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Richmond and Wandsworth Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW

‘Harvey’

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In order to protect the identities of individuals involved, this report uses randomly selected pseudonyms for all persons referred to in this report.

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INTRODUCTION

"Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult" (Department of Health, 2017).

Richmond and Wandsworth Safeguarding Adults Board considered the case of Harvey who died in January 2017 after being stabbed by Matthew at the Housing project where both individuals lived. Harvey and Matthew were known to services and received support for mental health from the Wandsworth Early Intervention in Psychosis Service.

The Safeguarding Adults Partnership Board have determined that the case of Harvey met the criteria for a statutory Safeguarding Adults Review under section 44 Care Act 2014. The purpose of a Safeguarding Adult Review (SAR) is to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented Harvey's death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

At the commencement of the Safeguarding Adults Review the case of Harvey had been subject to a number of investigations and reviews, including criminal, coronial, and internal to organisations involved. A Mental Health Homicide Review was also commissioned by NHS England. As a result of this parallel review process the start Safeguarding Adult Review was delayed until June 2020 when the Safeguarding Adults Review was commissioned by Richmond and Wandsworth Safeguarding Adults Board to avoid any further delay.

Background to the case

Harvey, aged 21-years-old, was receiving support from a specialist mental health team, and lived in a supported housing project. On 21/01/2017, Harvey was stabbed multiple times including fatal stabbings to the neck and chest by a fellow resident. He later died in hospital from his wounds. Harvey had a long history of involvement with statutory services. During his childhood he received support through CAMHS; he had previously lived in a secure unit, and in a Young Offenders institution. As a child, Harvey received treatment for ADHD and had identified learning and educational needs. As an adult, Harvey had identified needs for care and support that arose from his mental health, substance misuse, and personal and social history factors, including his having been a looked after child. Harvey had a diagnosis of unspecified non-organic psychosis and had been receiving support from Wandsworth Early Intervention Service, a mental health team, since April 2015.

Matthew, a 29-year-old man, was convicted of manslaughter by virtue of diminished responsibility (abnormality of mind). Matthew had a history of mental illness and was receiving specialist mental health support. He lived at the same supported housing project and was also convicted of grievous bodily harm to Harvey's fiancée who was present at the time and suffered defensive injuries. Matthew was open to the same mental health team having been accepted onto the Wandsworth Early Intervention Service caseload in 2014.

Methodology

The review methodology draws on systems learning theory to evaluate and analyse the significant amount of information and evidence already gathered about the case of Harvey. Documentary evidence, a draft version of the Mental Health Homicide Review, and the Serious Incident Investigation will be enhanced through methodological analysis of the events leading to Harvey's death and discussions with key staff from stakeholder agencies.

The Review took place at a time when public health measures have been introduced by HM Government to contain the spread of the COVID-19 virus. This influenced the approach taken to achieve the meaningful involvement of practitioners in the case.

About the reviewers

This Safeguarding Adults Review has been led by Eliot Smith and Jessica El-Kaddah. Eliot Smith is an Independent Health and Social Care Consultant who has no previous involvement with this case, with no connection to the Richmond and Wandsworth Safeguarding Adults Board, or partner agencies.

Jessica El-Kaddah is a trained reviewer and a Safeguarding Adults Coordinator within Richmond and Wandsworth, able to provide local expertise and knowledge, but with no previous involvement with the case.

Agency involvement

The following agencies were invited to contribute to the review:

- Richmond and Wandsworth Adult Social Services – Adult Mental Health Team
- South West London & St George's Mental Health Trust – Wandsworth Early Intervention Service
- Metropolitan Police Service
- Wandsworth Children's Social Services – Leaving Care Team
- Thames Reach Housing – at the time offering support to residents at the supported housing project

Thames Reach Housing were no longer delivering the supported housing project and were not able to identify any practitioners who had been involved in the case. Thames Reach Housing therefore were unable to contribute to the Review.

Family involvement

Harvey's mother was offered the opportunity to be involved and contribute to the review. Harvey's mother had also been contacted in relation to the Mental Health Homicide Review.

Principles

Safeguarding Adults Reviews must adhere to the six safeguarding principles outlined in Care and Support Guidance (DHSC, 2020); these are Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

In addition to these, this Safeguarding Adults Review will be conducted in line with the following principles:

- Culture of continuous learning – incidents can provide the opportunity to learn and improve
- Independence and independent challenge
- Meaningful involvement of practitioners without fear of blame for actions taken in good faith
- Involvement of family members and individuals affected by circumstances of the case
- Awareness of risks of hindsight bias and outcome bias
- Focus on system and teams functioning
- Not a re-investigation of incidents or performance

Terms of reference

Terms of reference for Safeguarding Adults Reviews are agreed by Safeguarding Adults Boards and should be published and openly available (DHSC, 2020). Initial SAR Terms of Reference were agreed by Richmond and Wandsworth Safeguarding Adults Board in August 2018 and updated in November 2019 the Mental Health Homicide Review. In June 2020, the Mental Health Homicide Review had not yet been published and the decision was made to proceed with the Safeguarding Adults Review in order to avoid any further delay.

The timescale for the review cover the period from November 2016 to January 2017. The following are the areas on which Richmond and Wandsworth Safeguarding Adults Board would like to focus the review:

1) How effective was the support provided to Harvey in managing and supporting his needs as a young adult?
2) How well did agencies work together to share information and ensure the best possible outcomes for Harvey?
3) To what extent did Harvey's complex history impact on how professionals treated his risk?

NARRATIVE SUMMARY OF PRACTICE

The Safeguarding Adults Review is concerned with the period from November 2016 to January 2017. During this time both Harvey and Matthew were open to the NHS Trust's mental health Early Intervention Service and lived in a supported housing project in Tooting. Wandsworth Early Intervention Service works with adult service users and their carers who have experienced a first episode of psychosis.

The Early Intervention Service kept their focus of treatment for Harvey on the relationship between mental health and substance misuse, although they had no specific expertise in the team in working with people with co-existing conditions, training in dual diagnosis, research or evidence-based practice. The team instead relied on the experience of the Care Coordinator to work with Harvey's mental health and substance misuse. This was a training gap for the NHS Trust, Local Authority, and Support Provider.

Matthew was also well known to mental health services and had been receiving mental health support from the same Early Intervention Service since 2014. Matthew had a diagnosis of psychosis and was also known to use substances. During the review time period Matthew was working full-time in the local area in a job that offered a pattern of flexible working hours. The focus of treatment for Matthew was on maintaining employment and vocational activity with additional support in crisis – provided by the Home Treatment Team[1].

At the time organisational roles and responsibilities, after the ending of a section 75 agreement between the NHS Trust and Local Authority, were felt to be unclear. Despite this. joint working between Harvey's Care Coordinator and Social Worker was felt to be positive and cross-organisational communication was effective. However, the roles of the mental health team and care leaver's team were not so effective, or well defined. The care leaver Personal Assistants were confused about how to navigate the adult social care and safeguarding system, For example, referrals and information sharing about Harvey did not go direct to his allocated social worker, but to the Access Team (front door); they "didn't know what door to knock on".

The Early Intervention Service use the Lambeth Early Onset (LEO) zoning system which categorises mental health need and risks to allow a team to concentrate a higher level of monitoring on the service users on their caseload who the most unwell or at greater risk. At the time of the review period the majority of the Service's caseload were on the amber zone. Having a significant proportion of service users on in the amber zone leads to a risk that the service becomes accepting of chronic poor mental state and risk factors. Since the death of Harvey, the Early Intervention Service have made system changes to their zoning practice and have introduced a monthly audit cycle of cases through supervision.

Harvey and Matthew were both supported through the Care Programme Approach (CPA). The Care programme Approach is the framework for the delivery of mental health care for those with the highest level of needs and who are the most at risk. The Care Programme

[1] The team followed the HTT model – this was not a Crisis Team, but a team offering flexible and intensive contact to individuals who consented to, and engaged with, the service. The HTT were also gatekeepers of admissions. Significant amount of contact was by telephone.

Approach sets out how service users are assessed, and services planned, coordinated, and reviewed. The Care Programme Approach was designed to be a collaborative and multi-agency approach where an individual's care was tailored to need with core components including a person-centred multi-disciplinary assessment, risk assessment and contingency plan, and a nominated Care Coordinator responsible for monitoring and reviewing the care plan and administering the process of continual assessment and review. CPA review meetings are a central part of the Care Programme Approach and provide an opportunity for the service user to meet with the professionals and carers involved in their care to review their progress and make decisions about interventions and treatment.

The case of Harvey and Matthew provides an insight into how treatment decisions were made. The Early Intervention Service appear over-reliant on apparent social and vocational functioning as an indication of mental wellbeing. The possibility of relapse, and associated contingency planning, was not considered despite disengagement and discontinuation of medication being a feature of both Harvey and Matthew's recent history. There was also a lack of flexibility and assertiveness in facilitating community contact. The Early Intervention Service could have made more use of a model of care which allowed flexible-working and visits and appointments at different times of the day, outside of traditional office hours.

Services also appeared to rely heavily on the views of family, and the housing support workers. Staff at the Housing Project became the main conduit of information supplemented by care coordinator contact through visits or telephone calls.

Harvey moved into the supported housing project from another provider due to issues with breach of tenancy – including ownership of a pet. Harvey's referral to the project was initially refused but later reversed after he was offered another chance at interview – which he attended with support. The view of professionals involved at the time was that the placement was suitable for Harvey and commissioned to meet the level of risk at which he had been assessed. There was a degree of optimism about the placement and a belief that the risk of homelessness would overcome the risks of placement breakdown. Shortly after Harvey moved in the support provider began to raise concerns about behaviours that jeopardised his tenancy. It is not clear how robustly Harvey's risks were assessed, or what multi-agency risk management plan and contingencies had been put in place to ensure the success of his placement. Harvey had been well-known to services throughout his adolescence and early adulthood. This history does not appear to have been captured in his adulthood risk assessments or management plans. It would have been best practice for the care leavers team, CAMHS, and mental health services to formulate a risk profile that recognised the impact of his childhood experiences on his adult life.

On 16 January 2017, Police were called to a disturbance at the supported housing project. On arrival, Police observed what they believed to be an incident of domestic abuse between Harvey and his fiancée. During her interview with Police, after Harvey had been taken into custody, Harvey's fiancée informed the Investigating Officer about a verbal altercation between Harvey and Matthew, in which Matthew had possession of a knife. This should have resulted in a separate crime report and investigation. However, there was no follow up with Matthew, and no further interviews with witnesses or investigation. There was a lack of flexibility to the Police approach; initial assumptions about the nature of the incident prevented other witness accounts being sought, and other scenarios were not considered. An account was later provided by Harvey's fiancée that she was trying to calm him, after the

verbal altercation with Matthew. The wider situation, context, and antecedents to the incident between Harvey and his fiancée was not taken into account in the management of the incident. As a result of the incident Harvey had stated later in the same week, that he felt his life was at risk.

More generally assumptions were made that relationships were 'stabilising' for Harvey, and protective factors in his behaviours and risks. There were some concerns about his relationships with his fiancée from a safeguarding children perspective – Harvey's fiancée was under 18 years old and herself in the care of the Local Authority. She had been reported as a missing person when the incidents occurred.

As the details of the incident and wider context became clear, the Early Intervention Service immediately made contact with Harvey and attempted to make contact with Matthew. A number of assumptions were made about how the incidents were being, or should be, managed. There was a belief and an assumption that the Police would, or should, be dealing with the knife aspect of the incident, but this was not checked with the Police. A Safeguarding referral had been made to the Local Authority, by the housing provider, but not progressed as the incident was seen as a one-off, not representing a pattern of ongoing abuse. It was not clear what the rationale was for this however had a decision been made to make enquiries under Section 42 of the Care Act 2014 this would likely have prompted further multi-agency dialogue and risk assessment which would have facilitated more effective information sharing.

There was no joined up risk management strategy for Harvey and Matthew. Each individual's experience and risk was assessed in isolation by the respective Care Coordinators in the Early Intervention Service, by the housing provider, and for Harvey with the addition of his allocated Social Worker. A safety plan was made with Harvey, to stay with his mother, however this plan was not confirmed with Harvey mother, or checked with her (only with Harvey). Harvey's option of moving to his mother's address should have received greater analysis – the benefits, and risks involved given the complexity of their relationship and previous Safeguarding incidents between them. No details had been worked out and, in the event, Harvey returned to his tenancy.

Plans were not discussed or implemented to facilitate the separation of Harvey and Matthew following the initial knife incident. A management plan for further altercations between Harvey and Matthew should have been completed.

FINDINGS

Harvey was a young man who had been known to services for much of his life, as a child and in his early adulthood. Harvey's death was a tragedy for his family and had a significant impact on practitioners and organisations who worked with him. Harvey's case has already been subject to scrutiny through a number of investigative processes, including a criminal case against Matthew, Coroner's inquest, a Serious Incident investigation by the mental health NHS Trust, and a Mental Health Homicide Review. These investigations have produced their own findings, which are not duplicated here. The Safeguarding Adults Review uses Harvey's case as an opportunity to shed light on multi-agency working and Safeguarding practice in Wandsworth.

The methodology and principles underpinning this review are not aimed at 'linear thinking' which leads to blame at a practitioner and also leans away from hindsight bias; this can lead to oversimplifying and judging more harshly if the outcome is poor. The approach adopted in this review is to explore the range of different organisational factors that may have come together in unexpected ways to create the incident. The Review seeks to bring out findings from this case that have general applicability for the wider system; they are presented thematically against the structure provided by the Terms of Reference set for the review. The findings of this review are based upon the analysis of documentary evidence and available data, information from organisations involved and practitioners who knew Harvey or his case.

TOR 1: How effective was the support provided to Harvey in managing and supporting his needs as a young adult?

Context

Harvey was known to Child and Adolescent Mental Health Services during his childhood and had been accommodated in a secure unit, and young offenders' institution prior to his 18th birthday. This made Harvey an eligible person for leaving care support from childhood into adulthood. Harvey would have remained a former relevant person until the age of 24. This support included a Personal Assistant and a Pathway plan that would have brought together partner agencies, such as Housing, Education and Youth Offending. This framework formed one aspect of the support that Harvey received, set out in a needs assessment and Pathway Plan to be reviewed on a regular basis.

Harvey was accepted onto the caseload of the Wandsworth Early Intervention Service in 2015, when he was 20 years old. He also had an allocated Social Worker from the Local Authority Adult Mental Health Team. As a resident in a supported housing project, Harvey received day-to-day housing related support from an independent provider, commissioned through the Local Authority. Harvey has access to keyworker support and one-to-one sessions.

Harvey's support was driven by a hierarchy of treatment that focused on goals set in assessment and review meetings with Harvey. The focus of mental health treatment was dominated by the theory of correlation between Harvey's use of alcohol and drugs and poor mental health. Mental Health services interventions were aimed at supporting Harvey to

understand the link between mental health and substance misuse and so moderate his use of illicit substances.

Findings

Dual Diagnosis – coexisting severe mental illness and substance misuse

The relationship between mental health and misuse of alcohol and substances (prescribed and illicit) is well known and for Harvey was considered significant. It is known that adults and young people with coexisting severe mental illness and substance misuse have some of the worst health, wellbeing, and social outcomes (SCIE, 2009).

This led to a formulation of diagnosis and treatment that placed substance misuse and non-concordance with treatment at the centre of his care plans as factors most likely to cause a relapse in symptoms of psychosis. There was also a view that across the supported living schemes, the incidence of service users with coexisting conditions of mental illness and substance misuse was high.

There is a particularly strong relationship between substance misuse and psychosis with specific guidance published by the National Institute for Health and Care Excellence (NICE, 2011), (NICE, 2016). Perhaps due to the prevalence of coexisting conditions this guidance encourages specialist mental health services to adapt to meet an individual's mental health and substance misuse needs, rather than to create specialist dual diagnosis services (NICE, 2016). Despite this, the team had limited access to specialist expertise on addiction and dependence, and expertise within the team relied on the learned experience of Care Coordinators. Greater investment in this area may provide dividends in the treatment of individuals with co-existing conditions.

Family involvement

Early Intervention Services aim to "protect social support networks, involve families in care, and providing prompt and intensive pharmacological and psychological treatment." (Neale & Kinnair, 2017). The Mental Health NHS Trust have since become a member of the Triangle of Care scheme, which promotes shared working between carers, professionals, and people using services (NHS Trust website). The Triangle of Care was developed by the Carers Trust and denotes the relationships between the service user, carer, and professional; "When a mental health trust joins the Triangle of Care membership scheme, it is committing to changing the culture of its organisation to one that is carer inclusive and supportive" (Carers Trust, 2020). Developing and maintaining family or other personal relationships is also one of the Care Act 2014 eligibility outcomes and positive relationships can be a positive influence on behaviours and a protective factor for many individuals who use services. In the case of Harvey and Matthew, services viewed their respective family members as potential "early alerters" of mental state deterioration and relapse, however, did not view them as full partners in care.

The Early Intervention Service had completed some work with Harvey and his family however it was recorded that the Harvey's relationship with his mother was "difficult". The Service felt that their rapport with Harvey's mother had been damaged following their referral

of an allegation of domestic abuse towards Harvey at his mother's address. This effectively ended formal therapeutic family work and it is not clear that much was done to repair this breakdown in rapport, or by any agency to support to protect or strengthen Harvey's relationship with his mother. Later, Harvey's safety plan relies on this relationship as he is encouraged to stay at his mother's address as a place of safety rather than return to the housing project. More effective family working may have helped services involve Harvey and his family more effectively in this intervention.

Personal relationships were generally considered as 'stabilising' for Harvey and protective factors in his behaviours and risks although Services did have some concerns about risk within the context of his relationship with his ex-partner, daughter, and about the vulnerability of his current fiancée. Further exploration and support of Harvey around his social and familial relationships would have enhanced the effectiveness of his support as a young adult seeking to become more independent, establishing his identity, peer group, and family.

Finding 1: Working with personal and family relationships

Underlying issue
There was a disconnect between the family and relationship-focused support offered to Harvey as a looked after child and former relevant person, and his support as an adult with experience of mental health difficulties which focused more on Harvey as an autonomous individual. The care and support offered to Harvey operated within respective frameworks with a narrow focus on social, medical, and behavioural treatment goals, and on dual diagnosis. There was no joined-up approach to supporting Harvey in the context of his family network (as a child and as a parent) to strengthen his relationships and informal support networks.

Impact on system
Many individuals who have been looked after children, who have diagnoses of mental health difficulties, or who use substances can often be socially isolated, and may struggle to maintain supportive personal and family relationships. Yet health and social care agencies often rely on families and informal carers to help support individuals with care and support needs. A failure to prioritise support for relationships can undermine the effectiveness of other interventions for support and risk management.

Recommendation
- *Review the prevalence and priority given to family work*
- *Link to transitions work and thematic findings of Safeguarding Adults Reviews and Safeguarding Children Practice Reviews*
- Could the NHS Mental Health Trust and other organisations share developments and strategic work on family and care-focused initiatives, such as the Triangle of Care scheme?

TOR 2: How well did agencies work together to share information to seek the best possible outcomes for Harvey?

Context

Communication of significant information is a key aspect of effective multi-agency assessment of needs and provision of services. When an individual is supported by a number of agencies and professionals, good communication can result in a more joined up service, reduces inconsistencies or duplications in interventions, and allows agencies to mobilise resources in the most efficient and effective way possible. Perhaps the most important communication will be to involve the individual themselves, reflecting the Safeguarding principles of empowerment and of accountability and transparency – *"I understand the role of everyone involved in my life and so do they"* (DHSC, 2020).

The timely communication and management of accurate and precise information is especially important when agencies are called to work together to manage a risky situation or respond to allegations of abuse or neglect. Information sharing must not merely occur but should lead to a collaborative understanding of the situation, analysis of events, risk, and protective factors, and to decisions and agreements about what actions are necessary, when, and by whom.

Harvey was supported by the Local Authority Care Leavers Service[2], an NHS Mental Health Service, Local Authority Mental Health Team, and the supported housing project. Each service operated its own unique framework, coming together through the respective review meetings and processes. In between formal reviews communication was ad hoc and relied on the nominated practitioners involved – the Care Leavers' Personal Assistant, Mental Health Care Coordinator, allocated Social Worker, and supported housing Keyworker. The effectiveness of the support provided to Harvey was dependent on the effectiveness of multi-professional, and multi-agency working.

Findings

<u>Single professional vs. multi-professional interventions and decision-making</u>

The benefits of multi-professional communication and intervention – or the limitations of single-professional responses – can be seen in the mental health service, and in the operation of the Lambeth Early Onset zoning system at the time. Parallel investigations have considered this agency-specific finding in more detail, however the mechanisms in place to manage cases of risk and need are a useful exemplar of the importance of group thinking and reflection. The zoning system is an attempt to categorise the service caseload by risk into green, amber, and red zones. As cases move between the zones, they receive different levels of supervision and team discussion.

At the time, red zone cases benefited from full team discussion in weekly zoning meeting, while amber cases were discussed in supervision. The majority of individuals were in the amber zone, which effectively reduced the ability to track subtle changes or events – such as gradual disengagement from services, symptoms or evidence of non-concordance with

[2] At the time contracted out to an independent provider.

medication, and less florid signs of relapse. The Care Coordinators for Matthew and Harvey did not work together well, or with the housing provider, and no contingency or crisis plans were updated for Matthew. The failure of the zoning system to highlight the situation of Harvey and Matthew, or mobilise a multi-disciplinary discussion or process, may have denied them a coordinated intervention to mitigate the risk of further conflict between them. Further analysis of the zoning system can be found in the relevant parallel investigations[3].

Multi-agency working

In 2016 the Local Authority and NHS Trust dissolved their section 75 (NHS Act 2006) agreement. Section 75 NHS Act 2006 makes provision for NHS bodies and Local Authorities to contribute to a pooled budget to enable partnership arrangements in relation to the exercise of NHS functions and certain health-related functions[4] of Local Authorities. Most commonly used in the delivery of specialist mental health services, this translates in practice to integrated Adult Mental Health Teams. Teams are made up of medical, nursing, allied healthcare professionals, and psychologists employed by the NHS trust, and Social Workers and other Social Care staff employed by the Local Authority.

The dissolution of the section 75 agreement may have been challenging organisationally, however in the case of Harvey there appears to have remained a good working relationship between his NHS Care Coordinator and allocated Local Authority Social Worker. The support offered to Harvey was joined up, and day-to-day communication was reported by those involved to be effective. When the incidents between Harvey and Matthew became known, Harvey's Social Worker and Care Coordinator worked together to formulate a safety plan with Harvey. There was also good attendance at Care Programme Approach review meetings and an agreement about the support and treatment being offered.

Multi-agency working was less effective outside of established relationships between NHS and Local Authority mental health teams working with Harvey, and in particular between mental health teams and the care leavers and children's services. Some communication had been evident in scheduled processes, such as attendance at review meetings, however there was still some distance between them.

An example of this is that the Care Leavers' Personal Assistants used the Local Authority Access Team to share information with the allocated social worker – rather than contacting the team directly. The Care Leavers Service have reported that at the time they were also less sure about how to navigate the adult Safeguarding system. There have been changes to the way the care leavers service is commissioned and provided, and the recruitment of a Care Act assessing social worker and a mental health specialist personal assistant. Evidence provided to the review indicates that for people with mental health difficulties, some difficulties remain in relation to pathway planning, transition work, and ongoing support.

[3] S.I. reference, and MHHR (if released for reference)

[4] "Health-related functions" of Local Authorities include any function that has an impact on a person's health, have an effect on NHS functions, or are connected with NHS functions (s.75(8) NHS Act 2006)

Finding 2: Multi-Agency working: a childhood-adulthood divide

Underlying issue
Effective multi-agency work in this case was more likely to occur where practitioners had established relationships and a clarity of understanding of role and was most effective when professionals themselves worked closely together with a shared goal. The case of Harvey reveals a divide between child and adult operational service structures, but also in the perspective of need and risk in relation to Harvey's childhood and adulthood.

The formulation of Harvey's mental health needs and risks appears to be confined to each different phase of his life – childhood experiences do not appear to have had much impact on the understanding of his adult mental health issues, or diagnosis – except in a prodromal sense.

Impact on system
For multi-professional and multi-agency practice to be most effective, services must have a good understanding of one another, and of the importance of positive and negative childhood experiences on an adult's independence, abilities, skills, and resilience. The failure to recognise the interdependence of child and adult services for people who leave care, and the need to work collaboratively may leave some individuals with a partial approach to management of risk. This is especially relevant to periods of crisis, outside of formal or scheduled reviews.

Recommendation
- *There is still much to be done to embed communication pathways and joint working between Care Leavers Service and Adult Services*
- *Have there been any reviews of the Think Family agenda in safeguarding practice in Wandsworth/Richmond*

TOR 3: To what extent did Harvey's complex history impact on how professionals treated his risk?

Context

This section of the review examines responses and attitudes to risk and how this may have impacted on the formulation of care and support. The Review also considered how decisions were made about the input Harvey and Matthew received, including after the first incident of conflict between them. In the formulation of findings against this term of reference, the review considers evidence from the services provided to both Harvey and Matthew.

In health and social care risk assessment and risk management are core considerations for all professionals as they make decisions about the care and support to offer and about their interventions with people who use services. Risk assessment can be described as an assessment of "the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others" (Morgan, 2007) combined with the imminence, and severity of the negative event occurring (Department of Health, National Risk Management Programme, 2007) (NCISH, 2018).

Risk assessment in mental health services has traditionally focused on prediction – assessing an individual's risk in certain domains (for example risk to self, to others, or of self-neglect) as low, medium, or high (NCISH, 2018). Risks can be general and specific and risk event prediction relies on analysis of historical and current risk factors. Risk factors are categorised as static (for example childhood events) or dynamic (use of drugs or alcohol and interpersonal conflict). Dynamic factors can be further divided into stable or chronic factors (changing relatively slowly over time), or changeable acute factors. In the case of Harvey, the acute risk situation did change rapidly. When working with individuals who use services it is important to recognise the distinction between the person themselves and the event – that the risk factors that may predict a specific event, or events, from occurring can be personal, environmental, and contextual. Good practice in risk assessment is about working together with an individual to understand behavioural responses and events within this context; most importantly risk work should be person-centred and empowering (SCIE, 2012). The approach to risk management my vary across organisation, or context.

Within safeguarding practice, interpersonal relationships are often a feature of risk assessment, where the potentially harmful event may be the result of behaviours by one individual or another. In cognitive theory a person's beliefs, experiences, motivations, and physiological sensations, and their thoughts, feelings and actions or behaviours are all interconnected. The management of risk is a collaborative process, with professional interventions often aimed at reducing 'risky' behaviours. Risk management may involve behavioural reinforcement, moderation or control; therapeutic interventions[5], offering incentives, giving advice, imposing sanctions, or licence conditions, removing opportunity, separation of parties, or even detention and incarceration are used across the health, social care, education, and criminal justice systems. A careful assessment of risk is crucial to enable practitioners to make a judgement on what risk behaviours require intervention (identify the risk) and to select an intervention that will be effective and proportionate to the likelihood and seriousness of harm (intervene to prevent harm).

[5] Cognitive Behavioural Therapy or psychosis (CBTp) is widely used in Early Intervention Services as the first-choice therapeutic intervention for symptom and risk management.

Findings

Identification of risk

The review has identified a number of areas where risk practice was driven not only by the events that were occurring, and understanding of the individuals involved, but also by practitioners' own assumptions. These included professionals' conscious and unconscious values and attitudes, patterns of practice and intervention, and experience of working with of people who have mental health problems, substance misuse issues, or who live in supported housing. Objective and subjective judgements about Harvey and Matthew and their respective personal and social histories also played a part in the way that risk events were managed.

In the case of Harvey, risk assessments for Harvey and Matthew focused on use of substances, insight, and concordance with medication, and for Matthew a risk of social withdrawal and self-neglect. New risk events, such as an incident at a housing office where Matthew was seen to be brittle, angry, and highly emotionally aroused, were not incorporated into the formulation. While the significance of these events may grow in hindsight, this event may have indicated not only a previously unseen capability for aggression in Matthew, but also an indication of relapse and deterioration in mental state. The practitioner group recalled using "an old Matthew yardstick". The over-reliance on the existing understanding of risk may have led to a number of assumptions about Harvey and about Matthew's mental state. Harvey's personal and social history was also less present – including conflict within relationships with family, in safety planning and interventions.

Significant weight was placed upon static and stable risk factors, or on initial observations of risk incidents. The formulation of risk for Matthew appeared to be more resistant to change, in the face of known information about a recent display of aggression at a housing office, a historical incident of possession of a knife, and new information about the incident at the supported housing project. This took place in the context of Matthew's previous disengagement with treatment and a period of months without anti-psychotic medication; if he were suffering from a psychotic mental disorder the risk of relapse would have become increasingly real. Over time the level of direct contact with Matthew had decreased and professionals appear to have been relying too heavily on information from third parties, such as family members or housing support staff for information and assessment of Matthew's mental state and wellbeing. The possibility of relapse was not seriously considered, and services were too easily reassured by Matthew's continued full-time employment.

Assumptions were made across agencies which demonstrated a degree of unconscious bias in the conceptualisation and management of risk. In the interface between the professional group and service user group, individuals inevitably bring their own values, views about power, equality, their personality, and their past experiences. These will affect how they interpret and respond to the intergroup context (Abrams, 2010).

A narrow interpretation of events was evident in the Police practice in the case. Initial assumptions about an occurrence of domestic abuse, reinforced by observations of expressed emotion, and failure to talk to other witnesses at the property (including Matthew) meant that the incident between Matthew and Harvey was not investigated. New evidence

and information, such as Harvey's fiancée's account of the verbal altercation between Harvey and Matthew and possession of a knife, was not incorporated into the overall assessment of risk.

Evidence provided to the review also indicates an acceptance of Harvey's chronic mental health presentation, historical difficulties in resolving interpersonal conflict, use of substances, and social behaviours. Matthew's apparent ability to work led to an assumption of wellness, and belief that he would withdraw from, rather than seek, conflict also came into play. Out of date care plans and risk assessments, not updated with newer information about agitation and aggression-capability, may have reinforced the view that serious harm was unlikely. Within the project itself, the response to the incidents were sanctions in the form of a warning letter to all parties – a usual response to conflict between residents.

The sum of bias in the case of Harvey and Matthew appears to be a general acceptance of a level of interpersonal conflict between individuals living in supported living who have experience of mental illness and substance misuse. In the case of Matthew and Harvey, the risk of further, and escalating, aggression was not identified.

Finding 3: Identification of risk

Underlying issue
The formulation of risk appeared to be resistant to change following incidents at the supported living project. There was a conflation of risk identification in responses to domestic abuse incident and conflict between Harvey and Matthew. Existing knowledge of Harvey and Matthew and assumptions about their usual presentation and behaviours, for different reasons, meant that the risk of further aggression between them was under-identified. Assumptions were made about both Harvey and Matthew – judgements on their behavioural norms, a reliance on third parties for assessment of mental state, and reassurances too easily obtained about Matthew's wellness, based on his ability to maintain employment.

Impact on system
There appears to be a general acceptance of poor mental health and substance misuse among the population of individuals living in supported housing projects. The reliance on third party information, and reverse engineered assumptions about wellness undermined an objective assessment of mental state and selection of appropriate intervention and treatment. Incidents of interpersonal conflicts within this group were not seen as unusual and could even be expected. There is a risk that such unconscious bias among the professional group may result in a lack of response to incidence of interpersonal abuse, and among the service user group that a level of conflict is to be expected and therefore tolerated.

Recommendation
- *Opportunity to expand single-agency initiatives around unconscious bias and professional curiosity*
- *Audit of professional views and attitudes – does unconscious bias exist in relation to service user groups, mental health, substance misuse, and or supported living*

Selecting effective and proportionate interventions

The failure of agencies to work together, due to ineffective or non-existent interagency communication and information sharing was a reoccurring feature of the 27 SARs reviewed as part of the 2017 'Learning from SARs study' completed by Suzy Braye and Michael Preston-Shoot for the London Safeguarding Adult Board (Braye & Preston-Shoot, 2017). This review has highlighted missed opportunities and a lack of multi-agency holistic working in response to the incident between Harvey and Matthew which demonstrates the continued work required across all agencies to embed such learning within their organisations.

This finding is focused on exploring the balancing act required in order to promote proportionate intervention when dealing with risk management. Risk assessment is one of the most frequently criticised areas of practice when cases are reviewed in the Safeguarding Adults Review arena, coroner's inquests, and other similar enquiries. Practitioners are often criticised for not intervening enough or being too easily reassured and not demonstrating enough professional curiosity.

Safeguarding processes provide a Statutory framework as a multi-agency coordinated response where there are concerns of risk to adults, who due to their vulnerabilities and care and support needs are unable to take steps to protect themselves. This Review has highlighted a lack of impetus across all involved agencies to trigger such a response which in turn hindered the interagency information sharing and communication which may have led to more urgent responses from different agencies.

A Safeguarding referral was made by the Housing provider following the initial incident was screened out by the Local Authority as it was viewed as a one-off incident. This decision did not appear to reflect the fact there were two potentially very mentally unwell adults and predictable further conflict through retaliation from Harvey or further aggression/intimidation from Matthew. This response may have been different had other agencies raised concerns via this pathway or challenged the response to the initial referral. This may have changed the temperature of the case and led to further enquiries being made. The police did not raise a Merlin, the Early Intervention Service did not trigger a Safeguarding referral, the social worker involved did not escalate any concerns which ultimately led to a single agency response to the incident.

A lack of information sharing across agencies led to assumptions being made about who was dealing with what. For example, the Early Intervention Service believed the police were taking action in terms of Matthew greeting Harvey with a knife which may have lowered the sense of urgency from their perspective. Had they been aware at the time that this was not the case it may have led to more proactive search for an alternative place of safety for either one of them.

The safety planning for Harvey as a result of this appears single agency and hasty; relying on a suggestion to Harvey that he manages his own risk by staying with his mother. Harvey's mother was not directly involved in this safety planning despite being viewed as a protective factor and agencies did not consider a previous domestic abuse between the two which had triggered a previous Safeguarding response. The fact that no agency tried to proactively explore Safeguarding implies that at the time it was not part of their thinking that this process would assist in the management of the situation.

The Multi Agency Risk Assessment Framework was developed in 2019 as a collaborative piece of work with all members of the Safeguarding Adults Boards for Richmond and Wandsworth. This tool was developed as a mechanism for those cases where professionals are worried about an adult in the Boroughs and have identified that a multi-agency response would be beneficial. The statutory Safeguarding criteria as set out in the Care Act 2014 does not have to be satisfied in order to initiate this tool. It can be led by any agency and provided the framework for information sharing and risk management. This tool may have been usefully applied to this situation – had it been available at that time, however it is still reliant on agencies thinking proactively. Going forward it is key that all partner organisations raise the profile of this framework and encourage the use of this tool for relevant cases.

The use of virtual platforms as a way of facilitating Safeguarding enquiries has been a positive step forward in promoting a more responsive approach to Safeguarding in Wandsworth. The accessible nature of such meetings has facilitated the regular inclusion of partners such as the police and health colleagues who ordinarily would struggle to access face to face meetings. This has enabled robust multi-agency safety planning to ensure that appropriate steps have been taken by relevant professionals in response to safeguarding's issues.

Finding 4: Safeguarding: Multi-agency risk processes

Underlying issue
Effective multi-agency and risk assessment response was required when considering the safeguarding concerns raised in this situation. There was a lack of a multi-agency and risk assessment response to this incident which was evidential from their being no plan initiated by any agency to support Harvey and Matthew to feel safe. There is an element of de-sensitisation to the situation where all agencies remained with their original plan and were not prompted by events to reflect and amend their interventions and approaches accordingly. This suggests a lack of professional curiosity which is key when dealing with any safeguarding situation.

Impact on system
For multi-professionals and multi-agency practice to be most effective services must have a good understanding of one another's' remits, roles and responsibilities particularly pertaining to Safeguarding.

Recommendation
- *Raise the profile of the Multi-Agency Risk Assessment Framework and encourage the use of this tool for relevant cases*
- *Consider whether services have become de-sensitised to risk, and a degree of conflict and violence among the mental health, substance misuse, or supported living cohort*

SUMMARY OF RECOMMENDATIONS

No.	Finding	Underlying issue	Impact	Recommendation
TOR 1: How effective was the support provided to Harvey in managing and supporting his needs as a young adult?				
1.	Working with personal and family relationships	There was a disconnect between the family and relationship-focused support offered to Harvey as a looked after child and former relevant person, and his support as an adult with experience of mental health difficulties which focused more on Harvey as an autonomous individual. The care and support offered to Harvey operated within respective frameworks with a narrow focus on social, medical, and behavioural treatment goals, and on dual diagnosis. There was no joined-up approach to supporting Harvey in the context of his family network (as a child and as a parent) to strengthen his relationships and informal support networks.	Many individuals who have been looked after children, who have diagnoses of mental health difficulties, or who use substances can often be socially isolated, and may struggle to maintain supportive personal and family relationships. Yet health and social care agencies often rely on families and informal carers to help support individuals with care and support needs. A failure to prioritise support for relationships can undermine the effectiveness of other interventions for support and risk management.	Review the prevalence and priority given to family work Link to transitions work and thematic findings of Safeguarding Adults Reviews and Safeguarding Children Practice Reviews Could the NHS Mental Health Trust and other organisations share developments and strategic work on family and care-focused initiatives, such as the Triangle of Care scheme?

No.	Finding	Underlying issue	Impact	Recommendation
TOR 2: How well did agencies work together to share information and ensure the best possible outcomes for Harvey?				
2.	Multi-Agency working: a childhood-adulthood divide	Effective multi-agency work in this case was more likely to occur where practitioners had established relationships and a clarity of understanding of role and was most effective when professionals themselves worked closely together with a shared goal. The case of Harvey reveals a divide between child and adult operational service structures, but also in the perspective of need and risk in relation to Harvey's childhood and adulthood. The formulation of Harvey's mental health needs and risks appears to be confined to each different phase of his life – childhood experiences do not appear to have had much impact on the understanding of his adult mental health issues, or diagnosis – except in a prodromal sense.	For multi-professional and multi-agency practice to be most effective, services must have a good understanding of one another, and of the importance of positive and negative childhood experiences on an adult's independence, abilities, skills, and resilience. The failure to recognise the interdependence of child and adult services for people who leave care, and the need to work collaboratively may leave some individuals with a partial approach to management of risk. This is especially relevant to periods of crisis, outside of formal or scheduled reviews.	There is still much to be done to embed communication pathways and joint working between Care Leavers Service and Adult Services Have there been any reviews of the Think Family agenda in safeguarding practice in Wandsworth/Richmond

No.	Finding	Underlying issue	Impact	Recommendation
TOR 3: To what extent did Harvey's complex history impact on how professionals treated his risk?				
3.	Identification of Risk	The formulation of risk appeared to be resistant to change following incidents at the supported living project. There was a conflation of risk identification in responses to domestic abuse incident and conflict between Harvey and Matthew. Existing knowledge of Harvey and Matthew and assumptions about their usual presentation and behaviours, for different reasons, meant that the risk of further aggression between them was under-identified. Assumptions were made about both Harvey and Matthew – judgements on their behavioural norms, a reliance on third parties for assessment of mental state, and reassurances too easily obtained about Matthew's wellness, based on his ability to maintain employment.	There appears to be a general acceptance of poor mental health and substance misuse among the population of individuals living in supported housing projects. The reliance on third party information, and reverse engineered assumptions about wellness undermined an objective assessment of mental state and selection of appropriate intervention and treatment. Incidents of interpersonal conflicts within this group were not seen as unusual and could even be expected. There is a risk that such unconscious bias among the professional group may result in a lack of response to incidence of interpersonal abuse, and among the service user group that a level of conflict is to be expected and therefore tolerated.	Opportunity to expand single-agency initiatives around unconscious bias and professional curiosity Audit of professional views and attitudes – does unconscious bias exist in relation to service user groups, mental health, substance misuse, and or supported living

No.	Finding	Underlying issue	Impact	Recommendation
4.	Safeguarding Adults: Multi-agency risk processes	Effective multi-agency and risk assessment response was required when considering the safeguarding concerns raised in this situation. There was a lack of a multi-agency and risk assessment response to this incident which was evidential from their being no plan initiated by any agency to support Harvey and Matthew to feel safe. There is an element of de-sensitisation to the situation where all agencies remained with their original plan and were not prompted by events to reflect and amend their interventions and approaches accordingly. This suggests a lack of professional curiosity which is key when dealing with any safeguarding situation.	For multi-professionals and multi-agency practice to be most effective services must have a good understanding of one another's' remits, roles and responsibilities particularly pertaining to Safeguarding.	Raise the profile of the Multi-Agency Risk Assessment Framework and encourage the use of this tool for relevant cases Consider whether services have become de-sensitised to risk, and a degree of conflict and violence among the mental health, substance misuse, or supported living cohort

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