Safeguarding Adults Review "Harry"
Overview Report March 2023

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1 Introduction

1.1 This Safeguarding Adults Review (SAR) concerns a man, Harry (a pseudonym), who died, in 2021, at the age of 34. Harry's cause of death is noted as being from Sepsis, Cellulitis and Liver Cirrhosis.

1.2 Throughout his life Harry had had several "working" mental health diagnosis. These had included Asperger's Syndrome, Dissocial Personality Disorder, Paranoid Schizophrenia and Polymorphic Psychotic Disorder with symptoms of Schizophrenia. At the time of his death, most of these diagnosis had been rescinded and it was believed that Harry had Dissocial Personality Disorder with narcissistic traits.

1.3 Harry was placed on the sex offenders register and allocated a probation officer in January 2016. This was following a conviction for sexual assault, which resulted him receiving a Suspended Sentence.

1.4 Between November 2020 and April 2021 Harry was on remand at HMP Doncaster for making threats to kill.

1.5 Many services could find Harry difficult to work with and support. Harry was often threatening and abusive to workers. He even threatened at least one workers family member. This led to him being suspended from services from Southwest Yorkshire Partnership Foundation Trust ("SWYPFT") in May 2020 for 12 months.

1.6 Harry would, at times, refuse to engage with assessments, or refuse the support offered. In 2018 Barnsley Metropolitan Borough Council ("BMBC") Adult Social Care ("ASC") conducted a Care Act assessment. This identified that Harry may benefit from some community support several times per week. This support would require a financial contribution from Harry, which he was unwilling to pay, Harry's stated preference was to be placed in 24-hour-care. This experience increased Harry's reluctance to engage with ASC assessments.

1.7 Post release from prison in April 2021 Harry did not receive any support from SWYPFT (SOUTHWEST YORKSHIRE PARTNERSHIP FOUNDATION TRUST) or BMBC ASC. Referrals were made to those services, but Harry was either triaged as being ineligible based on the information provided or would refuse to engage with assessments.

1.8 In his final days, Harry was arrested by South Yorkshire Police ("SYP") under suspicion for criminal damage and having threatened a 111-call handler. It was alleged that he has stated that he would *"rape women up and down the country starting with herself"*[1].

1.9 Harry's Solicitor raised concerns about Harry's mental health during interview with the Police. A Mental Health Act assessment led to him being detained under section 2 of the Mental Health Act. The assessment concluded that *"he lacked capacity"*[2] and

[1] Taken from the Individual Management Review for South West Yorkshire NHS Foundation Trust, dated 11 April 2022.
[2] As 1 above.

"also identified that there was self-neglect with threats of setting fire to property to get rid of 'snakes'"[3].

1.10 Harry spent 3 days on the mental health ward. On the third day Harry complained that he was short of breath and experiencing discomfort. A review by the duty doctor, resulted in a transfer to Huddersfield Royal Infirmary, where he was intubated and transferred to the Intensive Care Unit.

1.11 Harry's parents were informed of Harry's admission and advised that he would probably die. Harry's parents visited Harry at the hospital and remained with him until he died, the following day.

1.12 Harry could be abusive and threatening towards workers and even very resilient and experienced workers struggled to manage his behaviour. Some workers reported that use of strong boundaries and use of humour facilitated a working relationship.

1.13 At the time of Harry's death, he was receiving support from his GP, but was not under the care of mental health services or Adult Social Care. Harry and his family had a strong relationship with Harry's GP.

1.14 Harry had been suspended from Mental health services in May 2020, due to Harry's abuse of SWYPFT workers. Adult Social Care had made several attempts to complete assessments, Harry was reluctant to engage and was unwilling to accept the offers of support to meet his care and support needs proposed by Adult Social Care as this would require financial contributions from him.

1.15 Harry's support was primarily provided by his parents. However, this relationship had broken down in the last few months because of Harry's abusive behaviour and verbal and physical threats towards them.

1.16 Harry had the long-term support from a cleaner, who was one of his consistent relationships and was able to provide a valuable insight into his life.

2 Context of Safeguarding Adults Reviews

2.1 Section 44 of the Care Act states that a *"SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –*

a. *there is a reasonable cause for concern about how the SAB (Safeguarding Adults Board), members of it or other persons with relevant functions worked together to safeguard the adult"* and "*the adult has died,*
   and
b. *the SAB knows or suspects that the death resulted from the abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)."*

2.2 The SAR criteria were judged to be met because Harry died because of an infected wound. The cause of the wound and infection was unclear and was discussed during the review with differing information presented by different agencies. However, there

[3] As 1 above.

has been agreement that Harry was not in receipt of the support that he felt he required. Further, there was disagreement about his eligibility for services and support.

2.3 The purpose of this review is not to hold individual workers or agencies to account, but to highlight learning that needs to be adopted.

3 Terms of Reference and Methodology

3.1 The review focused on the period from the 1 June 2018 until Harry's death on the 21 September 2021. The review period was chosen to understand the impact that Barnsley Safeguarding Adult Board's Self-Neglect and Hoarding Policy and Procedures may have had on practice with Harry.

3.2 Compliance with agreed Self Neglect and Hoarding Policy including risk assessments

3.3 Examine the effectiveness of multi-agency information sharing and joint working

3.4 Did Harry have access to the services that he needed?

3.5 Evaluate if the learning from previous SARS/lessons learnt has been embedded in practice and how this has been evaluated

3.6 How effective was the supervision and support of people working with Harry, and mechanisms to escalate concerns?

3.7 Examine the impact of Covid-19 on the way that agencies engaged with Harry

3.8 Identify any good practice

3.9 Identify mechanisms, if needed, to embed learning from future SAR's and lessons learnt

Methodology

This is an initial methodology. Specific details may change as a result of findings and information gathered at prior stages.

	Process	Notes
1	Create Project Plan	Set Project Plan with dates and actions for the lessons learnt process
2	Engagement with Harry's family	We will write to Harry's family and ask if they will meet with the author so that we can learn more about: • Harry as a person • Harry's history, including his childhood and what affected him in life • Harry's needs • What Harry wanted? • Why Harry may have been abusive to workers? • Why Harry may have refused support?

	Process	Notes
		• The experience of the family in trying to help and support Harry? • The impact on the family or trying to support Harry? • The impact on the family of Harry's refusal to access services. • The impact on the family of Harry's needs not being met.
3	Individual Management Review ("IMR")	A questionnaire to gather important information will be drafted for all agencies that may be able to contribute to the learning event, as outlined in the "Required Contributions" section below. Questionnaires will be tailored to specific organisations where specific information and details may contribute to lessons being learnt.
4	Collate Information	Use the information collected to inform the exercises and discussions at the learning events.
5	Host a Practitioners' Learning Event (either remote via teams or face to face – depending on risks of Covid 19 and views of potential participants)	Host an event to learn about: • What policies, procedures and guidance were used? • The experiences of frontline workers visiting Harry or working with his family • Understand the challenges of meeting Harry's needs • Understand how our working met the principles of Making Safeguarding Personal • Understand the challenges in assessing and managing the risks of working with Harry, and that Harry faced. • Learn about when there was successful joint working between agencies • Learn about how agencies could have worked more successfully together • Learn about the support available to workers when working with Harry • How can we support other workers to learn from the experience?
6	Host a Managers' Learning Event (either remote via teams or face to face – depending on risks of Covid 19 and views of potential participants)	Host an event to learn about: • The support that was provided to workers when working with Harry • How were lessons from previous SARs (Safeguarding Adults Reviews) embedded into the practice of their teams? • How issues were escalated within organisations when workers were working with Harry • Were there any barriers that affected any collaborative working • What can be done to address any barriers in collaborative working

	Process	Notes
		• What can we do to support learning from these events?
7	Draft Report	Version 1 - 13/7/2022 Version 2 - 4/8/2022 Version 3 - 9/8/2022 Version 4 - 8/9/2022 Version 5 - 28/9/2022 Version 6 - 28/10/2022 Version 7 - 17/01/2023 Version 8 – 16/03/2023
8	Report approval	Date

4 The views of Harry's Family

4.1 Harry came to live with his parents when he was 20 months old, with a plan to legally adopt him, this was completed at the age of 5. Harry's parents described this as a very difficult time and couldn't understand why it had taken so long.

4.2 Harry's parents had very little information about Harry's birth mother. They believe that she lived in Ireland before moving to Barnsley. Harry's birth mother had eight children; it is believed Harry was not the only child removed from her care. Harry had been taken into care due to concerns that Harry was not being well cared for. Alcohol may have been an issue, but the author has been unable to confirm this with colleagues in adoption.

4.3 As a young boy, Harry was described as having an "angelic face." He was well spoken and polite, although he may have started speaking a little later than some people. Harry's parents said that Harry had an excellent brain and memory but could be *"emotionless."* As an adult, he was sometimes terrified of being killed and would sometimes talk about someone putting snakes in the ceiling of his home.

4.4 There were some challenges with his behaviour from a young age. Harry's parents mentioned an incident when he hurt his sister shortly before her first communion. They also mentioned that Harry struggled at school and was excluded from several schools, including primary schools. Harry's parents recalled that they received no support during this period and had to home-school Harry, as it was not possible to identify a school to accept him. Harry's parents said that they didn't have any contact with Childrens' Social Care after Harry's adoption was completed. Harry's dad could specifically recall being told, by one of the teachers at the point of one of the exclusions to find Harry a *"rough school.*

4.5 Harry's parents felt that Harry eventually found some structure at Cruckton Hall Boarding School in Shrewsbury and benefitted from a supportive Headmaster. Harry obtained some GCSE's while at the school.

4.6 Harry was assessed under the Mental Health Act, aged 15 or 16, because of him starting a fire at his school.

4.7 On leaving school Harry attended Shrewsbury College. The lack of structure caused him difficulties and he left without completing the course.

4.8 Harry's parents also said that they thought that he might have found it difficult being on public transport, this may have negatively impacted on his attendance at college.

4.9 When Harry left Shrewsbury College, he returned to Barnsley to live with his parents and attended Barnsley College. At the age of 18, Harry had a traffic accident on his scooter that required multiple surgeries on his leg. As a result, he had a limb shortness in one leg and walked with a limp for the rest of his life.

4.10 Harry spent 10 weeks in hospital and was transferred to a rehabilitation placement in the community but was asked to leave for being "disruptive".

4.11 Harry then moved to a mental health residential complex in Hull where he lived in his own bungalow. The author does not know whether this was organised by Harry's parents or other services as this fall outside the main period of the review. Harry's parents told us that Harry discharged himself from this placement as he wasn't allowed to lock the door of his bungalow.

4.12 Harry attempted to live in several bungalows in Hull. At least one of these were organised by Harry himself; however, his parents would often be required to arrange new properties when his tenancies broke down.

4.13 Many of the tenancies failed as they were physically unsuitable for his needs as a wheelchair user and the property sustained damage due to its use. At least one tenancy broke down when there were incidents between Harry and a neighbour. Harry said that he felt threatened by his neighbour.

4.14 Harry's parents suggested that Harry was vulnerable to financial abuse by "friends." They reported that people were sleeping in his second bedroom and Harry's father recalled an incident when he dropped Harry at a community centre and giving him £20 for food. Harry was surround by 6 people who wanted some of the money.

4.15 Harry's parents were concerned that his mental health was declining and following the breakdown of several tenancies Harry moved back to Barnsley.

4.16 Harry's parents tried to offer support to Harry whilst he was living in Barnsley. They were his primary carers. Harry's father supported him to manage his money and arrange for help from a cleaning service. However, Harry's behaviour towards his parents was sometimes threatening and aggressive. There were several occasions where Harry's father had to call the Police because of Harry's behaviour towards them.

4.17 Harry's parents felt that Harry required 24 hour per day care to be adequately supported. They were concerned about the risks that Harry posed to himself, and potentially other people. They were also concerned that Harry didn't have the mental capacity to make decisions about his care. On the 9 August 2018, Harry's parents attended a multi-disciplinary team meeting; during this meeting Harry's parents expressed their view that Harry needed 24-hour care. Harry appeared to agree with this. From the notes there appeared to be a general agreement between the MDT

(Multi-disciplinary teams) that 24-hour care might be required; however, other less restrictive options need to be explored and exhausted first. Harry's parents said that they could recall that the *"financial cost"* would prevent 24-hour care being an option for Harry.

4.18 Harry's parents continued to try to support Harry. Unfortunately, Harry's parents reached a point where they were unable to support Harry anymore because of his threatening behaviour. However, even after they made that decision Harry would still turn up at the home or call them at very late times at night/early hours of the morning.

4.19 In August 2021 Harry's parents were contacted by one of their neighbours while Harry's parents where on holiday. The neighbour was concerned about Harry. At the time, Harry was sat outside his parent's house. The neighbour said that Harry was *"yellow in his face and appeared quite poorly."* Harry's parents said that Harry was calling him frequently at this time, and they were also concerned that he was not washing his clothes.

4.20 In September 2021 Harry's parents received a call from Huddersfield Royal Infirmary to say that Harry was unconscious in intensive care and was likely to die. They went to the hospital and spent Harry's final hours with him.

5 Summary of what we found

5.1 Harry and his parents were unsupported for much of his childhood. This was despite being adopted and having been excluded from multiple schools. This meant that there could be no transition planning and support for Harry at the early stages of adulthood and becoming independent.

5.2 Several of Harry's tenancies failed or he was evicted due to his behaviour. Harry's family struggled to support him and latterly his father was scared for his physical wellbeing around Harry.

5.3 In isolation Harry's parents worked hard to try to secure Harry an education. This meant that he spent much of his childhood in boarding school. Would this have been different had Harry been offered more support as a child or a young person? Could this have also helped Harry to develop better independent living skills, and a motivation to use these, if this support had been available to himself and his family?

5.4 Collaborative working across several agencies and skillsets are a necessity when working with people that self-neglect. No single agency or worker can entirely meet someone's needs and support them to achieve their goals.

5.5 This is particularly important when there are risks of working with someone, whether these be risks to workers, the individual themselves or anyone else. Each agency and worker need to have a good understanding of the risks and the agreed plans to manage these. This includes setting and keeping strong boundaries with people who might test them. Strong multi-agency working support this. It also supporting individual workers to building strong relationships with people, which is an important element of supporting people who are at risk of self-neglect.

5.6 Whilst there is some evidence of joint working with Harry, this does not appear to be part of a coordinated plan. It also meant that there were assumptions about knowledge of Harry and his history across all agencies. Understanding someone's

history is important to ensure that someone is appropriately supported and the challenges that might arise when trying to engage with them safely.

5.7 What else can we do to ensure that we use the mechanisms and tools for multi-agency work across Barnsley?

5.8 In doing this would we relieve some of the pressure placed on individual agencies and workers that might lead to people being suspended from services, or having those services withdrawn?

5.9 This should include a review of the support that can be offered to the person and family members to raise their concerns, ask questions, and understand their rights. Advocacy can be a key partner in this.

5.10 Advocacy can also support people to understand their options and make choices. During interviews and workshops several people raised that Harry would not think about his future and would only consider his immediate desires.

5.11 It was clear through the review that the withdrawal of mental health services from Harry was not a decision that was taken lightly and there were concerns about the wellbeing of workers within the Early Intervention Team (EIT). However, it meant that there was support that was not offered to Harry at that time, and increased pressure on other agencies and people who were unable to withdraw their support from Harry.

5.12 When agencies are considering whether all actions have been taken to try to manage an individual's behaviour, prior to and individual being suspended from services, or them being withdrawn, they should consider whether all avenues for multi-agency work had been explored.

5.13 It is unlikely that agency is the only agency that will be struggling with the same individual, and their behaviour. Between BSAB's Self-Neglect & Hoarding Procedures, MAP and High Intensity User Group ("HIUG"), there were several options where the challenges in working with Harry could have been considered at a multi-agency level.

6 Analysis and Learning

6.1 <u>Understanding Harry and his changing diagnosis</u>

6.1.1 *"Early experience, trauma, loss and relationship all figured strongly in the service users' stories, and in the narratives of practitioners as they recounted how they had constructed bespoke interventions that responded to and took account of each person's personal life experience, networks, relationships and motivations."*[4]

6.1.2 Understanding someone, and their history, is critically important. However, there were considerable challenges in getting to know Harry. Harry would sometimes say things to shock people, or to present an image that he wanted to portray. Harry was known to talk openly and publicise on social media about his offending history. He told clinicians at Barnsley Hospital NHS Foundation Trust ("BHNFT") that he was dependent on alcohol (there is no evidence of this and everyone that knew Harry said

[4] Page 3 SCIE: *"Self-neglect policy and practice: building an evidence base for adult social care",* report 69, Braye et al.

that this was not the case). Harry told some workers that an injury to his leg, which may have been the source of the sepsis that led to his death, was a stab wound sustained in prison. However, information provided by HMP Doncaster, about Harry's time in prison in 2020/2021, states that there were no recorded incidents where Harry may have been stabbed. The information provided states that Harry had an abscess that burst while he was in Doncaster Hospital receiving treatment for the cellulitis to his legs at the end of March 2021. Harry did not return to prison after this stay in hospital and returned to his home on the 1 April 2021.

6.1.3 There was also evidence from Harry's time at HMP Doncaster in 2020 and 2021 that Harry would complain of symptoms linked to a decline in his mental health. However, when he was assessed in prison, they did not identify any mental health concerns

6.1.4 During the managers' workshop there was discussion that no one really knew what Harry's aspirations were. People that knew Harry identified that he knew what he wanted in the short term, but not what his long-term goals might have been, other than being in 24-hour care. The EIT discussed that they tried to do this work with Harry, but it did not lead to them understanding Harry's aspirations further.

6.1.5 Harry's parents reflected that Harry had a *"live for now attitude"* and he did not think about the future or the past and could be impossible to reason with.

6.1.6 Harry talked about his desire to be *"looked after,* and his parents advocated that he needed this support

6.1.7 Harry may have benefited from the appointment of an advocate, particularly, where there might be a history of someone being unhappy with the outcome of previous assessments, and several incomplete assessments. To support the advocate to work with Harry, they would have required access to the risks and risk management plans. I have commented about these below. The Care Act sets out statutory criteria where a referral must be made to an advocate to support someone through assessments, care planning and safeguarding enquiries[5].

6.1.8 Harry also had several diagnoses through his life. During the review there was discussion that Harry's diagnosis was a *"working diagnosis."* A clinician within SWYPFT explained a *"working diagnosis"* as:

"*The current diagnosis, the one, according to the treating clinician, is the most likely among the variety of other diagnoses at the moment and this could be concluded after further observations.*

It is important to note that the working diagnosis may change if there is more information available later.

In simple terms, it serves as a basis for which the clinician chooses his or her initial treatment approach. It is not a final diagnosis but seems to make more sense at the time of assessment and is a useful part of the initial case formulation. …., typically, clinicians will consider more than one diagnostic hypothesis or possibility as an explanation of the patient's symptoms and will refine this list as further information is obtained in the diagnostic process. Therefore, there is a degree of uncertainty associated with a working diagnosis."

[5] Sections 67 and 68 of the Care Act 2014 - https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

6.1.9 Not all agencies knew about Harry's background. During the workshop conducted for managers a question was asked whether Harry may have had Foetal Alcohol Syndrome (FASD). To the knowledge of the author, Harry was not assessed for this syndrome. If assessed and diagnosed, would this have supported an alternative approach to Harry and his family?

6.1.10 Many agencies did not know the history of Harry's school exclusions, or the childhood assessments. It was highlighted during discussions that this is information was not always recorded and/or accessible to all relevant workers/teams Again, such information could impact an assessment and possible conclusion.

6.1.11 It should also be noted that there is an impact from changing assessments and diagnosis, not just on the adult themselves and the treatment that they receive, but also on the family and friends that might be providing them with support. This emphasises the importance of ensuring that the needs of carers are understood. They must also be reviewed when there are changes to the adult's diagnosis and treatment.

6.1.12 The support provided by family carers may change, or need to change, with the diagnosis and treatment. Many carers will need support to be able to do this and may even find themselves under added pressure. Particularly, if there is a withdrawal of any treatment or services because of the changes in diagnosis. This is reflected upon further in paragraph 6.2 below.

6.2 Assessments

6.2.1 There were several incomplete assessments. Harry would often decline or withdraw from the assessment. Evidence exists to show that Harry could be abusive to workers during assessments, including threats to worker's families.

6.2.2 There is some evidence that workers relied on their managers to make decisions about Harry's eligibility for support. This may have damaged the confidence and trust that Harry had in some worker's assessments.

6.2.3 The delays in assessment decisions may have added to Harry's frustrations. People that knew Harry reflected that if he wanted something, he wanted at that moment in time and he struggled to "wait."

6.2.4 Harry was assessed as being eligible for Adult Social Care support, for a support worker to support him to access the community. However, he was unable or unwilling to meet his financial contributions. In such situations, where the risks are considered significant enough, BMBC ASC have the power to decide to provide the services, without the customer contributions. There is no evidence to show this was considered to meet Harry's needs and does not appear to have been known by workers.

6.2.5 Even if workers were aware that BMBC had discretion to provide the services without contribution there was not recognition amongst all agencies that Harry was at risk of self-neglect. Particularly, as Harry would sometimes refuse to engage with assessments. We have considered self-neglect in more detail in paragraphs 6.3 below.

6.2.6 The incomplete assessments present missed opportunities to recognise Harry's self-neglect. Although, it should also be noted that someone's refusal to engage with an

assessment is an indicator of self-neglect in itself. This does not appear to have been considered.

6.2.7 Harry appears to have been unsatisfied with the outcome of his assessments, yet Harry was not offered advocacy support through those assessments or to challenge the outcome of them.

6.2.8 There is no record of Harry's parents being offered a carer's assessment, despite their strong role in supporting Harry and their stated difficulties in this role.

6.2.9 It is well known about the impact that being a family-carer can have on people, and their relationships. A recently published thematic review from Manchester Safeguarding Adults Board[6] from January 2022 discusses the challenges and pressures that family-carers face. These are not just limited to concerns about the wellbeing of their loved one, but also fears about whether they may be held responsible for the risks taken by their loved ones and the challenges of caring for someone who is viewed to have *"mental capacity"* to make decisions that place themselves at risk.

6.2.10 Harry's mother reflected that this was something that she was worried about. She recalled on at least one occasion saying, *"don't blame us when he murders someone."*

6.2.11 The Manchester review echoed the challenge made by Harry's mum, recommending:

a. There is a need for family carers to be supported to understand that there is a limit to their responsibilities.

b. They still need support, even if the person being cared for refuses it, as they are left holding that relationship and worrying about their family member (often in isolation).

c. There were recommendations for the need for counselling, peer support and advocacy because of this.

d. These services may need to be provided confidentially from their family member that they care for as this might be a barrier to them being open and discussing their challenges and concerns.

6.2.12 The challenges of working with Harry and his multiple health diagnosis may have impacted on practitioners' ability to consider physical health issues. It has been highlighted in the review that sepsis can cause delirium. Sepsis related delirium may have been the cause of Harry's apparent mental ill health after his arrest in September 2021.

6.2.13 SWYPFT have conducted a service level review following Harry's death. The review did not identify that sepsis was missed. The review found that Harry would not consent to physical examination, which made it difficult for staff to identify Harry's physical health problems. It also identified that the response from staff was good when Harry's physical health deteriorated quickly. The review did identify potential

[6] https://www.manchestersafeguardingpartnership.co.uk/wp-content/uploads/2016/08/2022-01-20-MSP-Carers-Thematic-Learning-Review-Executive-Summary.pdf

learning with regards to the monitoring of service users' physical health. This has been incorporated into SWYPFT's physical health strategy and the development of physical health training with oversight from the Trust's Medical Director.

6.3 Self-Neglect

6.3.1 Paragraph 4.1 of the BSAB's Self-Neglect and Hoarding Policy defines self-neglect as *"the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and wellbeing of those who self-neglect and perhaps to their community."*[7]

6.3.2 It is important to consider this definition as questions were raised, and discussions had, about when Harry started to self-neglect. Feedback from practitioners was that Harry appeared to be managing his own needs and he appeared to have capacity to make decisions around them.

6.3.3 During the review there was discussion about whether Harry ever met his own needs. Harry had consistent support from Domestic Goddess service and his parents. It was only in the last few months where Harry's parents felt that they could not keep supporting Harry, because of Harry trying to harm his father.

6.3.4 Harry spent much of his childhood in boarding schools. As a young adult he spent a lot of time in hospitals and placements where he would have been "looked after" and his needs met. There is evidence that he wanted 24-hour care, and there was at least one meeting in August 2018 where this was discussed. There was also evidence of Harry stating his desire for this in an assessment in 2019. Harry's parents were concerned what would happen to Harry without this and were strong advocates for supported accommodation.

6.3.5 It would have been difficult for services to be aware of any signs of self-neglect after May 2020, as the EIT services were suspended. Any impact on this suspension of services might not have been immediately apparent. As Harry was arrested a few months later and held in Doncaster prison, this would have added further delay in identifying the impact.

6.3.6 Harry's cleaning service raised that they noticed a decline in Harry's mental health after this time, following the withdrawal of his medication. However, this change would not have been noticed by any workers within the EIT as Harry was suspended from the service at the time. Harry being suspended from SWYPFT services is documented in more detail around paragraph 6.5.

6.3.7 Harry's health may have declined significantly when he was released from prison in April 2021. Visitors to Harry's home would not have seen typical evidence of self-neglect due to the support from the Domestic Goddess Service. Indeed, the GP noted on one visit to Harry that she had concerns about his mental health, but he did not appear unkempt. However, concerns were raised by both the Probation Service and Berneslai Homes about the state of the property. The Probation Service Individual Management Review states that the probation worker highlighted Harry's open wounds and poor hygiene in August 2021 when making a referral to BMBC ASC.

[7] https://www.barnsley.gov.uk/media/15373/self-neglect-and-hoarding-policy-approved-bsab-may-2020.pdf

6.3.8 Harry's parents were unable to cope with Harry's behaviour. Harry was calling them several times a day. Sometimes late in the evening and early in the morning. Harry's parents felt that they had to contact the Police about this and some of Harry's behaviour when he was with his parents.

6.3.9 Through July and August 2021 Harry's GP was concerned about Harry's mental health and tried to make referrals to SWYPFT and BMBC ASC. From reading the referral, the Single Point of Access ("SPA") at SWYPFT did not consider that Harry had an identifiable mental health need or had he consented to the referral.

6.3.10 Assessments by BMBC ASC were not completed because of Harry's abusive behaviour towards workers. During this period concerns there were also issues raised by workers from Berneslai Homes about the state of the property and Harry's living conditions.

6.3.11 These were clear signs of self-neglect that appear to have been missed. These included:

a. Harry's refusal to pay a contribution towards community support, meaning that he did not receive those services
b. Harry's behaviour towards services and workers
c. Harry declining assessments
d. Harry's history of conflict with neighbours
e. Records about take away food packaging and *"50 - 100 empty coca cola cans"*
f. Reliance on takeaways
g. Concerns raised by housing workers about the state of the property.

6.3.12 A list of possible indictors of self-neglect is provided in BSAB's Self-Neglect & Hoarding Policy[8]. These include:

a. Neglecting Household maintenance, and therefore creating hazards within and surrounding the property
b. Portraying eccentric behaviour/lifestyles
c. Poor diet and nutrition. For example, eating foods that will increase the risks to their health (e.g., diabetes)
d. Refusing to allow access to health and/or social care professionals in relation to personal hygiene and care
e. Repeated episodes of anti-social behaviour
f. Being unwilling to attend external appointments with professionals in social care, health, or other organisations
g. Total lack of personal hygiene resulting in poor healing/sores

6.3.13 In writing this, the reviewer is mindful that with the benefit of hindsight and the sharing of information that has taken place for this review the warning signs appear clear. However, this may not have been the case for individual workers working with Harry on a day-to-day basis.

6.3.14 Depending on their role, many workers may only observe one or two of these factors. There is a question about the threshold that workers apply before they start to actively pursue methods of structured collaborative working, and the threshold for joint

[8] Paragraph 4.2 https://www.barnsley.gov.uk/media/15373/self-neglect-and-hoarding-policy-approved-bsab-may-2020.pdf

working that is applied by other agencies when another agency with concerns is trying to refer to them.

6.3.15 The Self-Neglect and Hoarding Policy provides tools for both, but it requires workers to be aware of it and to feel confident in using it.

6.3.16 It also requires professional curiosity, the lack of which is a frequently occurring issue in safeguarding adult reviews where people are at risk of self-neglect.

6.3.17 Professional challenge and escalation become important where an agency do not feel a response by an agency is sufficient. *"If an agency has concerns that a safeguarding matter is not being handled adequately or that repeated referrals is not triggering a meaningful safeguarding response, it is good practice to escalate this. There can at times be differing professional or agency opinions on the level of risk to an individual. An escalation process allows professionals and agencies to challenge the safeguarding team/system if a decision of no further action is considered inappropriate by the referring agency"*[9].

6.3.18 Where the Self-Neglect & Hoarding Policy is not applicable, there is the opportunity for joint working through the Multi-Agency Partnership Group ("MAP"). Most workers at the practitioner workshop were not aware of these tools, panels, and guidance.

6.3.19 The author notes that BMBC ASC can provide social care services without financial contribution from the adult, if this leaves unmet needs and/or risks. This is at the discretion of managers who do not appear to have been asked to consider this option for Harry.

6.3.20 As a final point, Harry's capacity to make decisions about his care is discussed in paragraph 6.6, but even if Harry had this capacity, it is not a deciding factor in whether or not someone is self-neglecting and multi-agency work to manage the risk around this are required. A recent safeguarding adult review[10] highlights this common misunderstanding. At section 3.2 in the report is states that a *"person is not vulnerable or self-neglecting if they have mental capacity.' This is simply wrong. Under the Care Act 2014, you do not need to lack mental capacity to be vulnerable or self-neglecting. Even if someone appears to be making free choices that lead to self-neglect, it is still self-neglect and action is still required under the English Acts".*[11]

6.4 Multi-Agency Working

6.4.1 "Given the complex and diverse nature of self-neglect and hoarding, responses by a range of organisations are likely to be more effective than single agency responses."[12]

6.4.2 The challenges of uncoordinated multi-agency response have been described in a recent thematic review of self-neglect cases in Manchester. *"The apparent lack of a coordinated safeguarding response to all three individuals hindered the fullest multi-*

[9] Paragraph 3.27 https://nationalnetwork.org.uk/2021/2021%2009%2006%20Self%20Neglect%20Thematic%20review%20FINAL.pdf
[10] SK SAR 2022, Merton Safeguarding Adults Board
[11] Page 8 https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf
[12] https://www.barnsley.gov.uk/media/15373/self-neglect-and-hoarding-policy-approved-bsab-may-2020.pdf

agency consideration: information sharing; safeguarding actions and risk management. Information sharing in particular was hampered………If an agency has concerns that a safeguarding matter is not being handled adequately or that repeated referrals is not triggering a meaningful safeguarding response, it is good practice to escalate this……The danger of an absent or superficial safeguarding response is that professionals become unclear who is leading the safeguarding process; where roles and responsibilities lie and the adult at risk is not afforded the protection they require or should be able to expect under the adult safeguarding system……a high number of professionals or agencies being involved does not equate to a lowered risk or a positive safeguarding system. In fact, too many professionals can lead to confusion as to who is leading the safeguarding response and can at times cause the vulnerable adult to disengage or decline……. a refusal to engage was seen in simplified terms and a reason to withdraw rather than be a risk factor in itself."[13]

6.4.3 There were several agencies involved in supporting or monitoring Harry, and there was engagement between individual workers around risks. However, there was not a joint strategic approach to work with Harry, meet his needs or to support him to consider his future.

6.4.4 Some workers had better relationships with Harry than others or were at least able to better manage some of his behaviours. Harry's GP appears to have had a positive relationship and was committed to try to continue to support Harry. Coordinated responses are often able to harness these relationships, whilst also offering support to those workers and planning for continuity if workers change. The importance of harnessing positive relationships has previously been highlighted in another safeguarding adult's review in Barnsley for Valerie and Ian[14].

6.4.5 The absence of strategic working prevented a shared understanding of the risks that Harry was exposed to, or that Harry may present to others. A robust multi-agency risk assessment would have captured the knowledge, skills, and expertise to inform a consistent and person-centred response. It is not possible for single agency or worker to have a complete understanding of all the signs of risk or harm. When there is an understanding of possible risks it is important that there is a joint plan to manage those risks, which is reviewed. This was not put in place for Harry.

6.4.6 Agencies involved with Harry were aware of the risks, however this was often limited to single agency's which negatively impacted on the effectiveness of the responses provided to the risks.

6.4.7 There is evidence that Harry may have played off agencies against each other. There was at least one occasion when Harry contacted the EIT to complain that he did not have any food at home. An offer was made that they would arrange for some shopping to be delivered so Harry could prepare his own meals; however, Harry was unhappy with this. It was noted that Harry refused this offer and said he could already get another agency to do this for him.

6.4.8 Throughout the review it has been clear how important it was to have clear and established boundaries when working with Harry. This was something discussed by every agency. A joint plan would mean that all the agencies would be working to shared boundaries. They would also have a shared understanding of the role of each

[13] Paras 3.25 to 3.32 of Manchester Safeguarding Adults Board Thematic Review of Self-Neglect from 2021 - https://nationalnetwork.org.uk/2021/2021%2009%2006%20Self%20Neglect%20Thematic%20review%20FINAL.pdf

[14] https://www.barnsley.gov.uk/media/18116/sar-valerie-and-ian-march-2021.pdf

organisation, involved in Harry's life. This reduces the risk of inconsistent boundaries and organisations being successfully played off against each other.

6.4.9 Where these issues cannot be resolved, Acceptable Behavioural Contracts can be used, which may lead to the Police using Community Protection warnings and notices to take enforcement action if someone's behaviour does not change.

6.4.10 In discussions with the High Intensity User Group Coordinator for Yorkshire Ambulance Service it was clear how important clear boundaries are when working with intense users of a service. Further, many workers find it difficult to give witness statements or make formal complaints against people that use their services.

6.4.11 There was discussion during the workshops that whilst Harry's behaviour towards workers was discussed by some agencies, and was considered a risk, no formal complaints and statements were made to SYP. This meant that SYP were not able to consider whether Harry's behaviour amounted to a crime and could not take appropriate enforcement action against him.

6.4.12 Workers working with Harry, and experiencing abuse, may have excused his behaviour towards them and not wanted formal action to be taken through compassion. However, the lack of collaborative action around Harry's behaviours and no formal enforcement action being taken might be a missed opportunities to try to manage and change some of Harry's behaviours.

6.4.13 There are procedures and mechanisms in place across Barnsley to support good joint working. These include:

a. The Risk Assessment and Management tools within the Self-Neglect & Hoarding Policy were not used. It was not recognised that Harry was at risk from self-neglect.

b. The Multi Agency Panel (MAP) – add link or appendix documents.

c. The High-Intensity User Group. The nature, and sometimes the volume, of Harry's interactions could have made this an appropriate environment for agencies to come together to agree boundaries and working processes to try to manage Harry's behaviour. Any agency could have brought Harry's threatening and abusive behaviour to that group, particularly during periods where there was a high volume of calls.

6.4.14 It is discussed below, in *Withdrawal of Service in paragraph 6.5*, that the absence of strategic multi-agency working might have increased the pressure individual workers felt and been a barrier to each agency supporting each other to cope with some of the aspects of Harry's abusive behaviour.

6.4.15 There is some evidence of some good individual joint working. This was predominantly about the sharing of risks when working with Harry.

6.4.16 There is also some evidence of joint visits by workers when Harry's GP visited Harry with a Probation Officer.

6.4.17 There were also times when the Police visited Harry just before, or with, the Ambulance service.

6.4.18 However, not every agency had information about the risks of working with Harry shared with them. There was at least one incident when a worker from South Yorkshire Fire and Rescue visited Harry, but had no information shared with them about risks. During the visit, the worker became concerned about Harry's behaviour towards them. It was only their skills at managing the risk on that day to de-escalate and an exit rout that prevented them harmed. Understandably, the worker was frustrated and aggrieved when they found about Harry's previous offending behaviour had not been shared with their service. This would have changed their risk assessment and how their visit was conducted.

6.4.19 Amongst the services that were aware of the risks of working with Harry at that time, and knew Harry well, there was an assumption that all agencies were aware of Harry's history and the risks. Good multi-agency working would have avoided such assumptions.

6.5 Withdrawal of Services

6.5.1 It should be noted that SWYPFT made three decisions in May 2020 that led to Harry being suspended from SWYPFT services for 12 months.

6.5.2 The first was that Harry's diagnosis of Polymorphic Psychotic Disorder with symptoms of Schizophrenia was rescinded.

6.5.3 This then led to the second decision which was that *"the long-acting injectable neuroleptic medication"* Harry was prescribed being withdrawn, as it had been prescribed for the rescinded condition. Further, as there were concerns about the impact of this medication on Harry's weight and physical health, it was not justifiable to prescribe Harry this medication and expose him to the potential complications associated with this without the relevant diagnosis.

6.5.4 The third decision was that Harry was to be excluded from community based offered by SWYPFT for 12 months. This was a result of his abusive behaviour to SWYPFT workers some of his behaviours making it difficult to provide services to other people (particularly ringing the phone lines on some days to block other people from being able to call in). If required, Harry was still to be able to access Mental Health Services from the Mental Health Liaison Team ("MHLT"), which is provided by SWYPFT and based at Barnsley Hospital, or through his GP.

6.5.5 SWYPFT were clear that the decision to withdraw services and his medication were not linked. Further, the withdrawal of services from Harry was considered a last resort. It was not a decision that was taken lightly and was taken by the Directors within the organisation.

6.5.6 It was explained that in the lead up to the decision being made Harry had received several warnings that it would happen if he continued to behave in the way that he was.

6.5.7 The organisation's exclusion policy was shared with Harry, and he was asked if he understood that this would happen. He confirmed that he did. Whilst Harry was excluded from those services, he was still able to access mental health support in a crisis by attending A&E.

6.5.8 It was also discussed that it was believed that Harry had some understanding of the impact of his behaviours. The manager of the EIT explained how Harry would ring up

to apologise at times when he knew that he had upset someone. However, they believed he would only show this contrition if he wanted something back in return.

6.5.9 Although the MHLT was to remain open to Harry during the period of suspension an episode was identified of Harry being admitted to BHNFT and a review being requested from the MHLT, but the MHLT did not conduct this review.

6.5.10 On the 23 August 2020 Harry was admitted to hospital feeling unwell and with a pain in his buttock. On the 28 August, a phone call was made by ward staff caring for Harry to the MHLT as Harry has commented about suicide on that morning. BHNFT staff documented that the MHLT knew Harry and would not review Harry's needs unless it was an assessment triggered by Harry being detained under s.5(2) of the Mental Health Act, this was because Harry had previously been aggressive with them.

6.5.11 SWYFPT have considered this interaction during the review. SWYFPT have stated that *"there could have been a misinterpretation in communication between the teams and due to there being no significant change in his mental health presentation, a mental health act assessment was not required and MHLT did not conduct an assessment." The position of SWYPFT differs from the records held within BHNFT*

6.5.12 There was also an impact of suspending Harry from the service on other services and workers. Harry's GP expressed their concerns about the additional pressures experienced because of this decision. They described that Harry's behaviour or needs had not changed and felt isolated in managing his needs.

6.5.13 Harry's Domestic Goddess service also expressed concerns that Harry's mental health appeared to decline sharply after the withdrawal of medication. They reported that they did not know how to address this or obtain support.

6.5.14 Harry's parents reported being under additional pressures at this time.

6.5.15 SWYPFT have reflected that a lesson could be learnt from withdrawing medication and services from Harry at the same time meant that there was no monitoring of the impact of withdrawing those services from Harry. This is particularly important given feedback that Harry's mental health might have declined following the withdrawal of medication.

6.5.16 It was discussed that services should not be suspended or withdrawn until there has been monitoring of the impact of withdrawing medication.

6.5.17 The reviewer questions, if there had been more strategic joint working between agencies, could Harry's behaviours have been better managed across all agencies and the skills or different agencies utilised more effectively? Would this have alleviated some of the pressures on SWYPFT workers or even helped to reduce the abusive behaviours? Possible missed opportunities and unused powers have been discussed in paragraph 6.4 above.

6.6 <u>Mental Capacity</u>

6.6.1 Mental Capacity is a frequently occurring issue when people are at risk of self-neglecting. *"Where decisional capacity is not accompanied by executive capacity, and thus overall capacity for autonomous action is impaired, 'best interests'*

intervention by professionals to safeguard wellbeing may be legitimate. Yet executive capacity does not routinely figure in capacity assessments, and there is a risk that its absence may not be recognised. There is concern too that capacity assessments may overlook the function-specific nature of capacity, with the result that apparent capacity to make simple decisions is assumed in relation to more complex ones."[15]

6.6.2 *"The autonomy of an adult with capacity is likely to be respected, and efforts directed to building and maintaining supportive relationships through which services can in time be negotiated. Capacity assessments, however, may not take full account of the complex nature of capacity; the distinction in the literature between decisional and executive capacity is not found in practice, and its importance for determining responses to self-neglect may need to be considered further."*[16]

6.6.3 Harry's parents had strong feelings about Harry's mental capacity, and what this meant for his life. Harry's mum said, *"whenever it was quoted, I would want to scream."* It was her *"most hated word with so many meanings."* It would either be an excuse to discharge Harry from a service, or a reason to make him do something that he did not want to do. From her perspective mental capacity was at the centre of everything, but never anything positive for Harry.

6.6.4 From the workshops, there was a belief that Harry had mental capacity to make decisions about his care. It was felt that Harry understood what his needs were and was able to make decisions around this.

6.6.5 The reviewer questions whether Harry had the ability to *"weigh up"* information to make a decision, or whether his personality disorder compelled him to *"live for now"* and not consider his future. This was also in the context of feedback from workers and managers that they could not support Harry to consider his future and aspirations.

6.6.6 When Harry's capacity was discussed within the practitioner workshop, it was discussed that when Harry was given several options in a decision, he would also pick the option that was the most damaging to himself.

6.6.7 The *"the concept of 'executive capacity' is relevant where the individual has addictive or compulsive behaviours……..It is accepted that for busy frontline professionals mental capacity assessments for more complex cases can be challenging…….some professionals may be more confident in assessing mental capacity and some appear to lack the professional curiosity in this regard……Professionals may be more confident applying a yes/no approach to mental capacity assessments but are less equipped to deal with more complex assessments or a fluctuating picture…..A person who may understand the need to act cannot be assumed to have the ability to act to reduce risk. Functional specific capacity assessment may mask a lack of capacity to sequence decisions in the way necessary to minimise risk………to undertake these more nuanced assessments of mental capacity takes time, skills, and expertise that not all professionals have acquired."*[17]

6.6.8 When working with people making unwise decisions that might place their health and life at risk, we need to consider their mental capacity to make decisions. This should

[15] SCIE Report 46 *"Self-neglect and adult safeguarding; finds from research",* Braye et al, September 2011.

[16] SCIE Report 46 *"Self-neglect and adult safeguarding; finds from research",* Braye et al, September 2011.

[17] Paras 3.18 to 3.22 of Manchester Safeguarding Adults Board Thematic Review of Self-Neglect from 2021 - https://nationalnetwork.org.uk/2021/2021%2009%2006%20Self%20Neglect%20Thematic%20review%20FINAL.pdf

also include considering their ability to act upon that decision and whether they have the motivation to do this.

6.6.9 Mental Capacity is broader than a person's ability to converse about a decision and understand information needed in making it. They must also be able to balance up that information to make an informed choice and be able to act upon that choice. These elements should be considered, assessed, and documented when conducting mental capacity assessments.

6.6.10 Paragraphs 4.36 to 4.39 of the draft Mental Capacity Act Amendments[18] details the need to consider the difference between people seemingly able to understand, retain and communicate their decisions versus their ability to actively use that information in making their decision. Whilst the examples used are in the context of eating disorders and brain injury, the draft guidance talks about peoples' *"compulsion…. being too strong to ignore,"* and people who might *"make impulsive decisions regardless of information they have been given or their understanding of it, which may indicate that they are not able to use of weigh the information."* The sections go on to say a *"person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information."*

6.6.11 During the review there were comments about Harry's fears about snakes in the ceiling of his home. Harry also made allegations about assaults on over 20 occasions to the police, between July 2018 and September 2021. Harry also reported that snakes lived in his ceilings. and told people that he feared his neighbours and contacted the police to report times where he thought people had assaulted him, or he was scared, on over 20 occasions between July 2018 and September 2021.

6.6.12 Harry's parents reported that they felt that Harry's fear and anxieties could control his behaviour and some of his decisions Harry's dad talked about a time when Harry had just had surgery on his mouth and was due to stay in hospital overnight but became scared and discharged himself.

6.6.13 This raises the question about whether Harry's fears and anxieties from would control some of his decisions and could have meant that his capacity was fluctuating.

6.6.14 Agencies need to ensure that information about people's mental and executive capacity are well documented. This is particularly the case when working with people at risk of self-neglect. Balancing people's rights of autonomy and self-determination with agencies' duties of care and desire to protect people's dignity is incredibly challenging where people refuse support. Doing this often requires workers to take time, using skill and determination to complete the assessments. Workers also need to know where they can get advice and support and need to request specialist advice.

6.6.15 Managerial support for these cases is essential to enable workers to develop strategies to work with someone who's behaviour challenges them, or they find objectionable.

6.6.16 Wren Aves recently published as a paper called *"if you are not a patient they like, then you have capacity"*.[19] This was a piece of service user led research. Many of the

[18]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080137/draft-mental-capacity-act-code-of-practice.pdf
[19] https://www.psychiatryisdrivingmemad.co.uk/post/if-you-are-not-a-patient-they-like-then-you-have-capacity

respondents have been diagnosed with personality disorders. It has been noted in discussions and commentary that there is no peer reviewed research into this topic at this time.[20]

6.6.17 This paper highlights the experience of service users where they feel that the belief of professionals that they have *"mental capacity"* at that moment in time is used as an excuse to not offer support to them. The title of the paper came from a comment of one of the respondents. Another respondent articulated as a belief from professionals that they were *"bad not mad."*

6.6.18 The paper discusses how the presumption of capacity in Mental Capacity Act[21] can be used as an excuse not to assess an individual's capacity. Even where there is evidence that they are making unwise decisions that might place their life at risk.

6.6.19 The author has not seen evidence of this being the case when reviewing the work done with Harry. However, we should all be mindful about how a worker's human reaction could potentially influence their decision making when they are intimated or scared of someone that they are working with. This is something that agencies must balance their responsibilities with supporting and protecting their workers with their duty of care to the individual.

6.6.20 It is important to be mindful that the views of some service users who participated in the survey were that they were at their most vulnerable times and felt that they were not in control of their behaviours but were considered to have mental capacity, as they appeared articulate or may have had capacity in the past. This even included people in crisis being told that they had *"mental capacity to community suicide"* and so support would not be offered.

6.6.21 The respondents to the survey talk about the distress this causes, but also how it destroys trust in the services that are supposed to help them.

6.6.22 As a final point about mental capacity, during the review a question was raised about whether or not a personality disorder would meet the criteria of "*an impairment of, or a disturbance in the functioning of, the mind or brain*[22]*"* Under the Mental Capacity Act. The reviewer believes that it would. In an article published by BJ Psych Bulletin in 2017 Arye et al[23] discuss that Borderline Personality Disorder is a mental disorder, and a condition that the Mental Capacity Act applies to. Further, consideration of mental capacity is frequently missed for people with Borderline Personality Disorder, and that Borderline Personality Disorder can have an impact on how people are able to use and weigh the necessary information when making decisions.

6.7 Support for parents of children that have gone through adoption

6.7.1 Harry's parents experienced significant challenges in caring for Harry throughout his life and there was an absence of support, despite Harry's exclusions from school. Further, there is no evidence that Harry received any support to transition into adult services.

[20] https://www.mentalcapacitylawandpolicy.org.uk/posts/
[21] https://www.legislation.gov.uk/ukpga/2005/9/section/1
[22] Section 2(1) of the Mental Capacity Act 2005.
[23] https://www.edgetraining.org.uk/post/mental-capacity-and-borderline-personality-disorder

6.7.2 Harry's parents stated that they were "left to get on with it."

6.7.3 It is not possible to know whether support for Harry's parents and inventions when Harry was a child would have led to a different outcome. However, the fact that no support was offered is a significant missed opportunity.

6.7.4 As part of the review, we have considered whether there would be offers to families in a similar situation now. In the 30 years since Harry was adopted, there have been improvements in the provision of support for adoptive parents and foster carers. These have included the right for an assessment for adoption of support services, support can be offered at the discretion of local authorities, support for the adopted child with education and access to therapeutic support through the adoption support fund.

6.7.5 BMBC's Children's Social Care ("CSC") provided feedback that schools would now be in a better position to identify when a child or family might need support, and expulsions from school would be likely to trigger a referral to BMBC CSC for triage/assessment of need. Without this referral BMBC CSC would be unlikely to know that a child or family might be in need.

6.7.6 Steps have been taken to improve transition planning for people in Barnsley with the creation of the Directions Panel to support the transition of those people that might be most at risk and may slip through the next between services.

6.7.7 Can we be assured that the current measures and arrangements that we have in place around children being excluded from school, missing education or who have been adopted would mean that a child being excluded from school would be referred to appropriate services for support?

6.8 Support for Workers

6.8.1 Not all interactions with Harry were challenging. Some workers and managers reflected that he could show an insight for the impact that his behaviour had on people. However, Harry's aggressive and abusive raised by several agencies and was the primary reason Harry was suspended from receiving services from SWYPFT.

6.8.2 Workers found it difficult to manage Harry's behaviour, and it had a significant impact on many of them due to

a. physical threats by Harry.
b. verbal abuse by Harry
c. Threats to members of workers families.
d. Worker's struggles to maintain strong boundaries

6.8.3 There was also an impact on workers in more than one agency that might not have worked directly with Harry but may have answered the phone to him or spoken to him on reception.

6.8.4 During the workshops, there was feedback that the withdrawal of mental health services from Harry was seen by workers at SWYPFT as being a supportive act and protecting their wellbeing and drawing a clear boundary with a service user that their behaviour was unacceptable.

6.8.5 During the workshops, the importance of workers being supported to conduct effective assessments was identified. In particular:

a. Workers being able to *"wear different hats"* if they are conducting assessments under different pieces of legislation.
b. Workers feeling confident to make their own judgements when completing assessments, and not deferring difficult decisions to their managers. There was some concern that this can damage confidence in the assessment process and cause delays.
c. Workers creating clear and effective documentation, including discussions in supervision, and conducting agreed actions.

6.8.6 Many workers required support from their managers and teams. There were references in notes that cases were discussed, or were to be discussed, in supervisions. However, there would not be records of what was then discussed and what actions might have been agreed. This is an important step.

6.8.7 Good documentation provides an opportunity for reflection and learning. Importantly, it allows for continuity and consistency of service. If actions are agreed, it is important to understand whether they have been acted upon. This is particularly important when working with someone like Harry who might challenge boundaries and decisions, or present high risks.

6.9 Escalation Guidance

6.9.1 *A frequently occurring issue in safeguarding adult reviews is a lack of professional challenge when an agency disagrees with the actions of another. Information disclosed as part of this review highlighted disagreements about roles and responsibilities for his care when organisation's withdrew access to the EIT service in SWYPFT. This was particularly around withdrawal and eligibility for a service.*

6.9.2 BSAB has agreed escalation guidance to support professional challenge, and this is monitored by both BSAB and BSCP since the review commenced. This would have been a recommendation if this had not been completed.

7 Recommendations

7.1 Recommendations when someone might be suspended from a service

7.1.1 The author recommends that agencies should not make a final decision to suspend someone from their services, or withdraw services, prior to a multi-agency meeting where they openly discuss their challenges and concerns, with all agencies working with the person at that time and that may offer support.

7.1.2 Any multi-agency meeting where suspension or withdrawal of services are discussed should include a risk assessment for the safety of workers from all agencies, and a risk assessment of the impact that suspending or withdrawing the relevant service may have on the service user and any third parties. Any risk assessment should be accompanied by an appropriate risk management plan and capacity assessment(s), if appropriate.

7.1.3 BSAB and its partner agencies should work together to create a protocol and guidance around supporting people whose behaviour challenges and may threaten workers. This should include guidance on the withdrawal or suspension of services.

This guidance should include procedures for multi-agency strategic discussions prior to the suspension of an individual from a service to safeguard the adult.

7.1.4 Minimising withdrawal of services should always be the goal, effective sharing of all organisation's skills, knowledge, working collaboratively may decrease the need to withdraw services. This may include the use of statutory and enforcement powers by relevant organisations, such as Community Protection Orders by the Police.

7.1.5 The guidance should reference the use of other multi-agency panels and processes such as the HIUG and the Multi-Agency Partnership group ("MAP"), and how referrals can be made.

7.1.6 Maintaining consistent boundaries across all agencies is important when working with someone who's behaviour can challenge or be abusive. All multi-agency risk assessments and risk management plans should consider the boundaries required by all agencies and what steps need to be taken to maintain these boundaries.

7.1.7 Clear communication between organisations involved with the support of an adult, subject to suspension, must be recorded to ensure that the adult is able to access services and support they are eligible for. Disagreements about support options must be escalated up to senior managers.

7.1.8 The Learning and Development subgroup should identify training to support workers and volunteers to respond effectively to adult's displaying challenging and threatening behaviours.

7.1.9 All internal policies should reference any guidance produced by BSAB, if not directly adopted.

7.2 Recommendations around Managing Abusive and Threatening Behaviours

7.2.1 BSAB should seek reassurance from all agencies that they have policies and protocols in place that discuss supporting workers with abusive and threatening interactions.

7.2.2 BSAB should seek reassurance that workers are supported to respond to adults who are challenging, including use of supervision, internal escalation, and involvement of South Yorkshire Police.

7.2.3 The procedures should also offer guidance on when and how an agency will get advice from the Police, or other relevant agency, about when potential crimes maybe committed, or enforcement action should be taken as a result of the individual's behaviour.

7.3 Develop closer joint working and sharing of information between SWYPFT SPA and Adult Social Care front door service[24].

7.3.1 Closer ties, sharing of information and working practices should be forged between BMBC ASC's front door service and SWPFT SPA. This should include sharing information on referrals submitted/received between the two services or to one or both services from external organisations.

[24] The Front Door Service acts as a single point of access for people into BMBC's Adult Social Care service.

7.3.2 Clarity about eligibility should be agreed to avoid disagreements that are likely to result in adults not receiving any support or services. Sharing information and risks assessments will support effective assessments of need.

7.3.3 This should include agreements about what information will be shared with referrals and by whom.

7.4 Recommendations around Foetal Alcohol Syndrome Disorder ("FASD")

7.4.1 The author would recommend that BSAB and Barnsley Safeguarding Childrens Partnership seek reassurance that services in health and social care, for both children and adults, are able to recognise the signs of FASD and access possible diagnosis and support for people and families that might be affected by FASD.

7.4.2 The author would also recommend that assurance is also support that Adoption services are able to recognise the risk factors for FASD and are able to provide support to the adoptive and birth parents around this.

7.5 Recommendations around Mental and Executive Capacity

7.5.1 BSAB should seek reassurance from agencies that their workers conducting capacity assessments have had training around executive capacity. Review of these assessments should be included in supervision and be supported by appropriate escalation if decisions are "unsound" and leave the adult at risk of harm.

7.5.2 Reassurance should also be sought from all partner agencies that the documentation used by agencies support workers to consider an individual's executive capacity and motivation to act upon the decisions that they may have mental capacity to make.

7.5.3 Documentation, policies, and procedures used by partner agencies should be clear that, even if someone does have mental and executive capacity to make a decision and act upon it, where the risks are high enough and the person may suffer harm there should be consideration of whether other legal avenues should be explored, such as inherent jurisdiction.

7.5.4 BSAB should seek reassurance that self-neglect policies and procedures used by agencies support workers to be professionally curious when adults are in receipt of care from relatives or friends. Guidance must consider the needs of those people providing care, and the impact on the individual if they were to be unable to continue to do that.

7.6 Recommendations around Self-Neglect

7.6.1 BASB should seek assurance from partner agencies that their workers recognise that an individual's mental capacity is not the single determining factor about whether someone is at risk of self-neglect.

7.6.2 BSAB currently offers bite-sized workshops on Self-Neglect & Hoarding. Self-Neglect & Hoarding also frequently arise in Safeguarding Adult Review workshops. The signs, and challenges to recognising and acting on these signs, are discussed during these workshops. Agencies should ensure that appropriate workers attend such workshops.

7.6.3 BMBC ASC should ensure that all workers are aware that if an adult is refusing to pay for their own support, when they have already been assessed as being required to contribute, and they have unmet needs as a result, this should be escalated to the worker's manager to consider providing the support without financial contribution from the adult.

7.6.4 BSAB's Pathways & Partnerships subgroup ("P&P") should consider the recommendation from the Managers' Workshop to review the Self-Neglect & Hoarding Policy to separate "hoarding" into a separate policy. When reviewing the policy, P&P must also consider whether additional guidance around hidden self-neglect is required.

7.6.5 P&P must consider what can be done to increase workers knowledge of the purpose of the Self-Neglect & Hoarding policy and procedures, and the use of the MAP where the threshold for s.42 of the Care Act might not be met but without partnership working the situation will only decline.

7.7 Recommendations for Carers

7.7.1 BSAB partner agencies to conduct an audit of cases where there were family, or other unpaid, carers to understand the risks of carers not being offered a carers assessment.

7.7.2 The author recommends that BSAB seek assurance from partner agencies that there is a mechanism for worker to record that carers assessments have been offered, and where they have been refused by the carers.

7.7.3 It should be noted that just because an assessment is refused in one instance, it would be refused again at a later time. Particularly if there were any changes in the adult's diagnosis or care needs. BSAB should seek reassurance from agencies that the guidance, training, and support provided to workers reflects this.

7.8 Ensure that people who have a right to advocacy are supported to access the service.

7.8.1 Sections 67 and 68 of the Care Act 2014[25] establishes a right to advocacy for people who may meet the relevant criteria within those sections, namely that the person may have *"substantial difficulty"* in engaging with the enquiry and there is no one *"independent"* to support them to do this. This is a right of the person and is not dependent on a view of other workers that the person would benefit.

7.8.2 The author recommends BSAB request BMBC Adult Social Care undertake an audit of closed cases to identify whether there were people that may have met the eligibility criteria for statutory advocacy under the Care Act.

7.8.3 The author recommends that BSAB approach the locally commissioned advocacy service to deliver training around advocacy eligible and the work of advocates.

7.9 Recommendation for Barnsley Safeguarding Children's Partnership to seek assurance

[25] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

7.9.1 Harry was excluded from several schools as a child; however, his parents have stated that they were offered no support during his period. The behaviour leading to exclusions were likely signs that support was required for Harry and his parents.

7.9.2 The author notes that these experiences would have been over 20 years ago and has been informed that practice has changed significantly. The author understands that it would now be expected that a child being excluded from school would be referred to Childrens Social Care for support. The author recommends that Barnsley Safeguarding Children's Partner seek assurance from their partner agencies that such concerns would be raised, and support would now be offered to the child and their families.

7.10 Recommendation for shared learning

7.10.1 Learning from these safeguarding adults review should be shared with the Preparing for Adulthood Service and adoption services working within Barnsley and regionally.

8 References

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