motor vehicles and for carrying an offensive weapon (a knife). Whilst Mark freely admitted that he smoked cannabis there was no evidence that he was involved in its supply. Thefts from motor vehicles appear to have involved him as at most an accomplice to his brother and the knife was used for self-harm rather than to harm others (although occasional threats were made of this, and Mark said that he also carried to knife for protection).

5.6 During Mark's meeting with members of the Hive and the PDS on 21st June 2017, Mark explained that he was a target for several people in Camden. He had been kidnapped and tortured the year before.

5.7 Mark spoke of chronic and cumulative childhood trauma, parental domestic violence, maternal heroin addiction and childhood sexual abuse. Mark was considered to be at risk of "seeking containment through the criminal justice system and was currently on a suspended sentence for destruction of property". This suggests that Mark wanted boundaries but could not find them outside of being arrested.

5.8 Mark said that he would kill his childhood abuser when he found him and that he was prepared to go to prison for this. Mark does not know the person's name or where he lived and said that he was not making attempts to find out.

5.9 During this meeting, Mark expressed no thoughts of harm to himself but scarring from severe self-harm (cutting to the arms and chest) was noted.

5.10 Consequently, the traumatic impact upon Mark of his adverse childhood experiences appears to have been recognised by agencies and was regularly mentioned in case records. However, the impact of these experiences on how Mark engaged with services does not appear to have led to an operational change in the approaches taken to engage with him.

5.11 **Engagement with and by services**

5.12 Practitioners identified that Mark and people like him, with complex and traumatic family backgrounds, do not easily fit into treatment pathways. Following his meeting with the PDS on 21st June 2017 and whilst waiting for care coordination, Mark was offered interim support on 4th December 2017. Mark refused to meet the PDS again since he had found the first meeting very difficult. The notes record that Mark,"…*is building a tentative engagement with (a worker at the Hive). His attachment is disorganised, and this is reflected in ambivalence, fearfulness, dismissiveness and mistrust in relation to services*".

5.13 Practitioners recognised the challenge of engaging with Mark. The PDS may have been able to help Mark but his engagement was limited and therapeutic interventions require commitment. The personality disorder service was not equipped to do outreach work and so Mark's GP was asked to liaise with the Hive as this service may have been more accessible for Mark.

5.14 Mark was also described by practitioners as the type of client whose needs they struggle the most to meet. The impact of life trauma is not well understood operationally. The practice of discharge following missed appointments, for example, does not fit well with people who behave in a chaotic way because of their traumatic life experiences. It is likely Mark was not able, rather than unwilling, to comply with requirements to attend regularly. Practitioners recognised that in many cases young people are not in the right place emotionally or cognitively to fit in with the demand of traditional services and instead outreach and mobile services, willing to meet service user where it suits them, may be more effective. Mark's engagement was often compromised by family problems, the need to move and difficulties travelling to attend meetings.

5.15 Mark often found it difficult to participate consistently and the experience of working with services became overwhelming for him. Consequently, he would disengage from them. Practitioners considered that a balance was needed between assertiveness and allowing people to engage on their own terms. Flexibility and different approaches are often required.

5.16 Many young people regularly disengage from services and they are advised that they can reengage when they want. Efforts are made not to pressurise them too much since a "softer" approach to compliance is often more effective.

5.17 Practitioners recognised that Mark wanted a more casual approach, where he would be met for short time whilst he was doing something that he enjoyed, playing pool for example. A team able to do this kind of work would have been useful. Young people affected by trauma living chaotic lifestyles cannot commit to attend regular appointments. The Personal Assistants who work with care leavers may have been able to provide the kind of support and guidance with, for example, accessing suitable housing that Mark would have found more acceptable.

5.18 Extensive efforts were made by Catch-22, for example, to maintain contact and engagement with Mark, who changed his contact number eight times in a year

and half and moved frequently. During the first period of Mark's contact with the service between 3rd May 2017 and 28th February 2018, Mark attended four face to face meetings but did not attend seven and a total of 104 attempts were made to contact him by telephone or text message. During Mark's second period of contact, there was one face to face meeting and three appointments that Mark cancelled or did not attend and 47 attempts to contact him by telephone and text message. Mark often did not know where he was going to be or where he could be contacted.

5.19 Across all the organisations involved, it was hard to gain a full picture of Marks needs and better interagency communication and access to information was required.

5.20 Practitioners identified that different ways of approaching engagement such as using a consistent named worker to make contact, understanding what motivates clients, forming relationships with them, not requiring them to travel far, making contact as simple and possible, should be tried. There is evidence that Mark had maintained relationships over extended periods of time with certain therapists so relationship-based approaches may have helped him, although this would not have ensured complete engagement: despite these relationships Mark still cancelled or did not attend meetings.

5.21 Relationship-based practice may, however, have enabled Mark to be more open. Mark's last two appointments were with locum GPs and it is conceivable that if he had met one GP more regularly and had formed a relationship with them this might have encouraged him to be more open about how he was feeling.

5.22 Irregular engagement, frequent discharge and disengagement with services is a regular feature in safeguarding adults reviews and can be considered as a risk factor in itself. Practitioners recognised that there was a need to identify when responses to disengagement with services required further escalation.

5.23 **Mental Capacity**

5.24 It does not appear that Mark's mental capacity was assessed in any of his contacts with services. Whilst a principle of the Mental Capacity Act is the presumption of capacity unless demonstrated otherwise, there were opportunities when a capacity assessment might have been useful**.** For example, Mark did not attend appointments, may not have been making use of the information provided to him and was caught in repeating patterns of behaviour. An assessment of Mark's mental capacity to understand the importance of engaging or of how to attend appointments may have identified that he required additional support, especially in the context of Mark's substance use. Mark's mental capacity to make decisions about engaging with services may also have fluctuated.

5.25 Mark was occasionally given information on the services available and was expected to make his own contact with them. For example, which waiting for

assessment in his second contact with the PDS, Mark was given crisis telephone numbers to use if he needed them.

5.26 Considered from the perspective of mental capacity, practitioners may have interpreted refusals to engage or to comply with requirements to be capacitous decisions rather than indicators of mental health needs, or of responses to traumatic events and which might have impacted upon Mark's ability to understand, retain and use and weigh information to make decisions.

5.27 **Risk of suicide**

5.28 Mark had an extensive history of self-harm with very severe and, in March 2017, recent scarring. Mark was having reconstructive surgery to cover the damage.

5.29 There does not appear, however, to have been any collective recognition of the increased, and on-going, risk of suicide for Mark. Reports of self-harming behaviours appear to have stopped after Mark's appointment with a GP on 13th May 2019. At this appointment, Mark said that he thought of deliberate self-harm sometimes but had no plans to act on it. Mark and the GP discussed the need to take the anti-depressant mirtazapine regularly rather than erratically and to tell his GP if his thoughts of self-harm increased. There does not appear to have been a further investigation of self-harm at Mark's final GP appointment on 26th February 2020. This appears to also have been Mark's last contact with any services.

5.30 Predicting suicide is difficult. The Royal College of Psychiatrists identified the limitations of the assessment of suicide risk and promoted the value of developing therapeutic relationships, so that people at risk of suicide feel freer to disclose their feelings and intentions. The report warned against the assumption that people experiencing mental distress, but who do not report suicidal ideas, are not at elevated risk of suicide. The report stated that, "*The current approach to risk assessment and responding only to those identified as 'high risk' is fundamentally flawed, and the use of terms such as 'low risk' or 'high risk' is unreliable, open to misinterpretation and potentially unsafe. The absence of risk factors does not mean the absence of any risk of suicide). For a variety of reasons (e.g. stigma, shame, fear, or embarrassment) people may conceal or minimise their suicidal thoughts*. *Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out regularly*".

5.31 Such an approach would require consistency in who was working with Mark, which was made more difficult by the fragmented nature of the services he was in contact with and, in the GP surgery, regular contact with one GP rather than with locums.

5.32 **Use of adult safeguarding processes.**

5.33 Mark was 19 years in 2015 when the Care Act 2014 came into statute and the agencies working with Mark may have needed time to become familiar with the

requirements for adult safeguarding the Act introduced. Despite this, and despite Mark coming to the attention of the police and being referred through Camden's Multi-Agency Safeguarding Hub (MASH), no safeguarding concerns were formulated and no safeguarding enquiries or interventions were made.

5.34 The London Borough of Camden and Camden and Islington Health Trust have a s75 agreement under the NHS Act 2006, by which some local authority resources, including social work for people with mental health needs, are dispersed to the health trust. Consequently, Camden and Islington Health Trust should respond to safeguarding concerns involving people it is providing services to. A planning meeting process is in place to resolve disputes over lead responsibility.

5.35 Since Mark was known to be in contact with mental health services, the MASH passed on any concerns raised about him directly to mental health services. As a result of the s75 agreement, the MASH is not resourced to screen concerns about people in contact with mental health services. It was the responsibility of the mental health trust to respond to the concerns and opportunities for using adult safeguarding approaches may have been missed. These approaches could include reviewing how interventions with Mark were progressing or identifying escalating patterns and coordinating multi-agency interventions in response. Practitioners also identified that the MASH does not receive any feedback or acknowledgement of the concerns and contacts it passed on to mental health services. There appears to have been a belief that if Mark required the support of a mental health team, then there was no role for adult safeguarding. health team, then there was no role for adult safeguarding.

5.36 **Information sharing and multi-agency working**

5.37 Mark was in contact with multiple teams and organisations, which may have complicated communication and information sharing. The Royal College of Psychiatrists' report identifies that "*a patient journey that is disjointed and fragmented, with poor or absent communication between agencies, is itself a risk factor for suicide*." The organisation of specialist services meant that Mark was frequently closed by one service and referred on to another. Practitioners considered that the role, eligibility criteria and approach of services such as the PDS, were not always widely understood. This created a risk of people falling through gaps between services when their case was closed.

5.38 Reflecting this rather disjointed relationship between services, no multi-agency multi-disciplinary team group conferences were held. These may have allowed concerns about Mark to be aired, information shared and multi-agency action agreed.

5.39 The purpose of the Minding the Gap programme, of which the Hive is part, is to improve multi-agency working but this often requires case leadership to bring different organisations together. Practitioners recognised that sometimes it was not clear who should take this lead and who should call multi-disciplinary meetings. A multi-agency meeting was suggested in May 2017 but was not taken further.

5.40 There were also signs of frustration of different services with each other as a result of the difficulties of trying to engage with Mark. For example, On 18th January 2019 the PDS asked Mark's GP to complete a referral form for Mark and asked the GP to confirm that Mark was willing to engage with the service. On 5th February 2019 the PDS closed the referral because of no response from the GP.

5.41 **Impact of Covid-19**

5.42 The final months of Mark's life took place within the context of the coronavirus pandemic. Since Mark had disengaged from services in February 2020, little is known about how the restrictions imposed in response to the coronavirus pandemic affected him and whether it prevented him from accessing help. It appears that he may have been living with his aunt and uncle.

5.43 Following its identification in the UK on 29th January 2020, there was a surge in infections through March and restrictions on movement were introduced. 'Lockdown' measures restricting contact and ordering the UK population to "stay at home" came into force on 26th March 2020. They did not begin to be lifted until 10th May 2020. Mark died on 7th May.

5.44 The national and local response to the pandemic also impacted widely. Face-to-face contact decreased yet demand for services, sometimes to replace those that had been closed or limited by the 'lockdown', increased. There was also an increase in mental health need, which had been predicted at the time but in hindsight seems to have been even greater in younger people (Ford et al, 2021; Ashton et al, 2021). There was also an increase in drug and alcohol related problems. A forthcoming thematic review of the deaths of homeless people identified that drug dealers did not comply with the lockdown restrictions whilst services did.

5.45 There does not appear to have been any contact with Mark to explore how the 'lockdown' was affecting him.

5.46 **Good Practice**

5.47 There were numerous examples of good practice with Mark. There was evidence that the services tried to engage with Mark and tried to keep regular contact with him often by text message. The Hive provided continuity for Mark as he transitioned from childhood to adulthood and there was evidence of consistent practitioner involvement with Mark through this. This approach provides a good model for working with other people in transition from children's to adults services.

5.48 There are also ongoing service developments which aim to reduce the risks of non-engagement and falling through gaps. These include Core Teams to bridge gaps between primary and secondary care without requiring referral to specific services. However, these teams may take some time to develop so in the interim further work to build relationships and a culture of cooperation will

be necessary. An action plan for how transitional safeguarding approaches can be developed to better support people with ACE and trauma is being created.

6 CONCLUSIONS

6.1 The risk of Mark's suicide was not fully understood

6.2 Assessments did not fully capture the risk that Mark might kill himself. Mark's death by suicide was unexpected, although this may have been at least partially due to there being no contact with him between 26th February 2020 and 7th May 2020. Assessments made before this time do not appear to have considered Mark's background, history of self-harm and emotional instability as suicide risks. Further awareness, consideration and exploration of these factors, either with Mark or within and between the different services in contact with him, might have helped to form a clearer picture of their circumstances and might have influenced the outcome of risk assessments beyond Mark's immediate presentation. History taking, spotting patterns and identifying escalation are essential activities in managing risks.

6.3 Practitioners recognised on reflection that Mark could be "on top of the world" such as when he had bought a houseboat with his brother, and then would quickly believe that everything hopeless. No appropriate risk management plan was created in recognition of this lability in how Mark felt and there were no plans put in place that recognised that Mark had made suicide attempts, had self-harmed and was emotionally volatile. Risk management plans would, however, have required more frequent contact with Mark and would not have been effective if Mark was not engaging with services. Some form of more assertive intervention would have had to be made but there were no events which might have precipitated this. The other option would have been to formulate risk management plans with Mark's family or friends.

6.4 Whilst there are suicide prevention and bereavement services in Camden and free training is provided on this topic by Samaritans as part of the Rethink Mental Illness contract, there does not appear to be a suicide prevention strategy in Camden.

6.5 There was a lack of involvement with Mark's family or friends.

6.6 Very little contact appears to have been made by any of the agencies with Mark's family or friends. Mark's mother had reported her concerns to a parenting worker in March 2015 that Mark had spoken about thoughts of suicide and about his fear that he might seriously hurt her and his father because he was feeling very angry with them. Mark's mother was also worried about Mark's potential risk to other people. These concerns were discussed with a transitions psychologist member of the CDAT and the parenting worker was asked to develop a plan with Mark's mother for what to do if Mark was at risk of harming himself. This seems to have been the last time that Mark's family were involved by any services.

6.7 There may have been a reticence by professionals to work with Mark's family because of concerns about confidentiality. Mark gave consent for his aunt to be contacted but then disengaged from the PDS. Mark did not give consent for contact any other family members or for any work to be undertaken with his family. Practitioners were aware of the needed to be careful about contacting Mark's brother as their relationship was described as, "not healthy".

6.8 The Royal College of Psychiatrists states that all health and social care professionals should be aware of the "*Information sharing and suicide prevention consensus statement*" (Department of Health, 2014) and adapt their practice as necessary to work with family and friends and prevent suicide. This guidance sets out the circumstances in which concerns about suicide can and should be shared even in situations where permission to do so has not been given by the person at risk.

6.9 There was no further exploration of the extent to which Mark's family could be involved as partners in Mark's care or act as protective factors in alerting services to self-harm and suicide risks.

6.10 **There was little inter-agency coordination and opportunities for joint working were not always taken**

6.11 Mark was in contact with multiple agencies and there was evidence of communication between them. However, there were also no multi-agency multi-disciplinary team group conferences or risk meetings at which concerns and information could be shared and at which multi-agency action could be agreed and monitored.

6.12 Agencies closed cases due to Mark's non-engagement. This is a regular feature in other SARs, to the extent that it could be a risk indicator in itself.

6.13 There does not appear to have been consideration of a single agency being given the lead on assessing and managing Mark. A mental health service provider and specialist in this area, may seem to have been the most likely organisation to have taken the lead, in partnership with the other agencies involved. However, any service or practitioner that was able to build and maintain a relationship with Mark may have taken this role. There is a need to help people like Mark to develop trust.

6.14 The impact of this was that a fuller and more accurate understanding of the risk of suicide and of Mark's engagement or disengagement with services was not formed. Had this been done then a more assertive approach to following up Mark might have been taken.

6.15 There does not appear to have been consideration of a single agency taking the lead on assessing and managing Mark. There is a need to help people like Mark to develop trust in services.

6.16 Mark's last two GP appointments were with locum doctors. If Mark had met one GP more regularly, with whom he had developed a feeling of trust, this might have enabled him to talk more openly about how he was feeling.

6.17 There is an opportunity to build on the joint work already taking place in Camden on transitional safeguarding, which considers the distinct developmental needs of young people transitioning into adulthood. Children's and Adult safeguarding partnerships are working together to connect and refresh their approach to how they work with young people. A working group led by Children's and Adults Directors, involving multi-disciplinary colleagues, has agreed a design-led approach to develop responses to the needs of young people transitioning into adulthood and this work will draw on practice from across all services. During 2022 targeted and measurable steps to do this, and specific interventions in areas that sit across children's and adults' services will be identified.

7 RECOMMENDATIONS

7.1 The recommendations from this safeguarding adults review are divided into the four domains proposed by Preston-Shoot (2017) and are for consideration and planned implementation by the Camden Safeguarding Adults Board.

7.2 Domain 1: Direct practice with individuals and systems

7.3 **Recommendation 1**: The CSAPB should seek assurance from partners that safeguarding processes are used as a means for identifying the need to review how cases are progressing, to spot escalating patterns and to coordinate multi-agency interventions.

7.4 **Recommendation 2**: The CASB should lead the agreement of a multi-agency risk management and escalation process for people who disengage from services and are assessed to be at risk. This should include consideration of how a "lead person" role could be created to maintain contact with hard to engage people. This role could be filled by whoever has the best relationship with a hard to engage person, including voluntary and community sector representatives.

7.5 **Recommendation 3**: The North Central London Clinical Commissioning Group and Primary Care Networks should identify how GP appointments for people who are hard to engage and are considered to be at risk can be made more consistently with a specific GP.

7.6 **Recommendation 4**: CSAPB partners should commission training to understand trauma and its impact and on how to work with people who are hard to engage. The Good Practice Guide: Engaging with Involuntary Service Users in Social Work may be a useful resource for all professionals and could form the basis of this training. The content of suicide awareness training should be reviewed since feedback on it has not always been positive.

7.7 **Recommendation 5**: The CSAPB should promote the Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020 and the Department of Heath's "*Information sharing and suicide prevention consensus statement*". This could be done by inviting a representative from the Royal College of Psychiatrists to attend a safeguarding adults board meeting to present the report. With permission this could be recorded and distributed to staff in partner organisations.

7.8 **Domain 2 and 3: Agency and interagency cooperation**

7.9 **Recommendation 6**: Partners should continue the work on creating Core Teams and should include:

7.9.1 Suicide risk identification and prevention
7.9.2 working with people transitioning from childhood to adulthood and
7.9.3 voluntary and community sector organisations

7.10 within the scope of the Core Teams approach.

7.11 **Recommendation 7**: The CSAPB should lead an audit of the use of multi-agency information sharing protocols to determine whether or not they promote effective joint working, cooperation, sharing information and prevention when working with people at risk of suicide and to the extent to which they include voluntary and community organisations and families. This could be done using a process similar to the existing London ADASS Safeguarding Adults at Risk Audit process, including a "challenge" event attended by partners. Following this, the CSAPB should lead action to make improvements as necessary.

7.12 **Recommendation 8**: Camden and Islington NHS Foundation Trust should review its processes for responding to safeguarding adults concerns so that the need for safeguarding enquiries and interventions in addition to mental health interventions is recognised. This should also include providing confirmation to the MASH of receipt of concerns and of any actions taken.

7.13 **Recommendation 9**: The CSAPB should lead a multi-agency audit of risk assessment and management processes for suicide across all agencies, including the creation and oversight of suicide Safety Plans. This could be done using a process similar to the existing London ADASS Safeguarding Adults at Risk Audit process, including a "challenge" event attended by partners. Following this, the CSAPB should lead action to make improvements as necessary.

7.14 **Domain 4: Board level**

7.15 **Recommendation 10**: Invite Camden Public Health Service to a CSAPB meeting to discuss the development of a Suicide Prevention Strategy in Camden based on the public health responsibilities for this area.

7.16 **Recommendation 11**: Consider holding a board-wide event to promote the findings from this safeguarding adults review so that the matters of life trauma, adoption, identity and depression and associated suicide risk can be discussed more widely and further actions identified within the local context of the London Borough of Camden.

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