# BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

# SAFEGUARDING ADULTS REVIEW

## Adult T

Executive Summary August 2017

**Robert Lake Independent Author**

## Introduction

1.1 This is a brief anonymised summary of a fuller report commissioned by Buckinghamshire Safeguarding Adults Board subgroup on behalf of Buckinghamshire Safeguarding Adults Board.

1.2 The report summarises the work of the Safeguarding Adult's Review subgroup.

1.3 The Panel was established following the death of Adult T (who will be referred to as Miss T throughout this report) whose body was discovered on the 23rd February 2016.

1.4 Miss T was a young woman, who was born in Buckinghamshire of Asian origin. She had mental health problems as well as a history of asthma and type 2 diabetes. Therefore in terms of Buckinghamshire's Safeguarding Adult Review Policy (http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/buckinghamshire-safeguarding-adults-board/subgroups-and-safe-forum/safeguarding-adult-review-subgroup/ ) she was an adult with "care and support needs" and therefore met the criteria for her death to be considered for the Safeguarding Adult Review process.

1.5 The Safeguarding Adults Review Panel, chaired by an independent chairperson was established by the Safeguarding Adult Review subgroup to review the circumstances of Miss T's death to establish whether there were lessons to be learnt about services provided which might improve them for the future. It covered the period from 1st October 2014 to 23rd February 2016.

1.6 The Safeguarding Adult Review Panel included senior representation from each of the Agencies with responsibility for arranging or providing services to Miss T. This included:-

- Buckinghamshire Adult Social Care
- Buckinghamshire Safeguarding Adults Team
- Buckinghamshire Safeguarding Adults Board
- Oxford Health NHS Foundation Trust
- Bucks Health Care
- Healthwatch
- Thames Valley Police

1.7 Individual Agency reviews were conducted separately by these representatives (who themselves had had no previous responsibility for the services under consideration). The final report, of which this is a summary, brings together those individual reports. They are the basis for the overview of what took place, and the conclusions and recommendations.

1.8 Safeguarding Adult Reviews are separate from criminal or disciplinary investigations and are not designed to apportion blame.

## The Facts as they were known to Services

2.1 Miss T had been known to the local mental health services from several years and also had been supported by primary care. During the period of the review she was living on her own in a rented property. Over the years she had been employed in an accountancy role but her employment was usually part time. She had no

contact or support from her parents since leaving home in 2013. Her partner had returned to his own country and therefore it would appear that she had limited network of support around her at this point in her life.

2.2 In November 2014 she was living alone in her rented accommodation and she was supported the mental health team under the Care Programme Approach. At this time she was working and manging well on her own, therefore she was discharged from the CPA and her ongoing support was provided by a support worker from the Mental Health Early Intervention Service.

2.3 By July 2015, she was doing well, and planning to go and see her partner in Pakistan. She was however unemployed and her support worker suggested that she look at voluntary work.

2.4 By August 2015 the Mental Health Trust had formally withdrawn all services to Miss T due to her making significant progress and a good recovery.

2.5 In September 2015 her doctor tried to contact Miss T without success regarding her blood tests for her diabetes without success. By October Adult Social Care had been contacted by a friend of Miss T, concerned that they had not been able to contact Miss T. The police carried out a safe and well check and having seen Miss T sent a referral to the Safeguarding Team regarding their concerns about the state of the property.

2.6 In October 2015 the Safeguarding Team spent time trying to contact Miss T and liaising with services who had provided services to Miss T. By the end of October the police again carried out a further safe and well check, having to force entry this time but again finding Miss T safe inside.

2.7 Throughout November there were contact between the Safeguarding Team, Miss T, Mental Health Team and her doctor. However the last recorded contact with Miss T was on the 23rd November when two staff from the Housing Trust visited Miss T regarding the damage that had been sustained to her door by the police's forced entry in September.

2.8 On the 23rd February 2016, following a call from Miss T's friend, the police forced entry and she was found dead. There were no sign of suspicious circumstances.

2.9 The Coroner concluded that the cause of Miss T's death could not be ascertained and an open verdict was recorded.

**Key Findings of the Review**

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

I. What did agencies know about Ms. T's involvement with her family and partner and about her support networks?
II. Were formal safeguarding referrals/alerts/concerns raised – if so, when and what action followed?
III. Were there any mental capacity issues and if so, were they dealt with appropriately and in line with the Mental Capacity Act 2005?

4.1 The evidence considered by the Review Panel suggests that there were areas of good practice and these are recorded in the report, particularly in relation to the practice of Thames Valley Police, her general practitioner, Safeguarding Team and the Housing Trust.

4.2 However the report raised areas for consideration. These included:
I. The difficulty that staff encountered around how best to act when the person at the centre of the concerns are not willing to accept help, or at best, to do so on his/her own terms.
II. The fact that this was a case of self-neglect and this may have affected the way in which Safeguarding functioned as there was no "perpetrator".
III. The lack of sharing information between the Mental Health Trust and her general practitioner when Miss T was being discharged from services.
IV. The fact that at no stage was Miss T offered an assessment under section 9 of the Care Act.
V. That the concern raised by the police on 8th October 2016 to the housing trust and was not actioned by them until the 27th October.
VI. A considerable final point concluded that when no action was taken by the Adult Mental Health Service in late November 2015, beyond referring the case back to the GP Miss T "fell into a void". We have been unable to ascertain why this occurred but it is perhaps the most significant area of concern of all, albeit Miss T could have already been dead by then.

5.1 The review also highlighted several specific areas for consideration which included:-
I. The way in which agencies could have worked more effectively together to safeguard Miss T
II. Whether agencies could have communicated and shared information more effectively with regard to Miss T
III. Whether there were any legal routes that agencies could have taken.
IV. Whether there were any policy gaps
V. Whether there were any equality and diversity issues
VI. And finally whether there were any lessons that could be learnt in regard to the way agencies safeguarded Miss T.

6.1 There were also two other matters that arose. One was regard to the Threshold for Police visits and the need for the Board to consider whether there should be a local policy on arrangements for missing people. Secondly, how feedback is given to members of the public who raise concerns about their friend, family members, neighbours etc.

## Conclusions and Recommendations

7.1 The report makes seven recommendations for the Board to consider:

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

## Summary

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 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.

The Board accepted the Report at an Extraordinary Board meeting on the 10th August along with the recommendations above. An Action plan will be created and

implemented and monitored on behalf of the Board by the Safeguarding Adult Review subgroup.