



**SAFEGUARDING ADULT REVIEW USING THE**

**SIGNIFICANT INCIDENT LEARNING PROCESS**

**OF THE CIRCUMSTANCES CONCERNING**

**ADULT C**

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**EXECUTIVE SUMMARY**

**The aim of this review**

Wiltshire Safeguarding Adults Board (WSAB) commissioned this Safeguarding Adults Review after the death of Adult C to establish learning in line with the Care Act 2014 Statutory Guidance. Agencies involved with Adult C have already undertaken work to improve local services and this report will add to that learning.

The review was carried out using the Significant Incident Learning Process (SILP) and was independently chaired and authored by Karen Rees.

**Findings**

Adult C was diagnosed with paranoid schizophrenia in 1989 and was resident in a local mental health hospital. However, supported by health and social care services, he was able to move out of the hospital to live independently.

At the time of his death Adult C was known to mental health services at the NHS and Local Authority and the Court of Protection Team at The Local Authority. Adult C was difficult for professionals to engage in his treatment. Adult C did not accept his diagnosis or comply with medication and because of this he was managed using a Community Treatment Order under the Mental Health Act. This ensured Adult C received his monthly anti-psychotic medication injection and reduced the risk he may have posed to himself or others. Those arrangements continued until he died.

In September 2017, there were increasing concerns about Adult C. There had been reports that Adult C’s behaviour was changing, and the police had been involved. There were also concerns about Adult C’s physical health and finally a neighbour informed the Housing Association that they were concerned for Adult C as they had not seen him that day. This led to a plan to recall Adult C to hospital for further assessment under the terms of the Community Treatment Order. It was necessary to arrange a bed for admission. This took a week.

When Adult C was recalled to the mental health hospital, it was recognised that his physical health was of grave concern. Adult C was admitted to hospital after a physical examination revealed he was emaciated and starved, and he died 8 days later as a result of community acquired pneumonia and paranoid schizophrenia.

After the death of Adult C his family found that payments to his personal account had been stopped and there were only a few pounds in the account. Adult C had not received regular physical health assessments and sufficient assessment of his capacity to make decisions in his own best interest are not clearly evidenced. Professionals had worked with Adult C over a number of years, however, the complexity of the case, Adult C’s reluctance to engage and a failure to work effectively across agencies posed an increased risk to Adult C’s health.

**Recommendations**

Adult C’s death has already led to changes in the way the Local Authority manage Deputyship Orders:

* + All customers of the Court of Protection team are subject to a risk assessment. Customers who do not engage are deemed high risk and are discussed in supervision every month.
  + A red flag system has been introduced that alerts managers to missed payments and visits.
  + New staff have been recruited to reduce caseload sizes.
  + A social worker has been recruited to the team.
  + Managers no longer hold a caseload.
  + Safeguarding training has been delivered to every member of the team.

The recommendations in this report also call for:

* + Measures to ensure improved communication and multi-agency approaches to care planning where adults at risk are unwilling to engage.
  + Better recognition of self-neglect and use of mental capacity assessments where someone who needs physical health care is reluctant to engage.
  + More effective engagement with families who are undertaking a caring role of those adults at risk who have long-term complex needs.

Agencies in Wiltshire have worked with, and Adult C’s family have spoken to, the author of this report to ensure that we can learn from experience and protect others from harm.

1. **INTRODUCTION** 
   1. Adult C was admitted to hospital after a physical examination revealed he was emaciated and starved. Adult C died 8 days later as a result community acquired pneumonia and paranoid schizophrenia. Adult C was known to mental health services of the NHS and Local Authority and the Court of Protection Team at The Local Authority. He was subject to a Community Treatment Order in relation to receipt of anti-psychotic medication and a Deputyship Order to assist with his finances.
2. **ADULT C BACKGROUND PRIOR TO SCOPING PERIOD**  
   1. The Background provides useful information to support the understanding of the rationale and ethos of the more contemporary care and supports learning.
   2. Adult C was the fifth child in a family that consisted of thirteen siblings (eight boys and five girls). As youngsters the family lived in two council houses knocked through to one. The family report a happy childhood and remain close today. Adult C was reported to have a wicked sense of humour. The family recall a comment on one of his school reports that reflected family thoughts of their brother: “His endearing ways are a joy to us all”. Adult C did not marry or have children. Adult C decided that he would like to seek a better life in Australia. He successfully emigrated and whilst there he worked and bought a home. He won the Australian lottery; the family described this as a substantial win.
   3. Adult C came back to the United Kingdom when he started struggling with his mental health. He was diagnosed with paranoid schizophrenia in 1989 and spent a considerable amount of time in a mental health hospital. In 2008 Adult C disengaged from services and was monitored by his family. He remained stable until December 2009. At the beginning of 2010, he was assessed under the Mental Health Act[[1]](#footnote-1) and although acutely psychotic he was not considered to pose a risk to himself or others.
   4. It was soon after this that the housing association who provided Adult C’s tenancy, revealed plans to refurbish the bedsits, to upgrade and develop a number of two-bedroom flats. Adult C was offered a one bedroomed flat close by, but he did not want to move. Adult C was eventually issued with a court order to move. It was anticipated that Adult C would not move and on the assigned date, several professionals were engaged in managing the move with the least distress to Adult C. In the end, Adult C agreed that he would look at the new flat. Once he saw it, he stayed, and no physical intervention was required. Adult C remained there until he died.
   5. Adult C was difficult for professionals to engage in his treatment and he did not accept his diagnosis or comply with medication. He was managed using a Community Treatment Order under the Mental Health Act in order to ensure he received his monthly injection. These arrangements continued until he died. Adult C was noted to be always clean and well presented; his flat, whilst sparsely furnished, was also always very clean.
   6. Historically Adult Cs finances were managed by his eldest brother until such time as he felt he could no longer undertake that role. The family agreed to their brother’s future finances being managed with the aid of the Local Authority Court of Protection Team. This agreement started out with letters of authority signed by Adult C. In 2012, when Adult C was assessed as no longer having capacity to manage his own finances, the Local Authority Court of Protection team were granted a Deputyship Order. This order was used by the Local Authority to manage all of Adult C’s day to day bills. There was a regular amount paid into a personal account of Adult C so that he could buy his food, clothes and any other sundry items. It was known that Adult C lived a frugal life, wearing the same clothes on most days. Due to this frugal lifestyle, money was building up in Adult C’s personal account. In October 2012, following discussions with his social worker, a decision was made by the Court of Protection Team to suspend payments until further monies were required. This was to be followed up when the statutory annual reviews were undertaken. The family had representation at a review meeting in November 2013 where this was discussed.
3. **ADULT C DURING THE SCOPING PERIOD**
   1. Adult C’s journey through services during the scoping period for this Safeguarding Adults Review, is identified in sections covering different elements rather than chronologically. There are some clear overlaps, but this approach provides the best opportunity to understand learning in this case.   
        
      **Mental Health**
   2. Adult C remained subject to the Mental Health Act with a Community Treatment Order in place throughout the period under review. Adult C’s mental health care plan was managed using the Care Programme Approach (CPA)[[2]](#footnote-2) with regular six-monthly reviews of medication and care. Copies of this were sent to the GP and were available to the Local Authority Mental Health Social Work Team on the database that the team had access to.
   3. Adult C remained at home in the community and received monthly visits by the Community Psychiatric Nurse (CPN) who was his Care Coordinator (as per CPA), from the Mental Health Trust to carry out monthly injections to manage his psychosis symptoms. Elements of care that required Mental Health Act administration were carried out by a Mental Health Social Worker from the Local Authority team. Adult C remained open to the Mental Health Social Work Team but not allocated to a specific worker; this happened as and when reviews or other Mental Health Act duties were required.
   4. Adult C always declined medication that would help to manage the side effects of his anti-psychotic medication. For example, he suffered from a significant tremor that could have been readily treated with medication.
   5. Adult C had a love of walking and was frequently not at home for his regular appointments. The CPN managed this by undertaking a cluster of visits to try and find Adult C at home. Historically Adult C would be issued with a recall to hospital for failing to comply with this medication regime.
   6. During the timeframe under review, Adult C was not recalled under his Community Treatment Order other than for the final admission to hospital. It appeared that having been recalled on several occasions previously that Adult C only had to be reminded of the terms of his Community Treatment Order. This appeared enough to result in a change in behaviour and Adult C agreeing to receive his medication.
   7. On 28/9/2017, there were increasing concerns regarding Adult C’s engagement. There were also reports regarding behaviour changes that resulted in him coming to the attention of the police. There were also concerns about his physical health. This led to a plan to recall Adult C to hospital for further assessment under the terms of the Community Treatment Order. It was necessary to arrange a bed for admission. This took a week and the recall happened on 03/10/2017. This was deemed the preferable option as opposed to immediate admission elsewhere in the country.
   8. There was family involvement in supporting Adult C with his Mental Health. The Mental Health Act requires a nearest relative[[3]](#footnote-3) to be identified. This is always the eldest sibling in cases where there are no spouses or parents. During the timeframe for this review, this role was undertaken by an older sister having passed from the eldest brother when he was no longer able to undertake the role. The main family contact, however, was a brother who lived close and visited Adult C. During the meeting the author had with the family, it was clear that these roles and what they involved and why they were needed were not fully understood.
   9. Adult C’s family were not invited to be part of the CPA reviews and were not aware of the content of the care plans.

**Presentations in the Community and Responses**

* 1. This section identifies that Adult C came to the attention of the police and other services following notification by members of the public and retail outlets for various concerns.
  2. The first incident in the scope of this review, happened in November 2015 when a member of the public informed the police that an attempted burglary was underway. It appears that Adult C had thought that he was viewing a property with the intention of moving. There was no crime committed and as Adult C was known to the police as a vulnerable person with mental health illness, information was sent to the Mental Health Control Room Triage [[4]](#footnote-4); police took no further action. This led to information being shared with the CPN. The information from the police indicated that Adult C was gaunt and thin.
  3. The CPN was due to see Adult C as his injection was due. When the CPN did see Adult C, it was felt that he would benefit from a social care assessment. A referral was made to the Mental Health Social Work Team for a care and support needs assessment. The visit from the social worker was difficult as Adult C did not want to communicate or engage in the assessment. Adult C did, however allow the social worker to view the kitchen. It was identified that the oven was not working and that some of the pots and pans needed replacing to help Adult C manage cooking better due to his tremor. This resulted in communication with the Local Authority’s Court of Protection Team to identify if there was money for kitchen equipment. It was also agreed that there should be an assessment by an occupational therapist to identify any further aids that would support Adult C.
  4. The Occupational Therapist was unable to engage with Adult C; there was no further occupational therapy or social work input for care and support needs.
  5. In the June before Adult C died, a neighbour reported to the Housing Association that Adult C was emptying glass bottles out of a recycling bin. The tenancy support officer contacted the CPN who spoke to Adult C. Adult C would not engage in a conversation about the behaviour. Housing did not know that Adult C had been spoken to nor did they follow up with the CPN.
  6. In the seven weeks prior to Adult C’s death, there were two further incidents. The first was in a local store where Adult C was banned. Adult C would not leave when asked and he entered into an altercation with a staff member. On the second occasion he was accused of stealing a pizza. In fact, he had paid for the pizza but had thrown the money at the member of staff. On both these occasions police were called. Police decided to handle these occasions sensitively given the known vulnerabilities of Adult C and no further action was taken. On the second occasion the police report records that a Police Community Support Officer (PCSO) was going to be having a meeting with Adult Services the following week.

**Physical Health**

* 1. Concerns were expressed regarding Adult C’s thin and gaunt appearance in November 2015. In the ensuing assessment and intervention that was attempted by the Social Worker and the Occupational Therapist, it was thought that Adult C may not be eating well due to lack of safe cooking equipment. Adult C’s reluctance to engage meant that there was no further intervention.
  2. There were also concerns expressed by family and professionals that Adult C may have a significant hearing loss. It was felt that further investigation and testing would not be possible due to assumptions that Adult C would not engage or comply with any testing or treatment.
  3. It was known that Adult C had stated no wish to engage with the GP practice. As required by the Quality Outcomes Framework[[5]](#footnote-5) for people with serious mental health concerns, Adult C had always been invited to attend the GP for routine annual reviews. Adult C only attended once back in 2007.
  4. In April 2017, Adult C’s brother had an appointment at the GP practice. Adult C’s brother updated the nurse on the current situation regarding Adult C. He stipulated that Adult C did go out and do shopping but did not engage with professionals other than to receive his monthly injection. He also informed the nurse that Adult C was very thin and did not eat very much. Adult C’s brother said that he would inform the practice if there was any change in Adult C but that he did not require any help from the practice at that time. The nurse updated the records of Adult C to reflect this.
  5. The CPN had attempted to undertake physical health checks but had not been able to engage Adult C. Within the timeframe of this review, the Mental Health Trust wrote to the GP in relation to Adult C’s physical health on two occasions. The latter of these being dated 07/09/2017, specifically outlined concerns with weight loss. There was no response from the GP practice to this request. It was known that Adult C would not attend the GP surgery.
  6. On 27/09/2017, a neighbour informed the Housing Association Tenancy Support Officer that they were concerned for Adult C as they had not seen him that day. The Tenancy Support officer was not in the locality so asked the local policing team to go and assess the welfare of Adult C. The Officer later left the Tenancy Support Officer a voicemail to say that they had to break in as there was no answer. Police had found Adult C sitting in the property, but he had made no effort to answer the door. They found him to be extremely thin and unwell looking and were going to report this to his mental health team. The officer said they had damaged the bolt on the door, but no other damage was done.
  7. Police transferred this information to the Mental Health Control Room Triage who recorded that all was well. On noting this information and concerns discussed with Adult C’s brother that he too had not had any contact with him recently, the CPN made plans to recall Adult C on his Community Treatment Order for further assessment.
  8. When Adult C was recalled to the mental health unit, it was recognised that his physical health was of grave concern. Arrangements were made to transfer him to the Acute Hospital the following day.  
       
     **Finances**
  9. Adult C’s payments into his personal account had been suspended in October 2012. In December 2015 there was still a balance of sufficient funds, therefore top up was not thought necessary. Adult C’s passbook was checked by the Social Worker that undertook the visit for a care and support needs assessment. Feedback to the Court of Protection Team was that there were sufficient funds in that account. Adult C did not appear to know that payments had stopped.
  10. The annual accounts were returned to the Office of the Public Guardian as is required. These consisted of the details of the account held by the Local Authority and not details of Adult C’s personal account. There was a question raised by the Office of the Public Guardian when the account was returned in 2014, as to why no payments of personal allowance were being made. No response or further activity was recorded at this time and the issue was not raised again by the Office of the Public Guardian. Annual reviews require a visit to the person; this would have included a check of the personal bank account passbook. These visits were not completed during the timeframe of this review. The last recorded visit was in July 2015. The CPN was not aware that payments had been suspended.
  11. The family did not know that payments had not resumed and assumed that all was well as finances were being managed by the Local Authority. It was only after the death of Adult C that the family found that there were only a few pounds in Adult C’s personal account and raised a concern.
  12. The system issues that led to the errors in undertaking these annual review visits will be subject to analysis in the next section.

1. **THEMATIC ANALYSIS AND LEARNING**
   1. Focussing on the systems that practitioners were working in at the time leads to important learning related to multi agency working to safeguard adults.
   2. Adult C was subject to several legal processes to manage his treatment, mental welfare and finances. Analysis of his care and treatment under headings related to these laws and processes is therefore useful.  
        
      **Application of Mental Health Act.**
   3. Adult C was subject to a Community Treatment Order for many years as it was clear that compliance with treatment was an issue. Over the years this appeared to ensure that Adult C had his monthly injections to keep his mental health stable. Initially, professionals within the Mental Health Team needed to recall Adult C to hospital fairly frequently to ensure he received his treatment. Adult C appeared to learn over the years, that if he had his injection at home this would prevent going back to hospital.
   4. In the timeframe of this review Adult C was more compliant and although recall papers were sometimes served, Adult C often agreed to have his injection rather than be recalled.
   5. Use of the Community Treatment Order meant that Adult C could live independently in the community, which was something that he was very clear he wanted. There was a recognition, however, that engagement with Adult C in any mental health recovery work or offers of care and support were likely to be unsuccessful. The only intervention therefore, that was reluctantly accepted by Adult C, was a monthly visit for his injection. Even then, that very rarely happened at the first attempt. The CPN adopted a ‘cluster visit’ approach to try and catch Adult C at home. Therefore, it appears that the Mental Health Act was used and had a reasonable effect.
   6. The family indicated some confusion regarding the various roles that they undertook. They did not understand the difference between the required formal Mental Health Act role of the ‘nearest relative’ and the more generalised Next of Kin/family contact/carer role. The Mental Health Act stipulates the order in which nearest relatives are appointed. In the case of siblings, it is the oldest sibling who is automatically given this role.
   7. In the case of Adult C, it was initially the oldest sibling (a brother), this was then passed to the next sibling (the sister next in age) by agreement when the older brother could no longer take on this role. This arrangement was checked at each stage that the Community Treatment Order was reviewed. On the last review in May 2017, the sister indicated that she was still happy to be the nearest relative. That was not to say that the younger brother who was known as the main family contact could not undertake the family contact role, but this was not the nearest relative. This issue also caused confusion when Adult C was admitted to hospital, with the hospital trying to contact the nearest relative and not the main family contact. There is therefore learning here to ensure, particularly in large families, that roles are clear to everyone.
   8. Alongside Adult C being subject to the provisions of the Mental Health Act, his day to day care within mental health services was managed using CPA. It appears, however, that CPA was not utilised as robustly as it could have been. Care plans were updated and reviewed as required (six monthly) and shared with the GP; care plans were not shared with the family. The family told the author that they had no idea about the CPA care plans or some of the issues that had arisen until after the death of Adult C.
   9. Use of CPA provides an opportunity for multi-agency reviews and inclusion of family particularly in complex and difficult cases. The care of Adult C and the patterns of behaviour regarding his approach to his medication had remained the same for many years. As difficulties were escalating, particularly in the last couple of months and Adult C was coming to the attention of the police more frequently, it would have been prudent to ensure that CPA reviews were undertaken more often. Adult C would have benefitted from these being a multi-agency process. This would have been an opportunity for all the information that each agency was aware of being shared. The shared understanding of the situation, the planning of care and intervention, could have resulted in a multi-agency plan that included all relevant family members.
   10. On reflection, the reasons why a multi-agency review was not considered may be that the CPN was not aware of all of the information and increasing concerns of other agencies. It was not apparent that Adult C was having any financial difficulties and the physical health issues had been referred to the GP (see below). The CPN was also carrying a considerable caseload at the time. This may have meant that long term cases that were well known, did not receive a fresh and objective view. On the face of it, Adult C was getting his injections and he appeared to be fairly stable from a Mental Health perspective.

**Learning Point 1:** Use of the CPA that includes a multi-agency review as well as input from family gives opportunities for sharing information, plans and thinking.

**Learning Point 2:** Clarity of family roles ensures good communication between families and professionals.

**Parity of Esteem and use of Mental Capacity Act[[6]](#footnote-6)/Care Act**

* 1. Parity of esteem is the United Kingdom Government’s plan to ensure that mental health is valued equally to physical health. Parity of Esteem is enshrined in the Health and Social Care Act 2012[[7]](#footnote-7) . It is known that people with a mental health illness are at higher risk of physical health problems, therefore for those with a mental health condition, access and treatment for physical health concerns should be equal.
  2. This was not the case for Adult C. It appears that because of his mental health difficulties, some assumptions were made regarding the engagement that Adult C would have with any professional whose intention would be to monitor or treat any physical health conditions.
  3. One example of this was the fact that professionals and family had concerns that Adult C had a hearing problem. When this was discussed at the Learning Event, professionals felt that, although they suspected this hearing problem, a decision was made that Adult C would not agree to being tested nor would he comply with any testing. This issue was therefore not explored more widely. Hearing as an issue that needed to be managed, did not form part of Adult C’s care plan and professionals did not appear to have tried to engage with Adult C to address his hearing issues. There was no planning for how Adult C would be alerted to professionals calling at his flat if his hearing loss meant that, on occasion, he would not hear the doorbell.
  4. There is documented evidence over several years of the apparent weight loss of Adult C. The Mental Health Trust Agency Report evidences several conversations with Adult C regarding the need for a physical health check. These were all declined. There were two referrals made to the GP practice by the CPN. The first referral coincided with a review that was due that Adult C’s brother gave information for at his own appointment. The second in September 2017, received no response. Adult C was therefore not seen regarding his weight loss.
  5. Contacts made with the GP practice, however, did not provide clarity regarding what action was being requested. It has been suggested that in a practice that receives hundreds of letters regarding many patients, that it is crucial that any action required of the GP is clearly highlighted. The term ‘BLUF’ (bottom line up front) is helpful here. This term is used to ensure that the recommendations and actions are clear at the start of a document rather than the end. In the case of letters to GPs, this ensures that the action required of the GP is clear at the start of any communication.
  6. It appears that whilst trying to maintain a relationship with Adult C, that it was in fact becoming increasingly difficult to engage with him. As identified in the above section, CPA reviews offer an opportunity for agencies to come together to plan and share thinking regarding best ways forward. This could have been the case with the issue of physical health checks. Using evidence base of the likelihood of poorer physical health in a person with enduring mental health illness, a more robust multi agency plan to identify ways to manage this should have been apparent. Regardless of whether Adult C engaged, a full and documented plan of how all agencies had tried to engage Adult C should have been evident.
  7. On each occasion that physical health care required an intervention, the Mental Capacity Act should have been applied. It does not appear that mental capacity was considered in terms of decisions Adult C was making when he was declining physical health care checks. Mental Capacity Assessment would have verified whether Adult C had capacity to understand the risks of not addressing the physical healthcare concerns that professionals had e.g. weight loss and hearing issues.
  8. If it had been deemed that Adult C did or did not have capacity to understand the risks he was putting himself at, then full and robust plans of managing this should have been apparent. The Mental Capacity Act allows for people to make unwise decisions, but that requires knowledge of the person to make such a decision.
  9. Where a person either with or without capacity continues to fail to address physical health care concerns, then the Care Act deems that may be self-neglect[[8]](#footnote-8) and therefore a safeguarding concern. Where a person without capacity is deemed to be self-neglecting, if the criteria are met, then a Section 42 enquiry[[9]](#footnote-9) can be undertaken. This would have again resulted in a multi-agency plan of how any risks and concerns would be addressed.
  10. A safeguarding plan may have included application to the Court of Protection (in the absence of a Health and Welfare Lasting Power of Attorney) to ensure that a court decision could be made as to how far professionals could go in order to ensure that Adult C’s physical healthcare needs were met. Where a person’s neglect of physical health is a serious concern and the person lacks capacity, then ultimately a case can be put before the Court of Protection to consider if there are any interventions that can be legally enforced. It is highly unlikely that the Court of Protection could force a physical health care intervention on a person such as Adult C who was very resistant to services. This course of action however, would have shown a concerted and documented effort to ensure every avenue had been tried.
  11. These actions could only be taken if there was a significant concern; it can be argued that the weight loss was well reported and had been noted over several years but had never been investigated. This may have resulted in a decision that in fact, as Adult C had always been resistant to services, then there was no ability to enforce any investigation or treatment. This would have meant that the decision had been made at the appropriate level regarding a person who lacks capacity, who was not engaging in physical health investigation or intervention that were deemed necessary by professionals.
  12. One of the factors that may have prevented professionals from seeing that Adult C was self-neglecting could have been that Adult C’s personal hygiene and cleanliness of his flat were never called into question; he did not present as a typical case of self-neglect. The definition is clear though, self-neglectful behaviours can be very wide ranging but include neglect of health.
  13. When Adult C was recalled on his Community Treatment Order following concerns that he was engaging less and less, it was noted on admission to the mental health unit that he was in a poor physical state. A question was raised as to why Adult C was not immediately transferred to the Acute Hospital. At the time of examination, the admitting medical doctor did not deem that Adult C was so ill that he required immediate transfer. It was felt that the mental health ward staff could manage his care overnight. It was further deterioration overnight that prompted a swifter transfer the following morning.
  14. When Adult C became too unwell to resist interventions and he was indeed assessed to not have capacity to decide on treatment decisions, he was treated in his best interests under the terms of the Mental Capacity Act.
  15. Another consideration in the treatment of Adult C’s physical health, was whether he was deprived of his liberty under the Deprivation of Liberty Safeguards[[10]](#footnote-10) when he was in the Acute Hospital. It was well known that Adult C had declined previous physical healthcare interventions. He, therefore may have chosen to try and leave hospital if he was physically able to. However, case law, from a court of appeal decision[[11]](#footnote-11) indicates that:

“any life-saving treatment of physical health will not in itself constitute a deprivation of liberty when an incapacitated person receives materially the same treatment as a capacitated person; thereby ensuring the care is non-discriminatory”.

* 1. There was no evidence that any investigations whilst Adult C was in hospital had identified a serious underlying medical condition that would have caused him to present in such a malnourished state. The cause of death was identified as Klebsiella pneumonia with schizophrenia as a secondary cause. The CPN who had given Adult C his last injection five weeks before Adult C was admitted to hospital, indicated that there had been enough muscle mass to inject with a normal sized needle and was not concerned regarding significant and /or sudden weight loss. As there was no post mortem or report to the coroner, it is not known if there was any other underlying condition or how quickly the weight loss had progressed.
  2. Hospital staff should have reported the death of Adult C to the coroner. A coroner’s report is always required[[12]](#footnote-12) when a person dies and:
* there is any question of self-neglect or neglect by others contributing to or causing the death;
* the deceased was detained under the Mental Health Act 1983.
  1. The Acute Trust Hospital records report the malnourished and cachexic state that Adult C presented with on admission. Further documentation during his time in hospital leading up to his death related to this. This did not lead to a safeguarding referral for concerns regarding self-neglect and no report to the coroner as a case of self-neglect.
  2. When admitted to the Acute Hospital Trust, there was initial confusion as to the Mental Health Act status that Adult C was subject to. Adult C had been recalled to a mental health hospital via his Community Treatment Order when he was admitted to the Acute Hospital Trust. This would have lapsed after 72 hours. The Community Treatment Order was not formally revoked, and Adult C was therefore still detained under the Mental Health Act Section 3.
  3. Referral to the coroner may not have led to a coroner’s post mortem as that would be the decision for the coroner. Without this, or a hospital post mortem, it has not been possible to understand if there was any more learning regarding the circumstances by which Adult C appeared to rapidly decline and died. The Acute Hospital stated that they had a conversation with the coroner with the outcome being that there was no involvement of the coroner required.
  4. It is not clear what the conversation with the coroner’s office included or why the decision was that there was no role for the coroner in this case. It can only be assumed that the two bullet points above were not made clear to the coroner within that conversation.
  5. It is of note that the Mental Health NHS Trust now has a CQUIN[[13]](#footnote-13) to ensure that physical health care checks are mandated in mental health services. The author has seen evidence of this in practice and understands the substantial benefit to patients and families of this recent development to ensure parity of esteem is embedded in everyday practice.

**Learning Point 3:** Robust communication that provides clarity of actions can ensure appropriate responses.

**Learning Point 4:** Including other agencies in CPA reviews can ensure a holistic approach to understanding risk and care planning**.**

**Learning Point 5:** Mental Capacity Assessments provide information as to the capacity of a person to understand their physical healthcare needs.

**Learning Point 6:** Safeguarding Processes need to be applied when there are concerns that a patient may have been neglecting their own care.

**Learning Point 7:** Where a patient is subject to Mental Health Act (or similar) or there are other circumstances that require report to the coroner, it is important to document decision making in this regard.

CPA

**Managing the resistant yet vulnerable person (Use of Criminal Law and Human Rights Act)**

* 1. In the early days of Adult C’s illness, professionals had learnt that the best way to keep him stable was to manage him in in as much as a ‘hands off’ way as they could. He responded better to this. In this way, professionals were working in the best interests of Adult C albeit that this was not formalised under Mental Capacity Act provisions. The mental health professionals (the CPN and the previous Mental Health Social Worker) who worked with Adult C, had remained a constant and this was helpful to Adult C who struggled to engage with many different people.
  2. Other professionals such as the Occupational Therapist, the new Mental Health Social Worker and the Deputyship Officer tried to engage with Adult C at various points. Whilst there were records to suggest the difficulties with engaging Adult C, those professionals did not always request the support of the Community Psychiatric Nurse, who Adult C knew well, to gain access to assess and support Adult C. It was felt that this might have helped Adult C’s engagement in further assessments.
  3. The family made comment to the author that they were not made aware of when Adult C was avoiding contact with professionals. They believed that if they had been copied into correspondence when Adult C was due to attend an appointment or be seen at home, that they might have been able to try and facilitate his engagement. As the family were not involved in CPA reviews, where family may have been able to support, was not part of the care plan.
  4. Where an adult is very resistive to services, monitoring and managing care can be difficult. Being cognisant of trying to act within the Mental Capacity Act and Mental Health Act (discussed above), Adult C’s human rights were upheld as much as possible, so that there was no unnecessary detention or intervention in his life[[14]](#footnote-14).
  5. This way of working with Adult C was possibly responsible for ensuring that Adult C continued to live an independent life with his rights and dignities being upheld. Albeit that he came to the attention of Police on occasion, he rarely became aggressive and did not pose a risk to anyone else. On most occasions that he did come to the attention of the police it was because of misunderstandings in the way that Adult C was presenting and not because of any aggressive behaviour.
  6. On occasion, Adult C had been accused of stealing food from stores. This featured in records and within the referral for this SAR. This review has not found evidence to prove that Adult C was actually stealing food. Adult C did come to the attention of police via food retail outlets, but he was not found to have stolen food. It is not clear if the behaviours that were of concern were because of agitation due to a shortage of money to buy food (discussed below), or if he was becoming more unwell physically and/or mentally. It does appear that there was a correlation between increasing incidents of coming to the attention of police, and the shortage of money that is now known.
  7. It was understood by this review that Adult C was well known to the community and local shops. It is not clear how many other times Adult C may have come to the attention of retailers regarding concerning behaviours that went on to be managed without police involvement.
  8. Where officers did attend incidents, they were able to see on their systems, that Adult C was known to mental health services and his history. This led to a sympathetic and sensitive view being taken. On these occasions, information was sent to the Mental Health Control Room Triage Team to enable information to be communicated to the CPN. This usually led to a response from the CPN.
  9. When Adult C was accused of taking a pizza from a local store, it is noted that a PCSO had recorded that there was to be a meeting with Adult Services the following week. In the production of the Police Agency Report, there is no further recording regarding this and the PCSO does not have any recollection of this. Adult Social Care do not have a record of any meetings planned with Police. Police have made a single agency recommendation regarding this learning.
  10. In the course of discussing these events, Police agency representatives have questioned whether a more robust multi agency response would have been triggered if Adult C had been subject to arrest under criminal law. Whilst the response taken by police was deemed to be in Adult C’s best interests, it led to a disjointed episodic reaction rather than a more robust multi agency risk management response. It was stated at the Learning Event that there is a lack of process for ensuring those who are not arrested, receive as robust a response as those that are. It was suggested that a person with a mental health illness that is arrested, receives immediate and robust intervention to address their needs and prevent reoffending. A person who is treated more liberally and sensitively because of their mental health condition, receives a less robust intervention.
  11. The author would consider that this is the purpose of the Mental Health Control Room Triage Team. In this case, the information was always transferred to the CPN, therefore, for those with a mental health condition, this response would seem appropriate.
  12. It is fair to say, that had there been multi-agency CPA meetings, then it is likely that the neighbourhood police would have been involved. It was Police that were passing information to the Control Room Triage Team, when Adult C came to their attention.
  13. Supervision is a key process to support professionals who are managing people like Adult C, who have long term and enduring mental health illness and are resistant to services.
  14. Those working with Adult C in the long term, did have regular and robust supervision. What was different was the long-term nature of this case. A tolerance can build up that requires regular objective reviews as to effectiveness of methods of working.
  15. It is clear that cases of this nature would benefit from a regular desktop review. The Mental Health Trust has considered this and will make recommendations, within the review of the CPA Policy to ensure that this happens in future.

**Learning Point 8:** CPA reviews that include other agencies can be a useful tool in sharing thinking and planning best responses to those who resist services.

**Learning Point 8:** Information coming from Street Triage Teams may evidence the need for a multi-agency review.

**Learning Point 10:** Professionals working with resistant adults benefit from regular and robust supervision to support their work and thinking and to allow for reflection and objectivity.

**Office of the Public Guardian[[15]](#footnote-15) and Deputyship Order for Finance[[16]](#footnote-16)**

* 1. Adult C’s finances were managed via a Deputyship Order made to the Local Authority. The suspension of regular payments in 2012, when amounts were building up in the personal account of Adult C, is not in question as this appears to have been the right decision at the time.
  2. It is a requirement of the order, that annual accounts are submitted to the Office of the Public Guardian, and although these on occasion had to be chased, the accounts were submitted annually.
  3. The Local Authority Court of Protection team, who manage the Deputyship Orders, do not have access to the personal account passbooks of clients. These should be subject to review on annual visits. There are several reasons why the decision to suspend payments did not receive review as it should have:
  + Adult C was resistant to visits so some of the visits that were attempted were not successful.
  + It was noted that although there was a diminishing amount within the account, (indicating that money was being spent) reviews up to 2015 indicated that there were still ample funds to sustain day to day expenditure of Adult C. Adult C was known to have a frugal lifestyle. Professionals discussed Adult C’s frugal lifestyle during the SAR review process. It was believed that Adult C lived on about £100 a month. This did not lead to questions as to whether adequate and nutritional food could be purchased with this level of monthly spending or whether more money was required.
  + Adult C was not aware that payments had been suspended. This became apparent as he told the assessing social worker that he got paid every three months.
  + Family were not aware that payments had been suspended, there was very little engagement with Adult C’s family by the Deputyship team.
  + The CPN was not aware that payment had been suspended.
  + There was no ongoing social work intervention and therefore there were no reports of how Adult C was progressing on the local authority record systems.
  + There was no trigger to managers of outstanding annual reviews or visits.
  + Court of Protection team were not contributing to CPA reviews or routinely gathering information from others before annual reviews.
  + Mental Health staff had little knowledge of how the Deputyship officers worked.
  1. For these reasons it was not identified that Adult C had very limited funds until after he died. It cannot be known if the alleged theft of food from supermarkets or the incident where Adult C was found emptying a recycling bin was linked to not being able to buy food. It is known that on a visit to Adult C by the CPN five weeks before hospital admission, that there was food packaging evident in the flat. Adult C had indicated he was going to be cooking food later that day.
  2. During the review, there were some suggested reasons for gaps in information sharing and communication between mental health teams and deputyship teams related to the organisational change that happened in May 2013.
  3. Prior to this time, the mental health service was an integrated service with teams made up of health workers and social workers. This enabled closer working and sharing of information with other local authority teams. Following the change, Adult C’s main care came from the Mental Health NHS Trust. The local authority mental health social work team provided the Approved Mental Health Professional function as required by the Mental Health Act. This was therefore on a needs basis and not allocated to a specific social worker. When the care and support needs assessment was being attempted, a social worker was allocated. Due to no engagement this assessment did not continue.
  4. Local Authority Court of Protection Team staff indicated that communication was easier when there was the integrated service.
  5. It has also been identified, that in cases where there are appropriate family members available to manage finances, either via a Lasting Power of Attorney or a Deputyship Order, then the local authority would no longer agree to hold a Deputyship Order.
  6. The Court of Protection team did not recognise that Adult C’s regular payments had not been reinstated when money in his account was diminishing. This issue was also not initially recognised as a safeguarding concern. The result of these failings however, led to a full investigation.
  7. As a result of the concerns that were highlighted in relation to this case and the investigation, many changes have already been made to the system of managing Deputyship Orders within the Local Authority Court of Protection Team. The following are now all in place:
  + All customers of the Court of Protection team are subject to a risk assessment. Customers who do not engage are deemed high risk and are discussed in supervision every month.
  + A red flag system has been introduced that alerts managers to missed payments and visits.
  + New staff have been recruited to reduce caseload sizes.
  + A social worker has been recruited to the team.
  + Managers no longer hold a caseload.
  + Safeguarding training has been delivered to every member of the team.
  1. Alongside these changes in the Local Authority, the Mental Health Trust have also recommended in their single agency report, that where a Deputyship Order is in place, that the information regarding annual accounts and visits is included in the CPA review.
  2. This review therefore, is not making further recommendation regarding this but will make recommendations of an assurance nature that changes have had an impact.

**Learning Point 11:** When the Local Authority Court Protection Team hold Deputyship Orders, their inclusion in any multi agency review is important to ensure all information is shared.

**Learning Point 12:** Where appropriate**,** Families’ involvement in annual reviews of accounts for those subject to Deputyship Orders ensures sharing of relevant information with those who are nearest relatives/next of kin.

1. **GOOD PRACTICE**
   1. It is important to note that most practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, Safeguarding Adults Reviews can also provide evidence of good practice. Agency Reports and attendees at the Learning Events were asked to identify good practice from their own and other agencies. It is important to highlight these as areas where learning can occur.

* All of the professionals working with Adult C, wanted the best for him and tried to let him live his life in the way he wanted. Professionals evidenced a person-centred approach.
* The CPN evidenced flexibility in order to try and ‘catch’ Adult C at home for his injections.
* Working with Adult C was recognised as complex and difficult, the Mental Health Social Worker (previous to scope of review) and the CPN did their best to keep Adult C engaged.
* The Agency reports evidence that professionals did know and understand Adult C, albeit that they did not always successfully engage with him.
* Police officers who engaged with Adult C recognised him as a person with vulnerabilities, they shared information with the Mental Health Street Triage Team rather than criminalise him.
* There was some evidence of good communication to try and limit visits with professionals working together.
* Adult C was recognised as a very vulnerable man who professionals worked with for six years to help support him to live independently in the community.
* When Adult C was admitted to hospital, staff there assessed he did not have capacity to make decisions for his care and treatment. They used the Mental Capacity Act Best interest decision making to carry out medical healthcare interventions in order to try and treat Adult C.
* Adult C’s family spoke very highly of some of the professionals involved in the care of their brother

1. **CONCLUSIONS AND LESSONS LEARNED**
   1. The main conclusions and learning identified within this review relate to the application of each legal and other systems and how they interacted together.
   2. Adult C had a longstanding history of schizophrenia and as such, was well known to the CPN who remained constant throughout the period covered by this review.
   3. There were two underpinning pieces of legislation that professionals were trying to balance in order to keep Adult C engaged; The Mental Health Act and the Human Rights Act.
   4. Whilst the Mental Health Act provided the necessary controls on Adult C to ensure that he received his medication, this was done in such a way as to allow for his privacy. liberty and security under the Human Rights Act. This very clearly enabled Adult C to remain as independent in the community as possible and to live his life with limited intrusion.
   5. This was commendable practice, but over the years it led to a tendency for professionals to see the behaviours they expected and not the changing nature of Adult C’s behaviour. This meant that a multiagency approach, that may have made a difference was not considered.
   6. Towards the latter half of the reviewing period, Adult C’s physical health appeared to decline to a level where he was admitted to the Acute Hospital Trust ‘emaciated and starved’. This review cannot discern whether the shortage of funds to buy food and/or an underlying physical health condition played a part in this. It is noted that no underlying health condition was diagnosed during his time in hospital. There is, however, a correlation between Adult C coming to the attention of police in food retail outlets, increasing frailty and eventual pneumonia. It was not assessed as to whether this was a case of self-neglect or if there were other causes for this decline. No safeguarding referral was made on presentation at either the mental health hospital or the acute hospital. This case only came to the attention of safeguarding services when family alerted professionals to the fact that there was no money in Adult C’s account. Initially this was not seen as a safeguarding issue leading to further delays before concerns of a safeguarding nature were highlighted.
   7. One of the difficulties was that Adult C did not like to engage with strangers, indeed those he knew he only engaged with on his terms. Therefore, when a social worker and an occupational therapist tried to assess Adult C’s care and support needs, this did not prove effective and assessments were not concluded. There was no plan for how best to achieve assessment and how best to work with Adult C. History showed that Adult C could be accepting of new situations (e.g. he accepted the new flat when he saw it) therefore new cooking equipment and cooker could have been delivered as the local authority had access to his funds. This action could have been undertaken in Adult C’s best interests and may have been accepted but this was not tested.
   8. Adult C did not want to be assessed for physical health conditions and did not access the GP as requested.
   9. This is where interaction with the Mental Capacity Act came in. On each occasion that Adult C did not seek support for physical health conditions, or did not access care and support help, these decisions should have been subject to Mental Capacity Assessment. Those who deemed the intervention was necessary, should have undertaken the assessment of capacity regarding those decisions and, if necessary, best interest decisions should have been made.
   10. This may well have meant Adult C having safe and working cooking equipment, but it would not have necessarily led to an acceptance of physical health care checks.
   11. This moves us then to information sharing and communication with all those involved, including family, in issues of concern. The vehicle for doing this was already in place but was not used as robustly as it could have been i.e. CPA. Reviews could have been undertaken involving family and other agencies. Plans could have been formulated to ensure that there was a joint understanding of the concerns and risks. This may have led to further processes being considered.
   12. Adult C was an Adult who did not appear to have capacity to understand the risks of not addressing the physical health concerns. This should have been deemed to have been self-neglect under Section 42 of the Care Act and therefore a safeguarding referral could have been made. This would have been another opportunity for a multi-agency response to the risk and concerns. It is of note that even after Adult C was admitted to the Acute Hospital and died in the circumstances that he did, there was still no recognition of neglect or self-neglect and the need to consider safeguarding processes.
   13. The Mental Health element of care and the CPA process did not include any knowledge of the Court of Protection team decisions regarding suspension of payments and that these had never been reinstated. As stated previously, it is not clear if there was a correlation to this and the stealing of food, but a multi-agency safeguarding, or CPA meeting would have led to shared information and this may well have come to light.
   14. The longstanding nature of the case did not lead to questions about the approach and risk management methods being utilised. Access to supervision did not lead to a rethink or challenge to reconsider if Adult C’s welfare was being maintained. When supervision in the Court of Protection team lead to an acknowledgment of outstanding visits, it did not lead to a visit to Adult C being prioritised.
   15. Albeit that there may have been no agreement from Adult C to address healthcare needs, a multi-agency plan and inclusion of family may have led to a shared understanding. It may well have been that if the risk had been better understood, that advice from the Court of Protection on how far professionals could go to be able to tackle unassessed health issues would have provided the documented evidence that all had been tried that could have been.
   16. This case highlights the difficulties faced by practitioners when a person does not comply with treatments. The Mental Health Act provides solutions for mental health and the Court of Protection can provide solutions for physical health where a person lacks capacity. Acting in a person’s best interests when they are resistant to assessment and/or treatment is not an easy position to be in. The Care Act provides for safeguarding a person who lacks capacity and may be self-neglecting.
   17. Ultimately, what is known is that Adult C had no money in his account when he died. In order to keep vulnerable people safe, systems need to provide barriers to failures being catastrophic. This means that no one system should be totally responsible for safety of a person such as Adult C. Other systems in place should provide triggers and alerts to possible failures in another system as an earlier warning. In that way, appropriate responses and actions can be formulated to prevent the catastrophe form occurring.
   18. It cannot be known whether, if all of the information available had been shared and all of the processes had worked as they should, the outcome would have been any different. What would have been apparent though, would have been documented evidence of the attempts and lengths that professionals had gone to in order to evidence that the systems were all operating efficiently and that no stone had been left unturned in order to safeguard Adult C.
2. **RECOMMENDATIONS**
   1. Where agencies have made their own recommendations from their single agency learning within their Agency Reports, WSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations. The Single Agency Recommendations are included in Appendix Two.
   2. The following recommendations are made to WSAB:
3. **Multi Agency Case File Audit**
   1. WSAB, through their audit function, should implement Multi Agency Case File Audit (MACFA) processes to test system responses to the learning from this review.
   2. Once implemented themed audits of cases in relation to the learning from this review should be undertaken:
   * People subject to CPA who are vulnerable and may require protection, evidencing that those cases are subject to multi agency CPA reviews. **Learning Point 1, 2, 4, 8 & 9 (As well as Single Agency Recommendations)**
   * People subject to Deputyship Orders managed by the Local Authority Court of Protection Team and have a low monthly spend. This needs to evidence that the new procedures and risk assessments are in place and highlighting appropriate responses to issues that are arising. **Single Agency Recommendations &** **Learning Point 11 & 12**
   * Where people are resistant to services and have been known for several years, caseload holders are subject to regular and robust supervision and that proactive desktop reviews are undertaken for such cases. **Learning Point 10**
4. **Self-Neglect**
   1. WSAB should ensure that professionals in Wiltshire have access to knowledge of the wide-ranging types and indicators of self-neglect. **Learning Point 5 & 6**
   2. WSAB should be assured that where a person does not engage in physical healthcare assessment and intervention, that action and decision making is underpinned by the MCA and self-neglect guidance. **Learning Point 5 & 6**
5. **Coroners Referrals**
   1. WSAB should seek assurance that there is clarity regarding the cases that should be referred to the coroner following death in hospital. This assurance should include that there is regular review to ensure that those in decision making roles are supported and have access to a supervisor. Decision making regarding reporting to coroner must be clear in-patient records. **Learning Point 7**
6. **Communication**
   1. The following recommendations are made in respect of communication. WSAB should seek evidence of implementation by use of appreciative enquiry or patient/client stories presented to WSAB as well as in MACFAs.
   * WSAB should ask those who write to GPs following consultations elsewhere, to ensure they adopt the BLUF (bottom line up front) model to ensure actions required of the GP are clearly highlighted at the start of the letter. WSAB should consider widening this advice to all those making formal communications on referral/post assessment/appointment etc. **Learning Point 3**
   * WSAB should seek assurance that Mental Health Teams (Local Authority and NHS) provide clarity to support families who undertake various caring roles e.g. nearest relative/ next of kin/nominated family contact roles. **Learning Point 1 & 2**
   * WSAB should seek assurance from partner agencies that, where appropriate (such as in the circumstances of this case), carers and families are copied into letters sent to patients/clients. Appropriate polices (e.g. CPA) should reflect this. **Learning Point 3**

**Appendix One: Terms of Reference (Anonymised and extended)**

1. **Introduction**
   1. Adult C was admitted to hospital after physical examination had revealed Adult C to have been emaciated and starved. Adult C died 8 days later as a result of hospital acquired pneumonia and paranoid schizophrenia. Adult C was known to mental health services and the Court of Protection Team at Wiltshire Council. He was subject to a Community Treatment Order in relation to receipt of anti-psychotic medication and a Deputyship Order to assist with his finances.
   2. This Safeguarding Adult Review is commissioned by Wiltshire Safeguarding Adults Board. The aim of the review is to establish whether there are any lessons to be learnt about the way in which local professionals and agencies worked together to prevent and reduce abuse and neglect of adults.
2. **Legal Framework & Methodology**
   1. The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.
   2. In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

* Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
* To explore examples of good practice where this is likely to identify lessons that can be applied to future cases  
  1. The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases.
  2. The Care Act 2014 Statutory Guidance states that the process for undertaking Safeguarding Adult Reviews (SARs) should be determined locally according to the specific circumstances of individual cases.
  3. WSAB agreed the criteria were met to undertake this review and to use the Significant Incident Learning Process (SILP)
  4. The Significant Incident Learning Process (SILP) methodology, reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers inthe review of the case, focusing on why those involved acted in a certain way atthat time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.
  5. This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.
  6. The SILP model of review adheres to the principles of;
* Learning from good practice
* Active engagement of practitioners
* Engagement with families
* Systems methodology
* Proportionality

1. **Scope of the Review**
   1. **Scoping period:** from thelast formal review by Court of Protection Team] to one month after death.
   2. In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of Adult C. This could include a significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review’s Terms of Reference.
2. **Agency Reports:**
   1. Agency Reports will be requested from:

* The County Council
* The Police (historic)
* The Mental Health NHS Trust
* The Housing Association
* The Health Centre (GP)
* The Acute Hospital NHS Trust Hospital (end of life care)
* The Ambulance Service
* Office of the Public Guardianship
  1. Agencies are requested to use the attached Report Template.

1. **The Lead Reviewer**
   1. Karen Rees is from a nursing background, having worked for 36 years in the NHS. Latterly Karen worked in safeguarding roles at a strategic level in two NHS organisations. Karen has worked with both Safeguarding Adult and Safeguarding Children Boards over a number of years and specifically on Serious Cases and Case Review sub groups. The lead reviewer is entirely independent of WSAB and its partner agencies.
2. **Areas for consideration:**
   1. Assessment:
      1. Were risk assessments carried out? How robust were these in terms of meeting any assessed need? Were these reviewed?
      2. How did the Care Programme Approach contribute to multi-agency analysis and evaluation of assessments and interventions?
      3. What mechanisms existed for communicating and managing any emerging issues and triggering a review?
      4. How were assessments, plans and interventions communicated to others who were providing care for Adult C?
   2. How were legal processes applied and reviewed to protect and care for Adult C e.g. Mental Health Act, Mental Capacity Act, Care Act, Court of Protection Processes etc. How effective were these in terms of keeping Adult C safe?
   3. How was Adult C’s family involved in the planning and delivery of his care and treatment? How were the family enabled to engage with services if they had concerns regarding planning and delivery of care?
   4. Was supervision and management oversight used effectively to support decision making and care delivery?
   5. Were professionals aware of others’ involvement, roles and responsibilities? Was professional challenge and escalation utilised where appropriate?
   6. How was working with Adult C, who had a long-term condition managed? How did understanding of him inform and change practice to enable best practice when dealing with resistant behaviours?
   7. How did recording systems contribute to care delivery and information sharing? Please analyse the impact of any issues with recording systems both within and across agencies.
   8. Identify examples of good practice, both single and multi-agency.
3. **Engagement with the family**
   1. A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. WSAB informed Adult C’s family that this Case Review is being undertaken. The author met with two of Adult C’s brothers and their wives in the week before the learning event. They provided some useful family information that has helped to inform the context for the background to this review. Their information and thoughts have been included within relevant points in this review. The family have indicated that they are hopeful that the learning from this review will make a difference to practice regarding adults with similar complexities and vulnerabilities that Adult C had.
4. **Process**
   1. Following the decision by WSAB to commission a SAR, a scoping meeting and authors’ briefing took place in June/July 2018 to agree the Terms of Reference with representatives for WSAB and to introduce the SILP model process and expectations to authors of Agency Reports.
   2. All Agency Reports were completed within the timescale and a Learning Event took place on 13th September 2018 which was well attendedby authors, managers, practitioners and safeguarding leads from the organisations involved in Adult C’s care.
   3. A Recall Event took place on 18th October 2018 prior to which the first draft of the report was circulated for comment. The Recall Event tested out the learning and gave opportunity for participants to give their perspectives.
5. **Parallel Proceedings**
   1. There were no parallel proceedings as a result of the death of Adult C.
   2. There was no post mortem or coroner’s inquest as at the time of death Adult C had been in hospital for seven days and his death was expected within the 24 hours before he died.
6. **Timetable for SAR**

|  |  |
| --- | --- |
| Scoping Meeting (teleconference) | 25 June at 1.30 |
| Letters to Agencies | 29 June 2018 |
| Agency Report Authors' Briefing | 5 July |
| Engagement with family | Begin June 2018 once authorized |
| Agency Reports submitted to WSAB | 31st August 2018 |
| Agency Reports quality assured by chair | 3-5 September 2018 |
| Agency Reports distributed | 6 September 2018 |
| Learning Event | 13 September 2018 |
| First draft of Overview Report to WSAB | 11 October 2018 |
| Recall Event | 18 October |
| Second draft of Overview Report to WSAB | 25 October 2018 |
| Presentation to SAR Panel | January 2019 |
| Approved by WSAB Executive | January 2019 |

**WILTSHIRE SAFEGUARDING ADULTS BOARD**

SAFEGUARDING ADULT REVIEW USING THE SIGNIFICANT INCIDENT LEARNING PROCESS - ADULT C

Single Agency recommendations

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Agency** | **Recommendation** | **Detailed actions** | **Person responsible** | **Timescales** | **Desired Outcome** | **Update** |
| Wiltshire Police | Force wide communication to be sent out to all staff reminding them of the importance to record all interactions and on-going developments on NICHE OEL’s. | Internal force wide communication to be sent as well as further comms to specific CPT teams. | Jenn Holton/ Dom Taylor? | October 2018 | Communication sent and officers recording and updating a better quality of information on the internal system. | This was completed but officers would benefit from a reminder message to be sent out in late November/early December 2018 ahead of a busy period to ensure this doesn’t slip. |
| Wiltshire Council | Risk assessment tool is required to ensure an appropriate level of scrutiny for high risk customers | A risk assessment has been implemented for every COP Team customer, and those customers who don’t engage with services are high risk and discussed in supervision every month | COP Team Manager | Completed | To support staff prioritise work effectively.  To ensure those who are most vulnerable receive appropriate support. | Risk assessment accessible to all COP team, to ensure updates are completed and visible to all team and managers and access is always available in case of staff absence.  Each Officer is aware they have a duty to view and update with any changes. They are required to view prior to supervision and high-risk clients discussed in 4 weekly supervision, with each one having a plan of action. |
| Wiltshire Council | A system is required to ensure missed payments and missed visits are highlighted to management | A red flag system is now in place to highlight missed payments and missed visits. Notifications are sent to the team manager on the Casper system | COP Team Manager | Completed | To provide management oversight on key performance targets | These are also covered in 4 weekly supervision. Officers are aware part of their duties upon reconciling monthly bank statements, to check client is receiving regular personal allowance.  Report run 4 weekly for each Officers case load prior to supervision, any outstanding visits are discussed in supervision. |
| Wiltshire Council | The team to be fully staffed. | New staff have been recruited and caseloads reduced in size. The COP Team Manager no longer holds a caseload. A social worker has also been recruited into the team – this is a new post | COP Team Manager | Already implemented although staff are still undergoing training | To provide continuity of case worker to ensure knowledge of customer needs and relationship is built | New staff have also been allocated an experienced Officer as their mentor, as well as their line manager. This is to ensure effective and full training given at a time of high new recruits into the COP team. |
| Wiltshire Council | Improved awareness of the Deputy role is required across all care management teams so Deputies can be appropriately involved in cases | To highlight across adult care the role of the Deputyship Officer and improve communication between the COP Team and other teams | Head of Service | December 2018 | To ensure effective communication between COP Team and other adult care teams | The Court Team are now within the operational structure. The COP team manager has been visiting individual operational team and is intending to do this on a rolling basis. |
| Wiltshire Council | The Care First system needs to be used to identify the COP Team’s involvement to other teams and to communicate | Make better use of Care First to alert teams to COP Team involvement | Head of Service | December 2018 | To ensure that information is shared effectively. | COP team details are added to CareFirst as a relationship. This cannot currently be flagged on front screen, but this will be addressed with introduction of Liquidlogic |
| Wiltshire Council | Provide safeguarding training to COP Team so they know how to make safeguarding referrals directly | Training to be organised | Head of Service | December 2018 | COP Team confident to make safeguarding referrals directly. | COP team now make direct safeguarding referrals via the Advice & Contact Team. HR / OD have been consulted and appropriate training will be arranged. |
| Wiltshire Council | CoP Reviews being jointly scheduled in CoP Team and MH SW/Adult Social Care Review systems. | To ensure both services add review Alerts to their systems for when CoP reviews are due. | Managers within Adult Social Care in Wiltshire Council. | Completed | To avoid the potential for CoP reviews to be missed. | This requirement will be added to operational guidance, and reinforced by the COP Team as they continue their visits to operational teams. |
| Stonewater | Where a call is made to another agency to raise concerns and feedback is not given; a follow up call should be made. | If a call back is requested and not returned, a follow up call is to be made within 2 days | Case Officer |  | To fully understand the position and be assured that concerns were followed up. | Staff working within the Wiltshire area have been instructed to follow up referrals within 2 days if feedback is not given. If no response is received this will then be escalated to the Area Manager for follow up.  Existing staff working within Wiltshire have received Safeguarding training with further training planned for new starters in the new year. |
| Adcroft surgery/ Trowbridge Health Centre | Case review multiple non-attenders to mental health reviews | To search and analyse all serial non-attenders to Mental health reviews and see if we can find out if they have other agency input and why they are not attending | Dr Bimbh | Apr 2019 | To make sure all our mental health patients are accounted for | To be completed at the end of our Quality & outcome framework year (ie April annually) this is when all patients have been asked to come in for their reviews and the surgery knows who hasn’t attended. |
| AWP | Ensure where involved Wiltshire Council Receivership department provide relevant information/concerns into the CPA process. | Agree protocol of what and how information will be fed into the CPA process. | Community Services Area Manager/Receivership Service Manager. | By 31 October 2018 | Agreed protocol. Ensuring finances are appropriately considered in care planning. | Agreement between agencies. Where it is known that the receivership department are involved they will be invited to contribute or attend CPA meetings as most appropriate. All team Managers advised. |
| AWP | Ensure risk concerns are appropriately recorded and incorporated into care plans. | Bespoke training session to be delivered. | Clinical Lead | By 31 October 2018 | Appropriate risks documented and incorporate into care plans. | Clinical Lead Senior Practitioners. Ongoing program focusing on quality and assurance relating to CPA processes. |
| AWP | Ensure that where there are complex issues and where the case would benefit from multi professional consideration a case conference is proactively called. | Agree commitment to engage from key agencies – police/Mental Health Social Work/GPs and others | Community Services Area Manager | By 31 October 2018  (Discuss at October multi agency interface meeting) | Agree case conference process. | Agreement reached with Police, Social Service and Adult care Service Leads that cases escalated within agency to a Service Lead can call a Multi-agency case conference, which will be treated as a priority within each agency. |
| AWP | Ensure involvement of carers throughout the CPA process | Deliver workshop to West CMHT relating to identifying, involving and supporting carers. | Clinical Lead | By 30 September 2018. | Improved carer involvement with AWP. | Clinical Lead has established ongoing monthly program focusing on quality within the CPA process with all Senior Practitioners. |
| AWP | Ensure CPA processes include all relevant information and involvement of other agencies involved. | Workshop with Senior Practitioners | Clinical Lead | By 31 October 2018. | Robust CPA process relating to care needs. | Clinical Lead has established ongoing monthly program with all Senior Practitioners. |
| AWP | Review of the CPA Process within AWP. | A review of the CPA processes in regards to this particular situation but also across the board to ensure consistency of approach and review the validity of current processes as a whole. | AWP Management. | This may well have already been undertaken but if not at an early opportunity. | Ensure a robust and meaningful CPA process. | Case report and learning submitted to Associate Director of Nursing to feed into ongoing review of Trust CPA policy. |

1. The [Mental Health Act (1983)](https://www.legislation.gov.uk/ukpga/1983/20/contents) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. [↑](#footnote-ref-1)
2. The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx>. [↑](#footnote-ref-2)
3. **Nearest relative** is a special term used in the Mental Health Act 1983. It gives one member of a family rights and responsibilities if a person is:

   * detained in hospital under sections 2, 3, 4 or 37
   * under a community treatment order, or
   * under a guardianship.

   The nearest relative is not the same as next of kin. The next of kin doesn’t have any rights under the Mental Health Act. Section 26 of the Mental Health Act 1983 sets out who will be the nearest relative. The list is in strict order and the person who is highest on the list is your nearest relative. If there are two people from the same group the elder person is nearest relative.<https://www.mind.org.uk/information-support/legal-rights/nearest-relative/about-the-nearest-relative/#.W7IQCBNKjJx> Accessed 1 October 2018. [↑](#footnote-ref-3)
4. **Mental Health Control Room Triage** (MHCRT) refers to a service where clinical mental health professionals (MHP) assist police with incidents where the mental ill health of an individual gives rise to concern. The mental health professionals will assist in ensuring the best option for the individual in crisis. They will do this by offering professional advice, accessing health information systems, and helping to liaise with other care services to identify the right kind of support required. [↑](#footnote-ref-4)
5. **Quality Outcomes Framework**. The QOF is a voluntary reward and incentive programme. It rewards GP practices, in England for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care. <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof> Accessed 1 October 2018 [↑](#footnote-ref-5)
6. Assessment of Mental Capacity is required under the **Mental Capacity Act (2005**) if there is concern that a person lacks the capacity to make a specific decision about care and treatment or other decision due to a disturbance or impairment in the functioning of the brain. <https://www.legislation.gov.uk/ukpga/2005/9/contents> [↑](#footnote-ref-6)
7. HM Government (2012) Health and Social Care Act <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> [↑](#footnote-ref-7)
8. **Care Act (2014) Self-neglect** – this covers a wide range of behaviour neglecting to care for one’s personal

   hygiene, health or surroundings and includes behaviour such as hoarding. [↑](#footnote-ref-8)
9. **Section 42 Enquiry**: An enquiry is any action that is 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.

   <https://www.scie.org.uk/safeguarding/adults/practice/questions> [↑](#footnote-ref-9)
10. **The Deprivation of Liberty Safeguards (DoLS),** which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005. The DoLS under the MCA allows restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes – but only if they are in a person’s best interests. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority. [↑](#footnote-ref-10)
11. <http://www.mentalhealthlaw.co.uk/R_(Ferreira)_v_HM_Senior_Coroner_for_Inner_South_London_(2017)_EWCA_Civ_31,_(2017)_MHLO_2> accessed 28 September 2018 [↑](#footnote-ref-11)
12. <https://www.judiciary.uk/publications/chief-coroner-guidance-no-23-report-of-death/> accessed 24

    October 2018 [↑](#footnote-ref-12)
13. **CQUIN** stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.  [↑](#footnote-ref-13)
14. **The Human Rights Act 1998** sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. The Human Rights Act came into force in the UK in October 2000. [↑](#footnote-ref-14)
15. **The Office of the Public Guardian (OPG)** protects people in England and Wales who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.

    OPG is an executive agency, sponsored by the Ministry of Justice. [↑](#footnote-ref-15)
16. Where an individual (the ‘Person’) lacks capacity and does not have a LPA in place already (or their LPA has become invalid) then the only legal way in which another person can make decisions on their behalf is through an application to the Court of Protection for Deputyship. <http://www.careuk.com/sites/rcs/files/Deputyship-and-the-court-of-protection.pdf> [↑](#footnote-ref-16)