BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult Q

Overview Report July 2017

Eliot Sullivan Smith, Independent Reviewer July 2017

PREFACE

"Local Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult" (Department of Health, 2017).

In 2016 the Buckinghamshire Safeguarding Adults Board considered the case of Adult Q who died in April 2016. Adult Q had been known to a number of agencies and following his death it was felt that agencies could have worked together more effectively to support him.

The purpose of a Safeguarding Adult Review (SAR) is to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented Adult Q's death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The Safeguarding Adults Board considered Adult Q's case carefully and determined that the criteria for a Safeguarding Adult Review had been met and a Safeguarding Adult Review was commissioned.

The Author is independent of the Buckinghamshire Safeguarding Adults Board and all agencies involved in this case.

CONTENTS

INTRODUCTION

Background

Adult Q was 74-year-old man who lived alone in a private rented dwelling. People who knew him painted a picture of a man who had lived a varied and exciting life, travelling the county, on the road – driving a lorry, or riding a traditional horse-drawn caravan, or on the canal network, travelling and living on a barge. During his life Adult Q had been married, and had a son. Adult Q lost contact with his wife and son after they moved away. Adult Q's son was three years old at the time. Adult Q also had a sister who he used to regularly visit when she was in a nursing home until her death.

Adult Q settled in Buckinghamshire and became a part of the local village community. Adult Q had one particularly close friend, Ms Y, who he used to see very regularly, they went on trips, and he became part of Ms Y's family – he was like a second father to her. Over time Ms Y began to provide Adult Q with a significant level of support, helping him to look after himself, and his home.

Adult Q was a well-known character in the village and a member of a local Church. He used to attend social groups during the week and services on a Sunday – he especially liked the music and would always join in.

Adult Q had a diagnosis of Bipolar Affective Disorder and Ankylosing Spondylitis[1] – a long term inflammatory condition affecting the joints of the spine, and later a diagnosis of Parkinson's disease. Adult Q had close friends locally who he saw throughout the week, and who provided him care and support. Adult Q has also been described as an active member of his local church, attending the mobility group, a social café, and weekly church services.

Adult Q died on 6th April 2016. The cause of his death was noted by the coroner to be bronchopneumonia[2], with associated severe kyphosis[3] which was secondary to that ankylosing spondylitis. At the time of his death a number of agencies were involved with Adult Q in the context of his health and needs for care and support. Agencies also became involved in a crisis period, responding to an allegation of financial abuse, and concerns raised through his care provider and informal support networks, regarding his mental state, home environment, and behaviours of self-neglect.

Methodology

The review methodology draws on systems learning theory to evaluate and analyse information and relevant evidence gathered through the case, incorporating relevant learning from research and other reviews. Agencies involved in the care of the Adult were asked to provide chronologies and carry out an Internal Management Review against agreed terms of reference. The Practitioners who knew and worked with Adult Q were also invited to contribute to the review through a multi-agency practitioner's event.

Adult Q had lost contact with his surviving family members, however his close friend and a representative from the local church were also invited to contribute and provided a useful

[1] Ankylosing Spondylitis is a long term inflammatory condition affecting the joints of the spine.
[2] Bronchopneumonia is inflammation of the lungs occurring as a result of a virus, bacteria, or fungi.
[3] Severe Kyphosis is Kyphosis is curvature of the spine that causes the top of the back to appear more rounded than normal – complications can include pain and difficulty breathing.

insight into how agencies work together to support and safeguard individuals in Buckinghamshire.

Which Agencies were involved in the Review?

The following agencies were involved in the Review:

- Buckinghamshire Safeguarding Adult Board
- Buckinghamshire County Council Communities Health and Social Care
- Frimley Health NHS Foundation Trust
- Healthwatch Buckinghamshire
- NHS Chiltern Clinical Commissioning Group
- Aysgarth Medical Centre, GP Practice
- Oxford Health NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Thames Valley Police
- Westminster Care Agency

Principles of the Review

The following principles which incorporate the six safeguarding principles apply to this SAR:

- The focus of the SAR is learning and improvement across the partnership to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Avoidance of hindsight bias and outcome bias
- The terms of reference have been drawn up to be proportionate;
- Adult Q's friends and informal support networks will be invited to meaningfully contribute to this review;
- Buckinghamshire Safeguarding Adults Board is responsible for monitoring its progress and outcomes so as it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- It is expected that practitioners will be involved fully in the Individual Management Reviews and invited to contribute their perspectives in an environment of supporting learning and without fear of blame;
- To secure real learning and improvement, organisations involved in this SAR are expected to 'tell it like it is'.

Specific Terms of Reference (TOR)

The main scope of the SAR will cover the period of time from 01/01/2015 to 06/04/2016. This SAR will specifically examine:

1. The circumstances and events surrounding Adult Q's death
2. If there were ways agencies could have worked more effectively with regard to Adult Q to safeguard him and others.
3. How legislation, policy and guidance informed the provision of care provided to Adult Q, including duties and powers under the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 1983.
4. How learning from previous related case reviews impacted on the care provided to Adult Q.

5. Information sharing, communication and coordination of multi-agency care, including referrals, assessments, discharges and transitions.
6. Management of Adult Q's physical and mental health conditions.
7. Whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Adult Q.

In addition, the following lines of enquiry were also examined through individual management reviews by involved agencies, and through the involvement of members of staff who worked with Adult Q and conversations with members of his informal support network:

- Cross-border hospital admissions.
- Risk management in relation to self-neglect
- Safeguarding responses to allegations of abuse.
- Involvement of friends and informal support networks.

NARRATIVE SUMMARY

Adult Q had a diagnosis of bipolar affective disorder, a serious mental illness characterised by periods of depression and/or mania. Adult Q through the last months of his life demonstrated a number of symptoms of mania, including disinhibition and reckless spending, paranoia, pressure of speech and flight of ideas.

Adult Q had a history of contact with mental health services, including psychiatric hospital admission under the Mental Health Act, in 1999, 2002, and 2010. Adult Q also had a history of contact with Thames Valley police in the context of fears for his personal welfare, but also in relation to money and concerns by Adult Q that he had been a victim of theft.

Between 2008 and 2010 Adult Q lived in supported housing, with access to staff, and a call-bell for emergencies. At this time his money and finances were managed through Appointeeship which ended in 2010 when Adult Q moved into independent living in a bungalow. There followed a period of stability where Adult Q received support from his GP, a twice-a-day package of care, supportive input from his close friend, Ms Y and members of his local Church, Mr C and Mr Attorney. During this time an arrangement was made between Adult Q and the Church who took over the management of his financial affairs through an Ordinary Power of Attorney[4].

Adult Q had periodic contact with adult social care services from 1999 onwards where he received regular reviews of a package of care and occupational therapy input. Adult Q had such reviews in 2013 and 2014, which noted his mental health history but also that he was at that time stable in his mental health – not requiring intervention or input from specialist mental health services. Adult Q's package of care had not been reviewed in 2015.

In August 2015 Adult Q was seen by his GP for a routine 'vulnerable adult review' which allowed the Practice to monitor his general health, review his medication regime, and Hospital Admission Avoidance Plan. Later that month Adult Q was supported to attend his

[4] An Ordinary Power of Attorney allows one or more person, known as an attorney to make financial decisions on behalf of the donor. It is only valid while the donor still has mental capacity to make their own decisions. For the Attorney to be able to make decisions after the donor has lost mental capacity (in relation to financial decisions) the donor would need to make a Lasting Power of Attorney – i.e. a power of attorney that last beyond a loss of mental capacity.

GP practice by his friend, Ms Y, who was concerned that he was mentally unwell. Blood tests were completed at this time, and Adult Q was referred to the Older Adult's Community Mental Health Team. The involvement of the Mental Health Team was brief and following an assessment period Adult Q was discharged back to the GP with the agreement of his friend Ms Y, in October 2015.

On 20th December 2015 Adult Q suffered a fall, and was seen by the ambulance service. Later that day Adult Q used his care line to summon the ambulance service. Adult Q was admitted to his local General Hospital suffering from leg pain and a Urinary Tract Infection. Adult Q was noted to have bilateral leg oedema and concerns of self-neglect were noted, including dehydration and a lack of nutrition.

While in Hospital the Adult Social Services Hospital Discharge Team initiated an increase in his package of care to four visits a day in order to enable and facilitate his discharge home in January 2016. Following his return home his package of care continued at four visits per day. The change to Adult Q's package of care was not evaluated, or 'resized' to meet his level of need, once he was back in his home environment. A comprehensive review had not been carried out since 2014.

On 11th March 2016 a safeguarding referral was received by Buckinghamshire Adult Social Care after Adult Q made an allegation about financial abuse by his close friend Ms Y.

During March 2016 a pattern of behaviours began to emerge, which taken together may have indicated a relapse in his mental illness. As concerns escalated, Adult Q's GP made an urgent referral to the Older Person's Mental Health Team, seeking a Mental Health Act assessment. The Team responded through duty visits by the Older Person's Mental Health Team.

The Older Person's Mental Health Team continued to attempt to support Adult Q through community interventions through duty practitioner visits. Adult Q missed a number of care calls, and despite frequent and persistent attempts by the care provider, mental health team, and adult social care team, limited contact or interventions were possible. Adult Q continued to experience poor mental health, concerns were escalated by the community mental health team for mental health act assessment. On 21st March 2016 an Approved Mental Health Professional (AMHP)[5] who had been allocated to the case was in the process of applying to the Magistrate for a warrant under section 135(1) MHA 1983[6].

Also on 21st March 2016, Police were called and forced entry to Adult Q's home due to a fear for his welfare. They found him on the floor, unable to get up and partially clothed. The Ambulance Service were called and Adult Q was admitted to Hospital. The state of the environment was noted to be "very messy, with rubbish covering the floor space and the bed covered in household items". There was little food in the fridge and rotten food in the kitchen. Concerns were also raised at that point regarding his own personal self-neglect and the lack of compliance to his medication, as his tablets could be seen strewn upon the floor. Adult Q admitted he hadn't eaten or drunk anything for two days.

Adult Q was discharged from Hospital on 29th March 2016. Adult Q was assessed briefly in hospital and then discharged back to his home address. The assessment in hospital does

[5] An Approved Mental Health Professional (AMHP) is a non-medical mental health professional approved under the Mental Health Act 1983 to discharge a number of legal functions, including the making of an application to detain a person to hospital for assessment or treatment of mental disorder – to 'section' them.
[6] A section 135(1) warrant allows a constable to enter, if need be by force, a person's home with a view to removing them to a place of safety for assessment under the Mental Health Act 1983.

not appear to have taken into account the level of concern that professionals had regarding Adult Q's mental health – in his state of relapse, self-neglect and non-compliance with medication, and the significantly deteriorated state of his home environment were serious risks.

During this time the Safeguarding Enquiry had begun into the allegation of financial abuse. The following day a visit by the Mental Health Team and Safeguarding Team concluded the safeguarding enquiry into financial abuse. The visit and enquiry found that no money had been taken, but that there had been a disagreement about how Adult Q's money was being managed.

Between 30th March 2016 and 6th April 2016 Adult Q cancelled or avoided ten care calls and the care agency continued to note concerns about his mental state. Concerns were also raised by Adult Q's informal support network that Adult Q was unwell, and that he was neglecting himself and his home. During this time Adult Q was supported through the duty service of the Older Adults Mental Health Team.

On 6 April Adult Q was found deceased at his home address.

ANALYSIS AGAINST THE TERMS OF REFERENCE

The following findings and recommendations have been produced following methodological analysis of the individual agency management reviews, of conversations with friends and informal support networks of Adult Q, Practitioner Events, and the individual input from workers who knew Adult Q and who worked on his case. The findings in this review have been categorised according to the terms of reference identified above.

TOR 1: The circumstances of Adult Q's death

Adult Q died in his own home in 2016. The cause of Adult Q's death was bronchopneumonia with associated conditions of severe kyphosis secondary to Ankylosing Spondylitis.

It is not possible to identify a direct causal link between any deterioration in mental state and his death. The relapse of his mental health condition may, however, have played a significant part in how Adult Q responded to the offers of support from services and his relationships with both his informal support network and the professionals working with him.

In the six months preceding his death Adult Q had two admissions to hospital. During his first admission, over Christmas and New Year 2015-16, Adult Q was treated for pressure ulcers and an infection. One week before his death, in March 2016, Adult Q was found on the floor at his home address.

As a result of the deterioration in his mental state Adult Q may have begun to avoid care calls, and appears to have become paranoid about his carers and members of his informal support networks – believing that they were taking money from him, moving items around in his home, and creeping around in the house in the middle of the night. On the occasion he was found on the floor, Adult Q stated he was hiding from people who were harassing him (believed to be a reference to the carers visiting to complete their four visits per day). It has been suggested that Adult Q may have also have been scared to press his call alarm when he was in need, because he was worried about being admitted to Hospital or being placed in a [residential or nursing] Home.

While it is not possible to say that the death of Adult Q was predictable or preventable, the circumstances of his death highlighted a number of concerns about the way agencies working together to safeguard Adult Q, including responses to self-neglect and a deterioration in his mental health.

TOR 2: Multi-agency working

Many people with care and support needs will require the input of a number of services in order for their needs to be met. Effective coordination across the Health and Social Care Economy is vital to ensuring that individuals – at the centre, benefit from a real partnership of support around them, including statutory agencies, religious and voluntary groups, friends, family members, and carers.

Government Policy reflected in the Care and Support Guidance, issued under the Care Act 2014, supports the working together of agencies in fulfilling their obligations to adults with care and support needs. Agencies are encouraged to take an integrated or aligned approach to carrying out assessments for individuals and their carers *"in order to better fit around the needs of the individual"*.

Partnership is also a core principle of safeguarding adults, seeking local solutions within a person's community, to safeguard them from abuse, neglect, and self-neglect. The Care and Support Guidance, issued under the Care Act 2014, states:

"Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention." (Department of Health, 2017)

In the case of Adult Q, there was evidence of this approach in the joint visit carried out by the Safeguarding Team and Older Person's Mental Health Team as part of the Safeguarding Enquiry, and assessment of mental health. Changes were also made to Adult Q's package of care following his winter Hospital admission, following the working together of the Hospital and Hospital Discharge Social Services Team. While there is evidence of such bespoke, and time-limited interventions, there is less evidence of a joined up and coordinated approach to the provision of Adult Q's ongoing support. There were a number of areas in which effective coordination and a partnership approach involving Adult Q's informal support network would have been beneficial:

- Response to mental health relapse
- Coordination of the mental health act assessment
- Lack of coordination and cooperation around hospital admissions
- Incorporating the condition of Adult Q's home environment and ability to execute decisions regarding discharge planning arrangements and self-care
- Safeguarding Enquiry
- Response to self-neglect

Managing a deterioration in a person's mental state, especially one of mania requires good coordination of all agencies involved. It is important that agency responses are consistent and proportionate. Each individual, and their insight into their condition is unique.

Adult Q, prior to 2015-16 had experienced a long period of stability with his mental health. He had not required acute specialist intervention or admission to psychiatric hospital since 2010. As Adult Q's mental health deteriorated, there appeared to be a fragmented and one dimensional approach to managing this. Team An example of this is the coordination of a Mental Health Act assessment. Adult Q's GP believed they had made a request for a Mental Health Act assessment. The Mental Health Team responded with a less restrictive option of community support, but did not feed this back, or involve the GP in this. Other interventions, including the oversight of Adult Q's package of care, Safeguarding Enquiry, and management of hospital admissions, were similarly undertaken in relative isolation.

Figure 1, the Relationship Ecomap provides a visual representation of the significant relationships[7] in Adult Q's life:

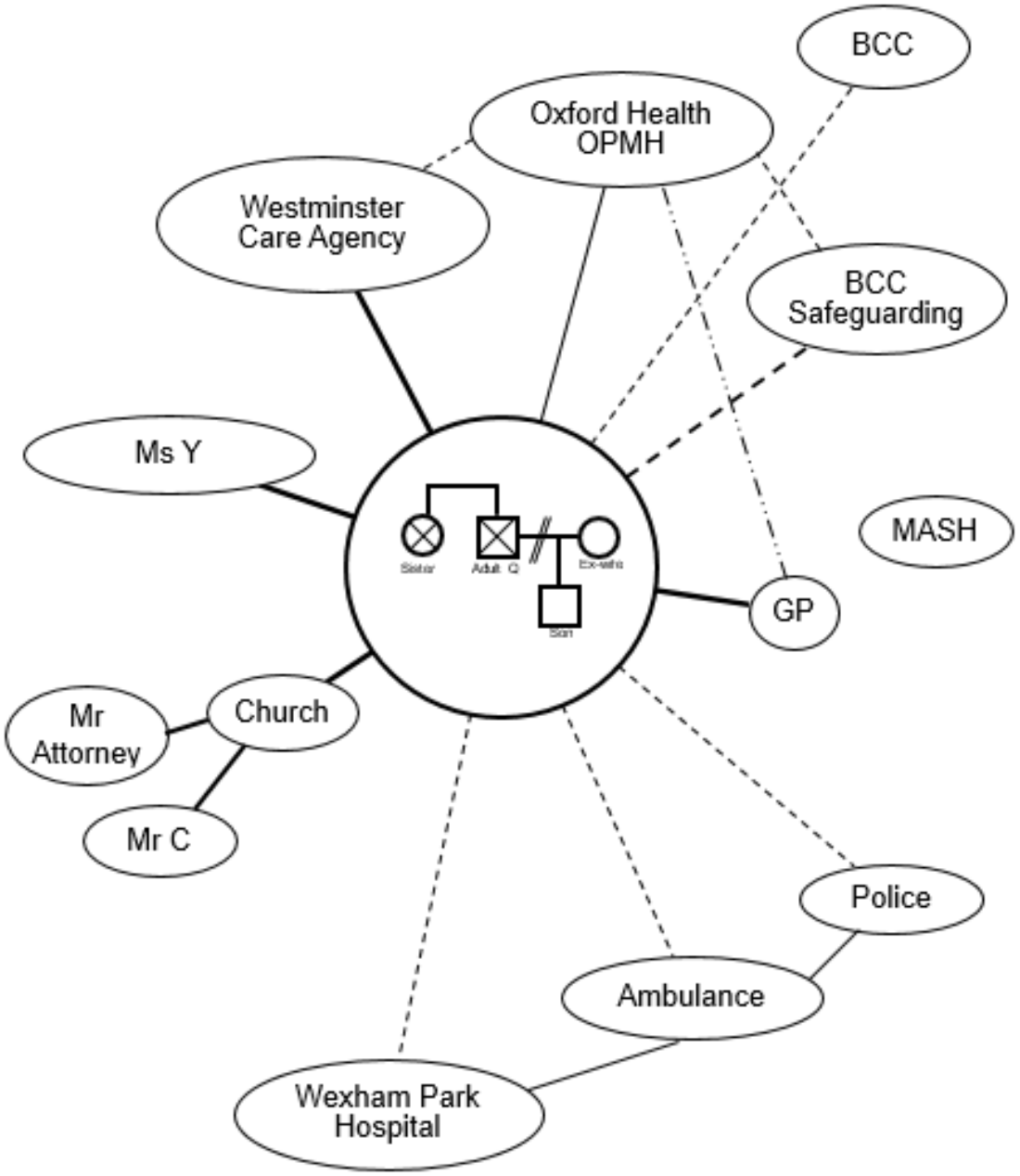

Figure 1: Ecomap, showing significant relationships

Adult Q had a number of significant relationships with individuals who were able to provide him with support. Until the deterioration in his mental states, Adult Q's strongest relationships were with his friend, Ms Y, and friends from Church. Adult Q also saw his GP regularly, and had some good relationships with his paid carers.

Figure 1 demonstrates that more could have been done by statutory agencies to explore with Adult Q his close relationships – who was he close to? Who provided help and support? Who would he like to be involved in his care, and who would he like agencies to contact on

[7] Ecomap, a representation of the key relationships during the time period of the Review. Solid lines represent strong relationships, dashed lines less strong or one-off interventions

his behalf? In this way, agencies working with Adult Q denied themselves the opportunity to make the most of these relationships, not simply as a means of obtaining information about Adult Q's, but also in planning and providing interventions to Adult Q: to support mental health recovery and rapport-based engagement with Adult Q's self-neglecting behaviours.

In Figure 1 there can be seen a number of key but separate interventions and relationships:

- Adult Q's informal support agency, providing care and money management
- Adult Social Care input – through a Safeguarding Enquiry and package of care
- Management of mental health concerns
- Management of physical health concerns, through Hospital admission

It is the finding of this review that the system's response to mental health crises self-neglect and allegation of abuse was fragmented and not joined up. This was also identified in a previous review, which recommended the development of a "multi-agency mechanism to facilitate shared decision-making" (see Terms of Reference 4, below). Since Adult Q's death the Board has piloted and launched a Risk Assessment Management Panel, known as the 'RAMP'.

The Terms of Reference to the Risk Assessment Management Panel, version 5 (revised in 2017) states:

> "RAMP is a multi-agency panel to support practitioners and service users where aspects of an individual's lifestyle are potentially or actually harmful to their wellbeing and aims to be beneficial in the following ways:-
>
> - To consider a variety of options for supporting individuals
> - Improved support for practitioners
> - Identification of risk at an earlier opportunity
> - A proportionate, coordinated, effective and timely response
> - Improved outcomes for the adult with care and support needs
> - Create wider understanding of the nature of care and support needs in Buckinghamshire"
>
> BSAB (2017)

The opportunity to have allocated a named worker to coordinate and 'pull together' the various strands of assessment and intervention, including involvement of informal support networks and friends, was an opportunity missed.

Recommendation: Multi-agency working

Individuals who self-neglect would benefit from the allocation of a named worker, or lead professional, to oversee and coordinate the various different interventions attempted to provide them with support. This would be a key part of any self-neglect pathway. Where individuals are at high risk of self-neglect the Risk Assessment Management Panel (RAMP) process is available to offer professionals multi-agency support, advice and consultation. The Safeguarding Board should continue to promote the work of the RAMP process.

The Board should carry out an evaluation and efficacy review of the RAMP process.

TOR 3: Legislation, policy, and guidance

Care Act 2014

The local authority have a duty to assess and provide services to meet the needs of adults with care and support needs under the Care Act 2014. Adult Q's needs had been well known and had remained stable for a period of years. It is important that local authorities continue to assess, reassess and review the needs of individuals for care and support. Even where a package of care is already in place.

Adult Q's package of care had been reviewed on a number of occasions until 2014. His package of care had been increased following a hospital admission in response to identified risks and in order to facilitate discharge. Historical reviews, or Hospital Discharge Team assessment failed to gain an understanding of the significant role that Adult Q's informal support network played in meeting his needs. This included the practical care and support offered by Ms Y, and the social and financial management support offered by the Church. In fact the Local Authority could have reached a better understanding of these relationships had he received a financial assessment for contribution to his package of care.

When the focus of a review or assessment is on the package of care or agency intervention and provision itself, rather than on the individual, agencies may miss an opportunity to fully understand life from the person's perspective. The winter season and associated 'winter pressures' can place a significant burden on acute hospitals and Hospital Social Care Teams, but it remains important to seek interventions that are person-centred, rather than service-led.

It is apparent from this review that Adult Q relied heavily on the support from his friend and from the informal support network he had built up through his membership of a local church. Adult Q's informal support network and friends provided him with a great deal of support, including support to maintain personal health and hygiene, social interaction trips, holidays and meaningful activity, and attended to his spiritual needs, practical needs and finances through the provision of a power of attorney. Adult Q's informal support network also played an important role in monitoring his health and ensuring his access to medical appointments his GP and social care services when needed.

It has been said that Adult Q responded positively to people, but not to job titles, demonstrating the importance of rapport and relationship in the assessment of and provision of his care and support needs. Adult Q had built up long-lasting and trusting relationships with the informal support of the church and the friends in his life.

Adult Q did not have the opportunity to develop the same level of rapport with the professionals that were involved in his care, this meant that when he was becoming unwell or when he was struggling he would approach informal support networks first and services second. An example of this is in relation to the management of his finances. Following the end of the Appointeeship system that was in place for Adult Q 2008 to 2010, Adult Q, after a time approach the church for help managing with his money. The church appointed an individual from the congregation to act as a power of attorney for Adult Q to monitor his finances, and help make decisions about spending. Adult Q would approach his attorney and ask for money when he wanted to make significant purchases. His Attorney would otherwise release a regular weekly amount into Adult Q's bank account. In this way the church and his attorney carried about an important function in the management of his daily needs.

Adult Q's friend also played a significant role within his life, providing him with a great deal of care and support. There is little evidence that Social Care assessments, or reviews of Adult Q's needs fully understood took into account. There was little documented about the significant role of this informal support network, the opportunity to have captured this information is an opportunity missed. This opportunity missed may have significantly hampered the ability for agencies to accurately assess the level of risk of self-neglect faced by Adult Q.

For a long period of time Adult Q's friend, Ms Y supported him to keep himself clean, to shower and to wash his feet. She ensured that he had adequate clothing, clean sheets, and she spent time washing his clothes and tidying his home. Members of the Church congregation also helped Adult Q to keep his home clean, helping to remove rubbish – something Adult Q was not always happy to allow them to do! Practitioners and friends also fed back that some members of staff of the care agency also worked beyond their hours to help Adult Q, or returned after their shift had finished to check on him. In this way the level of risk of self-neglect was 'hidden' from the view of services.

It is clear that towards the end of his life Adult Q had begun to disengage from formal and informal support, at the same time his mental state was deteriorating, and his physical ability to take care of himself and his environment was compromised by mobility difficulties and a new/tentative diagnosis of Parkinson's Disease (which he had researched and did not agree with!). It is impossible to explain the reason for such a rapid decline in Adult Q's environment or own health, which could be attributed to any of these factors. On balance of probability, however, the risk of self-neglect had been increasing for a significant period of time before it became evident, masked as it was, by the efforts and interventions of his informal support network.

Care and Support Guidance recognises the significant role carers play in *"preventing the needs for care and support for the people they care for"* concluding therefore, that it is important for Local Authorities to prevent carers from developing needs for care and support themselves (Department of Health, 2017). Section 10 (Care Act 2014) places a duty on Local Authorities to assess the support needs of carers. Considering legislative provisions for carers and the people they care for together, a holistic view of Adult Q's needs with his main carers, Ms Y, would have been preventative and protective against the risk of self-neglect, and helpful to the safeguarding enquiry was carried out in 2016. The use of section 10 carers' assessments can both help improve the quality of contingency planning, and reduce the need for contingency plans to be implemented in the first place.

Recommendation: Legislation, Policy, and Guidance

An individual's risk of self-neglect can often be masked by the efforts and interventions of informal carer support. Professionals must seek to assess a person's risk with this in mind, considering ways to prevent risk, and increases in care and support needs through supporting the informal support network, while considering how to protect individuals from increased risks should informal carers be unable to continue to support the individual.

Self-neglect pathways must include as standard expected practice, an evaluation of self-neglect based upon the individual in the context of their relationships, and a formulation of risk should informal support networks be compromised.

The Board should obtain quantitative and qualitative data on needs assessments and carers' assessments to ensure that professionals understand the duties placed on them by the Care Act 2014, and are meeting expected practice standards for holistic working.

Mental Health Act 1983 (as amended 2007)

The Mental Health Act provides a legal framework for detaining people to hospital for assessment and treatment of mental disorder. The Mental Health Act also contains a number of community provisions, allowing certain agencies to intervene in a person's life, or home – such as the powers conferred by a warrant obtained under section 135(1) described above.

Admission to hospital, particularly under section, is not always the most appropriate or proportionate response. Alternative community provisions may be considered such as supporter home monitoring, or changes to medication regimes and intensive support. In the case of Adult Q alternative options were pursued before the AMHP service was contacted and asked to make an assessment for admission to Hospital. The GP, who had raised the original concerns was not involved in the decision-making about attempting community support, and in the end no assessment took place as Adult Q was admitted to Hospital before it could take place.

Recommendation: Legislation, Policy, and Guidance

Organisations and individuals who regularly come into contact with individuals experiencing acute mental health crises, including Health and Social Care professionals, including GPs, Police Officers, Paramedics, and other Emergency Services staff, families and Nearest Relatives should be able to access information on how to make referrals for people to be assessed under the Mental Health Act. Referral pathways should be clear, consistent, and easy to understand and to navigate. When a referral is received for urgent or crisis mental health assessment, the referrer should be informed of the outcome, including whether an assessment will take place, or alternative interventions are to be offered.

1. **Relevant agencies should publish and disseminate to potential referrers clear information about the options available to individuals experiencing a deterioration in their mental health, and the difference between a mental health assessment and a Mental Health Act assessment.**
2. **Agencies responding to referrals about individuals experiencing a deterioration in their mental health, should ensure that appropriate feedback is offered including, where appropriate[8], the planned intervention and role the referrer could play in supporting the individual.**

Mental Capacity Act 2005

The Mental Capacity Act 2005 applies to everyone, paid and unpaid who work or support individuals who may be suffering from impairments or disturbances in the function of their mind or brain that compromise their ability to make decisions. When working with individuals who may have such an impairment, professionals are required not only to take as their starting point the assumption that the person is able to make decisions for themselves, but also to support them to make the decision, and recognise that unwise decisions do not in themselves demonstrate a lack of mental capacity. It is the ability to make a decision that is being assessed – not the decision itself. When working with individuals suffering from mental health problems who are at risk of self-neglect, the assessment of a person's capacity to make decisions about care arrangements and interventions is a crucial.

[8] Appropriate – i.e. subject to good information governance.

The Mental Capacity Act applies to all decisions that are within the power of the individual to make. The Mental Capacity Act does not prevent Local Authorities and Health organisations from making their own decisions about the interventions that they offer, or the manner in which they will be provided. Rather, when a person has been assessed to lack capacity in relation to a particular decision, the Mental Capacity Act sets out the process for ensuring that the individual's part of the decision-making process is undertaken subject to certain considerations – the Best Interests checklist. Case law suggests that *"the purpose of the best interests test is to consider matters from the person's point of view"* (Aintree University NHS Hospitals Trust v James, 2013). The Mental Capacity Act and Code of Practice notably includes encouraging the person to participation and consulting others who have an interest in the person's care as part of the best interests test.

Working with individuals who self-neglect requires agencies to enter in to a collaborative, relationship-based intervention, using negotiation and compromise to agree with individuals the level of intervention that they will accept. Working with individuals who self-neglect can therefore be a balance between respecting a person's autonomy and right to make unwise decisions (for example to refuse care services) and to live their life is they choose, with a wider public interest, the concerns of family, friends and informal support networks, and a duty of care owed to the individual to work together effectively to safeguard them.

It has been said that mental capacity is not an off switch for rights and freedoms[9], neither allowing services to intervene and ride roughshod over the views and wishes of individuals who lack capacity; nor acting as a justification for agency's non-intervention.

Mental capacity is both time and decision specific, and also for some individuals subject to fluctuation. Principal two of the Mental Capacity Act (S.1 (3) MCA 2005) requires professionals to take all practicable steps to support an individual to make decisions before they can consider that individual to lack capacity. This principle applies to both immediate and short-term decision-making, but also to medium and long-term decisions around lifestyle choices and the relationship with statutory services. The second principal not only requires agencies to attempt to support individuals to make ad hoc decisions, but also to work with individuals to support them to improve their decision-making ability long-term.

Within the context of health and social care, individuals have the fundamental right to make decisions about what happens to them (United Nations, 2006). The principles of valid consent within the provision of health care is are upon the rights of service users and patients to agree to proposed interventions or to say 'No'. Removing from a person the ability to make their own decision, either through compulsory legal powers (such as the Mental Health Act 1983) or through 'best interests' processes under the Mental Capacity Act places that agency in a position of great power over the individual.

In this respect decision-making agencies and those who assess capacity and implement 'best interests' carry a significant responsibility for the individual. They should therefore act with due care and attention to ensure that individuals who lack capacity are afforded all the necessary safeguards and rights accorded them through the Mental Capacity Act 2005.

In the case of Adult Q there were limited attempts to assess his ability to make decisions, despite the deterioration in his mental health condition, and history of dependence on others to make decisions for him, and support him, in particular in regard to his finances – Adult Q had previously been on Appointeeship and latterly made a Power of Attorney. Adult Q's ability to make other decisions could also be questioned, including decisions about his care

[9] *Wye Valley NHS Trust v Mr B* (2015) EWCOP 60

and treatment, self-neglect behaviours, and about his arrangements for independent living, including discharge arrangements from hospital. Adult Q's informal support network were also conspicuously missing from the mental capacity assessment and best interests decision-making processes. The consequences for the operation of his Ordinary Power of Attorney for finances could have been significant, had Adult Q lost capacity the power of attorney would have ceased to be valid and alternative arrangements made, most likely through the powers of the Court of Protection.

As Adult Q's mental health deteriorated his ability to make decisions and his mental capacity would have been likely to fluctuate and become increasingly variable. Where assessments of Adult Q's capacity were carried out, they were typically brief – at least in their recording, and appear to have failed to consider all relevant information. For example, in relation to decisions about independent living decisions, and discharge from hospital, views of his capacity varied and appeared to focus on the immediate "should Adult Q be allowed to return home". In one assessment, Adult Q is able to make his views known, but discharge is considered unsafe and discharge is prevented – in this instance capacity appears to have been used to override Adult Q's wishes. Later in his admission, once medically fit for discharge, Adult Q is assessed as having capacity to make the decision about self-discharge, and his discharge from hospital is facilitated. Decisions about whether a person has or lacks capacity should be person-centred and thorough, and should not be made simply to support a course of action that the agency wants to follow.

Recommendation: Legislation, Policy, and Guidance

Adult Q's decisional and executive capacity was certainly impaired in some areas. Adult Q's held unrealistic and arguably grandiose beliefs about his ability to look after himself. Adult Q's deterioration in mental state and behaviours of self-neglect were relevant to assessments of his capacity to make associated decisions. Fluctuations in his mental state and possible experience of a manic episode could have called into question his ability to make decisions about his finances, about living arrangements, and about his ability to self-care.

The Board needs to assure itself that the level of expertise and knowledge of staff across health and social care in relation to assessing capacity and carrying out best interests' decision-making is sufficient, and take any action to remedy skills and knowledge deficits

TOR 4: Learning from previous case reviews

In January 2015 the Buckinghamshire Safeguarding Adults Board published the findings from a Thematic Review into Self-Neglect and Partnership Review (Pearce & Scrafton, 2015). The review used the experiences and expertise of partner agencies, information from families, and academic literature on the subject of self-neglect.

A number of themes were identified through literature, other Case Reviews that appeared in the local reviews. These included:

- Lack of a clear position statement regarding self-neglect within Buckinghamshire allowing the issue to become diluted and confusion around 'eligibility'
- Lack of definitions, tools and inconsistent thresholds for intervention
- No specific training about this very complex area of risk resulting in a lack of theoretical understanding
- No clear pathways from referral to intervention
- Clear gaps in knowledge and understanding of the relevant legal framework meaning opportunities for intervention may be missed
- No agreed model of assessment for assessing self-neglect across stakeholder agencies
- No standardised toolkit for assessment of self-neglect, which is theory based and articulates relevant risk indicators
- Lack of timely and dynamic assessment both of self-neglect and Mental Capacity
- Not always a clear and timely identification of a lead professional to coordinate the response from the point of referral – consideration of 'who is likely to succeed'?

The Review made a number of recommendations across five key areas:

- Policy: Development of a clearer policy framework and 'position statement' on self-neglect
- Knowledge and skills: Development of the knowledge base in relation to self-neglect, executive and situational capacity, and revision of training materials used in the 'Mental Capacity Act Awareness'.
- Skilled intervention: Nominated trained practitioners, time, and resource to enable holistic work – outside performance driven areas of practice.
- Operational Guidance and toolkits: Assessment tools, risk assessment and guidance for staff including a clear definition.
- Multi-Agency Approach: Identification of a Lead Professional, agreed support plan, subject to facilitation and monitoring of a "multi-agency mechanism to facilitate shared decision making"

The current version of the Safeguarding Adults Multi-Agency Policy and Procedures was published in May 2016 – after the death of Adult Q. The current Policy and Procedures are hosted on the website and provided online for individuals to access and navigate. A number of toolkits are also available to download from the website.

The Board has also piloted, reviewed and re-launched the Risk Assessment Management Panel in July 2017. The Risk Assessment Management Panel "aims to support practitioners and service users in circumstances where engagement and risk management are challenging."

Many of the findings and recommendations of the previous reviews were implemented after the death of Adult Q so a true picture of the impact of learning from previous cases can only be evaluated following a further audit of policy effectiveness and practice culture.

At this stage, and in carrying out this review, it is apparent that Practitioners remain unaware of the toolkits available, or unsure as to when they should be used. It is not clear how teams and practitioners are using the new policy. Due to the level of detail in the policy, and the reference nature of its format and function, it may take time for practitioners to become accustomed to its layout, the location of the information they require, and to use the policy to its greatest potential.

Publication of the report and implementation of actions occurred in close proximity to the death of Adult Q, and some actions from previous reviews have been implemented since. It is therefore not possible to fully evaluate how learning from previous related case reviews impacted on the care provided to Adult Q.

It is the suggestion of this Review that the impact of learning captured in previous case reviews is evaluated and monitored by the Board alongside the learning from current reviews.

TOR 5: Information sharing, communication, and the coordination of care

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me." (Department of Health, 2017)

Service users must be at the heart of any information sharing decision. It is important conversations are held with service users, not just about confidentiality and the storage of their data, or indeed the need on occasion to share information with other agencies; but to reassure service users that the purpose of information sharing and multiagency communication can be to enable better decisions to be made based upon better information.

Communication between agencies and especially with service users is important way of ensuring that everybody involved in supporting an individual has a consistent and shared understanding of their needs, risks and the purposes of proposed interventions. Recruiting the service user into information sharing decisions, including agreement about what is relevant and need to know information to be shared is an important part of the client-agency therapeutic alliance.

Openness and transparency and genuine service user involvement is a vital part of establishing and maintaining the trust, in respect of how the multiagency partnership functions, interacts, and works with them. This is especially important where people may have a distrust of services, be reluctant to work with all agencies and fearful of outcomes, or where individuals may be suffering from mental health problems such as paranoia and guardedness.

Service users and professional agencies involved in providing care should be a part of all relevant information sharing decisions and processes. It is also important that informal support networks, friends and carers are invited to be a partner in the identification of need, and the management of risk. Information sharing and communication is not just about agencies or service users sharing information between each other, but also about listening to the views and opinions of families, carers and informal support networks and recognising that stronger the rapport and relationship, the better the potential for good communication, honest disclosure, and relevant sharing from service users.

Data protection and the management sensitive and privileged information is a legal duty owed to individuals, underpinned by the individual's right to privacy and family life[10]. It should not be, however, a barrier to information sharing where this is necessary in order for agencies to carry out their statutory functions or protect individuals at risk. Where individuals are unable to make decisions about what information is to be shared and with whom, this should be managed through the capacity act process as described above.

In the case of Adult Q, information sharing and communication was at times significant issue. Figure 2, the communication eco-map is based upon the time period covered by this review, in which examples of significant communication channels are shown – it is not intended to cover *all* communication, to prevent over-complication of the diagram.

[10] Article 8, European Convention on Human Rights, codified in the UK through the Human Rights Act 1998.

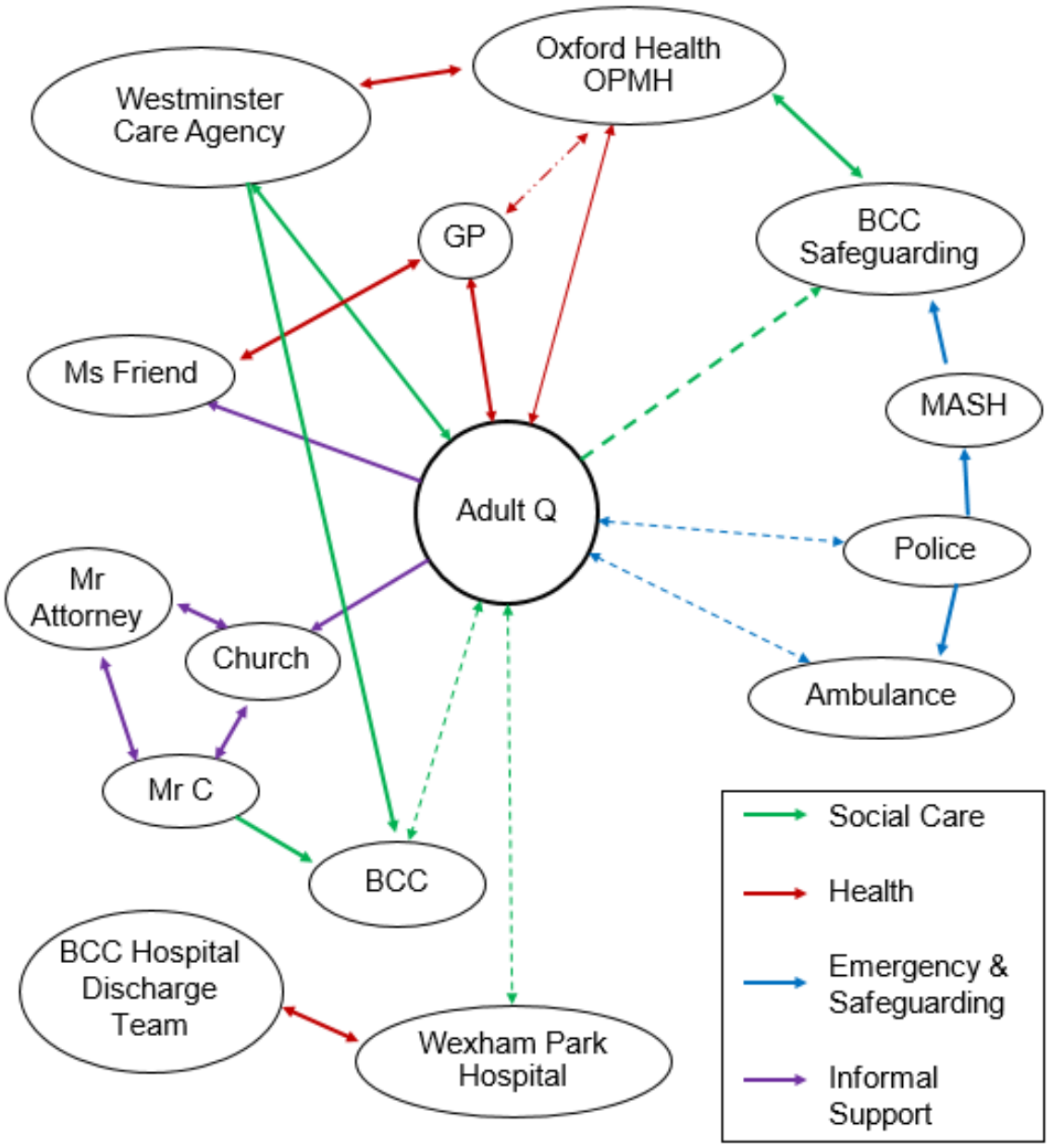

Figure 2: Communication Ecomap, showing examples of significant communication

The communication eco-map shows how information was held by a number of different sources, but not equally shared across the partnership. There are clear enclaves of multi-agency or multi-care communication. Overall, figure 2 demonstrates patchy information sharing, and a scattergun approach to communication. This increases the risk of poor coordination of services, and important clinical decisions being made in isolation of partial information. As can be seen from the communication eco-map there was no single professional or agency, who was able to act as a conduit for information – no one agency could see the whole picture. Neither Adult Q himself, nor his friends were provided with a single point of contact when they wish to raise concerns about Adult Q's self-neglect. An example of this is that Mr C, Adult Q's church friend, would tend to raise concerns contact social services directly, while Ms Y communicated predominantly with Adult Q's GP.

For information sharing and communication to be effective there needs to be a shared understanding and clarity in the language used and the way information is shared. For example there appears to have been some confusion about the difference between a request for mental health assessment, and Mental Health Act assessment. Adult Q's GP

believed that they had requested a Mental Health Act assessment from mental health services. The mental health team believed they were being asked to carry out a mental health assessment.

As described above, assessment under the Mental Health Act may not have in fact been necessary at this stage, but liaison with the GP to this effect could have enhanced the team's ability to engage Adult Q – even via GP Practice-based interventions. Figure 1, the relationship ecomap shows that Adult Q self-presented and worked well with his GP Surgery. This review has also found that Adult Q was not involved fully in key clinical decisions made about his care. One historical example of this was in respect of discharge from Mental Health Services, Adult Q's opinion was sought, but it is not clear how much further he was involved rather than being informed of decisions that have been made. The discharge from specialist services was in the end *"agreed by Ms Y"*.

Perhaps the strongest example of the failure of agencies to work together to communicate together and to share information together is in regard to Adult Q's second admission to hospital in March 2016, one week before he died. During this time in Adult Q's life a number of processes had begun:

- A request for a Mental Health Act assessment – by now by the GP and Mental Health Team, amid serious professional concerns around his deterioration in mental state
- A safeguarding enquiry had been launched under section 42, into allegations around financial abuse
- Adult Q was admitted to hospital having been found on the floor, either hiding from services or having fallen and unable to get up.

Information sharing did occur, in pockets. The acute hospital Trust and Adult Social Care Hospital Discharge Team communicated around discharge arrangements, the County Council Safeguarding Adults Team and Older Person's Mental Health Team conducted a joint home visit in order to complete the enquiry and to monitor his mental health, and the Hospital informed Adult Q's close friend Ms Y of the focus of the safeguarding enquiry – that she was under investigation for financial abuse.

Problematically these different processes were not brought together to provide one consistent picture of events at that time. Of note was also the omission of the acute hospital to share the discharge summary with all agencies, including Adult Q's GP. This meant that as individual agencies were making decisions about their own interventions, some were unaware that Adult Q had been in hospital at all, or that the Mental Health Act assessment had been stood down following an assessment of his mental state by a Psychiatrist at the Psychiatric Liaison Team at the Hospital.

Recommendation: Information sharing, communication, and the coordination of care

Communication between agencies and especially with service users is important way of ensuring that everybody involved in supporting an individual has a consistent and shared understanding of their needs, risks and the purposes of proposed interventions. When a number of agencies and individuals are involved in supporting a person with multiple needs, and service-involvements, the risk of communication 'enclaves' increases.

The Board should consider the role of Lead Professional / Communicator in the context of multi-agency self-neglect interventions and how the identification of a lead professional may be able to act as a conduit of information to facilitate multi-agency decision-making.

TOR 6: Physical and mental health conditions.

Since 1991 mental health services in England for many service users have been delivered through the Care Programme Approach (CPA)[11] – a form of case management designed to improve the experience of care in the community for people with serious mental illness. The Care Programme Approach was for a long time separated into two levels: Standard, and Enhanced. Following the publication of Department of Health guidance, Refocusing the Care Programme Approach, service users may or may not have received their mental health services through the Care Programme Approach (Department of Health, 2008) at all. The decision about whether to use the CPA to support service delivery was based upon a number of factors including level of need, complexity, the number of agencies involved, and the level of risk of harm identified to, or from the person. Even where individuals do not meet the criteria for care under the CPA, the principles of the CPA can still be applied to the manner in which multi-agency care is assessed, provided, and monitored.

There has been a recognised policy shift away from long-term case holding of individuals with long-term serious mental health conditions by secondary mental health services. Individuals with long-term mental health needs are 'clustered' to either primary care services, or secondary services according to their individual needs.

In relation to his mental health needs Adult Q had enjoyed a long period of stability without the interventions of specialist services or the need for acute admission to psychiatric hospital. He had therefore been discharged from Mental Health Services back to his GP. This meant that he was no longer in receipt of coordinated care under the Care Programme Approach (CPA) – an arrangement that had it been in place, would have seen a named worker overseeing the interventions of the various agencies who were working with him. Adult Q did, however, maintain regular contact with his GP who provided oversight and management of his physical and mental health needs, including community nursing interventions and prescription of medications for physical health and mental health conditions.

Adult Q's deterioration in mental state was recognised in March 2016. The GP, based upon reports of Adult Q's friends and paid carers, and a direct assessment of their own, made a referral asking for an assessment of Adult Q under the Mental Health Act. In response, the mental health team deployed duty psychiatric nurses and social workers from within their team to assess and monitor Adult Q's mental health mental state. Further assessments were made and monitoring arrangements put in place to assess for signs of relapse and the need for psychiatric hospital admission.
As a result of his previous period of stability (and discharge from mental health services) Adult Q was not well-known to mental health professionals, making it more difficult for them to identify the subtle signs and symptoms of his relapse. More importantly the mental health team were not well-known to Adult Q. Mental Health practitioners were required to develop a therapeutic rapport afresh during a time in which Adult Q had become wary of services, guarded and suspicious. In particular it is known that Adult Q was fearful of services as he was worried he would end up placed within a nursing home or hospital.

One of the areas of current mental health practice that could support the move towards longer term independence for individuals with chronic conditions, is the use of the recovery model. This approach enables service users to identify when they are beginning to suffer a

[11] The Care Programme Approach (CPA) is a framework for the delivery of mental health care for those with the highest level of needs and who are the most at risk. The Care Programme Approach sets out how service users are assessed, and services planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs

relapse in their condition, and to have been supported to pre-plan the interventions needed (and preferred) to restore them to good mental health. There is no evidence in the case of Adult Q that the recovery model was used, or that a recovery focused crisis plan had been completed. Such a plan, devised by Adult Q himself, would have given all agencies a shared understanding about the signs and symptoms of relapse, and the actions that should be taken in order to address this. A well-formulated recovery based crisis plan could also have confirmed to agencies who within Adult Q's informal support network should be involved and consulted, if and when Adult Q suffered a deterioration in their mental state.

As Adult Q began to deteriorate physically and mentally professionals required to undertake snapshot assessments of an individual who they did not know. It is vital in these circumstances that professionals are able to validate and confirm the findings of their assessment, and test out the reassurances given by individuals about their ability. In the case of Adult Q there appears to be a failure in the "tell me, show me" approach to assessment, whereby individuals asked about their ability to carry out certain tasks, and then encouraged to demonstrate their ability to carry out those tasks. There was a criticism among Adult Q's informal support network that professionals were too quick to take Adult Q at his word, naïvely assuming that he had the executive capacity to carry out at actions and tasks that he believed he could complete. When Professionals are assessing an individual who is less-known to them, they should adopt a "tell me, show me" approach to ensure they understand the ability of service users to adequately carry out necessary health and social care tasks. Organisations should consider how to encourage assessors to adopt this approach – through training, the configuration of assessment forms, and through practice guidance.

Recommendation: Physical and Mental Health conditions

The needs of individuals with chronic long-term conditions must be recognised by agencies providing specialist mental health care. Services should adopt a recovery-focused approach so that when individuals are discharged from services, they are aware of their relapse signatures and planned interventions, including re-referral pathways.

The Board should consider how a recovery-focused approach to mental health service treatment and support could be used to ensure that service users with long-term conditions who are discharged from services have a complete discharge plan including a summary of relapse indicators, a crisis and contingency plan, and information on re-referral pathways.

ADDITIONAL LINES OF ENQUIRY

Cross-border hospital admissions

Due to the location of Adult Q's address, his local admitting hospital in an emergency was a hospital outside the county of Buckinghamshire. The review was asked to consider whether the location of the hospital, and cross-border arrangements, may have impacted on the multi-agency care that Adult Q received.

As part of this review individual agencies were asked to undertake their own Individual Management Review to consider their own learning from the case. The quality of the Individual Management Reviews (IMRs) varied considerably in terms of format, detail, and evidence of critical analysis and learning by the Agencies involved. The Individual Management Review that could have shed the most light on the issue of cross-border hospital admissions, reflected that there was a limited evidence base upon which to draw generalised learning for the Multi-Agency system, or that the evidence base was not reflected in the IMR itself.

Recommendation: Individual Management Reviews
The quality of the Individual Management Reviews (IMRs) varied considerably in terms of format, detail, and evidence of critical analysis and learning by the Agencies involved. Buckinghamshire Safeguarding Adults Boards provide training and guidance on the completion of IMRs and would offer additional support to Authors where needed. Where agency IMRs struggled to deliver adequate information, evidence, or analysis, the relevant Quality Assurance process should be initiated to ensure that future submissions are of an adequate standard.

The Board should consider, in future Reviews, a pre-IMR briefing so that IMR Authors are aware of the methodology being proposed by the Independent Author, and can be reminded of what is expected of the Organisational involvement and IMR analysis.

In the case of Adult Q, his admission to an acute hospital outside Buckinghamshire did have an impact on the information available to assessing clinicians in the acute sector. Acute Hospitals often rely on specialist assessments when individuals are admitted with particular health concerns. In Adult Q's case he received specialist assessments from Physiotherapy, Occupational Therapy, and from the Psychiatric Liaison Service provided by different Mental Health Trust to assessments in Buckinghamshire.

Had Adult Q been admitted to an Acute Hospital within the Buckinghamshire County boundary, this service would have been provided by Oxford Health NHS Foundation Trust – the NHS Trust who knew him, and his psychiatric history. While the assessment itself appears to have been thorough, the assessing clinician would not have been able to access up-to-date information about his recent psychiatric history, including his deterioration, apparent mental health crisis, and referral for assessment under the Mental Health Act 1983.

Of concern, information about his admission, which was contained in discharge summaries and letters which were shared separately by the Acute Hospital Trust and Mental Health Trust. In the case of the Acute Hospital Discharge Summary, this was not shared with his GP Practice until after his death. The lack of contemporaneous information available to the Psychiatric Liaison Team at the Acute Hospital, the lack of evidence of coordination of different specialities within the hospital, combined with the poor communication outside of the hospital highlights a risk in the multi-agency system when individuals in crisis are

admitted to hospitals outside the coverage of their specialist health care provider – in this case the Older Adults Mental Health Team in Buckinghamshire.

Recommendation: Cross-border hospital admissions
Without access to Adult Q's electronic patient record, a crucial assessment of Adult Q's mental state and need for psychiatric admission was carried out without the benefit of significant collateral information about his social circumstances, relapse profile, and information about current treatment plans – including concordance professional interventions, care, and medication. Poor coordination, and poor communication post-discharge failed to equip local services to respond to issues raised by the acute admission.

Serious thought should be given to how specialist liaison services in acute hospitals outside Buckinghamshire access systems, or information held on systems, of local specialist services. This could be achieved through direct access to the electronic patient record, via communication between NHS provider Trusts, or brokered through the Acute Hospital, collating the history and collateral information.

Risk management in relation to self-neglect

The Buckinghamshire Multi-Agency Policy[12] and procedures includes the Care Act 2014 concept of self-neglect, which states that:

> *"This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support."* (Department of Health, 2017)

The policy recommends that the following aspects of are considered broadly as self-neglect:

- A lack of care for self to an extent it threatens personal health & safety
- Neglecting to care for personal hygiene, health or surroundings
- An inability to avoid harm to self
- A failure to seek help or access services to meet health or social care needs
- An inability or unwillingness to manage personal affairs

In the month before his death Adult Q began to significantly neglect his environment and his own self-care. In December 2015 signs of self-neglect had been noted. Historically, self-neglect was a known sign of relapse of his mental health condition, bipolar affective disorder.

In the weeks before his death Adult Q began to neglect himself in the following ways:

- Missed care calls and avoidance of contact with agencies
- Refusal of care
- Reduction in appetite, eating and drinking
- Non-concordance with prescribed medication

[12] The Policy can be found on the Safeguarding Adults Board website at: http://www.buckinghamshirepartnership.co.uk/media/4110337/J2678-BSAB-interactive-PDF_Update_FINAL.pdf

Prior to his death Adult Q was also known to have neglected his environment. This included hoarding and clutter, failing to throw away gone off food, and a number of behaviours that may have been linked his mental state. Adult Q may have pulled out some wiring to prevent telephone calls, and had various plans in the garden, including placing an electric fence around his fishpond to prevent cats from stealing his fish. Adult Q had purchased insects to feed reptiles he planned to buy, and it was noted that he also failed to take proper care of his pet bird, leading to possible environmental risks and infection.

Despite the identification of self-neglect, as early as December 2015, no specifically targeted interventions were attempted. Agencies would have been able to effectively deploy significant time to holistically support Adult Q through his period of self-neglecting through his package of care, friend Ms Y, and the Church, Mental Health professionals and local GP practice had this been coordinated.

Practice Suggestion: The Self-neglect Pathway

Professionals, having identified that Adult Q was at risk of self-neglect were unable to access a clear self-neglect pathway that would have ensured that Adult Q and his informal network benefitted from key practice interventions. The implementation of previous review recommendations may have addressed some of the practice deficits noted in this review, however it is suggested that the Partnership adopts a "Self-Neglect Pathway". The pathway would specify a number of actions and interventions that must be completed (for example the nomination of a lead professional, assessments of mental capacity, and use of the toolkits, risk assessments, and clutter tool. Individual cases could enter and exit the pathway, based upon multi-agency agreement or safeguarding procedures, and through completion of entry and exit checklists. Importantly, the Board could consider the use of Safeguarding Procedures, the Multi-Agency Safeguarding Hub (MASH), or Risk Assessment Management Panel (RAMP) to trigger the Pathway, ensuring the oversight and involvement of self-neglect trained practitioners and robust management oversight. This would ensure that individuals who are at risk of self-neglect receive evidence-based self-neglect interventions.

Safeguarding responses to allegations of abuse.

Section 42 (Care Act 2014) applies whenever a Local Authority has reasonable cause to suspect that an adult with care and support needs in its area may be suffering or at risk of abuse, harm, or neglect – including self-neglect. Section 42 places a duty on Local Authorities to make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any actions should be taken. Legislation and Statutory Guidance encourages Local Authorities to think broadly when considering actions resulting from a Safeguarding Enquiry – considering the provision of care and support, preventative services, and information and advice (Department of Health, 2017).

The safeguarding enquiry into the allegation of financial abuse took great care to establish Adult Q's views and wishes. The enquiry, however, failed to fully incorporate risks and issues regarding self-neglect or the priority of addressing the home environment, and his mental health relapse. There was good practice attempted within this investigation, such as a joint visit with the mental health team, however the focus of the visit appears too narrowly focused on the risk of financial abuse, rather than holistically considering changes in Adult Q's care and support needs, or re-defining the enquiry around the risk of self-neglect.

It was not necessarily the responsibility of the specialist safeguarding worker to make a reassessment of care and support needs or to review the existing package of care, however, the safeguarding policy and procedures may have provided an opportunity for the various different strands of assessment and investigation to be pulled together in a holistic and coordinated way.

Adult Q's mental illness may, and appear to have, contributed to both self-neglect and allegations against his friend. It is vital that all allegations of abuse are taken seriously and investigated thoroughly. However this should not be done in isolation and safeguarding processes need to be able to accommodate concurrent concerns and issues such as mental health relapse and other forms of 'abuse' such as an individual's neglect of themselves and their environment.

The Safeguarding Enquiry offered to Adult Q lacked robust management oversight, a clear understanding of the range of safeguarding activity beyond narrowly drafted terms of reference. The manner in which the Enquiry was conducted also demonstrated the lack of an evidenced-based investigation methodology and process that could have enabled key actions to be taken, and supported the Safeguarding Practitioner to carry out a well-constructed investigation into allegations of abuse.

By the time the Safeguarding Enquiry was launched into the allegation of financial abuse against Ms Y, agencies had already missed an opportunity to evaluate the level of support provided by Ms Y, and therefore the impact on Adult Q's health and safety should this support be removed. The narrow focus of the enquiry and lack of clarity about who should address Adult Q's social care needs, left him without a holistic response to the issues facing him. As a result of the Safeguarding enquiry, Ms Y withdrew her support for Adult Q – she was worried about how continued contact would be viewed, worried about getting into trouble, and worried about being accused of having done something untoward. Communication with alleged perpetrators should be carefully thought out so as to protect individuals from potential continued abuse, avoid the contamination of investigations or evidence, but also to ensure that perpetrators, until allegations are substantiated, are also offered appropriate support. When alleged perpetrators are also providing significant support to individuals, the impact on the individual or a loss of their support must be considered.

Recommendation: Safeguarding responses to allegations of abuse

The Local Authority, through Safeguarding Enquiries should consider the broad range of actions within their power – including the facilitation of assessment or review of a person's care and support needs. Local Authority led enquiries should benefit from robust management oversight and investigators should benefit from supervision, training, and a clear policy framework. The Safeguarding policy and methodology should support good practice in working with alleged perpetrators. Where alleged perpetrators are significant carers and mitigating support plan should be formulated to ensure that individuals do not suffer as a result of a reduction in their support.

The Board should ensure that the Local Authority and other organisations who may be 'caused' to carry out a Safeguarding Enquiry, have access to an evidence-based investigation methodology that encourages adherence to expected enquiry practice standards.

Involvement of friends and informal support networks.

In the early 1990s implementation of the NHS and Community Care Act 1990 signalled a whole-policy shift from institutional care towards care in the community. Community care sought to enable adults to remain independent for as long as possible, and to live in their own homes with the support, including support from family members, communities, friends and informal support networks. It was hoped that a thriving local community sector would enable people to live fulfilling lives outside of long stay institutions, or formal care arrangements, and this approach has continued to the present day.

The Care and Support Guidance (2017) identifies 'partnership' as one of the principles of safeguarding. In this context partnership refers to *"local solutions through services working with their communities"*. Throughout the care act and its statutory guidance agencies are encouraged to put into targeted interventions to identify carers and support them to develop knowledge and skills to care effectively (Department of Health, 2017). One of the key changes brought about by the care act as a strengthening of duties towards carers, from application of the wellbeing principle to carers, to assessments of a carer's needs in their own right.

Adult Q had a number of close relationships within his local community, he had a particularly close friend, Ms Y, and support from his local Church – both through social groups, and support of a Power of Attorney for his finances and money management. The issue of informal support involvement is reflected throughout the analysis and findings in this report, and this was a key failing in the multi-agency system – to identify Adult Q's informal carers, and to recognise and involve them as a partner in his care.

Recommendation: Involvement of friends and informal support networks

Organisations providing care and support should, as a matter of routine, seek to identify informal carers and the level of support that individuals may be receiving from them. The Local Authority should take its responsibility towards carers seriously, ensuring that the multi-agency partnership know how to make referrals for carers' assessments. Information on support for carers should be widely available to members of the public, and local community organisations providing support should be supported to publicise information, and support informal carers to access assessments and support available to them.

The Monitoring and Evaluation Committee should consider making 'Carers' a theme for audit work and evaluation of practice across the system. This should include but not be limited to how carers are identified, carers' assessments offered, and carers' services provided.

FURTHER STEPS AND ACTION PLANS

The Review has sought to undertake a systematic review and critical analysis of practice throughout the case of Adult Q. Findings and recommendations have focused on practice concerns that shine a light of wider system-learning – moving from the specifics of the case of Adult Q to the generalities of the Multi-Agency Safeguarding system in Buckinghamshire.

The LSAB is encouraged to use these as the foundations of a multi-agency action plan. There will be a number of potential solutions or actions that may address the recommendations and learning, and these should be considered across all intervention domains. Specific actions may include the need for communications, amendments to, or creation of, policy and guidance, or may have a training element.

In the course of this review agencies have been encouraged to identify their own 'single-agency' learning and actions, and these re re-produced in Appendix 1. Where significant *single-agency* failures or learning has been identified, that didn't appear to generalise to the wider system, these have been flagged to the relevant organisation for follow up through the appropriate governance and quality assurance processes. This means that the learning for organisations goes beyond the multi-agency system, to individual practitioners and organisations who were involved in providing care to Adult Q.

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TABLE OF CASES

Aintree University NHS Hospitals Trust v James (2013) UKSC 67.

Wye Valley NHS Trust v Mr B (2015) EWCOP 60.

APPENDIX 1: ORGANISATIONAL LEARNING FROM IMRS

CCG

- Communication regarding the mental health act assessment
- Safeguarding not considered in regards to self-neglect.
- What was the information governance status of the friend with their consent to share what is the guidance around involvement of informal support networks?
- An opportunity was missed from mental health act assessment be carried out in hospital too much emphasis was placed on single assessment by a junior doctor within the hospital environment.

Oxford health NHS

- The care plan and risk assessment they needed to be reviewed and that needed to be an update in training.
- Safeguarding recording needs to be clearer.
- There needs to be evidence of mental capacity assessments and best interests decision-making.

Bucks County Council, Adult Social Care.

- There is no follow-up following his discharge from hospital.
- No record of the mental capacity assessment having been completed, this needs to be more routine.

Bucks County Council safeguarding.

- A safeguarding enquiry did not address concerns with respect to self-neglect.
- There was an incomplete mental capacity assessment. Further training needed.
- Communication within the hospital and between the hospital and other agencies needs more work in particular, with regards to safeguarding lead at the hospital clinical commissioning group and multiagency safeguarding hub.
- There needs to be more joint working and work with care management in relation to safeguarding referrals safeguarding referral took a narrow view, this is the theme

Frimley Health NHS Foundation Trust

- The IMR failed to identify any opportunities for organisational learning
- No actions identified

Westminster care agency.

- No learning identified