Essex Safeguarding Adults Board

LEANNE

SAFEGUARDING ADULT REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF LEANNE, A 25 -YEAR-OLD FEMALE WHO DIED IN MARCH 2018

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OCTOBER 2020

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1. THE REVIEW PROCESS

1.1. This report outlines the Safeguarding Adults Review into the period of care prior to Leanne's death. Leanne died in March 2018, aged 25. She lived in supported accommodation. Leanne was recorded as being of White British ethnicity.

1.2. The Review process began with the decision of the Essex Safeguarding Adults Board to hold a Safeguarding Adults Review (Review). The Southend Essex and Thurrock Safeguarding (ESAB) Guidelines state the Board must arrange a Review "when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."

1.3. All agencies that potentially had contact with Leanne were asked to confirm whether they had been involved. Chronologies and IMRs were requested from all relevant agencies and a composite chronology was created.

1.4. Partnership Learning Events were held with practitioners and managers from the agencies, who were also provided with the opportunity to review the draft report. The report was reviewed by the SAR Sub-Committee in November 2019, following which minor changes were made. Prior to submission to the Essex Safeguarding Adults Board, the Board Chair requested further clarification on some matters, and the Report was amended to reflect this.. The final report was then submitted to the Essex Safeguarding Adults Board.

2. TERMS OF REFERENCE FOR THE REVIEW

2.1. The Review considered the period 1 January 2016 to 30 March 2018, to gain an understanding of the period of Leanne's contact with services prior to her death.

2.2. Based on the information gathered from agencies, the following terms of reference and key themes were identified:

- To develop an understanding of Leanne's vulnerabilities, her capacity to care for herself, her level of independence, her ability to manage her health, her housing situation, and consider in this context:
  - How she was managed through existing adult safeguarding procedures.
  - How agencies worked together to support her.
  - Whether different approaches could have been considered.
  - What preventative actions could have been taken by agencies that may have reduced the possibility of Leanne's health deteriorating.
- To identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including protocols covering:

- Raising safeguarding concerns.
- Information sharing.
- Risk assessment, management and review.
- Ensuring receipt and acknowledgement of referrals, concerns and emails, and ensuring action is taken promptly in response to these.

3. PARTICIPANTS IN THE REVIEW

3.1. The following agencies participated in the Review:

- Castle Point and Rochford Clinical Commissioning Group / General Practices
- Essex County Council Adult Social Care
- Essex Partnership University Trust
- Essex Police
- Mid Essex Hospital Group
- Newmarket House Hospital
- Priory Woodbourne Clinic
- Southways Group

3.2. The report author also had a conversation with Leanne's private counsellor for their input and expertise in relation to anorexia, and they commented on the report.

4. INVOLVEMENT OF FAMILY

4.1. The ESAB Team wrote to Leanne's mother. The letter invited contact directly from the family, if they wished to be involved. Leanne's mother informed the ESAB Team that she wanted to be part of the Review. The report author made contact and a meeting was held. Leanne's mother's and sister's feedback has been incorporated into this report.

5. AUTHOR OF THE REPORT

5.1. The independent report author was Althea Cribb. Althea has been delivering Domestic Homicide Reviews for six years and has completed twenty to date, including a number which have covered adult safeguarding concerns and issues, through which Althea has developed expertise in this area. This is the second SAR Althea has completed.

6. PARTNERSHIP LEARNING EVENTS

6.1. Two events were held to establish and agree the learning: one for practitioners and one for managers. Participating agencies were represented as follows:

Agency	Practitioner	Manager
Castle Point and Rochford Clinical Commissioning Group / General Practices	Y	Y
Essex County Council Adult Social Care	Y	Y
East of England Ambulance Trust	N/A	Y
Essex Partnership University NHS Trust	Y	Y
Essex Police	Y	Y
Mid Essex Hospital Group	Y	Y
Newmarket House	N*	N*
Southways Group	Y	Y
Priory Woodbourne Clinic	N*	N*

6.2. * Newmarket House and Priory Woodbourne Clinic were unable to attend due to their distance from Essex, but did contribute fully to the Review.

6.3. In addition, the report author spoke with Leanne's private counsellor for additional feedback, which was incorporated into the report. They were invited to comment on the report.

6.4. For the practitioner event, the independent chair analysed the combined chronology, the agency IMRs and information from the family to develop a series of exercises with participants to: establish and agree the facts of the case and identify gaps that needed further investigation; attempt to understand Leanne's lived experience; identify the good practice and learning within the case.

6.5. Following the practitioners' event, the independent chair wrote the report and a draft was shared with participants and sent to managers. The report, findings and recommendations were then discussed and agreed at the managers' event.

7. SUMMARY OF THE CASE

Pre-2016

7.1. Leanne had been adopted aged approximately four years old. Her sister, six years younger than her, had been adopted when Leanne was eight. They were not biologically related. Leanne had witnessed the death of her biological brother, due to epilepsy, when she was aged four. Leanne had some contact with her biological mother since she was aged 16. Leanne attained GCSEs and A-Levels and had applied to do a University course in Maths. She had put this on hold due to her inpatient treatment.

7.2. Leanne moved out of the family home at 18 to a flat. Following this she became unwell and was admitted to an acute mental health ward in 2010 before being transferred to day care. Following discharge, Leanne lived with her boyfriend and his mother for around three years. During this period Leanne was recorded as having severely harmed herself and caused seizures through hypoglycaemia. When the relationship ended she became homeless before moving into supported accommodation with Southways Group in 2013. She lived in that accommodation until her death.

7.3. Leanne had been known to mental health services (Essex Partnership University NHS Foundation Trust, EPUT) since 2009 (aged 16), and open to the Eating Disorders Team since 2011 (aged 18). Leanne received services from the Eating Disorder Team, Occupational Therapy, out-patient appointments with Consultant Psychiatrists and Care Co-ordinators. She had two admissions to Mental Health Trust Assessment Unit (Basildon) in October 2010 and June 2013. She had been under a Care Programme Approach (CPA) care plan throughout her time with EPUT and had a Care Coordinator.

2016

7.4. In 2016 Leanne attended Southend Hospital six times, and attended her GP surgery eight times. All attendances and appointments related to Leanne's mental health: her eating disorder or self-harm behaviours, or both. This included falls and ill-health due to the impact on her body of anorexia (e.g. potassium and sodium deficiency). She also continued to access services from EPUT.

7.5. In June her weight was recorded as 34 kg.

7.6. In September Leanne saw her GP who recommended that Leanne enter hospital for assessment as an inpatient. Leanne did not attend the next appointment and no action was taken; the GP recorded that Leanne had capacity and was aware of the possible serious or fatal consequences of her condition. In the same month Leanne's CPA care plan was reviewed by the Care Coordinator in a meeting with Leanne. Her extreme weight loss was identified as a risk and a plan was made for the Care Coordinator to refer Leanne to the Eating Disorders Team for urgent initial assessment and for a suitable inpatient bed to be found (while Leanne had been open to the service in the past, she was not accessing the service at that time). She was seen urgently and the CPA care plan was reviewed by the Eating Disorder Service to reflect the urgent need for inpatient care.

7.7. In early October Leanne was admitted, voluntarily, to inpatient care for anorexia at the Priory Woodbourne Clinic in Birmingham. Shortly after admission she disclosed alleged historical abuse by her adoptive mother. These allegations were reported to

Essex Police and Essex County Council Adult Safeguarding and Leanne was safeguarded in the hospital. Essex County Council passed the safeguarding concern to EPUT for progression. Essex Police interviewed Leanne and were satisfied that Leanne did not disclose any offences. EPUT concluded the allegations had been fully investigated and no action was required.

7.8. Staff in the unit recorded at this stage that Leanne presented as relatively bright in mood, although chaotically. She was recorded as appearing overwhelmed with her thoughts, with the fear that she would forget information and felt the need to write things down, regardless of what she was doing in that moment. Leanne was noted to appear to need to be in control as much as she could in her surroundings, including her meals, how she ate, how staff communicated with her and her peers. Self-harm (or attempts) were recorded by staff; this was recorded in the Risk Management Plan and support was provided. In December Leanne absconded from the ward. She returned of her own accord and was placed on a Mental Health Act section 3, and was closely monitored. Her weight began to increase and her CPA care plan was reviewed during her stay.

2017

7.9. Leanne continued to stay at Woodbourne Priory Clinic from January to March. She absconded twice, and was returned once by Essex Police and once by her mother. Her weight increased during time spent at the Clinic, however, and she was discharged home in mid-March weighing 39.5 kg. Her GP was informed, that Leanne would attend the EPUT Eating Disorder Service two days a week. Priory staff felt that while Leanne's weight had increased, and she had been discharged appropriately due to her wish to receive treatment at home, she had not engaged fully in the psychological work. They felt she had made the decision to restrict her weight, and this had not changed.

7.10. From March to July she saw either a GP or the Practice Nurse with regard to a persistent cough or treatment for self-harm burn injuries.

In April Leanne's CPA care plan was reviewed by her (new) Care Coordinator in a meeting with Leanne. A risk was recorded that Leanne had ongoing challenges with food intake. This was to be explored in her regular appointments with the Recovery and Wellbeing Service, and ongoing contact with the Eating Disorder Service.

7.11. From July onwards, Leanne regularly attended the Basildon Eating Disorder Service, and met with her Care Coordinator from the Recovery and Wellbeing Team. Leanne discussed her condition, behaviours and symptoms as well as her plans for the future and desire to recover from the anorexia. In August her weight had decreased by 6.85 kg since her discharge from the inpatient unit, to 32.25 kg.

7.12. In September Leanne called Essex Police to report that a male resident of The Avenue, aged in his sixties and suffering from schizophrenia, had assaulted her by punching her on the arm. She informed the officer that there were no staff on the premises as they worked nine to five. She went on to state that she was going to her room and would lock herself in. She stated she did not anticipate any further problems and requested to see an officer another day. The incident was graded as Priority 4 (Scheduled Response – Appointment within 48 hours). The case was allocated to an officer at Rayleigh Local Policing Team who spoke to Leanne on the telephone nine days later. During this conversation, Leanne stated she did not wish to make a statement nor did she wish the individual to be spoken with. She did not support a prosecution and only wished the matter to be recorded by the police. The officer recorded that they had discussed safeguarding with Leanne including if she required any additional support from partners, which Leanne declined. The investigation was reviewed by a supervisor and filed under 'Outcome 14: Evidential Difficulties Victim Based – Suspect Not Identified'.

7.13. At this time, the Nurse Practitioner allocated as Leanne's key worker at the Eating Disorder Service expressed concerns over her weight loss, and the high level of support Leanne was requiring from the Service, which could not be met due to the nature of the service. An inpatient stay was suggested. Leanne agreed that she needed more support but stated that she felt she was not unwell enough for an inpatient stay. She subsequently agreed to enter inpatient care at Newmarket House Hospital (Norwich). She stayed for five days at the end of which she self-discharged. The notification to EPUT stated that staff felt Leanne had struggled with the process of control being taken from her; this had been identified at intake and actions and plans had been made to try to address this. Leanne stated to the Nurse Practitioner that "the patients were simply left to their own devices and could leave the premises whenever they wanted and the food was less than she had been given on her meal plan from" the counsellor she saw for Cognitive Behavioural Therapy.

7.14. The Nurse Practitioner informed Leanne of staff concerns over her behaviour: apparent excessive exercise, and falling asleep during group sessions. As a result, Leanne was asked not to attend group sessions for the time being. Leanne stated that if she was not able to attend Day Care, she would simply 'binge' and 'purge' all day and do excessive exercise. The Nurse Practitioner reminded Leanne of her own responsibilities towards recovery and the importance of going back into an eating disorders unit to address this thought process. Leanne requested to attend the Support Group only and continue to see the Nurse Practitioner on a one-to-one basis weekly. Leanne was informed the Nurse Practitioner would continue to see her for

weekly one-to-one sessions and would discuss the request of attending the Support Group and inform Leanne accordingly, subsequently informing Leanne that she was not allowed to attend. Leanne's weight was recorded as 31.1kg, a decrease.

7.15. From this point onwards, Leanne's attendance at and contact with the Eating Disorder Service fluctuated, and she reported that she was not happy that she could not attend group sessions. She reported to the Eating Disorder Service that she was struggling to eat. Leanne started an Open University Maths course.

7.16. In December Leanne called police again to report an incident involving the same resident as in September. He had shouted at her and thrown a TV remote that had hit her hand, with no injury. Leanne met with the investigating officer two days later and agreed that the matter could be resolved using a Community Resolution. The officer spoke with the other resident with an appropriate adult present resulting in a verbal apology to Leanne.

7.17. Her CPA care plan was reviewed in December by her (new) Care Coordinator; it recorded the ongoing issues with the other resident, and challenges with food intake. Leanne informed the Care Coordinator of this incident, and the first one in September. She reported to the Care Coordinator that she was disappointed that the Southways staff had not contacted her about the incident, and she let down and unsupported. She felt she had to move out to another supported accommodation residence; but that she did not want to move until she had completed her Open University coursework. The Care Coordinator recorded a plan to raise a safeguarding concern with regard to the accommodation issues (this was made in January 2018); Leanne was to continue her engagement with the Eating Disorder Service.

7.18. At the end of December Leanne attended a GP appointment feeling frail and getting tired coughing. Antibiotics were prescribed, with a review to take place if her symptoms did not improve. This was the last contact Leanne had with the GP.

2018

7.19. Throughout January and February, Leanne attended the Eating Disorder Service regularly. She was allowed to return to group sessions. Her weight continued to decline.

7.20. Leanne's CPA care plan was reviewed by the (same) Care Coordinator, and the Nurse Practitioner and Care Coordinator expressed concerns over Leanne's weight loss, and discussed inpatient care. Leanne declined this and was informed that if her weight continued to decrease they would consider requesting a Mental Health Act assessment to ensure that her health could be managed. The care plan reflected these concerns and the ongoing issues with her accommodation. Leanne stated she

wished to move, but not to the first option that had been suggested, as her ex-partner lived in that area. She agreed for another placement to be sourced.

7.21. During this time communication was ongoing between the Recovery and Wellbeing Team, including the Care Coordinator, and the Essex County Council Adult Social Care Commissioning Team to progress a move for Leanne. There were many emails between the professionals in which information about Leanne's care and support needs were requested and provided. Leanne continued to express to mental health services that she was anxious and fearful of the other resident, and wished to move. At the end of February Leanne's weight was 29.4 kg, this was the last time it was recorded.

7.22. In March Leanne attended the Eating Disorder once, having missed a number of appointments and group sessions. She was allocated a new Care Coordinator and her move was discussed again for clarity over where she wished to move to. She stated that she would be prepared to move to another Southways residence, but would consider alternative accommodation if this came up more quickly. Her private counsellor attempted to contact the Eating Disorder Service to discuss their concerns but no conversation was recorded.

7.23. At the end of March, the ambulance service was called out twice to Leanne at home as she was unconscious. She was treated and remained at home, as she declined to go to hospital. Southways staff contacted the Care Coordinator with concerns over Leanne's very low weight and frailty; they reported that she had not been eating and that the ambulance service had been called twice that week. The Care Coordinator spoke to Leanne who stated that she had not collapsed, but had fallen asleep. She was planning to go on holiday with her family. It was recorded that Leanne appeared to have capacity to make this unwise decision, was able to retain and interpret the information given, and understood the risk attached to her condition and know what to do in case of emergency. This was the last contact Leanne had with the service. The Care Coordinator discussed the Southways staff concerns with the Senior Practitioner; a plan was made to email the Nurse Practitioner to make them aware.

7.24. The next day the ambulance was called for Leanne who had been found unconscious by staff. Paramedics recorded that they estimated her weight as three stone (19 kg). Leanne was taken to Southend Hospital where she later died. The coroner concluded that the cause of Leanne's death was septic shock with chest infection, chronic electrolyte imbalance and liver dysfunction/hypothyroidism.

8. INFORMATION FROM THE FAMILY

8.1. The report author met with Leanne's mother and sister. The process and purpose of the Review was explained and the report author invited them to share their experiences of and thoughts about Leanne, and her interactions with services. Their thoughts and feedback are summarised below, presented as close to their wording as possible but not verbatim. They would like to know the learning from the Review, and to understand what has changed in services since Leanne died.

About Leanne

8.2. Leanne was a genius at maths. She was artistic, articulate, and caring. She loved animals; her family felt that if she had been able to live somewhere with a dog, it would have helped her recovery. She was a deep person, quiet. She loved learning. She was a perfectionist.

8.3. She carried baggage from when she was young, including having seen her brother die before she was adopted. Her parents had tried to get her support when she was younger, but she had not wanted it.

8.4. At 18 she met her birth mum and following that she distanced herself from them, and moved away. They knew she was poorly then, and had been in hospital. She seemed to be very angry with the world. At age 21 she came back to the family.

8.5. Her anorexia could be up and down – she knew how strong the anorexia was. She would put weight on, be able to do voluntary work, but when it was bad she needed help 24/7. It was very hard for her to ask for help; so, then when she did do it, and she didn't feel heard, it was very hard for her.

8.6. She didn't want to burden her family. Her family were so scared all of the time – they knew how poorly she was, but couldn't do anything about it. They felt they failed her. All they could do was be there, and they were always there for her. What helped would change every day.

Leanne's Mental Health

8.7. Leanne found specialist private therapy that her parents paid for, and took her to. They were a great help, really good for her.

8.8. She felt that some professionals defined her according to the definition of anorexia or Borderline Personality Disorder. She would say "I am not a box – I am a person".

8.9. Leanne would talk to her mum and sister about it, and would get upset and angry that she wasn't getting the support she felt she needed. Any change, or something new, was hard; once she had done it she was fine but the first time would be very hard, this had always been the case since she was very young. She needed to be in control – not aggressively, but things had to be just so.

8.10. She wanted the right help; she would read books about her condition, she would read self-help books, she was always trying to get better. She would say to her family, please keep trying, keep offering help and support, one day I might say yes.

8.11. Her family felt they could have been more involved in her care and support – did services talk to Leanne about involving them? She might have said no but they wanted to have the option of helping. Leanne felt she had to fight it all on her own.

Mental Health Services

8.12. Leanne avoided mental health services when her condition was bad because she did not want to be sectioned, which was her number one fear. She hated it. She felt she wasn't taken seriously, that she was not listened to.

8.13. Her Care Coordinator changed so many times. She would be trying to reach them and be told they've left; you need to contact this new person. It took time for her to trust workers, and she kept having to do it over and over, trying to connect with a new key worker. And she felt that with each new key worker she had to go over everything again – which she didn't want to do – but didn't feel that the new worker had read her notes, or discussed her with the previous worker. She had to learn how to feel safe with each new person.

8.14. At a low point in 2018 she was told not to come to group sessions anymore. It left her with not enough support. They felt, you had to be ill enough to get the support, but not too ill. Some workers saw her as a whole person, but many didn't. She was assessed on her BMI, but there were so many other symptoms.

8.15. Leanne suffered from extreme insomnia, but when she called the crisis line she felt they couldn't do anything to help: they would just say, we can't do anything right now, try to take a walk, have a bath to calm down, if it doesn't get better then go to A&E, which she wouldn't want to do in the middle of the night and was worried about getting sectioned as well. She just needed someone to talk to, to be there. She would call her mum at 2/3am to have someone to talk to.

8.16. She knew what she was due to have, in hospital, how often the checks should be, and was aware when it didn't happen. Then when the checks were constant, accompanying her to the toilet and shower, she found it humiliating. She felt there was no understanding if you messed up (like leaving the ward) – you were punished rather than being asked why it happened. The doctor at the hospital (Priory) said to her, you are choosing this, you want this – she would argue with this, it made her angry. She would escape from the ward because she wasn't getting the support she needed.

The House

8.17. Leanne's main problem was after 5pm when the staff left: all of the tenants would lock themselves in their rooms, that was when the resident would 'kick off', when staff weren't there. She didn't condemn him – she understood that he needed more support. They were all so different at the house, and 9-5 was not enough, or there needed to be less of a range of needs. She needed care out of hours in the house – to have someone there 24/7. There was only one member of staff and if they needed to take a resident to an appointment or something, then there would be no staff left. So, Leanne would go out.

8.18. Leanne knew about her own condition, and the other residents'. She would work out what people were due in terms of hours of support, and would know when they (and she) weren't getting it. Leanne felt the house management were not always listening, that her concerns and reports about the other resident were dismissed. She was very angry at the whole support system.

8.19. They had a holiday planned before she died – they knew she was very poorly but wanted to get her away from the house. There were times when Leanne would not want to go back there, but she wanted to be there to support the other residents. She put herself last a lot of the time. She felt guilty when she wasn't there, she wanted to be there for the others.

8.20. The situation in the house made her condition worse. She needed someone in the house who understood her condition. Leanne would sometimes walk for miles; partly this was the disease; but it was also about being out of the house where she couldn't relax, she couldn't study.

9. FINDINGS

9.1. The Partnership Learning Event for practitioners discussed the summary of the case (section seven) and the key themes (section six) to produce the learning from this case, combined with information and learning from the IMRs and the feedback from Leanne's family. Individual agency and multi-agency findings, including changes that have taken place since Leanne died, have been collated and are presented in this section under the headings of the six guiding principles underpinning Southend Essex and Thurrock's Vision for Adult Safeguarding[1]. Section Ten gathers these findings under the key themes to identify learning and make recommendations where required.

9.2. The Review returned repeatedly to the complexity of Leanne's situation and diagnoses. The nature and impact of the anorexia, combined with the Borderline

[1] The Southend Essex and Thurrock Safeguarding Adult Guidelines Version 4.2, March 2017

Personality Disorder, was challenging for Leanne and for professionals trying to work with her. She wanted control and independence, and found it difficult to accept help that she knew she needed. There was evidence of good practice and professionals consistently tried to support Leanne in the context of her challenges.

9.3. Leanne was under Care Programme Approach (CPA) and had a care plan that was reviewed regularly by a Care Coordinator. EPUT CPA Procedure states Care Plans should be reviewed every six months, in response to any change and prior to any transition[2]. There was evidence of this taking place.

Empowerment: people are supported and encouraged to make their own decisions and give informed consent.

9.4. There was evidence of professionals discussing Leanne's situation and needs with her, and professionals recorded that Leanne understood her condition. This was also reflected in the feedback from Leanne's family.

9.5. Leanne had capacity, and this was regularly recorded by professionals: she could understand the information relevant to the decisions she was making; retain that information; and use/weigh up that information as part of the process of making the decision[3]. Participants in the Review questioned the extent to which professionals were able to understand the way in which Leanne's mental ill-health impacted on her capacity and decision making. In particular the intersection of anorexia and borderline personality disorder and the impact this had on her; and the physiological effects of malnutrition and how these may have affected her brain functioning. Consideration for this could have been made and recorded in the notes, to outline what capacity meant for Leanne and how it was in evidence.

Prevention: it is better to take action before harm occurs

9.6. Leanne's GP discussed her physical health with her and requested inpatient care to prevent further deterioration. This should have happened in December 2017 but the GP did not progress their concerns.

9.7. When Leanne's weight declined to a dangerous level, she was offered specialist eating disorder inpatient care to support her recovery. In early 2018, the Eating Disorder Service were again discussing this with Leanne, and recorded that if she declined to enter inpatient care then a Mental Health Act assessment would be requested in order to ensure she got the care she needed. At that time there were no

[2] https://eput.nhs.uk/publication-category/clp30-care-programme-approach-cpa-policy/ [accessed 2 July 2020]
[3] https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/ [accessed 09-October-2019]

beds available; the Review did not observe any actions to expedite this process, or look at alternatives, as Leanne's health deteriorated and weight declined from January to March. A crisis management plan should have been considered in the interim, involving all agencies and if possible Leanne's family, to respond to her continuing decline in weight while awaiting specialist inpatient care.

9.8. The Practitioner Learning Event with Managers also discussed whether it was appropriate for a Mental Health Act assessment to be mentioned in this way, with the suggestion that it should not have been raised until it was deemed necessary. This Review has learnt, and practitioners may have been aware at the time, that Leanne was highly resistant to such an assessment, and may have perceived this as a threat; and subsequently may have adjusted her behaviour and presentations to avoid this assessment being requested.

9.9. Actions were in progress to support Leanne to move to alternative accommodation to prevent any further incidents involving the other resident. This took a long time and had not progressed when Leanne died. Her family stated that this stressful situation made Leanne's health worse. The anorexia meant that Leanne was meticulous in preparing her meals and this could take some time; she also expressed fear and anxiety over the actions of the other resident. Although Leanne, like all residents, had free access to the kitchen, the impact of the anorexia and anxiety over the other resident appeared to mean that she did not feel able to do this. Participants in the practitioner Partnership Learning Event reflected that her borderline personality disorder may have impacted on the way Leanne presented in an apparently ambivalent way about moving, and questioned whether this was considered by professionals working with her.

Proportionality: the least intrusive response appropriate to the risk presented

9.10. The least restrictive options were pursued for her care whenever possible. Leanne was offered voluntary admission to inpatient units for anorexia treatment. She was discharged from the Priory Woodbourne Clinic when her weight had increased, in recognition that she wished to continue her treatment at home (it was recorded that she would continue her care with EPUT on a weekly basis).

9.11. The practitioner Partnership Learning Event questioned whether a Mental Health Act assessment could have been considered sooner for Leanne in 2018, when her weight was decreasing and she declined inpatient care. Leanne was recorded as having capacity to make "unwise choices" but, as outlined above (see 9.3), participants questioned whether this took account of the impact of her mental health conditions on her decision making. Additionally, there were no records to indicate that professionals

were considering the risks inherent in the 'unwise choices' Leanne was making and how the impacts of these needed to be managed.

9.12. Professionals respected Leanne's wish for privacy and independence, which at times was proportionate and the least intrusive response. As her health deteriorated and her weight declined in 2018, it would have been appropriate for professionals to challenge this and to work more closely together, and more proactively, to monitor Leanne's condition and health. The risk to Leanne's health increased as her weight decreased, and when she reduced her contact with the mental health trust as she did in March. Her family informed the Review that Leanne did this at times to hide her condition when it worsened. The increased risk from Leanne's lack of contact was not considered: concerns should have been shared earlier with the mental health service, and when concerns were raised this should have led to more proactive action with Leanne. The interaction between her mental health conditions, and the physiological impact of her malnourishment, could have led to a full Mental Capacity assessment followed by consideration to instigate a Best Interests Decision Making Process, which would have involved all relevant others (made when someone lacks the capacity to make a decision, and it needs to be made for them).

Protection: support and representation to those in greatest need

9.13. Leanne received high levels of support from EPUT, and support from her GP and Southways. Leanne knew that she needed the support but her condition meant that receiving and working with professionals could be challenging. This was reflected in her conversations with her family and some professionals when she talked about not getting the support she needed. She was, and wanted to be, independent and this could conflict with her need for support. Southways have now concluded they will not take referrals for the level of needs Leanne had.

9.14. When Leanne was informed that she could not attend group sessions at the Eating Disorder Service (see 7.14), she was upset and angry. This was evidenced in records of her contact with the Service at the time, and in feedback from her family. While she continued to receive support from the Nurse Practitioner, Leanne felt she needed the previous level of support. Additionally, the Review heard that in light of Leanne's Borderline Personality Disorder, and early experiences of trauma and loss, may have led to her feeling rejected by the service. Consideration for what impact this would have on Leanne's overall wellbeing and how this could be managed, or consideration of alternatives, was not evidenced in the records.

9.15. Safeguarding concerns should have been raised by Essex Police on the two occasions that Leanne reported incidents to them. Leanne's GP, and Southways

staff, should have raised safeguarding concerns. For the GP this would have been when Leanne's physical health and weight deteriorated, and she was self-harming, towards the end of 2017. For Southways this would have been in up to and in March 2018 when they were witnessing her declining weight and increasing frailty, and in relation to the impact on Leanne of the dynamics in the house. A recommendation (1) has been made.

9.16. These concerns could have been under the category of self-neglect. The Practitioner Learning Events discussed whether there was a perception that, because Leanne was under the care of EPUT, that her needs were being met; but Leanne did not consistently attend or comply with plans, and even if she did this does not negate the duty of professionals to raise safeguarding concerns when required. A recommendation (2) has been made. With the GP this issue was compounded by Leanne not having been flagged (like similar patients in her situation) as vulnerable on the GP system, as a result of which she did not have a named GP who checked the information shared by other health agencies, or who saw her each time. Instead she saw different GPs each time.

Partnership: local solutions through services working with their communities

9.17. There was evidence of partnership working between agencies. The GP was kept up to date by EPUT about Leanne's care, although the GP did not share information with EPUT. When Leanne went missing from the Priory Woodbourne Clinic, there was effective joint working between the clinic, West Midlands Police and Essex Police to locate and return Leanne.

9.18. There was no partnership approach to Leanne's care and support developed jointly by agencies with Leanne. Leanne had regular contact with her GP, different parts of EPUT, and Southways. At no point did all of these agencies come together to discuss Leanne's situation and needs, and information was not always shared between them. This could have been done through the Care Programme Approach (CPA) and reviews of Leanne's care plan: EPUT CPA Procedure states "It may be necessary on occasions to hold a multi-disciplinary professionals meeting to discuss and decide on the support and treatment of patients who may present with complex needs, high risks and probable non-concordance with their care plan, and where there maybe differences of opinion within the multi-disciplinary group."[4]

9.19. Discussions would have taken place annually with Leanne for her to give her consent to information sharing between agencies.

[4] https://eput.nhs.uk/publication-category/clp30-care-programme-approach-cpa-policy/ [accessed 2 July 2020]

9.20. In March 2018 Leanne reduced her contact with EPUT, and her weight declined significantly and subsequently her health deteriorated. Southways informed EPUT of their concerns; this could have been done earlier. Southways have now changed the way they work: all daily notes are made electronically; concerns are immediately flagged to the manager by staff and the manager also checks the notes on a regular basis; support plans are now clearer and there are regular meetings between the manager and EPUT. EPUT have identified a lead Senior Practitioner Social Worker for all the residents of Southways that are under the Knightswick Community Mental Health Team.

9.21. Leanne's private counsellor also attempted to contact EPUT but there was no follow up to this and so their concerns were not heard. When they received Southways' concerns, EPUT spoke with Leanne on the phone but did not see her and so did not have a full picture of her situation in order to assess the risk to her health; and on the phone she was deemed to have capacity to make "unwise choices". It is important to note that during this time there were significant challenges to EPUT staffing which impacted on communication. The relationship between EPUT and Southways was strained due to the organisational safeguarding process.

Accountability: accountability and transparency in delivering safeguarding

9.22. Safeguarding concerns with regard to Southways were reported to and acted on by Essex County Council Organisational Safeguarding Team promptly and the two services worked together to improve the situation. This did not refer to Leanne.

9.23. There was a lack of safeguarding action in relation to Leanne when she reported to police, and later to EPUT, the incidents involving the other resident. The Police Officers recorded that they discussed safeguarding and support with Leanne on both occasions, but did not submit safeguarding alerts following the two reports. When Leanne disclosed the incident to EPUT, it was over a month before the safeguarding alert was submitted.

9.24. From the information gathered by this Review it is clear that Southways had information about Leanne that, with consent, could have helpfully added to the risk management and response by EPUT for example that she attended weighing sessions at the Eating Disorder Service with weights in her socks or pockets; and that in 2018 she was having issues with her vision. This would have supported EPUT to have a fuller picture of Leanne's situation, and it is important for management to ensure practitioners feel comfortable sharing concerns.

10. LESSONS TO BE LEARNED

10.1. Drawing on the findings above, the lessons to be learnt from this case are set out below, under the headings of the key themes of the case.

How agencies worked together, the actions taken, and whether alternative, preventative approaches could have been considered

10.2. Agencies did not consistently work together to support Leanne. Regular changes in Leanne's Care Coordinator disrupted her relationship with services. Leanne at times presented differently to different services and a lack of information sharing between EPUT, her GP and Southways meant that professionals did not have a full picture of her situation and needs. A professionals meeting, or Multi-Disciplinary Team meeting, should have been held, with Leanne, to put in place a multi-agency plan for her care and support. The practitioner Partnership Learning Event recognised this, while acknowledging that it can be very challenging to bring professionals together for a meeting in a timely way.

10.3. The Care Programme Approach could have been a path to multi-agency working to address Leanne's risks and needs. While agencies were involved in this process, this was in the form of referrals in response to plans made. For example, Southways could have attended, to inform the care plan and reviews. Actions and changes have since taken place that go some way to address this learning (see paragraphs 9.20 and 9.21). EPUT have confirmed that all CPA Care Plans are automatically shared with the individual's General Practice.

10.4. This Review recognises the challenge that agencies faced in working together when Leanne often did not want them to, and they understood her wish to keep them separate. Nevertheless, the CPA care plan should have been clear about the level of risk to Leanne and when it may have been necessary to engage multi-agency involvement. Moreover, if agencies were concerned about the possibility of overriding Leanne's personal choice, and her mental capacity was fluctuating, a mental capacity assessment may have indicated that a Best Interests Decision Making process could have helped with decision making. A recommendation (3) is made.

10.5. An additional recommendation (4) is made for EPUT to ensure that, in cases such as Leanne's, appropriate multi-agency working is initiated alongside a crisis management plan.

10.6. There is a chance that Leanne's health may not have deteriorated if she had been able to move. The delay appeared to be due to staff changes and the need for more information to be shared, alongside questions about Leanne's wishes over where to move to. A suspension was also in place due to the Southways Organisational

Safeguarding Enquiry, which would have impacted on what was available. Prompter and more proactive work to support Leanne to move may have helped her to manage her conditions and her health. There should have been better recognition that her conditions impacted on her need to have control, including presenting in certain ways to professionals, and that this at times increased her vulnerability as she may not have shared what was happening with all professionals. While awaiting a move, work should have been done with Leanne to identify and address her concerns, safety and anxieties relating to what would have been a very significant change for her, in the context of her finding change hard.

10.7. The Partnership Learning Event with Managers discussed ongoing issues relating to applications for funding for meeting individuals' care and support needs via the Joint Referral Panel. The process is not necessarily clear to all professionals, and is not understood by some recipients. Since the Review was completed, EPUT have changed this process. There is currently a transition period to introduce a new framework and process. A recommendation (5) is made to ensure that the learning from this Review is addressed by those responsible for the new process.

Whether agencies complied with any safeguarding protocols that have been agreed within and between agencies

10.8. Risk assessment and management took place but this was often without the full picture of Leanne's situation gained from all professionals working with her. Concerns were shared by professionals but not consistently and when received they were not always acted on promptly. The risk associated with Leanne not attending services at a time when her weight was declining (and had been for some time) was not recognised. Safeguarding concerns were not consistently made, or were not made promptly.

10.9. There did not appear to be a full understanding of the ways in which Leanne's diagnoses (anorexia and Borderline Personality Disorder) interacted and impacted on her needs and presentations, and her capacity. The Review recognises that this is a very challenging area, and that Leanne was a very complex individual for professionals to work with. Her conditions and wellbeing may have been further compounded by her physical ill-health. The Review concluded that Leanne was not always 'seen', nor understood, in a holistic way by professionals. She was viewed through the lens of her presenting issue or one diagnosis and as a result, full consideration of her condition and situation were not evident in conclusions relating to her capacity and decision-making. Assumptions were made that she had support all around her, in part based on what Leanne was telling people, but also from a lack of

professional curiosity in response to Leanne stating that she was fine when her appearance and ill health should have prompted a different view. A recommendation (6) is made to share the learning from this Review with all members of the Essex Safeguarding Adults Board.

10.10. Records were made by EPUT, her GP and Woodbourne Priory about Leanne's self-harming behaviours for example burning herself. With the exception of Woodbourne Priory, there was no evidence that this was responded to specifically as part of Leanne's care, although it may have been but not recorded. The GP treated Leanne repeatedly for self-harm injuries but did not share this with EPUT.

Leanne's vulnerabilities, her capacity to care for herself, her level of independence, her ability to manage her health, her housing situation

10.11. Leanne had diagnoses of anorexia and borderline personality disorder. She had experienced trauma in childhood (witnessing the death of her brother) and challenges in relation to being a looked after child, and subsequently being adopted. The Review heard that early experiences of trauma are very common in diagnoses of personality disorders. Leanne was independent and liked to be in control; she was bright and articulate, and understood her situation and services. Her conditions of anorexia and Borderline Personality Disorder meant that she may have talked about not feeling supported, while getting support that she found difficult to accept. Some professionals, in particular at the Eating Disorder Service, got to know Leanne very well and developed trusting relationships with her and were aware of her history, taking this into account in their responses to her. Southways staff also reflected having got to know Leanne well, and there were good relationships with staff.

10.12. Practitioners reflected that this may have masked her vulnerabilities, and that professionals may have been overly optimistic about Leanne's ability to manage her conditions in particular the anorexia and when her physical health deteriorated. Research suggests that early experiences of trauma, or Adverse Childhood Experiences[5] (ACEs) can negatively impact brain functioning into adulthood. Leanne was capable, intelligent, capable of taking care of herself most of the time, and was planning for her future: the effects of her diagnoses and childhood experiences, and the impact of this on her capacity, treatment and recovery, needed to be more fully understood. In particular the impact of these on her ability to trust new professionals, in the context of regular Care Coordinator changes.

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5 https://www.actionforchildren.org.uk/media/5769/easy_guide_the_effects_of_trauma_and_neglect_on_behaviour.pdf [accessed 09-October-2019]

10.13. While Leanne may have presented differently to different professionals, feedback from services and her family evidenced that she wanted to move but that the move had to be the right one for her. Leanne's presentation as independent and capable, and in particular her wish to care for others and her anxiety over the feelings of others needed to be recognised as influencing her apparent ambivalence, and a more proactive approach should have been taken. This should have included conversations with Leanne about how her family could be involved in her support, if she wanted that, and if she didn't, then professionals should have sought to understand Leanne's family and social situation and how this impacted on her support needs. This should have included the extent to which Leanne's wish to care for others, as described by some agencies and Leanne's family in this Review, was a barrier to her accepting the support she needed. Recommendations (7 and 8) are made.

11. RECOMMENDATIONS

11.1. ESAB Independent Chair to write to Essex Police, Castle Point and Rochford CCG, EPUT and Southways senior management to share the SAR report and highlight the learning for each organisation in relation to: the missed opportunities for raising safeguarding concerns; and the importance of continuing to manage risk and safety while concerns are being processed and responded to. Independent Chair to seek assurance that actions have been taken by each organisation to address the findings for future practice. (Paragraph 9.15)

11.2. ESAB to include in the development of the Quality Assurance Framework the need for agencies to receive safeguarding adult training to cover self-neglect, when that meets a safeguarding threshold, recognition that anorexia can potentially fall within that category, and the need to raise safeguarding concerns even if an individual is under the care of another agency. (Paragraph 9.16)

11.3. Adult Social Care and EPUT to provide ESAB with reassurance, via policies and procedures and practice, that fluctuating capacity is fully considered in the development of both CPA care plans and ASC care and support plans. Specifically: Health and Social Care professionals must pay close attention to and demonstrate the application of the five principles of the Mental Capacity Act (2005) in assessing whether an adult has clear understanding and the ability to weigh up risks when making decisions. Professionals need to take into account that adults' capacity can fluctuate and therefore should consider whether it is appropriate to complete a mental capacity assessment to ascertain clarity and to enable best interest decisions to be made where capacity is lacking. (Paragraph 10.4)

11.4. EPUT to inform ESAB on how they ensure that reviews of Care Programme Approach care plans involve appropriate multi-agency partners, in particular commissioned accommodation providers; and that crisis management plans are developed and adopted when a patient's physical and/or mental health deteriorates. (Paragraphs 10.4 & 10.5)

11.5. EPUT to provide assurance to ESAB that the new arrangements have addressed the learning from this Review in relation to the former Joint Referral Panel: the need for clarity for all professionals on the information required; reducing the 'back and forth' nature of the process; ensuring that there is a clear escalation process to remove any barriers to applications being progressed. (Paragraph 10.7)

11.6. ESAB to be reassured that each agency has reviewed its Mental Capacity Assessment and Best Interest training to cover the need for professionals to see the whole person when considering capacity, to not make assumptions that someone is receiving care elsewhere, to ensure that professional curiosity is exercised and appropriate actions identified. (Paragraph 10.9)

11.7. ESAB to share the learning from this Review that agencies should discuss on a regular basis with service users their family and social situation; whether and how their family could be involved in their care; and any barriers to their care presented by their family or social situation. (Paragraph 10.13)

11.8. ESAB to be assured that Adult Social Care and EPUT care planning processes include a discussion with the patient/client to establish their view on the involvement of family/significant others so that privacy of the individual is not compromised and, where capacity to make a decision is assessed as lacking, best interest processes must be adopted in direct relation to the Best Interest Decision Making key principles set out in the Mental Capacity Act and practice must reflect The Statutory Code of Practice, Chapter 5. (Paragraph 10.13)

12. APPENDIX: INDIVIDUAL AGENCY RECOMMENDATIONS

From Individual Management Reviews.

Essex Partnership University NHS Foundation Trust

- Escalation process for urgent out of panel decisions to be discussed in team meeting to ensure all staff are aware of the process.
- Safeguarding alert should have been raised in December 2017 – all staff to be instructed to discuss concerns about possible safeguarding events with line manager/safeguarding team or safeguarding lead for the recovery and well-being team. Add this to the

supervision template/business meeting agendas to provide monitoring of staff and assurance for bedding into practice.

Essex Police

- November 2016: the Athena investigation log records that the Hospital and West Midlands Police contacted Essex Social Care however the log does not record any contact between Essex Police Triage Team and Essex Social Care in order to obtain any additional information regarding Leanne and her sister or provide an update regarding the outcome of the Essex Police investigation. *Recommendation*: Feedback to be provided to all Triage Team Supervisors to ensure they are clear on the requirement that all opportunities to share information with partner agencies have been actioned when reviewing an investigation before closure.
- September 2017: when Leanne called Police due to being assaulted, this incident was graded as a Priority 4 (to be dealt with within 48 hours) however it is considered that this was not the appropriate response. Leanne had previously been assaulted by the same male with mental health issues and who was still on scene. She herself was vulnerable, living within supported accommodation and there were no staff present at the premises and would not be until 09.00hrs the following morning. She had to lock herself in her room to feel safe. *Recommendation*: Feedback to be given to that particular officer around the importance of correctly grading incidents and providing a full clear rationale around their grading.
- September 2017: the call taker does not appear to have recorded a THRIVE (Threat – Harm – Risk – Investigation opportunities – Vulnerability – Engagement opportunities) assessment on the incident at the time of taking the call and the THRIVE has not been completed until the following day when crime bureau have crimed the investigation. *Recommendation*: Feedback to be given to that particular officer around the importance of risk assessing every incident at the time of dealing with it. This learning should also be extended to all call takers in the Force Control Room to reinforce the necessity to risk assess and record the risk assessment at the earliest opportunity.
- In regard to the same incident Safeguarding Adults Policy states the call taker should have added a tag for Public Protection Unit (PPU) Triage to the incident as it involved a vulnerable adult however this did not happen. *Recommendation*: Feedback to be given to each member of staff that dealt with the incident and failed to add the tag regarding the importance of tagging incidents for relevant teams to bring to their attention as soon as possible. This learning should also be extended to all call takers in the Force Control Room to reinforce the necessity to tag accurately at the earliest opportunity.

- In regard to the same incident, it took the officer 9 days to contact Leanne after the incident and this was via telephone. Had the officer gone to see Leanne in person he would've been able to conduct a better assessment of Leanne's vulnerability. Whilst the Author acknowledges that aspects of safeguarding were recorded within the investigation log with Leanne declining any further assistance and informing the officer that she did not wish the individual to be spoken with, the author considers that there was a missed opportunity to share information with partners regarding the ongoing safeguarding of Leanne, but also the wider safeguarding of other residents within the care setting and the 'offender' himself who appeared to be suffering from mental health issues. *Recommendation*: Officer in the Case (OIC) to be given feedback around the importance of making safeguarding referrals to partner agencies and the process on how to do so, to ensure this is not missed again.
- This investigation was filed under Outcome 14. The Author of the Chronology considers this to be the incorrect outcome. The offender was named by Leanne and therefore known to the Investigating Officer. As such the individual's details should have been recorded within the Associations as a suspect making him searchable against the investigation. *Recommendation*: Consideration to be given to reviewing the Athena outcome and to ensure the correct associations have been applied. The investigation officer and their supervisor to be provided feedback about this error and to ensure they use the correct outcome code's going forward.

General Practice

- A) Patients who are identified within the determined criteria as being vulnerable and/or complex are assigned to a named GP in the surgery who will act as a lead practitioner and ensure that there is ongoing oversight of the patient, particularly in terms of any concerns or escalating risk.

  B) An alert is entered onto the patient's electronic record identifying the above to ensure that other clinical staff in the surgery that may provide care to the patient are aware.
- The Hollies Surgery to review its systems and processes to ensure that their vulnerable and/or complex patients are discussed in MDT and Safeguarding meetings, and, when there is a shared management of these patients' information is shared appropriately with the specialist multi-disciplinary health services Consultant/Key Worker involved.
- The surgery to access guidance and training for GPs and Practice Nurses on Safeguarding Adults Level 3 to include a focus on working with patients who present particularly difficult and complex challenges, and the use of the Mental Capacity Act 2004 within this context.

Newmarket House

- Review our Self-Discharge policy to reflect what steps should be taken when patients want to discharge at the weekend or, for example, if the referring team want to discuss the potential for a Mental Health Act Assessment if a patient wishes to self-discharge against medical advice.

Woodbourne Priory Clinic

- Some actions have been taken in the period since Leanne's admission.
- Implement the divisional care planning approach (done).
- Quality review of Oak Ward by the Specialist Director for Eating Disorders Regional Head of Quality and Regional Quality Improvement Lead.
- Action plan with owners and timescales to be developed following the review by the Head of Quality, to include outcomes of audit referred to above.
- Actions to be included in the Site Improvement Plan which is owned by the Hospital Director and regularly reviewed by the Regional Managing Director and Operations Director. This is a RAG rated plan and improvement areas are met when process and systems have been embedded.
- The Hospital Director, Director of Clinical Services to identify ways of involving the community mental health teams more in Multi-Disciplinary review meetings on an individual patient basis.