Gloucestershire
Safeguarding Adults
Board

Safeguarding Adults Review

Learning from the circumstances around the death of

WH

Lead Reviewer: Kate Spreadbury

Date: 20 December 2024

Contents

Glossary.

ASC – Adult Social Care. **AOT** – Assertive Outreach Team.

CJLS – Criminal Justice Liaison Service. **CPA** – Care Programme Approach

DASH – Domestic Abuse, Stalking and Honour Based Violence risk identification, assessment and management tool.

FERN – Frequent Engagement Response Network.

GHC – Gloucestershire Health and Care NHS Foundation Trust; physical and mental health (including Crisis) teams.

ICB – NHS Gloucestershire Integrated Care Board.

MARAC – Multi- Agency Risk Assessment Conference (Domestic Abuse)

MASH – Multi-Agency Safeguarding Hub. **MHA** – Mental Health Act 1983.

OTA – Occupational Therapy Assistant.

GSAB – Gloucestershire Safeguarding Adults Board.

SAMM – Safeguarding Adults, Missing and Mental Health team.

SAR – Safeguarding Adults Review.

SDC – Stroud District Council. **VIST –** Vulnerability Identification Screening Tool.

1. Introduction.

1.1 This Safeguarding Adults Review (SAR) is commissioned by Gloucestershire Safeguarding Adults Board (GSAB) following the murder of WH in September 2022. The overall purpose of the SAR is to learn from the circumstances around her death, how organisations and services worked together to safeguard WH and how the wider safeguarding system supported this.

1.2 GSAB received a referral for a SAR in December 2022 from a neighbour of WH's via a local councillor. An independent lead reviewer was commissioned in September 2023 following the conclusion of criminal proceedings regarding Adult B. Adult B was found guilty of WH's murder and sentenced to a minimum of 24 years imprisonment in August 2023.

1.3 WH was of dual heritage; her father was South Asian and her mother a White UK citizen. Her sexual orientation was not recorded, but evidence to the SAR suggests that she had intimate relationships with men and women. WH was adopted at five months old. WH's birth mother had also been adopted, her adoptive mother died when she was a child, and

she was raised by her adoptive father. WH did meet her grandfather after her birth mother died. WH's birth mother is believed to have had schizophrenia and died when she was around forty years old. WH was diagnosed with schizophrenia in 2015 and detained on a Mental Health Act (1983) section 3 order, making her eligible for support under section 117 of the Act. WH was also diagnosed with cerebral palsy and appears to have been prescribed regular medication for hypothyroidism. Mental health services note that WH misused substances and experienced trauma during her life. WH was known to several organisations who were concerned about her mental health, exploitation by others, and neglect of her own wellbeing and environment. At the time of her death WH was not receiving any services.

1.4 This review is conducted in accordance with section 44 of the Care Act 2014 and the Gloucestershire Safeguarding Adults Board (SAB) Procedures. A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if 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 the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

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. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 Timeframe: The SAR considers events between August 2018, when WH moved into her flat, and the 4th November 2022, the day that WH's body was discovered.

2.2 The **specific areas of focus** for the SAR are:

- What did each organisation know about WH? How was information shared and understood? Did organisations share a common understanding of WH's circumstances, needs and risks? Did organisations know who else was involved?
- How did practitioners attempt to engage with WH? What would have helped them to do so?
- How did organisations work together to support WH?

- How typical is WH's situation in Stroud? Are there other people who are hard to reach but experiencing mental health and/or substance dependency issues and at risk from self-neglect, exploitation, and other forms of abuse by third parties.
- How can we develop multi-agency responses to people in WH's situation? How do organisations in Stroud work together, what is going well? What are the challenges? What needs to be developed?

2.3. Methodology.

Chronologies and analyses of involvement were received from involved organisations, with the exception of the GP surgery. Individual interviews were held with the Gloucestershire Health and Care NHS Foundation Trust (GHC) social care lead regarding the s117 system and with managers from Stroud District Council (SDC). A conversation was also held with the SAR referrer, WH's neighbour. A learning event was held to explore the themes from the chronologies and analyses, the changes needed, together with the barriers and enablers for change. Learning event participants acted as a Panel, receiving and commenting on draft overview reports.

2.4 Organisations who have supported the SAR.

Brandon Trust.

Gloucestershire County Council: Adult Safeguarding; Adult Social Care (ASC).

Gloucestershire Health and Care NHS Foundation Trust; physical and mental health (including Crisis) teams. (GHC)

Gloucestershire Hospitals NHS Foundation Trust.

Gloucestershire Constabulary.

NHS Gloucestershire Integrated Care Board (ICB).

People, Potential, Possibilities (P3).

Stroud District Council (SDC).

The involved GP surgery declined to contribute to the Review and there is therefore incomplete information regarding the care WH received after her discharge from mental health services. Information was later obtained from the GP practice with the support of NHS Gloucestershire Integrated Care Board (ICB). It is understood that the initial reticence of the GP surgery was related to a misunderstanding of GDPR requirements which the ICB has now addressed with the practice.

3.Family involvement

WH's parents met with the lead reviewer and gave information about WH's early life and adulthood. WH's parents met with the lead reviewer for a second time in August 2024, her brother also attended for the first time. They have reviewed and commented on the draft report before presentation to the Gloucestershire SAB. The family understands that the need to preserve the anonymity of others means that WH's name cannot be used in the Report and have asked that initials are used instead.

4. Other processes.

The trial of Adult B had concluded before the initiation of the SAR. GHC undertook a Serious Incident Report regarding Adult B. It is understood that he has given permission for any relevant findings to be shared with the SAR lead reviewer. Where relevant these findings have been incorporated into the SAR Report.

5. Relevant history prior to the time in scope

5.1 Excerpts from WH's parents account.

5.1.1. WH's parents describe her as loving music and Whitney Houston. She liked entering competitions online and often won. She loved being around people. WH was adopted at five months old; she has an older brother who was also adopted but at an earlier age. At first her parents did not realise she had cerebral palsy, there were no signs at birth and her developmental delay was initially thought to be related to the late adoption. WH was helped with callipers, trainers and support from an OT. However, she was bullied at school, she was teased as she could not run as fast as other children and, desperately wanting friends, would be '*easily led'* to do what other children told her to do.

5.1.2. WH was not diagnosed with a learning disability in childhood. She attended an Education Unit for children with behavioural issues full time. WH was assessed at a child psychiatry unit. Her parents did not think she was diagnosed with any specific disorder. Later WH was thought to have Obsessional Compulsive Disorder. WH's parents were advised that she would do well in a therapeutic residential school environment. She went to a residential school in Wales, returning home every three weeks. WH was expelled when she was 16, there were massive changes about to happen in her life, she was about to leave school, and this may have precipitated negative behaviour toward the head teacher who she was reported as being fond of.

5.1.3. At 16 WH attended Ruskin Mill College near Stroud and stayed in the area after leaving school. She lived with a man for two – three years who was in his forties and who worked with autistic people in the area. They travelled to the USA and appeared to be settled. This relationship broke down when WH renewed a friendship with a woman from Ruskin Mill and WH's partner left her. WH managed the tenancy alone for several years but

was ultimately evicted. After WH lost her tenancy she lived with a male friend who was in his 70s. WH's family report that he looked after her, but that she *'took his place over'* with her possessions. He died of cancer. WH was admitted to a mental health hospital in 2015 where she was diagnosed with schizophrenia.

5.1.4. WH moved to supported housing in 2016. Her time there is viewed positively by her family. She was in a protected environment, there were people around and a staff office on the premises.

5.2 Summaries from involved organisations.

5.2.1 Over time WH built good relationships with Rethink staff members at the supported living accommodation. WH had struggled to open post and manage bills, shop for herself and manage her personal care and medication. During her time in supported living she is reported to have felt proud that she could manage her own bills independently and, with support, go shopping. Joint working with WH's care coordinator in the mental health Recovery team meant that ReThink were able to encourage WH to accept support from Brandon Trust to help her with personal care and medication. This was still in place when she moved to independent living. The care coordinator continued to support Brandon Trust in working with WH, a connection that Brandon Trust found enabled them to continue to engage WH for as long as possible.

5.2.2. WH made good progress during the time she was in supported living and the service was confident that independent living was the best option for her. Some risks remained, in particular regarding WH forming relationships with people quickly, appearing to be looking for them to care for her but also trusting them with information. The level of risk in WH's life fluctuated along with her mental health. There were periods where she was admitted to hospital when her mental health deteriorated. In October 2017, she was sectioned under the MHA following threats she made online to a particular police officer.

6.Key Events and Analysis from the time covered by the SAR

6.1 Key Episode 1 August 2018 – January 2019

6.1.1. On the 27 August 2018 WH moved into a one-bedroom ground floor general needs flat, owned and managed by Stroud District Council (SDC). Because of her mobility issues WH needed a ground floor flat which was only available in this flat scheme. The mental health recovery team, Rethink and SDC worked closely together to support WH to settle into the flat and arranged for a charging point for her mobility scooter. A referral was made to P3, a housing related support service, who conducted a needs assessment with WH in October 2018. The referral stated that WH had a good support network around her, including her mental health care coordinator and Brandon Trust. WH told P3 that the new property was "*a good thing, but the isolation was not, her priorities were getting the*

property set up and getting the furniture needed. Also building social networks and accessing groups." WH did not take up P3's subsequent offer of support.

WH's parents helped her move into the flat. They bought furniture, carpeting and bedcoverings as well as a cardboard cut-out of Whitney Houston. Her parents also bought WH a computer, mobile phone and mattress and later a Sky internet package. After WH's death they discovered very little left in the flat, much of WH's property had been stolen.

6.1.2 Rethink made a safeguarding referral shortly after WH moved to Chapel Street, she had given a friend's partner her bank card and PIN number. Police were alerted to this incident and the local Police Community Support Officer visited WH. The service also liaised closely with the SDC Housing Officer and Brandon Trust, keen to ensure that all who supported her were aware of the risk.

6.1.3. By the end of November 2018 Brandon Trust had stopped supporting WH, she was not in when they called over many weeks. Brandon believe that once WH got her mobility scooter, and was able to travel around independently, she felt she no longer needed support. WH did not present as a person with learning difficulties and Brandon question whether another form of support would have been more helpful to her.

6.1.4. WH had been open to the Stroud Mental Health Recovery Team since 2015. Her care coordinator supported WH's transition to her new flat. It was noted that WH was in an on /off relationship with a male (W) who was also under care of the same team. This relationship was noted as volatile and WH disclosed domestic abuse, both herself and W were recorded as perpetrators and victims within their relationship. Rethink and WH's parents had also shared their concerns about this relationship. Verbal and physical abuse was recorded by the Recovery team from which WH had sustained bruising.

6.1.5. In November 2018 a Care Programme Approach Review (CPA) meeting took place and WH's care was transferred to the Assertive Outreach Team (AOT). This transfer took place over three months and was intended to promote WH's engagement with mental health support, including medication compliance. In the CPA review WH was noted to perceive W as her carer. She did not like to spend time on her own and was frequently in the company of W or friends. It was recognised in this review that WH was vulnerable and had been financially exploited by her "friends" on several occasions.

6.1.6 WH was also noted to have a volatile relationship with Z, a woman she had met whilst using mental health services. In December 2018 police attended an incident involving WH, Z and a male victim of both women. The male victim told the police of his concerns that Z was manipulating WH. Her relationship with Z led to an arrest on New Years Eve 2018, police attended after a complaint that WH was banging on Z's patio doors and shouting, WH subsequently broke a glass pane and assaulted an officer. In June 2019 WH was found guilty of criminal damage, assault by beating of an emergency worker, possession of class B and C drugs, and resisting or obstructing a constable. After her arrest WH was assessed by the

Criminal Justice Liaison Service (CJLS), she presented with bruises to her wrists and upper arms and alluded to smoking cannabis. CJLS noted follow up by AOT.

6.1.7. By January 2019 the three-month transfer period from Recovery Team to AOT was completed and two visits a week agreed as part of WH's care plan. Initial follow up attempts made by AOT were unsuccessful, WH was also reluctant to attend a review with the Consultant Psychiatrist. There were continued reports of domestic abuse between WH and W, and concerns about WH's financial situation, she was continually '*paying back loans*.' On the 3rd January WH told AOT that W had held her hostage, police broke the door down and W was tasered. This does not appear to have happened. WH did show bruising around her knees and thighs to AOT on the 4th January, she claimed it was caused by police during her arrest on New Years Eve. She denied this was caused by anyone else.

6.2 Analysis of Key Episode 1.

6.2.1 Prior to moving to independent living, WH is reported to have benefitted from a structure and supportive organisations working together to promote her independence. These arrangements continued after her move, with good support from her mental health care coordinator in maintaining support and liaising with other involved agencies. Brandon Trust may not have been the right fit for WH's needs but could provide consistency as she moved address. Organisations worked together well initially, but difficulties in maintaining engagement with WH impacted on any structured support.

6.2.2 Was this the right location for WH? Her move was influenced by the availability of a flat to support her mobility needs. By November AOT staff felt that WH's move to the location made her far more vulnerable, "*she was exposed to an area where there was an illicit substance misuse network, she formed relationships with other service users who were part of this. It was observed that this group on benefit pay day and prescribed medication drop, would get together (including WH's home) and use each other's medication as well as other substances."*

6.2.3 By November 2018 WH appeared more involved with a "*group of friends*" and her care coordinator often found that she was communicating with WH via W. It was harder for organisations to engage with her, hence the move to the Assertive Outreach Team (AOT) who can provide intensive focus on engaging with people who are experiencing "*serious psychotic mental illness, such as schizophrenia, and require more regular professional help than mainstream mental health services"*[1]. The move to AOT enabled focused engagement but meant that WH lost the last of her long-term relationships with individuals within services. Despite her ambivalence toward practitioners, WH demonstrated whilst in supported living that she could engage with and benefit from on-going relationships.

[1] https://www.ghc.nhs.uk/our-teams-and-services/aot-glos/

Perhaps her need to 'belong' to an identified group attracted her to groups of individuals who made her feel important and needed, but who also exploited her vulnerabilities.

6.2.4. The mental health service recognised and recorded the risks to WH at this time, most notably financial exploitation and domestic abuse, "*there are numerous entries of incidents disclosed by WH of domestic abuse, both herself and W were recorded as perpetrators and victims within their relationship. The abuse concerns included verbal, physical abuse to which WH had sustained bruising*." Practitioners did not contemplate carrying out a DASH[2] assessment or making a referral to adult safeguarding or to a Multi-Agency Risk Assessment Conference (MARAC)[3] during this or any other period. Was this because the mental health teams were not familiar with domestic abuse services, or because of WH's presentation as both a perpetrator and victim of abuse? This circumstance, previously known as 'situational couple violence' (SCV), is violence that occurs because both parties struggle to manage conflict which then escalates into emotional and physical violence. Women are as likely as men to engage in SCV, but the impact on women is higher in terms of physical injury as well as fear and psychological consequences. Substance misuse, anger and communication issues are often prevalent. Approaches to SCV are different from those used in coercive control and can utilise attachment theory and couples counselling. This model of domestic abuse is currently not as recognised in the UK where perspectives are orientated toward a victim and perpetrator model, "*mutual violence*" is viewed as "rare"[4] and the possibility of counter - allegations or resistance on the part of the victim must be considered. Because there is an appearance of both parties perpetrating abuse to each other we must be aware of the possibility of bias,

"*Language and terminology used can focus on the 'both as bad as each other' opinion. This is particularly prevalent when cohorts of people who have additional needs experience stigma from professionals and society, such as complex needs or/and substance use, homelessness, mental health. However, it is paramount that in all domestic abuse relationships, irrelevant of the need and other challenges people face, we need to understand and remember that it will always be unlikely that two people are both perpetrator and victim.*" Safelives 2023 page 6.[5]

An essential part of the MARAC process is to ascertain who is the primary victim and who the perpetrator. WH's vulnerabilities were noted together with the physical and psychological impact of domestic abuse on her, but no attempts are recorded to understand her position or connect her with domestic abuse services.

6.2.5 WH is described as a 'feisty' personality or a strong character. Her verbal and physical aggression is recorded by all involved organisations. She is also described as a vulnerable

[2] https://www.dashriskchecklist.com/

[3] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

[4] https://safelives.org.uk/sites/default/files/resources/Responding_to_Counter_allegations_Guidence.pdf

[5] https://safelives.org.uk/sites/default/files/resources/Responding_to_Counter_allegations_Guidence.pdf

woman who was easily influenced by others and whose mild learning disability and mental health issues might impair her ability to self-protect. These conflicting observations may have led practitioners to overestimate WH's ability to protect herself. Questions in relation to WH's capability to protect herself were not asked and no reasonable adjustments were made.

6.2.6 It is also recorded that WH was '*paying back loans,'* but we do not know how WH got into debt or whether there is a link with financial exploitation. The mental health teams were very supportive of WH in her dealings with the Citizen Advice Bureau and the courts, but there is no information recorded about how these debts were created.

6.2.7 The possibility of preventative work could have been explored during the CPA review in November 2018. Services recognised the contextual safeguarding risks around WH but did not consider preventative responses.

6.3 Key Episode 2: April 2019 -2020

6.3.1 AOT visited WH at varying degrees of frequency throughout 2019 and 2020. As well as delivering her medication, AOT practitioners supported WH to work with the CAB to resolve debts issues, including a court judgement which WH's parents paid. By September 2019 WH was £3,000 in debt from payday loans. WH's debt and lack of money continued to be an issue over the next three years.

6.3.2 In April 2019 AOT noted there was a deterioration in WH's mental health, and she appeared to be experiencing psychotic symptoms. AOT increased their visits to three times a week and WH was reviewed at home by the Consultant Psychiatrist.

6.3.3 AOT Risk assessments noted a moderate risk of self-neglect with WH not attending to her personal hygiene and not eating. A longstanding '*medium*' risk from other people was also noted, particularly from domestic abuse, sexual and financial exploitation. The risk increased with deterioration in her mental state.

6.3.4 Although WH's mental state initially settled it became evident that she again had been non-concordant with medication and had been using '*legal highs*.' WH now reported having a new partner. Her relationship with Z was still fraught and in May 2019 Z reported harassment from WH to the police, claiming that WH wanted to be in a relationship with her and was bombarding her with texts. Z dropped the complaint shortly afterwards, saying that both were now friends. Z contacted the police again on the 25th May reporting that WH was saying her furniture was moving on its own and that she was going to kill herself and had spoken to someone that has given her the tools to do it. Police attended WH's address; she was triaged by the Mental Health Crisis team who determined no concerns for her safety at that time. An appointment with AOT was made for WH for the next day.

6.3.5 In July WH got her first kitten at the address. The Housing Officer gave WH permission to keep a kitten and visited with the Animal Welfare Officer to give words of advice of how to keep the cat in line with the SDC pet policy.

6.3.6 After a visit later in the month the Housing Officer was concerned about WH's mental health and made a referral to the mental health service. A tenancy audit was carried out in August 2019, The property was untidy, but no repairs issues or tenancy compliance issue were identified. Advice was given regarding the tenancy agreement and expected conditions of property i.e., tenant responsibility to keep the property in good order. WH was supported through the appointment by a mental health practitioner.

6.3.7 In August WH told an AOT practitioner that she was using crack cocaine regularly. She did not wish to seek help as she did not feel it had become a problem. It was noted she was vulnerable and easily influenced by others who used her home to take drugs.

6.3.8 In October 2019 WH told AOT that her "ex-partner", W, had hit her in the face the previous night and that she punched him back. She also disclosed to AOT staff that she had hit her cat and made its nose bleed and also picked the cat up by his legs. During the visit WH showed AOT a "crowbar" which she kept in the cupboard "*in case anyone gets in her way."* AOT updated WH's risk assessment with information about the metal bar, but not in respect of violence to WH or animal cruelty. However subsequent notes regarding WH often note the condition of her cat.

6.3.9 A CPA meeting was held between WH and her mental health care coordinator in November 2019. No other agencies, including her GP, attended. WH's debts remained and she needed support to attend CAB. Her substance misuse continued and was impacting on her engagement and mental stability. WH did not wish to attend a substance dependency service or receive any support with substance misuse at that time.

6.3.10 Visits from AOT continued into 2020. By 20th January WH was staying with her female friend, Z, but called the police after being 'thrown out' of Z's house. Although WH reported that Z had assaulted her there were no injuries. WH had a pattern of calling the police for support but subsequently not following up any allegations. WH's flat was very cold by the end of January 2020, she said that she had lost the meter key several weeks ago and had not managed to replace this.

6.3.11 The first COVID pandemic lock down began on the 23rd March. AOT visited weekly to meet WH at her door and deliver medication. There was no consistency in which AOT practitioners attended.

6.3.12 WH's care coordinator visited her at home at the end of May 2020, Z was in her flat and both said they were off to score drugs and drink. WH wanted reassurance she was not going back to hospital. WH reported that W had hit her on the head the previous night and

another male had raped her. The care coordinator thought that WH was under the influence of drink and drugs.

6.3.13 During June 2020 WH seemed well, she was receiving her medication regularly and by July 2020 a plan was made for her to transfer back to the Recovery team. This would entail WH picking up her own medication. Although acknowledging that medication helped her, and more able to talk about her illness and hearing voices, WH reported forgetting to take her evening dose. AOT decided she should have a medication review.

6.3.14 The following week WH disclosed to AOT that W had hit her recently when she "*went to tell him (she'd) smoked heroin the other day*". WH was observed to be slightly dishevelled in appearance, but her flat was relatively tidy, good eye contact maintained, speech even in tone and volume and no evidence of responding to unseen stimuli. WH said that she took drugs when she was '*feeling low.'*

6. 3.15 On the 1st September Z alleged that WH had sexually assaulted her, this allegation was not taken forward by the time that WH had died.

6. 3.16 Two days later WH asked AOT for advice on stopping taking crack cocaine, although she did not yet feel ready to do so. She also reported using legal highs. She told AOT that she had stopped contact with Z for now as "*she keeps asking for money*."

6.3.17 AOT attempted to go ahead with a request to WH's GP to take over dispensing of WH's medication, but by the 18th September it was increasingly apparent that WH was not concordant with medication. She asked for help to access support with regard to crack addiction, but this appears not to have been arranged.

6.3.18 WH was reported to the police for an assault during a drunken argument on 11th October, but the victim did not pursue the matter. By the 12th October AOT noted that WH appeared more stressed and reported feeling troubled by voices, she had chronic symptoms of voices and paranoia. Her flat was cold, and she had no money for seven days. The transfer to the Recovery team was abandoned and AOT agreed to return to prescribing WH's medication, increasing contact to twice weekly for four weeks to monitor her medication compliance.

6.3.19 On 20th October Z reported to the police that WH had been raped by a mutual acquaintance. WH said that this was consensual.

6.3.20 On 2nd December AOT received a phone call from WH wanting to know when her medication would be delivered. AOT advised that her medication was not due until the next day, WH said she "*must have got muddled*" and passed the phone to a "*friend*" who claimed that WH had accidentally thrown away her medication, AOT reiterated medication would be delivered as per plan the next day.

6.3.21 On the 3rd December AOT was invited into WH's flat. The flat was dark and smelt of incense sticks. The kitchen area was cluttered and chaotic, WH admitted that she struggled with keeping her home tidy, she put this down to experiences of pain in her leg and not being able to move about easily. Assistance was given by AOT to wash dishes and tidy the kitchen. WH spoke about recent contacts with friends and mentioned that she thought she had found a new boyfriend. She had food and prepared herself something to eat. AOT observed that WH seemed quite settled in her mental health and was able to engage in almost an hour contact.

6.4. Analysis of Key Episode 2.

6.4.1 AOT continued their assertive support WH, facilitating her contact with SDC and the CAB. They continued to deliver medication to WH throughout the pandemic lockdowns, taking opportunities to ascertain her mental health and wellbeing at visits. In 2019 it is understood that AOT were able to send two consistent practitioners to engage with WH. However, with staff issues and COVID pressures from 2020 onward AOT could not send a consistent practitioner for each visit and lost the opportunity to build a consistent relationship. The police liaised with mental health services when concerned about WH's wellbeing.

6.4.2. WH's risk assessment of the time included a longstanding '*medium*' risk from other people, and from substance misuse, domestic abuse, sexual and financial exploitation. WH's debts had continued to mount without a documented understanding of why this should be. It is also hard to know whether WH was 'non-concordant' with medication or whether her medication was taken from her or sold. On occasion she handed back unused medication to AOT, but she was also prompted by "friends" to ask for more on the pretext that her medication was thrown away. WH was noted to neglect her own needs, and the theme of a cold flat recurs every winter from 2020 onward. WH may have either lacked the initiative to maintain heating or was unable to afford this. AOT's response is recorded as continuing to support concordance with medication, visiting between daily and three times per week.

6.4.3. WH was considered to misuse substances and, according to her notes, to be contemplating getting support to stop using. By September 2020 she was asking for support to get the help she needed. There is no recorded response to this request. The GHC report remarks that WH's dual diagnosis was not fully understood by practitioners, clinical supervision facilitated by the Dual Diagnosis Consultant Nurse may been beneficial for the team to reflect on their work with WH.

6.4.4 WH's situation became more complex whilst the mental health team's ability to engage with her became limited. A CPA meeting could have been used to explore a wide range of concerns with WH and multi-agency partners, her GP, the police and SDC. Given what was known about the context in which WH was living and the impact of identified risks on her mental and physical health a multi-agency meeting could have also been called to explore safeguarding issues.

6.4.5. WH was also eligible for s117 aftercare, services can be provided under this section to prevent a decline in mental health that may result in hospital admission.

We will discuss this further in sections 6.6.6.-6.6.7.

6.4.6 The AOT service was under great pressure from 2020 onward. The team continued to provide an in-person service throughout the pandemic lock downs, but because of COVID restrictions this was on the doorstep. The main AOT intervention was medication delivery. Staff were also off sick or caring for family members whilst trying to main a consistent service.

6.4.7. In addition to pandemic pressures, the AOT was struggling with staffing issues, they had no dedicated consultant psychiatrist and no manager, only one of the two care coordinators was working, and they were trying to manage a caseload as well as the team. AOT practitioners had no regular supervision. Staff morale was low, the team are reported to have been functioning in 'survival mode' and the need for responsive multi-agency work was too overwhelming. In such circumstances the professional curiosity needed to fully capture and address the complexity of WH's life will be limited. [6] The preventative, trauma informed and multi-agency working needed to address not only WH's situation but also potentially the situation of others in the location became impossible to consider in such circumstances. Locum consultants provided cover to AOT but the staffing and supervision issues for this team only began to be resolved in 2022.

6.5. Key Episode 3: 4 January – September 2021

6.5.1 On the 18th January 2021 WH's mother telephoned AOT concerned that WH had moved in with Z. Z had called WH's mother and said that WH was no longer taking any drugs and did not require money from them. WH had asked that her whereabouts was not disclosed to AOT.

6.5.2 WH's relationship with Z continued to be stormy. During January 2021, both parties made complaints to the police about each other, WH alleging that she had been assaulted by Z and Z alleging that WH's cat had scratched her car. Police submitted a 'low level' VIST regarding Domestic Abuse, viewing Z and WH as ex-partners. On the 21st January WH requested that her friend Z receive her medication, when told this was not possible WH agreed but said her "*legs were bad*". By the 22nd January WH had called the police to complain that Z had thrown her out of the flat but refused to return the cat. AOT checked WH's whereabouts with her mother who reported that WH and Z had fallen out, but WH's medication had been returned to her by a man on Saturday from Z's. WH continued to claim that the Pregabalin had been 'stolen.' On the 26th January a 'friend' of WH's called AOT to say that WH was spending £300-400 on crack and that she took heroin the previous night.

[6] Research in Practice (2020) *Professional Curiosity in Safeguarding Adults; Strategic Briefing.* Dartington Trust.

The friend also reported that she had video evidence of WH threating her and her partner with a 'hit man.'

6.5.3. A CPA meeting between WH and her care coordinator was held on 17th February. WH said that most of her needs were being met. She was struggling with voices and requested a medication review. The medication had helped her to feel stable. Her mobility was deteriorating due to her cerebral palsy, and she needed more support to get around. She had a trapped nerve in her leg. Her mobility scooter was out of use.

6.5.4. The police were called to an argument between WH and her male partner, W, on the 18th February and recorded concerns for both.

6.5.5. From February 2021 it became harder for AOT to contact WH. Any interactions were brief and at her door. During March 2021 AOT made strenuous efforts to find WH, she missed the delivery of her medication but insisted she was still *'concordant'* and had '*spare medications*'. By April 2021 she was spending more time at W's house and wanted her medication delivered there. She agreed to be at her flat to received medication but did not do so. At times AOT resorted to contacting W to find WH. Her care coordinator was trying to get a walker for her as she was complaining of pain in her legs and difficulty moving. By June 2021 WH was back at her flat as W was '*away on holiday'*. She no longer had a mobile phone and had borrowed one but would not share the number.

6.5.6. Even with W away WH continued to be hard to contact but was seen on the 24th June by AOT looking dishevelled and asking for a food parcel. She had a new kitten. Subsequently AOT were unable to contact her and, after making efforts to contact all known connections, asked the police to undertake a welfare visit on the 1st July. Entry was forced. WH later telephoned the police station and AOT to express her annoyance.

6.5.7. AOT delivered seven days' worth of medication to WH on the 1st July. WH was taken by ambulance to the hospital Emergency Department at 7pm on 3rd July having "*run out of medication*". WH was "*not stable on feet*." The ambulance crew recognised that "*this had happened before*" and that WH became agitated when she did not have her medication. We do not know what had happened to the medication delivered to WH only two days previously.

6.5.8. WH appears to have been staying at Z's house who once again refused to return her belongings and cat. WH reported to the police on 6th July that when she went to get her belongings Z spat at her and pushed her to the floor. WH did not respond to further attempts by the police to make contact and no further action was taken.

6.5.9 WH visited AOT on the 8th July. This time she reported that someone else at Z's demanded that she leave, pushed her and spat in her hair. Said she "hitch-hiked" back to Stroud and had been at W's today. She initially asked that AOT give her a lift to Gloucester

to collect some of her belongings but was informed this was not possible due to COVID restrictions and also the risk of violence from others present at Z's. WH was supported to speak with the police and given an incident number. The police told her that she could contact them on 101 if she went to Z's property and they would attend, when available, to prevent a breach of the peace. The Police could not enter the property or remove her belongings or the cat.

6.5.10. WH returned to AOT on the 14th July to collect her medication. She was agitated, wanted her kitten returned and that she knew a person who "*could smash faces in*" who she could pay to visit Z. She was upset that AOT could not recover her cat for her. It was suggested that WH wait for the situation to calm down before she approached Z, and she would get her clothes and hopefully the kitten back. WH was asked to consider the welfare of the kitten and where the kitten would be best placed, reminding her of fact that the kitten was left alone at her flat, she insisted this was just for one night and she had not harmed this cat.

WH became verbally aggressive and said she wanted no more to do with mental health services. She also said that W regularly "*beats her up"* and she had "*bruises all over*" her body. She did not want to report this to the police and spoke of wanting to "*torch*" the police station, "*that will get rid of them all*". WH was not willing to listen but kept saying how she wanted to be like Whitney Houston, and no one cared about her. WH calmed down after a while but insisted she wanted nothing more to do with AOT or mental health services.

6.5.11. On the 20th July WH's mother called AOT to say that WH was living at W's and had asked her parents for money, but they had decided to buy her a basic mobile phone instead. WH had told her parents that the police were involved in relation to the people that have been living in her flat. AOT advised WH's mother that they continued to try to support WH in relation to her debts but that she struggled to work with AOT and the CAB.

6.5.12. WH did not attend an appointment for a medication review on 21st July. It was decided to "*respect WH's views and discharge her from mental health services*." AOT informed WH of this the next day in person. She had a new kitten. WH is reported to have '*accepted*' that she would be getting a letter from the locum consultant about discharge plans.

6.5.13 In a discharge letter to WH's GP, the consultant advised that the GP should take over prescribing WH's medication. Because of concerns about WH's continued illicit substance misuse and regular compliance on Pregabalin, AOT recommended the Pregabalin should be gradually stopped. There was no mention of risks to WH, incidents of domestic abuse or the need to review her mental health or present medication in the discharge letter. There was no crisis contingency plan.

6.5.14. On the 28th July WH arrived at AOT with a "*fellow service user*" to request her medication. WH denied receiving a letter about her discharge and asked if she "*rang her GP would they be able to give her medications or would it be Boots*." WH was advised that she would have to speak to them. The person with WH was verbally abusive to staff and WH left with him.

6.5.15. The discharge arrangements were not well planned. The GP did not receive the discharge letter from WH's locum consultant, and by the 3rd August AOT realised no prescription had been set up with a pharmacy. WH called AOT on the 12th August to ask if they would pick up her medication from the pharmacy because "*her legs were hurting*". She was told that she had been discharged from AOT and needed to sort out how to pick up medication herself. The Mental Health pharmacy liaised with the GP who called to clarify the prescription and agreed a review to be arranged regarding the Pregabalin. The GP reports not being surprised by WH's discharge, the last communication they had about her contact with AOT was in April 2019 and they assumed she had not been seen for some time.

6.5.16. WH saw her GP on the 13th August to try to sort out her medication. On the 16th August the GP contacted AOT to say that they would not take over WH's care until a proper handover was made, i.e., a letter confirming exactly what medication she was currently on, when she last received this and how much she had received.

6.5.17. AOT explained the new arrangements regarding medication to WH's mother on the 18th August, the AOT team manager followed this up the next day and reported that WH's mother was accepting that WH "*makes many unwise decisions and is not engaging with services."* Information was given to WH's mother regarding local charities and CAB to pass onto WH. The Crisis team number was also given.

6.5.18 On the 27th September WH's CPA discharge review was held. WH's care coordinator, the GP and WH were not present.

In terms of 'unmet need' it was noted that WH was "*known to lead a chaotic lifestyle and had co-existing problems with illicit substance misuse. She continued to present a risk to herself in relation to this, however she had shown poor engagement with the services that could offer her support and had indicated a wish to be discharged from such services."*

It was noted that WH was eligible for support under MHA section 117.

6.5.19. WH saw her GP on the 5th October and requested diazepam, this request was refused. It was noted that she had been discharged from Mental Health services. WH stopped being prescribed Pregabalin in November 2021.

6.6. Analysis of Key Episode 3.

6.6.1 WH's close relationships with men and women continued to have an adverse impact on her. Whilst the risk of abuse from male partners was noted, only the police considered the situation between WH and Z as potential domestic abuse. Z appears to be a powerful

and controlling presence in WH's life and the consequences of this for WH, especially regarding Z's theft of her cat and involvement in violence, is significant. Was the impact of Z on WH's safety and well-being not recognised because she was a woman?

6.6.2. In Adult B's Patient Safety Investigation Report WH is reported as "*completely disengaged from services and asked to be discharged*." In the report for this SAR GHC have said that WH *"wanted nothing more to do with Mental Health services*." From the account given within the chronology submitted by GHC we can see that WH's rejection of Mental Health services appears to have been expressed in the context of her frustration that AOT could not assist her in getting her cat back. Her discharge was not managed or 'stepped,' the identified risks in her life remained and her situation was very unstable. In these circumstances a multi-agency meeting would be essential to ensure that all services were aware of WH's discharge, the risks to her and what contingency plans were in place should she become unwell, or her situation deteriorate further. The discharge CPA was not multi-agency, WH's GP in particular was not invited, WHA's s117 eligibility was not considered. The domestic abuse, exploitation, potential cuckooing, substance misuse in WH's life, together with her self-neglect and difficulties in managing her relationships, had not been explored over the previous two years, the impact of these factors was not considered together with what further arrangements might need to be made. Was there any other service who could be involved? WH regularly approached volunteer organisations in the area, could they have been approached to form a light touch plan around her? There was no information sharing around the discharge, the police and SDC continued to believe that WH was being seen by AOT, a risk in itself when identifying concerns about her wellbeing which they thought the mental health services would mitigate.

6.6.3. GHC discharge policies were not followed[7], in particular:
"*Before (discharge) can happen, the following things should occur: -*

- *The discharge process should be discussed with the service user receiving treatment*
- *If the service user's care is managed by a care coordinator then there must be a full care review meeting held to consider discharge*
- *It should be considered if any additional input is required from the service user's support network or local community or another agency to facilitate discharge and whether this is possible*
- *Any specific risks associated with discharge should be identified and transparently discussed with the service user and carer*
- *If for any reason the service user has disengaged with our services in an unplanned way it*

[7] GHC CLINICAL POLICY: Assessment and Care Management (Incorporating the Principles of the Care Programme Approach). Version 12.

will be important to follow this up and try and find out if we can do anything to support re-engagement. If not then a summary of the care offered to date will be produced, including the actual date of discharge, any potential areas of risk to self or others and any handover of pertinent information to other professionals still involved such as a Social Worker, or GP.

Once discharge has been agreed then –

- *An appropriate review and handover to primary care worker / GP is arranged*
- *Plans for review, support and follow-up are produced as appropriate*
- *A clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that service user's mental well-being*
- *A discharge summary completed to the approved Trust format is sent to the GP within 5 days.* GHC Page 40 *"*

6.6.4. WH's GP had been invited, but did not attend, a CPA meeting in 2019, but there is no evidence that they were invited to any CPA meeting connected to WH's discharge in 2021. GHC teams use a form to convey information to GPs who cannot attend, but it is understood that AOT does not use this form. When AOT did send information to WH's GP there was limited information regarding WH's risks and or history of domestic abuse, behaviour toward practitioners or history of self-neglect. The transfer of WH's prescriptions was not arranged. The GP appears to be expected to review WH's use of Pregabalin and taper this off, this does not appear to have been considered whilst WH was seen by AOT.

6.6.5 WH's parents were given information by AOT regarding local charities, CAB and the crisis team number. WH's parents lived 1.5 hours' drive away from WH and although they were concerned and very much part of her life they were geographically distant and had not been in a position to influence or monitor WH's wellbeing for many years.

6.6.6. Because she had previously been detained under section 3 of the MHA, WH was eligible for services funded via S117, which are intended to prevent a deterioration in mental health which might mean a return to hospital[8]. S117 aftercare does not end because a person has been discharged from mental health services. We do not know why WH was not considered in need of s117 aftercare on discharge from hospital in 2015 or why this was not reconsidered subsequently. WH's needs met the criteria for such support and consideration of her eligibility could have informed preventative and pro-active work with her. WH appears to have benefitted from a slightly more structured setting; would reconsideration of other options have been helpful at various points in the time considered by the SAR? Currently, people who are actively in receipt of s117 funded services are known in Gloucestershire, but not the people who are eligible. If a person is detained under MHA s3 this will be recorded on both of the recording systems used by the local authority and GHC. But this is reported as not always reliable. Gloucestershire does not have a s117 team.

[8] Section 117 of the Mental Health Act (S117 MHA): Aftercare Gloucestershire Joint Policy. Pages 23 – 34.

A team would enable effective gathering of information about all eligible groups. Eligibility can be forgotten, and older people in particular are often not reviewed or formally discharged from s117. A good system across all organisations and teams is needed ideally with the ability to show whether health or the local authority has responsibility for the funding. A team could ensure good reviewing and discharge practice as well as accurate information gathering.

6.6.7. The quality and frequency of s117 reviews and the consideration of s117 as part of CPA and discharge from MH teams is not always assured in Gloucestershire. However, there was an update of the s117 policy eighteen months ago and there is work going on to embed this supported by a focused training package which is expected to be shared across services in Gloucestershire.

6.7 Key Episode 4 October 2021 – 20th September 2022.

6.7.1 WH reported a theft to the police on 7th October, seven transactions at the same ATM machine removed £280.00 from WH's account, her card was also missing. No suspects were identified via CCTV and the police found no further lines of enquiry.
During the process of the investigation into this offence Police identified a possibility of WH being exploited by two individuals. WH had allowed these two people to stay at her property as they were homeless at the time. WH disclosed to police that they were aggressive and generally nasty towards her, prompting her to refuse them access the next time they wanted to stay over. Police identified concerns regarding cuckooing. This was the first VIST submitted by police in three months, WH had previously been a victim of cuckooing, but the suspects had now moved out, reducing risk. The VIST documented that WH had '*No obvious care and support needs'* but that any further VIST's should consider the local 'Vulnerable Adult Officer' and ASC. On the 17th November WH called police to report that one of the individuals had hit her around the head several times with a bag of shopping. WH did not wish for any formal action to be taken, and she declined to confirm their identity.

6.7.2. WH's parents last saw her just before Christmas 2021, and report that they had a lovely day. They were planning to come back in February when her father was going to put a new hob and kitchen tops into the kitchen and do general jobs around the flat.

6.7.3. On 22nd January WH called the police to say that a friend had outstayed her welcome and she wanted her to leave. The incident resolved itself without the need for Police intervention. Concerns were raised by attending officers regarding WH's flat being freezing cold, no heating and limited lighting, they noted "*these issues should be resolved by SDC as soon as possible*." WH also reported being "*bullied by the local druggies*", asking her for money, banging on her windows and being verbally aggressive. Police were concerned that "*these individuals are capable of taking advantage of a vulnerable person*." On the 25th

January WH called again to say that people were still banging at her window but would only co-operate with PC1. PC1 called WH who sounded confused and said nothing had happened that day. PC1 reassured her that she had contacted SDC who were going to contact her.

6.7.4. WH's father called the GP surgery on the 28th January worried that WH was not taking her medication.

6.7.5. Over the 1st and 2nd February WH called the police twice as a man had threatened to smash her window and then arrived at her flat and smashed a window saying, "*I hope you die*". Subsequently WH would not engage with the police.

6.7.6. During February 2022 the Police had a number of concerning interactions with WH. On the 11th February she called police wanting them to arrest her and take her to a Mental Health hospital. She stated she was feeling suicidal but had not spoken to the crisis team as they were "*not helpful*." Police attended and she was calm and conversational but talked of seeing spirits and interacting with them. Police remained with her until she became calmer. The flat was in "*reasonable order*," and she had a cat she was very fond of. WH declined support from Crisis team, Police noted that she was *'not medicated.'*
WH gave consent for the Police to contact her GP. A referral to the police Safeguarding Adults, Missing, Mental Health (SAMM) was considered but '*they have no capacity to review.'*

6.7.7. WH subsequently made two bizarre telephone calls to Police call handlers. A referral to the Mental Health crisis team was considered but not made.

6.7.8. On the 13th February WH was seen holding her cat outside her flat. She got into the back of the police car and when removed "*ran up the road stating that Fred and Rose West were around and killing people and that they had risen from the dead*. *She then gave a name of an ex-police officer as her own. She said that this person was inside her head. WH then left again and went inside her own property before handing a blanket out of the window to officers and asking us to dispose of it as Rose West was inside it. WH's flat looked slightly untidy inside but otherwise in good order (as seen through the window). It looked as though she has been sleeping on the sofa. WH was somewhat dishevelled and did not appear to be looking after herself particularly well. She did not seem to be posing a particular risk to herself, and the Crisis team have stated this is a fairly frequent occurrence for WH.*"

6.7.9. The Police had contacted the Crisis team and thought that they would make WH's AOT care coordinator aware so that there was no need for any onward referrals. The Crisis team have recorded that they gave a brief history of WH to the Police.

6.7.10. WH made another bizarre and threatening telephone call to the Police call handler on the 14th February. On the 15th February WH's father contacted the Police to say that she

had telephoned him to "*say goodbye and to take care and have a nice life*". He was unable to get hold of her again. Police visited WH who said she was "*fed up with local drug addicts bullying her*. *They often come to her address to speak with her. She says that this is affecting her mental health, and she now wants to move but feels like she can't. She also stated that she has learning difficulties which are also being triggered. When with police WH kept talking about an ex-police officer's spirit was looking out for her and was with her. She also mentioned that the spirit of Rose West was bothering her*." WH was advised to contact SDC about a move.
Shortly after this visit WH's parents believe she blocked them from telephoning her. They had purchased a TV/telephone/broadband package for her and therefore were sure that she had a landline installed.

6.7.11. Police sent a VIST to WH's GP which arrived on the 15th February. The GP practice interpreted this as 'information sharing' as the VIST contained the words '*does not require immediate support.'* The GP practice tried to contact WH via text and telephone over the next two days but had no answer, they then wrote to WH inviting her to make an appointment but again had no response.

6.7.12. During March 2022 WH caused damage to the communal doors at her address and also reported to SDC that her living room door had been kicked in, she was very abusive during the call to SDC. On the 15th she deliberately set off the fire alarm at the property.

6.7.13. In January 2022 GHC Occupational Therapy Assistant (OTA) ordered a replacement 4-wheel walker for WH following a previous referral from AOT. On the 1st of March, the OTA telephoned WH to review the replacement walker. WH's mobile number was answered by a man who reported that WH had been using his number but was not any longer. The OTA wrote to WH and continued through March to try to contact her through her GP and family, her family said they had no contact with her since February. AOT said they had no contact with her for the last year.

6.7.14. Police and SDC made a joint visit to WH on the 1st April. WH said that someone had '*recently*' thrown her down the hallway with such force that the door had snapped in half. WH would not say who did this. Police were hopeful that working with SDC would result in a move for WH, but SDC had not received any request from WH to move and were unaware that the police thought that a request had been made. The SDC Housing Officer visited her again on the 26th of April to check on her wellbeing and how she was managing the tenancy. At the visit concerns were discussed regarding the damp and mould in the property. WH said she was unable to afford to keep the heating on. She also said she felt that people took advantage of her. A surveyor's visit was booked to assess the issues of damp, mould and window safety.
The Housing Officer contacted the Police and asked if they could attend to talk with WH about her feelings of being taken advantage of and other potential vulnerabilities.

6.7.15 WH bought £205 into the Police Station on the 27th April, throwing it at the receptionist before leaving. This was one of "*a few incidents recently where she had attended the station to speak to officers or give them items such as bunches of flowers (some officers don't even exist)*." When officers attended her address to return the money they reported that her flat was in a desperate need of repair. There was an overwhelming smell of damp, the floor and walls were wet, there was mould all over the walls. Two windows had been smashed and damaged. WH explained she had no clothes, no food, and could not afford to pay for heating. She had "*minimal furniture and her duvet and mattress are brown and wet*." WH went to the food bank or scout hut to get food and said that SDC were going to get her food vouchers. WH had no Bank account; her local branch had shut down and she had lost her cards. She had no mobile phone to be able to ring them, the police officer did not think that WH had "*the capacity to be able to find ID, fill out forms etc to set one up elsewhere without any help. She has said people have taken her money before and bullied her because of her learning difficulties and taken advantage of this. WH appeared unclean and has one set of clothes, she said that she drank alcohol but was not a drug user. WH stated she would like some help."*

6.7.16. The Police made a referral to Adult Social Care (ASC) and WH's GP. The VIST stated the above concerns and also that: "WH *has previously had issues with drinkers and drugs users coming into her block demanding to be let in as a place to stay. She says this hasn't happened recently but there is a duvet in the communal area that wasn't there yesterday (there is no one else living in the block at the moment) according to the housing officer. She has said people have taken her money before and bullied her because of her learning difficulties and taken advantage of this. I have encouraged her to contact me if this happens again and to report incidents to the Police. She has disclosed an assault that took place recently (no further details) which ended up with her being thrown into a door at her property which caused it to break in half. I will create a crime report for this. Physically WH appears unclean as if she is not showering, cleaning or brushing her hair, changing her clothes or eating properly. She has one set of clothes which she wears constantly not being cleaned. I didn't see any items such as a toothbrush, towel etc. WH has stated she would like some help and both myself, and the housing officer, have explained referrals will be made to try and get her some."*

6.7.17. An SDC Surveyor visited WH's property on the 27th April property to take damp and mould readings. He requested a mould wash for three rooms, replacement kitchen and bathroom fans, locking window restrictors and a check for any leaks in the bathroom.

6.7.18. WH's neighbours have told the SAR lead reviewer of concerning interactions with WH during this time. She was entering her flat by climbing in and out of the windows. She asked a neighbour to go into her flat as she was afraid to go in because there were rats, and

these might attack her cat. After ascertaining no rats were present the neighbour tried to reassure WH.

6.7.19. The GP practice received a police 'adult at risk incident report' and VIST on the 4th May. The report detailed WH throwing money in the police station and taking flowers to various unknown police officers together with the police visit to WH's flat and the conditions there. The police report stated, "*housing involved*" "*done necessary referrals*." The only health related comment was that "*mental health could deteriorate*." The GP practice noted that no action was requested from them but sent a letter to WH inviting her to make an appointment. Her mobile phone was 'number unobtainable.' WH did not make an appointment.

6.7.20 The Police referral was screened by Adult Social Care (ASC) on the 4th May and passed to the enablement team for practical support around housing, money and access to food. The decision rationale was not recorded, but the referral was not passed on for a decision about whether the local authority section 42 duty applied with reference to WH's inability to protect herself against assault and financial abuse. The usual practice is for the enablement team to refer back to ASC if there were concerns about abuse or care and support needs identified. The enablement team made telephone calls to WH and visited at various times of day between the 7th June and 11th July but had no response. On the 14th July they found WH at home. WH said that she only wanted help with specific issues, e.g., food bank and help to get a scooter. Enablement agreed to visit the following week and felt that WH would be "*appropriate for enablement support initially*." No concerns were identified with WH's ability to make relevant decisions at this visit. Enablement did not find WH at home on the next two visits and sent her a "*trying to make contact*" letter on the 22nd August explaining that her case would be closed if no further contact was made. No contact was made with other agencies to check if there were any other concerns, and no contact with the referrer, the Police, to advise of difficulty in engaging WH.

6.7.21. On the 1st June, the SDC Gas Safety Engineer attended WH's flat to undertake a gas safety check and raised concerns with the Housing Officer about damp in the flat and about WH as a vulnerable tenant. No follow up action by SDC officer is recorded in response to this report.

6.7.22 On the 26th of July Police had reports that WH was in the street, shouting and banging, looking through windows. She picked up a spade and threw it on the floor. She looked distressed and agitated. Police undertook a welfare check "*and safeguarding completed."*

6.7.23. The damp work was completed by SDC on the 2nd of August 2022. The Property Repair Operative raised concerns about how WH was managing her tenancy with the Housing Officer. No follow up action by SDC officer is recorded in response to this report.

6.7.24. WH came to the attention of the police on the 2nd September when she allegedly stole a phone and sprayed deodorant in the owner's face, and on the 4th September when WH alleged that Z was at her home address and had unsuccessfully tried to steal her cat.

6.7.25. WH was murdered on 20th September by Adult B. Her body was not found until the 4th November. On attendance Police describe WH's flat as "*extremely bleak and probably speaks to the life that WH had been living. In the main living area there was a bed, a single chair, a cabinet and a small chest. There was no TV, no radio and the flat was devoid of any personal effects. The flat was very poorly kept, especially the bathroom and kitchen that were cluttered with rubbish. It was a very stark and sad space, and it is difficult to imagine how someone could live in those conditions."*

6.8 Analysis of Key Episode 4.

6.8.1 Over this time period WH's mental health appears to have deteriorated. It is unclear whether she was taking any of her prescribed medication and she is often described as 'unmedicated.' As WH's mental health deteriorated she appeared isolated and increasingly unable to protect herself from the risks already identified.

6.8.2. The Police and SDC made joint a joint visit and shared some, but not all relevant information. SDC operatives did express concerns about WH, but it does not appear any actions took place as a result.

6.8.3. WH was discharged without this information being shared with the other organisations involved with or likely to encounter her. The police believed that she was being seen by AOT, in February 2022 believing that the **"***Crisis team would make WH's AOT care coordinator aware so that there was no need for any onward referrals".*

6.8.4. The mental health crisis team were alerted by the police to WH's situation in February 2022. The crisis team record giving an overview of WH's history to the police after which the police recorded **"***this is a fairly frequent occurrence for WH."* Such a statement indicates that WH's behaviour and situation had become 'normalised' and changes in her situation were less likely to be observed or acted upon. The lack of communication, single or multi-agency contingency plan after her discharge from mental health services compounded this situation. The deterioration in her mental health and consequent rise in the impact of any risk on her became less visible.

6.8.5. WH was ambivalent in her relationships with both individuals and services. She was particularly ambivalent about the police who she often contacted for support and comfort but also made abusive telephone calls to. Police colleagues report that there are many people like WH who are isolated and use the police as a social care contact to fill a lack of services, friends or family, the Police "*will always be there and never say no."* How will this

change in the light of the Right Care Right Person" [9]initiative? WH did not appear to be in mental health crisis, but the paucity of support services around her meant that the police became her go-to service. How can police colleagues be supported by multi-agency partners in these situations?

6.8.6. The Police Safeguarding Adults, Missing and Mental Health (SAMM) team was established in 2021 to specifically deal with Safeguarding Adults, Missing and Mental Health calls/cases and is responsible for offences committed against vulnerable adults and the risk related to them. It is overseen by a Detective Chief Inspector who is also operational. The establishment for the team is a Detective Inspector, a Detective Sergeant and six investigators but these posts are not currently filled, and the team cannot function. There appears to be no parity in Gloucestershire between over-arching multi-agency systems for children and those for adults at risk. Police now use the Multi-Agency Safeguarding Hub to bring adult at risk cases to the attention of ASC, but adult safeguarding processes are not built in the MASH function. How do the police respond to adults in WH's situation? WH was not always seen by attending officers as an adult with care and support needs, an absence of information sharing meant that her mental and physical health needs were not clearly identified in any jointly agreed approach. There was no local police service ownership of WH's case, no referral to the Police local vulnerability officer, and no agreed consistent approach to her or others who lived in the area. The absence of a central focus within the Police may also lead to an absence of trend analysis, information gathering and followed up referrals to the relevant services. Police and SDC officers did work together to try to resolve some of WH's issues, but without a jointly agreed plan with input from other services these joint visits and conversations did not result in any consistent or agreed action.

6.8.7. From February 2022 WH told police that she wanted to move from the flat but "*feels she can't*". WH was advised by the police to speak with SDC. The police and SDC undertook a joint visit in April 2022, good partnership working, but whilst the police were hopeful that working with SDC would result in a move for WH, SDC had not had any request from WH to move and so did not progress this.

6.8.8 When sending VISTs to the GP the police had an expectation that the GP would take action regarding WH's mental health, assessing the information and speaking with mental health services. The police did not spell out this expectation as this is not their area of expertise.

6.8.9. The police made one referral to ASC regarding WH in May 2022. There does not appear to have been any ASC information gathering from other services who knew WH. AOT, a team set up maintain engagement with people who services find hard to consistently engage, had struggled to keep in contact with WH and could have offered insights as to what the challenges and potential adjustments could be. The referring agency, the Police, could have given more insights into WH's complex situation. The response appears to have

[9] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person

been predicated on WH self-neglecting and wanting help and as such missed much of the context around WH. The enablement team closed WH's case having not been able to maintain any contact with her. A review of the referral with input from the referrer and information from SDC and AOT may have resulted in an adult safeguarding approach or at least a multi-agency meeting prior to closure to determine further approaches.

6.8.9. From all the factors above, we can conclude that a key factor in the last year considered by the SAR was the absence of multi-agency information sharing, risk analysis or risk mitigation planning. Services appear to have limited systems to enable such approaches. We can consider two aspects to such an approach, the first with regard to WH and the second regarding the address at which she lived.

6.8.10. A multi-agency approach to WH's predicament would have led to:

- A lead agency to coordinate multi-agency working.
- Creative engagement plans utilising all involved services and voluntary agencies.
- A shared understanding of WH's care and support needs, her challenges and the impact of the known risks on her.
- A consistent and agreed approach to sharing information about WH including her contemplation of an accommodation move.
- A consistent and agreed approach to engaging and trying to build a relationship with WH.
- An agreed contingency plan, including indicators of WH's mental and physical well-being and a clear course of action utilising windows of opportunity when available.
- Identification of any statutory powers that could be used to address the situation.
- Named individuals in each service who could communicate with WH and each other.
- Review intervals to maintain the multi-agency approach.

Consideration could also be given to 'a team around WH' and, given her behaviour at times toward practitioners, support for those working with her.

6.8.11. A multi-agency approach is also indicated regarding the context in which WH lived. It is understood that this type of accommodation in Stroud is allocated to people who have mental health issues, who may have a dual diagnosis, and there are risks of a culture of exploitation. On numerous occasions people were noted to have been using WH's flat to deal and use drugs. AOT were concerned that there was an illicit drugs network around the area who would use the accommodation including WH's flat on benefit and prescription days. The police also had this awareness as did SDC, yet there were no discussions about use of powers including partial closure orders, discussion about approaches to any of the vulnerable individuals caught up in this network or agreed trauma informed approaches to those involved. We need to work together on the context of harm as well as with those individuals caught up it.

6.8.12 What frameworks might already exist for this approach? Each District in Gloucestershire has a community safety partnership (CSP). At the time of the SAR learning event (December 2023) these were not well attended in Stroud by the services and individuals who were invited. The Gloucestershire office of the Police and Crime Commissioner are working to shape consistency of approach across all six Districts. CSPs can develop agreed approaches to exploitation in local areas and are made up of 'responsible authorities' which are: Chief Officers of police, probation services, local authorities, health (Integrated Care Boards) and fire and rescue authorities. The responsible authorities have a statutory duty to work together to: reduce re-offending; tackle crime and disorder; tackle anti-social behaviour; tackle alcohol and substance misuse; tackle any other behaviour which has a negative effect on the local environment; and to prevent people from becoming involved in, and to reduce instances of, serious violence.
Since these events described within the SAR occurred there have been a number of developments which may support partnership working around a location, these are described in section 7.

7. What has changed since?

7.1 Community Safety

Councils, Police and Fire services and Integrated Care Boards (ICBs) are now subject to The Serious Violence Duty[10] which uses a multi-agency approach to identify, share information and prevent serious crime in a local areas of risk with high levels of serious violence and abuse. It is a multi-agency approach. The Gloucestershire Strategic Plan was published in January 2024.

Project Solace, initially piloted in Gloucester and Cheltenham in 2018, was initiated in Stroud in 2023. The aim is to reduce repeat incidents and victims of anti-social behaviour (ASB) by providing a consistent approach between police and the local authority alongside support agencies and other partners.

The Anti-Social Behaviour Crime and Policing Act 2014 introduced specific measures designed to give victims and communities a say in the way complaints of Anti-Social Behaviour (ASB) are dealt with. This gives victims of persistent ASB reported to any of the main responsible agencies (Council, Police, Housing and Health) the right to request a multi-

[10] Police, Crime, Sentencing and Courts Act 2022 see https://www.legislation.gov.uk/ukpga/2022/32/part/2/chapter/1/enacted

agency case review where the threshold is met. In October 2023, Health joined the other responsible agencies to commence regular reviews of ASB cases in Gloucestershire.

7.2 Gloucestershire Health and Care NHS Foundation Trust (GHC).

AOT now has a permanent Consultant Psychiatrist and team manager.

GHC now have two specialist Mental Health Independent Domestic Violence Advisors (IDVAs) funded until 2025 and working in the mental health teams. The IDVAs raise awareness and provide training to frontline staff, as well as working with the person.

The need for CPA meetings to be multi-agency is being reinforced in GHC.

GHC has developed a Frequent Engagement Response Network (FERN) team within the Complex Emotional Needs service. The FERN team focuses on improving responses to people presenting regularly to emergency services and is comprised of a police officer, an assistant psychologist and a lived experience practitioner who will work together to create person centred, psychologically informed plans that can direct responders towards a trauma informed approach in situations of high risk. There is a monthly FERN meeting which includes police, acute and mental health trusts, including the mental health crisis team and the voluntary sector. Information is shared and a plan to support the person formulated.

7.3 Gloucestershire County Council.

Decisions about whether adult safeguarding referrals meet the criteria for use of the Care Act s42 duty are now made by a specialist team of safeguarding practitioners and not the ASC front door team.

The local authority plans to initiate a Multi-Agency Risk Management (MARM) Framework in early 2025. The purpose of the MARM framework is to support organisations to work together to engage the person, enabling a collaborative, coordinated and multi-agency response to risks via timely information sharing, holistic assessment of risk and the development of multi-agency risk plans.

7.4 Gloucestershire Constabulary:

The police are now identifying repeat, low risk VIST submissions. Three high risk VISTs in three months received by MASH trigger a referral to the local Neighbourhood Policing Inspector. This can also be bought to the attention of the local Community Safety Partnership (CSP) if wider issues need consideration. The Police can also ascertain through data sharing or contact if other services are involved with the person. The wording of VISTs

is also being considered so that there can be no misunderstanding on the part of the recipient as to the level of concern police officers want to convey.

7.5 Stroud District Council and Gloucestershire Constabulary.

Partial Closure Orders are now being used; these bar certain individuals from entering a property rather than evicting the tenant. The SDC housing team meet regularly with the police to share information, the Partial Closure Orders put in place have made a difference to the tenant and neighbours.

7.6. Stroud District Council.

SDC has implemented a weekly meeting between Housing Officers and their manager to discuss any concerns or challenges on their 'patch.' Individual supervision takes place 4-6 weekly with all staff, safeguarding concerns are part of the agenda for discussion. A new referral portal for safeguarding concerns alongside a training matrix to support delivery of safeguarding training appropriate to each member of staff is in progress. The safeguarding module built into the new SDC Customer relationship management system will help to ensure that recorded safeguarding concerns are followed up.

8. Findings and Learning Points.

Findings and learning points will be considered against each of the specific areas of focus for the SAR.

8.1 What did each organisation know about WH? How was information shared and understood? Did organisations share a common understanding of WH's circumstances, needs and risks? Did organisations know who else was involved?

8.1.1. What did each organisation know about WH?

No organisation had a complete picture of WH and what was happening in her life. WH was an unreliable informant and capable of giving different accounts to each involved organisation.

Learning Point 1. When people are living in high-risk situations good practice is to use the professionally curious approaches of *respectful uncertainty* and *safe uncertainty*[11] to gather information about risk from different sources.

[11] **Respectful uncertainty**, the capacity to explore and understand what is happening rather than making assumptions or accepting things at face value, applying critical evaluation to any information received and maintaining an open mind. By acquiring an open minded, inquiring and curious mind-set, professionals can avoid linear and absolute explanations by exploring alternative, multiple perspectives on a situation. **Safe uncertainty**, it is safer in situations of risk to accept that you do not know everything, you cannot eradicate all risk.

8.1.1.2 WH's protected characteristics were not accurately recorded. GHC details appear incorrect regarding her dual heritage and her sexual orientation was not recorded. The latter had an impact on how her relationship with Z was perceived, and whether domestic abuse was considered by GHC in the context of this relationship.

Learning Point 2. **It is important to ask people to disclose any protected characteristics (Equality Act 2010) and to record these. Understanding all aspects of a person's life means that we can be truly person-centred, and able to discuss their experiences, their needs and identify risks with them sensitively and appropriately.**

8.1.1.3. WH was described by services as being '*feisty and strong'* and also as '*vulnerable*.' WH's vulnerability to violence and exploitation was recognised, especially when mentally unwell. WH physically and verbally assaulted practitioners and other individuals. At the same time, she was exploited and assaulted and her property and cats, which appear very important to her, were stolen. WH had great difficulty in organising her life or keeping herself safe. In an analysis of power between WH, her intimate partners and the people who used her flat and resources, she was vulnerable to harm, something that some of her friends and neighbours appeared to appreciate and attempt to alert services to. Working with people who challenge services and practitioners is exhausting. Bias against such people can emerge when services are themselves under resourced and struggling and there can be a tendency to stand back and not engage with the deeper concerns which underlie the person's presentation.

Police officers were also given the impression by the mental health crisis team that WH's behaviour in February 2022 was a '*fairly frequent occurrence for WH'* so '*normalising*' her behaviour. Mental Health services had not seen WH for five months at this point. In not discussing or challenging this perception of WH's behaviour over the next few days the police deferred to the expert opinion of mental health practitioners whilst attempting to find the best way to respond to WH.

Learning Point 3.

Practitioners need supportive supervision and dedicated time to work effectively with people in complex situations. This work requires professional curiosity and a trauma informed approach, but these approaches are difficult to maintain when practitioners and teams are also challenged or unsupported.

8.1.2 How was information shared and understood? Did organisations know who else was involved? Did organisations share a common understanding of WH's circumstances, needs and risks?

8.1.2.1. Information was rarely shared between the organisations working with WH after October 2019 when Rethink ceased to be involved. This meant that each service was often

reliant on the information WH gave which could be inaccurate, for example whether she had asked for a housing transfer or not.

8.1.2.2. The police and SDC, two organisations who frequently encountered WH, were unaware that she had been discharged from mental health services. This influenced how they responded to concerns about her, believing that AOT was still involved. WH was discharged to her GP with no relevant information, an action that was challenged by the GP, but which served to further complicate WH's discharge and medication compliance. Organisations were aware of each other, but unaware of who was still involved with WH. This created a false sense of security and disguised WH's isolation.

Learning Point 4

Times of transition can elevate risk for people in complex situations. When cases are closed, or patients discharged who are still in situations of risk it is essential that other services are informed of the end of involvement and of contingency plans together with the indicators that contingency plans could be needed.

8.1.2.3. Both GHC mental health teams and the police service observed that WH was experiencing domestic abuse and was being financially exploited. However there do not appear to have been any conversations between the two services about this. How each organisation viewed domestic abuse may have been influenced by WH's status as both victim and perpetrator. A common understanding of how domestic abuse can present will be helpful. A DASH assessment in such circumstances is useful in order to ascertain impact and future risk as well as to enable access to a MARAC or relevant domestic abuse advice.

Learning Point 5.

Common definitions will help to identify the need for information sharing and referral. Organisations must have a shared understanding of how domestic abuse may present in the lives of people who have a dual diagnosis and the pathways and approaches to take in such circumstances.

8.1.2.4. Police colleagues were unsure whether WH had '*care and support needs'* and whether therefore they should consider VISTS at an earlier stage or with safeguarding concerns clearly identified. GHC made no adult safeguarding referrals in response to reports of financial or physical abuse or exploitation. With no common understanding of WH's needs and risks services could not respond adequately.

Learning Point 6.

All organisations need a commonly understood definition of who an adult with care and support needs might be and in what circumstances a referral to Gloucestershire County Council should be made for consideration of a needs assessment by Adult Social Care under s9 of the Care Act and/or adult safeguarding using the s42 duty.

8.2 How did practitioners attempt to engage with WH? What would have helped them to do so?

8.2.1. AOT were aware of WH's needs regarding trust and consistency and initially were able to limit her contact to two workers who she felt safe with and who could build a trusting relationship with her. Developing new relationships was known to be difficult for WH.

The impact of staffing issues and the pandemic restrictions on AOT ended the consistent engagement with WH. AOT practitioners wanted to do their utmost to work with WH, but there was an impact from the lack of staff and supervision on the team performance. Nationally, funding for mental health services has been increasing, but not enough to keep pace with demand or address the chronic underfunding of mental health services over many years[12]. The pressures on mental health services are acute. It is understood that whilst nationally agreed tools exist to determine safe staffing levels in acute trusts and mental health inpatient settings[13], there are no tools to determine safety in community mental health teams. The lack of a nationally agreed tool can impede an analysis of impact and risk by providers, and informed discussion with commissioners. GHC have now been able to address the lack of permanent staff in the team, but how do Trust quality monitoring systems identify struggling teams and consider the impact on the people using the service and the systems around them? There had been a management decision to focus on medication compliance during the pandemic and, given the staffing issues, subsequently. Was this decision reviewed at any time? What was the impact of this key team struggling on other community mental health teams or wider services in the community? Were other organisations, including third sector or community organisations, considered as potentially able to work with WH in some way to mitigate risk?

Learning Point 7.

Struggling teams may need to pursue pragmatic rather than best practice approaches. Risks created by these arrangements need to be understood and monitored by senior managers in the wider organisation. Strategies to mitigate risk must be considered and used wherever possible. These efforts must be supported by nationally agreed tools to determine safe staffing levels.

8.2.2 The GHC IMR report writer has identified that the medication compliance focused visits to WH may have also decreased her engagement. Once practitioners could again enter homes practical support may have engaged WH more successfully as demonstrated in AOT's

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[12] Kings Fund (2023) Mental health 360: funding and costs. Find at https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-funding-costs

[13]NHS England 2023 Safer Nursing Care Tool find at: https://www.england.nhs.uk/nursingmidwifery/safer-staffing-nursing-and-midwifery/safer-nursing-care-tool/

time with her in December 2020. Had WH not been discharged from mental health services joint working with the enablement service would have also been useful. Joint working with a known practitioner can build trust in a new service. WH was also willing to use voluntary services to resolve her immediate problems, we need to include voluntary services in our thinking about engagement and relationship building. The OT and enablement services made strenuous efforts to engage WH, using letter writing and attempted telephone contact. The GHC OT tried to check who else was involved with WH, the enablement team tried cold calling. A multi-agency engagement strategy can help services work with a person, we will explore this in 8.3 below.

Learning Point 8.

All organisation who have contributed to this SAR accept that approaches to engaging people who have little trust in services must be flexible and creative, they may need to be trauma informed. We must create the thinking and systems to support these flexible responses which contain the 'reasonable adjustments' that a person who has experienced trauma or is fearful or ambivalent toward services can accept.

8.3 How did organisations work together to support WH?

WH's complex needs and situation needed a regularly reviewed multi-agency approach to effectively work with her, recognising and utilising opportunities and responding to her changing needs and situation.

8.3.1 There are examples of individual organisations working together to support WH, in the first few months of WH's tenancy the Recovery team coordinator and Rethink kept in contact with SDC and the police regarding specific issues, ensuring all were informed. AOT subsequently supported WH in working with the CAB to resolve her debt and in working with SDC to support her tenancy. SDC and the police carried out a joint visit to WH in April 2022, however the lack of information sharing between the two organisations meant that the opportunity presented by WH's wish to leave the property was not acted upon.

8.3.2 Whilst struggling to keep going AOT did not use the other services available to them to promote engagement within and outside of the Trust. The Trust complex emotional needs team could offer consultation, particularly around trauma informed approaches, the dual diagnosis consultant nurse could advise on approaches to WH's substance use, the interaction with her medication and impact on her mental health. The influence of WH's friends made engagement with her difficult and advice from domestic abuse services would also be helpful to practitioners trying to engage her. Referrals were not made to services in response to WH's needs or expressed wishes. There was no connection with domestic abuse services. After a time of contemplation, WH asked for help to start to address substance misuse issues in September 2020. This was not acted on, although mental health services accepted that WH misused substances and that this impacted on her mental health, no

communication or referral was made to substance misuse services or advisors. WH frequently presented to mental health services as being physically or financially abused, she was 'cuckooed' and exploited. No safeguarding referrals were made by AOT.

Learning Point 9.

Teams under pressure can become isolated from the systems around them. Senior managers will need to support and promote cultures of collaboration and partnership during and after pressurised periods.

8.3.3. Police safeguarding referrals were considered but impaired by non-identification of WH as an adult with care and support needs, or as someone no longer being seen by mental health services. Police responses were also impeded by no local ownership, for example by the local vulnerability officer, and by the lack of capacity in the police SAMM team to identify trends or consider eligibility for a safeguarding response. Police colleagues are developing trigger protocols and information sharing routes through MASH, but further work may be needed to align Adult Safeguarding concerns with existing arrangements. Consideration is also needed as to how the police convey concerns in VISTs, particularly those to GPs, assumptions as to how information will be received should be avoided.

Learning Point 10.

A police central team focused on adults at risk whether they have care and support needs or need a non-s42 response, will support local and central decision-making with an overview of trends, historical and current risk for individuals and locations and the actions needed.

8.3.4. It is noted that SDC now has a safeguarding portal and is working to improve awareness of the need for adult safeguarding in its workforce.

Learning Point 11

New safeguarding arrangements become common practice in time, these arrangements must be audited, and staff supported to continue to develop relationships with other involved organisations.

8.3.5. There were opportunities for services to work together to create a multi-agency response to WH's risks and needs. CPA meetings, safeguarding meetings and MARAC meetings all offer multi-agency frameworks. When implemented, the Multi-Agency Risk Management meeting (MARM) will also be a useful framework for people who do not fall within these services. GHC have set up regular weekly Local Community Partnerships meetings, where health, social care and voluntary sector partners can discuss how best to

support a person who may a have a serious or enduring mental illness, but do not currently 'fit' a single service or may have a level of complexity that needs a multi-agency response.

These frameworks need to be commonly known and used. Practitioners must have the knowledge, confidence and supportive systems around them to engage in multi-agency approaches. Mental health practitioners must be at the heart of these systems when people with mental health or dual diagnosis issues are involved.

Learning Point 12.

Multi-agency frameworks and meetings are key in sharing information and ensuring a common understanding of the person's circumstances, needs and risks. It is important that these frameworks are known and understood by all services and organisations. All safeguarding partners should assure themselves of the routes available to them for information sharing and convening multi-agency meetings. Ask the question: are these arrangements regularly used? If not, why not?

8.3.6. WH was entitled to s117 funding, discussion of this will bring health and social care organisations together to consider how the person's needs can be addressed. Gloucestershire County Council and Gloucestershire ICB have issued comprehensive guidance on s117 [14]. This relies on practitioners and managers being aware of the person's pre-existing entitlement and following the policy rigorously at all times.

Learning Point 13.

A team or central focus on s117 is needed to ensure that those who meet the criteria are known and that reviews, support planning and discharge arrangements take account of s117 eligibility or indeed that the person is no longer in need of s117 funding.

8.4 How typical is WH's situation in Stroud? Are there other people who are hard to reach but experiencing mental health and/or substance dependency issues and are at risk from self-neglect, exploitation, and other forms of abuse by third parties.

8.4.1 SAR participants were clear that there are currently people in a similar situation to WH in the Stroud. "Illegal drug networks" exist which involve people with mental health and dual diagnoses, which target those people on benefit pay day and prescription day and involve them in exploitative relationships. We need to be clear that many of these adults have care and support needs and are unable to protect themselves.

Learning Point 14.

People in Stroud who are unable to protect themselves need multi-agency responses that include mental health, substance dependence and adult safeguarding services, with

[14] Section 117 of the Mental Health Act (S117 MHA): Aftercare Gloucestershire Joint Policy version 4 2022.

trauma informed responses, coupled with statutory powers regarding partial closure and addressing anti-social and criminal behaviour, built into the approach.

8.5 How can we develop multi-agency responses to people in WH's situation? How do organisations in Stroud work together, what is going well? What are the challenges? What needs to be developed?

8.5.1 The Findings above demonstrate that there are a number of challenges for organisations in Stroud in working together to respond to people in similar situations to WH. However, the response to this SAR and the developments in several organisations since WH's death demonstrates that there is a willingness to develop improved multi-agency responses to individuals and to people living in premises where there is financial abuse and exploitation, and to understand and respond to domestic abuse however it is presented.

8.5.2. WH's neighbours were concerned for her and continue to have concern for people who are unwell, neglecting their own needs whilst experiencing potential exploitation and abuse. WH's neighbours were not always sure who to alert when concerned.

Learning Point 15.

Communities around a premises where there are people who have mental health, substance misuse or safeguarding issues may be concerned. Targeted information about how to contact Neighbourhood police, housing or adult safeguarding services will be helpful.

8.5.3. Stroud Community Safety Partnership has published a three-year strategy [15] which encompasses many of the themes within this SAR. Although it is understood that currently not all partners attend partnership meetings regularly, these meetings can offer the opportunity to develop responses to illegal drug networks which involve adults with care and support needs, particularly people with mental health and substance use issues. The voluntary sector as well as Stroud community volunteer groups need to be involved in these approaches, many people who mistrust services will turn to these volunteers who will be able to engage and support where others cannot.

Learning Point 16.

A focused response to the exploitation of adults with care and support needs must involve a coordinated range of local as well as county level services, with regular meetings to update and monitor actions and agreed information dissemination pathways to ensure consistent responses.

[15] Stroud District Community Safety Partnership Action plan 2023 – 2026 available at https://stroud.moderngov.co.uk/documents/s11105/Appendix%202%20Stroud%20District%20Community%20Safety%20Partnership%20Plan%202023%20-%202026.pdf

9. Summary or Conclusion

We do not know how WH perceived the man who murdered her, whether as 'friend' or 'partner' or neither. This SAR does not propose that her murder could have been foreseen any of the services working with her. However, WH was completely isolated from services at the time of her murder, she was mentally unwell and unable to care for herself. She did not wish to continue to live in her flat but lacked the means or support to extricate herself from the situation. Without support WH's physical and mental health would continue to deteriorate and the risks from violence and exploitation increase. WH was an adult with care and support needs but the range of possible interventions to support her were not utilised during the period of the SAR. The factors which led to WH's isolation may still affect other adults in the Stroud area and other areas in Gloucestershire.

10. Other relevant SARs.

The Gloucestershire Safeguarding Adults Board has commissioned SARs which resulted in recommendations that will be relevant to this SAR.

10.1 SAR 'Peter' (2021). In particular recommendations:

4.10 *GSAB would benefit from becoming more 'Making Every Adult Matter (MEAM)[16]' aware by mapping existing good practice and innovative initiatives within GCC to this approach, accessing the 'Making Every Adult Matter' learning and research and signing up to the roll-out of this approach so they receive national support.*

4.11 *GSAB should assure itself that partner agencies operate in a trauma- informed way and have policies in place that support this and that this is transferred to front-line practice.*

10.2 Alcohol Related Deaths Review (2021): What could help?

4.1*. Ability of services to work with people in a flexible way. Trauma-informed approaches needed.*

10.3 Learning from the circumstances around the death of five women in Gloucestershire (2021).

6.3 *GSAB is recommended to promote trauma aware and trauma informed responses to marginalised groups. There are a potential range of approaches that can be used to do this:*

- A film, written report or workshops led by NT peer mentors on their experiences and how they would advise organisations to work with their peers.

[16] http://meam.org.uk/wp-content/uploads/2019/02/HOMJ6444-MEAM-wheel-190208-WEB.pdf

- Other activities to raise awareness and improve identification of exploitation, duress and coercion, how care and support needs may present in this group of people, understanding what perpetuates self-neglect and self-harm.

- Asking each partner agency to consider what changes they can make to increase their ability to sustain engagement with marginalised groups using the learning within this SAR.

- Building in the expectation of trauma aware and/or informed responses into policies and procedures, particularly by connecting personalised and professionally curious trauma aware approaches to preventing harm and adult safeguarding.

6.4. *GSAB is recommended to work with all partners, including all relevant third sector organisations, to develop a shared risk assessment and management framework to underpin the identification and assessment of risk in marginalised groups in order to support multiagency responses. The framework should describe 'windows of opportunity,' person-centred contingency planning and how to create agreed engagement strategies that can be shared and understood by other organisations. Specific contingency planning around changes to benefits or similar should also be described.*

11 Recommendations to Gloucestershire Safeguarding Adults Board (GSAB)

11.1 GSAB is recommended to review the action plans from the SARs in section 10 in order to identify whether there are any outstanding actions which will be relevant to the service development recommended by this SAR.

11.2 GSAB is recommended to formally share the learning from this SAR with Safer Gloucestershire, the county-wide Community Safety Partnership, and engage in a joint consideration of strategic plans to address the exploitation of adults at risk in the area. (*Learning Points 16 and 14.)*

11.3 GSAB is recommended to consider dissemination of information to the public via partner organisations with a local presence in order to promote adult safeguarding concern referrals as required in identified areas. (*Learning Point 15.*)

11.4 GSAB is recommended to recirculate the current definition of an adult with care and support needs to all partner organisations (*Learning Point 6*.)

11.5 The GSAB Chair is recommended to consider using agreed regional and national escalation procedures to highlight the need for a nationally agreed NHS tool for use in determining safe staffing levels in mental health community teams (*Learning Point 7*.)

12 Recommendations to individual organisations.

12. 1 All partner organisations are recommended to consider how to build professionally curious approaches into engagement, information sharing, assessment and decision-making procedures and policies their organisation. Key questions will be: what are the enablers and challenges to using professional curiosity in the organisation? How can these be utilised or addressed? (*Learning Points 1 and 3.)*

12.2. All partner organisations are recommended to audit how protected characteristics are recorded in their organisations. Audits can focus on identifying the support needed to ensure that practitioners are confident in ascertaining these characteristics and understand the rationale for doing so. (*Learning Point 2)*

12.3 All partner organisations are recommended to take steps to ensure that their staff understand the multi-agency arrangements available to them, and to ascertain participation in such arrangements. *(Learning Point 12)*

12.4 All partner organisations are recommended to share their approach to and learning from trauma informed practice with the aim of sharing positive practice and creating consistency in understanding and approach across Gloucestershire. *(Learning Point 8)*

12.5 GHC are recommended to review and revise the relevant discharge policy and procedures to define when external agencies should be informed of a person's discharge from services in situations when the person is known to be in a high impact situation of risk. (*Learning Point 4*)

12.6 GHC are recommended to work with the countywide Domestic Abuse Strategic Partnership Board to consider how to share learning from the experience of the IDVAs working in the Trust, there will be useful perspectives and approaches about working with people with mental health or dual diagnoses who are experiencing domestic abuse. (*Learning Point 5)*

12.7 GHC, and other partner organisations, are recommended to develop indicators of struggling teams in order to identify risk to patients and available mitigators through single or multi-agency action. Mitigators can include how to promote cultures of collaboration and partnership. (*Learning Points 7 and 9.)*

12.8 Gloucestershire County Council and NHS Gloucestershire Integrated Care Board are recommended to explore the possibility of a dedicated s117 team in order to support and consistently fulfill their s117 duties. (*Learning Point 13*)

12.9 Gloucestershire Constabulary are recommended to consider potential changes to how repeat adult at risk cases are identified and managed, together with the resource needed to support change. Considerations should include the role and responsibility of Neighbourhood Policing Teams and any other specialist capability.
(Learning Point 10)

12.10 Gloucestershire Constabulary are recommended to consider their approach to adult at risk assessment and referral via the MASH and whether changes are necessary in order to provide a consistent assessment and referral process to both internal and external partners in repeat cases.
(Learning Point 10)

12.11 SDC are recommended to continue to audit safeguarding referrals via new arrangements and to support staff to develop pro-active safeguarding relationships with other involved organisations. (*Learning Point 11*)