OLDHAM SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review Report -
Sam

February 2021

Contents

1. Introduction

1.1.1. This review is about a 48 year man called Sam* who died in 2019. Sam was a person with multiple complex medical needs and additionally suffered from anxiety and depression. He was found deceased at home in May 2019 by his personal assistants. Sam was found with a ligature around his neck that was attached to his hoist. He was known to several agencies by virtue of his multiple needs.

1.1.2. The case was referred for consideration of a Safeguarding Adult Review (referred to as SAR thereafter) and was screened initially in July 2020 and again in August 2020.

2. SAR - Care Act 2014: statutory duty to review serious cases

2.1.1. Safeguarding Adult Boards (referred to as SABs thereafter) must arrange a SAR when:

- An adult dies as a result of abuse or neglect, or experiences serious abuse or neglect and
- There is concern about how agencies worked together to safeguard them

2.1.2 The purpose:

- To identify lessons to be learnt from the case and apply those lessons to future cases
- To improve how agencies work, singly and together, to safeguard adults

2.1.3 The SAB has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect.

3. Review methodology

3.1.1. A Rapid Review methodology was used for this review. Whilst this a relatively new and less usual approach to SARs it has facilitated a rapid process proportionate to the learning and other system demands.

3.1.2. In this case it additionally allowed concise and prompt learning which has already started to take shape within the Oldham SAB.

3.1.3. The process allowed for a good oversight of the strategic commissioning process, gathering of the right information and analysis to identify system findings and strategic action planning.

3.1.4. Process:

*Sam is an anonymised name

- SAR Consideration June 2020, August 2020, Rapid Review process recommended and 4 overarching themes identified
- Independent reviewer identified (October 2020)
- Agency records review (November 2020)
- Rapid Review meeting with Reviewer and key agencies (December 2020)
- Early analysis report (January 2021)
- Structured Multi-agency discussion (January 2021)
- System finding report presented to SAB (February 2021)

3.1.5. Agency reports and involvement in the process

- Oldham CCG (safeguarding report)
- Oldham CCG (Continuing healthcare report)
- Oldham Council Adult Social Care
- Oldham Council (Housing Options)
- First Choice Homes
- Pennine Care

4. Family and friends involvement with the review

4.1.1. As a Care Act requirement *"Early discussions need to take place with the adult, family and friends to agree how they wish to be involved".* In this case, there are adult daughters and close friends of Sam who also formed part of his package of care.

4.1.2. Family members and close friends were identified and contacted via letter and subsequent phone calls. Unfortunately despite the perseverance of the business unit they have so far declined to be involved in the review and have specified that they do not wish to see the report. They have requested that there is no further contact and their wishes have been respected.

4.1.3. As a result there is a missing context to Sam's life throughout this report.

5. Key themes for consideration

5.1.1. The SAR consideration group identified the following overarching themes of focus:

- Risk management
- Social prescribing
- Care planning
- Mental health

5.1.2. Additionally considered:

- The evidence based learning from research and findings from other reviews
- In view of "unwise decision making" was there a particular issue of self-neglect?

*Sam is an anonymised name

- Did agencies have concern about mental capacity and what actions were taken to consider this?
- How effectively did the agencies involved with Sam work together to address the many complex issues?

6. Overview - about Sam

6.1.1. Sam had complex health needs and required 24 hour care, he had Transverse Myelitis which is a disorder caused by inflammation of the spinal cord, his condition was exacerbated when he was involved in a road traffic collision in 2015. Sam was paralysed from the waist down and amongst other medical needs he also had epilepsy and suffered from anxiety and depression. Sam expressed on a number of occasions that he wished to die and in particular expressed that he wished to go to "Dignitas" which is a society that provides assisted/ accompanied suicide in Switzerland. Other medical needs included:

- Depression
- Hyperlipdaemia
- Crohn's disease
- Coeliac disease
- irritable bowel syndrome
- Paraplegia
- Migraine
- Sciatica
- CPAP – sleep apnoea
- Colostomy
- Seizures

6.1.2. It is very important to get a strong sense of Sam's personality and lived experience.

6.1.3. Some of his carers were also his friends and this was important to him. Sam also had adult daughters one of whom lived with him for a time but there is limited information available to provide a deeper understanding of his relationship with his family or the extent to which they were involved in his care. Sam's community and area that he lived in was very important to him, he got enjoyment from watching Manchester United. He wanted a "normal" life and to be independent and would reflect on his life before which was happy and "normal" and compare this to how difficult his life had become.

6.1.4. Sam expressed that he didn't want to be a burden to his family and friends and did not want to rely on others. Sam appears to have been fairly vocal and often articulated how his pain and physical health affected his mental health and his hopes for the future. The professionals who knew him well said that Sam found the circumstances of his complex conditions highly distressing. He was open and articulate with several professionals- what was more challenging to ascertain was the extent to which his wishes, thoughts and feelings influenced how his care was coordinated and provided.

*Sam is an anonymised name

6.1.5. Sam and his carers were very fond of each other. However because he was their employer and friend, the carers were often in a difficult position and did not know what to do when he sent them away. His consistent first goal was to get a local house with a bathroom that he could use. It was incredibly important to him that he lived in the same area as his social network. He had to use a "plasterers mixing tub" in his living room in order to attend to his hygiene needs, this included emptying and cleaning stoma bags which was deeply upsetting for him.

6.1.6. An insightful comment was made by the Focused Care Nurse: *"Many people didn't recognise the severity of his disabilities, as he tried to live as "normal" a life as possible. A different character would have given up and adopted the patient role…. He was a fighter and did not let his disabilities stop him"*

*Sam is an anonymised name

7. Thematic findings

7.1.1. Agency summaries:

CCCG/ Care Package	Council/ Housing Needs
Sam was a person with care and support needs and in receipt of services from multiple sources. He was eligible for a fully funded care package, Oldham CCG were the Responsible Commissioner for this care. This 24 hour care package was delivered via an Individual Budget (IB) which was paid as a direct payment from Oldham Council and reimbursed from Oldham CCG. This meant that Sam was the "employer" and coordinator of his care package and many of his personal assistants were also his friends. It is difficult to ascertain to what extent his family were also involved in his care. There were occasions when Sam would send away his carers thus leaving himself vulnerable and without the care and support that he required to be safe. Prior to his death, significant efforts and case planning via a third party management consultant (Bespoke Healthcare) was conducted to transition Sam's IB to a Personal Health Budget (PHB) - this would facilitate a strengthened oversight of the care package and mitigation of risk. At the point that the IB was to transition into a PHB, Sam declined this and refused further engagement.	Housing needs were a key feature of this review and are referred to by each agency report. Housing needs were provided/coordinated by the Oldham Council Disability Living Service (DLS) which at that time was managed by First Choice Housing. Sam's accommodation was not suitable for his needs and he was restricted largely to one room. There was concern about his dignity in terms of personal hygiene and bathing facilities. Sam had expectations of his housing options around his social network and geographical area. It was very important to him to remain in a specific area with access to his social network. It seemed that there was a difference of perception about a new build property that he thought he would be offered in his desired area- this contributed to a breakdown of future communications and all offers of housing were declined. A resolution was not reached before Sam's death.

*Sam is an anonymised name

Adult Social Care (ASC)

There were 4 separate safeguarding enquiries raised between 2016 and 2019- these did not lead to a full assessment however concern was raised about lack of risk assessment and oversight, this was escalated within the CCG and ASC to request a "risk management meeting". It is not clear whether this took place. The records reflect that there was confusion about who had oversight of risks relating to Sam. Also a view that his physical needs and disabilities impacted significantly on his mental health and wellbeing. Capacity was considered several times with consideration that this fluctuated particularly after Sam had seizures, which was regularly, particularly in the context of decision making. It was suggested by the Social Worker that legal literacy should be considered. The Social Worker was concerned that there was no clear "Lead professional" and the responsibilities of the Local Authority and the CCG were not clearly defined thus resulting in a lack of oversight and management of risk.

Focused Care Nurse and Primary care

Sam had a positive relationship with a Focused Care Nurse. The focused care model is a resource available in some areas of Greater Manchester and is aimed at supporting vulnerable or harder to reach households. In this case Sam's GP practice had referred to the Focused Care Nurse. This relationship appeared to be positive and trusting. It is very clear from the agency report and the discussion of the panel that the Focused Care Nurse made significant efforts to liaise between agencies, advocate for Sam and to coordinate services for him. The information from this service reflects Sam's personality, wishes, feelings and struggles.

The GP practice had a lot of involvement with Sam throughout the time period in terms of prescriptions, referrals, blood tests and Sam was seen regarding a number of medical issues.

Mental Health

Sam was in receipt of services from Pennine Care throughout the time period of the review. The service that he received was via the Psychological medicine service which is offered to people who have physical health problems and psychological needs. He was discharged from the service in 2018 after sporadic engagement. Sam was not under the care of the Community Mental Health Team for crisis management.

The mental health report gives us a sense of Sam's view of the world. The Consultant appears to have known him well and worked flexibly, frequently liaising with other services and agencies to support him. It is reflected that on each contact with Sam his psychical presentation, mood, mental health, mental capacity, social and housing situation were reviewed. Professional curiosity seemed to be used well, to explore factors contributing to deterioration or improvements in his mental health. The impacts of pain, physical conditions, changes in life, relationships and housing were all identified as significant factors and were explored at each consultation with Sam. His mental capacity was explored at each appointment and he was assessed to have capacity each time. Sam was consistent in his expressed plan for assisted suicide and the relevant policy was considered. Additionally he was continually risk assessed around immediate plans, mood and intention and at no point was assessed to be at risk of suicide. Sam was discharged from the service a few months before his death.

It is noteworthy that the Consultant formed the view that the focussed care nurse was the lead professional.

*Sam is an anonymised name

Key emerging themes:

- **Agency perception of "non-engagement/ difficult to engage"**
- **Unwise decision making/ capacity issues considered in silo**
- **Elements of Self-Neglect**
- **Risk management of the care package- lack of clarity**
- **Multi-agency risk management oversight**
- **Identification of a "Lead Professional"**
- **Little information about access to community assets/ social prescribing**
- **Housing as a key issue**
- **The extent to which Sam's feelings, wishes and thoughts influenced his life options**

*Sam is an anonymised name

7.1.2. The agency reports and panel discussions provided reflections on quality, appropriateness of practice and framed the wider systems including areas of strength/concern and contributory factors. Reports and discussions raise a number of questions and themes which are summarised in the table above.

7.1.3. It was clear to see evidence of good individual practice, persistent approaches and attempts to work with other agencies, however this was often in the context of unclear accountability, confusion and assumptions, inconsistent coordination and a lack of multi-agency risk management.

7.1.4. Agencies worked very hard in silo however there was an absence of regular multi- agency meetings with all relevant agencies represented which is key to shared understanding of risk and a joint approach to managing this. In this case such meetings could have brought Sam and his carers/family (if appropriate) Housing, Adult Social Care, the CCG, Primary Care and mental health services together to assess risk and agree a risk management plan.

7.1.5. One issue that was considered was that of "self-neglect" and "unwise decisions"- capacity was discussed on many occasions with some views that Sam always had capacity and others that it fluctuated. Within a multiagency discussion context, legal literacy could have been explored in greater depth in terms of capacity and decision making. It is difficult to now reach a conclusion as to Sam's capacity and whether there was self-neglect without hindsight bias.

7.1.6. The Care Act 2014 defines self-neglect as: *"a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding"* People who self-neglect will often have a combination of complex physical, mental, social and/or environmental problems, however when offered help and support from professionals they will tend to refuse assessments or support. Self-neglect is complex and a range of factors are known to be possible factors including fluctuating mental capacity, trauma, significant loss and other experiences in a person's' life. Working with people who self-neglect can be really challenging for professionals and applying standard working protocols such as closing cases for non - engagement are not appropriate.

7.1.7. The Rapid Review panel considered this and agreed that there are some elements such as lack of engagement on occasions and potentially fluctuating capacity. It was agreed that it was not intentional self-neglect and often the presenting elements were a result of Sam very much wanting to be in control of his own care/ life.

7.1.8. As far as the information available Sam was likely to experience low mood due to his complex health problems, and as having suicidal thoughts, but as not presenting with any acute symptoms of mental illness that would affect his ability to make decisions. This underscores the importance of multi-agency meetings to share information, a shared risk assessment, agreement of a risk management plan and identification of a lead agency and lead professional.

*Sam is an anonymised name

7.1.9. Oldham Safeguarding Adult Board are in the process implementing a Complex Risk Management Protocol and the panel explored Sam's case and considered whether his case would have triggered any of the agencies and professionals to use such a protocol. Without hindsight bias it was difficult to conclude with full confidence whether or not it would have. Thus there should be a focus on standard expectations of practice PRIOR to application of the protocol.

7.1.10. Expectations of standard practice was explored in terms of "pre complex risk management protocol" steps. The key elements of practice were identified as robust defensible decision making, asking the right questions/ not making assumptions, good legal literacy, coherent multi-agency coordination, identification of a Lead Professional (Key Worker) and a risk management plan that all agencies are signed up to. The panel and Author concluded that these elements of standard and partnership practice should be a focus for development.

7.1.11. The issue of access and availability of social and community resources and what may be available (or not) to a person in Sam's situation was not apparent in the agency information and thus one could conclude that it hadn't been fully explored or considered. However what we know of Sam is that his community was important to him and he may have benefited greatly from what may have been available to him.

7.1.12. There was a frequent and repeated pattern that Sam appeared to disengage if agencies attempted to strengthen what was available to him. Reports and discussions reflect a picture that suggests disengagement with some agencies and deterioration from 2017 onwards and thus a lack of resolution to the issues that deeply affected him. A Multi-agency Safeguarding Risk Assessment/Management tool would assist agencies to facilitate a focus on significant health issues causing risk, isolation and service refusal.

7.1.13. Practitioners who knew him have acknowledged that Sam could be difficult at times and often unwilling to engage. However, had a "Lead Professional" been identified they might have been able to build up greater trust. Assumptions were made by each agency as to who that person was when in fact it does not appear that there was an identified lead professional/key worker. It also posed the question as to who Sam would have considered his Lead Professional/key worker to be. It is important to recognise that this person does not need to be from one particular agency or another.

*Sam is an anonymised name

8. Recommendations

8.1.1. Reference was made earlier to research and findings from SARs that enable a model of good practice to be constructed. In line with Making Safeguarding Personal, this can be considered in terms of practice with the individual, how practitioners worked together, how practitioners were supported by their employing organisations and the contribution that SABs can make to the development of effective multi-agency practice. This should be applied to the learning from this case.

8.1.2. This case demonstrates the importance of multi-disciplinary and multi-agency meetings, awareness and timely responses to people's needs, recognition of the impact of complex health conditions on mental heath and ability to respond to advice. As discussed with the panel it is not indicated that this is a case of deliberate self-neglect.

8.1.3. The following points are to be considered:

- Involvement of friends and family members in order to strengthen oversight and support
- To be mindful of why people might fail to engage since this may be the result of multi-factoral issues rather than an unwillingness to engage.
- To consider the identification of a key worker/ lead professional to whom the person can relate
- To work together rather than in silo ensuring that risks are managed, concerns are followed-up and oversight is robust
- To put the person at the centre and apply a strengths based approach to assessment of need in order to consider what matters to them and what community support is available to them.

8.1.4. Review of the reports and discussions resulted in the shared view that this case was not unique. Interlocking systemic factors are recognisable that could reappear in other cases.

8.1.5. The recommendations that follow are designed to strengthen how agencies work together in similar cases in the future.

8.1.6. Arising from the analysis undertaken within this review the following 4 recommendations are made:

1) Strengthening partnership approaches/ standard practice in the management of risk.

a) Development of a multi-agency safeguarding risk assessment/ management tool that professionals can use as a baseline to aid practice where risk is indicated.
b) Development of practice through professional and managerial supervision to prompt professional curiosity, to ask the right questions and to mitigate against "making assumptions".
c) Identification of a Lead professional to be standard in practice rather than an exception.

*Sam is an anonymised name

2) **Complex Risk Management-** Recommendation 1 articulates the importance of robust risk assessment / management, it is recognised that there are instances when risk becomes much higher and thus it is recommended that the draft Complex Multi-agency Risk Management protocol is reviewed against the findings of this review and that it:

- Takes into account service refusal, mental capacity/legal literacy, advocacy, escalation and involvement of family and friends.
- Considers the extent the systems and processes enable a person centred and strengths based approach.
- Facilitates inter-agency communication and collaboration coordinated by a lead agency and lead professional, so that all agencies involved possess the full rather than a partial picture.

3) **Social Prescribing-** It is acknowledged that work has commenced with Oldham's SAB and Healthwatch to gather "questionnaire" feedback to understand access issues and information provision for wheelchair users in Oldham wanting to connect with social groups and support services. The SAB is asked to consider:

- To what extent the systems and processes enable a person centred and strengths based approach?
- To what extent community assets and social prescribing would form part of a complex package of care.
- To what extent the Voluntary and Community Sector are engaged with the work of the SAB?

4) **Responsible Commissioner Accountabilities-** Lack of clarity was identified in terms of the role of the Responsible Commissioner (the CCG) and the oversight of the package of care which was delivered via an IB. It is acknowledged that the CCG and Council have now reviewed each IB. Additionally the PHB processes have now been significantly developed to strengthen oversight of risk. This is an ongoing process and the SAB is asked to:

- Seek assurance that the current processes would militate against the risk of a similar set of circumstances arising in the future.

8.1.7. Additional acknowledgements:

- It was identified within the review than an incident took place in 2017 involving double prescribing, namely that the GP and the pain clinic were both prescribing Fentanyl. This has been investigated appropriately via the NHS Serious Incident Framework and has not been considered within the scope of this review.

*Sam is an anonymised name

9. Addendum (July 2021)

The Review of Sam was initially considered by the Oldham Safeguarding Adult Board (OSAB) in June 2020 and concluded in February 2021. The methodology included a review of agency information, panels meetings and a structured multi-agency discussion. It was recognised that there were some limitations in terms of insight, as family and friends declined to contribute or participate in the process.

Following conclusion of the SAR, the coronial inquest was held, and witness testimony provided information contradictory to that known and accepted by agencies. Namely the information suggested that Sam's health and care needs may not have been as severe as previously thought.

OSAB convened a virtual discussion with panel members to consider the new information against the conclusions of the review. It was unanimously decided that the findings and conclusions of the review were based on all the information that agencies held and therefore the learning was still valid.

It was also agreed that the findings and recommendations of the review were particularly relevant to the emerging information as they would strengthen general oversight. The issue of strengthening professional curiosity, identifying a "Lead Professional" and having clarity on the Lead Commissioner accountabilities would have strengthened assessment and oversight. If these processes had been in place, it is likely that a more robust understanding and accurate assessment of need may have been facilitated.

In conclusion, the findings of the SAR are valid and accepted by OSAB, however a review of health and social care information will be undertaken in the context of the inquest witness statement. This will facilitate an understanding of additional learning in terms of how agencies could challenge themselves to consider if their accepted understanding of a person's situation is correct. The review will take information into consideration from all agencies who contributed to the SAR.

*Sam is an anonymised name