Safeguarding Adult Review (SAR)

‘Michelle’

Independent Report Author: Samantha Lunnon

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Forward Provided by Michelle's Half-Sister

When a child is born it is reliant on the people around them to protect, love, educate them and keep them safe. Unfortunately, this is not always the case.

Bowlby's attachment theory emphasizes the crucial role of early caregiver and child bonding, in shaping the emotional development and future relationships, and the profound effect this can have emotionally, socially and the way relationships are maintained though adult life. Failure to form positive attachments can lead to mental health issues and emotional dissociation among other things.

As we are aware the bond a child makes is not always safe or secure. Giving a misguided sense of trust, love and security.

As children we trust those around us, but what happens when that trust is abused, mentally and physically. The mind becomes damaged, and the world is seen differently. Our cognitive functions become impaired, affecting our behaviour and overall quality of life.

We become lost, not seen and vulnerable.

Vulnerable adults and children are often not seen or are lost, often due to not being able to speak up for themselves, not knowing who to trust or where to turn. And yes, this still happens in today's society.

It is the little signs that are often missed, which generally start at an early stage. Is the introverted child just shy? Is the angry child just upset? There are many more questions like this that could be asked. But are you too afraid to ask or you simply feel it's not your business.

What happens when a child is so emotionally and physically abused that they fall through the cracks of society. Whose job is it to recognise and protect the vulnerable.

This things as are taught to believe as a child are the things we carry into our adult life, regardless of if it's good or bad.

Is it not everyone's fundamental right to live in a safe and secure environment.

The things that can always be improved on are:

Support in the community

Decrease waiting lists for Mental Health

Increase training for Mental Health

These basically all comes down to lack of government funding.

Preface

Members of the review panel offer their deepest condolences to Michelle's family and all affected by her death. The Independent Reviewer would like to thank Michelle's sister for her considerable contribution to this review, and to the agencies for their contributions to the review and their ongoing commitment to improving services for adults at risk.

Introduction

This review concerns the death of Michelle (a pseudonym), who died aged 56 years old. Michelle died in Hospital on 16.12.22. Her formal cause of death was found to be Multi-Organ failure, Neutropenic sepsis and pancytopenia, Intravenous drug use and Personality disorder.

1. Aim and Purpose of a Safeguarding Adult Review

A Safeguarding Adults Review (SAR) is a statutory requirement of the Care Act 2014 (Section 44). A SAR is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern of how agencies worked together to safeguard the adult. The primary tenet of a review is to establish what changes are required in policy, training, and practice to improve safeguarding practice and prevent deaths in the future. The Safeguarding Adult Review Committee and Barking and Dagenham Safeguarding Adult Board was notified of the death of Michelle on the 14th February 2024. An Independent Reviewer was appointed on 24th July 2024 and work on the review was started. However, due to unforeseen circumstances, another Independent Reviewer was commissioned in December 2024 to analyse the learning and deliver the final report. The Independent Reviewer is Samantha Lunnon. Samantha's occupational competency of working within the context of domestic abuse, adult and child safeguarding is diverse and spans over 30 years. Samantha undertakes specialist consultancy across strategic Safeguarding Adult Boards and Safeguarding Children's Partnerships.

2. Confidentiality

This report has been anonymised, with a pseudonym.

3. Involvement of Family in the Review

Michelle's sister contributed significantly to this review and provided a rich pen portrait and insight into Michelle's life. The voices of adults at risk are seldom heard in society. In an attempt to amplify Michelle's voice throughout the report, extracts from the chronology that capture her voice have been used.

4. Methodology

This SAR adopted methodology based upon [1, 2] Social Care institute for excellence, SAR in Rapid Time model an early analysis event was held in February 2025, with agencies that were involved with Michelle's care and support and wider agencies of the Safeguarding Adult Board, to consider terms of reference for the SAR and an opportunity to examine agency interactions with Michelle to look at practice in real time to identify any system changes. The information gathered at the event supported this report.

[1] Safeguarding Adult Reviews (SARs) In Rapid Time - SCIE
[2] List of 15 Safeguarding Adult Reviews Quality Markers - SCIE

5. Overview of the Terms of Reference and Key Lines of Enquiry

The SAR adopted a thematic approach and drew upon an evidence base for Adverse Childhood Experiences [3](ACEs) and [4]multiple exclusion and homelessness (MEH) to draw upon the following themes for analysis:

- Assessments of Michelle's Care and Support needs
- Mental Capacity
- Safeguarding
- Multi-Agency Working.

At the early analysis event, the methodology of a [5]strategic culture of hope was employed, which offers a framework to harness a hopeful culture by:

1) Setting collective goals, grounded in shared values
2) Supporting people to build their sense of power/agency/autonomy
3) Paying close attention to progress and celebrate it.

6. Parallel Reviews

Mental Health Services conducted a Root Cause Analysis Investigation Report in April 2023. The report was shared with the Independent Chair and Author.

7. Coroner

There are no Coronial proceedings related to this case.

8. Governance

The SAR process was delivered through the Safeguarding Adult Review (SAR) Panel that reports to the Barking and Dagenham Safeguarding Adult Board (SAB).

9. Structure of Report

The report is structured in a way that reflects Michelle's life across the system, beginning with her childhood that seeks to identify abuse and intervene early, through to adulthood in understanding the cumulative impact of adverse experiences and models of best practice in supporting challenging aspects of working with adults experiencing Multiple Exclusion Homelessness. Recommendations are provided throughout. These recommendations have been broken down into different themes.

10. Who was Michelle?

Michelle was born on the 22nd of July 1966, in London. Her ethnicity was White Irish. Michelle lived in Dagenham where she had been a tenant, at a property that was council-owned. Michelle's half-sister described Michelle as 'vibrant', she had a passion for music, particularly rap music, and she had supported producing some music within the local community. Michelle enjoyed writing poetry; she had a desire to help people and wanted to go on

[3] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation
[4] Rethinking multiple exclusion homelessness | King's College London
[5] The strategic power of hope. New article in Harvard Business... | Helen Bevan | 48 comments

holiday. Michelle had a Staffordshire bull terrier dog called 'Massie' and a goldfish, whom she was described to love unconditionally. Michelle had two sisters and a brother and a half-sister and a half-brother, whom she met later in her adulthood. Michelle had a very close relationship with her father, whom she was said to idolise. Throughout Michelle's childhood, her father had worked in different parts of the country but had provided support to Michelle in adulthood. Sadly, her father died in 2011. Staff from Mental Health Services who had worked with Michelle for many years spoke fondly of her, and her Support Time Recovery worker attended her funeral.

12. Michelle's Childhood

As a child, Michelle reached all her developmental milestones. Within mental health records, and from conversations with Michelle's half-sister, it is asserted that Michelle experienced significant adverse childhood experiences. Michelle had advised her Care Coordinator that at the age of six years old, her mother had sold her for money and drugs. She was sexually abused by a family friend of her mother's, however, when she tried to tell people what had happened, she was not believed. In her childhood, Michelle had suffered life-threatening physical abuse, sustaining stab wounds. Her half sister advised that Michelle had been misusing substances such as heroin from the age of eight. Michelle and her sister had run away from the family home. From the age of ten, Michelle was described as being in and out of Local Authority care and had difficulty with her Social Worker as a young person.

13. Michelle's Adulthood

As an adult, Michelle experienced multiple exclusion homelessness and socio-economic disadvantage. In her care plan, Michelle had expressed a desire to work; however, due to her ill health, Michelle was unable to work, and she received state benefits. Michelle had been known to Mental Health Services for many years and had a long-standing medical history of mental health disorders, which included self-harm and poly-substance misuse. She was formally diagnosed with Emotionally Unstable Personality Disorder and Mental and Behavioural Disorders due to Substance Misuse. She was known to have a comorbid physical health history of Chronic Obstructive Pulmonary Disease (COPD), Epilepsy, and Deep Vein Thrombosis. Michelle had told her half-sister that she had suffered a miscarriage after being stabbed in a park, whilst working as a sex worker, and the miscarriage had caused her further distress. Michelle was a victim of domestic abuse. In 2010, her ex-partner was convicted of an offence of grievous bodily harm against Michelle, whereby he had raped and poured boiling water over Michelle, and he was sentenced to 96 months in Prison. Michelle had contact with a number of statutory services. Professionals visiting Michelle at her home had observed drug paraphernalia, weapons and 'unsavoury characters' in attendance at Michelle's flat. Michelle had advised and it was observed by her Care Coordinator that she had weapons in the home such as knives as she felt she needed to protect herself due to often having strangers at her home in relation to her drug use. At a Multi-Agency Risk Assessment Conference meeting, it was advised that Michelle was a known sex worker, she had 66 arrests, 40 linked to sexual offences, Police records stated Michelle's occupation was a sex worker and she had offences for prostitution and possession of drugs.

14. Following Michelle's Death

Mental Health Services contacted Michelle's family to contribute to an internal root-and-branch review. Michelle's half-sister had advised that after Michelle's death, she had gone to Michelle's home and observed drug paraphernalia, including syringes. Her half-sister reported that Michelle was not known to inject drugs, but she had smoked them. She enquired whether the teams working with Michelle had addressed that there was evidence of substance misuse, and whether the teams had supported her in the context of her vulnerability from others.

She stated that, in her opinion "*as a vulnerable person Michelle did not have a proper care plan in place, and that Michelle's main concern was feeding her addiction. Upon entering her house following her death I found the place to be in a state of disarray and that is mildly putting it. I know that Michelle was not the tidiest or cleanest of people, but it was a lot tidier the last time I had visited her. It was heartbreaking and frankly disgusting. The house was damp from top to bottom, every piece of furniture was damp, and there was mould over most things. There was an infestation of mice, the kitchen looked like it had not been cleaned for a number of months. Upon trying to clean up I found hundreds of needles and drug paraphernalia, also there was at least 20 dosette boxes containing medication that she was obviously not taking. I had also been informed that Michelle had been sleeping rough. Michelle may well have died from her addiction; however, her life may have been prolonged if Michelle had an effective care plan in place.*"

Michelle's half-sister has contributed extensively to this review and has reiterated that following Michelle's death, she attended Michelle's flat and described the condition of the flat as 'diabolical' and somewhere that you would not place anyone in. It was clear that there was someone living in Michelle's flat. Michelle's half-sister stated that there were numerous contacts on Michelle's mobile phone asking Michelle to buy drugs within the local area.

15. Key Practice Episodes

Please refer to appendix 1.

16. Analysis of Practice

The following section of the report provides thematic analysis on the most significant themes that emerged from the afore chronology

16.1 The Linkage between Adverse Childhood Experiences and Multiple Exclusion in Adulthood

Michelle had experienced significant and considerable adversity throughout her childhood. [6] Adverse childhood experiences (ACEs) refer to traumatic life events experienced by a child under the age of eighteen. Traumatic events can be categorised as a child experiencing, all forms of abuse and neglect including witnessing domestic abuse, having a close family member who misused drugs or alcohol or has mental ill health or who served time in prison and parental separation on account of relationship breakdown. Over the past two decades extensive research has shown the profound effects of such experiences that may manifest in adulthood, (Hughes, et al, 2017) with multiple categories of adverse experiences exacerbating higher risks of poor physical health and increased levels of poor behavioural outcomes such as sexual risk-taking, mental health problems, quadrupling the likelihood of problematic alcohol use and increasing the risk of problematic substance misuse, interpersonal and self-directed violence, by Serval. Coronado, F. et al, 2006. [7]Within recent systematic review and in a meta-analysis the correlation of the prevalence of ACEs with health and functioning related outcomes with adults experiencing homelessness, has connected four or more adverse factors amongst people experiencing homelessness and a higher rate of 5 or more associated with suicidal ideation and attempts of suicide increased depressive disorders and problematic substance misuse. The studies however, fall short in identifying specific ACEs that are linked to causation of homelessness as opposed to ACEs that are associated with homelessness, but offer

[6] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation
[7] Adverse childhood experiences and homelessness: advances and aspirations - The Lancet Public Health

broader considerations of adversity to be considered such as the impact of poverty, racism, missing people, community violence, coercive control within a familial environment, poly-victimisation, experienced through experiencing multiple forms of abuse perpetrated by peers and adults outside of a familial setting and a lack of positive relationships with trusted adults and peers. In the field of Adult Social Work, the term [8]Multiple Exclusion Homelessness (MEH) describes the interface between homelessness and a myriad of forms of deeper levels of social exclusion, such as adverse childhood experiences, experience of domestic violence/abuse, trauma, institutional care, negative experiences of statutory services, substance use, as antecedent risk factors for individuals where such factors exist.[9]

The severity of the abuse Michelle experienced throughout the course of her life cannot be understated, the breadth of abuse she experienced across all of the categories of adverse childhood experiences, were strongly interrelated to her experiences of Multiple Exclusion Homelessness in adulthood and profoundly impacted upon on every aspect of her life, including adult relationships and in seeking and accepting help and support from professionals. From this lens we may then view Michelle's autonomy described by professionals as 'chaotic lifestyle choices' to one of coping strategies that were adopted as a necessity to survive.

What do we learn?
There is a strong correlation between the prevalence of adverse childhood experiences and multiple exclusion homelessness in adulthood. Emerging research suggests that wider forms of negative experiences that impact upon poor adulthood are not being identified within the current ACESs data set, including poverty, racism, peer and community violence. Research also shows promise in interventions in promoting resilience and social support that may reduce poor outcomes and mental health outcomes in adulthood. The bridging of academic fields of adverse childhood experiences (ACEs) and Multiple Exclusion Homelessness (MEH) is required to provide effective primary, secondary and tertiary responses in both ACEs and MEH.

Recommendation 1:
The Safeguarding Adult Board, Safeguarding Children Partnership and Community Safety Partnership to consider a system-wide joint priority that focusses on the negative impact of childhood adversity and the links to multiple exclusion homelessness and how this may marginalise adults in society in relation to the principles outlined in the Equality Act 2010.

16.2 Michelle's Care and Support – an Integrated Approach?

Michelle had been a service user of mental health services for many years and had received support at that time under a Care Plan Approach and the then the Community Recovery Team. This approach has since been superseded by, the [10] Community Mental Health Framework for Adults and Older Adults (CMHF). Locally from September 2022, the community recovery teams have been replaced by the Mental Health and Wellness Team. Michelle had an allocated Care Coordinator, who supported her to attend appointments and engage with the community drug and alcohol services. For a period of time Michelle had also been supported by community drug and alcohol services and was recorded to be on a methadone programme, however, she had stopped fully engaging with her methadone programme in 2017. Over the following few years, Michelle remained under the respiratory team for her breathing problems, however, her condition was managed at home with nebulizers, inhalers and rescue packs when required. It is beyond the scope of this review to comment on the clinical treatment Michelle received as part of the care plan approach, a Root Cause Analysis Investigation Report was undertaken by mental health services following Michelle's' death, outlining a number of recommendations that included improvements in clinical risk, partnership working and supporting the physical health of service users on

[8] Rethinking multiple exclusion homelessness | King's College London
[9] Full article: Homelessness in the UK: who is most at risk?
[10] NHS England » The community mental health framework for adults and older adults

antipsychotic medication. Of particular importance for this review is exploring what good practice looks like in supporting and safeguarding people with complex and multiple needs.

From the chronology it is evident that Michelle had complex co-existing needs that intersected across Health and Social Care support, that required an integrated team around the adult response. [11]Care and support statutory guidance of the Care Act, 2014 sets out the duties of the Local Authority to conduct an assessment of a person when it is apparent that they require care and support and the combining of a plan when a person receives NHS health care. Equally the [12] Care Plan approach position statement sets criteria to integrate relevant care planning procedures with specific mention in ensuring Care Act compliance. [13] NICE guidelines provide a wide range of guidance for supporting a multi-agency approach to care planning, for people subject to severe mental illness and substance misuse, [14]supporting people with borderline personality disorders and [15]in improving the experience of care for people using adult NHS mental health services.

From the period of 2017 - 19 eight [16]Merlin referrals were made by the Police that would have been received by Adult Social Care, only one of which in 2019, appeared to prompt action in conducting a Care Act Assessment. A conclusion drawn was that Michelle's needs were more of a mental health need than a social care need and that no further action was required from Adult Social Care. It is unclear to extent of information gathering from wider agencies, other than mental health services that a result of no further action was concluded, indeed over this time period Michelle had significant contact with a myriad of services including the Fire Service, Probation, hospitals, housing services and the Police who had reported concerns over Michelle's physical appearance, weight loss, and her risk of exploitation, financial and sexual abuse. In 2019, following the Merlin liaison between Michelle's Care Coordinator and Social Worker triggered a joint visit to conduct a social care needs assessment. At the visit Michelle was believed to be under the influence of substances and fell asleep, therefore an assessment was not conducted. At the visit, there were clear indicators of self-neglect and a high risk of imminent and significant harm from others that will be further explored within the safeguarding section of this report. A follow-up visit was conducted a month later to discuss her safeguarding outcomes. At this visit, there was further evidence of Michelle's unmet needs. Records denote Michelle presented unkempt, she was wearing clothes with stains and she carried a strong, unpleasant odour. Michelle had advised that due to her epilepsy, her health and drug intake she would fall unconscious, and that she was "scared" that if she was smoking in the home, and she fell unconscious the house would set on fire, and she was frightened that this could harm her dog and her fish. Michelle had showed the Social Worker her bathroom, which was recorded to be very cluttered, she said that she was scared to have a bath because she felt that if in any instance, she ''passed out" it may cause her to have a head injury if, for example, she hit her head on the sink. The home was recorded to be in a very poor condition. The outcome of the visit resulted in the Care Coordinator advising options to consider smoking outside, a heat sensor fire alarm that could detect, changes that triggered the fire brigade immediately and a key safe, due to her being locked out of her home in two instances when she left her key at home. Eleven days later, the Social Worker sent an email to the Fire Brigade, and two weeks after the home visit, a referral was sent to install a key safe. The chronology notes two months later, a further visit, took place and an assessment was completed an e-mail request was sent by the Social Worker, to a Care Company with a request for three hours per week care package, however, three months following the request for a care package to the Care Company it was identified by the Social Worker that the care package was not actioned, it was recorded that this was due to, Michelle's reluctance to engage and Michelle's Care Co-ordinator leaving, however the liquid logic system, showed an active care

[11] Care and support statutory guidance - GOV.UK
[12] Care Programme Approach: NHS England position statement
[13] *Coexisting severe mental illness and substance misuse: community health and social care services
[14] Borderline personality disorder: recognition and management
[15] Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
[16] Merlin is a Police report concerning vulnerable people, that alerts the local authority of concerns?

package was in place. When a package of support was put into place in March 2021, ten months since the assessment in May 2019, it appeared to be two hours weekly cleaning support.

16.3 Dignity and the Care Act

Under the Care Act, 2014 [17]the duty to promote personal dignity is one of the dimensions of wellbeing. There appeared little consideration in exploring wider options of how Michelle's deterioration in her physical health impacted upon her everyday life and, in turn her mental health and wellbeing. Despite Michelle advising she was 'scared' to wash for fear of falling unconscious, there did not appear to be any review of the care plan or any person-centred approach to address the issue, nor any crisis and contingency plans. Indeed, not only do [18]NICE guidelines advise that the care plan include an assessment of a person's physical health, social care such as housing and personal care and hygiene, to explore any barriers to self-care, the guidance also warns the impact of unmet needs potentially leading to negative consequences upon, a person's physical health, social isolation, homelessness, poor or lack of stable housing and a disengagement is services. [19]Case law has sought to conceptualise dignity:

Human dignity should not be regarded merely as a facet of human rights but as the foundation for them. Logically, it both establishes and substantiates the construction of human rights; Thus, the protection of human dignity and the rights that flow therefrom is to be regarded as an indispensable priority; The inherent dignity of a human being imposes an obligation on the State actively to protect the dignity of all human beings. This involves guaranteeing respect for human integrity, fundamental rights and freedoms. Axiomatically, this prescribes the avoidance of discrimination; Compliance with these principles may result in legitimately diverging opinions as to how best to preserve or promote human dignity, but it does not alter the nature of it nor will it ever obviate the need for rigorous enquiry.

It is important to recognise that at the time, of the joint visit by the Social Worker and Care Coordinator the impact of COVID-19 had placed unprecedented demand on all public sector services to provide adequate services, which may account in part for some of the delays in any action from the point of Merlin referrals, subsequent visits from the Social Worker and Care Coordinator and the care package being enacted. Records do denote that Michelle would decline support, [20]a refusal of services is a common pattern of behaviour, often due to negative experiences of statutory services. However, given that Michelle was 'well known' to first responding agencies, her level of risk of significant harm and complexity, it is of concern that swifter action was not undertaken to support her. Moreover, the chronology evidences critical junctures pre and post Covid, where there was evidence of her unmet care and support needs, self-neglect and declining physical health. For example, in 2018, her reliance on others to buy her shopping, providing them with her bank card had resulted in her experiencing financial abuse, and a theft of £400 from her bank account. Just two months prior to her death Michelle had been observed by her Care Coordinator and her Support Time Recovery (STR) worker to stockpile her medication, clear evidence of poor compliance with medication, cleaning staff reported concerns of Michelle collapsing, there were reports from the Police of Michelle appearing, very thin, rough sleeping, and just two, months prior to her death, Michelle had been described by her Care Coordinator and her Support Time Recovery (STR) worker as 'emaciated' and 'grey' in colour. The detail of the assessments that took place is unknown, however, it appears that there was no comprehensive attempt to triangulate multi-agency sources of information that could help to support, understand and unpick the dynamics and entirety of the reality of Michelle's lived experiences. Consequently there was no comprehensive assessment of care and support and no robust person centred care plan and risk management plan, that met her care and supports needs and managed inherent risks. In the absence of doing so, arguably meant that the care plan in place was inadequate in meeting Michelle's most basic human needs such as being able to wash, exasperating the

[17] Care Act 2014
[18] Coexisting severe mental illness and substance misuse: community health and social care services
[19] North West London Clinical Commissioning Group v GU | 39 Essex Chambers
[20] Rethinking multiple exclusion homelessness | King's College London

[21]stigma that people with living with multiple exclusion homelessness face and at worst was unconsciously, inadvertently discriminatory in practice. The extent of Michelle's mental capacity in relation to her care and support is explored within the next chapter.

What do we learn?

People who have experienced adversity in childhood and Multiple Exclusion Homelessness (MEH) require integrated, whole system working to meet complex needs, that require regular review that includes risk management plans.

Recommendation 2:
The Safeguarding Adult Board to scope local multi-agency best practice guidance in working with people experiencing multiple Exclusion Homelessness (MEH). Existing guidance needs to amalgamate the emerging range of national evidence-based guidance and research.

Recommendation 3:
The SAB should seek assurance that people experiencing Multiple Exclusion Homelessness (MEH) have in place, timely, person-centred, integrated care plans and ensure that the care plans include Care Act assessments, housing considerations, risk management and advocacy, and evidence that plans are reviewed when new information is shared, incrementally not just annually. With the appropriate supervision and governance oversight in place.

Recommendation 4:
The SAB should seek assurance of the implementation of the Hoarding and Self-Neglect guidance with specific use of the clutter scale across all services when working with people experiencing Multiple Exclusion Homelessness (MEH).

16.4 Mental Capacity in the Context of Multiple Exclusion Homelessness

[22]In England and Wales, the Mental Capacity Act, 2005 provides a legal framework to empower people to make decisions about matters concerning their care and treatment and to support people when it is believed that a person lacks capacity due to a disturbance in the functioning of the mind or the brain. There are five principles in applying the Mental Capacity Act: a person must be assumed to have capacity unless it is established that he lacks capacity; a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success; a person is not to be treated as unable to make a decision merely because he makes an unwise decision; an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. The Act sets out a two-stage test of capacity.

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

A person is unable to decide if they cannot:

1. understand information about the decision to be made (the Act calls this ‘relevant information’)

2. retain that information in their mind

3. use or weigh that information as part of the decision-making process, or

[21] Radical safeguarding toolkit for homelessness (2024) | Research in Practice
[22] Mental Capacity Act 2005

4. communicate their decision (by talking, using sign language or any other means).

The chronology is scant in consideration of Michelle's mental capacity. Assessing a person's capacity is a critical element in considering a person's decision-making regarding matters of their residence, financial affairs, health and social care etc. In 2021, an action from a professionals meeting to assess Michelle's capacity regarding her finances and her living situation, concluded that there was 'no reason' to doubt Michelle's mental capacity however, the assessment noted that Michelle made unwise decisions in regards of her finances. It is unclear how the care plan took account of the assessment in light of her finances, indeed a year on there were further reports that Michelle had loaned her bank card and was the victim of financial abuse. The internal Root Cause Analysis Investigation Report undertaken by mental health services cites that throughout Michelle's engagement with the service, there was 'never any reason to doubt her capacity'. However, in exploring the application of the mental capacity act in relation to assessing Michelle's mental capacity there are multiple factors to consider that give rise to further analysis:

Adverse Childhood Experiences, Multiple Exclusion Homelessness and Post-Traumatic Stress Disorder (PTSD)

Akin to the earlier chapter, the interrelationship between Michelle's adverse childhood experiences and the impact upon her cognitive function is of particular relevance, [23]research suggests that the experience of complex trauma in childhood can result in higher levels of cognitive impairment in adulthood (Lewis et. al, 2021). It is not known to what extent the impact of significant trauma was considered when assessing Michelle's mental capacity

Emotionally Unstable Personality Disorder and Mental Capacity

Michelle had a formal diagnosis of an Emotionally Unstable Personality Disorder and mental and behavioural disorders due to substance misuse, [24]Over the past decade, the status of the identification and classification of personality disorders in the context of mental ill health has been debated; however, the [25]World Health Organisation asserts that a personality disorder is a mental health condition that can involve significant disturbances in thinking, emotional regulation or behaviour. [26]The National Institute for Health and Care Excellence concurs that Borderline Personality Disorder (BPD) is a severe mental disorder. In the applicability of the Mental Capacity Act, 2005 by virtue of Michelle's diagnosis, the criterion of the Act was met in that: 'impairment of, or a disturbance in the functioning of, the mind or brain. Although the Mental Capacity Act states, a lack of capacity must not be assumed by the presence of a particular diagnosis, to the extent to which Michelle's diagnosis impacted her ability to 'use and weigh' information as part of the decision-making process is not known. Moreover, research asserts the [27]incredible complexity in the context of assessing mental capacity and personality disorders leading to inconsistency in patient care that warrants further research and guidance.

Existing guidance, such as the [28]Mental Capacity Act, 2005, code of practice and the [29]National Institute of Clinical Excellence in decision-making and mental capacity, and [30]Borderline Personality Disorder requires further review, to include best practice of assessing mental capacity in the context of personality disorders, in order to support and empower the workforce to conduct robust assessments of mental capacity and in supporting service users in decision making.

Impact of Domestic Abuse, Coercive Control and Exploitation

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[23] Fall prevention in community-dwelling adults with mild to moderate cognitive impairment: a systematic review and meta-analysis - PubMed
[24] The distinction between personality disorder and mental illness | The British Journal of Psychiatry | Cambridge Core
[25] WHO 2022, Mental Disorders
[26] Borderline personality disorder: recognition and management
[27] Mental capacity and borderline personality disorder | BJPsych Bulletin | Cambridge Core
[28] *Mental-capacity-act-code-of-practice.pdf
[29] Decision-making and mental capacity
[30] Borderline personality disorder: recognition and management

Michelle was a victim of domestic abuse, [31]research asserts that there needs to be a consideration of how the impact of coercive and controlling behaviour and associated trauma as a consequence of the domestic abuse can impact a person's mental capacity. There was also evidence of that Michelle was being sexually exploited and potentially cuckooed, [32]exacerbating the potential to be acutely impacted in her decision-making.

Substance Use and Alcohol Use

Professionals recorded at the point of intoxication Michelle did not have mental capacity, however to the extent of the long-term impact of substance and alcohol on Michelle's capacity is unknown.

16.5 The Assumption of Capacity and Unwise Decisions

The first principle of the Mental Capacity Act is to assume a person's capacity unless it is established that they lack capacity. The assumption of capacity is important, assuming capacity ensures respect for autonomy, however [33]case law has identified how the assumption of capacity can be misunderstood by professionals:

"*The presumption of capacity is important; it ensures proper respect for personal autonomy by requiring any decision as to a lack of capacity to be based on evidence. Yet the section 1(2) presumption like any other, has logical limits. When there is good reason for cause for concern, where there is legitimate doubt as to capacity [to make the relevant decision], the presumption cannot be used to avoid taking responsibility for assessing and determining capacity. To do that would be to fail to respect personal autonomy in a different way*."

It appeared that the professionals that were working with or came into contact with Michelle had an over-reliance on the assumption of Michelle's capacity. [34]The Mental Capacity Act Code of practice, 2005 emphasises the importance of assessing a person's capacity when a person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision, and when a person's decisions repeatedly put them at risk of significant harm or exploitation. Throughout the entirety of the chronology, there are numerous incidents whereby professionals were aware of evidence of impairment. For example, in 2017, Michelle made calls to the Police stating her neighbour had vandalised her garden umbrella, when there was no apparent damage. In 2018, Michelle had made a decision to provide her bank card to someone and was a victim of theft. In 2019, Michelle had rung the Police to report a burglary of her medication and reported that Boris Johnson had stolen this. At a meeting in early 2022, with her Care Coordinator and Doctor, Michelle presented as paranoid, complaining that her neighbour had put mice in her home. Just three months prior to her death, Michelle had advised hearing voices, stating that the 'IRA were following her'. Further examples were in 2022, when a Social Woker concluded that Michelle was deluded regarding all medication, finances, life insurance and the police. Michelle made a decision to leave the hospital against medical advice, the decision required her to consider her care and support post-discharge and her ability see the foreseeable consequences, not just her capacity to leave the hospital.

It is particularly concerning that despite such evidence, only on two occasions was an action to undertake a formal mental capacity assessment considered. The widespread and acute effects of childhood trauma, bereavement, abuse, coercion, substance and alcohol misuse were all dynamic factors that appeared to have been given little regard in assessing Michelle's capacity.

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[31] The person seems to be under the influence of someone else - Capacity guide
[32] cognitive-impairments-and-adult-exploitation-executive-summary.pdf
[33] Royal Bank Of Scotland Plc v AB | 39 Essex Chambers
[34] *MeNecessary and unnecessary complexity in decision-making capacity – and 'lifestyle choice' – Mental Capacity Law and Policyntal-capacity-act-code-of-practice.pdf

Prior to Michelles' death, in 2022 on one of her last admissions to hospital, a professionals meeting actioned a formal capacity assessment to be documented with regard to lifestyle choices and making 'unwise decisions' and that she used her home as a drug den and lived on the street. To the extent that Michelle had control over such decisions does not appear to be explored.

[35]Necessary Complexity

[36]NICE guidelines, refer to a concept of executive dysfunction, when a person's ability to think, act and solve problems, is impaired often at times of distress or heightened emotion and prevents a person from weighing up the information in decision making. Executive dysfunction is a clinical term, whereas mental capacity is a legal concept, [35]NICE guidelines state that in all cases, it is necessary for the legal test for capacity, as set out in section 2 and section 3 of the Mental Capacity Act 2005, to be applied.

16.6 The Court of Protection

[37]NICE guidelines state where there is a dispute about a person's best interests, it may be necessary for the matter to be referred to the Court of Protection for a determination of the person's best interests.

The Court of Protection is a court set up by the Mental Capacity Act 2005 in England and Wales The court is also required to make decisions that respect people's human rights under the Human Rights Act 1998. [38]Inherent jurisdiction is best understood as the ability of the High Court.

The courts advise the use of the inherent jurisdiction of the high court can be considered and used, for the protection of an adult considered vulnerable irrespective of any mental disorder or mental illness, where is it believed that they are to be, under constraint, subject to coercion or undue influence, deprived of the capacity to make the relevant decision, disabled from making a free choice, incapacitated or disabled from giving or expressing a real and genuine consent [39]Case law has provided examples of the use of inherent jurisdiction:

"[*T]he treatment of Mr Meyers has not merely been neglectful but abusive and corrosive of his dignity. To the extent that the Court's decision encroaches on Mr Meyers' personal autonomy it is, I believe, a justified and proportionate intervention." He could not return home unless son moved out.*

Given, the complexity of Michelle's circumstances and the inherent risk of abuse from others, the consideration of the Inherent jurisdiction of the High Court could have been considered.

[40]NICE guidance offers a framework in considering robust mental capacity assessments and recommends key components of a good mental capacity assessment, such as, a personalised approach, using knowledge to develop a shared and personalised understanding of the factors that may help or hinder a person's decision making, consider joint crisis planning to anyone who has been diagnosed with a mental disorder and has an assessed risk of relapse or deterioration, identify people who could be spoken with in order to inform the capacity assessment and the use of advocacy. The guidance makes further recommendations that all health and social care organisations should develop local policy and guidance, specific tools and training to support decision-making and audit the tools against adherence to the Mental Capacity Act Code of Practice.

What do we learn?
Mental capacity assessments are often complex to undertake. The compounding effects of childhood and abuse in adulthood, of abuse, coupled with substance misuse and mental health issues, require considerations of

[35] Capacity – the key points – Mental Capacity Law and Policy
[36] Decision-making and mental capacity
[37] *Decision-making and mental capacity
[38] Mental Capacity Guidance Note Inherent Jurisdiction May 2024.pdf
[39] Southend-on-Sea Borough Council v Meyers | 39 Essex Chambers
[40] *Decision-making and mental capacity

functional capacity using the Mental Capacity Act. These findings are similar to those published in the Safeguarding Adult Review Jack
FINAL SAR Jack Report.pdf

Recommendation 5:
The Learning from Practice Committee should undertake analysis and audit of learning opportunities across the partnership for professionals around the concept of functional capacity and what it means in practice to be assessing someone's executive and functional capacity.

Recommendation 6:
The Learning from Practice committee to consider how to measure the sustained impact of reviews.

Recommendation 7:
The SAB should seek assurance that hospital discharges consider a multi-agency approach and a review of care and support and where possible joint mental capacity assessments.

16.7 Safeguarding

Safeguarding is one of the most complex tasks carried out across all services and all sectors, however, the increased vulnerabilities of adults experiencing Multiple Exclusion Homelessness exacerbates significant safeguarding risk and complexity.

Safeguarding features overwhelming throughout the entirety of this review. From Michelle's early childhood and throughout adulthood Michelle had been the victim of almost all categories of abuse defined in both Children and Adult Safeguarding Legislation.

Cuckooing

Cuckooing is a form of exploitation in which a criminal takes over the home of a vulnerable person to use it as a base for drug dealing, storing firearms, and other criminal activity. From early in the chronology, there was evidence that Michelle was a potential victim of cuckooing, for example, weapons such as knives, screwdrivers and hammer were observed in the home, there was increased anti-social behaviour potentially masking cuckooing. Michelle had at times disengagement with support services/healthcare services, and on occasions the property appeared almost sparse of valuable possessions. Inside the home there were consistent and clear signs of drug use and unknown males that were described as 'unsavoury characters' that were observed by professionals attending Michelle's home. However, despite evidence of cuckooing in plain sight, the chronology only references once to a consideration of cuckooing by the support treatment worker. Michelle's vulnerabilities placed her at greater risk of cuckooing, the lack of the identification of cuckooing gives rise to a recommendation for professional awareness of cuckooing and forms a recommendation.

Sexual Exploitation

Police records state that Michelle had worked as a 'sex worker' for which she had also received criminal charges. Recent Government reports on Human Trafficking seek to label all prostitution as sexual exploitation, recommending that the Home Office no longer use the term "sex work". The term "survival sex" refers to the exchange of sex for drugs and money. Extracts from the chronology evidence the risk of and the sexual exploitation Michelle suffered, for example, in 2019, a man had gained her trust by telling her he was from the church before going on to sexually assault her. At a point within the chronology, of Michelle's Personal Independent Payments (PIP) being stopped, there had also been an allegation of rape. It is important that prior to any halt of benefit payments the Department of Work and Pensions (DWP) need to be part of wider safeguarding

meetings and plans to ensure the impact upon a person is carefully considered and doesn't inadvertently place them at greater risk.

Self-Neglect

The extent to which Michelle's self-neglect was a capacious lifestyle choice has been explored throughout this review. It is somewhat striking that, given the extent of Michelle's self-neglect that there were no safeguarding referrals from agencies under the category of self-neglect that could have prompted an opportunity for a much needed multi-agency response.

It appears that despite over seventeen Merlin alerts, only four reached the point of enacting a Section 42 Safeguarding Enquiry, none of which were made under the category of self-neglect.

Domestic Abuse and Domestic Abuse Related Suicide

It is important to acknowledge the scope of the review and the legislative changes that have occurred since the commencement of the Domestic Abuse Act, 2021. However, it is also important to consider real-time assurance should a woman be experiencing Multiple Exclusion Homelessness and domestic abuse. It is clear from the chronology that Michelle suffered significant domestic abuse from her ex-partner that continued even whilst the perpetrator was in prison. Threats to throw acid in Michelles's face were made by the perpetrator's friends, who arrived at Michelle's house. There appeared to be an onus on Michelle to report this incident to the Police herself, which she was reluctant to do, which created a further barrier for Michelle and left her at significant risk. Once Michelle had been advised that the perpetrator was due to be released from prison, Michelle displayed intense distress and chronic legitimate fear. She had advised professionals that she felt safer living on the streets, and the Police had been called by Michelle's neighbour as she stated had suicidal feelings. This represented genuine risk, and Michelle was accurate in her assessment of risk, as later in the chronology the perpetrator breeched his license conditions. It is noteworthy that at this time, some of Michelle's calls to the Police were made for burglary, however, the Police concluded that there was no evidence of a burglary or any vandalism. This may have been an inadvertent attempt to keep herself safe. There appeared to be a lack of clarity regarding when the perpetrator was due to be released, unfortunately resulting in a letter sent in error to Michelle advising incorrect release dates, which caused Michelle even further distress. Michelle was not informed until eleven days after the perpetrator was released in 2018, and Michelle was heard at a MARAC meeting in 2021. Although policy and practice has changed significantly over the review period, an assurance action is required for such significant delays. Although there appeared to be support from the victim liaison officer, an independent domestic violence officer needed to be considered. Research in supporting women with multiple needs experiencing domestic abuse has outlined best practice principles in working with women with complex needs and advocates a gender and trauma-informed response to all aspects of practice. Emerging approaches in supporting and safeguarding women experiencing Multiple Exclusion Homelessness includes MARAC meetings that consider wider assessment of need, which include housing, mental and physical health, adult and child safeguarding and support, drug- and alcohol-related vulnerabilities and needs and financial support.

16.8 The Effectiveness in the Application of Section 42 Enquires

Social Worker: *'what outcomes would you like from the safeguarding enquiry?'* **Michelle:** '*What options are there*?

The granular detail of the Section 42 Enquires is not known, but of the incidents that did trigger a safeguarding enquiry, it appears previous safeguarding concerns were not taken into account that linked an incident to a pattern of abusive behaviours that Michelle had been subjected to, nullifying the ability to track risk escalations over time.

Of the incidents that did lead to an enquiry, in the application of Making Safeguarding Personal, in ensuring safeguarding practice is person-led and outcome-focused, placed an onus on Michelle for finding her own solutions to safeguard herself, without providing her with a broader range of options that included a multi-agency focus to formulate a robust risk management plan.

High Risk Scenarios

The risk that Michelle faced was inherent and acute. It is unclear what professional responses were undertaken when Michelle appeared intoxicated, with only a chair or wooden slat against the door for security these were high stakes scenarios where the consequence could have led to her suffering further abuse, or even death, as in other SARs. That gives rise to concern in the application of the Human Rights Act 1998, Article 3, that states: no one shall be subjected to torture or to inhuman or degrading treatment or punishment. Agencies appeared to misunderstand and therefore misidentify dynamic and comprehensive risk that, in turn, did not capture the true extent of the abuse Michelle was experiencing and the ongoing and significant risk of harm that Michelle faced and a robust multi-agency risk management plan to effectively safeguard her was absent. This is by far an over simplified analysis of an incredibly complex situation and professionals working in the context of people with Multiple Exclusion Homelessness require a comprehensive suite of policy and practice guidance and high quality training and supervision to empower and support them effectively.

Financial Abuse

There were numerous incidents where Michelle was the victim of theft. In a professionals meeting in 2021, it was accessed that Michelle made unwise decisions with her finances. It is unclear how incidents of financial abuse triggered a review of her care plan. It is unclear if there ever was any criminal sanction for the abuse that Michelle experienced.

What do we learn?

Women experiencing Multiple Exclusion Homelessness are at greater risk of all forms of exploitation, including cuckooing, sexual exploitation and domestic abuse.

Domestic abuse continues despite a perpetrator being in prison.

MARAC meetings need to consider how women experiencing Multiple Exclusion Homelessness can be supported to accompany a wider assessment of need, that includes housing, mental and physical health, adult and child safeguarding and support, drug- and alcohol-related vulnerabilities and needs, financial support.

Best practice should include:

- a consistent trauma and gender informed response across all agencies (including people with pets require creative solutions, as part of a wider trauma informed response)
- understanding risk in the context of Multiple Exclusion Homelessness with a specific focus on women
- domestic abuse and domestic abuse related suicide
- the legal framework highlighted throughout this review
- supervision that prompts concerned and professional curiosity

- undertaking plans of support using the Equality Act
- cuckooing, sexual exploitation, financial abuse, self-neglect, high-risk scenarios
- high-quality mental capacity assessments
- high-quality integrated care plans
- integrated hospital discharges.

Recommendation 8:
The SAB should consider auditing safeguarding concerns to:
a) understand the categories of abuse being raised
b) see how protected characteristics are considered in safeguarding enquiries
c) see whether safeguarding concerns are screened appropriately in cases where there is a theme of multiple exclusion homelessness, particularly looking at risk management and safeguarding plans
d) review the effectiveness of multi-agency escalation and information sharing across agencies.

Recommendation 9:
The SAB to seek assurance that victims are kept informed of the release and management of perpetrators and the effectiveness of safety plans for people who are victims of domestic abuse.

Recommendation 10:
The SAB should seek assurances from all agencies how trauma informed approaches are applied across agencies.

Recommendation 11:
The SAB should seek assurance of how agencies ensure medication compliance to avoid service users stockpiling medication.

16.9 The Role of Housing in Safeguarding

It is clear from Michelle's sister, that the condition of Michelle's flat could be described as squalid and inhabitable. Professionals had also described the flat as a 'drugs den', and in a very poor state. Including mice infestation. in attempts at keeping herself safe Michelle had put furniture to jam the door, and wooden slats that covered the front door which was open at visits by professionals. The Care Act,2014 is clear that suitable accommodation can be one way of meeting care and supports needs and states: *Housing plays a critical role in enabling people to live independently and in helping carers to support others more effectively. Poor or inappropriate housing can put the health and wellbeing of people at risk, where as a suitable home can reduce the needs for care and support and contribute to preventing or delaying the development of such needs and that Health, care and support and housing services should centre on the individual and family, by helping them to articulate the outcomes they want to achieve a local authority can consider what support it can provide in or through the home*.

In 2021, the housing team set up floating weekly support to help Michelle with cleaning her home and services, however it was recorded that she lacked consistency in engaging with this. Sporadic engagement is not uncommon when working with people facing Multiple Exclusion Homelessness due to a range of factors, such as stigma, discrimination and negative experiences with services, leading to mistrust. A professionals meeting held in 2021 concluded there was no significant evidence that Michelle was at risk in the flat, despite reports of burglary and vandalism. Just a month prior to the professionals meeting, there had been extensive reports of burglary, theft and sexual abuse. Housing and other agencies had also been aware Michelle was a victim of domestic abuse. The chronology denotes the efforts that the Care Coordinator, Support Treatment Recovery Worker and Police had made in contacting housing services, to express concerns. Equally, Michelle was making fervent efforts herself in trying to remedy her housing situation. Michelle was liaising with Social Services with a consideration for rehousing her in supported accommodation, however, this was not achieved as she was keen to have her dog with

her, which led to significant limitations to rehousing opportunities. Research has identified the challenges and lack of pet-friendly provision, but purport, the vital importance of preserving such relationships between people who are homeless and their pets, as part of a wider trauma informed response. This situation albeit challenging required wider and more creative solutions, for example, when Michelle was taken into hospital the dog had stayed with foster carers, if Michelle still had access to her dog as part of the foster care this may have served as possible temporary solution. Records stated that Michelle 'has had a good go at cleaning herself but agreed it's still not where it needs to be'. Records capture a powerful narrative that articulates the lived experience of Michelle, just six months before her tragic death, in a text to the cleaning manager, Michelle had stated, 'I got my phone back, I am really, really NOT GOOD. Thank you for your help and support. I can't go back to that place, I'm at the end of the bullying and I'm really finding life difficult now than ever before'.

Michelle had expressed her wishes to move from the area, to another part of London, where she had wider family. The Care Coordinator had contacted the Landlord Service Manager and enquired whether Michelle could be temporarily moved whilst the property was treated, however, this was declined by the Local Authority. The rationale was unclear. The Police had also raised concerns for Michelle's safety, to the housing service. What is clear is that the entirety of Michelle's vulnerability and inaction left Michelle, unprotected. It is stark that in an attempt to safeguard herself Michelle had taken to live on the streets perceiving that she was safer on the streets than living at home. The location of the majority of the abuse was occurring in her home. Just 4 days prior to Michelle's death, liaison between professionals took place and considered a residential placement and a capacity assessment to consider changes in accommodation. there were much earlier points for multi-agency action for such decisions to be made. Michelle was a target in the community, even after her death, her sister stated that drug dealers were contacting her phone. By not supporting her to move to a place of safety, in line with her desired outcomes feelings and wishes, undoubtably placed at greater risk of harm, moreover her ex-partner who had perpetrated domestic abuse had knowledge of her address. This practice falls dramatically below expected standards and gives rise to how the Equality Act 2010, the Domestic Abuse Act, 2012 and the Human Rights Act, 1998 Article 3 was discharged in Michelle's case and formulates recommendations for assurance. There is also a range of legal frameworks that professionals could have enacted to support Michelle, such as:

The Care Act, 2014, section 1, promoting wellbeing, Local authorities must promote individual wellbeing, which includes the suitability of living accommodation. Co-operation Duties (Sections 6 & 7).

Local authorities must cooperate with relevant partners, including housing providers. This includes:

- sharing information appropriately
- participating in joint planning and service delivery
- supporting safeguarding efforts.

Prevention of Damage by Pests Act 1949 – Local authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice.

What do we learn?

The role of Housing in safeguarding is critical in enabling people to live independently and in prioritising a person's safety who is a victim of domestic abuse and had complex needs.

There are wider legal frameworks that can be used to support a person e.g. Closure Orders or Partial Closure Orders which are enforced by the Police.

People experiencing Multiple Exclusion Homelessness (MEH) with pets require creative solutions, as part of a wider trauma informed response such as Community MARAC.

Sporadic engagement is not uncommon when working with people facing, due to range of factors, such as stigma and discrimination.

Recommendation 12:
The SAB to be involved in the review of the Allocations Policy and Management Transfer Policy to ensure the needs of vulnerable people, particularly women experiencing domestic abuse and exploitation are met and the learning from this review is embedded in policy.

16.10 Discriminatory Abuse and the Equality Act

The Equality Act, 2010 provides legislation not to treat a person less favourably due to their protected characteristics. In considering Michelle's protected characteristics three are relevant. Disability: Michelle's diagnosis meant that she was classified as having a mental health disability. Sex: the gendered nature of domestic abuse, is evidenced through varied research and studies. Age: Michelle was aged 56 at the time of her death. It is not known how safeguarding enquiries considered Michelle's protected characteristics and how by virtue, of her identity she became a target within the community. It appears a rhetoric was felt by some professionals was that 'it has always been like this', 'her dispute with neighbours had been going on for 'years', 'it is very unlikely that Michelle's pattern of behaviours will change'. This view potentially skewed any scope for change, which perhaps accounted for limited strategies to support and safeguard Michelle and in turn was unconsciously bias. The chronology notes that there were times when professionals had referred to Michelles complex needs as a 'problem' rather than viewing her needs in light of her vulnerability. This concept has been identified with the latest SAR Analysis. Recent research purports that equality, diversity and inclusion is absent from safeguarding enquiries and reviews, (Chantler et al., 2024) and furthermore agency records lack detail of equality, diversity and inclusion demonstrating a lack of considering of the protected characteristics of a person when undertaking care plans. Particular attention needs to Michelle's sex, as a woman Michelle had faced structural inequalities and overlapping characteristics of disability, age and nationality, being of Irish descent, which potentially exacerbated access to support. Applying a lens of intersectionality supports our understanding of the reality of the lived experiences of people facing Multiple Exclusion Homelessness and is an important aspect to identify communities who may be underserved, to target appropriate interventions.

What do we learn?
Applying a lens of intersectionality supports our understanding of the reality of the lived experiences of adults, particularly women facing Multiple Exclusion Homelessness, and is an important aspect to identify communities who may be underserved, to target appropriate interventions. Barking and Dagenham face significant challenges related to deprivation, particularly when compared to the national average and some other areas within London that may amplify a person's experience of Multiple Exclusion Homelessness.

Recommendation 13:
Agencies to provide evidence that training across single agencies includes all forms of exploitation, domestic abuse and domestic abuse related suicide and the impact of this training on practice.

16.11 Multi-Agency Working - Team Around the Adult

In keeping with the findings from the mental health internal root-and-branch review, it is of concern that earlier opportunities for agencies to work together effectively to provide a multi-agency holistic team around the adult

approach were missed. Moreover, in a previous [41]SAR Jack, a lack of referrals from agencies to the complex cases group was highlighted, which formulates wider recommendations for this SAR of the impact of sustained learning from SARs. It should be recognised that working with people experiencing Multiple Exclusion Homelessness can give rise to circumstances and requires an integrated, whole system working, linking services to meet people's complex needs not solely one agency. It was good practice that referrals were made to adult social care by some agencies, and on occasions there were escalations of concerns to the Local Authority Housing and Adult Social Care, however by merely referring does not abdicate safeguarding duties and by working as a system, unlocks a broader range of support opportunities for a person.

Right Care Right Person (RCRP)

We often observed the Police as first responders to Michelle concerning suicidal ideation. Right Care Right Person (RCRP) is an initiative that seeks to ensure vulnerable people get the right support from the right emergency services. RCRP involves the Police working with partner agencies to identify the most appropriate agency to give vulnerable people the care and support they need. Given the extent of mental health crisis concerns that we observed in this review, much stronger collaboration with mental health professionals is required to ensure that an effective partnership approach assists in the identification and management of safeguarding risk.

What do we learn?

Multi-agency working and a team around the adult is critical working with people experiencing Multiple Exclusion Homelessness requires an integrated, whole system working, linking services to meet people's complex needs not one agency alone.

[42]Preston Shoot, 2019 characteristics what good practice looks like in complex cases in direct practice:

- Inter-agency communication and collaboration, working together, coordinated by a lead agency and key worker in the community to act as the continuity and coordinator of contact, with named people to whom referrals can be made.
- The emphasis is on integrated, whole system working, linking services to meet people's complex needs.
- A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture.
- Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs.
- Multi-agency meetings that pool information and assessments of risk, mental health and mental capacity, agree a risk management plan, consider legal options and subsequently implement planning and review outcomes.
- Use of policies and procedures for working with adults who self-neglect and/or demonstrate complex needs associated with Multiple Exclusion Homelessness, with specific pathways for coordinating services to address such risks and needs as suitable accommodation on discharge from prison or hospital.
- Use of the duty to enquire (Section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy.
- Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy.

In order for the above characteristics to be put in place Preston Shoot further asserts good practice from an organisational lens:

- Supervision and support that promote reflection and critical analysis of the approach being taken to the case, especially when working with people who are hard to engage, resistant and sometimes hostile.
- Access to specialist legal, mental capacity, mental health and safeguarding advice.

[41] FINAL SAR Jack Report.pdf

[42] Search results | Emerald Insight

- Case oversight, including comprehensive commissioning and contract monitoring of service providers.
- Agree indicators of risk that are formulated into a risk assessment template that will guide assessments and planning.
- Attention to workforce development and workplace issues, such as staffing levels, high caseloads and organisational cultures and thresholds.

16.12 Relational Safeguarding and a Trauma Informed Approach

It is clear that throughout Michelles life her negative experiences of statutory agencies that she experienced in childhood shaped her distrust of services in accepting support. Unequivocally we observed, facets of compassionate trauma informed practise, notably the support treatment worker that went in search of Michelle, when she could not be found at home and had been living on the streets. The Care Coordinator had sent her a birthday message wishing her happy birthday. There were considerations of how probation could deliver correspondence through Michelle's Care Co-ordinator, the Police and Fire Services had attended regularly in crisis episodes, and the Department for Work and Pensions liaised with the Care Coordinator in view how a payment could be made, when Michelle did not have an account. The assertive outreach service visited Michelle when she was living in a tent, escalating concerns. However, we also observed occasions where practice fell below expected standards of a trauma and gender informed approach. For example, Michelle was advised to attend a homeless centre, she attended in the rain, only to find the centre was closed, triggering overwhelming distress that led to suicide ideation, insufficient recognition was given to the cumulative impact of her childhood trauma and considerations and the impact on her capacity, implying her and self-neglect was a lifestyle was a choice. This was without the consideration of coercion, outcomes of safeguarding enquires offering very little in the way of protecting her, delayed action to trigger cleaning packages, actions from the safeguarding enquiry and the mice infestation in her flat that triggered memories of Michelle being held hostage in a basement. These experiences wholly reinforced her negative experiences of agencies. Working with adults experiencing Multiple Exclusion Homelessness can be emotionally challenging and at times there are risks. Michelle had made a threat to her Care Coordinator, she had alleged to be assaulted by Ambulance crews, and the Police to the extent that the allegations were corroborated is unknown. It was evident that Michelle had a good relationship with her first Care Coordinator whom she had worked with for many years. A consistent approach to working with people with Multiple Exclusion Homelessness is critical and of note is the chronology between 2015-17 there is a marked lack agency contact, that could be attributed to Michelle receiving continued support to accompany her to appointments etc. However NICE guidelines purport the emotional complexities of the work and assert regular supervision and oversight is a critical component in this field of practice. The first Care Coordinator appeared to influence professionals regarding the reliability of Michelle's accounts that potentially biased outcomes for Michelle, for example when Michelle had advised probation of the threat of the acid attack, by the perpetrators friends, the Care Coordinator's narrative that Michelle often relayed facts mixed with delusion, appeared to sway the Probation Officer of any further reporting until the advice of the Offender Manager rightly, that the allegation required further investigation. Trauma can impact memory recall and narrative coherence and are all facets that can have a significant impact on victims of abuse being believed. Indeed, as a child Michelle was not believed by family members about the sexual abuse she had suffered. Of significance, in 2019, Michelle's long term Care Coordinator retired, Michelle was reported to be extremely distressed about this, the plan of transition is unclear, however from that point due to a range of factors, including maternity, Michelle making threats towards staff, Michelle went on to be care coordinated by several different professionals over the course of two years. There was consistency in her Support Treatment Recovery worker, however the roles of a support treatment worker and Care Coordinator are different and a lack of a consistent Care Coordinator is highlighted as a risk, in the root cause analysis Root Cause Analysis Investigation Report. However, a recommendation to ensure consistency does not feature in the recommendations of the investigation report.

What do we learn?
Relational safeguarding is a critical element of a trauma-informed approach and must be informed by the impact of adverse experiences throughout the life course.
The emotional complexities of the work require regular supervision that can respectively challenge unconscious bias. Professionals need to ensure they are objective and not influenced by a rhetoric that impacts upon an adult being believed. All allegations of professionals must be followed up.
Consistency is a key component in working with adults experiencing multiple exclusion homelessness.

Recommendation 14:
The SAB should seek assurance that supervision supports the workforce in understanding the protected characteristics and challenges of professional bias.

Recommendation 15:
The SAB should seek assurance of the effectiveness of the transition of care from one key worker to another when working with people experiencing multiple exclusion homelessness.

16.13 Conclusion

Michelle's life exemplifies the cumulative impact of abuse across the lifespan and a powerful narrative of the reality of Michelle's lived experiences and the ongoing abuse and adversity she faced in adulthood. We frequently observed Michelle desperately navigating a variety of complex vulnerabilities and experiencing abuse in plain sight of statutory services. Concerned and professional curiosity, challenge, and assessing risk are multifaceted concepts, and applying them in practice is difficult and requires skilled work. Amore nuanced and grounded understanding of the concepts and their application in practice is required. Moreover, set against the backdrop of the safeguarding landscape where the Directors of Adult Social Services have outlined the national challenges across the current health and social care system, amplified by the legacy of intense pressures of the COVID-19 pandemic, cost of living issues and a shrinking adult workforce are issues faced by all organisations working tirelessly to safeguard adults experiencing Multiple Exclusion Homelessness. Needs are increasing and becoming more complex whilst resources are decreasing. Within this context, the ambitions and opportunities for learning from this review are harnessed to develop and address collective, specific and mutual issues and challenges, to support complex direct practice, inter-organisational working, organisational environment and areas and to utilise the role of the SAB governance and leadership and wider statutory boards, in supporting these challenges strategically and in ensuring accountability and most importantly a powerful memorial to Michelle and her family.

16.14 Summary of Recommendations

Assurance and Board Work
The Safeguarding Adult Board, Safeguarding Children Partnership and Community Safety Partnership to consider a system-wide joint priority that focusses on the negative impact of childhood adversity and the links to multiple exclusion homelessness and how this may marginalise adults in society in relation to the principles outlined in the Equality Act 2010.
The Safeguarding Adult Board to scope local multi-agency best practice guidance in working with people experiencing Multiple Exclusion Homelessness (MEH). Existing guidance needs to amalgamate the emerging range of national evidence-based guidance and research.
The SAB should seek assurance of the implementation of the Hoarding and Self-Neglect guidance with specific use of the clutter scale across all services when working with people experiencing Multiple Exclusion Homelessness (MEH).
The Learning from Practice Committee should undertake analysis and audit of learning opportunities across the partnership for professionals around the concept of functional capacity and what it means in practice to be assessing someone's executive/functional capacity.
The Learning from Practice committee to consider how to measure the sustained impact of reviews.
The SAB should seek assurance that hospital discharges consider a multi-agency approach and a review of care and support and where possible joint mental capacity assessments.
The SAB should consider auditing safeguarding concerns to: a) understand the categories of abuse being raised b) see how protected characteristics are considered in safeguarding enquiries c) see whether safeguarding concerns are screened appropriately in cases where there is a theme of multiple exclusion homelessness, particularly looking at risk management and safeguarding plans d) review the effectiveness of multi-agency escalation and information sharing across agencies
The SAB should seek assurance of how agencies ensure medication compliance to avoid service users stockpiling medication.

The SAB should seek assurance that supervision supports the workforce in understanding the protected characteristics and challenges of professional bias.
The SAB should seek assurance of the effectiveness of the transition of care from one key worker to another when working with people experiencing multiple exclusion homelessness.
Domestic Abuse
The SAB to seek assurance that victims are kept informed of the release and management of perpetrators and the effectiveness of safety plans for people who are victims of domestic abuse.
The SAB should seek assurances from all agencies how trauma informed approaches are applied across agencies.
Agencies to provide evidence that training across single agencies includes all forms of exploitation, domestic abuse and domestic abuse related suicide and the impact of this training on practice.
Housing and Homelessness
The SAB should seek assurance that people experiencing Multiple Exclusion Homelessness (MEH) have in place, timely, person-centred, integrated care plans and ensure that the care plans include Care Act assessments, housing considerations, risk management and advocacy, and evidence that plans are reviewed when new information is shared, incrementally not just annually. With the appropriate supervision and governance oversight in place.
The SAB to be involved in the review of the Allocations Policy and Management Transfer Policy to ensure the needs of vulnerable people, particularly women experiencing domestic abuse and exploitation are met and the learning from this review is embedded in policy.

Appendix 1 - Key Practice Episodes

These key practice episodes do not provide a forensic analysis of agency interaction but are shared here to help structure the timeline and reflect and focus on key issues that influenced Michelle's story.

2008	***Records denote:*** Michelle had suffered several traumatic events in the context of sexual assaults and bereavement. She was in and out of the hospital and was admitted due to relapses in her mental state and the risk of harm to herself following these events. Over the next few years, she continued to lead a challenging lifestyle in the context of drug misuse and poor mental health. She was recorded to have made multiple attempts to harm herself and was being supported with crisis and community support on each side of her admissions. She had some forensic history associated with antisocial behaviours and ongoing housing issues.
2010	Michelle's ex-partner was convicted of an offence of grievous bodily harm against Michelle and was sentenced to 96 months' custody.
2015	Michelle was under the Community Recovery Team at the time (now known as the Mental Health Wellness Team), and had continuity of care in her Care Coordinator, who supported her to attend appointments and engage with the community drug and alcohol services. However, Michelle continued to use substances namely, heroin, crack cocaine, and alcohol. Due to her chronic obstructive pulmonary disease (COPD), she was requiring nebulizers frequently at home.
2017 **July - October**	Over the following few years, Michelle remained under the respiratory team for her breathing problems, however, her condition was managed at home with nebulizers, inhalers, and rescue packs when required. She continued to use substances and was recorded to have stopped fully engaging with her Methadone programme. Her long-term partner also moved out of their shared property, and her Care Coordinator documented that there were regular visitors to Michelle's flat who were thought to be drug dealers. It was noted that unsavoury characters were staying in her flat, and this was recorded to be an increased risk to Michelle in the context of vulnerability and drug misuse. Due to a robbery by Michelle's ex-partner, whereby items of clothing, a watch and a necklace were taken from her home, a safeguarding concern was raised to Adult Social Care. At this time, there were also two Merlin Reports received from the Police, one was due to Michelle stating she would undertake suicide if the Council did not act on an ongoing neighbour dispute. It was recorded that Michelle was heavily intoxicated and was not making sense. The second Merlin report recorded that the Police went with the Council Housing Officer to conduct the yearly check. Michelle was found to be under the influence of drugs, she was checked over by the London Ambulance Service (LAS). She also had two males inside the address, and it was believed they were taking drugs. The house was messy and dirty with unknown fluids on the kitchen floor. It was noted that Michelle was very underweight.

November - December	Michelle contacted Probation in response to a letter that was sent to her by the Immigration Authority, advising her that her ex-partner (the perpetrator) may be released from prison at any time. She was extremely distressed, Michelle stated that the perpetrator would come straight to her home if he was released, as he hated women and would blame her for him being in prison. Michelle gave Probation her Community Psychiatric Nurse's details. Probation services advised that they would contact her local Police and see if they could put additional security measures in place at her home. A Victim Liaison Officer (VLO) also made contact with Michelle and advised that on release the perpetrator would be on license and there would be an exclusion zone and a condition not to contact Michelle. Michelle advised she had no faith that the perpetrator would abide by the conditions. 11 days after the conversation with the VLO, a Merlin report was received, noting the Police were called by Michelle's neighbour who stated Michelle had come to her address stating she wanted to kill herself. The Police arrived and spoke to Michelle who had returned home. Michelle stated she was very upset and said she was dying so wanted to end it. However, her neighbour stated that Michelle had asked her

	to call the mental health team however there was no number so asked for the London Ambulance Service instead. Michelle voluntarily went to King Georges Hospital. In November, the Fire Service were called to gain entry into Michelle's property. In December a Multi-Agency Public Protection Meeting was held to discuss the perpetrator it was advised that the Perpetrator was still in immigration detention, however, could be released at very short notice.
2018 **January - July**	In mid-January, Probation had contacted Mental Health Services informing Michelle's Community Psychiatric Nurse (CPN) that the Perpetrator would be released in several days' time. The Community Psychiatric Nurse advised she was seeing Michelle in two days. The Victim Liaison Officer explained that she would try and reach Michelle the next day. Two days later a letter confirming imminent release of the perpetrator was sent to Michelle. Six days later Probation had contacted Mental Health Services with an update that the Perpetrator would not be released. However, two days after Probation had contacted the Community Psychiatric Nurse to advise that the perpetrator would be released the following day. Probation contacted the Police confirming that the release of the perpetrator would be the following day, and that he would be subject to electronic monitoring. One day after the perpetrator's release, license conditions were confirmed. Sixteen days later a letter was sent to Michelle informing her of the release of the perpetrator. Approximately two months after his release the perpetrator was subsequently recalled for breach of Approved Premises rules. Eleven days later Michelle received a phone call from the Police to advise her that the perpetrator was back in custody, a letter was sent to Michelle advising her of a right to prepare a Victim Personal Statement. Within a three-month period three Merlin reports were received. Police had attended Michelle's home where she appeared to be very tired and did not really want to engage with officers verbally. Michelle stated her umbrella was damaged and that she believed that it was her neighbour who did the damage. Officers looked at the garden umbrella and it was not damaged. The fabric had just come away from the spikes. The second Merlin report received recorded Michelle being the victim of theft. Michelle apparently gave her bank card to a known male to get £10 out of her account for her, but the male had taken approximately £400 out of her account without Michelle's knowledge or permission. The report advised that Michelle suffered ill health and mental health, and that she appeared to be housebound now and relied on others to get her shopping. The third Merlin report recorded Michelle had believed that she had been burgled however the Police Officers attending believed that Michelle was suffering from mental health illness as there was no sign of any break-in.
2019 **January - July**	Michelle was allocated a Support Time Recovery (STR) worker under the community recovery team (CRT)and advised that her long-standing Care Coordinator (CCO) was retiring, which she was initially quite distressed about. A newly allocated Care Coordinator was assigned to her under the Barking community recovery team which she expressed displease about, as she only wanted her original Care Coordinator to support her. At the start of the national COVID-19 pandemic, home visits were not achieved as frequently, in part due to social distancing measures. Some contacts were delivered over the telephone, but the community recovery team continued to support with collecting medications and supporting with food packages, as required. A Merlin report was received. Michelle had called the Police and stated that she had been burgled and no longer wanted to live. The Merlin noted that, Michelle was extremely well known to the Police, and that there were several Merlin's due to her mental health, the records also noted that she had a diagnosis of schizophrenia, multiple personality disorder and epilepsy and that she was terminally ill with emphysema. The Merlin alert was sent to Michelle's Care Coordinator. Five days later the Fire Service had attended the address to gain entry into the property, and they attended once again eleven days later. Following the Merlin alert approximately a month later, Adult Social Care duty screening had assessed that Michelle 's case was of mental health need rather than a social care need and that the Mental Health Social Care Team would not take any further action. Liaison between Adult Social Care and the Mental Health Team, took place where the Care Coordinator reported Michelle's history, Michelle's home was described as a 'drugs den' and Michelle had a £80-£90 cocaine and heroin addiction. Drug use was

	evident in the home as there was drug paraphernalia such as, foil length lines, syringes and broken pipes. It was decided that the Care Coordinator would conduct a joint visit with the Social Worker. Seven days later, a joint home visit was conducted between the Social Worker and the Care Coordinator. Michelle opened the door after the Social Worker and Care Coordinator had waited for a period of time, she then laid on her sofa and fell asleep. It was decided that Michelle lacked capacity to engage, as the Care Coordinator believed that Michelle was under the influence of drugs (heroin). On the visit it was noted that the home was very unkempt, there was dog waste on the floor, the floor and the furniture were not clean and there was old food, cigarette buts, ash and drug related paraphernalia (crack pipes, tin foils and lighters). There were weapons such as knives, screwdrivers and a hammer in the home which the Care Coordinator moved. Michelle had locked her doors by placing furniture to jam the door, and a risk in the event of an emergency was identified. Due to Michelle being asleep, another visit was planned for another time.

August - September	Approximately a month later, another joint visit was conducted, between the Social Worker and the Care Coordinator. Michelle presented unkempt, she was wearing clothes that had stains and records stated she carried a strong unpleasant odour. Michelle explained that due to her epilepsy and her health in general she passed out often, and she attributed this to her drug intake, she stated she was fearful about herself and said she was "scared" that if she was smoking in the home, and she fell unconscious the house would set on fire, and she was scared for her dog and her fish. Advice was given about smoking outside, which Michelle stated she did not like to do but would try it. The Social Worker asked Michelle about what outcomes she would like from the safeguarding. Michelle asked what options are there? The Care Coordinator explained that a heat sensor fire alarm would be a good option as the alarm detects a change in temperatures and would call the Fire Brigade immediately. The Care Coordinator advised that a key safe would be another good option because Michelle has been locked out of the home in two instances as she left her key in the home. Michelle agreed with the two options and said she would like that. She then showed the Social Worker her bathroom, which was cluttered, and said she was scared to have a bath because she felt that if in any instance, she "passes out" it may cause her to have a head injury if, for example, she hit her head on the sink. It was recorded that Michelle's home was extremely cluttered, which in the event of a fire would cause concern, and that there was a high risk of catching fire due to Michelle smoking in the home and the clutter in the home. Eleven days later the Social Worker sent an email to the Fire Brigade, and two weeks after the home visit a referral was sent to install a key safe. The safeguarding referral was closed, and reports denote that Michelle's desired outcomes were that she wanted a key safe fitted into her home which had been completed, and she would like a smoke detector alarm fitted into her property which was currently in process. A further home visit was conducted, Michelle let the Social Worker and Care Coordinator in however, she could not be roused so another visit was arranged for five days later. At the visit, Michelle fell fast asleep on the sofa, so it was agreed another visit would be convened two days later. At the visit, Michelle was alert and busy with her flat and garden, and an assessment was completed. At this time a parole date for the perpetrator was set.

	Probation had contacted the Community Psychiatric Nurse to provide an update, it was agreed that the letter would be sent to the Community Psychiatric Nurse because Michelle lost letters and the Community Psychiatric Nurse would post the letter to Michelle. Three weeks later Michelle contacted Probation advising she had just received the letter and was very fearful that the perpetrator had been released. Michelle was advised that he was still in custody but if at any time she feels worried to call the Police first, then the Voluntary Community Services. Probation made a further call to Michelle to reassure her and advise her verbally that the hearing had been adjourned, and that her Victim Liaison Officer would be contacting her with a new date of the hearing when

	available. Just over a month later, Michelle had contacted Probation and expressed concerns for her safety and made allegations that the perpetrator had been making threats to throw acid in her face. She was in fear for her safety; she stated that people that had been in prison with the perpetrator had been coming out to tell her. She also stated that the perpetrator was recalled due to stalking her. Michelle expressed that she wanted him to be deported and disclosed that the Home Office did not execute deportation in time and so was unable to deport him. Michelle made threats to kill herself if the perpetrator was not deported. Michelle's Care Coordinator had spoken with Probation and advised that some of what Michelle discloses are facts mixed with delusion. The Care Coordinator advised that Michelle is likely to be using Class A substances, and that she will be visiting Michelle in four days' time before she begins to use drugs in the morning. The Care Coordinator informed the Probation Officer, that she will be leaving the service, and this may cause Michelle's behaviour to change (negatively), she provided a number for the office. It was agreed that Probation would disclose the allegations to the Offender Manager for further investigation. At this time, an email was sent by the Social Worker to a care company with a request for a three hours per week care package. Three months following the request for a care package to the care company it was identified by the Social Worker that the care package was not actioned, it was recorded that this was due to, Michelle's reluctance to engage and Michelle's Care Co-ordinator leaving. The Social Worker advised that Michelle's case could not be kept open to social care for long, as they did not hold cases, but would discuss the case in supervision with a view to closing the case to social care. The Victim Liaison Officer made contact with Michelle's new Care Coordinator to discuss how to effectively liaise with Michelle. It was agreed that the Care Coordinator would give any letters to Michelle during the home visits. Two months later Michelle had contacted Probation. The Probation Officer asked if Michelle had filed a Police report in regard to the alleged threats the perpetrator had made. Michelle stated that she wanted a panic button in her home. The Probation Officer advised Michelle that it is possible the allegations would be shared with the parole board and the perpetrator may have sight, so it was important that processes needed to be followed, in regard to reporting to the Police. Michelle stated that her former Community Psychiatric Nurse and Care Co-ordinator was aware of the allegations and Police report (the Care Co-ordinator had now left the service). Michelle became upset with the idea of going to the Police again and stated that she had a court case against the Police due to allegedly sustaining injuries after an engagement with them. Michelle had muted the call with the Probation Officer and then disconnected. The Probation Officer called Michelle back, a male who gave his name came on the line and stated that Michelle wanted the perpetrator deported, Michelle was in the background shouting and making threats to record the conversation on Facebook. It was recorded that it had been difficult to engage with Michelle due to being informed by the Community Psychiatric Nurse that some of what Michelle says can be fact mixed with delusion, and therefore the Probation Officer stated that they could not assess what is fact and what was not. The allegations had been referred to the Offender Manager who commented that they are serious allegations, and they need to be investigated by the Police if they have not been fabricated. Ten days later a safeguarding concern was raised. Michelle informed the Social Worker that the male had showed up at her house address whilst the Police were there, and he agreed that he would pay the £70 he owed to her. Michelle also stated that the male had a spare key and kept visiting her family in her absence, when she was asked how he had a key in his possession Michelle became upset and cut off the call. Two weeks after the safeguarding concern there was a further Merlin received - Michelle rang the Police to report a burglary for her medication and reported that Boris Johnson had stolen this.

2020 January - September	In early January, a review by Adult Social Care took place, it was identified that Michelle did not have a care package in place and that it had never started, records stated upon further exploration the previous worker had made contact with community recovery team due to

	Michelle not engaging (in September 2019) and suggested that they re-refer at a more appropriate time. At this time two Merlin's had been received. One related to a burglary that reported that Michelle's keys and medication were stolen and one log identifying that Michelle's case was open to the community recovery team and would therefore be closed to Adult Social Care. Michelle continued to contact Probation as she wanted information about the perpetrator's parole. The parole board confirmed the hearing date was 12th May 2020. In April, Michelle contacted the GP via a telephone consultation, she was believed to have sounded psychotic on the phone and was crying that she was in pain as she had been attacked by the Police viciously two years ago and they had broken multiple bones. She also stated that she was sexually assaulted by ambulance staff recently and that she is being spied on. The GP called the Mental Health Team with an update. In May, Michelle was contacted by Probation via telephone and informed of an oral hearing, it was advised that Probation would keep her updated on the outcome. Michelle wanted to ensure the conditions had been requested on her behalf. In May, the Fire Service was called to gain entry to Michelle's home. In September, Michelle was restrained by the Transport Police as they believed she was going to jump from the train. At her request she was taken to her sister's home as she felt unsafe in her own home. Michelle contacted the GP surgery to say that she tried to take her own life at Barking station yesterday. She stated that she is having problems and has moved away from home. She wanted to speak with her GP for extra medication and a letter to help her move away, as it was impacting her mental health. Following this, a receipt of a safeguarding concern was received by Adult Social Care from the British Transport Police, the referral stated Michelle tearfully divulged that she met a gentleman recently (a name was provided). He gained her trust by telling her he was from the church. He came back to her flat, and he undressed, groped her, and tried to force himself into bed. Michelle also reported that he smashed her phone, and that he had refused to leave her alone for several days. Michelle also reported a gentleman continued to knock at her door she stated, "*he left his wallet and keys here. I think he wants to get them*." Michelle expressed that she feared for her safety. At around this time, it was reported that there were issues with neighbours.

October - December	A Section 42 Safeguarding Enquiry commenced. As part of this a visit was undertaken to Michelle's home, Michelle's two family members (cousins) were present, and she said she would like them there as she feels safe when they are around. The Support Time Recovery worker and the safeguarding referrer and Police officers were also present during the enquiry. The enquiry closed as no further action for safeguarding, this was due to the risk assessment being inconclusive, as the Police were undergoing an investigation. In November, Michelle had telephoned the London Borough of Barking and Dagenham contact centre and expressed the intention to attempt to take her own life by suicide, stating that her house had been ransacked and that she wanted to leave the property. A safeguarding concern was completed with Michelle's consent. The contact centre was advised to contact the Police. Contact was made with the Social Care Mental Health Team to discuss and an email sent to request urgent intervention from Barking Hospital who currently provided support and care for Michelle. She was referred to the Acute Crisis and Assessment Team (ACAT) sue to increased risks of suicidal ideation. Michelle was visited by a member of the Acute Crisis and Assessment Team (ACAT), a voluntary admission to the hospital was not achieved as she did not allow the team in as she claimed she lost her keys. They discussed in her hallway the outcome of their assessment, that indicated that she presented with depressive episodes, with thoughts of suicidality, however no active plans or intent were present at that moment. There were no reported homicidal thoughts, limited spontaneous interaction, passive aggression and irritability. The outcome was that ACAT discharged her back to Home Treatment Team (HTT) and was due to determine the next course of action, either continuous monitoring or referral to the Approved Mental Health Professional (AMHP) service. Michelle required an assessment and was admitted to hospital. A Merlin report was received due to Michelle stating that she had been burgled and when officers arrived the locksmith was also present and stated that both doors were secure. There

	were no signs of a break in at Michelle's home, it was recorded that Michelle appeared to be suffering from mental health issues, and her property was full of rubbish on the floor, along with broken glass. In early December, a professionals meeting was held, and a Social Worker and Care Coordinator conducted a home visit to Michelle's home to undertake a social care assessment. It was recorded that the house was in a poor state and Michelle appeared unkempt. Michelle explained that she was not happy as she did not feel supported by her Care Coordinator. Michelle wanted to move from her current property and was hoping to move to North London. Michelle stated that she needed support and that she was struggling with everything. Michelle wanted to move to accommodation where she is able to take her dog with her. Six days later Michelle was tearful on the phone. She reported that she could not return to her flat because she had been burgled and that the whole flat had been trashed. Michelle stated she had last stayed at her flat six to seven weeks ago. She reported that she had been sleeping rough. Michelle was advised to attend John Smith homeless unit to discuss her accommodation for prompt support. The following day, Michelle called to advise she was taking her dog to a family and was going to take her own life, she stated she was fed up with people not helping her with her housing issue. Michelle advised that a day prior she was told to go to John Smith House for assistance as she had to walk, she was wet right through and cold, only to find the site is no longer open and all contact is made by phone. Michelle stated this is all pushing her over the edge and that she has a member of parliament's support. The Mental Health Duty Team recorded that they had tried to make contact with Michelle that day, however, Michelle was upset and seemed to be slurring, she then passed the phone to a man who said, "We are fed up with keeping repeating the same thing". Police arrived and noted the house was in a poor state, with rubbish and mud on the floor. She was feeling low and said she couldn't cope. She declined Ambulance Service treatment. Further housing problems were reported due to the neighbour.

2021 January - March	Throughout 2021, Mental Health Records denote Michelle continued to be visited frequently by her Support Time Recovery worker in the community recovery team. Her involvement with her Care Coordinator was limited to telephone communication, as her Care Coordinator. was self-isolating during the COVID-19 period due to personal risk factors. Michelle had frequent visitors to her flat, who she would often describe as 'family members', however, this was not usually corroborated. The Housing Team set up floating weekly support to help Michelle with cleaning her home and there was evidence of communication between the community recovery team, Support Time Recovery worker and housing services. However, Michelle's engagement with her medication regime continued to be sporadic and she lacked consistency in engaging with the housing services and floating support. Michelle was liaising with social services with a consideration to rehouse Michelle in supported accommodation, however, this was not achieved as she was keen to have her dog with her which led to significant limitations of rehousing opportunities. In early January a professionals meeting was held for Michelle, and it was agreed, that a capacity assessment in regard to both her finances and her living situation would be undertaken. In February Michelle had reported no heating in her home. Michelle had gone to the GP surgery to collect medication, but the surgery did not issue any medication as a letter from Mental Health services had been received that stated not to provide any medication. Michelle stated that she was going to jump in front of a train. Police Officers located Michelle at the surgery, and she was very emotional and initially did not want to speak to them, she explained that she had not been prescribed her usual medication as the Hospital (Goodmayes) had made an error which meant she could not collect it. She explained that she was having withdrawal symptoms from not having her usual tablets and that she desperately needed them as it was making her feel extremely ill. She was advised that seeking help at Accident and emergency would be the best thing to do and she agreed to an Ambulance taking her to King George Hospital. Following the joint visit to assess Michelle's capacity it was established that there was no reason to doubt her capacity. However, the

	capacity assessment identified she makes unwise decisions with her money. Housing had indicated that there is no significant evidence that she is at risk in the flat. Due to there being no risk re-accommodation in another flat could not be undertaken. Currently, the plan was for support to be put in place to clean her property, and this was to be reviewed in view of the decision for a transfer for re-accommodation to another flat. A care package commenced support for two hours once a week, single-handedly for domestic care, to help keep a habitual environment. Michelle had agreed to a new referral to Change, Grow, Live (CGL) who provide drug and alcohols services and support, and a hardship fund payment was provided. Michelle advised the Housing Officer, that she was really frightened last week when a man approached her house at 4am in the morning asking for paid sex. She had a friend with her who recognised him. She had a part recording on the phone, the Housing Officer advised, she would inform the Police. Michelle also advised that she had an epileptic fit where she hit her nose on the wall in the living room. Housing issues with the behaviour of the tenant and condition of the property were reported and the Fire Service was called to gain entry into the property.
May - June	A six-week review was completed that concluded that Michelle's current support was effective and reported that Michelle was doing well. A review was scheduled for one year. Michelle had received correspondence from Probation services that had unsettled her and raised concerns about her mental state, her dog was also ill, and this has also affected her, she advised that she left the house last week and will not stay there in case the perpetrator comes. It was explained that the letter stated a release date of 2023, but Michelle was convinced that he will be out, and his friend had come to the house two weeks ago, and she wants to move to Canning Town as she has family there. Professionals were not aware of the actual conviction. A referral was made to Multi -Agency Risk Assessment Conference from Tenancy Sustainment. The case was heard at the Multi -Agency Risk Assessment Conference, due to Michelle receiving a letter from probation with regards to a perpetrator being released early. It was advised that the perpetrator had raped and poured boiling water over Michelle. Michelle stated that she felt safer sleeping on the streets rather than in her own home. **Actions set at the MARAC meeting were as follows:** To make a new referral to Change Grow Live To follow up with probation as they had connection issues at the meeting today Housing to share new phone number with Refuge To share info on perpetrator's name and offence with housing Michelle was not reheard at Multi Agency Risk Assessment Conference, Michelle was being supported by Thames Reach, a London-based charity dedicated to supporting homeless and vulnerable adults. A mutual exchange had been explored, but it was felt Michelle would not meet transfer threshold. A safeguarding referral was made for Michelle as she had disclosed, that she felt suicidal. At this time carers were not attending. The manager at the care company who provided cleaning services to Michelle, advised that they have been going but Michelle would not allow them to clean. Michelle had made a complaint about the conduct of a member of the housing staff. Michelle was now engaged by outreach rough sleeping, she was supported to return home. A new carer was assigned to Michelle, to support her clean the flat, the new carer mentioned that Michelle was always intoxicated with alcohol, her flat was always in flames due to cigarette and weed smoke, there was also a man in her flat, but they are not sure if he lived with her. There was telephone contact from Police in relation to Michelle, the Police Officer reported the continued issue with Michelle wanting to leave her current home. Housing was contacted by Mental Health Services as Michelle had reported sexual assault. On December 25th, the Fire Service were called to gain entry into the property. GP records denote that two weeks prior Michelle alleged rape and she advised that the Police were due to make an arrest. On the 31st December Safeguarding Duty Response advised that a safeguarding concern was raised but it did not meet the threshold for a Section 42 enquiry and so there was no further action taken.

2022 **January - April**	In early 2022, Michelle continued to be supported by the community recovery team She engaged minimally with the Support Time Recovery worker and her Care Coordinator (CCO) and accepted the blister packs of medication that they collected and delivered to her. However, she was described to appear gaunt with weight loss, and she did not agree to engage in a physical health review. All staff that knew Michelle knew that she preferred to have her physical health managed by her GP who knew her well. In mid-January the Fire Service was called to gain entry into property. Michelle's Care Coordinator (CCO) was changed in March 2022, and she continued to be seen regularly by her Support Time Recovery worker for some consistency. In March, Michelle accused a man of taking some money and holding him hostage for two hours and threatened him by getting her cousins down to beat him up. The Fire Service was called to gain entry into the property. A joint visit was planned with the Antisocial Behaviour Officer (ASB) from the London Borough of Barking and Dagenham (LBBD), with a plan to meet Michelle at a local library. When Michelle did not show up, staff phoned her and she was upset stating that she had a mice infestation. The Care Coordinator visited her at home and noted evidence of mice activity. The Care Coordinator contacted the Landlord Service Manager and enquired whether Michelle could be temporarily moved whilst the property was treated, however, this was declined by the Local Authority. The Landlord Manager advised that he would look into pest control, a deep clean, and whether sheltered accommodation could be provided. Michelle declined the suggestions provided. The Care Coordinator liaised with Social Services to ascertain plans to have her flat cleaned. There was evidence that the Care Coordinator attempted to liaise with the council regarding issues with Michelle's property, but it was recorded that there was little response. In April, a safeguarding concern was received alleging financial abuse, as Michelle's debit card was stolen and used. A joint visit with Housing and an Anti Social Behaviour Officer to support a vulnerable tenant was actioned, and a Merlin was received. Police were called to Michelle's home address after she triggered her intruder alarm. When at the address there was a wooden slatted structure covering the front door which was open. Michelle was safe and well inside the address. Michelle thought someone had broken in seconds before the Police arrived. Michelle engaged in a Care Programme Approach (CPA) meeting at her home address, she was met with her Care Coordinator and Doctor. Michelle presented as paranoid, complaining that her neighbour put mice in her home. The impression was ongoing substance misuse, poor compliance with medication, and dissatisfaction with mental health services. The plan was to monitor medications, remove previous dosette boxes and encourage engagement with Change Grow Live. A safeguarding referral was made due to Michelle, loaning out her bank card along with not having it returned. Michelle informed the Safeguarding Enquiry Officer that she did not want a visit along with expressing thoughts that she could not stay in the flat, and abuse by Police. She appeared to be mentally distressed. The care company reported that Michelle would not let the carers gain access to her property even though she was at home. This behaviour was mostly when she was intoxicated with alcohol. Michelle received a letter in error from Probation, stating the perpetrator in her case would be applying for Home Detention Curfew. The Probation Officer reassured her that the letter was sent due to an administrative error. It was reported to the Victim liaison officer that Michelle was completely overwhelmed and that it was clear that she was not receiving the support she so desperately needed. The Victim Liaison Officer was advised to make a Victim Support referral to start the process of getting the assistance she needed as a vulnerable adult. The Probation Officer contacted the Community Psychiatric team who was supporting Michelle, to advise about Michelle speaking about suicidal thoughts, the nurse confirmed they would do a welfare check on Michelle. Michelle was visited by her Support Time Recovery worker. Pharmacy staff had reported to the Support Time Recovery worker that Michelle had collected her other medications, and they had no concerns. Michelle's cleaner was present and reported that she witnessed Michelle appear to collapse last week. She had been well since with no lasting issues, the cleaning Manager had encouraged Michelle to seek medical attention, but she had declined. Michelle did not engage

July and August	in efforts to discuss possible causes for her collapse, and she was advised to see her GP. Drug paraphernalia was observed by the Support Time Recovery worker. Michelle had called Probation Services and was very distraught. She was asking for help and stating she didn't feel safe in her home. The information was passed to the Victim liaison officer (VLO). The Victim liaison officer (VLO) explained that Michelle had called her stating concerning things such as she believes that people have stolen her house keys and then come back to property and returned them, it was recorded that she had paranoid statements. Possible low mood but she was not saying things to suggest imminent intention to harm herself. It was also recorded that her behaviour could be exacerbated by illicit drug use. Mental Health services had been informed, and they confirmed they would conduct a welfare check. The Care Coordinator received an email from the Housing Officer to advise that Michelle had requested a transfer due to ongoing disputes with her neighbours. Michelle advised that she had reported incidents to the Police and the Housing Officer advised that she would request the Police report to ascertain whether there was enough evidence to take the Michelle's case to the Management Transfer Discussion. Michelle had a friend with her who spoke to the Housing Officer and advised that Michelle would be staying with her. Michelle was advised that she would not be moved as there was limited housing. The Housing Officer advised that she would chase up the repairs to the front door. In June, Michelle was visited at home by her Care Coordinator, she appeared unkempt and took a while to answer the door as she reported she was asleep. She reported that she attended hospital two days previously following a fall and she had an x-ray, but self-discharged as she was recorded to state that she would be detained. The Care Coordinator encouraged her to continue to seek medical support and have the investigations completed, which she reportedly agreed to. Michelle thanked the Care Coordinator for phoning her on her birthday. The Care Coordinator recorded that her flat appeared unkempt and there was evidence of needles. It was recorded that Michelle allowed vulnerable people into her flat, she was recorded to have capacity to make decisions. Michelle was visited weekly by her Support Time Recovery (STR) worker and Care Coordinator. Her cleaning was recorded to have been reinstated, and it was recorded that the housing association was emailed due to concerns from Michelle that mice were an ongoing issue. In July and August, Michelle called the Police twice. She stated that someone had broken into her home address and was standing over her, she also requested an ambulance as she had a bleed on the brain. Michelle appeared confused when speaking with Police Officers and her home address was very untidy, it is recorded that she was very thin and frail but could move around with no issues. Michelle initially stated that she had a knife and when Officers attended there was a set of knives on the edge of the sofa there was no signs of a break in and this information was shared with Adult Social Care.

	The Care Coordinator visited Michelle at her home. Michelle reported that she had been taken to hospital via an ambulance and had spent four days in there. She had put her dog in foster care for the duration, but she was feeling better, and her dog had been brought home. A joint visit by Michelle's Care Coordinator and Support Time Recovery (STR) worker was made following a complaint made by Michelle regarding her care. The Care Coordinator recorded that the claims made by Michelle were untrue. During the visit, Michelle denied that she was upset and advised that she was tidying up. At the visit, the bank called her, and he was able to liaise with them on the phone. Michelle appeared unkempt, but the Support Time Recovery (STR) worker recorded that there was evidence of recent cooking and no evidence of severe self-neglect. Michelle stated that she allowed a female associate to stay at her home address for the evening and that the female had stolen her phone and run off. Michelle was seen by officers who described her as appearing confused and would often go off topic of conversation. Michelle was also described as being very frail, skinny, confused and paranoid. She stated she had been diagnosed with bowel cancer and was on various medications, this information was shared with Adult Social Care. Michelle continued to be seen regularly by the

	Community Recovery Team (CRT). She claimed that she had been broken into, but an email from the housing service advised that Michelle had not filed a Police report about this, and the Police had not attended her property, which was contrary to her claims. In August a Merlin was received, Michelle stated that she let her friend stay over as she had nowhere to go, and Michelle felt sorry for her and wanted to help. Michelle was sleeping on the sofa when she heard a noise which woke her up and she saw her friend taking her Samsung phone which was on the arm of the sofa next to her and then she ran out of the front door. The cleaning company had contacted Adult Social Care to state Michelle had not been available when they called to clean. Michelle had contacted the care company to state, that she was living on the street because her house was burgled. The Community Recovery Team (CRT)attempted a home visit and telephone call, to no avail. A plan was made to escalate to the Homelessness Team/Police if no contact. The Community Recovery Team (CRT received an email from the cleaning manager to advise that the Michelle had made contact with her via text. She wrote "*I got my phone back, I am really, really NOT GOOD. Thank you for your help and support. I can't go back to that place I'm at the end of the bullying and I'm really finding life more difficult now than ever before, I have to charge my phone then I will give you a call."* The Support Time Recovery STR worker attempted a visit at home to deliver medications, to no avail. He posted her Dossett box through the letter box. He recorded that he had been informed that Michelle was sleeping rough in a tent in a Barking car park. He went to the car park but was unable to locate her, similarly at the station and shopping parade where he recorded that she was known to sleep rough. The Support Time Recovery (STR)worker advised the Tenancy Sustainment Team that the Michelle had a history of sleeping rough in central Barking, and that staff had witnessed a social element to this, for example she will socialise with others, drinking and listening to music. She would return home periodically for food, clothing etc. He recorded that she remained at risk of cuckooing.

	He discussed this plan with the operational lead at the time and agreed to remain vigilant to Michelle's whereabouts. The Support Time Recovery (STR)worker recorded that he saw Michelle at her home address ad-hoc whilst on his way home from work. She confirmed where she was sleeping rough but declined to advise why she was sleeping there. She was recorded to be chronically underweight but confirmed that she was taking protein shakes which were prescribed. The Support Time Recovery (STR) worker recorded that he had updated those involved and chased up repairs to Michelle's door with the housing association. The Tenancy Support Worker reported concerns to the Mental Health Team from the Thames Outreach Worker, who reported that they had found Michelle bedded down in a tent inside a multistorey car park in Barking. She was reported to be very upset, frustrated, in enormous pain and suffering terribly. She advised her accommodation was not safe to return to as she was being targeted, someone is getting in by removing and then replacing the windows, she said she had the Police over multiple times in an attempt to safeguard her, but the problems persist, and she had to remove herself for fear of her own safety. There were also mice running around, which is incredibly traumatising as it causes her to have flashbacks from an earlier incident when she was held captive in a basement. The support worker advised that the car park is not safe, as there are several volatile people residing there, at least one of which is very heavily medicated and chaotic, at least one carries a weapon and there are several heroin users coming and going. The support worker advised that Michelle, was talking about not having much time left, she was in agony with her hip and lower back, as well as her chest (she was struggling to breathe properly as she spoke) she stated she wanted it all to be over, the support worker queried with Community Solutions, what could be done for her, immediately. A meeting was being considered, with Community Solutions, however, it was decided that Michelle's views and wishes, were required before the meeting. A plan to speak with Michelle

	and visit her was agreed, it was felt that simply moving Michelle would move the 'problem'. In addition, it was felt that it was very unlikely that Michelle's pattern of behaviours would change, as she likes to take people home which keeps her at risk. Previously Michelle has refused to consider supported/sheltered or extra care accommodation. A meeting was planned to visit Michelle at 9am 31st August. The following day, the Support Time Recovery (STR) worker delivered Michelle's medication to her through her letterbox, as he recorded that the Support Time Recovery she was known to return home regularly. The pharmacy staff confirmed that she was collecting her remaining medications and protein drinks as prescribed. The Support Time Recovery (STR) worker visited Michelle at her sleep site. He confirmed that her dog was with her and appeared well cared for. Michelle had bedding, a portable charger and phone. She appeared on friendly terms with others in the area and stated she was getting food from nearby shops. Michelle reported that she was sleeping rough due to the state of her flat, referencing the poor state of repairs and issues with her neighbour. Michelle called the Police and stated that her mobile phone had been stolen by a known male, who had stolen it from her before. The Support Time Recovery (STR) worker visited Michelle's sleep site. She was calm and presented appropriately. She insinuated that she was living as she was due to the way the council had treated her.

September	On the 9th September 2022, the Support Time Recovery (STR) worker received a call from the local authority to advise that Michelle had been evicted from the car park. Two days later the Police were called by Michelle outside the Job Centre in Barking, she stated she had been robbed and assaulted. She was displaying signs of being under the influence of drugs and/or alcohol. She stated her phone was taken but she was still in possession of it. Michelle had a small laceration on her hand, which appeared old, and she stated that she had nowhere to live and was essentially homeless. She also stated that she only weighed 4 stone. Michelle was taken directly to hospital by Police. This was shared with Adult Social Care. 12th September 2022 Michelle attended the Emergency Department at Newham University Hospital. She reported chronic hip pain and had investigations undertaken by the Orthopaedic Team, whereby she was discharged from their services. Michelle could not be discharged from the hospital as she reported that her house keys had been stolen and she was living homeless due to this. It was recorded that she would benefit from a package of care. On 13th-14th September 2022 Michelle remained an in-patient in hospital awaiting social support. On the 14th September the Fire Service was called to gain entry into the property. The following day, on the 15th September 2022 it was recorded that Michelle had discharged herself from the hospital and returned to her flat. It was recorded that she advised the Housing Team that she left the hospital because she did not want to wait and wanted to see her dog, who was being returned to her in the morning. She was not keen to stay at the flat but was not sure where to go. An email from the Mental Health Social Care Team (LBBD) was recorded within the Electronic Patient Record (EPR) that indicated that their involvement had ended, but recorded that a new front door was ready, as per housing involvement but that Michelle needed to be present to have it fitted. It was noted that Michelle had not agreed to be moved and her cleaning had been reinstated to 2 hours per week. The Social Worker requested that Michelle was seen by the Community Recovery Team (CRT) and her responsible clinician. Michelle had an unplanned home visit by her new Care Coordinator. The Care Coordinator introduced herself and asked whether Michelle could meet her next week. A meeting was scheduled for the 20th September. Barking Havering and Redbridge Discharge Hub sent an email to housing services to arrange a package of care. Michelle was visited at home by her The Support Time Recovery (STR) worker. She appeared reasonably clean, although she was wearing dirty clothes. Her medication was provided. Her front door remained damaged and she was advised that housing had been alerted. It was recorded that Michelle also had contact with the Housing Tenancy Sustainment Team. Michelle stated that she did not plan to stay in her home but would not advise where she would be

	going. Her presentation was recorded to be normal for her, and no immediate concerns were noted.

September	**16th September – 21st September 2022** The Hospital Discharge Service at Newham Hospital liaised with the Community Recovery Team CRT to ascertain whether Michelle required a package of care. The Support Time Recovery (STR) worker contacted the cleaning manager to advise that Michelle was back home, and the manager agreed to reinstate care twice weekly. **21st September 2022** Michelle was visited at home by her Care Coordinator. She reported two issues: 1. She does not want to live in her current accommodation due to it being in disrepair and she reported that she was not being listened to when she asked for a transfer. 2. She does not want to stay in Barking and Dagenham and would prefer to move to Bow where came from. Michelle reported that lies were being said about her, and the Care Coordinator agreed to liaise with the Tenancy Sustainability Housing Officer. The Care Coordinator observed a large bruise on Michelle's face, to which she reported she had seizures occurring 'all the time'. **23rd September 2022** Michelle was visited by her Care Coordinator to no avail. She had her medications posted through her letter box. The Care Coordinator engaged contact over the phone, however Michelle advised that she was staying at her daughter's house. Michelle reported that the medication was not working, and she continued to hear voices, stating that the 'IRA were following her'. A medical review was planned. She was recorded to sound fine on the phone. **29th September 2022** Michelle was visited by her The Support Time Recovery (STR) worker. She drew attention to several things that needed repairing, including the boiler which had been decommissioned by the Council. She reported that housing was aware. The front door continued to be damaged and did not lock. The Support Time Recovery (STR) worker recorded that housing had been chased regarding the door and were awaiting updates from the contractor.
October	**7th October –11th October 2022** Michelle was visited at home and spoken to via telephone. No change was noted. She was advised about her planned doctor's appointment on the 13th October but reported she wanted to see a consultant she had seen several years ago. **13th October 2022** Michelle attended a medical review at her home. Present was the Michelle, the Community Recovery Team CRT consultant and the Care Coordinator; Her history was noted. New issues were noted to be that she was feeling physically unwell and was losing weight. She complained about old grievances, often appearing to confabulate. The Fire Service was called to gain entry into the property. **20th October 2022** Michelle was visited at home by the Support Time Recovery (STR) worker, her Dossett box was provided. The Support Time Recovery (STR) worker recorded no concerns about behaviour or speech. The Support Time Recovery (STR) worker noted that Michelle was wearing lightly soiled pyjamas, with some blood on the top which Michelle reported was from a nosebleed. The Support Time Recovery (STR) worker recorded that Michelle's clothing made her seem Michelle emaciated than usual and there seemed to be a slight grey tone to her skin. However, she was recorded to possess her 'usual apparent vigour'. The Support Time Recovery (STR) worker noted the recent medical review which also noted Michelle's emaciated state, her Care Coordinator was recorded to have been updated**.**

October	**28th October 2022**

	The Care Coordinator had visited her and enquired if Michelle had visited her GP, she reported that she had attended her GP on Tuesday that week. Michelle called the Housing Team as they had not returned her call. She was advised that they were still looking for her file. The Care Coordinator suggested that she schedule a visit to attempt to engage with housing, but Michelle became hostile and aggressive to the Care Coordinator. Michelle stated that she was recording the call and became aggressive, stating that she did not like the Care Coordinator and that she would 'put her in a corner'. A joint visit with a Landlord Services Officer regarding the boiler and condition of the property was undertaken.
November	**4th November 2022** The Support Time Recovery STR worker visited Michelle at home to deliver her Dossett box. Michelle advised the Support Time Recovery (STR) worker that the Fire Service had visited her that morning. Her neighbour joined the conversation and said that Michelle's fire alarm was heard in the morning, and she had called the Fire Services. Michelle had allegedly fallen asleep whilst leaving a pan on the stove, which had caused it to smoke. The Support Time Recovery (STR) worker recorded that there was no sign of fire damage, but a slight smoke smell was noted. The Support Time Recovery (STR) worker recorded that it was unclear whether Michelle was intoxicated at the time. Michelle reported that she had found a solicitor to support her in suing the local authority for neglecting their landlord's duties. On a visit, the Support Time Recovery (STR) worker observed a slight tremor, which Michelle denied. The Support Time Recovery (STR) worker recorded that it may have been due to the cold of the doorway but advised her to see her GP. The Support Time Recovery (STR) worker recorded that Michelle's home was dirtier than usual. Michelle complained that the cleaner was not doing her job and had raised this with the agency. The plan was for the Support Time Recovery (STR) worker to continue to discuss the pattern of visits with the newly allocated Care Coordinator. The Fire Service was called out within four days of one another. A newly allocated Care Coordinator (CCO) from the Mental Health and Wellness Team (MHWT) contacted Michelle by telephone to introduce herself. A voice message was left. **11th November 2022** Mental Health Duty confirmed that the care package was suspended but has since been restarted. She informed that Michelle continues to bring items into her property and the carers visit to assist with tidying up. The new Care Coordinator attempted contact with Michelle via telephone, to no avail. She emailed the Support Time Recovery (STR) worker to ascertain a plan for a joint visit so that the STR worker could introduce her to Michelle. The Support Time Recovery (STR) worker recorded that he received an email from the Local Authority to advise that Michelle was showing signs of deterioration following a recent visit. She attached photos of syringes and drug misuse and advised that she planned to arrange a professionals meeting. The Support Time Recovery (STR) worker was recorded to advise that he had emphasised to the team the risks from Michelle's chaotic lifestyle were present and acknowledged. A joint visit with the new Care Coordinator was planned for the 21st November.

November	**17th November 2022** The Mental Health Duty Team made a telephone call to the care company to inquire about the state of hygiene in Michelle's property, who advised that despite cleaning Michelle's flat, it is always dirty and even if domestic care is commissioned every day, Michelle will still not keep her flat clean. An incident happened when the carer attended and they found a knife on the floor and when the carer attempted to pick it up, Michelle became very upset and presented with aggression that the knife should be left on the floor. She advised she would send an incident report. **21st November**

	A joint visit was attempted by the new Care Coordinator and Support Time Recovery (STR) worker at to no avail. A piece of wood was recorded to have been placed over the inside of the letterbox, preventing the Support Time Recovery (STR) worker from posting Michelle's medication. The lights in her property were on and Michelle's dog was heard to be yapping and restless. Her handbag was noted to be hanging on the back of a door. Neighbours reported that they had not seen or heard from Michelle in several days, but her dog had been barking loudly at 5am. The pharmacy reported that they had not seen Michelle for the last 10 days, since she collected her protein shakes. The Support Time Recovery (STR) worker noted that Michelle's physical health medications had been sent to a different pharmacy for over a year, for reasons unknown. The Support Time Recovery (STR) worker requested a welfare call from the Police, given the increased indications of vulnerability recently. It was recorded that the Police visited Michelle's home at 5.30pm. They advised that Michelle was not at home and that they knew her well, indicating that perhaps she had gone to live on the streets of Barking again. The Support Time Recovery (STR) worker recorded that her medications had been left at work premises. **22nd November 2022** Michelle called the Police and stated she thought someone was trying to break into her property. Her speech was slurred, and she appeared under the influence of drugs, she was dressed in a hospital gown and still had the ESG stickers on her person. Michelle stated she had been at Queens Hospital and had been diagnosed with cancer, the officers confirmed that Michelle hadn't left before treatment, she appeared to be suffering from harmless delusions, and she is described as being very thin and frail and her home address was very untidy, this information was passed to Adult Social Care. The Mental Health and Wellness Team received a call from the street vet to advise that Michelle had been admitted to Queens Hospital as she was physically unwell. Her dog had been on the property alone for a few days. The vets were happy to look after the dog but needed access to her property. An email was sent to the clinicians involved in Michelle's care. The Care Coordinator then liaised with the Police who ascertained that the dog was in their kennels. The vet was provided with this information. The Support Time Recovery (STR) worker liaised with Queens Hospital who confirmed that the Michelle was an inpatient and that there was no imminent plan for discharge. The Support Time Recovery STR worker shared contact details for the team and asked that they call the Mental Health Wellness Team before discharge. **25th November 2022** Michelle was visited by the Queens Hospital Psychiatric Liaison Service (PLS). The referral had been initiated by ward staff regarding the management of challenging behaviours and the appropriateness of 1:1 supervision given the risks.

	28th November 2022 Michelle's case was discussed in the Psychiatric Liaison Service Multi Disciplinary meeting, with a plan for the Senior House Officer (junior doctor) to review Michelle on the ward. The Senior House Officer (Senior House Officer -junior doctor) recorded that she was short-staffed medically, and the case had been allocated for her to review. It was noted the Psychiatric Liaison consultant had contacted the pharmacy for advice on medication, but no response had been received so a request was resent, and the team was called via switchboard. One of the lead pharmacists responded with advice regarding antipsychotic medications and blood problems disorders. Police were called by Michelle to report that she felt somebody was trying to get into her house and that she had a problem with her neighbour that had been ongoing for years. On Police arrival, Michelle was very thin and frail. She was very unsteady on her feet and kept slurring her words. She was dressed in a hospital gown, with ESG stickers still attached to her person. **29th November 2022** The Mental Health and Wellness Team Care Coordinator and Support Time Recovery (STR) worker attended a professional's meeting along with the local authority housing team.

	The main points were highlighted as follows: • Repairs to Michelle's property pursued by housing. • Social care referral to review a package of care. Acknowledged the challenges for any package of care to have the desired effect due to Michelle's chaotic lifestyle. She was often noted to admit to deliberately maintaining her home to portray those involved in her care in a bad light. • Formal capacity assessment to be documented with regard to lifestyle choices/making unwise decisions, using her home as a drug den, living on the street. • The outcome of the above will guide housing's decision on whether to enforce a behavioural contract, seek eviction or sheltered accommodation etc. It was then noted that attendees were not aware that Michelle was no longer an inpatient at Queens Hospital. A home visit was scheduled to ascertain whether Michelle was home on 1st December. An urgent medical review was planned for the 2nd December. The Senior House Officer (SHO junior doctor) recorded that she had been unable to see Michelle the previous day due to staffing issues. She planned to review 29th November. She reviewed the East London Patient Record to ascertain medication information. The Senior House Officer (SHO Junior Doctor) visited the ward in Queens Hospital to assess Michelle, but Michelle was not available. It was recorded that the ward clerk advised that Michelle had been transferred to the cardiac care unit but was unsure why this was. It was noted that Michelle had been discharged on 27th November at 1:30 pm from the cardiac care unit. There is no evidence that any NELFT staff were informed of this discharge plan. It was noted that Michelle could be discharged from the Psychiatric Liaison Service but a summary is to be emailed to the Care Coordinator and Support Time Recovery STR worker, to share with the community consultant, which was recorded to be sent at 3:39pm. **30th November 2022** A Merlin was received. Police were called by Michelle to report that she felt somebody was trying to get into her house and that she had a problem with her neighbour that had been ongoing for years. Upon Police arrival Michelle was spoken to, her voice was slurred and was unsteady on her feet, it appeared she may be under the influence of some substance, she stated that she had just been released from Queens Hospital and was wearing a hospital gown she stated she had been diagnosed with cancer. It was checked to see if there were any calls from Queens Hospital to a female of her description walking out recently to which there was none, on the same day, there was a Merlin case note that recorded, a telephone call to the care agency to enquire about Michelle's domestic service. The Care Coordinator was advised about the Merlin report regarding Michelle's extremely messy and very unkempt house. It was advised that Michelle refused to open the door for the carer last week. It was also advised her that the carers should continue to encourage her to accept support from them. No further action was required from the duty officer.
December	**1st December 2022** There was a request for reassessment of Michelle's care needs. The Support Time Recovery (STR) worker and Care Coordinator attempted to visit Michelle's property as planned. Michelle did not appear to be at home. A neighbour informed staff that an ambulance had attended the property in the early hours of 30th November and believed that she had been readmitted to hospital. The Psychiatric Liaison Service was emailed to ascertain whether Michelle had been readmitted. A referral to Mental Health Social Care for a needs assessment was completed. **2nd December 2022** The Care Coordinator was advised that Michelle was in the Intensive Therapy Unit (ITU) at Queens Hospital. She was unconscious and unable to breathe on her own. It was advised for ITU to liaise with Psychiatric Liaison. The Senior House Officer (SHO) liaised with the ITU doctor. The intensive therapy unit (ITU) doctor advised that Michelle had self-discharged home on the weekend and was readmitted in the late hours of 30th November. She was awake, but drowsy and she had presented with neutropenic sepsis, secondary to an anaemic which made her

	immunocompromised. She was also suspected to have a chest infection and had been intubated following difficulties in breathing. A telephone call, with the care company, was made, and the manager, was spoken to. It was advised that Michelle was admitted to the Hospital there was no date of discharge and the cleaners should endeavour to call Michelle first before visiting. There was evidence of liaison between the Queens ITU team, the Mental Health and Wellness Team and Psychiatric Liaison Service. **8th December 2022** The Mental Health and Wellness Team held a professionals meeting with the Housing Team and Senior Mental Health Leads regarding concerns for Michelle's wellbeing if she were to re-attempt to leave the hospital. The consultant shared his concerns with the Psychiatric Liaison Service and was advised that Michelle remained in the Intensive Therapy Unit. The concerns regarding Michelle's risk if she left the hospital were shared with the Intensive Therapy Unit consultant and it was agreed that a capacity assessment would be required before discharge. **9th December 2022 - 15th December 2022** Ongoing liaison between services to advise that Michelle remained intubated and very unwell. **16th December 2022** Michelle sadly died on the morning whilst on Intensive Therapy Unit.

End Notes

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