Safeguarding Adults Review Report

William
Deceased 30 December 2016
Aged 82

Robert Lake
Independent Author

Section 1: Introduction

a) The Legal Framework

Section 44 of the Care Act 2014 places a statutory duty on Local Safeguarding Adults Boards (SAB) to undertake a safeguarding adult review (SAR) in certain circumstances as set out below:

(i) 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.

(ii) Condition 1 is met if:

(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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In March 2017, the Protection Sub Group of the Sandwell SAB determined that the criteria for a learning Safeguarding Adult Review had been met. The SAR was to concentrate on the period between the 17th March and the 23rd August.

I was appointed by the Sandwell Safeguarding Adults Board (BSAB) in March2017 to assist them in the preparation of this Safeguarding Adult Review (SAR) learning report. [I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. Subsequently, I have held senior executive and non-executive Board level positions in the NHS and as a non- Executive Director with a large voluntary housing association. I have authored several SAR's for different Local Safeguarding Adult Boards.]

The purpose of a SAR is to gain, as far as is possible, a common understanding of events, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. A SAR is about learning, not blaming, and aims to improve future practice.

When a SAR is to be conducted, family members are invited to contribute to the report. I have not been able to meet with any of William's family: a meeting had been arranged with William's daughter but she had to cancel at the last minute. It has not been possible to re-arrange the meeting until after this report has been presented to the Safeguarding Board but arrangements are in hand for me to meet the daughter then and I will be accompanied by a member of staff from the Safeguarding Board.

I have chosen to use the name William is throughout the report: this was not the person's given forename and is used to protect anonymity.

b) The Background

This SAR arises from the death of an elderly woman (who we can refer to as Betty) who was a resident in the same care home as William. On the 17th March 2016, Betty was sitting on a chair outside the treatment room when, allegedly[1], William, approached her and, threw her off the chair onto the floor. He then sat in the chair. The incident was witnessed by a carer who alerted other staff members. Betty was unconscious on the floor and after treatment by ambulance staff, she was take to the local Hospital where a brain haemorrhage was found. Elizabeth remained in hospital until the 22nd March 2016 when she passed away.

In January 2017, the SSAB agreed that a SAR should be conducted in relation to Betty's death. When I and SSAB staff were scoping that report, we came to the realisation that the perpetrator of the assault on Betty, William, could also be regarded as a "victim" in that the care afforded to him after the event may not have been to the high standards required by the Board and its partner agencies. It was therefore decided to undertake a learning SAR to consider the care provided to William – this to run in parallel to the review relating to Betty. The timescale for the Review was to be the 17th March 2016 to 23rd August 2016, the latter being the date William was admitted to a specialist care home in Staffordshire. William passed away at that care home on 30th December 2016 – his death was due to natural causes.

William was 82 years old at the time of his death. He was born and educated in Trinidad, coming to the UK in 1960 and working as a moulder and later as a labourer. He was one of 6 siblings having 4 sisters and 1 brother. He had 4 daughters and 3 grandchildren and was divorced. He owned his own home in West Bromwich. There is a query in medical notes that his first admission to a mental hospital may have been in Trinidad in 1956. His first recorded contact with mental health services in the UK was in 1994 when he was made subject to Section 2 and later Section 3, Mental Health Act 1983, and given emergency treatment. It is recoded that he was verbally and physically aggressive at that time. William had several admissions to psychiatric hospitals since then. Each time he was discharged, he was followed up by community psychiatric nurses and provided depot injections to manage his condition.

In 2010, he was detained under Section 3 of the Mental Health Act

The Terms of Reference for this Review are given at Appendices 1. For the purposes of this report and in line with standard practice for Safeguarding Adult Reviews, the agencies and individuals providing information to the Review are not identified.

[1] The word "allegedly" is used because there has been no formal finding of guilt in relation to this matter. A Police murder enquiry was undertaken but William died before the Crown Prosecution Service made a final decision on whether to mount a prosecution, or not. The words "allegedly/alleged" will not always be repeated throughout the report (in order that the report can flow) but the reader must remain aware that there has been no prosecution nor formal verdict in this case.

This Safeguarding Adults Review primarily used an investigative, systems focus: relevant agencies were asked to provide an Individual Management Review (IMR) of their involvement. This ensured a full analysis by the IMR authors (and subsequently by the multi-agency Protection Sub-group) to gain a comprehensive overview and alignment of actions. In addition to the meetings with the IMR authors and the Protection Sub-Committee, a Practitioners Event was held which gave an opportunity for some of those directly involved in Betty's and William's care to comment on the factual accuracy of this report and to start the learning process.

At the outset, I wish to record my thanks to all those who have assisted with and provided information for the review including the authors of the Individual Management Reviews (IMR's) and the members of the Protection Sub-group. Particular thanks go to the Sandwell Safeguarding Adult Board Business Manager and her staff who have provided excellent professional and administrative support.

Section 2: A Summary Chronology of Key Events:

Of necessity, in the interests of brevity, the following section can only include key events. Some events which pre-date the review periods are also listed to aid a greater understanding of the matters under consideration. The details here are taken from the various IMR's and are listed without comment. Any quotations used are taken directly from the IMR's.

2a) Events Leading to William's Admission to the Care Home

William was admitted to the local acute hospital, from his home, on 18 January 2016 following a fall. He had been lying on the floor for some considerable time. While at home, William had been supported by a local, community based, domiciliary care service twice daily. He had also received support from a community psychiatric nurse as he was subject to a Care Programme Approach[2] as he was suffering from mental ill-health.

On admission to hospital, it was noted that William's medical history included diabetes, dementia and bi-polar affective disorder. It was also noted, by the acute hospital, that he had stopped taking his medication and that physical examination suggested that he had fallen on several occasions previously. (Note: It was subsequently established that William had been given his depot injection on time.)

While in hospital, William received medical, physiotherapy, nursing and speech and language services. It was confirmed that he was at high risk of falls and that he had a tendency to choke on his food.

On the 29th January 2016, William was transferred to the pre-discharge ward within the hospital. It is recorded that his behaviour was non-compliant, agitated and aggressive but this settled for a few days.

[2] The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

On the 3rd February 2016, William was assessed by adult social care. He expressed a wish to go home. A mental capacity, decision specific, assessment was completed and it was concluded that William lacked capacity to make informed decisions and that 24hour care is required. William's daughter was consulted and she agreed to the 24hour care plan.

On 10th February 2016, liaison between the hospital social worker and William's Community Psychiatric Nurse established that William had a diagnosis of schizoaffective disorder rather than dementia/bi-polar affective disorder. The nurse advised that William would not accept a 24hour placement.

On 11th February 2016, William was transferred back to an acute ward, from the pre-discharge ward, suffering from cardiac problems. On the 12th February, a pacemaker is fitted. William is also assessed by the psychiatric service and appropriate medication prescribed.

On 12th February 2016, the social worker requested funding approval for "a residential Elderly Mentally Infirm" placement for William, noting that he was entitled to after care services under Section 117 of the Mental Health Act. Approval was given on 16th February. William's daughter was given assistance in choosing a placement for her father. {The social worker was not asked to take a view on the suitability of the care home.] There is no record of the requirements of the Mental Capacity Act being considered at this time. William's medication was reviewed and confirmed by a psychiatrist.

On 20th February 2016, nursing records show that William is displaying increased aggression and he had hit another patient. An incident form was completed but there is no evidence to suggest that the hospital's "violence and aggression policy had been followed appropriately".

On 21st February 2016, it is recorded that "a staff member was in the bay at all times due to [William's] aggression". There is no record of Deprivation of Liberty issues being considered at this time.

On 22nd February 2016, William was transferred to the care home by ambulance. His daughter was present. This followed a pre-admission assessment by the care home manager.

2b) William's stay in the Care Home.

22nd February 2016: Almost immediately upon admission to the care home and over the next seventeen days, William displayed agitated and verbally aggressive behaviours towards staff on an almost daily basis. This extended to physical assaults on staff and residents – a total of eight incidents while he was in the care home. He also had a tendency to wander into other resident's rooms and, on one occasion, William had to be restrained from attacking another resident (not Betty). On 9th March, William was given his depot injection by the CPN.

11th March 2016: *"Betty was on [the] floor next to her favourite chair, screaming, and William was sitting where Betty was sitting moments before."* There were no witnesses

to the incident but the records state *"[William] has knocked Betty onto [the] floor, suspected of pushing off chair"*. Betty was helped to her room but, as far as can be ascertained, there was no medical assessment or treatment undertaken.

11th to 15th March 2016: William continued to show aggressive and threatening behaviour.

16th March 2016: William went into another resident's room and attacked him, causing cuts to the face and neck.

17th March 2016: William was visited by the community psychiatric nurse. He could not recall assaulting anyone and wanted to go home. The nurse discussed progress with the home manager and was told that the home was equipped to care for William. The nurse agreed to contact the social worker to request a review of William's placement.
Later that day, *"At 15:30, [William] was walking up the corridor staff could see him from the lounge and [a staff member] seen him pick another resident off the chair - Betty - by treatment room before carers could get to them he threw the resident on the floor, he was asked why he had done it he said, he didn't do anything."* (Care Home IMR). Betty was left unconscious. She was taken to the local hospital by ambulance where a brain haemorrhage was diagnosed.

Betty died from her injuries on the 22nd March 2016.

2c) William's Transfer to a Psychiatric Unit

On 17th March 2017, following the attack on Betty, and at 15.56 hours, the care home contacted the social worker and told her of the assault on Betty. The care home requested that William be moved. Between 16.00 and 17.15 the social worker contacted three local psychiatric hospitals requesting that William be seen and assessed. None of these hospitals were able/prepared to assist. The GP was contacted and he advised that William should be sent to A&E if suffering a psychotic episode.

At 20.18, the Out-of-Hours community psychiatric nurse visited William in response to a call from the care home. The nurse advised that William should be re-assessed by social care with a view to an alternative placement.

At 21.40, the Out-of-Hours Adult Social Care service was contacted by NHS 111: they have been contacted about an attack on a resident by William. [Note: the resident named was not Betty. This may have been a reference to the incident on the 16th March] The Emergency Medical Services are not prepared to respond as there are no medical concerns.

On 18th March 2017, at 10.23, Adult Social Care received a Safeguarding Concern form the local acute hospital in relation to the attack on Betty. At 13.23, a Safeguarding Concern was received from the care home relating to the incident on 16th. March. At 13.46 the GP was contacted but "refused to assist on the basis that William was refusing to see anyone and not letting anyone near him" (Adult Care IMR). At 16.26, a Safeguarding Concern was received by adult social care, from the

NHS 111 Service, in relation to William. However, this was not followed up as William was regarded as the perpetrator rather than the victim.

Earlier that day, at 11.30, William's community psychiatric nurse spoke to the social worker on the telephone. After some discussion, and at 13.50, the Mental Health Social Work Team were contacted and requested to assess William. The Mental Health Act (MHA)assessment was undertaken at 15.30 and William was detained under a Section 2 Order and, at 19.56, admitted to a local psychiatric unit. The initial plan was for William to be further assessed with a view to placement in an alternative care or psychiatric setting or a return home.

2d) William's Time in the Psychiatric Unit while Detained under Section 2 MHA 18th March 2016 – 19th April 2016.

After admission, William continued to show signs of aggression and be quite challenging and wandering into other people's rooms. At times, he appeared confused. The ward manager became concerned for his safety in an environment where other patients were much younger – this was discussed with the mental health trust's safeguarding team and a transfer to the Older Adults Service was sought. This was declined by the medical teams involved as it was felt that William's aggressive behaviour could be better managed and be less dangerous to elderly patients in the unit in which he was already placed.

On 7th April, William was taken to A&E, by ambulance, as he was suffering some chest pain. Initially, William was calm but then became very abusive and disruptive – he appeared to think that the A&E ward was his house and he wanted everyone out of it. William was returned to the psychiatric unit late in the evening where he continued to tell staff to "get out of my house".

The next day, a doctor attempted to take blood for tests to rule out the possibility that William had suffered a heart attack. William did not cooperate.

By this time, the police were actively investigating the circumstances of Betty's death: they were conducting a murder enquiry.

On 12th April, a Ward Round was held, attended by two of William's daughters and the community psychiatric nurse. Discussion centred on a possible return home with daytime support for William: his daughters were of the view that he would be at risk at night.

On 13th April, adult social care was informed that William is fit for discharge. The police called at the psychiatric unit and advised staff that they should be informed of William's discharge date.

On 18th April, William was seen by an Associate Specialist Doctor from the Older Adults Service, at the request of the Consultant Psychiatrist, who concluded that William was suffering from vascular dementia with behavioural and psychological symptoms of dementia and required a 24hour, a specialist residential placement. The doctor also concluded that William did not have the capacity to make an informed decision about where to live and suggested that William may require

referral to the Deprivation of Liberty Safeguards Team. This should be done urgently and, if necessary, a Best Interests assessment should be undertaken. There is no evidence that the Best Interests assessment was undertaken. The Doctor also queried if William was under Section 117 aftercare. [This was the first occasion on which William was seen by the Associate Specialist Doctor from the Older Adults Service.]

Also on the 18th April, a "Professionals" Meeting was held, at the request of the police. It was agreed that the psychiatric unit would ensure that the Police are updated on assessments undertaken and plans for William's discharge - discharge not to take place without Police being informed. "The case is currently an active homicide investigation - Police will confirm when safeguarding can undertake enquiries/investigation."

On the 19th & 20th April, William was confused and complaining of chest pains but he refused to go to A&E.

2e) Events Leading to William's Admission to a Specialist Care Home 20th April – 24 August 2016.

Throughout this period, William's mood and behaviour continued to fluctuate. There were further aggressive outbursts and William was on 2:1 and sometimes 1:1 nursing support.

He was made subject to a Deprivation of Liberty order on 21 April, for fourteen days (this was extended to a four-month order on 5th May).

On the 28th April, the Clinical Commissioning Group received a request from the mental health trust for Continuing Health Care funding approval. By 3rd May, it had been established that as William had previously (from 4th October 2010 to 13th April 2011) been detained under Section 3 of the Mental Health Act, he should be entitled to Section 117 Aftercare.

By 10th May 2016, William was considered to be fit for discharge and a protracted search for a suitable care home placement began. (It is known that at least seven care home providers were approached before a placement for William was finally secured. It is apparent that the CCG was not involved in the search, in the early stages – their knowledge of specialist placements could have been invaluable.)

William's mental capacity was kept under regular review. As part of the Deprivation of Liberty process, one of William's daughters was given the role of Relevant Persons Representative but it would appear that she was not given any information as to what this entailed.

William's community psychiatric nurse continued to make regular visits and, together with the social worker and the ward manager, was heavily involved in the search for an alternative placement for William – a search that was comprehensive, lengthy and marked by a significant number of alternative residential placements declining to accommodate William.

On 31st July, William was involved in an altercation with another patient which resulted in William having a heavy fall. He was taken, by ambulance, to A&E. An x-ray showed no fractures and he was discharged back to the psychiatric unit. (An Adult Safeguarding Concern was raised in relation to this incident.)

On 1st August, William was assessed and accepted for placement by the specialist residential care home in Staffordshire.

On 3rd August, William was continuing to complain of pain in his hip and he was admitted to the local acute hospital for further investigation. A small fracture to the pelvis was identified on the 4th August, but this only required analgesic treatment.

On 9th August, the CCG emailed the psychiatric unit instructing them to move William from the acute hospital with immediate effect due to him posing a significant risk to the safety of others. Solicitors for the acute hospital and the police were supporting a move to "a place of safety". A move for William to an alternative psychiatric unit was considered but deemed to be inappropriate owing to William's age. It would appear that William remained at the acute hospital until his discharge to the care home towards the end of the month. It is to the credit of the acute hospital that they continued to offer good care to William in what must have been, trying circumstances.

On 11th August, a Safeguarding Meeting was held. The CCG agreed to provide additional support to the hospital, through the mental health trust, while William remained an in-patient there.

Also on 11th August, it transpired that William's daughter was reluctant for her father to be placed at the care home in Staffordshire because of the distances involved. The social worker agreed to take the daughter to view the care home before a final decision was made. This was subsequently done and the daughter then felt more comfortable with the placement. This is an example of best practice and should be acknowledged as such.

On 15th August, the Deprivation of Liberty Order was renewed.

On 19th August, it was confirmed by the local authority and the CCG that funding was now in place for William to be placed in the Staffordshire care home.

On 24 August, William moved to the specialist care home in Staffordshire. He settled well: the home was particularly cognisant of William's cultural background and responded accordingly. William died at the home on the 30th December 2016.

Section 3: Areas for Consideration

Within the Terms of Reference for this Review, there are four areas listed for consideration. These are:

- How the agencies upheld "Making Safeguarding Personal"[3];

[3] Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to

- How and when the Mental Capacity Act principles were upheld in the context of any Best Interests decisions being made;
- Consideration of Deprivation of Liberty Safeguards and less restrictive alternatives where appropriate;
- How multi-agency working was demonstrated at times of critical decision making.

Making Safeguarding Personal

In the light of William's mental ill-health, it was difficult for agencies to gain an understanding of William's wishes and preferred outcomes. Having said that, the one thing William was quite clear about was that he wanted to be in his own home. This extended to him at times believing that the care or medical facility he was in was, indeed, his own home and some of his aggression was because he felt people had invaded his home. As is apparent from all the foregoing, a return to his own home was not going to be possible but it is questionable whether the least restrictive alternatives were always considered.
I have no evidence to suggest that all those who provided care to William failed to apply the underpinning philosophy of Making Safeguarding Personal on a daily basis. The one exception could be that when a Safeguarding Concern was raised, with William as the subject, on 18th March, this was not followed up as he was regarded as the perpetrator not the victim. Had the Concern been actioned, then a safeguarding plan would have been drawn up which would have clarified key roles and responsibilities in relation to future care planning. This may well have avoided some of the delays that were to follow.

How and when the Mental Capacity Act principles were upheld in the context of any Best Interests decisions being made

As stated in the report, a Mental Capacity Act assessment was undertaken in early February, prior to his admission to the first care home. It was concluded, and discussed with William's daughter, that he lacked capacity but there is no evidence that this led to any formal Best Interests decision.
During the period from 18th March to 19th April, William was Under Section 2 of the Mental Health Act. Prior to the end of the order, William was assessed under the Mental Capacity Act and it was concluded that he lacked capacity to make decisions in relation to where he should live. It is stated that William was nursed at the psychiatric unit and at the acute hospital under a Best Interests decision. It is worth noting that at the point where the Mental Capacity Act/Best Interests assessments were being made, that the psychiatric unit involved a local independent mental capacity advocate (from an organisation known as POhWER).
In cases where it may be deemed that the safeguarding measures proposed or being put into place may infringe the civil liberties of the adult, advice should be sought from the local authority's legal advisers. This is to ascertain whether the case needs to be brought to the attention of the Court of Protection, if the adult is deemed to lack capacity in accordance with the stipulations of the Mental Capacity Act 2005. This was not done in this case.

safeguarding work, and a range of responses to support people to improve or resolve their circumstances

Consideration of Deprivation of Liberty Safeguards and less restrictive alternatives where appropriate

While in the psychiatric unit, an application was made for a Deprivation of Liberty Safeguards order. The initial 14day order was extended for a further 4 months. There is no evidence of less restrictive alternatives being considered (albeit the psychiatric unit was considering returning William home) not least because William's behaviour precluded such alternatives.

How multi-agency working was demonstrated at times of critical decision making.

Above all, this is the major area of concern arising from this Safeguarding Adult Review.

In the period under review (17th March to 23rd August), the first point of critical decision making for William came when, not unreasonably following the assault on Betty, the first care home wished for William to be removed elsewhere. From the point where the care home made that request, it took 28 hours to transfer William to a more appropriate placement.
From the accounts that I have seen (and as summarised earlier) the GP was particularly unhelpful and various parts of the mental health service were initially reluctant to help. The NHS 111 Service became involved as did the adult social care emergency service, but all to no avail. It was not until the late morning/early afternoon of the day after the incident with Betty, that the community psychiatric nurse and the social worker were able to gain assistance from the Mental Health Social Work Team which ultimately led to William being assessed and made subject to a Section 2 Order. There should be clear patient pathways known and understood in circumstances such as these.

A further problem with multi-agency working was exemplified by the issue of funding William's placement in the specialist care home. While resident in the first care home, William was funded, jointly, by the local authority and by the health service under Section 117 After Care arrangements. I find it difficult to understand why this arrangement was simply not 'rolled over' to his new placement. Instead, initially, there were erroneous efforts to have a Continuing Health Care assessment undertaken – erroneous because a Section 117 aftercare agreement takes precedence. It was on the 26th April that it was noted, by the Mental Health Coordinator for Continuing Health Care, that William was eligible for Section 117 funding and this was confirmed by the CCG in early May. However, it was not until the 19th August that joint CCG/local authority funding was finally confirmed for William's placement at the Staffordshire care home.

Section 4: Other Areas of Concern

In addition to the areas of concern given immediately above, I would add:

- I have serious concerns about the way the first care home dealt with the threats posed by William's behaviour from the date of his admission. This is explored fully in the parallel report into the death of Betty, so will not be repeated here. It should also be noted, with concern, that information held by

the hospital was not shared with the hospital social worker nor with the care home for the first week of William's stay.

- There was a lack of a shared, multi-agency action plan, for William, during the majority of his stay in the psychiatric unit. Agencies appeared to be working to their own agendas and losing sight of William's needs. According to the Code of Practice attached to the Mental Health Act, there should have been a multi-agency planning meeting very early on in William's stay when joint risk assessments and joint care plans could have been drawn up. That is not to say that the care provided by the psychiatric unit was not to a good standard, but William's needs could have been even better met, and possibly sooner, through a more coordinated approach. If nothing else, it would have been known who the lead professional or agency was for William's care.

- Associated with this, there was a lack of clarity of roles, responsibilities and expectations of others and a lack of clear multi-agency pathways for patient care.

- There are some issues to address in relation to compliance with Safeguarding concerns procedures by a number of agencies and also in relation to the actions which follow such concerns.

- There are concerns that, on 31st July, at the A&E department, there was a failure to identify a fracture to the pelvis. [I am aware that this incident has been fully investigated by the hospital authorities and that the reasons for the mistake are not fully clear.]

- That William's daughter was not given information and advice to help her fulfil her role as Relevant Persons Representative.

- That following the Safeguarding meeting on 11th August, it was not until the 6th September that the minutes of the meeting were circulated to those attending. Accurate and timely minutes are essential to support shared understanding of decision making and risk and to facilitate partner agency working.

Section 5: Learning Points/Recommendations for Action

This Safeguarding Adult Review was commissioned in order that Learning Points could be identified to improve future practice. As part of the IMR process, the authors identified actions/learning opportunities for their and other agencies. These are listed, by agency, below:

(MA: For multi- agency action; SA: For single agency action.)

<u>From Adult Social Care</u>:

Note: A number of these recommendations will need to be addressed at both strategic and operational levels

- Improvements required in inter-agency working including Improved information sharing (MA)
- All agencies to work together in the best interests of the individual and not having a sole focus on their own criteria/threshold for services and budget (MA)
- Crisis management needs to improve as this case highlights involved agencies' eagerness to hand over to other professionals/agencies as soon as possible rather than risk assessing and requesting additional support as identified (MA)
- Coordination of clear action plans for all agencies involved that identify roles, responsibilities and identified timescales for outcomes (MA)
- In relation to challenges re budget and delays, the recommendation would be that the CCG should agree to facilitate a transfer pending resolution of funding difficulties, without prejudice, thus avoiding a delayed transfer/discharge (MA)
- Improved recording in case records (SA)

Author's Note I would extend this recommendation from Adult Social Care thus:

- Adult Social Care should establish closer line management of case recording ensuring that the content is accurate, appropriate and completed in a timely manner (SA)

There was also a recommendation made by the CCG which is for Adult Social Care to action:

- A process should be established for ensuring that minutes from safeguarding meetings are circulated in a speedy manner to ensure that all parties are able to work to the agreed actions (SA)

From the GP:

- An internal review to be carried out to review the practice's organisational policies and consider how the practice would respond to similar incidents in the future (SA)
- The outcome of this review to be disseminated across the practice's clinical teams (SA)

From the Mental Health Trust:

- All care coordinators to be offered training and/or undertake refresher on the Care Programme Approach to include monitoring of S117 Aftercare (SA)
- A Joint Guidance/Policy for Section 117 After-Care: Eligibility, Review, Discharge and Funding Arrangement, between the Trust and the CCG to be drawn up (MA)

From the Acute Hospital:

- To raise awareness around Deprivation of Liberty Safeguards, including Deprivation of Liberty e-learning (SA)
- Safeguarding metrics and training to be reviewed (SA)
- Arising from William's transfer to the first care home, to ensure that all information available at the time of discharge is shared with the care provider (SA)
- To raise awareness around violence and aggression policy (SA)

From the Clinical Commissioning Group:

- The CCG should ensure that Section 117 discharges are allocated to an interim case manager to liaise with the local authority in identifying care provision and commissioning this (SA)

NB There are recommendations made in the Betty Report relating to actions required of the care home in which Betty was resident which are highly relevant here. It is assumed that these will be followed up under the action plan relating to that report.

I would add three further **recommendations:**

- That the Safeguarding Board considers how it might develop a Lead Professional process, to be utilised by Adult Care Management Teams and the mental health trust (whoever has lead responsibility for the case). Any person so appointed in a particular case will need to have the power to make things happen on behalf of the service user. The role will need to reflect the requirement for Joint care planning, including discharge planning meetings, and for generating Care/Support plans (what is to be done, by whom and by when). (MA)

- That further, inter-agency training be developed /considered on the Mental Capacity Act, this to include the role of the Court of Protection in complex cases – this training to be at both Introductory Level (for all) and more In Depth for those who will be involved in appropriate cases (MA)

- That the Mental Health Act Code of Practice, as it relates to the holding of early multi decision making after care planning meetings, should be adhered to by all relevant agencies, notably the Mental Health Trust.

In my opinion, when taken together, the learning points comprehensively address the issues and learning points arising from the review.

It is Recommended to the Sandwell Safeguarding Adult Board:

a) That where a learning point/action is specific to one agency alone, that the Board requests that agency to produce an action plan stating how the action will be taken, by whom, by when and what the expected outcome will be. The action plan to be submitted to the Safeguarding Board by an agreed date. The Board will wish to ensure that these plans are then audited, over time, to be assured that the desired outcomes have been achieved.

b) That where a learning point be best addressed by two or more agencies working together, then the Board's Protection Sub-Group should be requested to produce a joint action plan stating how the learning point/action will be addressed, by whom, by when and the desired outcome. Again, the Board will wish to ensure that these plans are submitted for approval and then audited, over time, to be assured that the desired outcomes have been achieved.

Section 6: Closing Remarks

During the period under review, William was clearly a very troubled individual who, for much of the time, had little awareness of his own actions or surroundings. As shown in this review, while the day-to-day care of William cannot be generally faulted, the ability of agencies to work together to quickly address his needs was sadly lacking. It is to be hoped that if similar circumstances arise, as experienced by William, in the future, that the learning from this review will ensure that there is a more effective response from the agencies involved.

Robert Lake
Independent Author
July 2017

APPENDIX 1

Safeguarding Adult Review

William

TERMS OF REFERENCE

Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) 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:

(c) 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.

(ii) Condition 1 is met if:

(b) 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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Circumstances of Incident

- William was admitted under the Mental Health Act to a local Psychiatric Hospital, from a Care Home, as no alternative setting was available to meet his complex needs
- Admission to an alternative Hospital was not an option due to the risk William may pose to other patients
- The hospital to which William was admitted routinely serves working age adults who are experiencing an acute episode of serious mental health problems of a severity that cannot be treated in the community – admission for a man of William's age, frailty and disability while seemingly unavoidable, would mean he was potentially vulnerable from other patients. On 10/5/16 William was deemed fit for discharge from Hospital.
- William had care and support needs and on 31.07.16 was involved in an altercation and subsequently sustained a pelvis fracture at the psychiatric hospital, that went initially undiagnosed at the local General Hospital. He was taken to A&E again 3 days later due to ongoing pain and the fracture was then diagnosed. In August 2016, a safeguarding meeting took place at the hospital to discuss future care arrangements and to address concerns regarding the undetected pelvic fracture and the appropriateness of care provision prior to admission.

- William's discharge from the psychiatric hospital was delayed due to a difficulty in identifying a specialist service to meet his needs and due to a lack of agreement regarding how funding for the placement would be authorised.

Methodology

The Safeguarding Adults Review will primarily use an investigative, systems focus and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author or multi-agency Protection Sub-group to show comprehensive overview and alignment of actions

Scope of Safeguarding Adult Review:

Adult - William (Deceased)
Date of Birth- Records show various DOB - 24/04/1934/ 21/02/1934
Date of Death -30/12/16 (not related to SAR)

Timeframe

The scope of the SAR will be from 17/3/16 to 23/8/16

Agency Reports

Agency Reports will be commissioned from

- Adult Social Care,
- the local General Hospital,
- the Mental Health Trust,
- the CCG
- William's GP while residing at a previous care home

Agencies will be expected to complete an IMR with chronology, template and guidance attached.

Any references to the adult, their family or individual members of staff must be in a consistent format, e.g. by Initials, and for Professionals, identity such as Health Visitor- HV1 or Social Worker SW1.

Any reasons for none cooperation must be reported and explained, this also applies to timescales which should be strictly adhered to.
All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

Agencies will be asked to update WSAB on any actions identified in section 8 of

the IMR prior to the completion of the SAR which will be fed into the final report. Updates will then be requested until all actions are completed.

Areas for consideration

How the agency upheld Making Safeguarding Personal
How and when MCA principles were upheld in the context of any Best Interests decisions being made
Consideration of DoLS and less restrictive alternatives where appropriate
How multi-agency working was demonstrated at times of critical decision making

Parallel Process

This SAR for William will run alongside the SAR for Betty. William was the person accused of causing harm to Betty, but later became the subject of an SAR himself for different reasons. Accordingly, SSAB recognises the duplicity of some information and as such a single IMR which responds to the questions in each of the two Terms of Reference will suffice. However, there is clear recognition that two separate final reports will be produced by the independent author on behalf of SSAB

Engagement with the individual/family

While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the individual/family and details of their involvement with the SAR are included in this.

In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Sandwell Safeguarding Adults Board.

All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

Media Reporting

In the event of media interest all agencies are to use a standard no comment approach until the report is approved for publication.

Publishing

It should be noted by all agencies that the SAR report will be published once

complete unless it would adversely impact on the adult or the family.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

Administration

It is essential that all correspondence with identifiable information is sent via secure methods only.

Specific Questions for ALL Agencies to Consider:

What was the understanding around William's entitlements to Section 117 aftercare?
What did you understand about CHC screening?
What did you understand about safeguarding alerts and timescales?

Additional Questions for the Mental Health Trust

What considerations were there, and what care was in place for William under CPA arrangements and how was this co-ordinated?

Additional Questions for Adult Social Care and the Mental Health Trust

While William's daughter acted as RPR for DoLS, what information was she given to help understand her role and how was this monitored?
Prior to being accommodated at the care home, William lived at home with a small package of care. What alternative care arrangements were considered for William and how was this aligned with his own thoughts and wishes?

Additional Question for the General Hospital

What considerations were made about what we now know was an undetected pelvic fracture?

Additional Question for the GP

After the telephone call from the care home on the 17/3, describe the concerns that were outlined and what recommendations were made for managing William's behaviour.
Were there any considerations of safeguarding issues?

Additional Question for the CCG

What services were available to be commissioned for William and describe the appropriateness of these.

Timetable for Safeguarding Adult Review	DATE
Scoping Meeting to agree on agencies to be involved, terms of reference, methodology etc. Letter to IMR agencies to identify authors and secure documents	23/3/17 27/3/17
First introduction and discussion with the individual / family	27/3/17
IMR Authors' briefing **Sandwell Council House 1.30-3.30**	27/3/17
Completion date for IMRs	3/5/17
Review of **IMRs Independent Living Centre Combined Room 10-4**	18/5/17
Draft report and recommendations circulated to Panel members- **Protection Sub Group, Extra Ordinary Protection Sub Group Meeting 13/6/17 Council House G5 1-3** Individual/ family	13/6/17 19/6/17
Date for final amendments to draft report and recommendations	5/7/17
Date for final report submission to board with all partners of SSAB -presented by author with recommendations	27/7/17
Date for final report amendments and recommendations	TBC
Date for final board ratification of report and recommendations Feedback to individual and /or family	TBC
Date for Protection Group to determine multi-agency action plan from the SAR recommendations	TBC
Date for learning events	TBC
Date for publication on website	TBC
Closure letter to individual and/or family	TBC