BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult T

Overview Report July 2017

Robert Lake, Independent Author

Section 1: Introduction

This young woman, referred to as Ms. T throughout this report to ensure anonymity, was of Asian origin. She was born in Buckinghamshire and, it is believed, lived in the County for most of her life. She studied accounting at Bradford University and lived with her parents until sometime in 2014. At the time of her death, and as far as can be established, Ms. T was living alone, in a social housing tenancy.

Ms. T had a history of asthma, type 2 diabetes and mental ill-health (paranoid schizophrenia). She had been known to the local mental health services for several years and had also been supported by primary care. She was aged 34 at the time she was found deceased. It would appear from agency records that she was last seen in November 2015 but was found in an advanced state of decomposition some 3 months later. The cause of death could not be established.

A referral was made to Buckinghamshire Adult Safeguarding Board's Safeguarding Adults Review Sub-group in October 2016, raising concerns about the circumstances leading to Ms. T's death. After careful discussion at the sub-group, it was decided that the criteria were met, as described in the Care Act 2014, for a Safeguarding Adult Review into the care provided to Ms. T. It was also decided that the scope for the Review should be the period from the 1st October 2014 to 23rd February 2016.

I was appointed by the Buckinghamshire Safeguarding Adults Board (BSAB) in January 2017 to assist them in the preparation of this Safeguarding Adult Review 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 Safeguarding Adult Review's for different Local Safeguarding Adult Boards.

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

The Terms of Reference for this Review are given at available from the Board Administrator. 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.

When a Safeguarding Adult Review is to be conducted, family members are invited to contribute to the report. In this case, letters were sent to Ms. T's father, in his own language and by signed for delivery. There has been no response.

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 Safeguarding Adult Review Panel. Particular thanks go to the Buckinghamshire Safeguarding Adult Board Manager and her staff who have provided excellent professional and administrative support.

Section 2: A Summary Chronology of Key Events: 1st October 2014 – 23rd February 2016.

Note: The Safeguarding Adult Review Panel received extensive and very helpful reports (Individual Management Reviews – IMR's) from the agencies involved in Ms. T's care. The Mental Health Trust who had provided care to Ms T had undertaken a Root Cause Analysis of their involvement in May 2016 and a copy of this was provided to the Safeguarding Adult Review Panel.

Of necessity, in the interests of brevity, the following section can only include key events. Some events which pre-date the review period are also listed to aid a greater understanding of the matters under consideration.

Relevant Events Prior to October 2014.

On the 23rd September 2011, Ms. T was arrested following an assault on her mother. The Police detained her under a Section 136 Order (later converted to a Section 2, Mental Health Act order) and Ms. T was admitted to psychiatric hospital as suffering from an acute psychosis – paranoid schizophrenia. After discharge on the 13th October 2011, and until August 2015, Ms. T was subject to a Care Programme Approach[1] and was under the care of the Early Intervention Service (EIS) of the local Mental Health Trust

In September 2012, Ms. T was diagnosed, by the mental health service team, as suffering from Type 2 diabetes. This was poorly controlled.

In August 2013, Ms. T was referred for a Neurology assessment, having previously had an MRI scan in March 2013, which had proved inconclusive. There were concerns that she may be suffering from a problem with her central nervous system. She did not attend for this assessment: it now appears that the appointment letter was sent to Ms. T's parents address but she may have been no longer living there.

In October 2013, Ms. T was pregnant and attended the early pregnancy unit and had an initial ultrasound scan. At this time, Ms. T was required by her family to leave their

[1] 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.

home. She then lived with her partner, at his friend's home whilst the friend's family was away. A second ultrasound scan in November 2013 showed that Ms. T had miscarried. She remained in the relationship with her partner; she did not return to her own family and it is understood that she had no further contact with them

In April 2014, Ms. T was reported as having a job in accounts. (Ms. T worked, from time to time on an agency basis and usually on a 2 day a week basis.)

In June 2014, a Care Programme Approach Review was undertaken by Ms. T's Care Coordinator.

By June 2014, Ms. T was living in temporary accommodation: when the friend's family in whose house Ms. T and her partner were living returned to their home, Ms. T became homeless and the mental health team supported her in obtaining temporary accommodation at a homeless shelter. In August 2014, she secured a more permanent tenancy with the local Housing Trust.

Key Events 1st October 2014 – 23rd February 2016.

7th November 2014: Ms. T was now settled in her new accommodation. The Care Programme Approach Care Coordinator withdrew, ongoing support to be provided by a Support Worker from the Mental Health Early Intervention Service.

February and March 2015: Ms. T attended her GP surgery, seen by the Practice Nurse for asthma and diabetes review – not compliant with diabetes medication. Blood tests were taken.

20th April 2014: Ms. T was routinely visited by a member of staff from the Housing Trust – the property was described as "immaculate".

20th July 2015: Ms. T invited her support worker to view her flat now that decoration was completed. Ms T reported that she has been unemployed for some time – was seeking jobs regularly. She was planning to go to Pakistan the following year to see her partner: the partner's visa had expired that month and he had returned (possibly being deported) to Pakistan. Her partner's departure meant that she no longer had contact with his extended family and Ms. T was already estranged from her own family. She was therefore, quite isolated. Ms. T reported that she was lonely. The Support Worker advised contact with the Citizens' Advice Bureau for advice on partner's visa and also suggested that Ms. T consider voluntary job opportunities to combat loneliness.

27th July 2015: Ms. T saw her GP at the surgery. She was taking some medication. Ms. T reported that she has been seeing her Support Worker weekly but that the Early Intervention Service is to withdraw this support. (It should be noted that, in fact, contact between Ms. T and the Early Intervention Service was far less frequent – Ms. T's mental

health was adjudged to be stable and she was budgeting well and buying and preparing her own food.) The GP contacted the mental health "key worker" requesting that Ms. T should not be discharged from the mental health service – Ms. T requires continued support with medication and her diabetes is poorly controlled.
A double appointment was made, with the GP, for the following month: diabetes and mental health review.
Also on the 27th July, Ms. T telephoned her Support Worker to tell her of the GP's concerns about the withdrawal of mental health support services. A Mental Health Trust worker said that she would talk to the GP. There is no record of this happening.

19th August 2015: the GP attempted to contact Ms. T by telephone: Ms. T had failed to attend the double appointment. The GP left a message asking to be called back and followed this up in a letter.

24th August 2015: The Early Intervention Service formally withdrew services from Ms. T. Ms. T was judged to have made significant progress and a good recovery during the period of the Service's involvement, according to the agreed plan of care, and to have made and retained insight into the importance of managing her condition with prescribed treatment, as well as understanding the impact of her mental health on her physical health condition. Ms. T was now able to function well independently. She was therefore discharged to the care of her GP as it was determined that there was no longer a need for support and monitoring from secondary mental health services

2nd September 2015: The GP had a telephone conversation with Ms. T – the GP had made previous attempts to contact Ms. T by phone (on 19 August) and by letter (on 20 August). Ms. T was informed that her blood sugars were high and that she must take the diabetic medication.

21st September 2015: the GP again attempted contact by telephone but no reply. Message left re need for further blood sugar review.

8th October 2015: the Community Response and Reablement Team Contact Centre at the County Council received a telephone call from a friend of Ms. T who had not seen Ms. T nor been able to talk to her on the phone for some weeks. Contact was made by phone with the family – Ms. T's brother stated that they had had no contact with Ms. T for over a year "since she got married". The Contact Centre asked the Police to undertake a welfare visit. Before doing so, the police spoke to Ms. T's friend who told them that, prior to August, they would have weekly contact and also that she (the friend) had managed to speak to Ms. T's partner in Pakistan: he had had no contact from Ms. T for some time either. The police visited Ms. T's address and were eventually able to gain entry and speak to Ms. T. The police were concerned about the uncleanliness of the flat and a lack of food – there was no food in the fridge but there were some food items in cupboards. The police decided to refer the case to adult safeguarding for further checks on Ms. T's welfare. [Note: This was a formal written referral, but not a safeguarding alert requesting a multi-agency strategy meeting. It is a LA responsibility

to assess whether a Section 9 Assessment should be completed. The police also decided to inform the housing provider of their concerns. This was done by email on 8th October, the police requesting a housing manager visit because "the smell [in the flat] was overpowering – it was very untidy throughout. Food in the fridge going off – some food in the cupboards but not much – [you] may be shocked at the state this female is living in".
A written referral was completed and sent by the police on 9th October 2015 and reviewed by the Safeguarding Adults Team on the 14th October.
[Author's Note: it is established practice that referrals between agencies should only be made with the consent of the subject of the referral. In this case, the police officer decided that Ms. T's needs were such that the referral(s) should be made without Ms. T's consent. I concur.]

19th October 2015: the Safeguarding Team at the County Council made several failed attempts to contact Ms. T by phone.

27th October 2015: further attempts were made by the Safeguarding Team to contact Ms. T by phone but there was still no reply. A check was made with the local mental health team who stated that Ms. T was not currently an open case to them. A letter was sent, by the Safeguarding Team, to Ms. T asking her to contact them. An email was also sent to the GP expressing concerns for Ms. T's welfare. On the same day, the GP had received a copy of the police report of their visit to Ms. T on the 8th October and she had responded by attempting telephone contact with Ms. T but without success.
On the same day, the Housing Trust wrote to Ms. T to say that a member of their staff would visit Ms. T on the 9th November 2015.

28th October 2015: the GP had a telephone conversation with the Safeguarding Team in which she stated that Ms. T had not had a prescription for her medication since August. The GP had telephoned and visited Ms. T that day before but had not been able to contact her. The GP agreed to write to the local mental health service with her concerns and also agreed that the Safeguarding Team should request a further police welfare visit – the GP agreed with the police to be on standby to see Ms. T. In the event, the police were unable to find Ms. T at home. She was logged as a missing person. At 22.00 hours that evening, a police officer put a note through Ms. T's letterbox asking her to contact them.

29th October 2015: the Mental Health Street Triage Service visited Ms. T at home but there was no reply.

30th October 2015: the GP and the police agreed that, at this stage, a forced entry to Ms. T's property was not appropriate neither should a formal warrant be sought. However, the police would continue to make enquiries and at 23.15 hours that day, the police made a visit to Ms. T's home but were unable to gain a response. Checks were also made with neighbours.

31st October 2015: the police visited the home address again, in the morning, and decided to force an entry and found Ms. T inside. The police requested a health check by paramedics who concluded that no action was required by them.

9th November 2015: A member of staff from the Housing Trust visited Ms. T but gained no reply. The damage to the front door (caused by the forced entry on 31st. October) was noted. The Housing Trust's member of staff decides to rebook a further visit.

12th November 2015: Ms. T telephones the Safeguarding Team at the County Council (presumably in response to the letter sent to her on 27th October). She stated that she was managing fine and had enough medication. She also said that she had a telephone consultation with the GP booked for the next day.

13th November 2015: A report from the police detailing their visit on the 31st October was received by the Adult Safeguarding Team and by the GP. There is no record of the reportedly planned telephone consultation between Ms. T and her GP having taken place.

17th November 2015: Ms. T contacted the police asking for an Incident Number relating to the forced entry on the 31st October as this is required by her housing provider.

20th November 2015: In response to the missed telephone consultation on the 13th November, the GP again attempted telephone contact with Ms. T but without success.

23rd November 2015: the GP referred Ms. T to the local mental health service's "Assertive Outreach Team", requesting that a home visit be made by them. [Note: by this stage, the Assertive Outreach Team was no longer in existence and had been replaced by an Adult Mental Health Team (AMHT).] The same day, the Adult Mental Health Team assessment nurse recorded that they made several attempts to call Ms. T on her mobile number, but all calls went unanswered and then cut off. They called the GP surgery for more information but were unable to speak to the referring GP as she was away that day and the day after. A covering GP therefore called later and was told by the Adult Mental Health Team nurse that she had concerns about complications from Ms. T's non-compliance with diabetes medication and non-engagement, and that there was a need to prioritise time due to non-compliance, non-engagement, non-adherence and the possible complications that might result from this. The nurse also reiterated the dangers of referring a patient that had not been seen, suggesting that the surgery consider calling for a Mental Health Act Assessment due to the risks identified. It was agreed that the covering GP would discuss the situation with the referring GP on her return, and the Adult Mental Health Team nurse agreed to discuss the referral with the team consultant psychiatrist and team manager the following day.

Also on the 23rd November, two staff from the Housing Trust visited Ms. T as a follow up to the abortive visit on 9th November. Ms. T was advised to report the front door for repair – it was dented but secure. It was noted that there were no issues with

cleanliness in the property. **This was the last recorded contact between Ms. T and any public agencies.**

24th November 2015: at the Adult Mental Health Team's "assessment function" meeting it was agreed that there was insufficient information regarding Ms. T's physical health issues and that these needed to be determined before her mental health could be assessed. It was further agreed that a letter be sent to the referring GP to advise of this. The assessment meeting decided that if Ms. T was referred again to mental health services, she would be referred directly to the treatment team for increased support. There is no record of a letter being sent to the GP on or after the 24th November nor of any other contact between the two services after that date.

23rd February 2016: a friend of Ms. T contacted the Police stating that she had not seen Ms T since the previous November. She had visited Ms. T's address on several occasions during that time. There was now a strong smell coming from the property. The police attended Ms. T's address and, on forcing entry, they found her badly decomposed body on the bed. There was no sign of suspicious circumstances.

20th April 2016: the Coroner concluded that the cause of Ms. T's death could not be ascertained and an open verdict was recorded.

Section 3: Key Lines of Enquiry.

Within the Terms of Reference for the review, three key lines of enquiry were listed:

What did agencies know about Ms. T's involvement with her family and partner and about her support networks?

From October 2011 to August 2015, staff from the local Mental Health Trust were well acquainted with Ms. T's domestic circumstances. Indeed, they assisted her in setting up home in her own flat in August 2015 following a period in temporary accommodation. However, for other agencies, the fact that Ms. T had become estranged from her family and that her partner had returned to Pakistan, did not emerge until mid-October 2015.

Were formal safeguarding referrals/alerts/concerns raised – if so, when and what action followed?[2].

[2] The formal raising of an issue, suspicion or allegation of potential abuse or harm or neglect which may have arisen from: ♦ A direct disclosure by an adult at risk♦ A complaint or expression of concern by someone else♦ An observation of abusive behaviour or an observation of the indicators of possible abuse or neglect.

The police referred Ms. T to the County Council on 8th October and this was received by Safeguarding Adults Team on 14th October who made several failed attempts over the coming days to contact Ms. T.

Were there any mental capacity issues and if so, were they dealt with appropriately and in line with the Mental Capacity Act 2005?[3]

There were no mental capacity issues, within the meaning of the Mental Capacity Act 2005, identified at any stage. There is no compelling evidence to suggest that a Mental Capacity Act assessment should have been undertaken but had there been wider information sharing across a range of agencies, such an assessment may have been considered appropriate.

Section 4: Analysis and Comment

Areas of good Practice

From a careful analysis of the Individual Management Reviews made available to me and the Safeguarding Adult Review Panel, it became clear that there were examples of good practice in the way in which the various agencies responded.

- It is not part of the core duties of the Police to carry out general welfare checks on behalf of other agencies. The Police do have a duty to protect life and limb and as such will conduct 'welfare checks' if it is an emergency and there is a genuine concern that something serious is about to, or has already occurred. If the person cannot be located, the police will undertake a Missing Person investigation. If information comes to light that would suggest a direct risk to the person's safety, they can decide on which police powers to use at the time.
  Throughout their involvement, the police acted diligently and professionally. Particularly in the period from 8th October to 31st October 2015, they maintained a positive and regular watch on matters, taking the initiative to try and establish Ms. T's whereabouts and well-being on several occasions.
- Beginning in mid-August and through to late-November, the GP endeavored to contact Ms. T and raised her concerns with relevant agencies.
- Following receipt of the referral from the police on 14th October, the Safeguarding Adults Team made regular attempts throughout October 2015 to contact Ms. T

[3] The MCA enshrines the presumption of capacity in law for everyone aged 16 and over. Where there is doubt that a person does not have capacity to make a particular decision, the MCA sets out a two-stage test:
Does the individual concerned have an impairment of, or a disturbance in the functioning of, their mind or brain, whether because of a condition, illness, or external factors such as alcohol or drug use? Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make the specific decision

by phone and by letter – resulting in Ms. T contacting them on 12th November 2015.
- The Housing Trust provided an appropriate level of tenant support to Ms. T.

Areas of Concern

It can be difficult for Agencies to know how best to act when the person at the centre of concerns is not willing to accept help or, at best, to do so on his/her own terms. (This is particularly true in cases involving self-neglect.) From all the information made available to me, I conclude that Ms. T did not feel the need for health and social care agencies to be involved in her life beyond an occasional contact with her GP. She may well have been missing her partner who had returned to Pakistan (she was reported to be planning a visit to see him/find ways to have his visa renewed and, we are told, kept in touch with him by telephone) but, as far as we know, she was resigned to having no contact with her family. It is known that Ms. T had one friend locally and regularly frequented local take-away food outlets but she also expressed feelings of loneliness. While we will never know the direct cause of her death, this wish for independence was, more likely than not, a contributory factor.

Had a formal Safeguarding Referral or Concern been raised in October/November of 2015, there could well have been a very different outcome. Despite Ms. T's wish for privacy and independence, there was adequate evidence to suggest that she was, at least, at risk of failing to care for herself adequately and there was a known history of significant physical and mental ill-health. Police Officers had expressed the view that Ms. T appeared to be far from well and it was known that she could not have been taking her various medications properly, if at all. The fact that there was no third party "perpetrator" could well have affected people's judgement.

At a minimum, a Concern would have led to formal information sharing between a range of agencies and, in turn, a formal inter-agency strategy could have been established to find the best way to work with Ms. T and safeguard her. In the period from September 2015 to February 2016, several agencies were involved but, ultimately, no-one had clear responsibility for Ms. T's welfare. A major area of concern here is that, at the point where Ms. A was discharged from the Early Intervention Service in August 2015, there is no evidence of a formal discharge process involving the GP nor of a discharge letter being sent from the Early Intervention Service to the GP. A discharge plan should have been agreed and shared with Ms. T and her GP at the time of Ms. T's discharge from mental health services to identify the ongoing arrangements for support, relapse indicators and triggers, and crisis and contingency plans. [Note: In addition, there was no Care Programme Approach care plan or risk assessment recorded in Ms. T's health record for the last year of her involvement with the Early Intervention Service.]

Similarly, and perhaps alternatively, at no stage was Ms. T assessed under Section 9 of the Care Act 2014 - an assessment of an adult's needs for care and

support/safeguarding. (The Early Intervention Service was responsible for undertaking Care Act assessments and commissioning any required services.) Had such an assessment been undertaken, Ms. T may have been prepared to receive services and support which could have avoided her tragic death.

It is of concern that the referral from the police to the Housing Trust on the 8th October was not actioned by the Trust until 27th October when a letter was sent to Ms. T to set an appointment for a visit on 9th November. (The housing trust acknowledges that the delay was unacceptable.)

In considering the matters before us, the Safeguarding Review Panel members and I have concluded that when no action was taken by the Adult Mental Health Team, in late November 2015; beyond referring the case back to the GP, the ongoing monitoring of Ms. T "fell into a void". We have been unable to ascertain why this occurred (it may have been due to a service re-design in the Mental Health Trust at that time) but it is, perhaps, the most significant area of concern of all, albeit, for all we know, Ms. T could have already been dead by then.

Section 5: Specific Areas for Consideration.

Within the terms of reference, there were seven specific areas for consideration in the Safeguarding Adult Review. I will deal with each in turn and in doing so, may inevitably and unavoidably reiterate some points made earlier.

"If there were ways agencies could have worked more effectively to safeguard Ms. T and others. "

As stated above, each of the agencies involved could have raised a formal Safeguarding Concern to request a multi-agency strategy meeting. The Safeguarding Adult Team would then have been able to be proactive in encouraging agencies to come together to share information and develop a joint strategy. There is also the major concern about the way in which Ms. T "fell into a void" between mental health services and her GP in late November 2015. There appears to be a lack of guidance/procedures relating to what agencies should do when an individual is not engaged/contactable. There also appears to be a lack of understanding of self-neglect which is often a complex interface between:

- Physical health issues: impaired physical functioning; pain; nutritional deficiency;
- Mental health issues: depression; mental health problems; frontal lobe dysfunction; impaired cognitive functioning, substance/alcohol misuse;
- Psychological and social factors: diminished social networks; limited economic resources, lack of access to social or health services, personality traits, traumatic histories and life-changing events, personal philosophy. [4]

[4] See also "Serious Case Reviews Findings on the Challenges of Self Neglect: Indicators for Good

"Whether agencies could have communicated and shared information about Ms. T's circumstances more effectively and whether this case raises any general concerns about difficulties in information sharing and communication."

There were several examples of two agencies communicating one to the other: e.g. the police and the Safeguarding Team; the Police and the GP; the GP and Mental Health Services but few, if any, examples of multi-agency information sharing – information sharing which could have led to an intervention/support plan. Furthermore, at no stage was there a request made for a formal, Section 9 or Section 42, assessment:
I am told that, at the time of these events, the Multi Agency Safeguarding Hub (the MASH) was still in its infancy: The Buckinghamshire Safeguarding Adult Board should seek reassurance that the MASH is now fully functional and is able to facilitate multi-agency information sharing. This may involve a re-visiting of the membership of the MASH and of the information sharing protocols and governance arrangements that are in existence, to ensure that they are fit for purpose.

"If there were legal routes that could have been taken by any of the agencies that would have had a positive impact."

It has been concluded earlier that there was no compelling evidence of the need for a Mental Capacity Act assessment. The Police appropriately used the powers available to them under the Police and Criminal Evidence Act 1984 to gain access to Ms. T's flat on two occasions. However, on the 23rd November, a formal Mental Health Act should have been undertaken by staff from the Mental Health Trust: it is not clear why the need for a primary care medical assessment was suggested to the GP's colleague, by the mental health team, rather than being actioned by them. The mental health team should have attempted contact with Ms T and referred for a Mental Health Act assessment, if required. The Mental Health Trust was the only agency (apart for the GP) to have had substantial prior involvement with Ms. T.

"If there were any policy gaps that impacted on this case or on the action taken by organisations and agencies involved."

As far as I can establish, there is no multi- agency policy and procedures relating to missing people. It would be sensible for such a policy and procedures to be joint with the Safeguarding Children Board.

I would also draw attention to the fact that I was told of "service redesigns", in at least one of the agencies involved during the period under review, having had a potential impact on other agencies' understanding of referral pathways (e.g. the withdrawal of the Assertive Outreach Team service). The BSAB should ensure that all partner agencies take steps to inform each other when service redesigns are being planned and/or

Practice". Braye, Orr, Preston-Shoot. Page 76 The Journal of Adult Protection Vol 17 No 2 2015

introduced and give partner agencies the opportunity to draw attention to any unintended consequences that might accrue.

"Whether there are any equality and diversity issues in relation to this case" and
"If there were any culture, status or reputation issues that impacted on this case."

It is probable that the reasons for Ms. T leaving her parents' home were rooted in cultural issues (albeit we have no evidence to directly support this). However, it is known that she was cut off by her entire family including all aunts, uncles, cousins etc. (It is reported that on one occasion, Ms. T 'bumped into' an aunt in a local shop and was deliberately ignored.) She knew that she could not contact anyone in her family even after her partner had returned to Pakistan. This very real isolation must have impacted, negatively, on Ms. T's overall wellbeing.

"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 Ms. T."

As stated earlier, the failure to raise a formal Safeguarding Alert and/or request a Section 9 or Section 42 assessment was a key omission by all agencies involved: while there was some excellent bi-agency work undertaken, the lack of a multi-agency strategy meeting, action plan and formal assessment could well be the reason why Ms. T was not effectively safeguarded.

Section 6: Two Other Matters Arising

1. Thresholds for Police "Welfare Visits"

As stated earlier, the Police have a duty to protect life and limb and if there is an emergency or genuine concern for a person's safety they will conduct 'welfare checks'. In this case, on each occasion on which they were asked to undertake a welfare check, the police did so. However, it is not clear what the threshold is for such checks. Other agencies seemed to regard police action as the default position – they could have made visits to Ms. T's address themselves before contacting the police for assistance. Having said that, the GP did make one, abortive, home visit and, as matters transpired, on the two occasions in October when the Police acted, they did find Ms. T at home. Nonetheless, it is understood that a new Missing Person scheme is currently being piloted in Buckinghamshire and it could prove useful if the Safeguarding Board were to explore this threshold issue further as part of this pilot. It should also be noted here that there is a force wide protocol, prepared in April 2015, dealing with "The Management of Mental Health Crises: An Interagency Agreement between the [….] Police and Health and Social Care Agencies" This is a very useful document in which the threshold for police welfare checks is discussed. However, as far as can be ascertained, it has never been discussed or adopted by the relevant agencies in Buckinghamshire.

2. Giving Feedback to members of the public who have raised concerns/made a referral.

It is standard practice that when a referral is made from one partner agency to another that feedback is given to the referring agency on the outcome of the referral. However, this practice does not extend to referrals made by members of the public. This is understandable: unless the subject of the referral gives express permission for feedback to be given, then it cannot occur. However, in cases such as the present one, it might be helpful if some very limited feedback could be given: professionals regularly state that "safeguarding is everyone's business" and the help of concerned friends and neighbours can prove invaluable. The BSAB may wish to explore this issue further.

Section 7: Recommendations for Action

1. Individual Agency Recommendations and Action Plans

One of the main purposes of a Safeguarding Adult Review is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and to ensure that those lessons are applied in practice to prevent similar harm occurring again. As part of the Individual Management Review process, the authors were asked to identify any lessons learned for their agency and to draw up an action plan accordingly. Two of the IMR's (Adult Social Care and the GP/CCG) identified areas in which their agency's practice could be improved. In addition, the Root Cause Analysis prepared by the mental health trust included an action plan – please see Appendix one. (The Board may consider it appropriate to ask the CCG/GP to produce a formal action plan in relation to the actions listed.)

I would recommend to the Buckinghamshire Safeguarding Adult Board (BSAB) that the Board notes the issues identified as requiring action by the agencies and approves the associated action plans. The Board will wish to ensure that these plans are audited to be assured that the desired outcomes have been achieved.

2. Recommendations to the BSAB

Except for an absence of a Missing Persons Policy, I have found nothing to suggest that the Adult Safeguarding Inter-Agency Policies and Procedures for which the BSAB is responsible are in any other way lacking, albeit, in some instances, adherence to these policies and procedures has not been what should have been expected (for example, in the raising of formal safeguarding concerns).

From the detailed examination of the circumstances leading to Ms. T's sad death there

are actions which, in addition to actions being taken by Single Agencies, the BSAB, as an Inter-Agency body, should consider. These actions/recommendations are as follows:

(i) **That the BSAB redoubles efforts across all agencies to address the issue of self-neglect especially when an individual is non-engaged/non-contactable. The BSAB should audit the levels of awareness of the policy and the Self-Neglect Toolkit, in partner agencies, and ensure that there is consistent application of the Toolkit by all.**

(ii) **The BSAB should seek reassurance that the Multi Agency Safeguarding Hub is now fully functional and is able to facilitate multi-agency information sharing and action planning. This may involve a re-visiting of the membership of the MASH and of the information sharing protocols and governance arrangements that are in existence, to ensure that they are fit for purpose.**

(iii) **That the Board should carry out an audit to determine what partner agencies understand about the Safeguarding processes in Buckinghamshire, including where to refer Safeguarding concerns, where to get advice and guidance on Safeguarding issues, what constitutes a Section 42 Enquiry, the Safeguarding Process and the Threshold Guidance. This should include partners' awareness of other routes that they can use to protect the interests of adults with care and support needs including calling a multi-agency meeting, when it is appropriate to involve the police etc.**

(iv) **That, working with the BSCB, the BSAB should develop a "Missing Persons" policy and procedure.**

(v) **That the Board should explore further the issue of thresholds for police welfare visits and discuss/adopt the police initiated Joint Protocol on the Management of Mental Health Crises.**

(vi) **The BSAB should ensure that all partner agencies take steps to inform each other when service redesigns are being planned and/or introduced and give partner agencies the opportunity to draw attention to any unintended consequences that might accrue.**

(vii) **That the Board should explore the issue of providing some limited feedback to friends and other members of the public who make referrals to safeguarding agencies.**

If these recommendations are accepted, the Board will wish to draw up action plans for implementation and keep these under review until completed.

Section 8: Closing Remarks.

It cannot be said definitively that Ms. T's death could have been prevented or avoided, not least because we have no way of knowing the actual cause of her death. However, opportunities to formally refer/assess her because of safeguarding concerns or a more general assessment of her health, social care and mental health needs were missed (in particular, she was not assessed by the adult mental health team in late November 2015). Had any, or all, of these assessments been made, the outcome for Ms. T may have been different.

Robert Lake - Independent Author (1st June 2017)

Appendix One

BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD (BSAB) Case Ms.T. County Council Action Plan

		Findings from Adult 'T'	Action to address finding	Lead Person	Date for completion	What improvement are you hoping to achieve?	Completion Date
AGENCY name…Buckinghamshire County Council, Safeguarding Adults Team.							
		A Referral for S.9 Assessment could have been made at the point of the initial contact. This would have made sure there was more ownership of the concern rather than TVP feeding back to someone from the contact centre. I believe there should be a strong process for S9 / 10 requests between safeguarding and care management teams.	Review of process of referring cases between teams and then disseminate between teams.	Head of Service for Safeguarding Adults	May 2017	A clear streamlined process on transferring cases to Care Management.	
			Improve links with Mental Health during information gathering. Numbers of Mental Health duty workers to be provided to staff.	Business Manager for Safeguarding Adults	March 2017	Stronger links between the MASH and Mental Health Services.	March 2017
		There should have been a follow up conversation with the GP after NB requested no further action.	Reflection with Referral Coordinator and the wider team on how we work and engage with GP's	Business Manager for Safeguarding Adults	March 2017	Improve inter agency working.	March 2017
		Consideration for home visits when clients not engaging / difficult to get hold of	Reflection with Referral Coordinator and the wider team on how we work on a daily basis.	Business Manager for Safeguarding Adults	March 2017	A better level of engagement for clients.	March 2017
		A MASH enquiry to our partner agencies should have been requested.	Ensure staff are using MASH referrals appropriately. Reminder to be sent to staff to make use of MASH requests	Business Manager for Safeguarding Adults	March 2017	Improve inter agency working.	March 2017

Mental Health Trust Action Plan (Taken from the Root Cause Analysis)

Recommendation	**AMHT should have tried to visit Ms. A when she could not be located by telephone, considering the concerns raised by GP1 and Ms. A's recent discharge from EIS.**	**As a part of the review of EIS the Trust should look into discharge planning arrangements to check processes are robust.**	**The findings in relation to health records to be addressed individually with relevant staff with consideration to professional responsibilities using appropriate HR structures.**
Action to Address Root Cause	**1. Feedback to the AMHT regarding findings to ensure appropriate decision making and appropriate actions in future. 2. Findings and learning to be cascaded across the directorate via governance meetings.**	**The report to be shared with EIS review leads and the request to include discharge planning processes within that review and a review of current caseload sizes.**	**Individual meeting between relevant staff and Clinical Lead to discuss findings and identify appropriate actions to address concerns raised HR process to be used to guide and follow up with individual staff**
Level for Action (Org, Direct, Team)	**1. Team 2. Directorate**	**Directorate**	**Team**
Implementation by:	**Complaints and Patient Safety Investigator; AMHT Manager); Head of Service Bucks and Head of Service Oxon**	**Professional Lead Occupational Therapy Social Care Lead**	**EIS Manager**
Target Date for Implementation	**30th June 2016**	**1st October 2016**	**30th June 2016**
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion	**The report was shared with the SMT and with the clinical team and the reviewer of the EIS**		

Monitoring & Evaluation Arrangements			
Sign off - action completed date:	**1st September 2016**		
Sign off by:			

Issues Identified for Action by the GP

Training for all GP practice safeguarding leads on

- Using an appropriate read code to flag vulnerable patient records
- Understanding of self-neglect and the use of the self-neglect toolkit ahead of its launch
- Discussion of thresholds for safeguarding adult referral.