SAR Mike
Improvement briefing

Supporting people experiencing the physical and cognitive impairment impacts of alcoholism, and their families.

What have we learnt about ordinary work across partners in Bedford and Central Bedfordshire and the implications for creating more conducive practice conditions for personalised, timely and effective support?

Commissioning SAB: Central Bedfordshire

Independent reviewer: Dr Sheila Fish

12 March 2025

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1 A legacy for Mike

1.1 REMEMBERING MIKE

1.1.1 Mike was a much-loved older brother, uncle and for many years life-partner of Susan. He was born and raised in Gateshead and moved south for work and to start over.

1.1.2 He was a bar manager and worked all his life in hospitality, pubs and clubs. He was a qualified chef and was known for 'turning around' pubs. He enjoyed fishing, had great wit and could tell a good story.

1.2 SYSTEM LEARNING

1.2.1 Mike struggled with alcoholism throughout his adult life, managing times of abstinence from alcohol and times when he was drinking again. This impacted his health. He suffered a seizure during detox, which left him with a visual impairment, and reduced mobility. He was seen by Gastroenterology specialists, for decompensated alcohol-related liver cirrhosis. It impacted and interrelated with his mental health; he had a mental health inpatient admission due to psychosis, and experienced anxiety and low moods. He appears to have been diagnosed with Korsakoff syndrome – alcohol related cognitive impairment. It impacted on his loved ones and his relationships. He became an abusive partner, and his life-partner of 15 years who had cared for him for five years since his seizure was forced to leave for her own safety, meaning he was very much alone bar the distance friendship of his nephew.

1.2.2 In 2021 there were 9,626 alcohol-specific deaths across the UK. Alcoholic liver disease was the most common cause of death in all nations (accounting for 78% of alcohol-specific deaths in the UK), followed by mental and behavioural disorders due to use of alcohol (12%).

1.2.3 Statistically, central Bedfordshire has some of the lowest rates of alcohol-related harm in the country.[1] This must not detract from the level of tragedy and harm caused to those affected, both the person and those close to them.

1.2.4 This review aims to derive systems learning from the experiences of Mike and his loved ones. The goal is to illuminate key areas where improvements are needed in order to make it easier for practitioners, clinicians and managers to provide the quality of care and support they strive to provide.

1.2.5 Central Bedfordshire and Bedford Borough Safeguarding Adults Board and partner agencies are then responsible for supporting and holding partners to account for the actions they take in response to the learning, and reporting this in the WSAB annual report.

1.2.6 As the independent reviewer, I hope this provides some assurance to Mike's ex-partner and others who cared about him.

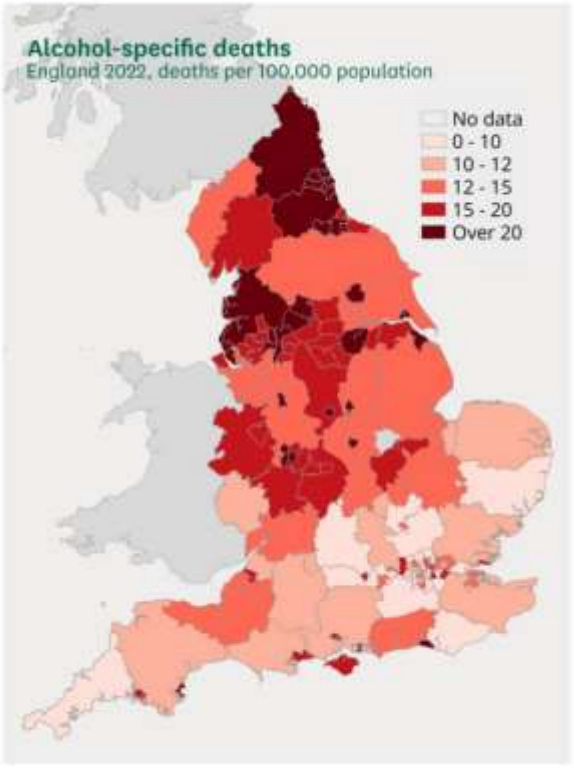
[1] **CBP-7626.pdf (parliament.uk)**

Alcohol-specific deaths
per 100,000

10 HIGHEST RATES	
South Tyneside	28.3
Derby	27.2
Middlesbrough	26.3
Leicester	24.9
Blackpool	24.0
Bury	23.9
Rochdale	23.7
Sandwell	23.7
Stoke-on-Trent	23.7
Darlington	23.7

10 LOWEST RATES	
Bromley	6.3
West Berkshire	6.9
Wokingham	7.6
Thurrock	7.6
Central Bedfordshire	7.8
Kingston upon Thames	7.8
Greenwich	7.8
Camden	8.1
Richmond upon Thames	8.2
Southwark	8.2

Source: PHE Local Alcohol Profiles

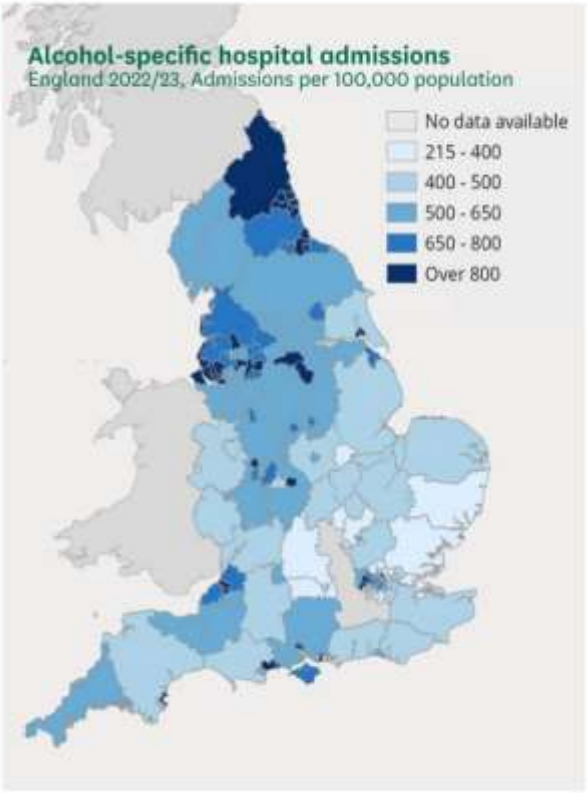


Hospital admissions
per 100,000

10 HIGHEST RATES	
Southampton	1,981
South Tyneside	1,260
Blackpool	1,219
North Tyneside	1,208
Hartlepool	1,183
Newcastle upon Tyne	1,152
Salford	1,128
Bristol	1,111
Gateshead	1,105
Sunderland	1,082

10 LOWEST RATES	
Rutland	220
Wokingham	280
Redbridge	306
Essex	315
Sutton	320
Enfield	323
Thurrock	358
West Berkshire	360
Central Bedfordshire	363
Barnet	365

Source: PHE Local Alcohol Profiles



2 Introduction

2.1 DECISION TO UNDERTAKE A SAR

2.1.1 A SAR referral was received on 26 May 2021 from Central Bedfordshire Council, Safeguarding Adults Team and this was discussed during the SAR Subgroup meetings on 27 July 2020 and a decision was made to conduct a SAR.

2.1.2 Mike was a 52-year-old with care and support needs. He was known to mental health and adult social services. He had a personal budget and employed a personal assistant to help him with tasks of daily living. On 20 April 2021 the alarm was raised with Mike's nephew by Mike's ex-partner, due to incoherent emails including the word help. His nephew contacted his personal assistant who had had no contact with him for two weeks. On getting to his home, she could hear Mike but was not able to understand him, he did not answer the door and through the letter box she saw bottles of vodka on the table.

2.1.3 This raised serious concerns about his health and wellbeing. There was contact with the allocated social worker, police and mental health services. But it took Mike's nephew to drive over 250 miles to discover his uncle in a state of collapse in his bathroom, his home covered in human waste, and nobody having seen in his home possibly since December 2019. Mike was taken to hospital where he received treatment and sadly died on 24 April 2021 of multiple organ failure.

2.2 LEGAL MANDATE

2.2.1 Central Bedfordshire Safeguarding Adults Board determined that Mike's case met the criteria for a mandatory Safeguarding Adult Review in terms of section 44 of the Care Act.

2.2.2 The SAR Subgroup determined that Mike was an adult at risk (as described by The Care Act 2014) and that condition 1a, 2a and b of Section 44 of the Care Act (2014) have been met.

Section 44 of The Care Act 2014 requires Safeguarding Adults Boards to undertake a Safeguarding Adult Review as follows[2]:

(1) "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 reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

[2] **http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted**

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other 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).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases."

2.3 A SYSTEMS BASED METHODOLOGY

2.3.1 Across multiple sectors, the evidence base suggests that a systems based approach provides the most useful learning from practice, to drive improvements. This is reflected in the new Patient Safety Incident Response Framework (PSIRF) in the NHS.[3] It is also reflected in the work led by the reviewer for this SAR, Dr Sheila Fish, over nearly two decades at the Social Care Institute for Excellence (SCIE) to support multi-agency safeguarding reviews in both child and adult safeguarding.[4]

2.3.2 A systems-based approach assumes that multi-agency working takes place in a complex, adaptive system. In such complexity, reviews of practice provide an invaluable opportunity to better understand ordinary practice in contemporary contexts. By this means, a systems approach uses a single case to give a 'window on the system'[5] revealing how social and organisational factors, and complex systems dynamics influence what practitioners and clinicians do in direct work with citizens.

2.3.3 This approach uses the specifics of what happened and why in the index case under review, to explore what is typical and usual. It moves from the 'case findings' of what went well and where engagement and outcomes were not optimum in terms of appropriateness, timeliness or quality, to draw out wider, generalizable learning about strengths and vulnerabilities in single and multi-partners social and organisational set-

[3] See: **NHS England » Patient Safety Incident Response Framework**
[4] See: **SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews | The Learning Exchange (iriss.org.uk)**
SCIE SAR Quality Markers March 2022 (lbbd.gov.uk)
[5] Vincent, Charles ref

ups and ways of working. This wider learning can be distinguished with the terminology of 'systems findings' that identify what is enabling good practice and what is getting in the way and making it harder to achieve.

2.3.4 Using this methodology involves:

- Meaningful engagement with family members or equivalent
- Enabling collaboration with practitioners and managers involved at the time (Case group)
- Close working with strategic leads of involved agencies and services (Review team)

2.3.5 A concise, practical focus on learning relevant to improvement activity across partners and SAB assurance work

2.4 SYSTEMS ORIENTED RESEARCH QUESTIONS

2.4.1 As described in the opening section, Mike appears to have struggled his adult life with alcoholism. It negatively affected his health, his cognition, his mental health and his relationships.

2.4.2 He is one of a small number of people who die of alcohol-related deaths in Central Bedfordshire each year.

2.4.3 This SAR has the potential to open a 'window' on to this area of health and care service provision and identify gaps and weaknesses in set-ups, arrangements and working practices.

2.4.4 At the point of commissioning therefore, the following systems focused lines of enquiry were set for exploration through SAR XXX:

What can we learn from Mike's case about:

- **What barriers and supports are there for professionals in Central Bedfordshire in meeting the needs of working age adults with complex risks and needs resulting from alcohol dependency?**

2.4.5 The sort of terrain that the review expected to be able to explore through Mike's experiences included:

- What housing and care services are in place when family carers can no longer cope?
- How well can the system understand the role of Personal Assistants paid for with Direct Payments?
- How well is the risk of domestic abuse of those family carers understood in the context of the cohort of adults whose care and support needs arise from being dependent drinkers?
- What would a preventative system look like for Central Bedfordshire, taking account of the Borough's demographics and geography?
- How well equipped are professionals to deal with articulate adults who are adept at minimising their very considerable needs in order to avoid visits and interventions that are the current offer of help?

- How does the voice of a person who is a dependent drinker get heard, and what is it that professionals are hearing?
- What information and support would better equip professionals anticipate the risks of someone doing an unsupported detox, either accidental or intentional>
- What systems and support would best enable practitioners to work with the issue of mental capacity in the context of vulnerable, dependent drinkers? This includes working with the cognitive and social consequences of Wernicke-Korsakoff' Syndrome.
- What systems and support could respond to the psychological impact on professionals of working with an adult with Wernicke-Korsakoff' Syndrome?

2.5 METHODS, TIMELINES AND PARTICIPANTS

USING THE LEARNING TOGETHER SYSTEMS MODEL (FISH 2010)

2.5.1 This SAR has used the process and methods of the Learning Together model (Fish et al. 2010)[6] The development of Learning Together pioneered the use of a systems-based approach to reviewing multi-agency safeguarding practice. It is the most tried and tested approach to-date.

2.5.2 Practically, this meant that background reading of case related documentation was conducted, allowing the timeline to be divided into Key Practice Episodes, and an early analysis of practice to be progressed. Early analysis is supported with a table layout, distinguishing evaluation of practice minimizing hindsight bias, from questions raised about the context, influencing contributory factors and how ordinary and usual responses seen in the case are more generally.

2.5.3 A multi-agency workshop aimed to involve key practitioners and clinicians involved in the various KPEs and enable an appreciation of the 'view in the tunnel'[7] rationale and intended goals of professional decision making and activity, and a grasp of the pressures and dilemmas faced on the ground. The workshop was structured around the KPE analysis, allowing for those directly involved to check, challenge and amplify the detail.

2.5.4 From this evidence basis, draft systems findings were then drawn out and prioritized, discussed with the senior leads in the Review Team as well as in a regroup meeting with operational staff and managers.

REVIEW TEAM AND CASE GROUP

2.5.5 The organisations to be involved included:

- Central Bedfordshire Council Adults Services
- BLMK (Bedfordshire, Luton & Milton Keynes Health and Care Partnership)
- Bedfordshire Police
- Personal Assistant

[6] **Heading 1 (19 pt Arial no bold) (iriss.org.uk)**

[7] Dekker, S (DATE) Fieldguide to accident investigation.

- East London Foundation Trust, CMHS, P2R, Community Nursing
- East of England Ambulance Service
- GP – Ivel Medical Practice
- POhWER
- Fire and Rescue
- Grand Union Housing

2.5.6 The tables below detail the roles/agencies that were represented in both the strategic leadership group and the group bringing together those who had had an operational role in Mike's case.

Practitioner event		
Those who had had a direct role: • Manager of Chase House (respite home?) • Team manager for North Locality ASC team • Support worker, Grand Union Housing	Those with no involvement at the time: • ASC Quality improvements • BBC Care Standards Team • Ambulance • ICB SAR Panel member • Domestic abuse advisor at Grand Union Housing • Ops manager North Older Adults team	Absent: • Respite? • ASC Review officer • GP before Mike's move () • Mental Health Consultant Psychiatrist • Hospital Liver consultant • Ophthalmologist • Allocated Social Worker • Police who responded at time of crisis • Ambulance who responded at time of crisis
Interviewed but not in attendance at workshop		
• Personal Assistant (interview) • CMHT who responded at time of crisis (interview) • New GP (interview; practice now closed)		

INVOLVEMENT OF MIKE'S FAMILY

2.5.7 The Board and reviewers are extremely grateful for the contributions by Mike's nephew and his ex-partner to this review.

2.5.8 The initial reviewer and Board manager met with Mike's nephew – who has sadly himself since died.

2.5.9 Mike's ex-partner wrote a detailed five-page letter of feedback on the handling of Mike's case from May 2020 to his death.

2.5.10 This input has been invaluable to allow the review to understand the full realities of this case.

2.6 METHODOLOGICAL COMMENT AND LIMITATIONS

2.6.1 Fran Pearson, the original lead reviewer, suddenly, unexpectedly and tragically died in the course of this SAR. I, Dr Sheila Fish, a good friend and colleague of Fran's, was asked to pick up the SAR and build on the work Fran had conducted, in order to conclude the SAR, as Fran would have wished.

2.6.2 I have made use of all the notes made by Fran and Business Manager Barbara Grell, and the data from involved agencies that has already been gathered. My analysis builds on Fran's, but I take full responsibility for the final output.

2.6.3 I noted that there were key gaps in terms of people who had had a direct role in the case, at the practitioner event – as noted in the table above. This means the SAR has been able to get much less of a rich picture of ordinary practice and the systemic influences than is ideal.

TIMELINES, TIMESPAN & CAPACITY

2.6.4 Table 1 below captures the original process and delivery dates of the SAR process.

September 2022 First panel to confirm TOR and a template for agencies - Thursday 15th PM Preparation of materials plus panel and doing my notes afterwards – 1 day Site visit 15th – 30th To see Mike's home and meeting with PA, relevant other local community members – 0.5 day Meeting no 1 with relative - 0.5 day ***2 days September***
October Review of submitted material with panel and planning practitioner event, including reading and summarising ahead of panel; and follow on with materials for panel - 1 day 1:1s with relevant professionals who may have useful detail needed ahead of practitioner event - 1 day ***2 days October***

November

Practitioner event including preparation early Nov 1 - day

Writing draft 1 for rest of Nov - 1 day

2 days November

December

Panel no 3 to review draft early Dec - 0.5 day

Further work on report – 1 day

Meeting no 2 with relative – is this sooner than you usually do it though? 0.5 day

2 days December

January 2023

Final panel – 0.5 day

Case Review Group for QA? – 0.5 day

Final amends – 0.5 day

1.5 days January

Later in 2023

SAB - 0.5 day

Unforeseen - 1 day

Total 11 days

Discussions and planning for how best to complete the SAR following Fran's death were first started in September 2023, agreed in November 2023 with files shared in January 2024 with a view to completing latest by the end of the year.

2.7 OUTLINE OF THE REPORT

2.7.1 The rest of the report is divided into two different sections. Firstly, a brief overview is presented of Mike's care journey, in the context of his wider history.

2.7.2 Secondly, we present the wider learning we have drawn out from Mike's case. These are issues that need to be tackled in order that people who find themselves in circumstances similar to Mike's, might receive a better response. They are illustrated with detail of Mike's experiences and further evidenced with wider intelligence.

3 Oveview of Mike's care journey

3.1 MIKE'S LONGER HISTORY

3.1.1 **2005** Mike appears to have had a long battle with alcoholism. His nephew referred to him moving south from the Northeast for a fresh start. Susan and Mike met in a bar when he was working as a manager in Waterloo. That must have been approximately 2005 – 15 years before the start of our timeline.

3.1.2 We know nothing of the intervening 10 years.

3.1.3 **In July 2016**, he attended the Pathway to Recovery Hub (P2R) in Bedford, to refer himself for treatment. P2R is the Drug and Alcohol Treatment Service for Bedford Borough and Central Bedfordshire residents aged 18+. Engagement with Mike at P2R included keeping a drink diary and relapse prevention work. This gave P2R the view that Mike appeared to have brief periods of abstinence but more regularly was drinking ten units per day.

3.1.4 P2R record that it was shortly after this that Mike when on holiday where he appeared to have a seizure that left him with blurred vision and some mobility issues. ASC records state that he stopped drinking alcohol and suffered a seizure. This caused brain damage with visual impairment and reduced mobility. His partner has described that he also suffered from anxiety and low mood and described himself as having a formal diagnosis of Alzheimer's, as well as liver failure. [The agency returns gave no detail about formal diagnoses.]

3.1.5 Following the seizure, Mike became completely reliant on Susan for everything. She worked full-time in London, working from home three days a week. They had no family support.

3.1.6 -**August 2017** At the time P2R were offering planned inpatient detox, which was discussed and agreed with Mike to take place, he became too unwell and was admitted to Lister hospital August 2017. Whilst in Lister hospital, he was detoxed - discharged with a package of Care Oct 2017.

3.1.7 His partner described to ASC that (3 years ago from April 2020 which would match with August 2017): he was admitted to hospital with liver failure and gradually got better, but suffers with long term problems with memory, confusion, getting to grips with new tasks or understanding finances, he gets confused when in new places and cannot use public transport as he would get lost or forget where he is going and then panic. He has poor manual dexterity, and has chronic pain in his joints, muscles, and head. He also has pins and needles in his feet and lower legs. He also suffers from confabulation, which means he often tell me things that have happened which aren't true. He thinks they are, but they are not.

3.1.8 Adult Social Care became involved after this hospital admission for liver failure. Care Act Assessments took place as follows:

- Care Act- Hospital discharge Assessment 04/10/2017
- Care Act- Visual impairment assessment 14/11/2017

3.1.9 **Oct 2017** Following discharge from hospital in October 2017, Mike had his first of a total three periods of respite care – Dec. 2017 (5days). Mike was not the youngest there at

the time. The support worker from Chase house described him as ‘very reserved’. He would not leave his room and was in control of what he wanted.

3.1.10 Mike was assessed under The Care Act 2014, and he was provided care and support to meet his assessed eligible needs. Mike primarily required support with shopping and socialisation via a day service and previously a Personal Assistant. It is noted at this point that: “however he also had medical conditions that were likely to deteriorate and impact on his life”.

3.1.11 **Nov 2017** P2R visited Mike at home. Dec. 2017 it was agreed with Mike - who had been abstinent since August 2017 – to close his case to P2R. Alcoholics Anonymous in Shefford and the Living Room in Stevenage were agreed places for continued support for Mike and his partner.

3.1.12 **Dec 2017** Mike’s had his second period of respite care – Dec. 2017 (5 days)

3.1.13 **March 2018** Mike had a third period of respite.

3.1.14 **June 2018** His partner told ASC in April 2020 that: He is under a psychiatrist at Spring house following admission to a mental health ward two years ago. In **June 2018** Mike was in an inpatient mental health unit. He was on Willow Ward being treated for his psychosis. [Very little detail is available on this period].

3.1.15 From the mental health unit, he was taken to the Emergency Department, then inpatient admission (17-29 June 2018) presenting with increased confusion. He was diagnosed with a neurological event secondary to his decompensated alcoholic liver disease. [Neurologic events were defined as ischemic stroke, haemorrhage, hypoxic ischemic injury, or acute symptomatic neurologic dysfunction without central nervous system injury]. He was already on antibiotics in the community for a urinary tract infection. He was discharged back to inpatient mental health bed. Hepatology to review in 4-6 weeks. GP to titrate up dose of carvedilol [for high blood pressure]. He then remained reasonably well.

3.1.16 **Aug 2018** He was seen at Gastroenterology outpatient clinic at Lister and Dunstable Hospital for a review of liver for decompensated alcohol-related liver cirrhosis. Liver and renal functions are normal. Noted to have been abstinent from alcohol for one year.

3.1.17 **End August 2018** Mike had an MRI scan, and was seen at the neurology outpatient clinic for results September 2018, with his partner. Inpatient CT head scans showed ischemic changes in the right centrum semiovale. MRI scan reviewed and showed multiple T2 FLAIR hyperintensities in the periventricular distribution. He was prescribed Levetiracetam.

3.1.18 Cranial nerve examination was normal including fundi and visual fields. Limb power, tone, reflexes and co-ordination were all normal. He was discussed with consultant and due to good response to medication and no changes in his mood no changes to medications were made and was to be reviewed in six months’ time.

3.1.19 **October 2018** The third period of respite care (7 days). In October 2018, he was more sociable and joined in. The Support Worker recalled him being anxious; he did not like new staff. Mike was in a seven-bedded unit.

3.1.20 **Summer 2019** relationship between Mike and Susan started to become very strained. Susan experienced a change in this behaviour and the angry / loud scary outbursts and

arguments. With hindsight she thought this was explained by his starting to drink again.

3.1.21 **November 2019** Mike's sister died.

3.2 SUMMARY OF TIME PERIOD UNDER REVIEW

3.2.1 The time period that this SAR has looked at in detail ran from December 2019 to April 2021.

3.2.2 The case really falls into two distinct elements:

- Professional responses to Mike's ex-partner handing his care and coordination over to professionals as she fled the domestic abuse
- Professional responses to Mike's nephew flagging urgent concerns about Mike's health and welfare

3.2.3 The timeline covering the first half has been broken down into seven Key Practice Episodes (KPEs), that reflected the unfolding of Mike's case and the progression of professional activity over that time. These are captured in the table below.

KPE No.	Title & timeframe
KPE 1 11 Dec 2019 - 27 Feb 2020	**First alert of carer breakdown** Initial alert to Social Care from Susan that a change of care arrangements is needed for Mike and Social Care responses Home visit. Seeking funding authorisation for 6-week rolling respite, PA under DP. Respite at Penrose Court for Mike.
KPE 2 27 Feb - end March 2020	**Escalation of home situation for Mike's partner** Situation has escalated significantly for Susan – Chis is drinking; she's scared for her own safety linked both to his alcohol and cognitive impairment; she has contacted the police; needs him out the house. Nothing immediate possible due to his age and current drinking. (09 March) Susan goes to B&B. Mike sends increasingly strange and abusive texts so Susan calls crisis team, who advise take to A&E. MH-crisis team said nothing wrong with him. ASC funding approved and Susan arranges respite for Mike for 2 weeks. CMHT Intake team contact ASC in response to Susan's contact to push for assessment of Mike's care needs.
KPE 3 Begin April – 26 June 2020	**Covid lock down and efforts to set up alternative accommodation for Mike by new social worker while keeping partner safe (SW2)** Covid lock down and Mike returned home from respite. Susan reluctant to just make him homeless, and scared of provoking him, so trying to get alternative accommodation set up before telling him he has to leave. Stressed. Scared. Original SW redeployed as part of Covid response. New SW

	allocated (SW 2). Long email exchanges with Susan gets the full picture Response to Susan a month later (06 May) re complications in securing housing as require Mike's consent and he will be contacted. Susan response immediately – she is scared about what will happen if she tells him, what are her rights? Does she need a new social worker? Next day SW response with detailed email including updating that safeguarding alert has been raised; Susan should have a carer's assessment with her own different SW; if Susan gets Mike into respite, SW will arrange it is extended until alternative accommodation secured. Last 2 weeks May SW liaising with Mike re. respite then alternative accommodation. Susan has discussed with him. Housing options explored while Mike in respite and agreed 16 June. Tenancy support worker helps him move on 26 June.
KPE 4 July 2020	**Mike in new accommodation but declining care agency and first efforts by SW2 to arrange review meeting about Package of Care (POC).** Mike in new bungalow on his own. 6th Tenancy Support Officer flags to SW Mike's preference to return to Direct Payments (DP). SW clarifies need for care review to discuss a way forward. He is not able to manage his direct payments independently and was in a crisis situation. 14th Susan alerts both she has blocked Mike from all communication; he has contacted her every day - he is very confused and scared at the moment – that he really needs support from someone. 16th Care Agency serve notice on his care package to end 29 July 2020. 30th. Nephew advises can't support as previously agreed. But then recants saying he's read about Alzheimer's which is compounded by 2 bereavements in the family – death of Rober's mother and grandmother, who is Chri's mother. SW transferred to another team, good summary of uncompleted tasks. Nb at this point capacity only being queried for managing finances Uncompleted Tasks noted as: 1. Urgent review of Home Care service (3/8) with Personal Assistant. **service began on 26th June 2020, but client has been declining to be supported via commissioned care as DP is his preference**. However, in my professional opinion, it will be unsafe to provide care via DP without completing MCA for finance

	management to determine options of either providing DP or should be referred for Money Management/ Support with Managed account. 2. The review is also to determine if care and support is required at all as Mr Elliot has been cancelling all care, how does he manage? 3. Review should also consider why Mr Elliot has rejected Safe Key and Life 24 (Grand Union as Emergency Respondent and paid for by CBC). Key contact is: Independent Living Officer (Tenancy Support)(phone number; email) 4. Advocacy / Befriending referral could be explored with Mr Mike as he has no family except a nephew, RE (phone number) who lives in Gateshead and only visits occasionally. 5. The Ex-Partner, Susan has advised that there is an unused amount of £1,797.94 sitting in the DP account which she used to manage for Mike and need to be taken back by CBC so that she will have the DP account closed and end her involvement.
KPE 5 03 Aug – 21 Sept 2020	**SW 3 takes over. Escalation of concern as Mike continues to avoid meeting in person for care review, while chasing via emails, complaining via FB about being charged for care he is not receiving and cancelling all involvement in exasperation.** 03 Aug End of involvement email from SW1 to Mike. 11 Aug Mike using FB to ask who new SW is and wants DP. 18 Aug Tenancy Support asking who new SW is. 19 Aug 2nd allocated SW tries to contact Mike next day and liaise with Tenancy Support worker. Flamboyant emails from Mike to new worker 02 Sept. Susan calls to flag that he needs to register with new GP and meds are running out this week. SW liaises with GP and does delivery. SW discusses with senior. 07 Sept Flamboyant email cancelling review and advising does not want any involvement. Response from SW, still need to ensure he has all the relevant info hence need for a visit. Reminds of need to register with GP and ultrasound appt. Then liaise with Tenancy Support. Both concerned. Housing support to email Mike. SW to disc with senior if no improvement with engagement. 11 Sept. Mike writing on Council FB page about being charged or care he is not receiving. TM advising SW: worker to send an email to Mike acknowledging decline of support

	and advise how to contact ASC if support required in future. Email to also clarify invoice issue and if Mike responded that he is happy for support, worker to refer to Finance team to get in touch with Mike. Mike replies incensed. TM advises: to respond to Mike stating that I will come back to him in a few weeks to see if he has changed his mind. Contact details provided for team and EDT. 15th September Discussed in supervision and agreed to reallocate to a male worker. (4) Case reallocated on 16 Sept.
KPE 4 25 Sept – 13 Oct 2020	**Mike, ex-partner, advocate all trying to escalate need for resolution to Mike's care, tenancy support worker raises a safeguarding alert** 21st Susan informed after she emails about concerns about all the invoices and letters. 22nd Advocate flags Mike awaiting contact. 25th Mike makes contact with new SW. 30 Sept Mike chases SW for an updated. 06 Oct. Mike calls duty requesting a call back to discuss his awaiting care to be put in place. Outcome unknown. 06 Oct Mike puts 12 messages on FB naming his allocated worker asking for an update. SW has spoken to Mike who says he's going away today and returning on Monday [me -where? With whom? Seems unlikely] 13 Oct. Tenancy support raises a safeguarding – receiving high volumes of emails from Mike. He's on his 3rd SW since he moved in mid-June and hasn't been seen in 3 months sine respite. Safeguarding share back with locality team allocated worker with request they make contact with Mike.
KPE 5 Mid-Oct – 30 Dec 2020	**Concerted efforts by SW3 to arrange a meeting with Mike, identification of need for a professionals meeting and need for MH worker to co-work the case** 15-17 Oct. emails between Mike and SW – Mike stressed about the invoices and being black balled for credit 22 Oct. another email exchange – SW trying to rebook 30 Oct. Mike searching company house info re SW and sharing 11 Nov. SW calls Susan – SW says need to call a professionals meeting with CMHT, Grand Union Housing and SW to discuss a way forward. 17. Nov. SW calls CMHT requests contact details for Dr Ademola to write to him about the need for a MH worker to be allocated to joint work to support Mike and set up plans to support him going forward

	07. Dec Fk you. Do what I want sign arrives from Mike for SW. 21 Dec. Advocate liaises with SW 30 Dec. Decision taken to end the support plan and stop charges being sent to Mike for care he is not using. He cancelled his care on 15.07
KPE 6. 11 Jan- 18 Jan 2021	**Agreement to meet via MS Teams to conduct the care review** 11 Jan. advocate – SW update that Susan says Mike has a tablet 18 Jan. Teams meeting with all including Susan and Mike. A plan was agreed- to reinstate his care as originally was i.e. DP with support from nephew in the interim later managed by DRC or other; SW to contact Tyneside council for a plan to move closer to his nephew. Another meeting scheduled 25.
KPE 7. 19 Jan – 20 April 2021	**Attempts to implement interim agreements for care plan** 06 Feb. Susan says not so straightforward. 10-16 Feb. more email exchanges btw Mike and SW 26 Feb. Advocate – SW exchange 3 Mar. Mike- SW wanting PA to be cardholder; but that not possible 4 Mar. Mike re. bailiffs 11 Mar. advocate- SW re outcome of dismissing charges from CBC. SW gives info from collections – he still owes 408. Later comms from Debt recovery – he wishes to pay in weekly £10 instalments. Needing to know he has online banking and a standing order set up. 16 Mar. Advocate forwards message from Mike – more about the debt . 20 April. Concern raised by Susan and then nephew

3.3 EXPERIENCES AND VIEWS OF FAMILY MEMBERS

3.3.1 Feedback from Mike's ex-partner makes for exceedingly difficult reading. She accurately describes the way that she effectively conducted a thorough, detailed hand-over of Mike to statutory services. This was a hugely generous act given the context. With his relapse into alcoholism, his behaviour had become abusive, and she was no longer safe to stay together in a relationship with him. This in itself had a huge emotional cost for her but this was nothing compared to the impact of what was to follow over the following ten months. She details as follows:

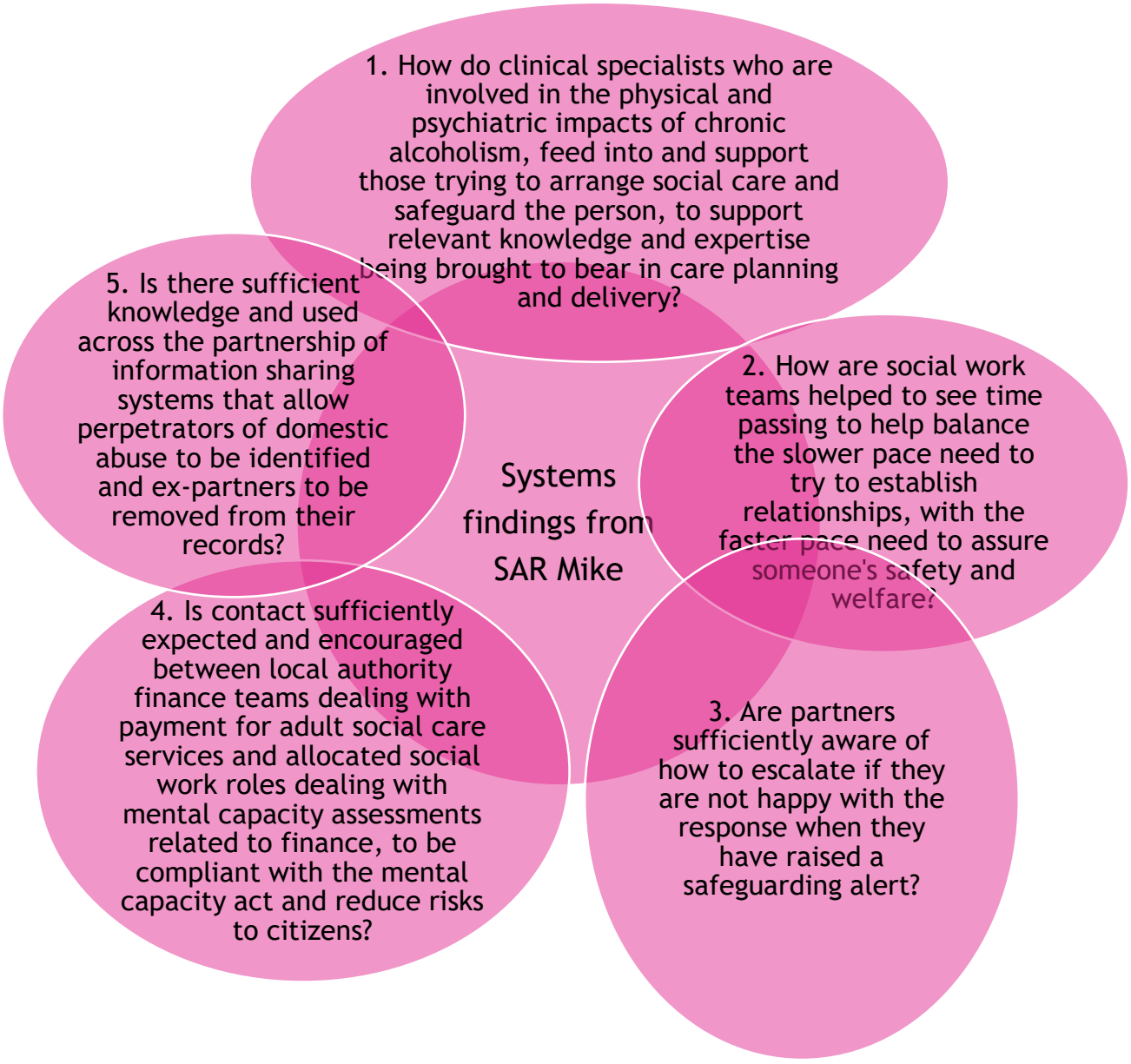
- Despite her handing over clear details of all Mike's medical conditions and when and with whom the next appointments were for all his conditions, cc-ed to adult social care, Mike did not attend any of his appointments – including liver specialist and ophthalmologist or mental health.
- There also seemed to be no adjustments made e.g. for his visual impairments.
- Mike was not provided with any kind of care-coordinator, or single-point of contact, even though after the separation from his partner, he had no family to help him. He was permanently confused about which agency was which and why he was having so many assessments. No-one seemed to have a holistic view of everything that was happening from a medical perspective.
- On a number of key occasions assurances by the psychiatrist or by the social worker, that action would be taken to arrange some kind of intervention for Mike, were given but not followed through. Nothing happened as a result of all the information and concerns shared.
- Information sharing from mental health was erratic. Winter 20/21 when Dr Ademola called Mike's ex-partner, her address was still down as his address. There had been no letters from Spring House for Mike. Yet Dr Ademola was ringing about a missed appointment. It does not seem like Mike ever received an invitation for an appointment. Letters that arrived after Mike died, referred to an "initial" assessment when he had been a long-standing patient of Dr Ademola's. Why was the appointment a month after Mike's nephew had raised a red flag and the situation was critical? Why were there 2 letters one confirming a telephone appointment and another a home visit?
- Even 10 months after their separation, professionals continued to rely on Mike's ex-partner to contact Mike, explain what was happening in and try to get his agreement – when she was very unwell herself.
- The failure and mismanagement of Mike's case is a long standing one. Not just at the end. No practitioner visited him for 10 months from June 2020 when he was placed in the bungalow in Broom.

3.3.2 She also details in stark terms the impact of experiencing these failures, and of having to attempt to balance her own self-care and the desperately obvious needs of Mike, on her physical health and well-being. She had to be on sick leave from January 2021, as she was so debilitated eventually diagnosed with PTSD. She had to create boundaries with Mike, who was still turning to her for help. Toward the end of April, it was Mike's ex-partner who alerted Mike's nephew to emails that were unintelligible apart from the word 'help'.

4 Systems findings drawn from MIKE's case

4.1 OVERVIEW OF SYSTEMS LEARNING

4.1.1 Following review of the agency returns, integrated chronology, notes from conversations and the practitioner event, has allowed five systems findings to be identified. These are issues that make it harder for practitioners and clinicians to do a good job providing timely, effective, rights-based, person-centered care and support. They are currently phrased as questions.



4.2 FINDING 1

HOW DO CLINICAL SPECIALISTS WHO ARE INVOLVED IN THE PHYSICAL AND PSYCHIATRIC IMPACTS OF CHRONIC ALCOHOLISM, FEED INTO AND SUPPORT THOSE TRYING TO ARRANGE SOCIAL CARE AND SAFEGUARD THE PERSON, TO SUPPORT RELEVANT KNOWLEDGE AND EXPERTISE BEING BROUGHT TO BEAR IN CARE PLANNING AND DELIVERY? (COMMUNICATION AND COLLABORATION)

BACKGROUND

4.2.1 Cognitive impairments can have different causes, including among others:

- Traumatic brain injury,
- Alcohol-related brain damage (ARBD)
- Severe deficiency of thiamine (vitamin B-1) causing Korsakoff syndrome (chronic memory disorder), most commonly caused by alcohol misuse
- Neuro-degenerative conditions such as Alzheimer's, Parkinsons, Huntington's and Motor neuron disease
- Hypoxia, other toxic insults and
- Vascular causes
- Schizophrenia, depression and or other serious mental illnesses.

4.2.2 A person's cognitive impairments may stem from any number of the above at the same time.

4.2.3 As cognitive impairments increase, they can progressively impact on a person's executive functioning and functional capacity. This is typically evident in worsening:

- Memory problems
- Confusion / disorientation
- Falls
- Socially inappropriate behaviour
- Disinhibition including sexually inappropriate behaviours
- Self-neglect
- Inappropriate spending and management of money
- Changes in personality
- Difficulties concentrating and motivating oneself.

4.2.4 Consequently, as a person's cognitive impairments progress, they often face increased risks and can also pose increased risks to others.

4.2.5 The tendency for people with reduced executive functioning ability to be able to perform normally in traditional conversation-based assessments, together with the ethos of personalization and empowerment and prioritizing the voice and wishes of the person, mean that social workers can easily over-estimate a person's mental capacity to make their own decisions in these circumstances.

4.2.6 The requisite expertise for assessment and interventions to sustain good lives and mitigate risks linked to new behaviours usually comes from a multi-disciplinary team including psychologist, occupational therapists, nurses, social workers, who could help minimise risks. Such MDTs often exist as part of Older Adults Community Mental Health

Services for people with dementia diagnoses. Accessibility if often a problem for people with alcohol dependencies and on-going problematic alcohol use.

IN MIKE'S CASE

4.2.7 Mike had struggled with alcoholism his entire life. He suffered a seizure during a period of abstinence on holiday July 2016, causing brain damage that left him with blurred vision and some mobility issues. A year later he suffered liver failure and was admitted to Lister Hospital (2017). June 2018, he seems to have suffered psychosis and was admitted to a mental health unit, under the Mental Health Act. He was diagnosed with a neurological event secondary to his decompensated alcoholic liver disease.

4.2.8 August 2018 he was seen for a review of decompensated alcohol-related liver cirrhosis. End August 2018 he had an MRI scan and was seen by neurology outpatient clinic for results in Sept 2018. In December 2018 he began to drink again. He continued to be under a Consultant Psychiatrist at CMHT (ELFT), though it is unclear with what focus or to what end.

4.2.9 Mike's ex-partner gave a clear summary of Mike's history and a good description of his cognitive impairments, when she was first in touch with adult social care April 2020:

> *"We are not married. The property we live in is mine. His only income is a PIP, and he is an alcoholic. 3 years ago, he was admitted to hospital with liver failure and gradually got better, but suffers with long term problems with memory, confusion, getting to grips with new tasks or understanding finances, he gets confused when in new places and cannot use public transport as he would get lost or forget where he is going and then panic. He has poor manual dexterity, has chronic pain in his joints, muscles, and head. He also has pins and needles in his feet and lower legs. He also suffers from confabulation, which means he often tell me things that have happened which aren't true. He thinks they are, but they're not. He is under a psychiatrist at Spring house following admission to a mental health ward 2 years ago".*

4.2.10 Yet no-where in his case notes is his medical history, and what it means for his current cognitive functioning, and therefore his care and support needs, anything like as clear.

4.2.11 Mike described himself to professionals as have a diagnoses of early onset Alzheimer's, a rare strain called Korsakov's (which is inaccurate). His nephew also referred often to Alzheimer's. This appears to have been absorbed without check into the local authority records: e.g. March 2020, Mike's medical history is described in local authority notes as follows:

> *Medical History of Alcohol Dependency, Seizure during detox, Visual Impairment, Reduced Mobility, Liver Problems, Anxiety/Low Mood, and formal diagnosis of Alzheimer's. disease. liver failure and suffers from severe depression and anxiety*

4.2.12 The GP notes (07.10.2020) after he moved to independent accommodation, mentions a discussion with Mike of Korsakoff's related to alcohol. However, we have not been able to find any diagnosis in any of his notes. For example, the ELFT records confirm Mike had the following diagnoses on record:

- Severe depressing without psychotic symptoms (resolving) F32.2

- Alcohol Dependence F10.2
- Amnestic syndrome due to excess alcohol intake F10.6
- Unspecified mental disorder due to brain damage and dysfunction and to physical disease F06.9

4.2.13 There does not appear to have been any discussion between the GP and the allocated social workers, in order to better understand the nature of Mike's situation, causes, impact, prognosis or implications for capacity, communication and care.

4.2.14 Similarly, Mike being open to CMHT does not appear to result in any expert input to help social care and housing partners understand his presentation of needs.

4.2.15 At early point CMHT were contact by his partner in what she considered a crisis; she was so worried about his strange messages she had left her 'safe house' B&B and taken him to A&E. CMHT's response was only to refer back to social care and flag the need for a care act assessment about his eligible needs. No expert input was offered.

4.2.16 By September 2020, Mike's behaviours in cancelling visits to review his care plan, and increasingly long and flamboyant emails were causing the tenancy support worker and allocated social worker heightened concerns. By KPE 5, in November 2020, the allocated SW identified the need for Mike's case to be co-worked with a mental health worker, to help set up plans to support him going forward.

4.2.17 However, contact with CMHT did not result in a case discussion with adult social care; a home visit was scheduled (that then does not take place). In desperation, Mike's cognitive impairments then seem to have fallen out of focus, as practitioners bend over backwards to try to arrange interim agreements around DP in order that Mike can have some care provided.

4.2.18 Hence the question raised in this finding: **How do clinical specialists who are involved in the physical and psychiatric impacts of chronic alcoholism, feed into and support those trying to arrange social care and safeguard the person, to support relevant knowledge and expertise being brought to bear in care planning and delivery? (communication and collaboration)**

HOW DOES THIS ISSUE PLAY OUT TODAY

4.2.19 Discussion of this type of scenario as part of the SAR, surfaced a lack of clarity about a number of issues.

4.2.20 Firstly, how is Korsakoff's currently being diagnosed locally? Can this occur in the community or are we reliant on acute admissions – as appears to have been the case for Mike – then resulting in involvement of neurology departments leading to diagnosis?

4.2.21 Secondly, what is the agreed pathway for support following diagnosis of Korsakoff's? Are there secondary services commissioned to advise or be involved? If someone is experiencing neurological behaviour changes due to Korsakoff's is CMHT expected to pick it up, or who?

4.2.22 What is the role of the GP as conduit for information from consultant liver specialists? Are GPs supporting adult social care assessments and care planning, through the sharing expertise around clinical information? E.g. explaining liver cirrhosis, impacts including potential impact on brain functioning.

WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.2.23 This finding is phrased as a question. It needs to be part of the SAB response to confirm and evidence whether what the agreed pathways and arrangements are for multi-agency collaboration around neurological deterioration caused by chronic alcoholism, amongst other causes, and how many people are affected.

Finding 1. How do clinical specialists who are involved in the physical and psychiatric impacts of chronic alcoholism, feed into and support those trying to arrange social care and safeguard the person, to support relevant knowledge and expertise being brought to bear in care planning and delivery? (Communication and collaboration)

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

4.2.24 Is this a gap in multi-agency communication and collaboration that the SAB has previously identified?

4.2.25 How best to engage psychiatric consultants and CMHT, as well as liver failure consultants in the discussion?

4.2.26 Are there other circumstances where clinical info and expertise does better feed into care planning and implementation as relates to alcohol dependencies and cognitive impacts?

4.2.27 How would you know if the situation had improved?

4.3 FINDING 2

HOW ARE SOCIAL WORK TEAMS HELPED TO SEE TIME PASSING TO HELP BALANCE THE SLOWER PACE NEED TO TRY TO ESTABLISH RELATIONSHIPS, WITH THE FASTER PACE NEED TO ASSURE SOMEONE'S SAFETY AND WELFARE? (TOOLS)

BACKGROUND

4.3.1 There is clear consensus around the key principles that underpin good social work and good safeguarding practice: person-centered, strengths-based, rights based.

4.3.2 Individual case work often requires fine judgements about the competing priorities of the time required to get the right practitioners in place and allow enough time for them to build relationships and trust with a person, versus the risk that allowing the passing of time, in terms of the person's safety and well-being.

IN MIKE'S CASE

4.3.3 What we saw in Mike's case was a lot of skilled, and persistent social work as allocated workers tried to arrange with Mike so that they could meet to conduct his care review.

4.3.4 The start of the Covid pandemic meant staff were redeployed, creating a break in relationships. At other times, there was an active decision to change worker, in order to try to enable Mike to engage. What got lost in this focus, was exactly how long it was he had not been seen in his new property, in the context of his known care needs and risks.

4.3.5 The social work chronology did not appear to automatically log how long since he was last seen – a critical issue in this case because it was the first time Mike was living alone. Hence the question raised in this finding: are practitioners supported adequately with practical tools that make it easy to keep abreast of the amount of time that has past?

HOW DOES THIS ISSUE PLAY OUT TODAY

4.3.6 Discussion with leads from involved agencies as part of this SAR, highlighted how, in the four years since this case, councils have moved to more intelligent IT systems. Examples shared included how, the new Care Direct system in Bedford, tells you automatically how long a case has been open. In Bedfordshire, the Liquid Logic systems allows you to set alerts for particular things. Some alerts are automated e.g. following a new care package, the requirement to review after 4-6 weeks. However, how long since the last home visit, so how long since a person drawing on care and support was last seen would need to be set up proactively.

4.3.7 Further discussion highlighted that automated alerts tend to be used more by managers for oversight of caseloads. Their use by practitioners to support case work would depend on the initiative of the individual practitioner.

WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.3.8 This finding is not relevant only to people in circumstances such as Mike's related to chronic alcoholism and complex health needs, but potentially to all case work where

someone is unable to tend to their own self-care, or has other deteriorating conditions, whether related to mobility or to neurological functioning.

Finding 2: How are social work teams helped to see time passing to help balance the slower pace need to try to establish relationships, with the faster pace need to assure someone's safety and welfare? (tools)

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

4.3.9 Is the SAB aware of the numbers of cases where people have been left too long without being seen by any professionals? Is this issue relevant within and/or beyond adult social care?

4.3.10 Can the Board seek assurances as to whether new IT and case management systems are being used to help see how long since someone has actually been where this is relevant?

4.3.11 To what extent is there human factors expertise on the Board and across partners to help consider how ergonomic approaches including the design of processes or tools can be brought to bear in quality improvement work?

4.3.12 How could the Board explore whether other areas/ agencies have tried and/or succeeded in tackling this issue?

4.3.13 How would the SAB know if things had improved?

4.4 FINDING 3

ARE PARTNERS SUFFICIENTLY AWARE OF HOW TO ESCALATE IF THEY ARE NOT HAPPY WITH THE RESPONSE WHEN THEY HAVE RAISED A SAFEGUARDING ALERT?

BACKGROUND

4.4.1 When someone has a concern about potential abuse or neglect, including self-neglect, they are expected to raise a safeguarding alert with the local authority safeguarding team. This is an important route for information sharing and escalation of concerns.

4.4.2 While safeguarding is not considered a 'blue light' service, the timeliness of responses can be critical to timely interventions for citizens. Therefore, escalation pathways form an important additional layer of system resilience. All partners are expected to use the SAB escalation pathways, if they are concerned about the quality of practice of a partner in any particular case.

IN MIKE'S CASE

4.4.3 In the case records about Mike, the attentiveness and proactive engagement of the tenancy support worker and advocate involved with Mike shine out brightly. They both

demonstrate a marked tenacity in raising the same issues, when they have not been addressed, and amplifying Mike's experiences and his voice. This includes, in KPE 4, the tenancy support worker raising a safeguarding alert.

4.4.4 This was a missed opportunity to use a different legal framework to see Mike, and to pull all relevant partners together. Unfortunately, the attempt was effectively neutralized because the concern was passed on to the locality social work team and allocated worker and therefore did not trigger any change in approach or urgency of attempts to see Mike.

4.4.5 This procedure of passing concerns back to the allocated worker where there is one, has strengths. New information is potentially shared with the people who know the case best, and are best placed to respond to it. The drawbacks appear when it is the current responses of precisely that allocated worker, who are implicated in the risk that is being flagged. In these scenarios escalation becomes necessary. From the data gathered as part of this review, it is unclear if the escalation option was considered, and it does not appear to have been pursued.

HOW DOES THIS ISSUE PLAY OUT TODAY

4.4.6 This scenario was discussed with leads from partner agencies as part of this Review. This clarified that the safeguarding procedure in Bedford Borough Council does not mean that safeguarding concerns are automatically passed back to the locality social work team that is involved with the person. Instead, in Bedford, all safeguarding alerts are reviewed by the council safeguarding team who conduct the three stage test to check if safeguarding duties under the Care Act apply depending if the adult:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

4.4.7 The safeguarding team then decide who is best placed to take any action, which may be the locality team if they are already involved with the person but is not automatically the case.

4.4.8 If a partner agency were not happy with the response to the safeguarding alert, the suggestion was that they would come back again to the safeguarding team. There appeared to be less clarity about how you would escalate the issue, particularly in circumstances where there was a perceived urgency.

WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.4.9 This finding is phrased as a question. It needs to be part of the SAB response to confirm and evidence whether there is a lack of clarity and usage of escalation processes following safeguarding alerts, where this is appropriate, where it exists and how many people may be affected.

Finding 3: Are partners sufficiently aware of how to escalate if they are not happy with the response when they have raised a safeguarding alert? (Communication and collaboration)
QUESTIONS TO CONSIDER IN DETERMINING RESPONSES 4.4.10 What does the SAB currently know about levels of clarity and confidence across partners about what to do if you are not happy with the response to a safeguarding alert or outcome of a s.42 Enquiry? 4.4.11 What data is available about who is escalating? Are housing and advocacy active? 4.4.12 Is there a clear, accessible flow-chart to capture the escalation process, that is widely disseminated? 4.4.13 Is there more that needs to be done to market the SAB escalation route and promote its use? 4.4.14 How would you know things had improved in relation to this finding?

4.5 FINDING 4

IS CONTACT SUFFICIENTLY EXPECTED AND ENCOURAGED BETWEEN LOCAL AUTHORITY FINANCE TEAMS DEALING WITH PAYMENT FOR ADULT SOCIAL CARE SERVICES AND ALLOCATED SOCIAL WORK ROLES DEALING WITH MENTAL CAPACITY ASSESSMENTS RELATED TO FINANCE, TO BE COMPLIANT WITH THE MENTAL CAPACITY ACT AND REDUCE RISKS TO CITIZENS?

BACKGROUND

4.5.1 In all areas of England, councils ask social care recipients to contribute towards the home care and support they receive, following a financial assessment. Councils therefore operate processes for the collection, recovery and enforcement of Adult Social Care charges owed to the Council. The Care Act 2014 consolidates the Council's powers to recover money owed for arranging care and support for a customer.

4.5.2 Bedford Borough Council's Charging and Financial Assessment for Adult Care and Support Services Policy 2024/25 is available here: **Adult Care and Support Services Policy**

IN MIKE'S CASE

4.5.3 Soon after Mike moved into new accommodation at end of June 2020, he began receiving invoices from the local authority finance team for the pack of care that he was in fact declining. His preference was to be supported by commissioned care via direct payments as he had been previously while still living together with his long term partner. However, his allocated social worker rightly identified that this would be unsafe before completing a mental capacity assessment for finance management. His ex-partner had

previously managed the direct payment account for him.

4.5.4 All the correspondence around charges that Mike was receiving, he found incredibly stressful and frustrating given he had not in fact accepted / received any care. By August and September, Mike was complaining on the Council's Face Book page about being charged for care that he was not receiving and, in exasperation he cancelled all involvement with services. A third social worker was briefly allocated Mike's case at this point, and on advice from the Team Manager emailed Mike, clarifying the invoice issue (though the notes give no detail of this explanation).

4.5.5 The case is then reallocated to a fourth allocated worker (male) in mid-September. Mike's anxiety and anger at the correspondence about invoices is also flagged by his ex partner, and the need for him to be seen and care to be arranged is being escalated by the tenancy support worker and his advocate. Mid-October, Mike is emailing the new (4th) social worker stressed about the invoices and saying he has now been officially black balled for any kind of credit. Only on the 30 December is the decision taken to end the support plan and stop charges being sent to Mike for care he is not using and that he had cancelled in mid-July.

4.5.6 However, this does not seem to be applied retrospectively. By March Mike emailed the social worker saying he has received an authorization by the council for debt recovery and the initiating of court proceedings. The social worker appears to liaise with the finance team and requests that if Mike continues to receive letters requesting payments he should sent them to the social worker who will address the matter with the finance department

4.5.7 By mid-March, the advocate together with Mike emails querying the outcome of CBC dismissing charges. The SW replies: I have spoken to a colleague in collections about the demands for payment Mike is receiving. I have been told that Mike owed the Council over £800. When he presented 15/07/2020 as the date he cancelled his home care that left him a week of contribution to pay. He owes contributions towards respite from 02/06/2020 to 30/06/2020. The cancellation date of the 15/03/2020 has been taken into consideration and he now owes the council £408.70. I have been advised to ask Mike to make an offer of how much he wants to pay back in instalments.

4.5.8 Debt recovery later confirmed with the social worker that Mike had agreed to pay weekly installments of £10 for a debt he has accrued for care; "We are in agreement to him paying £10 per week but we will need confirmation that he has set this up, including the start date assuming he has online banking to do so. If not, we will need to send him a standing order form which will take longer to process so will need to know as soon as possible".

4.5.9 There seems to have been no connection made between the determination that Mike did not have mental capacity for finance management, so was unable to manage direct payments independently on the one hand, and communication about or arrangements for his debt accrued for case.

HOW DOES THIS ISSUE PLAY OUT TODAY

4.5.10 When this issue was discussed with partner leads as part of the SAR, all agreed that in Mike's case there should have been conversations about whether he could understand the charging information being sent to him, and what help he needed to do so. At the time, however, it was not possible for allocated social workers to see on the IT systems what correspondence was being sent to clients. With the new IT system, social workers

can now have direct access to communication from the Finance Team. The expectation would be that where a mental capacity assessment is being arranged for a person, then the social worker would liaise with finance to request the invoicing and/or debt recovery action be paused until the mental capacity outcome is clear.

4.5.11 What participants were less clear about is whether there is an equivalent process for Finance Teams, whereby they would initiate contact with the social work team, when invoices have not been and debt recovery is being considered.

WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.5.12 This finding is phrased as a question. It therefore needs to be part of the SAB response to confirm and evidence where this issue exists across the locality and how many people may be affected.

Finding 4. Is contact sufficiently expected and encouraged between local authority finance teams dealing with payment for adult social care services and allocated social work roles dealing with mental capacity assessments related to finance, to be compliant with the mental capacity act and reduce risks to citizens? (Communication and collaboration)

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

4.5.13 How much does the SAB know about the amount of people assessed for mental capacity around finances, living alone, and also being invoiced for adult social care and/or receiving debt recovery correspondence?

4.5.14 Is this an issue that the SAB has previously considered?

4.5.15 How might the Charging and Financial Assessment for Adult Care & Support Services Policy be reviewed to reference expectations about communication and collaboration across departments, and safeguarding?

4.5.16 Does the same issue affect any other partners?

4.5.17 How would the SAB know if there has been improvement in this area?

4.6 FINDING 5

IS THERE SUFFICIENT KNOWLEDGE AND USED ACROSS THE PARTNERSHIP OF INFORMATION SHARING SYSTEMS THAT ALLOW PERPETRATORS OF DOMESTIC ABUSE TO BE IDENTIFIED AND EX-PARTNERS TO BE REMOVED FROM THEIR RECORDS?

BACKGROUND

4.6.1 Where a perpetrator of domestic abuse also has care and support needs, there is a need to share information about their past behaviours, in order to manage potential

risks for future practitioners involved in care and support roles.

4.6.2 In addition, agencies also have a duty to protect the ex-partner and victim of the person's domestic abuse. This includes supporting the breaking of ties and actively avoiding leveraging the carer role they had previously played in order to allow professionals to keep contact with the ex-partner. The unintended consequence can be to draw the victim back into the abusive relationship.[8]

IN MIKE'S CASE

4.6.3 Mike's partner of 15 years had been his carer for five years. She ended the relationship when he started drinking again and his behaviour towards her became unacceptable and it became an abusive relationship. Yet she was extremely considerate and generous in the way that she enabled arrangements for Mike to be in place before she forced him to leave her house. She did a thorough handover of all the details of Mike's medical conditions and of when and with whom the next appointments were for all his conditions.

4.6.4 She also continued to help with the practical arrangements by sharing information about Mike's needs and appointments after he had moved into his own accommodation.

4.6.5 At a certain point however she drew the line and said clearly that she had to prioritise her own health and care needs, and was withdrawing. But still her details were on agency records and she was contacted to help agencies in their contact with Mike. In her feedback she is very clear: "they should not have kept involving me". The impact she described was profound.

4.6.6 Simultaneously, the knowledge of Mike's domestic abuse was not fed into the planning of his care and support. The personal assistant was unaware of this background. There does not appear to have been any risk assessment regarding her, and her lone working.

HOW DOES THIS ISSUE PLAY OUT TODAY

4.6.7 Discussion of this scenario highlighted that in some IT systems, Next of Kin can be changed to Contact of Concern.

4.6.8 More broadly, it did not appear that there was a strong common understanding about how information would be shared, stored or used across partners, in circumstances where a person with care and support needs is also a perpetrator of domestic abuse.

WHAT IS THE GEOGRAPHIC SPREAD AND HOW MANY PEOPLE POTENTIALLY AFFECTED

4.6.9 This finding is phrased as a question. It therefore needs to be part of the SAB response to confirm and evidence the extent to which this pattern exists across Bedford Borough and Central Bedfordshire, and how many people may be affected.

[8] See **azz011.pdf**

Finding 5. Is there sufficient knowledge and used across the partnership of information sharing systems that allow perpetrators of domestic abuse to be identified and ex-partners to be removed from their records? (Communication and collaboration)

QUESTIONS TO CONSIDER IN DETERMINING RESPONSES

4.6.10 Do any partner agencies attend to this issue? What sort of numbers are we talking about in these circumstances in central Bedfordshire?

4.6.11 Are arrangements different anywhere in the county or borough?

4.6.12 What are the GDPR implications?

4.6.13 Are there ready solutions that could be transposed to this area?

4.6.14 What domestic abuse specialisms locally or nationally might help?

4.6.15 How would the SAB now if there had been improvements?