Kent and Medway Safeguarding Adults Board

Safeguarding Adults Review

Mrs D

D.O.D. 31.01.2016

Executive Summary

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1. Introduction

1.1 This is a summary of the Overview Report of a Safeguarding Adults Review, commissioned by Kent and Medway Safeguarding Adults Board (KMSAB), following the death of Mrs D on 31 January 2016. The KMSAB Decision Making Panel concluded that the case met the threshold for a Safeguarding Adults Review as Mrs D's death was the result of her ending her life in a fire, with concerns for her self- neglect. A Review Panel was established with an Independent Chair, terms of reference for the review were agreed and reports were requested from all the organisations that had been involved in Mrs D's care and support. The period covered by the review was from 1 January 2013 until Mrs D's death. The Review Panel worked from a chronology of the activities of the agencies involved, the reports agencies provided and further information sought for clarification. The Panel carried out its work between May and November 2016.

2. The Background to the Review

2.1 Mrs D was a 68 year old woman who died in her home after setting fire to her clothing. She had a diagnosis of recurrent depressive disorder and emotionally unstable personality disorder (borderline type). She had been known to Kent and Medway NHS and Social Care Partnership Trust (KMPT) since the 1980s and she had a long history of suicide attempts and self-harm. She lived in independent living accommodation with her own front door with 24/7 emergency support available on site. She also received a twice daily care and support package from a separate care company, to assist with her personal care and medication. She employed a private carer to help with her shopping.

2.2 Mrs D's main contact with KMPT services was through the Dartford, Gravesend and Swanley Community Mental Health Team (DGS CMHT). Her other significant KMPT contacts were with the Crisis Resolution and Home Treatment Team (CRHTT) and with the Liaison Psychiatry Services. Borderline Personality Disorder (BPD) is one of the more difficult conditions to manage successfully in mental health and Mrs D was often anxious, distressed and angry. She had a low threshold in tolerating any stressful situation and it would seem that even minor changes in her routine or life would cause her to worry and seek reassurance. As a result she was a frequent caller to the emergency services, mental health services and her care providers. Her treatment plan focused on the importance of self-management. Mrs D was expected to take personal responsibility for managing her symptoms and condition with support from her Community Care Coordinator, the Crisis Resolution Home Treatment Service (CRHTT), her GP, carers and her daughter (Miss B). The plan focused on strategies to prevent a hospital admission.

2.3 In the months leading up to Mrs D's death her condition continued to be unstable and she was repeatedly saying she could not cope and saw being in hospital as the solution. In December 2015 Mrs D was in hospital for thirteen days. She was diagnosed with anxiety, depression and Ventricular Tachycardia, and had a cardioverter defibrillator fitted. Whilst in hospital Mrs D discussed that she did

not want to return home. As an inpatient Mrs D had more one to one care and, as loneliness was a significant trigger to her anxiety, it may have reinforced her need to see hospital as the solution to not staying in her own home.

2.4 By January 2016 there was a noticeable decline in Mrs D's physical and mental health, with particular concerns for her weight loss and poor nutrition, which was observed by her care workers and the staff at her accommodation. She also experienced almost daily episodes of increased anxiety, culminating in excessive calls by her to the emergency services; 51 calls to South East Coast Ambulance Service (SECAmb) and 32 calls to Kent Police.

2.5 Mrs D did not always see the Community Mental Health Team (CMHT) and the Crisis Resolution and Home Treatment Team (CRHTT) as providing a supportive response. Over the last weekend of her life she saw them as obstructive and raising the thresholds for her admission to hospital. On the day Mrs D died she had been referred to, and accepted by, the Crisis Team but she was not visited by the team. She had also not taken her medication as it was missing. It was well documented that any delay in Mrs D receiving her medication increased her anxiety and she kept asking to be taken to hospital. She set fire to her clothing whilst her care worker was with her which the care worker put out. Mrs D later tried to swallow moisturiser cream, a pen and paper. A paramedic attended and liaised with the Crisis Team, the decision was made not to take Mrs D to hospital and a prescription to calm her was requested. Items that Mrs D could use to harm herself were removed by her care worker and the paramedic. Eventually Mrs D became calmer and the paramedic put her to bed. She was left, awaiting her medication from the Crisis Team, but with access to on site staff if she needed them, via a buzzer system in her home. Later Mrs D made several calls to the emergency services threatening to set fire to herself, before eventually setting light to her clothing and killing herself.

3. The Panel's Discussion and Analysis

3.1 It was agreed that Mrs D's case was complex and there were significant risks involved in caring for her over many years. The challenges were in ensuring that decisions made could be effectively communicated to all parties, followed through and that these decisions were in line with her agreed care plan. The key considerations in this analysis were: the effectiveness of inter-agency communication and how information was shared to meet Mrs D's needs; how risks were assessed and managed both in hospital settings and in the community; how decisions were made and what actions were taken at significant points in the chronology; and the use of the Mental Capacity Act 2005. As polypharmacy featured in this case, it merited particular focus. The Review Panel also considered whether Mrs D's death was inevitable at some point due to her long history of self-harm and frequent suicide attempts, and if her death could possibly have been avoided, at least on this occasion.

4. Examples of Positive Practice

4.1 The focus of this Review is on lessons learned and where improvement was required. There were examples of positive practice which included:

- The care workers from Mrs D's care company communicated well with each other. They always reported to their office staff where another agency's services were involved with Mrs D, either on their arrival or during their visit and reported any concerns they had about Mrs D. They were sensitive to Mrs D's need for consistency in supplying care workers.
- The large amount of time, on a very regular basis, that emergency service practitioners, Mrs D's carers, office staff and KMPT practitioners spent talking to Mrs D to try and alleviate her anxiety and provide her with coping mechanisms.
- SECAmb did have Mrs D identified as a frequent caller and she had an Intelligence Based Information System (IBIS) profile set up which was managed and updated by Mrs D's Care Coordinator at KMPT. This profile informed ambulance staff of Mrs D's crisis plan and ensured that she would receive the most appropriate outcome when ringing 999.

5. Conclusions Reflecting the Key Lessons Learned from the Analysis of the Care and Support of Mrs D

5.1 Some of the shortcomings in Mrs D's case are attributable to individual poor practice which included: the recording of concerns with no evidence of any follow up of those concerns; statements regarding intended actions and then a failure to take those actions; normalising and minimising the potential impact of Mrs D's behaviour and poor communication across agencies. Individual poor practice was not the subject of this review process but it highlighted the need for improvements to be made in staff training, individual and agency communications and managerial supervision to address these issues.

5.2 There were a number of missed opportunities to provide better management of Mrs D's needs that may have influenced the course of events. The most significant failing identified by this Review was that agencies did not work in a joined up manner. KMPT, as the lead agency, must take responsibility. Mrs D's Care Coordinator should have identified the agencies and the individuals who had involvement with Mrs D. It was their role to facilitate and seek information about Mrs D and to identify what further support could be provided. Better communication and information sharing should have been in place with all agencies, and as a result KMPT were never aware of the full extent of Mrs D's calls to the emergency services or of her many attendances to A&E, or latterly the concerns for her physical decline. In addition, a multi-agency review of these concerns did not take place.

5.3 During the period of the Review there was only one multi-agency meeting, which was a professionals meeting held in January 2015 after Kent Police had identified Mrs D as a frequent caller to their service in November 2014. Other than KMPT, only Kent Police and Kent Adult Social Services (KASS) attended. SECAmb and

Mrs D's housing provider were unable to attend, but there was no record of any attempt by KMPT at further engagement with these agencies. Mrs D's GP and her care providers were not invited to the meeting. This meeting was a missed opportunity for agencies to really grip this case and ensure that all information was captured and shared, to identify triggers, agree responses to Mrs D and look at what further support could be offered. Actions were set with no timescales, there was no follow up of actions and there were no further multi-agency meetings held. There was a lack of supervision or management oversight of KMPT practitioners adequately engaging with partners, especially as concerns for Mrs D continued.

5.4 No single agency could address Mrs D's support needs but KMPT and Kent Adult Social Services (KASS) never worked collaboratively to provide coordination and resolution for this case. An holistic assessment of need and risk was not achieved or recorded in Mrs D's case by either agency. Mrs D's referral to KASS from KMPT was based on the need for a care package to support her with her physical needs. Although Mrs D continued to be seen by her Mental Health Care Coordinator, at the point of referral best practice would have been to complete a joint risk assessment to identify potential risk factors and management strategies. All future reviews were single agency and there was no evidence of joint working with Mental Health. In January 2015, Mrs D's Psychiatrist identified that she was not coping living independently and an action was given to her KASS case worker to conduct a reassessment of need, but it was not completed. There were two further care reviews in 2015 by KASS practitioners and on both occasions Mrs D spoke of feeling suicidal and not coping. Seemingly, Mrs D's KMPT Care Coordinator was not informed of either incident. The practitioners involved did not appear to discuss Mrs D's risk of suicide with their line manager, nor was the level of risk escalated to senior clinicians. Management oversight should have identified the risk factors documented at the review and triggered an appropriate response.

5.5 There was a further missed opportunity for an holistic assessment of Mrs D's case by KASS in December 2015 when Mrs D was admitted to a district general hospital. She was saying she was anxious and lonely, worrying about debt and did not want to return home. She said that staff from her housing provider did not understand her mental health. She was seen by a social worker whilst in hospital but she was discharged home on 31 December 2015, without a reassessment of her care plan and without a named worker allocated to her case. This hospital admission should have triggered a multi-agency reassessment of need.

5.6 There were many examples of agencies passing on concerns for Mrs D to an individual agency such as Mrs D's GP, CMHT, CRHTT or SECAmb, but it led to incidences being dealt with in isolation, with different presentations being treated separately. Each agency has a responsibility and accountability to ensure that issues concerning the safety and wellbeing of individuals with whom they are working are addressed, and to ensure that actions are taken to reduce perceived risk/concern. In many cases there was no active follow up of referrals, contacts, or concerns by the referring agency. There were also examples of some referrals not in the receiving agencies' chronologies, which may mean that there were occasions when an agency thinks another agency is safeguarding Mrs D when no action was in fact taken.

5.7 There were only two referrals to KASS during the Review period, which were both made in the last week of Mrs D's life, one by her GP and one by her housing provider and were further missed opportunities to complete, by then an urgent, multi- agency reassessment of need. Both referrals were seeking consideration of a residential placement or respite care for Mrs D, as her current placement appeared to be unable to meet her needs and maintain her ability to live independently. The need for respite care to be arranged as a contingency in an emergency situation had been written in Mrs D's care plan since March 2014, but it was never offered to Mrs D. Seemingly, this was because the criteria for it was wrongly considered to relate only to the need for support with physical needs, rather than considering the wider implications of psychological and emotional needs. The GP's referral did result in Mrs D's case being allocated to a case officer in the Complex Team on 26 January 2016 who recorded they would arrange to visit Mrs D's home on 4 February 2016, to reassess Mrs D and speak with her housing Scheme Manager.

5.8 The term 'carer' was used by all agencies but it was not always clear whether the carer referred to was staff from Mrs D's housing provider, her care provider or her private carer. Agencies did not have clarity on the roles that the different carers delivered in supporting Mrs D, or the extent of their caring responsibilities. There were occasions when agencies wrongly believed Mrs D was being supported more than she actually was. Mrs D's housing provider saw themselves as her housing landlord only as they did not provide her personal care package. However they did provide Mrs D with an emergency support function, albeit that the demands she made on their staff were in excess of what they would normally have provided to other tenants living independently in their accommodation. The care company provided the care and support to Mrs D as commissioned through KCC and regularly reported concerns for Mrs D's physical health to her GP. There was no apparent evidence of any follow up of a referral and they were not proactive in raising any concerns to KASS or to Mrs D's Mental Health Care Coordinator.

5.9 KMPT did not include Mrs D's housing provider, care provider or her private carer in her care plan reviews and they were not updated with the results of assessments following Mrs D's incidents of self-harm. These agencies and Mrs D's private carer were also not given the opportunity to contribute to Mrs D's assessments, although they had daily contact with her and had the most knowledge on the triggers that would increase her anxiety and which led to her episodes of self-harm.

5.10 During the period of the Review there was only one meeting held by KMPT with Mrs D's housing provider, in June 2015, in response to concerns for Mrs D's behaviour raised by the housing provider. The meeting was attended by Mrs D, her daughter Miss B, the housing Scheme Manager and Mrs D's Care Coordinator. Mrs D's housing provider stated they were only invited by mistake, in the belief that they were Mrs D's care provider, who were not notified of this meeting. This was another example of Mrs D's housing provider not recognising that they did provide a support function for Mrs D and it was correct that they should attend the meeting as well as Mrs D's care provider. Mrs D's health, finances, calling the

emergency services and the impact on the housing provider staff were discussed but no outcome from the meeting or action plan was documented.

5.11 There was evidence of a person-centred approach to planning Mrs D's care. She always attended her mental health care plan reviews, KASS care reviews andshe was in regular contact with other professionals responsible for her care. However practitioners did not always appear to act on what Mrs D had said and seemingly failed to address her concerns. From October 2015 Mrs D was repeatedly saying, to every agency she was in contact with, that she was lonely, not coping and that she saw being in hospital as the answer. Practitioners did not discuss alternative care options with her. Consideration of moving Mrs D into a residential care home was never actively explored, even though this option might have provided her with a level of enhanced support.

5.12 By January 2016 Mrs D's carers were noticing her weight loss, but no agency seemed to recognise self-neglect. There appeared to be a common view that formal safeguarding procedures did not apply in Mrs D's case. It is unclear whether this is because agencies rather narrowly interpreted the procedures as applying only to vulnerable adults at risk of harm from others, not those suffering from self-neglect. Mrs D's poor diet and losing weight were indicators of self-neglect. There had been concern for Mrs D's poor nutrition as far back as 1990 when Social Services first became involved with her to provide a frozen meals service. The last GP's investigation into Mrs D's weight loss did not result in an assessment of Mrs D's mental capacity as advised by Community Health. No enquiries were made with Mrs D's front line carers or her daughter who had knowledge of Mrs D's poor eating habits, coupled with her deteriorating mental and physical health. When the GP wrote to KASS for consideration of respite or residential care for Mrs D, there was no mention of her physical decline in respect of her weight loss or concerns of self-neglect.

5.13 During the period of the Review there were referrals concerning Mrs D to local Community Nursing Team and DGS IMPACT Team for catheter care and pressure area care. The GP medical summary encounter report, which accompanied some of the referrals, included a history of her mental health diagnosis and self-harm. There was no evidence that the teams who had face to face contact with Mrs D considered her mental health needs and its impact on her physical health; and if her mental health needs required liaison with her GP and partner agencies, except in January 2016 when Mrs D's GP wanted Mrs D's weight monitored by Community Health and for her to have a blood test. The community nurse informed the GP that they did not monitor a person's weight if they were not eating, and advised the GP that further investigation was required as to why a person was not eating, or a Mental Capacity Assessment may be appropriate.

5.14 There were several missed opportunities by agencies including SECAmb, Dartford, Gravesham and Swanley Clinical Commissioning Group (DGS CCG) and Kent Police to follow their own safeguarding procedures and they did not raise any safeguarding alerts during the period of this Review. There is a need to address with all agencies their lack of understanding as to what constitutes a safeguarding alert for self-neglect and when to refer such concerns.

5.15 Kent Police has a vulnerable adult policy which is also linked to mental health policies, in addition they have a Suicide Prevention Strategy. Each linked Standard Operating Procedure (SOP) clearly defines vulnerable adults and outlines the procedures to be followed. It includes vulnerable adults who are not subject of abuse but are at risk because of their vulnerability. The Police has a responsibility to refer any suspicion, allegation or disclosure that a vulnerable adult is suffering and likely to suffer significant harm to KASS or Medway Council Adult Social Care (ASC) and refer all concerns received by the Public Protection Unit (PPU) or Community Safety Team (CST) to KASS/ASC.

5.16 Mrs D was a person who for some years had been a multiple caller to Kent Police. Each time she called her case was considered and dealt with appropriately, that is to attend, divert the call to another agency or give advice to the caller. The majority of her calls related to her feeling unwell or escalating the calls threatening self-harm to encourage attendance, usually in response to SECAmb not attending. The Police are limited in what they can do in these situations and referrals were made where appropriate to Mrs D's housing provider to complete welfare checks, or to SECAmb or KMPT as appropriate. However on the few occasions when officers did attend, usually in response to a suicide threat, there were no referrals from patrols to the PPU, CST or KASS identifying Mrs D as a vulnerable adult.

5.17 On 20 January 2016 Kent Police contacted KMPT about Mrs D and a meeting was held by CMHT on 25 January 2016 to discuss Mrs D's contacts with the emergency services. The plan was to have a professionals meeting after Mrs D's next care plan review on 10 February 2016. There was no mention in KMPT's chronology of any concerns for Mrs D's physical decline or consideration of self-neglect and Mrs D's case was not considered as requiring immediate action.

5.18 Mrs D attended A&E thirty two times during the Review period. The majority of occasions related to her mental health, anxiety, overdoses, self-harm and suicidal ideation. Dartford, Gravesham and Swanley CCG (DGS CCG) confirmed that Mrs D did not have a special register flag to identify her vulnerabilities. This would have allowed for her treatment and crisis plans to be documented on her patient file and could have triggered their safeguarding lead to become involved. Since Mrs D's death a Frequent Attenders Steering Group has been set up to identify and coordinate the care pathways for patients who frequently access health care, social care and Urgent and Emergency Care (UEC) services across DGS CCG. A frequent attender (FA) is identified as an individual who has ten or more attendances or contacts with a service in a 6 month period.

5.19 Every time Mrs D attended A&E where there were concerns for her mental health she was referred to Liaison Psychiatry Services and assessed. However, on two occasions, both significantly in January 2016, Mrs D was not referred to Liaison despite having suicidal thoughts and feeling unwell, not eating, and not coping. When the circumstances for not referring to Liaison were looked into there was no rationale recorded by the doctors but the Matron was of the view that because Mrs D became calm the doctors may not have seen a need to refer her to Liaison. However KMPT were unaware of two A&E attendances where there were concerns for Mrs D's physical and mental health and there was no follow up with Mrs D by her Care Coordinator.

5.20 SECAmb recognised that there was significant Trust reliance on the out of hours Crisis Team taking over management of the issues Mrs D was presenting with and that between the 999 ambulance calls, involvement from the carers and calls back from the Crisis Team, Mrs D appeared to continue to have unmet needs. SECAmb staff did not submit any Vulnerable Person referrals and despite onward referral in many incidences directly to mental health services, SECAmb recognise that these referrals still needed to be backed up using the Trust's Vulnerable Person referral process.

5.21 It appears likely that emergency staff knew Mrs D was receiving support from services already, and having spoken to the Crisis Team or CMHT, incorrectly believed it provided sufficient 'safety netting'.

5.22 Kent Fire & Rescue Service (KFRS) only had contact with Mrs D on two occasions before the date of her death. In January 2015 KFRS received a call from Mrs D threatening to set fire to her flat, the call was passed to SECAmb and KFRS did not respond. KFRS has amended its response to threats of suicide since Mrs D's death and their policy now states that a fire appliance and a level 2 officer will attend any threat of suicide. The second incident was in August 2015 when KFRS responded to a call by Mrs D that she had burnt a hole in her chair with a cigarette, approximately one hour before she phoned. The attending officer was not aware of the previous call in January 2015. KFRS is currently reviewing the capabilities of its communication system and how it can be used by their controllers to better inform the correct response to the caller. This incident was assessed as an accident and a Vulnerable Person referral was not made by the fire officer due to adequate fire safety measures within Mrs D's home and there were no concerns of self-neglect identified. It is not recorded whether the fire officer knew of any concerns for Mrs D's mental health and he gave her advice on safe smoking. KMPT's view was that Mrs D did not do things accidentally but they were not aware of either incident.

5.23 Agencies showed a lack of engagement with the principles and practice guidance set out in the Mental Capacity Act 2005 (MCA) and in the Code of Practice. There was a unanimous view amongst professionals that Mrs D's capacity was retained in relation to key decisions about her health and welfare, but there were failures to assess Mrs D's capacity. There was also a failure to work consistently within the principles of the MCA by some agencies when Mrs D refused medical treatments or when judgements were made that she could keep herself safe. There was an absence of documented capacity assessments which also raised questions about the decisions of professionals regarding Mrs D's care, or the lack of it in some instances.

5.24 The principle of presumption of capacity was followed by nearly all agencies. Not questioning Mrs D's capacity in circumstances that should have warranted it meant that agencies missed opportunities to explore how Mrs D was being supported with her anxiety. Despite the presumption of capacity. practitioners still made best interest decisions in respect of Mrs D's personal safety. KMPT put controls and steps in place to minimise the risk she posed to herself; such as having her medication kept in a locked cupboard and having it administered by carers, as well as limiting her access to products that could cause herself harm. SECAmb and Kent Police also removed items from her home after episodes of self-harm, in order

to keep her safe.

5.25 Mrs D was taking multiple medications and there were concerns about polypharmacy that were considered by this Review. Mrs D was quite clear that she had no real interest or trust in talking therapy to help with her depression or anxiety and for her the answer lay in more or different medications. She frequently made requests for changes to her medication, either by asking for a different medication or an increase in the dose of her existing medication, her drug of choice seemed to be Diazepam. Reviews of Mrs D's medication were carried out frequently and some adjustments were made.

5.26 Of note was that Mrs D was taking both Benzodiazepines and Buspirone and the British National Formulary (BNF) advises withdrawing Benzodiazepines gradually before starting Buspirone as the combination of both drugs together could cause increased sedation and dizziness. However Mrs D's Psychiatrist's assessment was that she would not have been able to cope with the recommendation to withdraw Diazepam prior to starting Buspirone and it had to be given consideration due to the challenges faced in terms of her management. Although Mrs D was taking multiple medications due to the complexity of her disorder she was closely monitored by her Psychiatrist and her GP for the emergence of side effects as well as tolerability.

5.27 The Review has considered whether Mrs D's death was inevitable at some point owing to her long history of self-harm and frequent suicide attempts and if her death could have been avoided on this occasion.

5.28 Had Mrs D's physical decline and inability to cope living independently been reviewed more promptly by the statutory agencies that were relied upon to support Mrs D and manage her risk, then respite accommodation could have been sought for her more speedily in line with her KASS care plan. An urgent joint review could have taken place to assess if a residential placement was better able to meet Mrs D's needs. A more supportive residential placement where staff had a better understanding of Mrs D's Borderline Personality Disorder (BPD) may have helped to alleviate some of her anxiety and improve her physical health, possibly leading to a reduction in her episodes of self-harm and in turn, her demands on the emergency services.

5.29 Finally, on the day Mrs D died she should have been visited by the CRHTT and the fact that they did not know there had been a referral to their agency is of particular concern, but whether this was an individual's mistake or a fault of KMPT's recording processes was not identified by KMPT. The situation was further compounded by Mrs D not taking her medication on the day she died as it was missing, which added to her anxiety. The CRHTT claimed they were not told by Mrs D's carer or the paramedic that Mrs D's medication was missing, which is disputed by her care worker, or that she had earlier that day set light to her clothing and that she had tried to swallow objects to harm herself. They claimed that, had they known of these concerns, they would have visited Mrs D as a priority. If they had attended her anxiety may have been reduced, especially once she received her missing medication, and her self-harming behaviours may not have escalated, or CRHTT may have recommended that Mrs D be taken to hospital for further assessment. This would have limited her access to items that she could have used

to self-harm, which may have ensured her safety on that day.

6. Recommendations

6.1 The agencies involved in this Safeguarding Adults Review are committed to ensuring that the issues highlighted in the Review are addressed. They have identified actions within their own agency which will help to ensure that single agency shortcomings are addressed.

6.2 The following recommendations will form the basis of a Kent and Medway Safeguarding Adults Board (KMSAB) action plan designed to address multi-agency failings.

1. KMSAB partner agencies will ensure that front line staff/officers and their managers are trained to recognise self-neglect and associated level of risk, particularly in relation to people with complex mental health issues, where there can be an impact on behaviour and psychological needs, and escalate appropriately.

2. KMSAB partner agencies will ensure that appropriate and effective training is in place for staff who are responsible for undertaking Mental Capacity Act assessments. This training is to be updated/renewed via refresher training.

3. KMSAB partner agencies, with responsibility for managing safeguarding and risk associated with people with complex mental health needs or other vulnerabilities, must demonstrate a joined-up approach. The lead practitioner must take responsibility for co-ordinating the work of all agencies involved in the individual's care to enable accurate risk assessment, risk management and improved outcomes.

4. Responsible agencies will ensure, where there is an adult with complex mental health and care needs, that their health and social needs are jointly reviewed on at least an annual basis to improve information sharing and co-ordination of care, or more frequently as determined by the specific circumstances of the individual case.

5. KMSAB is to be assured that the Kent and Medway Mental Health Crisis Care Concordat Steering Group's actions are progressed in respect of:

- developing a multi-agency repeat presenter protocol - Concordat Action Plan 2.17; and

- evaluating the effectiveness of multi-agency information sharing protocols and ensure it operates at all levels of all organisations - Concordat Action Plan 2.18.

6. KMSAB partner agencies are to map the current provision/arrangements in place where information is shared in relation to vulnerable persons with repeated safeguarding issues/incidents. Agencies are to consider how to address/manage any gaps in provision and agree an assessment process and referral mechanism to a multi-agency risk management forum.