Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

Summary

Concerning the care of Andrea

Independent Reviewer

Pete Morgan BA, MA, MA & CQSW

1. Introduction

1.1 This Safeguarding Adult Review (SAR) was commissioned by Northamptonshire Safeguarding Adult Board (NSAB) in accordance with the NSAB Safeguarding Adult Review Protocol.

1.2 In accordance with the Care Act 2014, Safeguarding Adults Boards have a statutory responsibility for considering and commissioning Safeguarding Adult Reviews (SARs).

1.3 NSAB has taken the decision not to publish the full overview report due to the sensitive nature of Andrea's personal circumstance but wishing to ensure as much information as possible is shared, this summary is provided which included the full set of recommendations. The overview report will only be shared with the agencies directly involved with Andrea to support learning from her death.

1.4 The period of the Safeguarding Adults Review (SAR) was from the 1st January 2017 until the 12th December 2017.

2. Summary of Events

2.1 During 2017, concerns were expressed about Andrea by a range of agencies, including her GP and a specialist health service, as she was not taking her prescribed mediation, was not attending appointments and her physical and mental health appeared to be deteriorating. In addition, her estranged husband contacted services seeking support for her, but when contacted by services she always refused any offers of help.

2.2 Matters came to a head in mid-October 2017, when her GP raised a safeguarding concern on the grounds that she was self-neglecting. Attempts to contact Andrea by Adult Social Care Social Workers, the Police and the East Midlands Ambulance Service were unsuccessful as she refused to speak to them or answer her door when they called. Throughout this period, the presumption of capacity was applied to Andrea and therefore capacity was assumed under the Mental Capacity Act 2005 (MCA), and not formally assessed about whether she could make decisions regarding her physical and mental health needs.

2.3 On the 23rd November 2017, a meeting was held under the Inter-Agency Safeguarding Adults Procedures and it was agreed to assess Andrea under the Mental Health Act 1983 (MHA). In order to complete this assessment, a warrant was obtained under Section 135 (s135) of the Mental Health Act 1983 on the 24th November 2017.

2.4 The warrant was executed on the 5th December 2017 but no assessment of her mental health was completed as Andrea's physical health caused such concern that she was taken by ambulance and admitted to Northampton General Hospital, where she subsequently died on the 12th December 2017.

3. Independent Management Reviews

3.1 To support the findings of the review, Information Management Reviews (IMRs) were completed by the following agencies:

NHS Nene & Corby Clinical Commissioning Groups – GP Services;
Northampton General Hospital NHS Trust;

Northamptonshire County Council, Adult Social Care;
Northamptonshire County Council, Children First Northamptonshire (formally Children, Families and Education); and
Northamptonshire Healthcare Foundation Trust.

3.2 In addition, the following agencies were identified as having had less, but still important contact with the family, were requested to provide Statements of Information (SOI):

East Midlands Ambulance Service;
Northampton Partnership Homes; and
Northamptonshire Police.

4. Identified Themes and Recommendations

4.1 Mental Capacity Act 2005

Recommendation 1 - That partner agencies and the services they commission should assure the Board[1] that their policies and procedures have been reviewed and revised as appropriate to ensure that the Mental Capacity Act 2005 and its supporting Code of Practice are implemented properly, with particular regard to 'unwise decisions' and situations of self-neglect.

Recommendation 9 - That partner agencies should assure the Board that they and the services they commission are appropriately training staff to implement the Mental Capacity Act 2005 and it's supporting Code of Practice, particularly in cases of possible or actual self-neglect.

4.2 Self-Neglect

Recommendation 6 - That partner agencies should assure the Board that they are implementing and monitoring the use of the self-neglect guidance.

Recommendation 7 - That partner agencies should assure the Board that they are implementing and monitoring the appropriate use of the Adult Risk Management (ARM) guidance.

Recommendation 12 - That partner agencies should assure the Board that they are implementing appropriate and proportionate policies and procedures to ensure that cases of self-neglect are identified, triaged and safeguarding concerns raised.

[1] NSAB is also referred to as 'the Board' throughout the recommendations in the report.

Recommendation 13 - That the Board consider liaising with the Health and Wellbeing Board to establish a governance process to manage cases of self-neglect that fall outside Section 42 of the Care Act 2014.

4.3 Mental Health Act 1983

Recommendation 10 - That partner agencies assure the Board that they and the services they commission are advising service users and their families or significant others of their rights under the MHA 1983.

Recommendation 16 - That ASC, NHFT and the Police should assure the Board that they have reviewed and revised their joint procedures for applying for and executing s135 warrants and are monitoring their implementation.

Recommendation 17 - That partner agencies should assure the Board that they and the services they commission have reviewed and revised as appropriate the recording processes that apply to the obtaining and execution of s135 Warrants.

4.4 Safeguarding

Recommendation 3 - That partner agencies should assure both the Children Safeguarding Board and the Adult Safeguarding Board that they are implementing and monitoring their policies and procedures to identify and support Young Carers.

Recommendation 11 - That the Board liaise with the NSAB to jointly develop a process to ensure that partner agencies and the services they commission are appropriately cross-referring when a child is identified as being at possible risk of abuse or harm in a safeguarding adult case and vice versa.

Recommendation 14 - That the Board review and revise as appropriate the Inter-agency Procedures in place to receive, triage and respond to safeguarding concerns re adults and the recording systems to support them.

Recommendation 15 - That the Board liaise with the Northamptonshire Safeguarding Children Board to ensure that the above policies and procedures complement those for safeguarding concerns for children.

Recommendation 19 - That the Board review and revise as appropriate its current Inter-agency Procedures, which were due for review in April 2017, to ensure they are compliant with and implemented in accordance with the Care Act 2014, its supporting Statutory Guidance and Making Safeguarding Personal.

Recommendation 20 - That the Board review and revise as appropriate its monitoring processes of the implementation of its Inter-agency Safeguarding Procedures to ensure they are fit for purpose.

4.5 **Recording**

Recommendation 2 - That Children First Northamptonshire should assure the Board that they have reviewed and revised recording and assessment within its practice standards to ensure they are compliant with the latest requirements under current legal requirements.

Recommendation 18 - That the AMHP Service should assure NSAB that it has reviewed its recording procedures and practice re assessments under the MHA.

4.6 **Domestic Abuse**

Recommendation 4 - That partner agencies should assure the Board that monitoring and implementing information sharing protocols for domestic abuse is in place, particularly where the victim/survivor has additional care and support needs or there are children present.

4.7 **Non-engaging service users/patients**

Recommendation 5 - That partner agencies should assure the Board that they, and the services they commission, have monitored and revised as appropriate policies and procedures regarding DNAs to ensure they are proportionate and fit for purpose, particularly for those with a history of not engaging with services.

4.8 **Care Act 2014**

Recommendation 8 - That Adult Social Care should assure the Board that they are ensuring their service users, their families and partner agencies are provided with adequate information as to their rights to request assessments under the Care Act 2014.