Version 4:

SAFEGUARDING ADULTS REVIEW

Report into the death of Adult Mr A. who was found dead on the 15th August 2017

Report produced by Richard Proctor
Independent Chair and Author

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ACKNOWLEDGEMENTS

Calderdale Safeguarding Adults Board would wish to place on record their sincere thanks to the family of Mr A. who worked closely with the board and Independent author. They provided valuable information and an insight into the life of Mr A. which was used in shaping and informing this review.

This Safeguarding Adults Review would not have been possible to undertake without the co-operation and information supplied to the SAR Panel by those agencies who provided care and support for Mr A. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.

This report reflects the combined views of the SAR Panel who have invested their time, commitment and expertise throughout this process. The input and professional support provided by the Business and Quality Assurance Manager, Designated Nurse for Safeguarding Adults, and Business Support Co-ordinator were invaluable throughout this process.

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Mr. A

All names in this report have been anonymised for publication and dissemination.

1. Introduction

1.1 Statutory Framework

Section 44 of The Care Act 2014 states that the Safeguarding Adults Board must arrange for there to be a review of a case involving

a) an adult in its area with care and support needs (whether the local authority was meeting any of those needs)

b) if there is reasonable concern about how the Board, or members of it or other persons with relevant functions worked together to safeguard the adult and

c) the adult has died and the board suspects that the death resulted from abuse or neglect. (whether it knew about or suspected the abuse or neglect before the adult died).

The decision to undertake a Safeguarding Adult Review in relation to the tragic death of Mr A. was made on the 2nd October 2017 by the Independent Chair of the Board, this following consideration of the case and being satisfied that the criteria to undertake such a review was met.

The timeline period for the review was identified as the 3rd August 2015 when Mr A. was identified as potentially suffering from Dementia up to and inclusive of the 15th August 2017 when he tragically died.

1.2 Summary of events leading up to his death.

Mr A. aged 70 years was found dead in the River Calder at Brighouse, West Yorkshire on the 15th August 2017. His cause of death was confirmed as drowning combined with a pre-existing heart condition.

Mr A. was reported as a missing person to West Yorkshire Police by a family member on the 14th August 2017. The last confirmed sighting of him alive was

captured on a CCTV system at 1955 on the 13th August 2017 which showed him struggling to walk on a street near the River Calder.

Despite what the analysis indicates was a comprehensive response by the Police in attempting to find him safe and well following his appropriate classification as a high risk missing person, he was tragically discovered dead and the cause of death confirmed as drowning combined with a pre – existing heart condition.

When his body was recovered he was found not to be wearing the Buddi monitoring system which had been provided by Adult Social Care (ASC), a measure utilised to manage the known risk factors in relation to Mr A. wandering and getting lost.

2.0 Service Involvement

The review was informed by information provided by the following agencies.

South West Yorkshire Partnership Foundation Trust- SWYPFT

West Yorkshire Police.

Calderdale Clinical Commissioning Group- CCCG

Calderdale Local Authority Adult Social Care- ASC

Calderdale & Huddersfield NHS Foundation Trust-CHFT

Yorkshire Ambulance Service- YAS

Glossary of Names

CC1 SWYPFT Care Coordinator

CC2 SWYPFT Care Coordinator

CSW1 ASC Social Worker

GP1 CCCG General Practitioner

GP2 CCCG General Practitioner

Summary of Significant Events

2.1 Mr A. lived independently for all his adult life. On the 3rd August 2015 when concerns were raised by his family in relation to memory loss and a general deterioration in his well-being, GP 1 considered that Mr A. at that time may be suffering from a condition of dementia. Alzheimer's disease is the most common type of dementia in the United Kingdom, the symptoms of which include an ongoing decline of brain functionality which may affect memory, thinking skills and other mental abilities.

2.2 On the 18th August 2015 Mr A. attended at the GP surgery. A six-point cognitive impairment test was undertaken by GP2 to assess potential mental deficits. Mr A scored poorly in the test. Such a score was indicative of a condition of dementia.

http://www.wales.nhs.uk/sitesplus/documents/862/FOI-286g-13.pdf

Additional concerns were noted in relation to his use of alcohol. No action other than words of advice in relation to this concern were provided.

Mr A. initially refused to be referred to the memory clinic to undertake a memory test, one of the processes undertaken to attempt to identify a diagnosis of dementia it being thought by GP2 that Mr A. had the mental capacity to make this decision.

2.3 On the 29th September 2015 the GP made a referral to Calderdale Single Point of Access (SPA) seeking support for Mr A.

This followed concerns raised by family and friends regarding Mr A.s deteriorating condition, that he lived alone and was suffering from memory loss. The referral was accepted, and the case allocated to the SWYPFT Older Peoples Community Mental Health Team.

2.4 On the 15th December 2015 CC1 attended at Mr A.s home address to undertake a memory screening assessment the outcome of which was unrecorded.

2.5 On the 6th January 2016 Mr A. attended his GP surgery to undertake his annual review in relation to a condition of hypertension. Hypertension is a term used to describe a condition where an individual has high blood pressure which if untreated can increase the risk of serious health problems such as a heart attack or a stroke. It was recorded by the GP health care assistant that his alcohol consumption continued to be above recommended levels.

https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/

No action was taken in relation to his alcohol consumption or escalated further for clinical oversight to be undertaken within the practice.

2.6 On the 3rd March 2016 Mr A. was arrested by West Yorkshire Police following a report being that he had stolen food from a local supermarket.
Whilst in police custody he provided a sample of breath which recorded an alcohol reading above that of the legal limit to drive. Whilst non-mandatory, no referral was made to alcohol treatment services though apparently when committing this offence, he was under the influence of alcohol.
The custody record recorded Mr A. had a condition of dementia although there was a lack of clarity that a clinical diagnosis of dementia existed at that time.
Mr. A was subsequently released without being prosecuted, the rationale recorded as it not being in the public interest to prosecute owing to mental health issues.
Information that Mr A. had been in police custody was shared with Calderdale Single Point of Access, no further action resulting from this contact.

2.7 On the 9th April 2016 Mr A. was admitted to Huddersfield Royal Infirmary with rectal bleeding. He was transported by Yorkshire Ambulance Service (YAS) who reported he was unkempt, confused, with short term memory lapses and provided information that highlighted his neighbours were concerned that he was not presenting in his usual manner.

Despite this information being made available, no safeguarding concern was raised by YAS.

2.8 At hospital it was recorded Mr A. had an existing condition of dementia and was admitted to the surgical assessment unit. He was subsequently referred to attend an outpatient appointment for a surgical procedure. Whilst in hospital a mini mental test was undertaken in which he scored poorly. This indicated potentially severe cognitive impairment.
MiniMentalStateExamination.pdf

Despite Mr A.s assumed diagnosis of dementia and the results of the mini mental test, no assessment was undertaken as to whether Mr A. had mental capacity to consent to the surgical procedure, or whether upon discharge if community support was required, in relation to his care and support needs.

2.9 On the 11th April 2016 a hospital discharge letter was received at the GP practice and viewed by GP 1. This letter identified an existing history of dementia, which was the first diagnosis of Mr A.s dementia recorded at the GP surgery.
Guidance published by NHS England -Dementia Good Care Planning
developed for primary care and commissioners advises as soon as practicable following dementia diagnosis, a written care plan should be developed in conjunction with the individual, social care and carers with the aim of improving post diagnosis treatment and support for people living with dementia.
No such plan was produced.
https://www.england.nhs.uk/mental-health/resources/dementia/

2.10 On the 11th May 2016 CC1 received information from Mr A. s family that he was refusing to attend hospital to undertake a brain scan. Additional concerns regarding him not eating and living in poor conditions at home were highlighted. This the first reference that Mr A. may be self-neglecting, though no safeguarding concern was made as detailed within Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure.
Multi-Agency Safeguarding Adults Policy and Procedure for West Yorkshire, North Yorkshire and York December .pdf

CC1 who had concerns regarding Mr A. s non-attendance for his scan, contacted the consultant to express concerns of the need for Mr. A. s attendance so that the scan could be undertaken.

2.11 Additionally on the 11th May 2016 a letter was received by Mr A.s GP from CHFT informing them Mr A. had declined to undertake a flexible sigmoidoscopy investigation which is used to check the inner lining of the rectum and lower part of the colon. This following his previous admission to hospital on the 9th April 2016. It is apparent an assumption was made Mr A. had mental capacity to make such a decision. No formal assessment was recorded in respect of his capacity.

2.12 On the 17th May 2016 CC1 visited Mr A. at his home address. CC1 recorded there was no deterioration with regards to evident self-neglect but recorded concerns relating to medication compliance, apparently not associating this behaviour as a potential indicator of self-neglect.

2.13 On the 10th June 2016 a letter was received at the GPs containing information Mr A. had cancelled the endoscopy appointment at the hospital. An endoscopy is a procedure undertaken to examine the inside of the body using an instrument known as an endoscope. Despite previous concerns raised by the family regarding his worsening condition, no contact was made with Mr A. to secure his attendance at the surgery. This would have provided an opportunity to consider the concerns raised by the family and consider whether he had mental capacity at that time to decide to cancel the hospital appointment.

2.14 On the 22nd June 2016 CC1 accompanied Mr A. to the hospital to undertake an MRI (magnetic reasoning imaging) scan, the conclusion drawn from this was there was gross generalised brain parenchymal atrophy with localised altered signal and volume loss in the right temporal and bilateral basal frontal regions of the brain. This may indicate old trauma related brain parenchymal damage. No recommendations were made by any agency upon receipt of this new information.

2.15 On the 16th August 2016 Mr A. failed to attend an appointment at the outpatient's clinic. This coincided with CC1 being away on leave and Mr A.s family

being unavailable to transport Mr A. to the hospital. The family were asked to contact the clinic to re arrange the appointment.

2.16 On the 1st September 2016 a concerned member of the public contacted the GP surgery relating to concerns regarding Mr A.s general well-being and that he was not changing his clothes. Consequently, a plan was established by the GP to offer Mr A. an appointment, so his well-being and alcohol intake could be assessed. This plan was never activated.

2.17 On the 20th September 2016 family members contacted SWYPFT regarding concerns for Mr A. in relation to his hygiene, reluctance to attend medical appointments and a lack of information that had been provided in respect of the outcome of the MRI scan which took place on the 22nd June 2016.

2.18 On the 7th October 2016 a visit to Mr A.s home was undertaken by the Locum Consultant Psychiatrist and CC1. Present were family members of Mr A. It was explained that Mr A. could be suffering from an Alzheimer's type dementia. Medication in relation to the condition was discussed as was a six-point care plan which included support from a worker in relation to hygiene and alcohol issues.

2.19 On the 24th October 2016 CC1 undertook a visit to Mr A.s home in company with the identified support worker CC2. The purpose being to discuss practical things that may assist Mr A. with his personal care needs and family were contacted to update them.

2.20 On the 29th November 2016 a letter was received by the GP from SWYPFT Older Peoples Service. This provided information that concluded Mr A. probably had a condition of Alzheimer's type dementia. Dementia Revealed (DOH 2014) recommends that an information prescription is supplied by GP practices upon initial diagnosis and then subsequently at annual reviews. Whilst this review has identified that annual reviews are undertaken by the practice there is no evidence to demonstrate such information was ever provided to Mr A. or subsequently his family. The letter once again highlighted issues in relation to his alcohol consumption and concerns in relation to personal care.

https://dementiapartnerships.com/wp-content/uploads/sites/2/dementia-revealedtoolkit.
Pdf

2.21 On the 1st December 2016 CC1 was replaced by CC2 as Mr A. s Care coordinator. A subsequent introductory meeting took place where family members were in attendance though it was not recorded that they were present. The GP was additionally informed by SWYPFT, Mr A. was now being prescribed Donepezil medication for treatment of his Alzheimer's condition. It was confirmed that CC2 would monitor Mr. A.s response to the medication over the forthcoming month.

2.22 On the 3rd January 2017 CC2 visited Mr A. at home after reportedly several failed attempts to make contact. The visit identified concerns relating to medication compliance where it is described tablets being "spread all over the table". This was the last recorded "face to face" visit undertaken by CC2.

2.23 On the 4th January 2017 Mr A. attended the GP surgery to undertake a lifestyle assessment. This was carried out by the health care assistant. The results evidenced a weight loss of 13lbs over the preceding 12 months and continued consumption of alcohol over and above the recommended levels. However, there was no clinical escalation of the issues highlighted to the GP.

2.24 On the 25th January 2017 a progress note is recorded by CC2 at SWYPFT to direct attendance payments to be paid to a family member. This an allowance paid by the government to help support people who are over 65 years of age and who are physically or mentally disabled. The rationale provided in making this request was that Mr A. had no understanding of the need to replace or repair things and may lack capacity. However, CC2 did not undertake any formal assessment as to whether Mr A. had mental capacity to make decisions in relation to finances or personal care.

2.25 On the 10th February 2017 Mr A. refused to attend an appointment at his GP surgery with regards to the results of blood tests that had been undertaken previously. This coincided with Mr A. cancelling a hospital appointment to undertake a planned sigmoidoscopy procedure.

2.26 On the 15th February 2017 a family member attended a planned appointment for Mr A.at the GP surgery. Concerns were raised regarding Mr A. living in poverty regarding his surroundings, issues regarding nutrition, compliance of medication, personal care and that he is now wandering were highlighted. Consequently, a contact telephone number for Gateway to Care (GTC), Adult Social Care (ASC) was provided to make a referral in relation to the concerns raised and they were advised to approach the chemist for the provision of a "dosette box to aid with medication management.
http://www.newlinepharmacy.com/pharmacy-services-2/dosette-box/

2.27 On the 21st March 2017 CC 2 contacted GTC requesting a pivotell dispenser to be provided to assist Mr A. with managing his medication and detailed concerns regarding memory loss. No risk assessment was undertaken.
http://www.pivotell.co.uk

2.28 On this same date a family member attended at SWYPFT premises to raise concerns Mr A. had not been visited by the agency they believed since November 2016. They informed SWYPFT Mr A. was incapable in attending to his personal cares, was non-compliant regarding his medication and unable to manage his finances.

2.29 On the 5th April 2017 Telecare (ASC) visited Mr A. at his home. Present were family members. The purpose of the visit was to arrange a pivotell to support Mr A. with his medication management. It was recorded Mr A. had issues relating to memory loss. No risk assessment was undertaken at that stage in relation to the management of medication.

2.30 On the 25th May 2017 the family member who had previously visited the GP on the 15th February 2017 made a referral to GTC, requesting an assessment for support to be undertaken in relation to Mr. A. Identified concerns included worsening dementia ,the pivotell supplied to support medication management was not working, that he hadn't changed his clothing in six months, personal care issues, poor

nutritional intake, that his central heating boiler had broken and that he was now getting lost on his way to the public house he regularly visited. It was confirmed no contact from SWYPFT had taken place for some time. Advice was provided regarding the potential deployment of a Buddi system and the completion of the Herbert Protocol document to help manage the issues in relation to him getting lost. Informal support was agreed in relation to the family providing microwave meals to the public house he visited so that the concerns relating to nutrition may be managed. No information was shared between ASC and SWYPFT regarding individual agency involvement, or how they may work together to manage the identified concerns.

2.31 On the 5th June 2017 the case was allocated to a member of ASC Community Social Work Practice Team, CSW1 to manage. CSW1 made 3 unsuccessful attempts to contact the family member referrer, to arrange an appointment, so they may meet with Mr A.

Upon the last unsuccessful contact, it was confirmed by CSW1 if there was no response an assumption would be made no further support was required from ASC and the case would be closed.

2.32 On the 13th June 2017 the family member referrer contacted ASC where an appointment was made to visit Mr A. on the 19th June 2017. Records do not show if any conversation took place at that time to consider whether concerns relating to Mr A. had escalated or explore other methods of communication to ensure Mr A. could be seen.

2.33 On the 19th June 2017 CSW1 visited the home of Mr A. but received no answer. A letter was posted at his home and two subsequent phone calls made to the family referrer to arrange contact but these were not responded to. Once more the same assumption was made that a lack of response meant no further support from ASC was required and the case would be closed.

2.34 On the 29th June 2017 Mr A. attended an appointment with GP2 accompanied by a friend. The friend expressed concerns regarding medication compliance, Mr A. being unable to manage the pivotell provided, that he recently had started falling and was not at home when friends or family attended. There is no established falls policy in Calderdale Primary Care though a physical examination was undertaken which identified no issues of concern. GP2 because of the growing concerns, established contact with the memory clinic (SWYPFT) regarding an outstanding review that required conducting.

2.35 On the 10th July 2017 CSW1 successfully met with Mr A. in the presence of the family member referrer. The issues as identified within the initial referral were confirmed by the evidence from the visit, though the levels of concerns had increased in relation to frequently getting lost, not eating, having no concept of time, losing his bank cards, out of date medication that was being taken from different prescription boxes and that he was leaving the house insecure. In response a referral to ASC reablement team was made to provide support. However, owing to his deteriorating condition this referral was later deemed inappropriate as detailed within the analysis section of this review. No formal risk assessment was undertaken, or safeguarding concern completed in relation to the identified issues regarding potential self-neglect as per, Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure.

Multi-Agency Safeguarding Adults Policy and Procedure for West Yorkshire, North Yorkshire and York December .pdf

2.36 On the 11th July 2017 CSW1 requested the supply of a Buddi system to support Mr A. regarding the concerns identified in relation to getting lost. They recorded concerns that Mr A. may be unable to remember to wear and keep the device charged, which was necessary for it to be effective.

2.37 On the 1st August 2017 CSW1 visited Mr A. and undertook a mental capacity assessment to establish if he had capacity to consent to the provision of the Buddi system. The conclusion drawn was that at that time he lacked capacity to consent to

its provision and a best interest decision made on his behalf for it to be provided. Records demonstrate the capacity assessment was back dated to the 10th July 2017 though not completed until 4th August 2017. The date and time of when the best interest decision was made was unrecorded or anything recorded to demonstrate a family member was present when this decision was taken. The Mental Capacity Act codes of practice clearly state, "consultation must take place before any such decision is made with anyone caring for the person or interested in their welfare". However, when family members were interviewed by the independent author they confirmed that they were present when this meeting took place and were consulted in relation to the provision of the Buddi system. Good practice would have been for CSW1 to record both the family's presence and how they had been consulted to evidence compliance with the Mental Capacity Act codes of practice.

Mental-capacity-act-code-of-practice.pdf

2.38 On the 2nd August 2017 it was confirmed by CSW1 that there was no known start date for the reablement service to commence supporting Mr A. but that a family member can provide interim support in the meantime. No risk assessment was undertaken in relation to Mr A. or carer assessment completed in relation to the family members capacity to undertake the role of informal carer.

2.39 On the 4th August 2017 a family member of Mr A. attended at Brighouse Police Station and shared information with West Yorkshire Police regarding the current medical condition and presenting risk factors relating to getting lost and wandering and the fact a Buddi system has been deployed to monitor his movements. Consequently, the "Herbert Protocol" was completed which could be utilised by the police to assist in locating Mr A. should the scenario present itself of him being reported as a missing person.

https://www.westyorkshire.police.uk/herbert-protocol-missing-person-incident-form
https://www.buddi.co.uk

2.40 On the 7th August 2017 a safeguarding concern was submitted via the NHS 111 telephone service locally provided by YAS, to Gateway to Care in relation to Mr A. It

highlighted concerns regarding worsening dementia, that he is becoming agitated, that no support was in place, he had soiled himself and is refusing to accept support. It included information that was recorded that the concerns had been referred to Mr. A. s GP who had been requested to contact Mr. A. within 24 hours. This however was contradictory to the report provided to the GP surgery with a request for the caller to contact the GP surgery within 24 hours. No such contact occurred or neither did GTC raise a Safeguarding concern which would have enabled immediate risk assessments to be undertaken and a multi-agency review commenced of the support currently being provided.

2.41 On the 9th August 2017 ASC in response to the concern contacted family members where it was reported by them that they were struggling to adequately support Mr A. and data from the Buddi system demonstrated he was wandering. No risk assessment was undertaken, no contact made with other agencies or safeguarding concern raised.

2.42 On the 14th August 2017 Mr A. was reported as a missing person to West Yorkshire Police.

2.43 On the 15th August 2017 Mr A. was found dead in the River Calder, Brighouse. by West Yorkshire Police.

3.0 Methodology

SAR methodology is non- prescriptive within the Care Act with the overall aims of the review that wherever possible it is both timely and proportionate.

In this case a systems model often utilised in undertaking Serious Case Reviews in Children's Safeguarding was broadly utilised, to identify factors that supported both good practice and what may have contributed to creating unsafe conditions where safeguarding practice may require improvement.

Such a model seeks to be collaborative in its approach where those directly involved in the case are centrally and actively involved in the analysis and development of the recommendations.

The process undertaken was as follows.

3.1 Panel Membership

A Safeguarding Adult Review panel was established consisting of senior managers nominated by their agency with no previous involvement in the case, and authority to effect change in their own agency, meeting on five occasions.

The Chair and author of the Overview Report has been commissioned by CSAB to produce an independent report and was not involved in the delivery of identified services; line management for any service or any individual mentioned within the report.

The author and the SAR Panel agreed terms of reference as detailed below to guide and direct the review. They undertook responsibility to look openly and critically at individual and agency practice; to identify whether this SAR indicates changes could and should be made to practice and if so how these changes will be brought about. An expert dementia advisor was sought via SWYPFT to support the panel with this review. Whilst unable to physically attend the meetings they did provide some remote support in answering queries raised through the process.

Agency	Role
Independent consultant	Chair and review author
Calderdale Safeguarding Adults Board	Business and Quality Assurance Manager
NHS Calderdale Clinical Commissioning Group	Designated Nurse for Safeguarding Adults
West Yorkshire Police Calderdale District	Detective Inspector
Calderdale and Huddersfield NHS	Head of Safeguarding

Foundation Trust	
Calderdale Metropolitan Borough Council	Service Manager Adult Health and Social Care
South West Yorkshire Partnership NHS Foundation Trust	Assistant Director of Nursing and Quality
Calderdale Safeguarding Adults Board	Business Support Coordinator

3.2 Terms of Reference

1. Are there lessons to be learned about the way in which professionals worked in partnership to support Mr A. and his family and to safeguard Mr A.?

2. Following the notification of Mr A. as a missing person, did partner agencies work effectively together to gather and share information?

   The SAR was asked to take into account:

   - What evidence was there of appropriate and adequate communication and information sharing between services?
   - The timeliness of interventions for Mr A. and his family.
   - Did services listen to the concerns of the family and did we act on the concerns raised?
   - Was mental capacity adequately considered and were the actions of services in relation to this appropriate?
   - Was risk to Mr A. adequately considered by services and were risk management actions appropriate and adequate?
   - To what extent did record keeping meet expected standards?
   - Were services easily accessible?
   - Were services co-ordinated?

3.3 Family Involvement

It was a priority for the panel to allow the family to have a voice in shaping and informing this review.

Subsequently the author and board business quality assurance manager met with family members to capture their view of events leading up to Mr. A.s tragic death.

They provided an insight into his life and evidence of his deterioration, captured in photographs of his visible presentation, as their concerns escalated.

3.3.1 They were complimentary of the initial work undertaken by CC1 highlighting the considerable efforts made by the practitioner to ensure Mr. A. attended his appointment to undertake a brain scan on the 11th May 2016. However, they were never informed of the handover of care coordinator to CC2 only discovering this information at the coroner's inquest.

3.3.2 They stated following contact by the family with GTC in May 2017, Mr. A. was supported with equipment for medication management, guidance on how to use his microwave oven and the provision of the Buddi system in relation to managing the risk posed from getting lost.

However no formalised care or risk plan was established and despite the items provided the same issues of concern continued which failed to address the issues.

3.3.3 Informal support was provided by family members and friends regarding nutrition, medication management and maintenance of the Buddi system, however their capacity or capability to provide the appropriate level of support was never assessed.

3.3.4 They dispute that they were contacted by ASC when they were considering closing the case owing to no established contact and felt throughout, communication to them as informal carers and between agencies should have been better.

3.3.5 Whilst it was not identified as an issue of concern by the family, information provided by ASC demonstrated that despite Mr A.s death on the 15th August 2017 the agency was unaware of this fact and subsequently attempted to make contact with the family on the preceding day following his death, to make enquires in relation to his care. Whilst recognised this was not a deliberate act to cause upset to the family, future other families in similar circumstances may be disturbed where

following the death of a loved one, agency contact is made where there is a complete unawareness of the death. The SAR panel expressed a desire that future situations of this nature should be avoided and a recommendation to establish a multi-agency information sharing protocol following the death of a service user in Calderdale is addressed at **Recommendation 11** below.

3.3.6 The family's overarching wishes were that the lessons learnt from this case, inform future practice and stated they now lacked trust in some of the agencies who they felt should have done more to safeguard Mr A.

The desired outcomes they wished to see following the review were

- More communication with family by professionals (via phone calls and visits);
- More help for informal carers
- A more assertive approach by professionals if attempted contacts and/or visits are unsuccessful;
- Workers should leave a note to say when they have visited (especially when there is no answer);
- Consider placing a flag on the record of a vulnerable person to show the need to share information with other agencies.

These have been considered and have informed the review recommendations as detailed within Section 5 of the report.

3.4 Documentary Review

- Relevant agencies provided chronologies of service involvement within the identified timeline
- The chronologies were utilised to create a multi-agency chronology
- Individual Agency Management Reviews were provided drawing on the terms of reference and ten key questions identified by the panel to assist with analysis and learning.
- Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure
- Calderdale Safeguarding Adults Board SAR toolkit

- The Care Act 2014
- NHS England Dementia Good Care planning
- Dementia Revealed 2014
- Alzheimer's Society
- Mental Capacity Act 2005
- Recognition and Services Act 1995
- Herbert Protocol
- The College of Policing Approved Practice Missing Persons Investigation Guidance
- The Management of Police information Codes of Practice

3.5 Learning Event

The event took place with multi-agency staff participation from the key agencies involved in providing care and support for Mr A. apart from the GP practice who did not attend.

The key objectives of the event were established as,

- To consider what happened and why
- Identify areas of Good Practice
- Identify areas for Improvement
- What are the lessons that we need to learn?

Emphasis was placed upon the participants to seek to avoid "hindsight bias" a psychological phenomenon where past events appear more prominent than they appeared while occurring and subsequently may lead to an individual believing an event was more predictable than it was, resulting in an over simplification of cause and effect.

3.5.1 Following a brief synopsis of the case it was established by participants that communication between agencies and with family could have been better. It was recognised as concerns escalated relating to Mr A. it was felt upon reflection earlier opportunities existed where a safeguarding concern could have been raised so that a risk assessment and plan may have been developed, informed by holding a Multi-

Agency Strategy meeting if deemed appropriate to share information between partners.

3.5.2 It was identified that addressing the complexities of individuals presenting signs of Self Neglect was a challenge for agencies in Calderdale and would benefit from further support with regards to policies, procedure and toolkits for practitioners in identifying and dealing with the issues.

3.5.3 The development of a Calderdale multi-agency risk enablement panel led by ASC and an existing mental capacity forum were highlighted as areas of good practice. Such a multi-agency forum it was felt if adapted from its current position could in the future be utilised to discuss cases such as Mr A. to seek problem solving solutions to address the challenges posed by such a case, but that its further development, existence and benefit required promoting owing to a lack of awareness across the partnership.

3.5.4 Areas for improvement were identified as,

- Communication between agencies requires improvement by raising awareness of existing information sharing protocols where safeguarding is an issue of concern.
- A requirement exists to raise the profile and content within the Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure relating to safeguarding concerns, risk assessment planning and management.
- Calderdale Safeguarding Adults Board to develop policy and procedure together with toolkits to assist practitioners in identifying and managing risks to adults in relation to Self-Neglect.
- Calderdale Safeguarding Adults Board to raise awareness of the existing Mental Capacity Act forum and Risk enablement panel.

These areas of improvement have been considered and informed the review recommendations as detailed within Section 5 of the report.

4.0 Analysis

Introduction

This analysis is based upon the written information provided to this review and upon enquiries and discussions held with the family and practitioners.

4.1 Term 1.

Are there lessons to be learned about the way in which professionals worked in partnership to support Mr A. and his family and to Safeguard Mr A.?

Analysis and Learning

Several agencies including GPs, SWYPFT, YAS, CHFT, ASC and West Yorkshire Police held information with regards to Mr A.s care and support needs, and concerns raised by family and friends with regards to his deteriorating condition.

The review has identified that whilst there were exchanges of information at different stages between agencies, no multi-agency strategy meeting or discussion was ever held to share information, review care arrangements or establish a Safeguarding plan to manage the identified risks of Self Neglect as Mr A.s condition deteriorated.

The information of when to consider such an approach is detailed within Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure “as likely to be required where a multi-agency perspective is required to assess risk, inform or contribute to a safeguarding plan or inform a formal enquiry”. No such approach was evident in practice in this case or apparently ever considered, despite several agencies holding information which if shared and considered would have allowed a coordinated Safeguarding plan to be established to manage the identified risks posed to Mr A.

Recommendation 1

Calderdale Safeguarding Adults Board to be assured that agencies have implemented the Joint Multi Agency Safeguarding Adults Policies and Procedures (April 2018), and understand the importance of risk management, holding multi-agency strategy meetings and developing a coordinated safeguarding plan where self-neglect is evident.

Analysis and Learning

There is evidence of the GPs listening to family concerns, acting upon these to arrange appointments with the support of family and friends. Additionally, making a referral to SPA in relation to Mr A.s deteriorating condition and checking on progress with regards to memory tests.

In November 2016 when it was formally recorded by the GP practice that Mr A. probably had a condition of Alzheimer's Dementia. *Dementia Revealed* a toolkit developed by the Royal College of General Practitioners recommends an "information prescription" is supplied by practices at initial diagnosis and subsequent annual reviews. The review has identified no such information was ever provided and forms part of the CCCG single agency recommendations.

The initial work of SWYPFT CC1 in accompanying Mr A. to the hospital to undertake an MRI scan, after initially refusing to attend is seen as good practice. There is evidence they established a relationship with Mr A. and his family through phone calls and joint visits.

However, when CC1 was replaced by CC2 contact with Mr A. and his family deteriorated the last recorded face to face visit by CC2 being in January 2017.

Additionally, the family and other agencies were never informed of the change of care coordinator and had been unsighted upon this until this was revealed to them at the Coroner's inquest. If the subsequent change of coordinator had been communicated to the family or other agencies, a similar relationship could have been established to enable them to work together in providing continued support to Mr A.

Recommendation 2

SWYPFT to assure Calderdale Safeguarding Adults Board that the Care Programme Approach is effective; that service users, carers, family members and partner agencies are clear about the process and expectations of service delivery, together with ensuring where appropriate the change of care coordinators is communicated.

Analysis and Learning

Families and informal carers are recognised as playing a vital role in supporting individuals diagnosed with dementia.

The definition of a carer (as defined within the Recognition and Services Act 1995) identifies anyone who is supporting a relative, friend or neighbour who cannot manage without help due to illness or disability.

There were several individuals who provided support for Mr A. who may have benefited from additional support to assist them in meeting Mr A.s complex needs.

These included assisting with medication management, supporting with nutritional intake and ensuring the Buddi system was functioning.

The review has identified no carers assessment as per the Care Act 2014 was ever undertaken by the local authority, with family or friends who were providing what was deemed as necessary care to Mr A.

Necessary care within the Care Act is defined as activities an individual requiring support should be able to carry out as part of normal daily life but is unable to do so.

Recommendation 3

ASC to provide assurance to Calderdale Safeguarding Adults Board that where individuals are deemed to be providing necessary care, that a carers assessment as per the Care Act 2014 is undertaken.

Analysis and Learning

Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure define an “Adult at risk**”** as someone who has or may have needs for care

and support (whether the authority is meeting any of those needs), is experiencing, or is at risk of, abuse or neglect, and because of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
The procedures detail that any person or agency may raise a Safeguarding Concern with the local authority where they are concerned an adult with care and support needs is experiencing, or at risk of abuse and neglect (including self-neglect).

By raising such a concern an initial safeguarding enquiry consequently should be undertaken by the Local Authority as per Section 42 of the Care Act. 2014.

This allows the local authority to assess the risks posed and review current support arrangements. If the concern is unresolved then ensure there is a proportionate response to manage the identified risks, together with considering a Safeguarding plan is established and a multi-agency strategy meeting is held to discuss the case and share information where appropriate.

Self-Neglect is defined within the Care Act 2014 as “covering a wide range of behaviour, including neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding”.

The review has identified there were several occasions where concerns raised by family or friends or identified by agencies indicated Mr A. may be at risk of Self Neglect, but these resulted in only one Safeguarding Concern ever being raised by YAS following contact being made to the NHS 111 telephone service on the 7th August 2017.

These concerns included failing to attend or cancelling medical appointments, issues with personal hygiene, that he had soiled himself, medication compliance, concerns regarding nutritional intake and weight loss, alcohol intake, falling, wandering and getting lost, failure to replace items within the household such as heating systems.

There was only one occasion on the 7th August 2017 where an agency made such a referral to GTC, this by YAS regarding Mr A.s deteriorating dementia, his refusal to receive support and that he had soiled himself. However, despite this referral no safeguarding concern was generated but instead the information being forwarded to

a duty worker, who contacted the family to inform them the case had been allocated to the reablement team but were still awaiting confirmation of a start date. Consequently, there was no risk assessment undertaken or other response to address the issues of concern.

The review identifies there were several missed opportunities to raise a safeguarding concern by agencies. The causation factor appears to have been the assumption that Mr A. always had mental capacity to make decisions although as already detailed only one formal assessment was ever completed. This has led the review to determine that practitioners made assumptions that his self-neglect was a personal lifestyle choice, despite the concerns raised by family and friends in relation to deterioration and presenting risk factors.

NHS guidelines recommend men should not regularly drink more than 14 units of alcohol per week. It was recorded on the 8th February 2017 by the GP practice that Mr A. was consuming 70 units of alcohol per week. NICE guidance states any individual who may be drinking harmfully should be assessed for risk to inform the development of an overall care plan that covers risk to self-including the risk of neglect. No such assessment was undertaken, or overall care plan developed to manage the risk posed to Mr A. in relation to self-neglect.

alcohol-use-disorders-assessment-for-harmful-drinking-and-alcohol-dependence (1).pdf

The lack of identification and recognition of Self Neglect as a potential Safeguarding Concern was a key theme identified throughout the review where it was apparent it was deemed as a lifestyle choice.

The learning event highlighted practitioners had challenges regarding identifying and managing the associated risks owing to a deficit in local policy, guidance and toolkits. The review has identified a requirement to close this gap to produce local policy, guidance and toolkits to support practitioners across the partnership.

Recommendation 4

Calderdale Safeguarding Adults Board to produce a policy, guidance and practitioner toolkits to assist in the management of the associated risks of Self-Neglect, including alcohol misuse and mental health concerns.

Calderdale Safeguarding Adults Board to be assured that all agencies recognise and apply the actions to take when an 'adult at risk' is self-neglecting.

4.2 Term 2.

Following the notification of Mr A. as a missing person, did partner agencies work effectively together to gather and share information?

Analysis and Learning

On the 4th August 2017 the "Herbert Protocol" document was completed when a family member visited the local police station. The report provided information to West Yorkshire Police regarding Mr A.s condition, habits and the identified risk factors of wandering and getting lost, together with information that he carried a Buddi system**.** This information provided, was recorded within the Force intelligence data base and could be used to aid the police in searching for Mr A. should the future scenario present itself where he was reported as a missing person.

The normal procedure adopted by West Yorkshire Police is for the "Herbert Protocol" to be completed and retained by a family member, carer or friend to be provided to the police in the event of the person going missing. Whilst on this occasion the "Herbert Protocol" information relating to Mr A. was recorded within the Force intelligence database, the code of practice in relation to the management of police information identifies when the police may obtain, retain and use information to discharge their duties effectively in support of a "policing purpose", one of which is clearly defined as "protecting life". Whilst the review has identified normal procedures in relation to the "Herbert Protocol" were not followed, considering Mr A.s identified risk factors which may have placed his life at risk, the retention of the information

and its subsequent use in directing the missing person investigation is deemed to have been appropriate in this case.

Management-of-Police-Information (1).pdf

On the 14th August 2017 Mr A. was reported as a missing person to West Yorkshire Police and within two minutes of contact he was appropriately assessed as High Risk owing to his vulnerabilities, this in line with The College of Policing Approved Practice Missing Persons Investigation Guidance.

https://www.app.college.police.uk/app-content/major-investigation-and-publicprotection/
missing-persons/

A comprehensive investigation was undertaken by the police which included extensive searches, house to house enquiries, use of social media, utilising specialist search advisors drawing on the information captured within the Herbert Protocol form.

With regards to the specifics of partner agencies working effectively together, there is evidence of the Police contacting the hospital to check whether Mr A. had been admitted, shared information of the missing episode with SWYPFT and made use of the data downloaded from the Buddi system to inform the search areas.

However, several agencies held information regarding Mr A. and the perceived risks relating to his deteriorating condition. A more holistic multi-agency input would have been beneficial regarding the information provided within the Herbert Protocol form. This would have enhanced the risk assessment process undertaken by the police in considering other known risk factors such as falling, alcohol and medication compliance, albeit the review has not identified this as a barrier with regards to attempts to find Mr A. safe and well.

Recommendation 5

When completing the Herbert Protocol document where the circumstances dictate that an individual may be assessed as "high risk", West Yorkshire Police should develop a process to identify other agencies providing care and

support to the person and obtain relevant information, subject to consent or as a best interest decision, to enhance future risk assessments and responses.

4.3 Term 3.

What evidence was there of appropriate and adequate communication and information sharing between services.

Analysis and Learning

As detailed at 4.1 at no time was a multi-agency strategy meeting held to share information between services to facilitate the development of a coordinated Safeguarding plan to manage the assessed risks posed to Mr A.

The review has sought to identify areas of good practice in relation to appropriate and adequate communication and information sharing.

With regards to the GP practice there is evidence of good practice in June 2017 of communication with the memory clinic regarding a follow up appointment for Mr A. not being undertaken.

In May 2016 SWYFPT CC1, made an appropriate communication with the hospital to facilitate Mr A. undertaking an MRI scan, sharing information they held in relation to his habits, to identify a suitable appointment time to ensure attendance. This is identified as good practice.

There were though missed opportunities where by communicating and using the information held by other agencies more effectively in this case, improvements could have been made in meeting Mr A.s care and support needs.

When attending hospital in April 2017 despite there being an assumption that Mr A. had a diagnosis of dementia, this was never confirmed by checking the GP record

which is available to view by the CHFT in the emergency department. This however had no negative impact upon the care and support provided to Mr A. at the hospital.

Establishing an agreed procedure to ensure this is undertaken in future similar circumstances CHFT have identified as an improvement action contained within this agency's IMR.

Following ASC involvement with Mr A. from April 2017 there were on three separate occasions considerations recorded of closing Mr A.s case. This following a lack of contact and an assumption made that everything must be in order owing to no response and subsequently no support was required. On no occasion did ASC contact SWYPFT or the GP surgery to identify contact details of family or friends, who may be able to assist with contact or gain a better understanding of his routine habits, so contact may be established.

This was identified by ASC during the review as a recommendation for improvement and contained within this individual agency's IMR.

4.4 Term 4.

The timeliness of interventions for Mr A. and his family.

Analysis and Learning

In August 2015 following the concerns raised by the family to the GP, interventions were timely with an appointment being made for Mr A. 15 days later, where the six-point cognitive test was utilised as an initial dementia screening test. Consequently, a timely referral was then made to the memory clinic.

Initially when SWYPFT began to support Mr A. from September 2015 interventions were timely where for example CC1 escorted Mr A. to secure his attendance at the hospital for his MRI scan to be conducted.

Following the case being transferred to CC2 interventions became virtually non-existent with only one face to face visit recorded as ever taking place in January 2017 and nothing subsequently after.

Following ASC involvement from March 2017 following a request by a family member for assistance regarding medical compliance, a pivotell medication dispenser was provided and a joint visit with family undertaken within two weeks. There are no performance indicators within ASC that would demonstrate as to whether this would have been judged as an appropriate length of time to wait. However, no risk assessment upon receipt of the information was made, details of the medication being missed recorded and potential consequences of doing so, which should have been captured to determine the timeliness of the response.

Mr A.s case despite the factors known at that time in relation to his deteriorating condition, had his case allocated to the reablement team who were neither equipped or available at that time to provide the appropriate level of support to Mr A. Subsequently he never received any support from this team before he died.

Recommendation 6

Adult Social Care to assure Calderdale Safeguarding Adults Board that the need for immediate risk assessment and risk management is considered when allocating resources and determining priority of response.

Analysis and Learning

In May 2017 ASC were aware of concerns in relation to wandering and whilst advice was given with regards to the supply of a Buddi system and completion of the Herbert Protocol, neither were supplied or completed until August 2017. As no risk assessment was undertaken in relation to these concerns it is not possible to judge if the timeliness of these interventions were appropriate.

The learning event identified ASC need to develop a systematic approach to undertake assessment of risk so that it may inform the prioritisation of case load and subsequently improve the overall management of risk.

Recommendation 7

Adult Social Care to assure Calderdale Safeguarding Adults Board that they adopt a systematic approach to assessing and managing risk where safeguarding concerns are identified.

Analysis and Learning

CHFT only had a brief interaction with Mr A. when he was admitted overnight in hospital in April 2016. Timeliness with regards to the interventions to identify a possible diagnosis relating to rectal bleeding and assessing his condition whilst in their care were timely and appropriate.

4.5 Term 5.

Did services listen to the concerns of the family and did we act on the concerns raised?

Analysis and Learning

In August 2015 when family raised concerns with the GP regarding Mr A.s deterioration these were acted upon with referrals made to the memory clinic relating to apparent memory loss.

In February 2017 where concerns were raised by the family to the GP relating to Mr A.s further deterioration and presenting risk factors these were responded to by providing contact details to allow the family to make a safeguarding concern to GTC.

In June 2017 when Mr A. attended the GP appointment with a friend and concerns were raised with regards to recent falling episodes, a physical examination was

conducted by the GP additionally contacting the memory clinic in relation to Mr A.s annual review which was outstanding at that time.

In September 2015 up to and including the time SWYPFT CC1 handed the case management over to CC2, there is evidence of CC1 undertaking joint visits and phone calls with the family, which facilitated CC1 to identify Mr A.s routines and visiting time preferences. In adopting such an approach CC1 ensured Mr A. attended an MRI appointment through accompanying him, which previously had proved challenging to Mr A. and his family.

Following handover of the case to CC2 from January 2017 no further contact with the coordinator and family is recorded as taking place.

In March 2017 a family member made representations to SWYPFT that Mr A. had not been visited for several months, was non-compliant with his medication, and unable to manage his finances or personal care. Consequently, a request for a pivotell to be provided was made, to assist with medication compliance and for CC2 to visit. The visit did not take place and despite the pivotell being provided by ASC following contact by SWYPFT, medication compliance continued to be an issue of concern.

In May 2017 a family member contacted GTC requesting support for Mr A. owing to his worsening dementia condition and increasing risk factors including wandering and getting lost. A comprehensive screening process was undertaken which identified the family concerns which included evident self-neglect and getting lost when visiting his regular public house. However, despite the information that was provided no safeguarding concern was raised by the agency though advice was provided to the family with regards to the Herbert protocol and provision of a Buddi system which was subsequently provided in relation to the risks posed to Mr A through getting lost.

On the 4th August 2017 a family member approached West Yorkshire Police to raise concerns in relation to Mr A.s wandering and getting lost, together with his worsening dementia condition. Consequently, in response the Herbert Protocol was completed by the police in conjunction with the family member and as described earlier assisted the police in searching for Mr A. following him being reported as going missing.

On the 7th August 2017 a family member contacted the "111" NHS telephone service to raise concerns regarding Mr A.s worsening dementia condition, that he is becoming agitated and has no support. This resulted in YAS making a Safeguarding referral to GTC. However no subsequent Safeguarding concern was raised, no risk assessment was undertaken the matter simply referred to a duty worker who contacted the family to explain Mr A. had been referred to the reablement team with no confirmed start date known at that time.

4.6. Term 6.

Was mental capacity considered and were the actions of services in relation to this appropriate?

Analysis and Learning

The Mental Capacity Act 2005 states a person must be assumed to have capacity unless it is established they lack capacity, if they have an impairment or disturbance that affects the way their mind or brain works, and the impairment means that they are unable to make a specific decision at the time it needs to be made.

The review has identified that Mr A. on 3rd August 2015 was recorded as potentially suffering from a condition of dementia when visiting his GP practice, the actual diagnosis confirmed to the practice on the 29th November 2016, the conclusion being he probably had a type of Alzheimer's disease.

Throughout the timeline of this review agencies who engaged with Mr A. recorded information regarding his condition which may have indicated he potentially could have an impairment or disturbance of his mind or brain. Despite this awareness the

review has identified that only on one occasion was capacity formally assessed, this by ASC. The assessment was recorded as commencing on the 10th July 2017 based on information gathered at that time but subsequently not completed until the 4th August 2017.

The conclusion drawn is whilst the review recognises an assumption of capacity existed, these assumptions were only ever tested on one occasion. A formal assessment may have identified Mr A. may lack capacity to make certain decisions which could have allowed others to make in his best interests particularly in relation to his care and the risks posed through Self-Neglect.

Recommendation 8

Calderdale Safeguarding Adults Board to understand the extent to which the Mental Capacity Act is implemented in Calderdale and make recommendations for improvement across the partnership.

4.7 Term 7.

Was risk to Mr A. adequately considered by services and were risk management actions appropriate and adequate?

Analysis and Learning

Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure state where neglect is suspected consideration of risk should be integral in all assessment and planning processes.

The review has identified that there was only ever one risk assessment completed in relation to Mr A. conducted on the 1st December 2015 by SWYPFT. This assessment identified risks relating to self-neglect however other symptoms associated with self-neglect for example body odour were not present which may have consequently influenced the decision at that time not to raise a safeguarding concern.

The procedures explain that the process should be dynamic and ongoing with the aim to identify current and potential risks.

Whilst the review recognises the initial risk assessment undertaken was good practice, at no time was it ever reviewed or revisited, despite the changing circumstances relating to Mr A.s deteriorating condition or the information ever shared with other agencies.

The deficit in relation to risk assessment, management and planning resulted in no formalised safeguarding plan ever being established.

This has been addressed within recommendation 1.

The review has identified several risk management actions that were utilised by agencies which attempted to address some of the presenting risk factors.

In relation to medication compliance a dosette box and pivotell were provided to assist Mr A.in self-managing his medication intake, informal support provided by a family member in relation to supervision, together with information provided by SWYPFT to the GP confirming they would be monitoring medication intake, though it is not evident this ever happened.

Despite the concerns in relation to medication compliance this was still an ongoing issue and highlighted as such on the 2nd August 2017 by ASC recognising whilst the family member could provide some support in relation to this matter it was unsustainable.

Hence the conclusion that is drawn is that whilst the actions taken were appropriate they were inadequate in eradicating the risk of medication compliance.

With regards to the risk posed from wandering, falling and getting lost, actions were taken which included the completion of the Herbert Protocol as described earlier and

making best use of technology through the provision of a GPS Buddi system which helped to track the movements of Mr A. and raise alerts should he fall. This system was provided on 1st August 2017 via ASC where it was recognised it would require charging on a regular basis and that Mr A. will need to wear it when venturing out of home.

On the 9th August 2017 ASC were informed by a family member that the Buddi data showed that Mr A. was wandering all around the local area and that they continued to struggle to support him.

As stated earlier, when Mr A. was found dead in the River Calder he was found not to be wearing his Buddi system.

When the family were interviewed by the reviewer they explained that from their perspective it was their view Mr A. was unaware that a Buddi system had been supplied to him and had he known so they suspected he would have refused to wear it. Consequently, the device was secreted within his favourite jacket which he regularly wore when venturing out the house. Tragically when he went missing he was not wearing his favourite jacket and consequently neither the Buddi system.

The completion of the Herbert protocol and deployment of the Buddi system were appropriate measures taken to attempt to manage the risks posed through wandering and getting lost.

The Herbert Protocol as described earlier assisted the police in attempting to locate Mr A. once he went missing.

The deployment of the Buddi system could have been more effective if a robust safeguarding plan had been established that ensured the system was always charged and worn when venturing away from the house. However, no such formalised written plan was developed which resulted in the system proving to be inadequate in mitigating or eradicating the known risks posed to Mr A.

Recommendation 9

Adult Social Care to assure Calderdale Safeguarding Adults Board that they have a mechanism in place for the deployment of a GPS tracking system, which includes assessing both an individual's mental capacity to consent to its provision; and their capability to utilise the system effectively; and that the provision is therefore suitable as an early intervention measure in keeping an individual safe before further deterioration.

A formalised written safeguarding plan should be in place and regularly reviewed which addresses how the system is maintained and the circumstances in which it is required to be worn.

4.8 Term 8.

To what extent did record keeping meet expected standards.

Analysis and Learning

Record keeping in relation to Mr A.s interaction with the GPs was found to be timely, accurate and captured concerns of family members in relation to his condition. The review identified this information was used by the GP following concerns raised by the family to enquire about delays in his annual memory review and demonstrated how the GP had sought to support Mr A. and his family by providing contact details for GTC and the Community Mental Health Team.

Regarding SWYPFT, initially appropriate and timely progress notes were recorded by CC1 including an initial risk assessment although this was never reviewed or refreshed.

Following handover of the case to CC1 the last recorded visit with Mr A. was in January 2017 and from then to the time of his death only limited information recorded, detailing contact with a family member and details of the provision of a

prescription. Such a lack of contact should have been identified through regular quality supervisory checks, the review has been unable to identify any evidence to indicate such checks were undertaken.

Recommendation 10

SWYPFT to ensure that quality supervision processes and systems identify failed or missed contact events so that interventions are applied to re-establish contact with the service user.

Analysis and Learning

In relation to ASC, case recordings were completed and appeared timely. Initial screening notes and duty notes were thorough identifying levels of concern and support required, but lacked risk assessments being undertaken, despite recording concerns associated with self-neglect, wandering and getting lost. There is documentary evidence of a mental capacity assessment taking place based on information gathered in July 2017 but used to support the provision of the Buddi system in August 2017. This does not support the principles of the Mental Capacity Act in relation to the assessment of capacity to consent should be time and decision specific.

A best interest decision was additionally made for the provision of the Buddi system but was undated. No record was made that family members were present when this decision was made or the fact that they were consulted to evidence compliance with the Mental Capacity Act codes of practice. Calderdale Safeguarding Adults Board should consider this issue when implementing **Recommendation 8.** above.

When attending hospital in April 2016 appropriate record keeping was undertaken by CHFT regarding Mr A.s clinical reason for his overnight stay. The notes recorded concerns in relation to diagnosis of dementia but failed to capture personal contact details of family members or friends who may be providing support for Mr A. Given nursing staff understood Mr A's dementia had already been diagnosed and that he

would therefore need support from a family member or friend as a minimum requirement to facilitate a safe discharge this was a significant omission.

Consequently, CHFT have identified this within their agency IMR, as an area for improvement to ensure such contact details are always recorded in future similar situations.

4.9 Term 9.

Were services easily accessible.

Analysis and Learning

When first presenting to the GP following raised concerns relating to memory loss and general deterioration, accessibility for Mr A. to services were effective. Despite an initial resistance from Mr A. to attend hospital appointments, through working together with a family friend the GP secured his attendance at the Memory clinic to aid with diagnosing his condition.

The GP did not have another consultation with Mr A. until June 2017 albeit Mr A. during this time had attended the surgery for routine lifestyle checks and vaccinations delivered by health care assistants.

A few months prior in February 2017 Mr A. failed to attend an appointment at the GPs, where a family member attending on his behalf, explained he had refused to attend. They raised concerns regarding medication compliance, poverty of surroundings and wandering. This shortly after his diagnosis of dementia had been confirmed. There was no attempt to visit Mr A. or arrange another appointment.

The GP did provide the family member with contact details for ASC GTC to make a referral, providing advice to contact the Community Mental Health team and chemist supplying Mr A.s medication, to seek provision of a dosette box to aid with medication compliance.

Whilst there is much ongoing debate regarding the challenge of managing the demands in relation to GP workloads and an aspiration of providing more proactive intervention in the community, the action taken is seen as appropriate in the circumstances.

Following referral by the GP to SPA and the case being allocated to SWYPFT Community Mental Health Older Peoples Service, CC1 worked in partnership with Mr A. and CHFT to secure his attendance at hospital to undertake an MRI scan.

There was further good evidence of service accessibility when CC1 attended the home of Mr A. with a doctor from SWYPFT where the diagnosis of an Alzheimer's type of disease was confirmed.

Following a joint visit by CC1 with the newly appointed CC2 who was taking over responsibility for Mr A.s care, only one initial visit on 3rd January 2017 is recorded with no further visits being undertaken by SWYPFT despite ongoing ownership of the case. A lack of engagement or visits being undertaken by SWYPFT is addressed by recommendation 10 above.

In May 2017 following contact by a family member to GTC to seek support for Mr A.s deteriorating condition, the case was allocated to CSW1, 11 days after initial screening.

The worker made attempts to contact the family member on three occasions without any response, whereupon an assumption was made that the lack of response indicated no further support from ASC was required and the case would be closed. No home visit was undertaken or consideration for other methods of communication to be utilised, for example communicating by letter.

Following further contact by the family member a visit to Mr A. s home was undertaken by ASC in June 2017. There was no answer upon attendance which

resulted in advice being issued to CSW1 at a supervisory meeting that further attempts at contact should be made but if these prove unsuccessful then the case should be closed. No consideration was given to contact other agencies involved with Mr A. to consider other approaches to establish contact.

Whilst it is recognised that cases cannot be left open indefinitely, consideration as to other methods of communication or working with other agencies who may have held information relating to Mr A.s movements and habits should have been attempted, before forming the assumption that no contact indicated no support was required.

This has been identified by ASC as an area within their individual agency IMR as a recommendation for improvement.

In July 2017 a planned visit went ahead with Mr A. at his home by CSW1. The same issues of concerns previously identified were recorded and worsening.

Despite this further deterioration he was not referred to the ASC crisis support service who deliver bespoke packages which may have met his care and support needs and manage the identified risks, but alternatively referred to the ASC reablement team, despite this team having the remit of supporting people to maintain and improve independence. Whilst this offer of support may have been made with the right intentions, it was inappropriate at the time as it would not provide the appropriate service in relation to meeting Mr A.s needs owing to his presenting risk factors and deterioration.

The reablement team never contacted Mr A. before his death, delays attributed to high demand upon this service.

This identifying issue relating to delays in provision is addressed at recommendation 7.

4.10 Term 10.

Were services coordinated.

Analysis and Learning

Whilst the review has identified that Mr A.s needs were complex, and his daily movements and habits proved challenging for agencies to always engage with him, there would have been significant benefit in agencies working more closely together in sharing information.

This would have enabled levels of concern to be established where potentially he would have been recognised as an “adult at risk” so a safeguarding plan may have been established in addressing issues in relation to self-neglecting.

GP, SWYPFT, ASC, West Yorkshire Police, YAS and CHFT all held information in relation to concerns regarding Mr A. but at no point was a Multi-Agency strategy meeting held to share concerns, share information or establish a coordinated safeguarding plan to manage the assessed risk as detailed in the Safeguarding Adults West and North Yorkshire and York Multi Agency Policy and Procedure.

It is unclear why such an approach was not considered in this case and dealt with above in relation to Recommendation 1.

During the Learning event it was identified ASC are establishing a risk enablement panel, where a complex case such as Mr A.s may have been utilised to identify problem solving approaches to such cases.

Whilst it has not been possible to quality assure this process at this time, in principle it would appear potentially good practice and something the Calderdale Safeguarding Adults Board may wish to champion, if the proof of concept can be established.

RECOMMENDATIONS

1. Calderdale Safeguarding Adults Board to be assured that agencies have implemented the Joint Multi Agency Safeguarding Adults Policies and Procedures (April 2018), and understand the importance of risk management, holding multi-agency strategy meetings and developing a coordinated safeguarding plan where self-neglect is evident.

2. South & West Yorkshire Partnership Foundation Trust to assure Calderdale Safeguarding Adults Board that the Care Programme Approach is effective; that service users, carers, family members and partner agencies are clear about the process and expectations of service delivery, together with ensuring where appropriate the change of care coordinators is communicated.

3. Adult Social Care to provide assurance to Calderdale Safeguarding Adults Board that where individuals are deemed to be providing necessary care, that a carers assessment as per the Care Act 2014 is undertaken.

4. Calderdale Safeguarding Adults Board to produce a policy, guidance and practitioner toolkits to assist in the management of the associated risks of Self-Neglect, including alcohol misuse and mental health concerns.

Calderdale Safeguarding Adults Board to be assured that all agencies recognise and apply the actions to take when an 'adult at risk' is self-neglecting.

5. When completing the Herbert Protocol document where the circumstances dictate that an individual may be assessed as "high risk", West Yorkshire Police should develop a process to identify other agencies providing care and support to the person and obtain relevant information, subject to consent or as a best interest decision, to enhance future risk assessments and responses.

6. Adult Social Care to assure Calderdale Safeguarding Adults Board that the need for immediate risk assessment and risk management is considered when allocating resources and determining priority of response.

7. Adult Social Care to assure Calderdale Safeguarding Adults Board that they adopt a systematic approach to assessing and managing risk where safeguarding concerns are identified.

8. Calderdale Safeguarding Adults Board to understand the extent to which the Mental Capacity Act is implemented in Calderdale and make recommendations for improvement across the partnership.

9. Adult Social Care to assure Calderdale Safeguarding Adults Board that they have a mechanism in place for the deployment of a GPS tracking system, which includes assessing both an individual's mental capacity to consent to its provision; and their capability to utilise the system effectively; and that the provision is therefore suitable as an early intervention measure in keeping an individual safe before further deterioration.

A formalised written safeguarding plan should be in place and regularly reviewed which addresses how the system is maintained and the circumstances in which it is required to be worn.

10. South & West Yorkshire Partnership Foundation Trust to provide assurance to Calderdale Safeguarding Adults Board that quality supervision processes and systems identify failed or missed contact events so that interventions are applied to re-establish contact with the service user.

11. Drawing on the learning from this case, Calderdale Safeguarding Adults Board should assure itself that statutory agencies have an established multi-agency information sharing protocol, to notify agencies of the death of a service user, to avoid unnecessary contact with surviving family members.

Additional recommendations generated by learning event

12. Calderdale Safeguarding Adults Board to raise awareness of the existing Mental Capacity Act forum and Risk enablement panel once established.