Walsall Safeguarding Adults Board Safeguarding Adult Review for Grant.

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Section 1; Introduction and background.

This report has been commissioned by Walsall Safeguarding Adults Board through its Subgroup. It has been carried out in line with their Safeguarding Review Policy and Protocol.

This review is in response to the death of a 77-year-old gentleman (D.O.B. 05/10/1941) referred to in this report as Grant to preserve his anonymity in line with the Safeguarding Adult Review Guidelines.

On the 10th December 2018 Grant died following an incident whereby he was found on the ground outside his third-floor apartment. Ambulance and Police services attended, and he was pronounced dead. Suspicions were raised that he may have jumped from his window as the window was open, a knife was near the window inside, the restrictor had been forced and the bedroom blinds were on the garden wall outside. A subsequent coroner's inquest stated Death by Misadventure.

Grant had moved to Walsall from the London area in 1981. He had worked locally and was an owner occupier of an apartment (Apartment 1). He was estranged from family members and reported that he had no close friends but previously had many acquaintances through his work (Housing Department), political contacts and at the local public house. In 1993 (age 52) following an allegation at work he was suspended. A long protracted legal challenge ensued and resulted in an out of court settlement for him. It is reported that the stress of this incident appeared to have led to a mental breakdown and first admission to a psychiatric hospital. Grant took early retirement in 1994 and never formally worked thereafter.

Grant became involved with mental health and community services in Walsall from 1996 up to the time of his death. He had a diagnosis of Chronic Schizophrenia and personality problems. He also suffered from several physical health conditions including gout, osteoporosis, mobility issues, registered blind in one eye and wore glasses, he was deaf and wore a hearing aid. He also experienced Tinnitus. He was a heavy smoker and used to drink in excess in younger years but had cut it down to moderate later in life. He had experienced a fractured neck of femur in 2013.

Grant had for many years lived in his owned apartment (Apartment 1). Following periods of hospital admissions for his mental health he was discharged to alternative accommodation(s) including a Care Home and Apartment 2 where he was living at the time of his death.

Following the death of Grant and his recent and continued contacts both as an inpatient and in receipt of community support the local Mental Health Trust carried out a Serious Incident Review with Root Cause Analysis (date of report final 08/03/2019).

A Rapid Review meeting was requested by Adults Social Care (ASC) and held on 30/01/2019. The agencies in attendance were as follows:

Local Clinical Commissioning Group (CCG)

Adult Social Care (ASC)

Housing Association (HA)

Local Health Trust (HT)

Local Mental Health Trust (MHT) including hospital.

Safeguarding Adults Board (SAB).

The outcome of the Rapid Review meeting was a recommendation for a Safeguarding Adult Review (SAR) to be considered in respect of the death of Grant. It was agreed that the SAR would build on the Serious Incident Review completed by the local MHT.

I was recruited by the SAB in April 2019 to assist them in the preparation of this Safeguarding Adult Review. I am an independent social care consultant and qualified social worker with extensive experience of reviews, safeguarding services and investigations.

A Scoping Panel meeting was arranged for 12th April 2019 and later cancelled due to difficulties in agency attendance and was re-arranged and held on 14th May 2019.

2. The purpose and Terms of Reference for this Safeguarding Review is to:

a. Establish as far as is possible whether there are any lessons to be learnt from the circumstances of Grant's sad death and (in particular) about the way in which local professionals' and agencies involved, work together to safeguard adults at risk.

b. Review the effectiveness of procedures (both multi-agency and those of individual organisations).

c. Inform and improve local inter-agency practice.

d. Improve practice by acting on learning (developing best practice).

e. Commission an overview report that brings together and analyses the findings of the various individual management reports (IMR) from agencies in order to make recommendations for future action.

This SAR will consider any lessons learnt by each agency and will inform a single interagency plan for implementation. Responsibility for driving through any required process for implementation will sit with the Chair of the Safeguarding Adults Board

3. Methodology:

The Safeguarding Adult Review has been undertaken using a hybrid methodology that analyses the complex circumstances that practitioners work in and provides opportunities for shared learning and lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and wellbeing of adults.

Key agencies were asked to nominate a senior member of staff to be a panel member and where agencies had significant involvement with Grant they were asked to provide a detailed chronology of their contact with him and also conduct their own internal agency independent management review (IMR) and submit a report.

This was followed by the sharing of written material in order that learning can be shared and analysed taking account of the views of the professionals that were involved at the time. This took place at a round table Practitioner Reflection and Learning Workshop on 24th July 2019.

IMR's were requested and submitted from:

The Ambulance Service

Local Mental Health Trust

Adult Social Care

Local Healthcare Trust

British Transport Police

Police

Clinical Commissioning group

Housing Association responsible for apartment 2

Care Home

Key areas of consideration included agencies to provide any relevant background information that would be important in setting the context for Grant's situation.

4. Key themes for consideration:

A Safeguarding Adults Review Panel (consisting of representatives from each agency) meeting was held on 14th May 2019 and set the scope for the review and key lines of enquiry.

Scope:

The scope for the review was agreed to cover the time period from Grant's admission to Hospital on the 4th February 2018 up to his unfortunate death on December 10th, 2018.

Key Lines of enquiry:

1. Liaison and information sharing between professionals and record keeping in the case.
2. Identify examples of good practice, both single and multi-agency.
3. Was capacity assessed, recorded and specific to certain decisions?
4. Was legislation (Mental Capacity/Mental Health Act) used appropriately?
5. Was there appropriate focus on Grant's health and wellbeing and how was this considered and addressed?
6. What risk assessments were undertaken to consider other vulnerabilities Grant may have had?
7. Was Grant able to access the right services at the right time?
8. What have you learnt from this case?
9. Highlight good practice.

10. In what ways could practice be improved; what might have made a difference to the way Grant experienced your service.
11. Are there implications for the ways of working; training (single or interagency); management and supervision; working in partnership with other agencies; resources, commissioning?

Each agency involved submitted an Individual Management Report (IMR) within the timescale.

5. Practitioner Learning events

The Regional Safeguarding Adult Review Policy includes this process which characterises a reflective/action learning approach in a no-blame environment. Two events were arranged and attended. The first event was held on the 24th July prior to writing the draft SAR report.

This event:

- Heard first- accounts of involvement with Grant
- Provided an opportunity to ensure an accuracy of the 'case story'
- Provided an opportunity to consider and analyse interventions in a safe, reflective environment
- Considered the context within which the practitioners were working at the time
- Explored what information, activity or circumstances might have influenced decision making
- Considered recommendations for the review
- Provided an opportunity for practitioners to shape future policy and practice.

The second event was held on the 3rd September following circulation of the draft report and provided the opportunity for clarifications, amendments and comments to be shared and agreed.

6.Chronology of significant events:

Overview of mental health relevant history and specifically leading up to re-admission to hospital on 04/02/18.

Grant was voluntarily admitted to a local psychiatric hospital following his hearing unpleasant voices and becoming disturbed by the experience. He was diagnosed with a relapse of Schizophrenia and remained in hospital for further assessment and management from 11/09/17 to 24/01/18. During his time on the ward he improved without any change to medication and is reported as having capacity, good insight and scored low on self-harm risk assessments. Grant was living in Apartment 1 at that time and had expressed a wish not to return there as he felt the neighbours had changed and he was not happy living there. He remained in hospital whilst his social worker looked for alternative accommodation. This was found at a local Housing Association complex. Grant was accepted by the housing association complex which is a semi-independent sheltered accommodation where you could purchase care support as necessary. Grant went without requiring/wanting personal care support. Grant had a trial stay arranged for the end of October 2017.

Unfortunately, Grant did not stay long (4 days) and returned to the ward on 3rd November2017 saying he could not settle and was agitated. He did however keep his tenancy until 21st March 2018. The IMR from the Housing complex Apartment 2 state that they were informed of Grant's re-admission to hospital in early January 2018.

On returning to hospital Grant settled and remained stable. He discussed his care with the staff and made choices about his medication regarding a return to a previous one that he felt was more suitable. Grant wanted to explore other accommodation options other than Apartment 2. He was supported to look at other places but after seeing them refused them all. In January 2018 he decided to return to Apartment 1 which he still owned. An Occupational Health assessment and home assessment were carried out to enable a return. Grant was visited on the ward by a social worker on 18/01/18 he refused any social care support and would not divulge information for a financial assessment. He was deemed to have capacity and insight to make this decision. Grant was discharged home to Apartment 1 on 24th January 2018 with a mental health support package.

On 01/02/18 a Support Time Recovery Worker (STR1) visited Grant but got no answer at the door or via phone. They left a voicemail message stating they had called and reminding Grant of 'Monday's' appointment. This appointment would have been on the 5th February 2018.

04/02/18. Ambulance Service contact.

Grant called 999 to the police at 08.06 stating that he felt unwell and feeling suicidal. This call was transferred to the Ambulance service. An ambulance was dispatched and on arrival Grant told them he had run out of his Schizophrenia medication 3 days ago and said he had been trying to suffocate himself with a carrier bag as the voices in his head were telling him to kill himself. Grant also informed the ambulance crew that he had fallen the previous day and hurt his wrist. He was examined and medical observations carried out. He refused any pain relief. He was then taken to A&E at the local hospital.

04/02/18. Accident & Emergency contact.

Grant was seen in A&E at 09.59 on the Sunday morning of 04/02/18. The records noted that he had a history of suicidal thoughts and had run out of his medication 3 days ago. Grant told staff he wanted to throw himself under a bus and that he couldn't stop crying and hadn't slept. A mental health referral was made, and he received this at 10.40 am. During Grant's time in A&E STR Worker 1 arrived following a discussion with the Older People's Mental Health Liaison service. Grant expressed his feelings of hopelessness. He said his move to apartment 2 had not improved his social situation, he did not wish to return to apartment 1 and he believed he had been '*conned into moving and the system was against him'.*

STR Worker 1 noted that Grant was showing signs of paranoia and wondered if issues with his medication may have affected this. It was further noted that Grant was unkempt with a strong body odour suggesting that he was not fully meeting his personal hygiene.

Grant was admitted voluntarily to the local psychiatric hospital where he had been discharged from on 24th January 2018.

Re-admission to hospital 04/02/18

In hospital Grant recommenced his medication and his mental state soon settled with no psychotic or depressive symptoms or signs persisting.

Risk and capacity assessments were carried out on the ward and Grant was deemed able to make decisions about his management. His risk assessment did not indicate any concerns. Cognitive tests indicated a mild degree of age-related impairment that warranted further investigation in view of his inability to cope with living independently and the apparent forgetting to take medication.

The quick successive failures for Grant to live in the community prompted a more structured placement with 24-hour support to be considered. A Residential Care Home setting was proposed rather than independent or semi-independent living. This view was supported by the observation that Grant's mental state quickly settled whilst in hospital even without any changes to his medication.

The above proposals were discussed with Grant and he was reported as seeming receptive to it and accepting that he would need more support than was available to him in recent placements.

The process of funding and finding suitable accommodation was difficult and protracted. Grant refused to discuss and disclose his finances with social workers (a pre-requisite to applying for funding for a residential placement). Grant had a long-term mistrust of social workers and Social Services. In March 2018 an advocate was suggested to assist him with sharing his views and wishes with the Social Services Department. Further delay to his discharge occurred as Grant had doubts about going into residential care and requested more time to make up his mind. An advocate was found at the end of two weeks and attended a meeting a week later.

At the beginning of March 2018 Grant had to transfer to a different hospital as the ward was being closed temporarily for a water system flush. Grant was upset about the move but was pleased to receive continuing support/visits from STR worker 1. The support included taking Grant to apartment 1 and apartment 2 to sort out post, collect clothes and clear things where necessary.

During Grant's time in hospital a Deprivation of Liberty Safeguards (DoLS) assessment was completed and he did not meet the requirements as he was assessed as having capacity and able to give valid consent to care and treatment on the ward.

In March 2018 Grant's Community Psychiatric Nurse (CPN) changed. The CPN contacted Grant's social worker introducing themselves as the care co-ordinator (CPN/CC2).

On March 20th notice was given on Apartment 2 and Grant wished for his furniture to be disposed of. Capacity was again deemed in respect of this decision and his allocated Social Worker formed part of a multi-disciplinary approach preparing Grant for discharge.

Invitations to Adult Social Care regarding a ward meeting took place on the 27th March 2018. Grant was flagged up on the email exchange between the Ward and Adult Social Care as a Delayed Discharge. The appointed Advocate had arranged to meet Grant on the 28th therefore ASC staff would not attend the ward meeting as they said they had nothing to contribute until after the Advocates visit on the 28th.

Grant remained stable in hospital from February to April and after viewing a few care homes he decided to return to his own apartment (1). It was felt by the hospital staff that a trigger to return to

his own apartment may have been when he found out that he would have to contribute financially towards his placement. Assessments carried out during his period in hospital deemed Grant to have capacity and mental stability to make this decision to return home.

Further home assessments were carried out and a Case Conference was held during early May 2018. Grant was involved in part of the case conference and advised that he would need to decide within the week as to whether he returned to Apartment 1 or accept a placement found for him at a care home for people with mental health conditions including a dementia care service. Grant had visited a different care home previously and did not like it. Grant was enabled to research the care homes placements being considered.

Discharged back to Apartment 1.

Grant decided to return to Apartment 1. A care support package was put in place to support him at home. He agreed to receive the care package and to be visited by his support worker, the Home Treatment Team and Older Adults Community Mental Health team on a regular basis. He was due to be discharged on the 9th May but on the 8Th May he refused to go. A physical examination was completed on the 9th May and showed no acute concerns. He was deemed medically fit for discharge. During Grant's hospital stay his glasses had broken and he had ongoing issues with his hearing aid stating that staff had damaged it. Ward staff reported that Grant had a problem cleaning the plastic tubes to the hearing aid and was agitated by this. The process for replacement and repair of glasses and hearing aid was a lengthy one as Grant refused to use certain services. He was to be discharged home with 14 days of medication. An escort and transport were provided to take him home. An outpatient follow-up appointment was made for two weeks' time.

Grant returned home on 10th May 2018. It was noted by the CPN **that it would be difficult to see a successful discharge to Grant's apartment.** The hospital ward staff requested a contingency plan to be formulated in conjunction with the social worker to avoid inpatient readmission due to Grant's history with non-compliance with services and medications. The plan agreed a joint visit would take place with the CPN and social worker.

The Home Treatment Team visited on 11th May for their planned assessment. Grant reported that he felt stable on his medication and hadn't heard any voices since being at home (1 day). He said he was socially isolated and being registered blind and deaf he found it difficult to interact with others. He said he missed interaction. He was offered a place at a local mental health wellbeing support group to enable social interaction, but Grant was hesitant as some of the activities included pub gatherings, he said he did not want to overindulge in alcohol. Despite other activities being available he still did not accept. Grant told the assessment staff that he had no active intent to end his life but that with his increasing disabilities that were inherent with age he just had thoughts of wanting to die rather than deteriorate with age. He said he had no plan to hasten his death with suicide.

The assessment showed no clinical indication for the Home Treatment Team at that stage as they *'had not identified a crisis or medication concordance or any delusional beliefs or psychosis elicited'.*

The assessment concluded that being visually impaired Grant was finding it difficult to navigate the steps to his 2nd storey apartment and that he was lonely and wished to engage socially – a befriending service was suggested. Grant also had difficulty cleaning his hearing aid owing to poor eyesight.

On the 12th May the CPN was unable to contact Grant at his apartment and contacted the ward who informed him that as his hearing aid was broken, he may not have heard the call. The CPN rang again and spoke with Grant. When he was asked how the home placement was going Grant became abrupt, said he was fine and ended the call.

On the 15th May Grant was visited by the Older Adult Mental Health Team but Grant was not at home. A further visit was made that afternoon by the team consisting of the CPN, Care co-ordinator and social worker. Grant was at home. He was reported as argumentative and angry in relation to almost all suggestions. He then declined any social support. He was annoyed about his hearing aid blocking up he thought that someone had destroyed it whilst on the ward. He wanted a replacement but was unwilling to pay for it. He expressed irritation at people trying to phone him from the team as he could not hear them or understand messages left. It was agreed that any written contact would use a font size of 16. Grant was informed about an outpatient appointment for 3 weeks' time. Grant was not happy about this and told the team that he wanted medics to visit him. This was agreed to be discussed with the medics. The social worker agreed to make enquiries about his hearing aid and informed him that as he had refused any social care support he would be discharged from the service.

The arranged joint visit was made by the Older Adult Mental Health Team on 22nd May 2018. Grant was found to be *'euthymic in relation to his mood, had stopped taking one of his evening medications. Was negative regarding offers of social care. Did not like living in his flat due to anti-social behaviour (*of others*).* Grant said he was expecting his GP to visit and was told that he would have to arrange a home visit. His outpatient appointment had arrived. It was agreed that STR worker1 would continue to look for suitable social activities in the area.

A Ward review took place on the 1st June 2018. Grant was not present at this review. It was reported that Grant's mental health was reported as stable and there were no self-harm thoughts, or psychotic or depressive symptoms elicited. He was still declining social care input.

Railway incident and admission to hospital.

On the 4th June 2018 at a local railway station a member of the public notices Grant walk down on to the tracks. This member of the public escorts Grant off the tracks and contacts via 999 the police. The police contacted the British Transport Police (BTP) who deal with such incidents. Grant informed officers that he wanted to end his life and wanted to step in front of the train. BTP opened a Suicide Prevention Plan (SPP) in line with Procedure. All documentation and follow up processes were carried out in accordance with the plan.

An ambulance was called, and Grant was taken to the General Hospital nearby for a Mental Health Assessment. A Rapid assessment and intervention & discharge review referral was made, enhanced observations carried out and noted as high risk. He was kept in the Emergency Department until he was transferred under MHA section 2 to a psychiatric bed. Following extensive searches for a suitable bed within the Trust locally and further afield a bed was found at the same hospital where he had

been up to his discharge back home in May 2018. Grant was offered the bed informally however he refused and was subsequently admitted under Section 2 of the Mental Health Act (MHA). He was re-admitted to the same ward. The legal status of the section2 of MHA was discharged on 26/06/2018.

Whilst on the ward Grant was deemed as having capacity to consent to admission and treatment. It is reported that Grant's suicidal idealisation and threats were due to him wanting a more supported placement as he was finding it difficult to cope in his own home. Grant stated he did not like the ward environment but showed reluctance to consider other options. He would not participate in ward activities and stated he would prefer a care home environment. It was felt at this time that a care home with 24-hour support would be the most appropriate setting to meet his care needs. He remained on the ward until a suitable placement was found.

Grant complained about his not having suitable reading glass*es or* hearing aid and this was making his life difficult. His care plan reflected actions to rectify both needs.

The ward review held on 12th June identified the risk that Grant had suicide ideation and non-compliant with medication. Prior to the review Grant had stated that he regretted the suicide attempt – he had thought of the driver and changed his mind. He said he recognised he had difficulties self-administering his eye drops. He would consider warden-controlled accommodation. A further supply of clothes for Grant were requested via the Community Mental Health Team. Grant attended the review meeting and consented to those present. He stated that he felt 'claustrophobic' as he is used to his own company. He compared being on the ward to being in prison and he was restricted. He told them he was a '*lonely old man without any friends and recognises he does need help but is stubborn and did not know which frame he fitted in'*

STR worker1 and STR worker2 visited Grant to discuss accessing his property to obtain some clothing. Grant was adamant and reluctant to allow STR worker 2 into his property without him being present. Ward staff and the ward Doctor advised that Grant was unable to leave the hospital as Section 17 would have to be arranged and he was at risk of not coming back to hospital. By the 19th June the section 17 leave was completed.

Grant was the subject of many multi-disciplinary ward reviews and lengthy discussions were had with him regarding his condition and needs especially his reduced ability to cope on his own. He continued to refuse to discuss his finances and assets for Social Services to decide what his financial contribution would be towards the cost of living in a care home. His mental state during this admission was reported as stable and regular assessments did not indicate any risk if he was in a structured and supporting environment. Adult Social Care were requested to become involved again regarding a social care assessment and finding a suitable care home for Grant.

The ward review held on 19th June 2018 reflected that Grant remained settled on the ward often reading and isolative in his manner, eating and sleeping well and no new physical health issues. There were no safeguarding concerns. Grant requested that he wanted to look at CQC reports prior to going on visits. He said he did not want to return to his Apartment 1 and felt neglected by social

services. He requested an optometric appointment and discussed his eyes and hearing issues. There were concerns regarding capacity decisions regarding health and finance. It was agreed that a mental capacity assessment regarding Grant's decision making would be carried out. The assessment findings

revealed no risks in relation to health concerns but highlighted risk regarding self-neglect, self-harm and non-compliance with medication. It was noted that the services of the Independent Mental Health Advocate were still in place. A Psychiatrist present questioned Grant's capacity, feeling that he lacked insight into his home situation, becomes unwell and then back into hospital. It was noted that Grant had 6-7 admissions over the last 8-9 months. A decision was made to take Grant off the Section 2. Grant remained in hospital as an informal patient.

At the next review held on 26th June 2018, Grant mentioned that he would like to re-locate back to London where his nephew lived. It was proposed that a social worker when allocated could look in to contacting the nephew. A social worker (SW1) was allocated to Grant on 27th June 2018 and an invitation sent for the ward round to be held the following day. The social care record did not reflect whether SW1 attended. SW1 did attend the ward round held on 10th July 2018 where it was noted that Grant's antipsychotic medication had been changed and were effective. SW1 visited Grant again on the ward on the 19th July 2018 and completed a Care and Support assessment. The need for a residential placement was identified. The risk assessment carried out identified risk of self-harm with reference to suicidal ideation. The assessment did not detail how the risks were to be managed.

Grant had been on the ward for four months. On the 25th July he was reported by ward staff to have requested to 'check out' of hospital but was encouraged to remain informally until the duty doctor could discuss this with him. Grant remained in hospital and was reported at the ward round on 31st July as settled, eating, socialising and sleeping well. SW1 identified several placements for Grant however he was still refusing to discuss his personal finances and was aware he would be self-funding. SW1 had sourced Care Quality Commission (CQC) reports on the three establishments being considered. Eventually five reports on establishments were provided.

Grant attended an audiology appointment on the 27th July 2018 for a new hearing aid. He requested assistance from the audiology department for its maintenance.

A ward review was held on the 7th August 2018. The Ward received a telephone call from the British Transport Police (BTP) as follow up to the rail track incident and no further action or follow up was agreed and the BTP case was closed.

At the review Grant was reported as euthymic in mood, engaging well with staff and peers. There were no new physical health issues. There were no safeguarding concerns or new risks identified. Grant was assessed as having capacity. A contingency plan pre-discharge was planned. It was agreed at the review that SW1 would take Grant to visit one of the care homes identified.

CPN/CC2 visited Grant on 9th August 2018 on the ward and explained his role. Grant voiced his concerns with mistrust of workers, that he already had people working with him in the same capacity. He informed them that he did not like being patronised and complained about a variety of issues including lack of support from social workers, ward staff and community nurses. He wanted to go to the Bank, but this had not happened. He complained that his hearing aid had not been fixed and that he was not treated as a person. He explained that he felt he was taken advantage of due to his age and he had real difficulties that needed practical help. He said he had too many promises that were not fulfilled. He said he was not a three- year old. CPN/CC2 explained to Grant that they wanted to build trust with him.

The ward review held on 14th August 2018 Grant stated he was not happy with the establishments proposed and from the CQC reports seen he would not be accepting anywhere soon. He was still not willing to discuss his finances. Ward staff reported that Grant was refusing to move to a care home as he said he '*did not want to pay a lot of money and he would be served cold food'*. It was noted that a care home identified had no vacancies at that time. CPN/CC2 agreed to work with SW1 to identify a suitable placement that preferably catered for Elderly Mentally Infirm residents.

Whilst SW1 was on annual leave the CPN/CC2 contacted Adult Social care requesting whether a cover social worker could be provided to discuss care home placements. The CPN/CC2 was advised that the SW1 would be at work the following week. CPN/CC2 visited Grant on 16th August and was told by him that he wanted to bank a cheque for a significant amount and had been unable to do this. Contact was made by CPN/CC2 with Grant's previous support worker (STR Worker 3) to assist.

On the 21st August 2018 Grant was taken to the bank by CPN/CC2 and STR Worker 3 and then visited the residential care home identified. Grant said he quite liked the care home and would consider it overnight. Grant then said that he would accept it. STR Worker 3 informed the ward, the care home manager and social worker about this decision (however *it was noted at the Practice Learning Event 2 that there was no record of the social worker receiving this information*). The home manager agreed to visit Grant on the ward later that week.

Grant chose not to attend his ward review meeting on the 28th August stating it would agitate him and be counterproductive. The review identified that risks identified were managed in the ward environment, his mood was stable and no new issues. Grant was recorded in a pre-review discussion as looking forward to moving to his new home and would give it a good try. He had insisted on having an agreement that he could go out on his own from the home. The care home insisted that he sign a disclaimer to be able to do this. Grant was assessed as having capacity. Grant had been accepted at the care home for a trial period of 6 weeks due to his history. The plan for Grant was recorded as 'the medical team' to apply for Guardianship once Grant was in the care home. Grant was to be discharged with two weeks of medication and the trial period to start as soon as possible.

Grant arrived at the care home on 31st August but was not expected until the following week, however he remained there. A report to STR Worker 3 from ward staff records that on arrival at the care home Grant had become aggressive saying he had not agreed to go there. STR Worker 3 agreed to check on him later that day which he did and reassured Grant.

STR Worker 3 visited again on 3rd September. Grant informed STR Worker 3 that he was not happy at the care home and was hoping his nephew would find a place. Grant was told to discuss this with his social worker who was to visit the next day. STR Worker 3 was informed by the home manager that Grant had tried to leave the home the evening after admission and had pushed a member of staff in the chest and shouted at them. Grant had been critical of everything the staff did and was rude to residents. The home manager stated that unless Grant settled, they would not be able to keep him. They requested that STR Worker 3 visited more often to monitor the situation.

The care home recorded on the 3rd September that they informed Grant that his current GP was unable to visit him at this address and so Grant agreed to a change of GP. Grant was visited by the GP/Practice Nurse on the 2nd October (GP 2), 4th October (Nurse) 16th October (GP3). It was noted that Grant had been with the original GP (GP1) practice for 9+ years.

The ward review held on 4th September noted Grant as 'mood stable no new physical issues and no new risks identified'. There is mention that Guardianship is to be applied now that Grant is in placement. A telephone call was made by the Consultant during the review to the care home to inform them of the importance of books to Grant and his positive relationship with STR Worker 3. He also asked for staff to be reminded that Grant required support with cleaning his hearing aid. The social worker informed the review that Grant had 'punched' a member of staff – not severe. SW1 planned to visit Grant later that day. The plan for MDT reviews was for them to continue and a contingency plan to be put in place regarding future re- admissions.

SW1 and CPN/CC2 visited Grant on 4th September. Grant stated he was not happy, and the care home was not suitable for his needs 'as many patients have dementia and restrict socialisation'. He said no-one wanted to help him fix his hearing aid. He said he did not have dementia and he felt out of place. He said the staff were good people. SW1 proposed further assistance from support workers to enable him to go out. The CPN records that SW1 agreed to look for an alternative placement and support workers. CPN/CC2 would continue to offer support visits.

On the 5th September STR Worker 3 visited Grant who was sitting in the lounge with his eyes closed. Grant informed him that he was trying to block the world out. He said he was depressed and although would not harm himself he did not care if he lived or died. He further said he did not want to be in a care home and wanted supported housing. STR Worker 3 informed Grant that a new support worker from the 'Council' had been asked to become involved with him and they would follow up this request with his social worker. STR Worker 3 recorded that they were concerned about Grant's low mood. Further contacts occur between STR Worker 3 on the 7th and 10th September. It appears that these were by telephone as there is no recorded visit at the home on those dates. Grant is requesting that he is not at the care home in 6 months' time and wants his nephew contacted. Grant is informed that he may have to wait for a new suitable place to live. He is told that a Social Care support worker will be visiting him on the 8th September to take him to the Bank and look at housing options.

A ward review took place on the 11th September in the absence of Grant. The review received information that Grant's mood was stable, no new physical health concerns and no safeguarding concerns noted. The Consultant stated he had spoken with the care home and told Grant is settled. The review was informed that Grant had only one change of clothes and so the Support Worker/CPN were requested to urgently obtain clothes from his home in Apartment 1. The care home had contacted the ward to obtain clothing for Grant and arranged that the social worker would collect them. It was later arranged that Grant would be supported to go back to Apartment 1 and collect clothing. The Plan agreed that the trial period (leave) would continue owing to Grant's possible agitation. It was noted that Grant maintained capacity.

The CPN/CC2 visited Grant on 12th September following the ward review the previous day. Grant told them he wished to return to Apartment 2 at the sheltered accommodation he had lived in briefly in May 2018. The CPN advised that Grant tell the support worker (Mental Health Social Worker MHSW working for Adult Social Care) who was to visit the next day. MHSW visited on the 13th September and took Grant as arranged to collect clothing from his home. It is reported that Grant recognises he cannot return to Apartment 1 but does not wish to remain in the care home. An application for a Housing Agency was given to Grant which he agreed to read through over the

weekend. When contacted by STR worker 3 on the 14th September it was noted that Grant seemed brighter in mood and this seemed to be down to the support he was getting in moving forward.

On the 18th September Grant was officially discharged from the ward to the care home. It was recorded that the placement was deemed suitable for his needs at the present. The after-care plan was agreed for psychiatric follow up. His Care Coordinator to arrange regular monitoring, support and medical review at the care home as needed. He was given a 2-week supply of medication and the GP was requested to continue to prescribe the same psychotropic medication. Grant's GP was also requested to regularly monitor his physical state and medications. It was agreed at the review that the care plan include that re-admission to hospital was not an option for Grant and he would be formally discharged.

Following notification from the ward regarding Grant's discharge and noting that re-admission to the ward was not an option ASC continued to pursue alternative housing through the Housing association with joint visits to the care home being maintained. STR Worker 3 contacted Grant and was told by him that he was still not happy at the home and did not want to be there at Christmas. STR Worker 3 noted that the conversation was very repetitive and difficult to disengage from. Grant asked for support to fill out the Housing Application which STR Worker 3 agreed to if the social care support worker was not available. STR Worker 3 assisted Grant to fill out the housing application form on the 22nd September but was noted to be threatening to leave the care home once the 6-week trial period was completed.

On the 24th September Grant was visited by CPN/CC2. Grant told them that he was not willing to stay and was not happy and wanted to leave after the 6-week trial. The issue of not remaining was discussed with the Manager of the home and CPN and it was agreed that 'something needed to be done as it was 4 weeks into the 6-week trial. The CPN agreed to speak with the social worker.

On the 28th September Grant tells STR Worker 3 that he wants to return to Apartment 2, and he will '*go walk about if he can't find somewhere else to live'*. He further informs them that the last time he went into hospital was because of a 'walk about' and a confrontation with neighbours resulting in his not feeling he could return to his original Apartment 1 because of this.

Grant was supported with his application form and it was taken to the Housing Association with responsibility for Apartment 2 on the 3rd October 2018. There was the possibility of a ground floor apartment or his old one on second floor that still contained the remainder of his furniture. STR Worker 3 agreed to visit Grant to consider his options.

On the 4th October 2018 SW1 and the MHSW visited Grant where he expressed his dissatisfaction with not being visited by them during the last week to support him with his application form. Grant was supported to his home to get some items.

Grant expressed his happiness to STR Worker 3 regarding the move to Apartment 2. He had accepted his old apartment back. He agreed to remain at the care home until he could move.

On the 15th October contact was made to STR Worker 3 as Grant was threatening to leave the care home and return to Apartment 1. He was upset that he had been given his medication late and he had got himself angry. STR Worker 3 managed to calm him down and to remain at the home. Grant was very negative about his move to Apartment 2 and living in the location. It was noted by STR

Worker 3 that the Manager of the care home would like Grant to leave as soon as possible owing to his threatening behaviour. STR Worker 3 agreed to visit the following day. SW 1 had visited Grant to discuss the move, but Grant told her he was not happy with the suggested plan for his support needs.

SW1 telephoned CPN1/CC2 and explained that she was visiting Grant later that day regarding the move to Apartment 2 and that she would facilitate the move. The visit took place and Grant expressed that he wanted to move the next day. It was explained that he would need to wait as support was needed to be determined and what was needed for the apartment. CPN/CC2 rang the care home to arrange to visit Grant either later that day or the next (19th). There was no record that a visit took place either from Oasis record or the care home register.

Accompanied by STR Worker 3 Grant signed his tenancy on 22nd October 2018 for Apartment 2. He was to return to the second-floor apartment where he had lived from 16th October 2017 up to his hospital re- admission on 3rd November 2017. Grant questioned why he should pay the service charge and only agreed to purchase bedding and a radio. Much of the furniture had been disposed of at the end of his previous tenancy in January 2018. The apartment had no cooking facilities and no fridge. Meals could be purchased on site and washing facilities were also available.

SW1 had a brief meeting with CPN 1 on 22nd October 2018 to discuss ongoing support for Grant stating that he still wanted to make the move.

CPN/CC2 visited Grant at the care home on 23rd October. Grant appeared settled but complained about not being able to move yet. Grant stated he would move the next day. Grant was informed by CPN/CC2 that he was expected to move on the 26th October. Grant expressed that he was not wanting to make this move his permanent place. CPN/CC2 reported that Grant was moving from one issue to another in one long speech.

Grant was accompanied by STR Worker3 on 24th October to purchase items for the apartment. Grant stated he '*did not want to spend money in case he does not want to stay there and go walk about back to hospital*'. STR Worker 3 explained that the hospital may not be able to take him, and he may be placed in another care home for his own protection. Grant stated he would not pay for another care home. STR Worker 3 agreed to see Grant again on the 26th October to help him move.

SW1 and STR Worker 3 had an email exchange on 25th October 2018 regarding Grant's move and whether any additional support could be given. STR Worker 3 stated that Grant was adamant he was moving on the 26th and only had a bed and wardrobe, he was reported as he 'wouldn't listen and has capacity but needed help'. SW1 advised that her involvement would not be for much longer.

Grant moved to Apartment 2 on 26th October 2018 with the assistance of STR3 worker. On the way there a radio was purchased and some lunch. Grant was made aware of his medication times and what to take. Grant was informed that he could order his meals for the following week from a menu provided from a restaurant on site. He was further informed that the care home he had just left had arranged for the chemist to deliver his medication at this new address in future.

On the 8th November 2018 SW1 rang the office at Apartment 2 to enquire how Grant was settling in and was told he was 'doing well'. SW1 arranged a joint visit to Grant with STR Worker 3 for 13th

November 2018. This visit was unfortunately cancelled owing to sickness absence. A re-arranged meeting was not made.

Staff at the housing association reported that Grant initially socialised with other residents in the communal areas, even having lunches on occasions. There were no housing management concerns and they were aware that Grant had visits from service professionals.

CPN/CC2 visited Grant for a pre-arranged meeting on 15th November 2018. They knocked the door several times but there was no answer. It was suspected that Grant was inside but unable to hear the door. CPN/CC2 planned to visit again in two weeks. CPN/CC2 rang the housing association office on the 28th November 2018 and as there was no answer left a voicemail message to be called back. A telephone call was made to the Care Home by CPN/CC2 enquiring which chemist Grant's medication was coming from. They were advised that Grant had been temporarily registered with a local (to the home) GP. It was advised that the Co-ordinator contact the GP practice. The Manager at the housing association contacted CPN/CC2 informing them that Grant had approached her expressing a worry over his medication saying he only had a 'weeks- worth' left. The pharmacy was contacted, and arrangements made for a further month of medication, but Grant would need to register at a local pharmacy following his move. CPN/CC2 contacted the GP to determine the new link Pharmacy.

CPN/CC2 visited Grant on 6th December. Grant was reported as cheerful and pleasant in mood stating he was happy for the visit. Grant said he was lonely and isolated. He apologised that he did not have a proper chair for him to sit on and for having too much smoke in his room. He said he could not listen to music as it may be too loud for others. He said he wanted to go back to hospital to learn how to use his hearing aid. He mentioned that he was being charged two amounts of council tax and needed help. CPN/CC2informed him that he would speak with his social worker.

Grant mentioned that he could do with a residential home rather than his own flat. He did not like being on his own. He admitted that he was 'a difficult customer' but he needed practical help and support in the community. CPN/CC2 reported that Grant was concordant with his medication. Grant stated that he had a constant humming sound in his head and had Tinnitus. Grant was told that CPN/CC2 would visit again in two weeks.

On the days prior to the 7th December Grant had sat in the office with staff and seemed to want company appearing a little agitated and concerned about his medication. A senior care worker present contacted Social Services to obtain advice however social services were unable to find a record of this call. The Senior Care Worker also spoke with the CPN/CC2 who visited on 6th December and was told Grant was okay at that visit.

On the 7th December 2018 Grant came to the office around 4.00pm and asked staff to ring his doctor as he wasn't feeling very well. He told staff he was hearing voices and loud music in his head. Grant told staff his GP was Dr S at named health centre (HC1). Staff rang to be told by answerphone to ring the on-call system. The call was made, and staff were told a doctor would ring back. Grant told staff that he had bought a bottle of alcohol the previous day and had a drop in his coffee and so hadn't taken his medication that afternoon but would take it that evening. The on-call staff rang back to say that Grant was not registered with GP S and they would need to ring the practice he was registered with whilst living at the Care Home (HC2). A call was made to the Practice telling them that Grant was hearing voices and were advised that there were no appointments available and to ring on the

Monday 10th December. Grant said he was adamant that he wanted to see a doctor and was feeling panicky and scared. He said he wanted to speak to someone at the hospital on the ward where he had been admitted previously. The hospital was rung, and the call put through to the ward but there was no answer. Grant insisted that staff then ring 999.

At 17.03 hours the Ambulance Service (AS) received a 999 call for Grant who was reported as hearing voices and music and he was scared to go into his flat so was waiting in the reception of . An ambulance was dispatched which Grant met in the car park. The ambulance crew were told by Grant that he gets no help but needs some. His apartment was noted to be sparse with no food and no care package in place. He was conveyed to hospital for a full assessment. A safeguarding referral was completed by the AS which was passed immediately to Adult Social Care. The Practitioner Learning Event discussed the issue of the AS sending referrals about individuals needing welfare and care rather than abuse or neglect needs and recording them as Safeguarding referrals. Adult Social Care highlighted that this issue had been raised in a previous SAR and will be addressed in the recommendations of this report.

In Accident and Emergency Grant was assessed and referred on to be seen by the Psychiatric liaison Nurse. Grant said he was hearing voices with loud noises and felt he was in fear of being killed. A joint assessment by the Liaison Nurse and duty Senior House Officer Psychiatrist.

The summary of Grant's assessment was reported as- *presenting to A&E complaining of hearing voices. He is known to the Mental Health Trust having a diagnosis of Chronic Schizophrenia and Personality problems. He was admitted to hospital in June 2018 and discharged September 2018. He has a history of 4 previous admissions since last year. It is documented that most admissions were precipitated by Grant's dissatisfaction with accommodation and social circumstances. He was seen by his CPN yesterday and he was stable in his mental health. Grant had all necessary investigations that came back negative.*

Grant was in A&E a significant time where it was assessed that '*there was no evidence of overt psychotic symptoms or evidence of distress to his experience. He presented as euthymic in mood. It was concluded that the main concerns for Grant were social issues as he was struggling to cope at home. It was further reported that Grant denied suicidal thoughts and no risk to self or others was identified. It concluded there was no evidence of acute mental illnesses.*

Grant was discharged home. The discharge records noted that the Home Treatment Team were to review the following day, contact was made to the CPN to review on Monday 10th December and an urgent Outpatients appointment to be made.

The AS safeguarding referral was recorded as received by the Adult Social Care Emergency Duty Team EDT at 22.20 on the 7th December. The referral advised that Grant was '*hearing voices in his head threatening and loud music, scared to go back in to flat. No care, flat very clean but no cooking appliances, kettle or food. Wants to be re-housed. Taken to hospital.* EDT logged the concern.

On Sunday 9th December 2018 the ambulance service received a call at 13.18 for Grant who was reported as suffering with his mental health. Grant had used his emergency call system in his apartment to call for assistance triggering an emergency call for an ambulance. The ambulance crew arrived at 13.43, and reported that on arrival the doorbell was broken, no mobile or landline phone,

and no fridge which is required for eye drops and food. Grant stated that he is waiting for social services support since he moved in 6 weeks ago and consented to a re-referral to social care. Grant told the crew that he has been hearing voices intermittently for 'a number of days' and has run out of Procyclidine tablets for the last 3 days and not been taking his Chlorpromazine for a number of weeks. It was observed that there were 3 blister packs with Chlorpromazine still in the packs untouched. Grant informed the ambulance crew that he was not suicidal and had no suicidal thoughts. He passed the mental capacity questioning from the ambulance crew. The Crew contacted 111 for advice from a GP regarding prescription advice. The GP stated that Grant required a medication assessment and that he (GP) will email the Health Centre (HC1) to contact Grant tomorrow. *N.B. this contact was the Health Centre who had stated Grant was no longer registered with them.* Further conversation discussed the need for Grant to be visited by his CPN to monitor medication compliance. The ambulance clinician made telephones calls to mental health care from Grant's bedroom. It was confirmed that Grant had a CPN and had received a visit on Friday. Whilst the call was being made Grant entered the bedroom and opened his wardrobe door pulled out some clothes and pulled out a large bag of up to date medication. The ambulance clinician updated the mental health care person of this development. Action was then taken to remove out of date blister packs and replace with new ones and instruction was given to Grant regarding what to take. Grant took his morning dose and was told to take the evening medication later that night. Grant agreed to do this. Grant said he did not need to go to hospital and would await being contacted by the CPN and GP the next day. A Safeguarding referral was made by the Ambulance crew and submitted to the Local Authority ASC. The ambulance crew left at 16.20.

The Safeguarding referral was dealt with by the out of hours social care EDT who received the alert and reported no further action (NFA) as Grant was known to be supported by SW1 and issues were known.

On the 10th December at 08.05 the ambulance service received a 999 call for Grant who had been found in the grounds outside his apartment by a passing carer at his apartment complex. The ambulance dispatched three resources and arrived to find Grant receiving chest compressions from the carer. Grant was confirmed as deceased on the scene and police were requested to attend as it appeared that Grant may have jumped from his bedroom window. Grant's apartment bedroom window was open, the blinds from that room were found outside on a garden wall and a knife was found in the bedroom where window restrictors had been removed.

The concerns about Grant over the 7/8th and 9th December were picked up by SW1 at work who then had a discussion with SW2 and had agreed to visit Grant that morning. Sadly, on arrival she was informed of the tragic event. The CPN 1 involved with Grant was informed of his death by telephone contact from the social work department. CPN/CC2 was informed by staff of the events over the weekend and of Grant's death. The safeguarding alert from staff regarding Grant over his behaviour during the 7/8th and 9th December was seen by staff at Adult Social Care on the morning of the 10th December but was not progressed as they also received notification of Grant's death.

7. Outcome of Mental Health Trust Root Cause Analysis.

The MHT carried out a Root Cause Analysis following Grant's death in line with their policies and procedures. A report was produced and submitted to Commissioners on 8th March 2019.

Lessons learned:

1. The need to ensure MDT discussion/MDT case conference when making significant decisions about changes in patient care.
2. In accordance with the Trust Mental Health Clinical Risk Assessment and Management Policy: It is essential that the risk assessment and risk management plan is reviewed if there is a significant change in presentation of the service user or a change in care circumstances.
3. To re-enforce the need to consider other antipsychotic medication through case reflection.
4. Timely medical reviews following discharge from inpatient care, should be provided. *When patients are stable following a crisis/expressing suicide ideation staff should assertively query underlying reasoning such as loss of social status and to ensure that a robust contingency plan is in place. Specific Older Adults training should be provided to support this. There is a need to ensure recognition and consideration of patient specific early warning signs of relapse.*

Recommendations made:

1. When making significant decisions about changes in patient care, staff should consider an MDT case conference to ensure all relevant professionals are involved.
2. It is essential that the risk assessment and risk management plans is reviewed if there is a significant change in presentation of the service user or change in care circumstances.
3. Following inpatient discharge, ensure all patients have a pre-booked medical review within 4-6 weeks, either in OPA or at home. This is to be incorporated into Trust Care Programme Approach (CPA) Policy which currently does not stipulate timeframes for medical reviews.
4. Specific Older Adults 'Dealing with Bereavement' practice sessions to be considered to inform meaningful discussions with patients and robust contingency plans.

The above report was accepted by the MHT and an action plan developed and monitored. This report has served to inform this SAR and all recommendations made have been included in this SAR to be presented to the Safeguarding Adult Board alongside any new recommendations.

8.Key themes, analysis and comment including examples of good practice, both single and multi-agency. *Where recommendations have been made by the agencies and detailed in their IMR they will be included in section 9.*

Liaison and information sharing between professionals and record keeping in the case.

The main agency providing care to Grant during the time period for this review was the MHT hospital ward. Grant spent more than 6 months on the hospital ward over two 3 + month periods between February 2018 and October 2018. During his time on the ward staff liaised with other agencies in pursuit of discharging Grant to appropriate alternative accommodation. Regular ward reviews were held, some included Grant and others (at Grant's request) did not. Towards the point of discharge planning Adult Social Care and Community Mental Health support teams were involved jointly and attended ward reviews.

Grant's admissions to Accident and Emergency departments were preceded by differing mental health issues and incidents including self-referral, suicide attempt and requiring a Section under the Mental Health Act. The agencies involved with Grant during these crisis episodes were found to liaise very well including the use of follow up documentation and monitoring as completed by British Transport Police, Ambulance Service and Accident and Emergency staff. Two Adult Safeguarding referrals were made by the AS to ASC. This is in line with best practice and with the intention to keep safe and support vulnerable adults. Both safeguarding referrals were picked up by the Emergency Duty Team and appropriate enquiries made. The first concern raised on the 7th December 2018 resulted in no further action as Grant had been taken to A&E and assumed that he would be seen by mental health professionals. EDT were not informed that Grant was discharged from A&E and there was no record that the hospital was contacted by EDT to check the current situation or that the concerns raised in the Safeguarding alert were shared with the hospital.

The second Safeguarding referral on the 9th December 2018 was also received out of hours by the EDT. This alert concentrated more on the lack of furniture and cooking facilities in Grant's apartment. The referral was screened with no further action on the basis that SW1 was supporting Grant and the MH duty worker was to follow up the next day. Given that this second referral made it clear that only two days later Grant was in his own home, it may have been beneficial for further enquiries to be made by EDT to ensure that at least he had some food. It should be acknowledged that this would have been difficult as Grant had no telephone and it was late in the day. An urgent visit for his social worker was flagged for the next day.

The Individual Management Review submitted by ASC identified some evidence of some good detailed record keeping within Grant's case notes but did note that at times there were gaps making it difficult to fully understand what happened at certain meetings and not fully reflecting the outcome of a meeting.

There was good information sharing between ASC and MHT in relation to supporting Grant with his choices regarding potential accommodation providers. There were regular contacts between the Ward and ASC when Grant spent long periods of time in hospital. Information regarding discharge dates, case allocations and updates were evident and timely. ASC shared Grant's care and support plan with the care home for information to support his discharge.

The MHT ward initiated in a timely manner the two inpatient discharges for Grant and notified the GP by letter alongside a treatment plan. There was evidence that the GP service had information about Grant from the ward but little or nothing from any other agency. There was a comprehensive discharge letter from the A&E department where Grant was admitted following the railway incident.

When Grant moved from the residential care home to supported living the GP details did not appear to have been communicated to all parties. This did cause undue confusion and delay when Grant was asking staff to contact his GP when he was unwell, and his mental health was deteriorating. It can be deduced that when the Ambulance crew were contacting 111 the confusion over the duty doctor sending information to Grant's old GP rather than his current one, implied a delay in updating the records. The speed of changing the GP for Grant in the residential care home, albeit with his agreement, seemed hasty and it would be worth considering that during the trial period for a resident it may be better to negotiate with the long-term GP to offer care where possible. Geographically the distance was not too far for this to happen. It appears that a 'blanket decision'

occurs for residents entering the care home to change GP Practice. Grant had been with his GP for over 9 years and given his mistrust of some professionals this may have been a relationship to hold on to at the time of change. The last GP (GP3) who saw Grant in October 2018 did not record in the patient notes any arrangements for a follow-up appointment.

Staff from the residential care home visited Grant on the ward and completed an assessment for admission. Information was provided from the ward and ASC regarding a care plan and risk assessment. The planned discharge required that Grant would only be discharged if the trial was successful. Despite Grant being told that he was on a 6-week trial, the hospital discharge letter was sent out on the 18th September 2018. It appears that both the care home and Grant adhered to the timescale of a 6-week trial.

Staff from ASC and MHT were responsive to change in Grant's choices about where he wanted to live. When the move to the residential care home took place, ASC allocated a mental health support worker to assist Grant to access his previous property and to set up direct debit payments for his tenancy bill. From the chronology record of contacts with Grant during the time that he was in the residential care home there were numerous contacts both in person and by phone. Looking at the number of people involved with Grant and their differing roles (whilst it is good that staff were responding to Grant) it could have been confusing for him to know who was responsible for each action that he was requiring. This may well have exacerbated his frustration with his service received. This manifested itself in his expressing his anger and frustration with every member of staff who visited him. Whilst the support was good and during his time in the care home was more than weekly it was a stark contrast to the visits/support he had once he moved into a less supported environment.

When Grant moved back to Apartment 2, no information about his previous suicide attempt or formal assessment was shared with the Housing Association. As Grant was taking a tenancy agreement and was not requiring social care support (despite his initially saying he would and was deemed at risk if he was not in a supportive environment) very little information was available to staff at the Housing Association. *It is recognised that Grant was entitled to privacy and confidentiality and the repercussions of this are covered elsewhere in this report.*

Was capacity assessed, recorded and specific to certain decisions? Was legislation (e.g. Mental Capacity/Mental Health Act) used appropriately?

Whilst in hospital Grant's capacity was recorded as assessed throughout the case notes and formal assessments were recorded as completed. When Grant was admitted to hospital in February 2018 he was assessed as lacking capacity to make an informed decision regarding his admission to hospital and treatment. He was placed on urgent DoLS and safeguard alert. During his two episodes of hospitalisation in 2018 there were occasions throughout treatment when Grant's capacity was fluctuant as he on occasion found it difficult to make decisions regarding day to day management. It was noted that concerns were recorded about risk if Grant was not in a 24-hour supportive environment such as a care home. In June 2018 the Consultant for Grant considered instituting a Guardianship Order to enable keeping Grant at the care home MH should he decide to leave. It was unfortunate that the medical team were not consulted or made aware of Grant's move out of the care home into Apartment 2. It is also of significance that Grant's capacity was not assessed prior to his move from the care home. The IMR's from ASC and MHT have made recommendations regarding

this issue. Other legal options could have been explored regarding Grant's reluctance to engage or make best interest decisions that may present a risk. The Guardianship order would have been able to deal with Grant's place of living but would not have dealt with his money or property.

The BTP identified that when their Officers attended the incident at the railway station where Grant was reported as a 'suicidal person' their use of a 'voluntary basis' admission to hospital did achieve a positive place of safety but have recognised that the use of a different Section, namely a Section136 would have been a more appropriate route to have used . Refreshed guidance has been delivered to frontline officers to empower them with knowledge and give them confidence to utilise their powers more proactively.

There was good use of Deprivation of Liberties (DoLS) and Best Interest assessor with Advocacy eventually being provided for Grant. This added an extra safety-net layer to the risk management and capacity processes. It should be noted that during the assessments in May 2018 there were differing views regarding Grant having or not having capacity. Psychiatrist 2 stated that they had a view that Grant was unable to weigh up information to decide. The IMR for ASC identified a weakness here and suggests that where there were concerns that Grant was lacking some capacity (or decision specific capacity) then a further DoLS should have been submitted. In June 2018 following the railway incident Grant was re-admitted back to MHT hospital and taken off the Section 2 MHA. A ward review on 19th June 2018 recorded that Psychiatrist 3 had concerns about Grant's capacity to decide regarding paying for care and support, insight into his medication, discharge destination and managing his mental health in the community. This view influenced finding a residential care home environment for Grant.

There is no evidence from any of the agencies involved with Grant taking legal advice for dealing with people who refuse to engage regarding their finances but may need support.

ASC fulfilled its review duty under S.27 Care Act 2014 and started a review on 15th May 2018 however Grant at that point refused any adult care support and the case was closed. A further request to ASC involvement was triggered on 19th July 2018 where a review of Grant's needs was completed and a support plan for discharge to residential care was provided. ASC identified that although this request should have triggered a 'new' assessment rather than review this had no bearing on the outcome. It is interesting to note that at several times throughout Grant's times of crisis he was asking and recognising the need for social type of support. It is not clear how much negotiation techniques or drawing up a contract could have helped or the use of very clear role and responsibility explanations, but it may have been worth trying. Grant continuously asked numerous staff to support his social care needs expressing anxiety over tasks such as cleaning his hearing aid tubes and repair of his glasses.

Was there appropriate focus on Grant's health and well-being and how was this considered and addressed?

Both the AS and BTP showed appropriate focus and support for Grant during their interactions with him. The AS spent considerable time with Grant in his apartment on the 9th December making sure

both current and future support was in place. Their use of Safeguarding alerts should be commended. The follow-up process for BTP also demonstrated robust systems in place including regular follow up checks.

During the periods of hospital admission Grant experienced problems with his hearing aid and glasses both of which needed repair and he continually had an issue about cleaning the hearing aid tubes. The timescale for the replacement and repair of these aids was lengthy and investigated with staff during the Practitioner Learning event as part of this SAR. Staff explained that delays were caused from Grant insisting that he only wanted to obtain new glasses by attending an appointment at a specific hospital first. This necessitated a request to be seen and placed on a waiting list. Grant also insisted on a private hearing aid rather than an NHS one. It is evident that he was still having difficulties with his new hearing aid when discharged from hospital.

Grant complained about being lonely and isolated at the care home as he had no one he could talk to. He recognised that most residents had dementia and this lack of company appeared to affect how he behaved with people. After time Grant was noted to become critical of staff, rude to other residents and exhibiting threatening behaviour. Staff at the care home liaised heavily with external health professionals and contacted them whenever Grant requested to see them. The care home reported that Grant showed no signs of confusion or becoming unwell whilst at the home but that he did not waiver in his wish to move to a more appropriate home.

This SAR reveals an overwhelming wealth of persistence and going 'over and above' by many staff to attempt to secure Grant in a safe and acceptable placement. The time leading up to his discharge from the care home in October 2018 saw many visits to Grant from numerous staff with differing roles and responsibilities. Grant's frustration regarding who would help him with his required tasks was evident. The placement of a residential care home was settled on as it offered the 24- hour care possibly replicated by the ward regime. Grant showed improvement in a well-structured and supportive environment and an added positive for him was perhaps the absence of having to pay for hospital care. Grant was described as an intelligent man, proudly independent being very reluctant to accept support. As the time passed it appears that Grant accepted that he needed support but was concerned about who would provide it and what it entailed and the cost. Grant showed a pattern of agreeing to receive support care prior to discharge then changing his mind.

It is not clear how much negotiating over-paying for services took place or whether discussion over his finances were part of an MDT process. It may have been useful to have taken legal advice and looked at managing his financial refusals through a more creative approach to enable trust to be gained. A detailed contract with Grant may have been useful and a breach could have triggered a more in-depth investigation into executive capacity in addition to decisional capacity especially when refusing services where self-harm could occur. (e.g. not taking his medication). Attempts were made whilst Grant was in hospital to investigate whether Grant was experiencing cognitive deterioration, but Grant refused to have an MRI. There was no further reported attempts to re-visit this post discharge.

When Grant moved to the care home his support worker needed to source clothing as he was reported as having little with him. It was noted that a plan to obtain clothing had been delayed in July whilst in hospital and required a Section 17 to enable Grant to be accompanied home to gather clothing. Grant was eventually accompanied home to sort out some issues and collect clothing. Staff

at the Learning event explained that Grant was quite adamant about what he was taking away from his apartment and this resulted in limited clothing. Ward staff explained that this did cause problems about washing his clothes and they tended to wash them at night and have them dry for daytime.

There seemed to be pressure from Grant on the staff involved to react quickly to enable his moves. When Grant initially refused to stay at the care home ward reviews were still being held (September 2018) and could have been resurrected over the 6 weeks following discharge. This would have been a forum where an MDT approach could have considered the risks associated with Grant leaving the care home.

Grant was reported as having a 6-week trial period in the care home and if the placement had broken down, normal practice would be that his case would have gone back through his Consultant for assessment. This did not happen. The Trust responsible for Grant's support in the community explained at the Practice Learning Event that the staff member dealing with Grant at this time was an agency staff and has not worked with the Trust since this incident. It was further explained that the Trust no longer use Agency staff.

Ward reviews held whilst Grant was at the care home did not appear to accurately reflect his behaviour at the home or his wishes to leave. The community based MHT staff supported Grant with his application to move and assisted him with practical issues to furnish his apartment. Grant was refusing to purchase certain white goods some of which were necessary such as a fridge to store his eye medication. At no time was a risk assessment done prior to his discharge. It could not have been helpful to staff involved to have Grant threatening to go 'walk about' if he didn't move the next day and the manager of the care home stating that they would no longer be able to have him if his behaviour continued. **These pressures should have triggered a review and risk assessment as a minimum.**

During Grant living in the care home he voiced his anxiety about growing old and feelings that he was not suited to living in a place with people with a dementia. Alternative places within a community setting that would offer the type of support that Grant wanted were limited and of those proposed Grant turned them down.

Prior to Grant moving from the care home to Apartment 2 he received a visit from the social worker to determine what support could be offered and what was needed for his apartment. Grant was not in agreement with the social worker and wished to move the next day, refusing to wait for additional items of furnishings or support to be arranged. It was stated that he had capacity but would not listen. This report has already detailed the error in not returning to an MDT forum at this point. It is further noted that following numerous visits to Grant at the care home, especially from STRWorker3, they dramatically dropped once he had moved back to Apartment 2.

Grant moved to Apartment 2 on the 26th October 2018 he was hard of hearing and may have had a broken doorbell (as indicated by CPN visit on 15th November when there was no response but could hear him in apartment and as reported by AS visit on 9th December 2018) from this time. He had little furniture and no cooking facilities. The CPN who had no response planned a visit for two weeks later. The social worker was planning a joint visit with the mental health support worker to take place on the 13th November, but this was unfortunately cancelled owing to the mental health worker

being off sick. There was no evidence that the meeting was re-arranged**. Grant was unfortunately left with no visits for over a month.**

The CPN was contacted on 28th November about Grant only having a week of medication left. The CPN sorted out a delivery and which chemist would provide them, but this did not trigger any earlier visit to take place. The first visit took place on the 6th December where Grant expressed his pleasure to receive the visit stating that this was the first to take place since moving. Grant said he felt lonely and isolated, could not listen to his music as it may be too loud for others, wanted to go back to hospital to learn how to use his hearing aid. He finally asked for help about his council tax as he was paying two amounts. The pattern of Grant's needs reaching a crisis point and to be reacted to rather than planned could not have been helpful to the staff attempting to support him or for Grant who felt isolated and lonely. At this meeting Grant described to the CPN that he did not like being on his own, admitted he was 'a difficult customer' but needed practical help. The CPN arranged to visit again in 2 weeks. It was recorded that '**Grant was concordant with his medication but hearing humming sound in his head and had tinnitus'.** The benefit of hindsight from this SAR suggests that this should have triggered a more in-depth consideration of Grant's mental health well-being as his history would indicate that his relapses were preceded by hearing humming noises.

It is not surprising that Grant was not managing well in Apartment 2 as all his recent reviews, plans and associated risk assessments indicated the need for a more structured and supported accommodation. This has been fully explored earlier in this report.

The AS made two safeguarding referrals for Grant one of which reported him as having no food in his apartment amongst other issues. Whilst he sometimes bought a meal from the restaurant facility on site. It is not clear that this was a daily occurrence and as he had no facility to heat any food his nutritional welfare may well have been marginalised.

What risk assessments were undertaken to consider other vulnerabilities Grant may have had?

Much of the background and evidence for this section has been addressed in other sections of this report and highlighted gaps identified.

The ASC Support Plan Review dated 19th July 2018 was completed and identified risks in relation to self-harm, self-neglect and vulnerability regarding anti-social behaviour. The IMR from ASC identified a shortfall in practice as the risk assessment did not identify a risk plan or a separate risk assessment completed. This was found to be missed owing to staff being unaware of the existence of a separate risk assessment to be done. ASC have rectified this oversight with the staff concerned by making them aware of the accepted practice. ASC highlighted that it would have been beneficial and best practice for the CPA risk assessment to have been shared by the MHT to ASC as it was very detailed and provided good detail in relation to risk, crisis and contingency planning. However, this SAR notes that despite this detailed MHT risk assessment there was little reference to it being used by MHT staff regarding Grant's move or time spent back in Apartment 2.

Was Grant able to access the right services at the right time?

Emergency services dealing with Grant responded in a timely, supportive manner dealing with his issues sensitively and appropriately. The service Grant received at his A&E admissions dealt with his needs for a mental health assessment and intervention both speedily and appropriately.

Grant's discharge from A&E on the 7/8th December prompted scrutiny both from the Root Cause Analysis undertaken by the MHT and this SAR. It is known that he spent a significant time being assessed and examined by the Psychiatric Liaison team clinician, then jointly with the duty SHO Psychiatrist. All the necessary investigations carried out came back negative and there was no evidence of overt psychotic symptoms identified. It was noted that he had a history of several previous inpatient admissions in the last year and most of his admissions were precipitated by his dissatisfaction with accommodation and social circumstances**. There was no recognition during this assessment that Grant was no longer living in a well-supported environment as detailed for his last discharge from hospital.**

MHT hospital services made huge efforts to support Grant's mental health to stabilise and for him to reach his desired goal of remaining as independent as possible. Where this was not achievable, they made huge efforts and attempts at planned discharges to more suited accommodation, only to find that Grant would change his mind. It is understandable that the ward staff were concerned at the length of time that Grant was spending hospitalised and receiving no treatment, both for his sake and that of blocking a much-needed bed.

Grant was provided with a range of people to support him including an Advocate, STR Worker, a Mental Health Worker, Social Worker and CPN. The SAR has been unable to see a referral to or support from sensory impairment services during 2018. The records indicate that they were involved in 2013. Clarification was sought at the Practitioner Learning event and it was confirmed that Grant had no additional sensory engagement in place.

- **What have you learnt from this case?**
- **Highlight good practice and in what ways could practice be improved; what might have made a difference to the way Grant experienced your services?**
- **Are there implications for the ways of working; training?**

From the IMR's submitted the following areas were identified:

Adult Social Care- Lessons learnt:

1. Consideration needs to be given within the multi-agency context to the full toolkit of legal options that are available to all professionals to ensure that they are fully explored in the best interests of adults, especially where there are differences in opinion in relation to capacity, risks and maintaining an adult's wellbeing.
2. Record keeping needs to be comprehensive and contemporaneous to ensure that the adult's story can be followed.
3. Separate risk assessments need to be completed where complexities arise in relation to choices and risks and where support that has been assessed as required is refused. A refusal of support is not always a reason for ASC to end their involvement and needs to be balanced against the case history presenting needs, risks and choices.

4. Self-neglect was referenced by agencies as part of their concerns for Grant, however this does not appear to have been considered formally in the wider context of single agency/multi-agency involvement or even as a safeguarding concern. Although it is evident that ASC were supporting Grant, it may have been beneficial to have a formal single or multi-agency plan in place.
5. Where EDT receive information from the ambulance service, where it is clear that an individual has complex mental health issues and lives alone that the EDT worker will make contact with the hospital (if admitted) to ensure that the individual will be assessed regarding their mental health needs and for the hospital ward to be asked to contact EDT if there are any welfare issues/care needs in the community, prior to or at point of discharge, to ensure that any appropriate possible crisis care support is considered.
6. When concerns are passed to EDT regarding the immediate mental health of vulnerable individuals (who live alone) in the community, the EDT worker to make appropriate endeavours to contact family, mental health workers, out of hours GP service, or to seek advice from the on-call AMHP, to ensure that family or appropriate services are able to explore support options. Services people are signposted to at the time by EDT needs to be proportionate and appropriate. The EDT is not a mental health service, but there will be occasions when further information may need to be ascertained or such signposting to partner agencies out of hours may be necessary and to ensure partnership working within our safeguarding responsibilities.
7. When it is clear that information passed to EDT about vulnerable adults may have no food, EDT staff to consider if food can be obtained for that individual on that day from a food bank supply or through other means to promote their immediate welfare when this is possible.

<u>Good practice</u>

- Advocacy provision
- Support to identify potential residential placements
- Ongoing commitment and responsiveness to supporting Grant with changing decisions regarding his future options
- Ensuring Grant's capacity was considered for key decisions
- Provision of a support worker to settle Grant into the new residential care home and to get personal belongings from his flat.
- Offer of support by SW1 to assist with move into flat in October 2-18
- All ASC support was provided to maximise Grant's well-being (as per S1 Care Act 2014) and to enable him to have choice and control.
- Good communication between ASC, MHT and hospital
- Exploration of options to promote independence and preventative support options, as per S2 Care Act 2014.

<u>Areas for improvement</u>

- To support the legal options considerations by engagement with our legal services.
- The refusal of a care support review and services is not always a valid reason to close a case and best practice would continue to explore alternate ways to achieve successful engagement with Grant. In hindsight it may have been helpful to have considered the

appropriateness of the case closure in May 2018 based on Grant's history, mental health, choices and risks.

- Separate risk assessment to be used to ensure risk assessment and more robust risk plans are in place.
- Case recording needs to be more detailed and contemporaneous to ensure that an adult's journey can be followed.

Are there implications for ways of working and actions already taken?

- ASC have introduced a new supervision policy in September 2018 that promotes robust standards in supervision to ensure that staff receive regular, good quality supervision. This also enables the discussion of complex cases so that management oversight and support can be provided. Practitioners felt that there are positive relationships with other agencies involved at the time and were able to work together.
- ASC are currently revising risk assessments and working within a risk enablement model, to enable practitioners to balance legal duties to protect and respect a person's right to self-determination. On a multi-agency basis, a local self-neglect pathway is being developed to co-ordinate responses to such concerns.
- ASC intranet now provides clear links to local safeguarding procedures as well as local practice guidance. This includes the Adult Self-Neglect Best Practice Guidance. A multi-agency localised self-neglect pathway is also being developed.
- ASC case recording policy and supervision policy was devised and launched in September 2018. This provided explicit agency requirements regarding case recording, supervision every 6 weeks and that high risk and/or adult safeguarding cases are discussed in depth during formal supervision.
- A Mental Health Practice Lead has been appointed and recently started within ASC. This lead officer will be able to provide professional support and advice for complex cases where mental health is a feature,
- The mental health team now routinely hold best interest meetings for complex cases and where there may be differences in opinions. Future 'can do' meetings are planned across ASC and will enable case discussions to be held with wider staff participation so that knowledge and options can be explored in a shared forum.
- The Mental Health Team are now routinely using the ASC separate risk assessment. ASC are in the process of reviewing their risk tools with a view to developing a risk toolkit with training delivered.
- The Mental Health Team are using a Specialist Intervention form, which enables specific information that cannot be easily recorded and identified within the Mosaic workflow to be captured e.g. details of mental health review meetings.

Mental Health Trust -*see section 7.*

Care Home – the only identified lesson learnt was that a less dementia heavy environment would have been more suitable for Grant.

Good Practice

Grant was well supported to contact his social worker, CPN and STR worker.

Information was shared appropriately between external health professionals and included a behavioural support plan for Grant.

Housing Association for Apartment 2.

Lessons learnt

- Additional care support services were available to Grant if this had been identified and Grant had agreed. This would have triggered an assessment that may have detailed the wider risks for Grant.
- There could have been more direct contact from professionals involved with Grant and additional information obtained at his point of application. *This is recognised as obtrusive given that Grant had capacity and not relevant to his application.*
- We need to ensure that agencies and professionals are clear on the type of service provided, the services available through housing staff and the potential to receive a care or well-being service.
- This case has raised questions regarding the sharing of information has been or will be shared in the future to maximise opportunities to provide effective and coordinated support. It is also important that housing staff identify the possibility of s decline in a person's health and well-being and to escalate appropriately.
- We are reviewing the level and type of mental health awareness training available to our housing staff. Although we don't believe in this instance that additional training would have improved the way staff supported Grant.

Clinical Commissioning Group – CCG

Lessons learnt

- Consideration needs to be given regarding the effect of changing a GP Practice when someone goes into temporary accommodation, some people will have been with the same practice most or all their lives and will have built up a relationship with them. If this is necessary, then the person would need to be fully consulted and the new GP information shared with all those that need to know.
- It could be reasonable to ask whether the GP Practice should have arranged a follow-up after seeing Grant in the residential care home and then not having contact for 6-8 weeks

before he died – following the second Practitioner learning event, this issue was followed up and the response received was as follows:
Grant was actively open to Mental Health services and had a CPN, it would have been for them to monitor him. Only if the GP had started or changed Grant's medication should the GP have followed him up. Whilst Grant was open to a Psychiatrist it was unlikely that a GP would change his medication.

- The last GP (GP3) to see Grant didn't document the review in the notes but this was done 2 days later by an administrator when sending a directive to stop a blood pressure tablet. This is not standard practice and has been communicated to the Practice.
- When patients are moving accommodation, it is important to include the GP's as they are often the route to referrals to other services. The CCG lead and named GP for Safeguarding will work with GP practices and other agencies to improve the communication flow.

Good Practice

- Both GP practices reviewed Grant in good time after receiving the discharge letter and treatment plan.
- The discharge letter from A&E following the railway incident was good with lots of information.

Health Trust with responsibility for A&E.

There were no implications for practice or areas for improvement from the SAR IMR submission or review.

The Trust should be commended for their effective practice in their support of Grant when admitted to A&E. He was quickly seen, and his mental health was the primary focus as he had no physical health issues. Appropriate referrals were made completing the mental health triage assessment tool and where needed Grant was in direct observation.

British Transport Police -BT

Officers attending Grant at the railway incident conducted all necessary actions and liaison without hindrance and within acceptable timescales. The procedures for reporting, recording and progress chasing on Grant was noted to be of a very high standard. The force has identified that the use of the Section 136 may well have been a preferred route for the situation for Grant, namely enabling him to be taken to a place of safety and receive treatment. This had no bearing on the outcome for him.

The wider implications for similar situations where an individual is deemed at risk of self-harm and attended to by BTP will benefit from actions already taken by BTP-

- As part of a Force-wide restructure, the delivery of safeguarding and public protection now comes under one central command. Refreshed guidance and briefings are being delivered to frontline officers in order to empower them with knowledge that gives them the

confidence to utilise their powers more proactively. Incidents are dip sampled and quality assured, and feedback is provided holistically and, in some cases, shared for wider organisational learning.

9. Conclusions.

All agencies engaged positively in this SAR by initially attending a SAR panel meeting and subsequently submitting IMR's on time providing useful and constructive review information. Where agency representatives attended the Practitioner Learning event, they provided reflective conversations enabling an honest and open sharing of their experiences of support to Grant.

It is noted that the absence of an agency attendance at the Learning event does limit the opportunity for a truly reflective review. When an agency does not attend as they believe they have no identified issues for lessons learnt or practice changes, their lack of attendance can inhibit the whole process of interaction as part of partnership working/development and therefore they should be encouraged to attend.

Working to support Grant had many challenges for staff and the emotional impact of his death was understandably felt by them. It was evident that the involvement by the staff who worked closely with Grant demonstrated total perseverance at times to meet his changing requests. There are numerous examples where staff went over and above their normal work roles to assist Grant in his quest for a suitable place to live.

This case should serve to remind everyone of the importance for staff guidance, supervision and case management when clients reject the relationship of support being offered but clearly still in need of intervention.

Grant had many staff involved in his care during the time period identified for this SAR. A key issue for Grant was his not wanting to engage in the requirements of the financial assessment for community care. Grant was clearly in need of living in a more supportive environment than he settled for in Apartment 2. He recognised this fact himself on many occasions. The Housing Association responsible for have stated that they had a variety of levels of care support that Grant could have accessed if he wished and this would have triggered assessments to have taken place. Having looked at the website it appears that there are low level support services available locally offering interventions for people who are socially isolated or would like a friendship support. It is a shame that Grant was unable to be persuaded to consider them or that something similar could have been offered whilst in the care home. This might have made Grant feel less isolated and lonely.

Grant's discharge process to the care home wasn't the best practice as he arrived on the wrong day. The breakdown of the placement did not trigger a further risk/capacity assessment. There was no clear measurement for how much of an effect the social isolation and loneliness had on Grant's ability to live independently and with a reasonable quality of life. A pattern of re-admission to hospital took place when Grant deteriorated and started hearing humming sounds. This appeared to have been missed as an alert during the visit to Grant on the 6th December. It should be acknowledged that Grant was inconsistent in informing service practitioners in attendance about his mental/physical needs. An example of this is when he informed the ambulance crew that he was not known to mental health services.

It could be easy to get bogged down by expectations that 'something should have been done' when Grant made 'unwise' decisions. This is the ethical territory where rights of the individual must be balanced with a duty of care. The IMR's submitted and the Root Cause Analysis undertaken have carefully considered this issue with helpful actions identified to help practitioners in the future.

A theme that appeared to dictate Grant's reluctance to engage or accept certain support services was the issue of having to pay for them. It was not possible to know if he had enough disposable income other than his word for it. It is a thought that maybe this was a worry and a trigger for some of his decisions. Research as part of this SAR has revealed very little information or guidance available for practitioners attempting to engage with vulnerable adults specifically about their finances when they are not willing to disclose details.

Effective communication with schizophrenic individuals is particularly important because they are easily overwhelmed by the external environment (*schizophrenia.com)*. Skilful communication can make an enormous difference in the ability of patients and families to resolve the problems of daily living. From the information received for this SAR it has not been clear whether any of the support plans for Grant looked at the best way to communicate with Grant whilst living in his apartment(s). This was especially pertinent with the added issue of Grant being hard of hearing.

Grant was not in receipt of sensory services during this latter period but had been in 2013. He was expressing difficulties with his sight and hearing aid and may have benefitted from re-visiting whether services could have assisted him again.

10. Recommendations from agency IMR's and RCA.

MHT & Hospital (including from RCA).

1. When making significant decisions about changes in patient care, staff should consider an MDT case conference to ensure all relevant professionals are involved.
2. It is essential that the risk assessment and risk management plans is reviewed if there is a significant change in presentation of the service user or change in care circumstances.
3. Following inpatient discharge, ensure all patients have a pre-booked medical review within 4-6 weeks, either in OPA or at home. This is to be incorporated into Trust Care Programme Approach (CPA) Policy which currently does not stipulate timeframes for medical reviews.
4. Specific Older Adults 'Dealing with Bereavement' practice sessions to be considered to inform meaningful discussions with patients and robust contingency plans.

Adult Social Care:

1. New case recording policy to be developed and rolled out to all staff, with briefings held**. (N.B. Policy in place and accessible on intranet Dec.2018)** To be monitored through case audits – **Ongoing.**
2. Develop new risk assessment tool and guidance, embed new tool and guidance within ASC, training to be delivered to ASC staff.

3. ASC staff to ensure they explore legal options where appropriate- to be sought from LA Legal department where required. Improve legal literacy by training through the delivery of safeguarding training to managers and operational staff. (**training provided June 2019)**
4. Ensure a robust response is provided by ASC for when out of hours concerns are raised- EDT to ensure staff are briefed on the response standards for out of hours concerns. (**Standards have been identified and shared with all EDT staff)**

Clinical Commissioning Group:

1. Feedback to GP's where there was a lack of documentation.
2. Promote GP's being included in multi-agency meetings/communications for all aspects of working, to include discharge arrangements and safeguarding concerns.
3. To work with the named GP for Safeguarding Adults and Children on finding ways of improving communication with GP practices, to include looking at the quality of discharge summaries from hospital settings.

Healthcare Trust:

1. To ensure that the Mental Health triage tool is audited as part of the Emergency Department audit plan to ensure continued use of the tool.

Housing Association:

1. Undertake an internal review to include and ascertain wider risks at the point of referral and or receiving the housing application. This would potentially give additional information in respect of the tenant and could flag a need for earlier intervention.
2. Ensure all referral agencies are clear on the nature of the service to enable better supporting information to be provided.
3. Consider the current mental health training offer for our housing staff.

<u>From this SAR the author has the following recommendations to make in addition to those from the IMR's.</u>

Safeguarding Board:

1. The Safeguarding Adult Board should satisfy themselves that the above Recommendations have been completed within the timescales applied.
2. The SAB must ensure that Adult Safeguarding Training and Guidance includes a multi-agency approach to self-neglect, risk management and communication with people who do not easily engage.
3. The SAB has received information in a previous SAR regarding the notification of Safeguarding referrals from Ambulance Services. Clarification should be made to enable

a greater understanding regarding referrals to be made as a Safeguarding issue and those as Care and Welfare issues.

All agencies:

1. All relevant agencies ensure there are arrangements in place such as a multi-agency risk panel where practitioners could refer concerns about adults who do not engage or are at risk of self-neglect. A multi-disciplinary approach would ensure a holistic view of the individual and their circumstances, with a collaborative approach to offering advice, information, specialist knowledge and practical support.