Bristol Safeguarding Adults Board

Executive Summary

Of a Serious Case Review regarding Mr C who died as a result of a fire in his own flat on 6th September 2014

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Acknowledgements

The author is grateful to all those who have contributed to this report, and particularly to Mr C's son, who supported his father for many years and enabled all those involved to have a rounded picture of Mr C.

1. Introduction

1.1. This report provides a summary of the process, findings and recommendations of a review initiated by Bristol Safeguarding Adults Board (BSAB) following the death of Mr C.

1.2. On September 6th 2014, Mr C, aged 61, died in a fire at his flat in Bristol. There were no other casualties. He had been known to a variety of agencies locally including Avon and Wiltshire Mental Health Partnership NHS Trust, (AWP), Bristol City Council (BCC) Housing services, Primary Care and the Police over a period of years, and had more recently become known to Avon Fire and Rescue (AFR) and BCC Adult Social Care.

1.3. The SCR was commissioned by the BSAB and was overseen by a panel led by an independent Chair. Partner agencies provided panel members who had no direct involvement with Mr C. The report has been prepared by an independent author, based on information provided in the Internal Management Reviews (IMR) produced by all the agencies involved.

1.4. The purpose of the review was to:

- review effectiveness of individual agency and joint working
- inform and improve local practice, by acting on learning
- bring together analysis and findings of the IMRs in order to make recommendations for the future.

In addition it was to link with the Coroner's investigations and consideration of any findings made by the Coroner.

1.5. The key outcome for the review was that people in Bristol who self-neglect would be safer in future, because of the learning from Mr C's death and the circumstances, both longer term and more immediate, leading up to it.

1.6. The victim's family were invited to contribute to the review, and his son has both contributed and been kept apprised of progress.

2. Summary Narrative

2.1. Mr C first became known to mental health services in Bristol in 1997, and notes from that date state that he had suffered mental health problems as early as May 1985 having suffered what was described at that time as a 'hypomanic breakdown'**.**

2.2. In the period from 1997- 2011 Mr C was admitted to psychiatric in-patient services on eight occasions, twice under Section 3, Mental Health Act (MHA), and four times under Section 2, MHA. Deterioration in his mental state was characterised by behaviours symptomatic of a bi-polar disorder that recurred during this period. At certain times, for example he threw items from the balcony of his flat; expressed grandiose ideas, or threatened violence against people he perceived to have treated him unjustly, although these threats never resulted in actual violence. From 2006 -2009 Mr C is reported as being consistently depressed, at which time his behaviour was relatively stable and he was more enable to engage with support offered. When his mood improved, this was seen as recovery and led to his discharge in September 2010 from secondary mental health services. Nowhere in the records is it recognised that he continued to be covered by Section 117 (Aftercare) of the Mental Health Act (MHA). Between hospital in-patient episodes he received support variously from Community Psychiatric Nurses (CPNs), Community Care Workers (CCWs) and psychologists.

2.3. Mr C was not always willing to engage with services and his behaviour caused sufficient concern to his landlord, BCC Housing Services that in 2003 they obtained a Deed of Variation to his tenancy agreement, so that it became a condition of his tenancy that he engage with support services. Throughout his life Mr C used street drugs. He was open about his drug use and firmly believed that this had no negative impact on his mental well-being.

2.4. The pattern that emerged between 1997 and 2011 was repeated during the last three years of his life with increasing intensity, but three further events took place in 2012 which can be seen to have changed the context, how he was perceived and thus how he was responded to. In 2012, Mr C's son, who had previously been an important source of practical and emotional support to his father informed AWP formally, that because of his father's increasingly difficult behaviour related to his use of cocaine, and the threat of danger to himself, he, Mr C's son, was no longer able to continue to support his father as he had been doing up until then.

2.5. Mr C was admitted to hospital for a short period in June 2012, and at his discharge meeting it was noted that Mr C did not accept he had any chronic mental health needs and rejected Care Programme Approach (CPA) or other

care planning processes as helping him avoid crisis or improve his quality of life. CPA documentation stated that 'it is important he has a trusting relationship with allocated community staff and that he is kept within the service due to the severity of his relapses', but in the light of Mr C's unwillingness to engage with services, the decision was taken at a meeting in September 2012 to discharge Mr C from mental health services.

2.6. Mr C's car was towed away in late 2012 and this led to several incidents involving him making threats against the people he thought were responsible for this, and which required police intervention. An ASB tag was added to police records, which was not unreasonable as an immediate response to the reported incidents, but this, coupled with the recent discharge from AWP services meant that henceforward, agencies coming into contact with Mr C seem to have viewed his behaviour as primarily being anti-social, exacerbated by his use of drugs. In this context, his long history of mental health issues seems to have been underestimated or discounted. This meant that when his behaviour deteriorated, it was no longer seen in terms of mental illness, so that police no longer responded by using a Section136 MHA, which in the past had led to a hospital admission. Instead the agencies involved had to find an alternative way of responding to the situation that was now viewed as ASB.

2.7. In June 2013 BCC Housing received a report that smoke was coming from Mr C's balcony. He said he was having a barbecue, but the person reporting it said it smelt like plastic burning. Mr C said he was cooking there as he was in dispute with his electricity supplier, because of previously accrued debts. The Housing Officer tried to visit Mr C on several occasions, but there was no reply. In August 2013 after a further incident of items being thrown from the balcony, a warning letter was sent, but this was not escalated to the anti-social behaviour team, as the Housing Officer was continuing to try to engage with Mr C because they recognised his vulnerability. They also made a referral to Adult Social Care, requesting a Community Care Assessment. Adult Social Care responded by advising that they had referred Mr C on to the mental health recovery team, as he was previously known to them. An appointment was sent by the mental health recovery team for reassessment, but Mr C did not attend, and a decision was eventually taken by AWP not to take him back on to services 'as his behaviour was felt to be anti-social and not driven by mental illness, and unlikely that [he] would work with services due to recent history.'

2.8. Twice in September Avon Fire and Rescue (AFR) was called to attend a 'barbecue' fire on Mr C's balcony. Fire Officers noted the cluttered state of the flat and gave fire safety advice. Later that month the police saw Mr C in his flat, although he was agitated and very angry with the police. The flat was very cluttered and there were lots of flies. Mr C was told he could not have

barbecues as this was causing a nuisance and was a breach of his tenancy conditions. He declined offers of support, saying he was fine.

2.9. In October 2013 a Vulnerable Tenants Case Conference was held by the Anti-Social Behaviour team, at which the primary care liaison manager from AWP was present. The concerns centred on the risks of setting fires. Landlord services were considering eviction via the court unless there was a change in Mr C's behaviour. The advice from AWP was to treat Mr C as any other case of anti-social behaviour as his behaviour 'was down to choice'. It was agreed to convene an anti-social behaviour conference. Mr C was sent a letter warning him not to light fires, and that further breaches of his tenancy conditions could jeopardise his tenancy, but the letter also offered to refer him for support to help maintain his tenancy. A letter from the GP in response to the invitation to the case conference confirmed that Mr C had a diagnosis of Bipolar Affective Disorder, but had not been taking any medication since March 2012. The Vulnerable Tenants meeting took place three days after the letter was received but the information from the GP does not seem to have had an impact as it is reported that the conclusion after discussion of the case was 'to treat Mr C as any other case of ASB as behaviour is down to choice.'

2.10. An Anti-Social Behaviour conference was held in mid-November. This meeting was attended by the Police, BCC Legal Services and Housing. At this meeting an in-principle decision was taken to serve a Seeking Possession notice, if there was further anti-social behaviour and also to seek an injunction if there was an immediate need to protect others. Housing and the police agreed to monitor Mr C at multi-agency meetings.

2.11. There were no further reports of anti-social behaviour until March 2014 when smoke was seen coming from Mr C's balcony. The Housing Officer visited Mr C with the Police, who warned him against burning anything and he agreed to stop.

2.12. In May there were reports to BCC Housing of Mr C putting excrement down the rubbish chute and defecating into it. He was also continuing to light fires on his balcony resulting in a further two call outs to the AFR. A fire officer attending the first incident reported his concerns about Mr C's safety and the safety of others to Care Direct (BCC Adult Social Care) because of the conditions he had seen in the flat, and because of lighting fires. After the second call out Fire Officers again reiterated to Mr C the dangers of lighting these fires. At the same time it was reported to BCC Housing that Mr C had no clean clothes and was inviting commercial sex workers and drug users into his flat, who then stole from him. A letter was immediately sent to him reminding him of his tenancy conditions. The Anti-Social Behaviour team agreed to pursue an injunction and that Mr C should be referred for a Community Care Assessment.

2.13. At this point Care Direct contacted Housing to say they had been contacted by AFR because of their concerns about Mr C's balcony fires. On 30th May an injunction was granted prohibiting Mr C from lighting fires or doing anything that would constitute a serious fire hazard in his flat. In June a referral was made to Adult Social Care for an assessment. At a home visit on 11th June by the Police and Housing, Mr C said he understood why the injunction was necessary.

2.14. The BCC ASB team made a referral to AWP on 17th June, for 'an assessment of mental health (capacity)' [sic] as a necessary precursor to initiating eviction proceedings, so Mr C was sent an appointment for 27th June. He did not attend so was sent a further appointment for 7th July, this time at his flat. A Housing and an ASB worker visited Mr C on 3rd July at which time it was noted that he was wearing women's clothes, because he had no clothes left. He had lost a lot of weight, was not washing and was walking barefoot. A few days later a joint visit with mental health and housing took place at which Mr C was again wearing women's clothing and was seen have bare feet, 'very ingrained with dirt and he had long curling toe nails that clearly needed attention.'. Mr C's flat was 'filthy and full of old rubbish broken furniture and numerous electrical speakers that were all piled high. The only access was to climb over a broken settee that blocked the door from opening fully. Flat full of flies and mess…. Balcony door and windows open and more broken furniture and clothes outside. Evidence of charred and burnt furniture.'

2.15. Although he made derogatory comments about mental health services, he was polite to the individual who attended and 'was pleasant and engaged appropriately....' This visit identified a number of serious risks, both to Mr C and to others. In respect of Mr C, these were self-neglect, lack of insight, and personal safety. The risk to others was around his continued use of candles and fires for cooking that he did not see as a fire hazard. Despite Mr C's appearance and the state of his flat it was reported that Mr C 'appeared to have capacity', although what this capacity relates to is not defined in the records. The assessor concluded that 'as there does not appear to be a role for mental health services and as Mr C is refusing to engage, will be discharged'.

2.16. Later in July a Vulnerable Tenant's Case Conference was held at which it was noted that in the interim Mr C had made 'some efforts to comply… has allowed workmen into flat.' It was agreed that 'Mr C is vulnerable but continues to engage with BCC staff. There does not appear to be a role for MH services at this time.' It was noted that mental health services might be needed to further assess mental health. Actions arising from the conference were agreed; the ASB officer was to find out whether lighting candles was sufficient to apply for a breach of the injunction or whether the injunction could

be varied. The Housing officer would try to agree a plan with Mr C to clear his flat and if this failed would explore instructing a contractor to enter Mr C's flat and to pursue a Notice of Seeking Possession (NOSP). Legal services advised there was insufficient evidence to reach the standards required for a case to be successful, based as it was only on Mr C's own admissions that he had been lighting candles.

2.17. During August an arrangement was made to visit Mr C with a social worker in order for a Section 47 Community Care Assessment to be undertaken, however Mr C was not at home on the appointed date.

2.18. At a meeting on 1st September, Legal Services favoured varying the injunction in order to allow removal of flammable items from the flat, but it was felt this could not be done until after the Community Care Assessment. On 2nd September the joint visit with the social worker took place. The Housing Officer noted that there was some improvement in the condition of the flat, and Mr C claimed he was no longer lighting fires to cook. He declined to have a community care assessment and said he did not need any support. Adult Social Care closed the referral at that point as the social worker concluded that the state of his flat was a lifestyle choice and he had capacity so his wish would be respected. On 3rd September the Housing officer and ASB officer agreed to visit jointly the following week on the 8th September to agree an action plan with Mr C to clear the property. However two days before the planned visit, on the 6th September a fire broke out in the flat in which Mr C died.

3. Findings

3.1. How agencies worked together to identify and manage the risks posed to the victim and others

3.1.1. Mr C's mental illness was, by its nature cyclical. Periods of relative stability were followed by periods when his behaviour aroused concern both for his and others' safety. Agencies were in touch with each other during these crisis periods, but there is no evidence of overall analysis or planning to inform a shared strategic approach. Each episode or incident tended to be viewed in isolation and not in context, either of Mr C's previous history, or of other agencies' experience of him. His history of serious mental illness was downplayed when the decision was taken to discharge him from secondary mental health services in 2012. This meant that the pattern of his breakdowns was not factored in when agencies were assessing or considering appropriate responses to his various anti-social behaviours.

3.1.2. The inconsistency of joint working meant that individual agencies did not have a clear idea of what input was being provided to Mr C by others, so, for example, no agency appears to have registered the significance of his son's withdrawal or responded to his reasonable expectation that Mr C would now need to be monitored more closely.

3.1.3. There appears to have been no proactive input from the GP throughout the period under review, which is a concern given the key role of GP's in the continuing care of all people who experience serious mental ill health and the NICE clinical guidelines (CG185) on Bi-polar Disorder. Equally, there is evidence that the GP was not involved in Mr C's discharge from mental health services.

3.1.4. Looking at the whole narrative it appears that for much of the time Housing Officers were working alone, and were not able to rely on consistent help from other agencies. This meant that they were not always aware of the most effective referral route to find the help they thought Mr C needed.

3.1.5. None of the agencies saw it as their role to provide a leadership or coordinating function across all partners. This meant for example that information was not shared when one partner decided to discharge, was not taking up a referral, or was passing it to another agency. When referrals were passed on from one agency to another, there was no follow up to see what had happened as a result of the referral.

3.1.6. The lack of consistent joint working meant that frontline staff did not have the opportunity to learn about the way that other agencies work, how to target

referrals or what their duties or powers are. This lack of understanding also meant that agencies were unable to escalate their concerns effectively when they identified deterioration in Mr C's situation.

3.2. The part played by the removal of essential services in subsequent events

3.2.1. Mr C was not deprived of essential services. He had a long-term history of debts owing to his energy supplier and therefore had a prepayment meter which he declined to use because he was in dispute with the supplier. Housing officers offered support to help Mr C to speak to his electricity supplier, which he declined. However, housing could have offered more in the way of direct support via the Tenant Energy Advice service which was commissioned in 2013, but at the time, this was not well-publicised within Housing. This is an optional service which may have been able to advocate on Mr C's behalf with his energy supplier

3.3. The decisions made about managing risk and the context in which those decisions were made

3.3.1. Mr C's mental ill health and the way it manifested itself, together with his lack of willingness to engage posed risks to both Mr C and to others. However whilst each agency recognised those risks no agency took the lead in developing an overall risk mitigation or management plan. Agencies including Adult Social Care, focussed mainly on the risks posed by Mr C to himself, and underplayed the risk to others, which meant that decisions were made predominantly on the basis of Mr C's willingness to comply, or assumptions about his capacity to make choices about how he lived. Whilst Housing was more alert to the risk to others, staff did not know how best to use other services to help mitigate this risk. Fire officers too highlighted the risk to others.

3.3.2. Agencies failed to recognise Mr C's anti-social behaviours that posed risks to himself and others as symptoms of the deterioration of his mental health, because the background information about his history of mental had been overlooked.

3.3.3. Mr C's inability or unwillingness to engage with the support offered was not recognised as a risk in itself, and therefore no strategy was developed to try to re-engage Mr C. There is no evidence that there was any guidance for staff or systematic approach to working out what might be the best way of working with someone who did not engage with services

3.3.4. Describing Mr C's behaviours as anti-social or as life-style choices, may have resulted in underestimating the significance of his underlying chronic mental health issues, or recognising the escalation of his behaviours as evidence of deteriorating mental health. This therefore led to the exclusion of the possibility of interventions based on his mental health state. Referring to the fires on his balcony as barbecues may have led to underestimating the seriousness of the situation. Even though the fires were in a barbecue, the materials being burnt made it clear that he was not using a barbecue in a conventional way

3.4. **Identification of any missed opportunities**

This review has deliberately set out to consider what happened in the context at the time, however it is inevitable that hindsight comes into play, and it is the Panel's view that each incident noted below represents an opportunity for working together that was missed:

3.4.1. Mr C's mental capacity was formally assessed but despite his history of serious mental illness, and current behaviours and rationalisations, he was assumed to have capacity. The BCC social worker assumed capacity on the basis of Mr C's verbal reassurances and the Housing Officer noting that his flat was tidier than on a previous visit, and did not take into account the context of Mr C's serious mental health history.

3.4.2. There was lack of consistent multi-agency working which meant that important historical and contextual information was lost. This had serious consequences for the way Mr C's behaviours, including his use of cocaine and cannabis were viewed and responded to in the latter part of his life, in particular the damaging effect of his behaviour being labelled as anti-social. This may also have led to there being only limited follow-up when Mr C failed to attend health check appointments with his GP.

3.4.3. Agencies lost sight of the fact that Mr C, having been detained under S3 MHA was entitled to care and support under S117MHA. There is no evidence to show that he had been discharged from S117. If Adult Social Care had known he was still entitled to S117 aftercare services then consideration should have been how to comply with that duty, and whether services were needed to prevent readmission to hospital. Although agencies were aware of his past mental history of mental illness, knowledge of his continuing status would have been a reminder of the seriousness of these mental health issues.

3.4.4. Although the GP was aware that Mr C had given up taking Lithium, there was no proactive follow-up. Mr C's history showed that he found it difficult to

engage with professionals and also demonstrated that Lithium had been effective in the past, therefore it is a cause for concern that the GP seems to have accepted Mr C's unwillingness to comply, and not alerted other agencies to this. It is a concern that Mr C's GP did not play a more prominent role in Mr C's history and was neglected as a possible resource in responding to Mr C's needs.

3.4.5. Mr C's son, was known to play an important part in his father's life, but when, in 2012, he informed mental health services that he could no longer shoulder the burden of being the person to alert services to his father's needs and act as his father's advocate, it appears that no-one registered the pivotal nature of his role and the significance of this withdrawal, and therefore no action was taken to make good the gap that this would leave.

3.4.6. It is evident from the records that Housing Officers were consistently trying to get support from other agencies, but that these did not elicit the responses that the seriousness of Mr C's predicament warranted.

3.5. The influence of considerations about organisational capacity on key workers' and agencies' responses

3.5.1. It should be noted that between autumn 2011 and the summer of 2012, the social work service of AWP was moved back to BCC Adult Social Care, to become part of BCC's social work teams. AWP was also going through a transformation post the BCC social workers leaving. During the early autumn of 2013 Adult Social Care underwent a major restructure, with an emphasis on short-term problem solving, and referral to appropriate external agencies. No agency has identified organisational capacity per se as an issue in relation to its support of Mr C, but it must be noted that both these organisations went through a period of great change from 2011-2013.

3.6. Learning to be derived that will inform engagement in similar situations in future

3.6.1. The IMRs show that there is more that needs to be done in terms of helping staff develop a better understanding of the respective roles and responsibilities of partner agencies, for example members of the Housing team were unaware of the best way to approach AWP in order to get support for Mr C's mental health issues.

3.6.2. Because Mr C was articulate and resistant to receiving help, staff seem to have taken his reassurances at face value, but greater knowledge and understanding of capacity issues may have given staff greater confidence to try to work around Mr C's resistance. Mental capacity as an issue is mentioned, but understanding of the complexities of the concept appears

underdeveloped. People having direct contact with Mr C were too ready to accept his verbal reassurances about his well-being and ability to cope and did not ask Mr C to demonstrate how he was coping. The history of professionals' interactions with Mr C shows possible deficiencies in the ability, confidence or willingness of professionals to challenge.

3.6.3. Strong multi-agency protocols for working with people who self-neglect are needed with a view to promoting robust and consistent joint agency work, with action plans/strategies, and programmed follow-up when working with an individual who has a chronic mental health condition and who self-neglects, and with whom it is difficult to engage. The current trend for agencies to adopt a 'one-touch' approach in dealing with requests for assessments, with a view to swift onward referral to an alternative appropriate provider needs to be critiqued in the light of the disjointedness and lack of follow-up that occurred in Mr C's case.

3.6.4. Mr C's circumstances were seen as lifestyle choice, but insufficient attention was paid to the threat his behaviours posed to others, particularly in relation to the accumulation of rubbish in his flat and his propensity to start fires, and this behaviour, together with his diagnosis of bipolar disorder should have led to a thorough assessment of his mental capacity. The impact on others needs to be considered as a key part of assessing the appropriate response to the presenting situation.

3.6.5. The ability to challenge Staff did not receive support, or recognise the need to work more assertively in the light of the level of self-neglect and within the context of Mr C's history of mental health issues.

3.7. **Good practice**

3.7.1. Successive Housing officers went out of their way to try to engage Mr C, for example making visits in person in order to try and foster a positive relationship, and tried to find ways to help him sustain his tenancy rather than taking a more punitive approach, even though he did not always welcome their support.

4. Recommendations

In the light of the analysis above the following recommendations are made:

4.1. **Recommendation 1**

That the Bristol SAB should develop a joint protocol to be followed when working with individuals who self-neglect.

Any such protocol should explicitly address the issues identified in the Analysis above and the Board should assure itself that there is compliance with the protocol. All agencies will need to agree, implement and monitor use of the protocol. In the case of the CCG it will be necessary to ensure that GPs' are aware of the protocol, and their compliance monitored.

4.2. **Recommendation 2**

That the Bristol SAB should assure itself that partner agencies have adequate policies and training plans in place to ensure improved practice in matters relating to Mental Capacity Assessments and that these plans will enable staff both to become more confident and competent in carrying out such assessments, and also to understand and respond appropriately to the findings of the assessment.

4.3. **Recommendation 3**

There is no local inter-agency understanding or agreement about how concerns can be escalated in any cases requiring multi-agency input, including self-neglect, so the Bristol SAB should draw up a local agreement identifying how agencies can flag concerns about escalating problems, and what responses are required.

4.4. **Recommendation 4**

The Bristol SAB should seek assurances from AWP that policies and practice guidelines in relation to engaging with individuals with co-morbid mental health and drug misuse issues have been reviewed in the light of learning from this case.

4.5. **Recommendation 5**

Bristol SAB should assure itself that the relevant agencies are robustly recording and tracking any individuals who are subject to S117MHA.

4.6. **Recommendation 6**

Given that there are lessons to be learnt from this case for all agencies involved in Mr C's life, Bristol SAB should accept this report; disseminate its findings to all SAB partner agencies and assure itself that individual action plans are being implemented.

Appendix A Panel Members

- Adult Safeguarding Lead, North Bristol NHS Trust
- Area Manager, Risk Reduction Avon Fire and Rescue
- Inspector, Avon and Somerset Police
- Head of Patient Safety Systems, Avon and Wiltshire Mental Health Partnership NHS Trust
- Service Manager, Estate Management, Bristol City Council
- Service Manager, Strategic Safeguarding Adults and Deprivation of Liberty Safeguards, People Directorate, Bristol City Council
- Designated Safeguarding Adults and MCA Lead Nurse, Bristol Clinical Commissioning Group

Appendix B Glossary

AFR	Avon Fire and Rescue
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
ASC	Avon and Somerset Constabulary
BCC	Bristol City Council
(B)SAB	(Bristol) Safeguarding Adults Board
IMR	Individual Management Review
CCG	Clinical Commissioning Group
MHA	Mental Health Act 1983
S2 – MHA	**Admission for assessment.** A patient may be admitted to a hospital and detained there for up to 28 days
S3 – MHA	**Admission for treatment**. A patient may be admitted to a hospital and detained there for the period allowed by …..provisions of this Act
S17- MHA	**Leave**. The responsible clinician may grant to any patient…. Leave to be absent from the hospital subject to such conditions (if any) as that clinician considers necessary….
S117 – MHA	**After-care**. This section applies to persons who are detained under Section 3 above,… and then cease to be detained and leave hospital. It shall be the duty of the Primary Care Trust [now CCG]…and of the local social services authority to provide, … after-care services for any [such] person … until such time as … [they] are satisfied that the person concerned is no longer in need of such services….
S136 – MHA	**Mentally disordered persons found in public places.** If a constable finds … a person who appears… to be suffering from mental disorder and to be in immediate need of care or control, the constable may… remove that person to a place of safety.
MHW	Mental health worker
Lithium	Medication commonly used to help stabilise mood swings
Bipolar	A condition that affects mood, which can swing from one extreme to another. Someone with bipolar disorder, will have periods or episodes of

disorder	depression – where they feel very low and lethargic, and mania – where they feel very high and overactive (less severe mania is known as hypomania)
ASB(O)	Anti-social behaviour (order)
CPN	Community Psychiatric Nurse
NOSP	Notice of seeking possession
PCLT	Primary Care Liaison Team
PICU	Psychiatric Intensive Care Unit
SCR	Serious Case Review (before April 2015)
SAR	Safeguarding Adults Review (from April 2015)
CPA	Care programme approach (structured follow-up in mental health services)
NHSE	National Health Service England

Appendix C Author Details

Lal Heaton is an experienced social care professional, having worked at a senior level in health and local authorities, in both strategic commissioning and operational management roles. She now works freelance, and is involved with a variety of agencies and projects, including supporting the Southwest Association of Directors of Adults Social Services safeguarding leads network and conducting quality audits for a major provider of services to people with learning disabilities. She is also a Director on the Boards of two learning disability provider organisations.