KENT AND MEDWAY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Charlotte Burton

Executive Summary

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Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

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Kent and Medway Safeguarding Adults Board
Safeguarding Adults Review

Executive Summary

1. Introduction

1.1 This Safeguarding Adults Review (SAR) was commissioned by Kent and Medway Safeguarding Adults Board (KMSAB), following a referral made on 16 April 2018 by Kent Police.

1.2 The referral followed the death of Charlotte Burton, a white British woman aged 20 years, who died on 11 April 2018. During her short life, Charlotte had been a looked after child and on reaching adulthood she led a transient lifestyle, living at addresses in various towns across Kent and Medway. She had contact and involvement with numerous professionals, who worked in the organisations subject of this Review.

1.3 This SAR is based on information and facts, gathered from organisations that had adult safeguarding responsibilities to Charlotte during the period between 1 January 2015 and the date of her death (this period is referred to in the SAR as 'the review period').

1.4 The agencies that reported having safeguarding involvement with Charlotte during the review period were:

- Kent Police
- British Transport Police
- Kent County Council Children's Social Services
- Kent County Council 18+ Care Leavers Service
- Kent County Council Adult Social Care and Health
- Medway Council Adult Social Care
- GP Practices *
- Sussex Partnership NHS Foundation Trust **
- Kent and Medway NHS and Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust ***
- Medway NHS Foundation Trust ***
- Dartford and Gravesham NHS Trust ***
- Maidstone and Tunbridge Wells NHS Trust ***
- South East Coast Ambulance Service NHS Foundation Trust

* During the review period, Charlotte was registered with at least six GP practices in Kent, Medway and West Sussex. To provide anonymity to her and her family, GP practices are not named.

** During the review period, Sussex Partnership NHS Foundation Trust was commissioned to provide Child and Adolescent Mental Health Services (CAMHS) in Kent and Medway.

*** These are NHS Hospital Trusts. During the review period, Charlotte was taken to or presented at one or more acute hospitals managed by each.

2. Background and Chronology

2.1 Charlotte was born in Town A, Kent and lived there with her mother, father and elder sister. When she was 4-5 years old, her parents separated, and her mother took the girls to live in her new home nearby. When Charlotte was 6-7 years old her father was awarded custody of the two girls, and Charlotte lived with him until she was taken into care shortly before her fifteenth birthday.

2.2 Charlotte's father said that at primary school Charlotte began seeking the attention of those in authority; she continued to do this through adolescence and into adulthood. Her behaviour at primary school was good, but it deteriorated after she began secondary education.

2.3 About a month before her fifteenth birthday, Charlotte went into the care of Kent County Council (KCC) Children's Social Work Services (CSWS) and became a Looked After Child. She was initially placed in a children's home in West Sussex.

2.4 In August 2014, due to her approaching adulthood, the progress she had made while living at the home and the possibility of starting a college course, Charlotte was moved to a foster placement in Kent. This was unsuccessful and after other attempts to place her, including at her sister's home, were not successful, she was admitted to hospital in Surrey under S.2 of the Mental Health Act 1983 (S.2) in October 2014 following a drug overdose.

2.5 After being discharged from the hospital in November 2014, Charlotte moved to a children's home in Town B, Kent. Due to her ongoing mental health problems, she continued to receive Child and Adolescent Mental Health Services (CAMHS), delivered by Sussex Partnership NHS Foundation Trust (SPFT).

2.6 At the start of the review period, Charlotte was 17 years old and living in the children's home. She was assigned a social worker and was receiving treatment from SPFT. She frequently absconded and called emergency services; she had been doing the latter since she was 13 years old. She was known to be vulnerable by the organisations she was involved with.

2.7 At the start of her adult life, Charlotte's personal circumstances underwent a significant change. Having been a Looked After Child, accommodated in children's homes for about three years prior to her eighteenth birthday, she moved into supported accommodation in Town C, Kent. The organisations providing the two services she relied on most, social care and mental health treatment, changed. She would have no further contact with professionals she knew and who knew her.

2.8 Charlotte's father was concerned that, having been in children's homes for three years, at the age of 18, Charlotte was suddenly expected to fend for herself. He said she no longer felt safe and he still feels strongly that she was let down.

2.9 Her father said that Charlotte's behaviour did not alter significantly when she reached adulthood. This was to be expected; because it was driven by diagnosed chronic mental health conditions. She continued to make frequent 999 calls to Kent Police and SECAmb, and to present at hospital A&E departments. Much of the involvement organisations had with her related to self-harm and threats of suicide.

2.10 Charlotte's father said that, while she was living in supported accommodation, she went and stayed with friends. This did not comply with the conditions of the supported accommodation and he said that she was required to leave. During the next two and a half years leading to her death, her lifestyle was transient. She had lost the structure that living in care had provided. She moved from town to town in Kent and Medway; her accommodation became a mix of sofa surfing, short-term housing and, finally, provided accommodation.

2.11 Charlotte's involvement with Kent Police was a seamless continuation of that which she had as a child, with the exception that she was no longer reported as a missing person. Generally, her calls were to report self-harm and suicidal ideation or crimes. Kent Police generated 424 computer entries relating to Charlotte during the review period while she was living in seven towns across Kent and Medway.

2.12 Charlotte had boyfriends during the review period and alleged that she was a victim of domestic abuse and harassment. These allegations were investigated but never led to a prosecution. Her father said that having lived in children's homes, Charlotte was frightened to live alone, but the people she lived with were not always able to provide her with safety and stability.

2.13 Charlotte was detained innumerable times under Section 136 of the Mental Health Act 1983 (S.136) and arrested seven times for criminal offences. She also reported being the victim of crime on several occasions. These cases were investigated, and, although some were found to be true, a number were not.

Charlotte was also involved with British Transport Police (BTP) as a child and as an adult.

2.14 Charlotte was taken to acute hospitals on numerous occasions by ambulance and she would also present herself at A&E departments. It was a feature of her involvement with NHS services that she would often discharge herself before treatment or not attend appointments.

2.15 Charlotte frequently told professionals she was pregnant, or that she had been pregnant and then miscarried. On occasions, she reported that she had two children who were living with her brother, and that she had a child who had died. Charlotte never gave birth to a child and apart from one positive pregnancy test that was followed by a negative test a few days later, there is no evidence she was ever pregnant.

2.16 Charlotte's father confirms that she would often say she was pregnant, but he did not see evidence of this. He confirms she never gave birth to a child. During the review period, Charlotte's grandmother died and left her a considerable inheritance. Her father estimates that she spent about fifteen hundred pounds on baby apparel. She would put this into baskets, which she would label with the names of imaginary babies.

2.17 Charlotte also told professionals about serious illnesses she was suffering from; most significantly Type 1 diabetes. She was treated on several occasions for hypoglycaemia caused by insulin overdose. There is no record available to the SAR that she was ever diagnosed with Type 1 diabetes or prescribed insulin.

2.18 Charlotte was living alone in a flat in Town D when she died. Kent Police was called by her father on 5 April 2018 because he was concerned about her not answering his calls to her mobile phone. When a police officer and a Kent and Medway NHS and Social Care Partnership Trust (KMPT) Community Mental Health Nurse from the Medway Street Triage Team went to her flat the following day, they found her unconscious on her bed. She was taken to hospital, where she remained in a coma until her death on 11 April 2018.

2.19 Although Charlotte threatened to take her own life many times, there was no evidence available to the review that her death was suicide.

3. Analysis of Issues and Themes

3.1 <u>Transition and Transfer to Adult Services</u>

3.1.1 Charlotte's transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services and from child to adults' social care took place in

2015. The transition and transfer of both is detailed in Section 2 above – both were poorly managed and uncoordinated. The complexity of her needs was clear but at the start of the review period, nine months before she became an adult, planning for her transition had not begun.

3.1.2 The transition from child to adult social care and mental health treatment should have been linked, but there is little evidence that this was the case: there was a lack of communication and information sharing. Several multi-agency meetings, variously titled as Looked After Child, Network and Risk Management meetings, were held, but attendance was patchy, meaning that her complex needs were not discussed in a meaningful way.

3.1.3 Throughout the transition and transfer, there is little evidence that Charlotte's voice was being heard – there is only one record of this, when she expressed prescient concerns about how she would be supported as an adult. The approach was not child focused.

3.1.4 During the period of Charlotte's transition and transfer, an Independent Reviewing Officer had statutory responsibility for reviewing transition arrangements and pathway planning. The Independent Reviewing Officer assigned to her case first met her in January 2015. From then until she reached her eighteenth birthday, he made frequent and concerted attempts to ensure that the need to transition Charlotte's treatment and care from child to adult services was recognised and delivered. His effort to drive the process were commendable, but it was not matched by others, whose responsibility was to implement it. The statutory role of the Independent Reviewing Officer ended when Charlotte became an adult.

3.1.5 In February 2016, five months after Charlotte's transfer, the National Institute for Health and Clinical Excellence published *'Transition from Children's to Adults' Services for Young People using Health or Social Care Services'*. This eponymous guidance document is for: health and social care providers; and health and social care practitioners in children's and adult health, mental health and social care services. If the guidance is now being followed by the organisations involved in Charlotte's transition and transfer, most of the concerns identified will have been addressed. Those issues that arose from Charlotte's poor transition are considered below.

3.1.6 KCC Children's Social Work Services (KCC CSWS), KCC Adult Social Care and Health (KCC ASCH), Kent and Medway NHS Social Care and Partnership Trust (KMPT), and Sussex Partnership NHS Foundation Trust (SPFT) must each provide Kent and Medway Safeguarding Adults Board (KMSAB) with evidence of how they ensure the transition and transfer of care and treatment from child to adult services is now delivered in a well-managed, coordinated and client focused way. **(Recommendation 1)**

3.2 KCC Adult Learning Disabilities Team

3.2.1 For the first seven months of her adult life, Charlotte received no support from KCC Adult Social Care and Health. The Adult Learning Disabilities Team stated in June 2015 that she did not meet the criteria for its services, but a month later decided she did. The Adult Learning Disabilities Team then closed her case less than a month after she became an adult, because it could not engage with her. Charlotte was a vulnerable young adult with care leaving status, who had been diagnosed with learning disabilities and mental health problems; the Adult Learning Disabilities Team should have realised engaging her would be challenging.

3.2.2 The Adult Learning Disabilities Team has not contributed to this SAR because it has no records of its involvement in Charlotte's case. Reference to actions attributable to the Adult Learning Disabilities Team comes from information provided by other organisations. It is not known what, if any, attempts the Adult Learning Disabilities Team made to engage with Charlotte as an adult, or why it closed her case after less than a month.

3.2.3 Concerns about the Adult Learning Disabilities Team date from 2015 and may not reflect the current level of service it aspires to provide. KCC ASCH must provide KMSAB with evidence of the process the Adult Learning Disabilities Team now uses to decide whether a person is eligible for its services, and its criteria for closing a case when it fails to engage with a person who it has identified as meeting those criteria. **(Recommendation 2)**

3.3 KCC 18+ Care Leaver Service

3.3.1 KCC 18+ Care Leaver Service (18+) did not engage with Charlotte when she became an adult because KCC's responsibility for care leavers services was taken on by the Adult Learning Disabilities Team. The first contact 18+ had with Charlotte as an adult was in April 2016, when the ASCH Out of Hours Service sent it a referral. By this time, the Adult Learning Disabilities Team had withdrawn its service because it could not engage with Charlotte.

3.3.2 When 18+ engaged with Charlotte, it appointed a Personal Advisor (PA) to her a fortnight later. Although she had four PAs during the review period, there was a clear handover from one to the next. Records show all were in regular contact with her. Home visits were made, some unannounced, which was good practice. She was provided with practical help, such as small cash amounts when she was struggling to buy food and given transport to a court appearance. Much of the contact between Charlotte and 18+ was initiated by her ringing the KCC Out of Hours service. A message was then left for 18+, who invariably called her back promptly during working hours.

3.3.3 18+ initiated contact with other organisations that were involved with Charlotte, such as KMPT and Kent Police. This included joint visits where appropriate, which was good practice. Records suggest that 18+ PAs had a good rapport with Charlotte and were persistent when she said she did not want their help. She disclosed her feelings to them, which may be indicative of the value of having a professional who is engaged with a service user for long enough to get to know them and gain their trust. This is more difficult when the person has a transient and chaotic lifestyle. 18+ teams cover a wider geographical area than some other organisations, so the same PA was able to support her when she moved - this may have contributed to its success in engaging her.

3.3.4 Charlotte was transferred from one 18+ team to another in March 2018 due to her moving to Medway. This went smoothly and she continued to receive a good level of support. The day after the transfer, her new 18+ PA visited her at home and continued to have regular contact. Contact between 18+ and other relevant organisations continued, ensuring Charlotte's PA knew about her involvement with them. Information sharing at practitioner level was good, showing professionals were focused on her safeguarding. Practical help also continued; in March 2018, Charlotte was given £120 to buy clothing. Once 18+ engaged with Charlotte, the support she received from its professionals was of a high standard.

3.4 Adult Social Services

3.4.1 Once Charlotte became an adult, her lifestyle became transient; she changed her address several times, although she always lived in Kent or Medway. This was a factor in the way organisations provided services to her. When she moved between Kent and Medway, her safeguarding would have been the responsibility of the adult social care services of Kent County Council and Medway Council respectively. Both councils deliver adult social care using teams, which are either functional on an authority wide basis, or work within geographic areas. Safeguarding adults was delivered geographically by KCC ASCH during the review period. Medway ASC was structured into specialist, user-group specific services until September 2017, when it began delivering services by way of generic locality-based teams.

3.4.2 The involvement of Medway ASC with Charlotte's case in March 2018, when two safeguarding adult referrals were made, raises concerns. The first referral, made on 9 March by a doctor at MMH, was recorded on Framework-I, the Medway Adult Social Care IT system, but there is no evidence of any action being taken to safeguard Charlotte or her alleged unborn child – one of the referrals was made by the doctor who conducted Charlotte's only positive pregnancy test.

3.4.3 On 11 March the second referral, made by a KCC AMHP, was received and a decision was made two days later to open a Section 42 Enquiry. The referral

included details of domestic abuse that Charlotte had suffered at the hands of her partner. Medway ASC accepts that this statutory enquiry was not conducted properly. Charlotte was spoken to by telephone once, but there was a lack of effective communication with other relevant organisations and nothing was done to increase her safeguarding.

3.4.4 Medway ASC has explained possible reasons why the first referral was not responded to and the S.42 Enquiry was not progressed effectively. Medway ASC must provide KMSAB with evidence that its response to safeguarding adult referrals is now managed effectively. **(Recommendation 3)**

3.4.5 In addition to the safeguarding referrals, Charlotte was assessed by Medway ASC AMHPs on 28 February and 21 March 2018. The AMHP conducting the first assessment did not record it on Framework-I until 24 April (after Charlotte's death), so the Social Worker who was allocated the S.42 Enquiry did not know about it. The second assessment was carried out while the S.42 Enquiry was ongoing, but the AMHP did not tell the Social Worker about it. Medway ASC must have a system in place to ensure its AMHPs record mental health assessments in a timely manner and make relevant ASC staff aware of the results. **(Recommendation 4)**

3.5 Adult Mental Health Services

3.5.1 Kent and Medway NHS and Social Care Partnership Trust (KMPT) provides adult mental health services across Kent and Medway. Community Mental Health Teams (CMHTs) and Crisis Resolution Home Treatment Teams (CRHTTs) are geographically based, but their boundaries are not coterminous. For example, there is a Medway CMHT but the CRHTT covering Medway also covers Swale in Kent.

3.5.2 During the review period, Charlotte was involved with numerous different elements of KMPT. She had contact with seven CMHTs, four CRHTTs, three Liaison Psychiatry Services in acute hospitals, the Criminal Justice Liaison and Diversion Service in police stations, the Mental Health Learning Disabilities Team (MHLDT), a Therapeutic Community and three inpatient hospitals. The number of professionals who dealt with her would have been a significant multiple of the teams. While the structure of KMPT (and other organisations) makes this inevitable, it can be confusing for clients, who need to know who their point of contact is.

3.5.3 Because of the failure to manage Charlotte's transfer effectively, her CAMHS records were not sent by Sussex Partnership NHS Foundation Trust (SPFT) to KMPT. There is one record of a request made by KMPT for these, nine months after she became an adult. SPFT stated it required Charlotte's written consent.

The legal duty to share information, in appropriate cases without the person's consent, is set out in Section 3 of the Health and Social Care (Safety and Quality) Act 2015. There is no evidence that consideration was given as to whether sharing Charlotte's records without her consent would have been appropriate. In any event, KMPT did not seek consent and never received Charlotte's CAMHS history, which contained a recent diagnosis of learning disabilities and mental health conditions.

3.5.4 Sussex Partnership NHS Foundation Trust (SPFT) no longer delivers CAMHS in Kent and Medway; North East London NHS Foundation Trust (NELFT) is the current provider. In accordance with the purpose of this SAR, SPFT, NELFT and KMPT must provide the KMSAB with confirmation that patients' records are now transferred from CAMHS to adult mental health services in accordance with the provisions of Section 3 of the Health and Social Care (Safety and Quality) Act 2015. **(Recommendation 5)**

3.5.5 The KMPT professional who should be a long-term client's point of contact is the CMHT Care Coordinator. The person performing that role changes when a client moves from living in one CMHT area to another, so it is important that the transfer is well managed, and the service level remains consistent. KMPT uses a single IT system (Rio), which allows all KMPT clinical and social care professionals to access a client's treatment history.

3.5.6 Charlotte's transient lifestyle meant it was sometimes difficult to identify where she was living. This meant that the Care Coordinator transfer could not always be completed before she moved again, even if it was made in a timely way. However, the failure to transfer Charlotte's case from Town L to Medway CMHT raises specific concerns. When it became clear this transfer was not progressing as it should, the Service Manager of Town L CMHT told the Town L Care Coordinator to escalate the transfer to the Service Manager of Medway CMHT. This should have been managed between the two Service Managers, not delegated to the Care Coordinator.

3.5.7 While the transfer process was ongoing, a KMPT professional recorded criticism of other professionals on Rio. This indicated a greater focus on the internal workings of KMPT than on a vulnerable client. Time and effort wasted on this would have been better used ensuring that the transfer was made efficiently and expeditiously.

3.5.8 In order to provide reassurance that transfer between CMHTs is client focused, KMPT must provide KMSAB with evidence that it has an effective process for transferring a client from one CMHT to another and that all relevant staff understand it. **(Recommendation 6)**

3.5.9 During a period of a month, while she was a hospital inpatient, Charlotte was found by staff with a ligature around her neck on at least seven occasions. This was something she had done before she became an adult; it was in her CAMHS records, but KMPT did not have these. On some occasions she allowed staff to remove the ligature, on others she resisted. During one incident she assaulted a staff member and following another she left the hospital grounds with the ligature still in place. There is no record of a risk assessment relating to ligatures, even after she had been found with one. Given that it is not unheard of for patients staying in mental health hospitals to take their own lives in this way, the repetition of this risk so many times in a short period raises serious concerns.

3.5.10 KMPT must provide KMSAB with evidence of its plan to close the gaps in its environmental ligature risk controls, and that self-harm risk assessments with appropriate controls are being completed for patients who are resident in its hospitals. **(Recommendation 7)**

3.5.11 The fact that a person (JF) purporting to be Charlotte's stepfather could have been present in a discharge meeting and be referred to as a person into whose care she would be discharged, raises concerns. She had absconded from hospital two months previously and was found by police officers the next day at JF's flat. The police disclosed to hospital staff that he was a person identified as posing a risk to children, and this information was recorded on Rio. As well as not making the link with the man to whose flat she had absconded, there was a lack of professional curiosity about his identity. Had Charlotte's Care Coordinator and/or her 18+ PA been invited to the discharge meeting, as they should have been, either would have been able to confirm that JF was not her stepfather.

3.5.12 Charlotte was an adult and there is no evidence that she lacked mental capacity. She knew that JF was not her stepfather but did not declare this, nor did she demonstrate a reluctance to living with him when she was discharged. Had his identity been known at the discharge meeting, it may not have affected the outcome: she would have been discharged and, as an adult, there was no requirement for her to have been discharged into someone's care.

3.5.13 The concern is that the failure to identify the man, both by not making the link to where she was found after absconding and by not inviting the appropriate professionals to the discharge meeting, meant that there was a lack of consideration of Charlotte's safeguarding. It is likely that she would still have gone to live with JF, but the appropriate organisations would have been made aware, with the potential of reducing her risk of harm.

3.5.14 KMPT must provide evidence to KMSAB that it has a process in place to ensure that, when the discharge of an inpatient is being considered, their safeguarding

always forms part of the decision making and that all relevant professionals are invited to the meeting. **(Recommendation 8)**

3.5.15 Charlotte claimed to have overdosed on drugs on many occasions. This always involved over the counter medication, such as paracetamol, or drugs that are available on prescription. Although she mentioned smoking cannabis and using speed on one occasion, she never claimed to have overdosed on controlled drugs. In addition, there is no evidence that she suffered from chronic alcohol abuse.

3.5.16 In May 2016, Charlotte told a nurse at a KMPT hospital that she had been diagnosed with Type 1 diabetes three months previously. Without any confirmation or checking of this, the Duty Doctor at the hospital gave her a prescription for insulin. This would have been poor practice in any hospital; it was particularly so in the case of KMPT, to whom she was known as someone who fabricated what she told staff. The pharmacy at the hospital refused to authorise the prescription and Charlotte did not receive the insulin. This was good practice and shows the pharmacist was alert to wrongly prescribed medication.

3.6 NHS Hospital Trusts

3.6.1 Charlotte attended six acute hospitals during the review period; three managed by East Kent Hospitals University NHS Foundation Trust (EKHUFT), one each by Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust. In general, she attended the hospital she was living nearest to; she was either taken there by SECAmb or self-presented. There is only one record that she was admitted to a ward; on all other occasions she was treated in the A&E department or by specialist staff without admission. This included KMPT Liaison Psychiatry staff, who were based in each acute hospital.

3.6.2 When Charlotte attended acute hospitals, staff dealt with the conditions she either presented with or described, but on occasions signals that she was vulnerable and needed safeguarding were not always followed up.

3.6.3 When Charlotte presented to EKHUFT hospitals, staff did not use its SMART+ mental health assessment tool, although she was referred to KMPT Liaison Psychiatry Service on several occasions. EKHUFT's IT-based patient records system is shared across its facilities, however the records were sometimes poor-quality scans of hand-written clinical documents, making it difficult for staff under pressure to read them easily. When she attended the hospital in July 2017, stating she had been kicked in the abdomen, it was not identified as potential domestic abuse. She called the same hospital again a few days later, stating she

had been assaulted and raped. Again, this was not identified as potential domestic abuse or a safeguarding issue.

3.6.4 Between 18 July and 15 August 2017, Charlotte presented 17 times at Darent Valley Hospital (DVH), on some days more than once. She reported variously taking drug overdoses, being the victim of domestic abuse, and having suicidal thoughts, anxiety and depression. She also presented suffering self-harm and stating that she was pregnant. On those occasions where she brought to DVH by the police under S.136 of the MHA, she received medical treatment and then discharged into the custody of the police, who took her to the dedicated S.136 suite at a KMPT facility.

3.6.5 On two occasions in August 2017, Charlotte attended the A&E department at DVH, and on both occasions, she was referred to the KMPT Psychiatric Liaison Team based there. There were also occasions when she was brought to DVH by KMPT professionals; as she was in their care on admission and discharge, there was no need to refer her to the Psychiatric Liaison Team.

3.6.6 Charlotte presented twice at Maidstone Hospital. Her attendances were on consecutive days following her discharge from KMPT Priority House, and during both she reported having taken drug overdoses. It was positive that she was assessed using the hospital's SMaRT safeguarding risk assessment tool. A referral to mental health clinicians was considered but, on both days, she told staff she already had appointments booked with CRHTT, so referrals were not made.

3.6.7 On both occasions, Maidstone Hospital recorded a description of Charlotte's physical appearance and clothing. This is a practice the hospital adopts in its A&E department if staff think a person might abscond before treatment or otherwise need to be identified. This is good practice for safeguarding patients who may be vulnerable and/or confused.

3.6.8 KMSAB should recommend the adoption of Maidstone and Tunbridge Wells NHS Trust's procedure for recording the description of patients to other Hospital Trusts in Kent and Medway. **(Recommendation 9)**

3.6.9 Charlotte presented at Medway Maritime Hospital (MMH) 63 times during her adult life, all but once after June 2017. There was a significant gap in her attendances between August and December 2017 but following this they became frequent. All instances of her reporting insulin overdoses were at MMH.

3.6.10 MMH employs a SMaRT tool to assess a patient's safeguarding risk and during July and August 2017 this was used with Charlotte, although not consistently. This may have been because she chose not to engage with the assessment. No referrals were made to the hospital's Safeguarding Team, although it was clear

she was a vulnerable young adult with care leaving status, having presented following overdoses and being recognised as at high risk of suicide. She self-disclosed bipolar disorder, attention deficit hyperactivity disorder, epilepsy and asthma, but there is no record any of these conditions were discussed or explored with her.

3.6.11 During December 2017, Charlotte presented with self-harm following overdoses and threatening to jump off a bridge. She also reported her ex-partner had assaulted her. From February 2018, she presented frequently at MMH with hypoglycaemia, which she said was caused by deliberate insulin overdoses. On one occasion, she was referred to the Diabetes Specialist Nurse but discharged herself before being seen. The nurse confirmed with Charlotte's GP that she had never been prescribed insulin but, although this was recorded in her notes, she was not challenged on subsequent presentations for insulin overdose.

3.6.12 In addition, Charlotte told staff she had cystic fibrosis; a life-shortening genetic physical condition. She displayed no symptoms of the condition, but on several occasions she reported being pregnant. Cystic fibrosis can have consequences for a sufferer's child, but there is no record her self-disclosure was questioned, corroboration sought or that there was concern for the unborn child.

3.6.13 The only safeguarding alert sent from a hospital to a local authority was from a doctor at MMH to Medway ASC. Given that overall there was a lack of consideration of Charlotte's safeguarding at MMH, it is ironic that this referral was not acted upon.

3.6.14 On numerous occasions, Charlotte either attempted to, or did, self-discharge from acute hospitals which made treating her difficult. This behaviour was more common when proposed actions might have resulted in her self-disclosures being found to be false.

3.6.15 East Kent Hospitals University NHS Foundation Trust, Dartford and Gravesham NHS Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust must each provide KMSAB with evidence of a robust adult safeguarding policy and that relevant staff have been trained in its implementation. **(Recommendation 10)**

3.6.16 From January 2018, in the months leading up to her death, Charlotte presented to SECAmb and hospitals on numerous occasions stating she had taken an insulin overdose. She was seen by various clinicians and gave differing accounts of when she was diagnosed with Type 1 diabetes. On one occasion she said she was diagnosed at birth, which could not have been correct. She stated on one occasion that she was getting insulin *'from Town H'* and on other occasions that she was sourcing it online. Insulin is a prescription drug, although a determined

person can buy it online without a prescription. However, it is unlikely that she had the knowledge, facilities or funds to do this.

3.6.17 There was a lack of professional curiosity about where Charlotte was getting prescription drugs from or what conditions they were being prescribed for. She was usually specific about the type and quantity of drugs she had taken. The number of reports of overdose should have given professionals, particularly those working in the NHS, concern about the quantity of prescription drugs she claimed to have taken.

3.6.18 KMSAB should highlight the concerns raised in this Review about the lack of professional curiosity displayed by health professionals about Charlotte's access to prescription drugs. **(Recommendation 11)**

3.7 GP Practices

3.7.1 As an adult, Charlotte was registered with at least six GP practices in Kent and Medway. GP practices do not share a single IT system, so records must be transferred when a person moves from one practice to another. In contrast to other organisations she accessed, Charlotte was not a frequent user of GPs. However, it appears she registered with a local GP practice each time she moved. Her records would have followed her, the transfer process being managed by a nationally commissioned private contractor. There can be a delay in transferring records, so it is possible that Charlotte presented for treatment at GP surgeries before her notes arrived. This may have increased the likelihood of drugs being prescribed based only on self-disclosure of conditions. However, there is no evidence available to the SAR that this happened.

3.7.2 There is no record of Charlotte being prescribed drugs, including insulin, by a GP during the review period. After initially agreeing to do so, one GP checked her notes and found no record of a Type 1 diabetes diagnosis or previous prescriptions. He cancelled the prescription within minutes, before it was issued to Charlotte. What is of some concern is that there is no record of GPs taking any action following the receipt of letters received from A&E clinicians who had dealt with her. These letters included mention of her disclosure of conditions including Type 1 diabetes, epilepsy and cystic fibrosis. Her GP notes do not record diagnosis of these conditions, but no GP contacted a hospital to discuss her case.

3.8 Kent Police

3.8.1 Kent Police recorded involvement with, or activity regarding, Charlotte on hundreds of occasions during the review period. She called 999 to report crimes, self-harm and suicidal ideation. Investigation of crimes frequently revealed no evidence, and, on several occasions, she admitted her reports were false.

Similarly, on many occasions police responded to incidents where Charlotte said she had self-harmed or was threatening suicide but found when they arrived that this was not the case.

3.8.2 As an adult, Charlotte was arrested seven times for wasting police time, although she was never prosecuted. This is an example of action that focuses on solving a problem for an organisation, not on safeguarding a person. Charlotte was well known to Kent Police for having mental health issues. A previous Kent SAR, published in 2015, made a similar finding about the inappropriate use of the criminal justice system to try to manage the demand made on Kent Police by vulnerable people.

3.8.3 Kent Police must provide evidence to KMSAB that its policies for dealing with vulnerable people are focused on ensuring that they receive the care, treatment and support they need, where appropriate involving other organisations.
(Recommendation 12)

3.8.4 Charlotte was detained under S.136 innumerable times, being discharged after assessment on all but a handful of occasions. Calls she made to Kent Police were attended by response officers and she was dealt with in seven different towns. This meant that she would have had contact with many different officers who, despite the frequency of police involvement with Charlotte, may have had little or no personal experience of her.

3.8.5 Kent Police officers dealt with the immediacy of Charlotte's situation; until mid-2017 there is no evidence that there was a plan aimed at safeguarding her. During that period, there is no record she was referred to KCC ASCH using a KASAF or that there was any attempt at a multi-agency solution initiated by Kent Police.

3.8.6 In September 2017, Kent Police introduced New Horizon, a strategy for dealing with vulnerable people. A Mental Health Team was set up, with a remit to support frontline officers dealing with frequent callers with complex needs arising from their mental health conditions. From the time it was set up, the Mental Health Team was managed by an officer who holds professional qualifications relevant to working with people suffering from mental health problems.

3.8.7 From its inception, the Mental Health Team was involved in Charlotte's case, and an officer was assigned to it. The Mental Health Team initiated attempts to try to promote multi-agency solutions to support Charlotte. Although response officers continued to attend calls, the Mental Health Team tried to encourage a more strategic approach to her problems. It also began the work necessary to support an application for a Community Behaviour Order. However, Charlotte was never convicted of a criminal offence, so was never subject of a Community Behaviour Order.

3.8.8 Kent Police's approach to Charlotte's allegations of domestic abuse from January 2017 to March 2018 seems to have been uncoordinated. Its records conflict on the action taken: on 13 January 2018, an Acting Detective Sergeant stated that *'…it is my firm belief that [Charlotte] is fabricating [all allegations against PB] for attention or malicious reasons'*. Six days later, she was subject of a MARAC referral by Kent Police having been assessed as high risk following a report of abuse by PB. In 2016, one of Charlotte's previous partners received a suspended prison sentence and a restraining order for domestic abuse offences committed against her. The assertion eighteen months later she was making up all the allegations against PB showed a lack of acknowledgement of that history and was not victim focused.

3.8.9 Specific offences that Charlotte reported included rape, burglary, threats and harassment, all of which fit the definition of domestic abuse because Charlotte and PB had lived together. She reported these while living in different towns, and Kent Police dealt with them in those locations. This is potentially another example of an organisation that covers Kent and Medway struggling to coordinate its involvement with a vulnerable person leading a transient lifestyle.

3.9 British Transport Police (BTP)

3.9.1 BTP is a non-Home Office police force that provides policing services for the railways. It had an established Suicide Prevention and Mental Health Team prior to Charlotte becoming an adult. From August 2017 to March 2018 she was an open case to the team. During this time, its staff made numerous enquiries of relevant organisations to get an understanding of Charlotte's current situation, and what treatment and support she was receiving. This was good practice because it provided information that, while not resolving Charlotte's problems, enabled them to better provide her with an appropriate level of service when they dealt with her. This was enhanced by briefings about Charlotte given to BTP staff who were likely to respond to calls involving her. The BTP was an example of an organisation whose systems could cope with Charlotte moving around Kent and Medway because the Suicide Prevention and Mental Health Team covered the whole area.

3.10 Multi-Agency Risk Assessment Conference (MARAC)

3.10.1 Charlotte was the subject of referrals to MARAC meetings held in June 2016, and July and October 2017. At the 2016 meeting, the alleged perpetrator was different to those held in 2017. Organisations that knew Charlotte shared information about her and, where appropriate, actions were allocated. Each meeting was in a different MARAC area and those in 2017 did not reference previous meetings.

3.11 Multi-Agency Working

3.11.1 Examples of good practice and areas for improvement in sharing and seeking information from other organisations have been highlighted in the analysis of each agency's involvement with Charlotte.

3.11.2 Charlotte repeatedly claimed she had children or that she was pregnant. She never gave birth and although she had one positive pregnancy test, it is likely that she was never pregnant. There is little evidence that she was ever challenged about her claims, even when it was clear that professionals knew of a propensity to make false claims. If she was ever believed, it never resulted in a referral to Children's Social Work Services, which would have been expected given her mental health problems and lifestyle.

3.11.3 Similarly, Charlotte often claimed to be suffering from serious medical conditions. She variously told health professionals that she suffered from epilepsy, cystic fibrosis and Type 1 diabetes. There is no record that she was ever diagnosed with any of these illnesses. Her father had no knowledge of such diagnoses, although he said that she told him she was suffering from Type 2 diabetes, which she referred to as 'sugar diabetes'. Again, there is no record of diagnosis of this condition. It is unclear whether medical professionals did not question Charlotte about the illnesses because they did not believe her and dismissed her claims or because of a lack of professional curiosity.

3.11.4 Had there been more communication between agencies, it would have become clear that Charlotte's mental health issues were causing her to make false claims about illness, pregnancy and motherhood. There is little evidence that these issues were shared.

3.11.5 A promising multi-agency development arising from a previous SAR is a recommendation for Kent Police to establish a Community MARAC process known as Operation Engage. This involves organisations sharing information on complex repeat caller and repeat presenter cases regarding vulnerable persons, who persistently call or utilise partner agencies for a variety of reasons. Through a coordinated approach with partners, this group will primarily seek to ensure that the individual's needs are addressed, whilst reducing demand and making the best use of limited resources of all relevant agencies.

3.11.6 As promising as Operation Engage is, there has been a lack of real progress since its inception and this is a missed opportunity. KMSAB should develop a multi-agency risk management framework, supported by appropriate policy and procedure and agreed with the Board partners, committing all agencies to working more closely together and more collaboratively with a shared approach to managing risk **(Recommendation 13).**

3.11.7 A footnote to the analysis is to recognise that, during the period from September to December 2017, when Charlotte was living with the parents of a friend in Town L, she was much happier. Her self-harming and reports of suicidal ideation reduced greatly. Organisations had far less involvement with her during this period. Her father said she felt safe again for the first time since becoming an adult. As soon as she left, her problems began again in earnest. Stability and safety appear to have been what Charlotte needed.

4. Conclusions

4.1 Charlotte was a vulnerable young adult with care leaving status with mild learning disabilities and chronic mental health issues, which had been diagnosed before she became an adult. She was a frequent user of the organisations subject of this Review; she was well known to many professionals. There are examples during the review period of her receiving good care and support, and of multi-agency working. Despite this, she died alone in circumstances that could have been foreseen. Charlotte was not an 'attention seeker'; she was a young person who, having left care on reaching adulthood, desperately needed help.

4.2 The issues arising from this SAR are either case-specific or systemic. Case-specific findings may relate to single events or courses of action. Systemic findings may apply nationally and relate to significant issues that cannot be easily resolved by local recommendations.

4.3 The case-specific findings identified in this Review are:

1. Failure to effectively transition and transfer Charlotte from children's to adults' social care and from CAMHS to adult mental health services.
2. CAMHS records held by SPFT, which contained a diagnosis of Charlotte's mental health conditions and a lot of background information, were requested late and were not then available to KMPT without written authority from Charlotte.
3. The failure to consider Charlotte's safeguarding when discharging her into the care of a person posing a risk to children in July 2016.
4. The frequency of the use of a ligature by Charlotte while an inpatient in a KMPT hospital.
5. The lack of focus on the service user during the transfer of Charlotte's case from Town L to Medway CMHT in 2018.
6. The failure to effectively deal with the safeguarding referrals made about Charlotte to Medway ASC in March 2018.
7. A lack of consideration of safeguarding in acute hospital A&E departments.
8. Kent Police arresting Charlotte for wasting police time, rather than seeking to safeguard her.

9. A lack of professional curiosity, particularly within NHS services, about how Charlotte was obtaining the drugs on which she repeatedly overdosed.

4.4 The evidence supporting the case-specific findings is set out in the analysis in Section 3 of this SAR. Each is subject of at least one recommendation.

4.5 The systemic findings are:

4.5.1 <u>Systemic Finding 1</u>

1. Organisations that deliver services through locally based teams may struggle to do this effectively when a person moves regularly, even if their transience is within the area covered by that organisation.

2. During her short adult life, Charlotte lived in eight towns: six in Kent and two in Medway. Her transience, coupled with problems that professionals experienced engaging her, caused difficulty for organisations that deliver services through small, geographically based teams. When a person moves to live in a new area, the service provision must also be transferred. Even if the transfer process is efficient and expeditious, this can result in a lack of continuity in care and support from the person's perspective, because the professionals delivering it change.

3. The professionals meetings that were held, including the MARAC, were locally focused. Once Charlotte moved out of the area, any agreed actions were unlikely to be delivered.

4. The service provided by some organisations, such as hospitals and GP practices, can only be delivered in a local area, but those organisations that cover the whole of Kent and Medway should consider how they can improve service delivery to people like Charlotte. This requires the identification of frequent, vulnerable users of services and assigning resources to them. This would ensure that service delivery is focused on what the person needs rather than being driven by organisational structure. The best example in this SAR of better service being delivered by a team covering a wider area is the 18+ Care Leaver Service.

5. The understanding that organisations covering Kent and Medway would gain from client-focused service delivery would enable them to inform multi-agency work with other organisations that are locked into a local area. This would also make it easier to address a client's holistic needs and reduce the disproportionate demand made on services by frequent users.

4.5.2 Systemic Finding 2

1. There is evidence in this SAR that, in respect of S.136, the same action was taken repeatedly, which not surprisingly yielded the same result. There were periods when Charlotte was detained by Kent Police under S.136 on an almost daily basis. In nearly all cases, she was discharged following assessment by mental health professionals. This is not a criticism of the police officers who detained Charlotte or the clinicians who assessed her; the former were exercising their lawful powers, the latter their professional judgement. However, repeating the same actions and expecting the result to change is not an effective way to deal with any issue. When the action deprives a vulnerable person of their liberty at times of crisis, but ultimately fails to address the cause of their problems, careful consideration should be given to whether, although lawful, it is appropriate.

2. This repetitive action stemmed from the lack of a joined-up approach to Charlotte's complex needs by all the organisations that dealt with her. 18+ tried to bring an element of coordination but their efforts were not supported. The work of Kent Police's recently established Mental Health Team provides some hope that things may improve. However, too often, organisations dealt with each of their frequent encounters with her as a discrete event, failing to develop a strategic approach to their own involvement, let alone working strategically with others. This resulted in repeated actions that were ineffective. A more coordinated approach between relevant organisations would have been more likely to achieve the primary aim of safeguarding Charlotte. It would also have resulted in a potential benefit for those organisations. An initially increased investment of resources might have led to a long-term reduction in demands for services.

3. It would show significant progress if there was senior level commitment by all organisations to Operation Engage (see para 3.11.5 above). The emphasis should be on the benefits to vulnerable people, but effective implementation could see a reduction in demand.

4.5.3 Systemic Finding 3

1. While Charlotte was an inpatient in a KMPT hospital under S.2, a Mental Health Review Tribunal decided she should be discharged and treated in a Therapeutic Community. An assessment at a Therapeutic Community then recommended she be treated in a secure environment. At that time, she was living in the community and could not be sectioned based solely on the Therapeutic Community recommendation.

2. Charlotte went from receiving treatment in a secure environment to living in the community without support. This was the result of an uncoordinated system that failed to recognise the potential consequences of decisions made in good faith. In Charlotte's case, the Mental Health Review Tribunal decision failed to consider that treatment in a Therapeutic Community is reliant on the person meeting its criteria for assessment. Charlotte did not meet these criteria, so the consequence was that she was left in a worse situation.

4.6 Overall Findings

4.6.1 This SAR identifies the failures of organisations to provide effective safeguarding to Charlotte. Senior leaders appear to have been unaware of the disproportionate demand a person with such complex needs and a transient lifestyle was placing on their organisations. Increasing demand needs effective management before calls for more resources gain traction; there was little evidence of this need being met in Charlotte's case.

4.6.2 There was a failure to address Charlotte's needs strategically. Practitioners worked hard and generally did their best during hundreds of interventions, but senior leaders have the skills to identify significant issues, and the creativity to produce innovative solutions. There was little evidence of any intervention at this level; if there had been, it could have driven an effective multi-agency approach. This is essential in complex cases, because multi-agency working is the only way to achieve a solution. Those representing organisations must have the necessary level of seniority to commit resources and the skills to persuade and negotiate with others to find the best way forward.

4.6.3 If such senior intervention is effective, it will result in processes that can be used repeatedly, an approach that parallels investing to save. It could also have the additional benefit of saving lives.

4.6.4 The need to better manage people with mental health conditions who present frequently to services has been recognised in Kent and Medway. In 2015, the Kent and Medway Mental Health Crisis Care Concordat Steering Group produced an action plan, which included the requirement to *'Develop a multi-agency repeat presenter protocol.'* In 2016 a previous Kent and Medway SAR (Mrs D) contained a recommendation that this action should be progressed. In a subsequent updated version of the action plan, a closed action states that *'…the definition of frequent attender criteria agreed, cohort of frequent attenders determined.'* The Review Panel members of this SAR are unaware of either the agreed definition or the cohort of frequent attenders. The evidence from this Review suggests that no

effective progress has been made on this action. The recommendation from the previous SAR is therefore repeated: 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. **(Recommendation 14)**

4.6.5 If the Concordat is struggling to establish a definition for a repeat presenter, NHS Scotland's guidance on frequent presenters provides one:

> *Adult frequent attenders at Emergency Departments are defined as patients age 16 and over who attend any Emergency Department 10 or more times within a year or attend 5 or more times within a 3-month period.*

4.6.6 The conclusion of this SAR is that there was no coherent intra- or inter-agency strategy for managing Charlotte's complex needs. This should have started when she was in the treatment and care of children's services, because it was clear she would need ongoing care and treatment in adulthood.

4.6.7 The poorly managed transition and transfer meant that Charlotte never benefitted from a coordinated approach that might have ensured she received the treatment, care and support she needed to safeguard her as an adult. Despite some good work by professionals at practitioner level and several professionals meetings, there was never the breakthrough that saw an agreed strategic plan to manage Charlotte's needs.

4.7 Family Concerns

4.7.1 The views of Mr Burton, Charlotte's father, about specific issues are mentioned at relevant points in this report, but below is a summary of the key points he raised during the meetings with the Independent Author/Chair of the SAR:

1. Charlotte received a lot of support as a child – *'they couldn't do enough'* – but little when she became an adult.

2. When a child reaches adulthood and comes from an institution where they have been closely supervised, they need a lot of care and support in an environment where staff are present. This may require persistent and concerted efforts.

3. In Charlotte's case, professionals did not consult with or listen to her father. The way he described the attitude of professionals *was 'We're trained, we're professionals, you're just parents.'* He added, about professionals *'They don't*

listen, they think [parents are] stupid and [parents] don't know their child.' He appreciates the confidentiality issues but feels he could have provided information that would have helped those supporting her.

4. The flat she was given in Town D was barely habitable. The only cooking facility was a microwave oven. The flat had not been cleaned since the previous tenant had left and there were pigeon droppings on the bedroom floor. Charlotte's social worker had not visited the flat before she took occupancy, so these issues were not addressed.

5. Recommendations

5.1 The Review Panel makes the following recommendations:

	Recommendation	Agency
1.	KCC Children's Social Work Services (KCC CSWS), KCC Adult Social Care and Health (KCC ASCH), Kent and Medway NHS Social Care and Partnership Trust (KMPT), and Sussex Partnership NHS Foundation Trust (SPFT) must each provide Kent and Medway Safeguarding Adults Board (KMSAB) with evidence of how they ensure the transition and transfer of care and treatment from child to adult services is now delivered in a well-managed, coordinated and client focused way.	KCC CSWS KCC ASCH KMPT SPFT
2.	KCC ASCH must provide KMSAB with evidence of the process the Adult Learning Disabilities Team uses now to decide whether a person is eligible for its services, and its criteria for closing a case when it fails to engage with a person who it has identified as meeting those criteria.	KCC ASCH
3.	Medway ASC must provide KMSAB with evidence that its response to safeguarding adult referrals is now managed effectively.	Medway ASC
4.	Medway ASC must have a system in place to ensure its AMHPs record mental health assessments in a timely manner and make relevant ASC staff aware of the results.	Medway ASC
5.	SPFT, NELFT and KMPT must provide the KMSAB with confirmation that patients' records are now transferred from CAMHS to adult mental health services in accordance with the provisions of Section 3 of the Health and Social Care (Safety and Quality) Act 2015.	SPFT NELFT KMPT
6.	KMPT must provide KMSAB with evidence that it has an effective process for transferring a client from one CMHT to another and that all relevant staff understand it.	KMPT

7.	KMPT must provide KMSAB with evidence of its plan to close the gaps in its environmental ligature risk controls, and that self-harm risk assessments with appropriate controls are being completed for patients who are resident in its hospitals.	KMPT
8.	KMPT must provide evidence to KMSAB that it has a process in place to ensure that, when the discharge of an inpatient is being considered, their safeguarding always forms part of the decision making and that all relevant professionals are invited to the meeting.	KMPT
9.	KMSAB should recommend the adoption of Maidstone and Tunbridge Wells NHS Trust's procedure for recording the description of patients to other hospital trusts in Kent and Medway.	KMSAB
10.	East Kent Hospitals University NHS Foundation Trust (EKHUFT), Dartford and Gravesham NHS Trust (DGT), Maidstone and Tunbridge Wells NHS Trust (MTW) and Medway NHS Foundation Trust (MFT) must each provide KMSAB with evidence of a robust adult safeguarding policy and that relevant staff have been trained in its implementation.	EKHUFT DGT MTW MFT
11.	KMSAB should highlight the concerns raised in this Review about the lack of professional curiosity displayed by health professionals about Charlotte's access to prescription drugs.	KMSAB
12.	Kent Police must provide evidence to KMSAB that its policies for dealing with vulnerable people are focused on ensuring that they receive the care, treatment and support they need, where appropriate involving other organisations	Kent Police
13.	KMSAB should develop a multi-agency risk management framework, supported by appropriate policy and procedure and agreed with the Board partners, committing all agencies to working more closely together and more collaboratively with a shared approach to managing risk.	KMSAB
14.	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.	KMSAB

Glossary

This glossary contains explanations of acronyms and terms that are used in the main body of the Overview Report.

Acronyms/Abbreviations

18+	(KCC Children, Young People and Education) 18+ Care Leaver Service
A&E	Accident & Emergency
ASCH	(Kent County Council) Adult Social Care and Health
CAMHS	Child and Adolescent Mental Health Services
CRHTT	(KMPT) Crisis Resolution Home Treatment Team
CMHT	(KMPT) Community Mental Health Team
EKHUFT	East Kent Hospitals University NHS Foundation Trust
GP	General Practitioner
IMR	Independent Management Report
KCC	Kent County Council
KMPT	Kent and Medway NHS and Social Care Partnership Trust
KMSAB	Kent and Medway Safeguarding Adults Board
MARAC	Multi-Agency Risk Assessment Conference
MASC	Medway (Council) Adult Social Care
MHA	Mental Health Act 1983
MHLDT	(KMPT) Mental Health Learning Disabilities Team
MMH	Medway Maritime Hospital, Medway
NELFT	North East London NHS Foundation Trust
NHS	National Health Service
PA	(18+ Care Leaver Service) Personal Advisor
S.2	Section 2 of the Mental Health Act 1983
S.3	Section 3 of the Mental Health Act 1983

S17	Section 17 of the Mental Health Act 1983
S.136	Section 136 of the Mental Health Act 1983
SAR	Safeguarding Adults Review
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SPFT	Sussex Partnership NHS Foundation Trust
SW	Social Worker

Terms

Looked After Child

The definition of looked-after children (children in care) is found in the Children Act 1989. A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

On reaching the age of 18, children cease to be considered looked-after by a council.

Independent Reviewing Officer

Independent Reviewing Officers are social workers, who are also experienced social work managers whose duty is to ensure the care plans for children in care are legally compliant, and in the child's best interest. All local authorities have a duty to appoint an Independent Reviewing Officer to every child in care. IROs are required to oversee the child's care plan and ensure everyone contributing to the care plan fulfils their legal obligations to the child.

Section 12 Approved Doctor

A medically qualified doctor who has been recognised under Section 12 of the Mental Health Act 1983 (as amended), who has specific expertise in mental health disorders and has received training in the application of the Act.

Approved Mental Health Practitioner (AMHP)

AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act 1983. They are responsible for coordinating the assessment and admission to hospital of a person who has been sectioned. AMHPs may be social workers; nurses; occupational therapists; psychologists.

Psychiatric Intensive Care Unit (PICU)

A PICU is a ward for people with mental health conditions who pose a risk to themselves, other patients or staff. PICU wards are locked and most patients will have been sectioned under the Mental Health Act 1983. Staffing levels on PICU wards are generally higher than on open wards.

Therapeutic Communities

Therapeutic Communities are structured environments where people with a range of complex psychological conditions and needs come together to interact and take part in therapy. Therapeutic Communities are designed to help people with long-standing emotional problems and a history of self-harming by teaching them skills needed to interact socially with others.

Most Therapeutic Communities are part-residential; clients stay for around one to four days a week. As well as taking part in individual and group therapy, clients are expected to do other activities designed to improve their social skills and self-confidence, such as:

- household chores
- meal preparation
- games, sports and other recreational activities
- regular community meetings – where people discuss any issues that have arisen in the community

Even if a care team thinks one of their clients may benefit from spending time in a Therapeutic Community, it does not automatically mean the Therapeutic Community will allow them to join. Therapeutic Communities may set guidelines on what is considered acceptable behaviour within the community, such as not drinking alcohol, no violence to other residents or staff, and no attempts at self-harming. Those who break these guidelines are usually told to leave the Therapeutic Community. The strict rules on behaviour mean Therapeutic Communities may not be suitable for a person who has significant difficulties controlling their behaviour.

Medway Street Triage Team (MST)

The MST was a pilot scheme run in Medway for a time during the review period. Its aim was to provide appropriate early help to people who appeared to be suffering from mental health disorders, which might make them liable to detention by the police under S.136 of the Mental Health Act 1983. A KMPT Community Mental Health would patrol with police officers and attend incidents involving people who might be suffering from mental health problems.

Section 42 Enquiry

An enquiry is any action taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

Community Behaviour Order (CBO)

Part 2 of the Anti-social Behaviour, Crime and Policing Act 2014 introduced CBOs, which came into force on 20 October 2014. A CBO is an order on conviction, available following a conviction for any criminal offence in the Crown Court, Magistrates' Court or Youth Court.

A CBO:

1. Prohibits the offender from doing anything described in the order (which might include a condition preventing specific acts which cause harassment, alarm or distress or preparatory acts which the offending history shows are likely to lead to offences (for example the individual entering a defined area));

2. Requires the offender to do anything described in the order (for example, attendance at a course to educate offenders on alcohol and its effects).