



BUCKINGHAMSHIRE
SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult Q

Executive Summary August 2017

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Executive summary

Introduction

- 1.1 This is a brief anonymised summary of a fuller report commissioned by Buckinghamshire Safeguarding Adults Review Subgroup on behalf of Buckinghamshire Safeguarding Adults Board.
- 1.2 The report summaries the work of a Safeguarding Adult Review Panel.
- 1.3 The Panel was established following the death of Adult Q (who will be referred as Adult Q throughout this report) whose body was discovered on the 6th April 2016.
- 1.4 Adult Q was a 74 year-old man who lived alone in a private rented dwelling. He had a diagnosis of Bipolar Affective Disorder and Ankylosing Spondylitis – a long term inflammatory condition affecting the joints of the spine and a later a diagnosis of Parkinson’s disease. In terms of the Buckinghamshire Safeguarding Adults Board SAR policy, Adult Q was considered to be an adult with “care and support” needs and therefore his death could be investigated under the SAR process.
- 1.5 The Safeguarding Adult Review Panel, chaired by an independent chairperson was established to review the circumstances of Adult Q’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 1.1.2015 to 6.4.2016.
- 1.6 The Safeguarding Adult Review Panel included senior representation from each of the Agencies with responsibility for providing services to Adult Q which included:-
 - Buckinghamshire Safeguarding Adults Board
 - Buckinghamshire County Council Communities Health and Social Care
 - Buckinghamshire Safeguarding Adults Team
 - Healthwatch Buckinghamshire
 - NHS Chiltern Clinical Commissioning Group
 - Oxford Health NHS Foundation Trust
 - Thames Valley Police
- 1.7 Individual Agency reviews were conducted separately by these representatives who had not been directly involved in the case. Reports were also produced by other agencies not on the panel, which included, Frimley Health NHS Foundation Trust, South Central Ambulance NHS Foundation Trust, and West Minster Care Agency. A Practitioners event was arranged as part of the review process to enable workers who had been involved with Adult Q to meet together to discuss the report and its accuracy in relation to front line practice. 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.

2.0 The Facts as they were known to Services

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

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

2.2 Adult Q had a history of contact with Mental Health Services, with several admissions to Psychiatric hospitals, however by 2010 his mental health was considered to be stable and he moved into independent accommodation with support via his GP and a twice daily package of domiciliary care and the support of his friend Ms Y.

2.3 In August 2015, Adult Q was seen by his GP for a review and again later the same month due to concerns from his friend Ms Y that he was becoming unwell. There was a brief period of involvement from Mental Health Services at this point and he was then discharged back to his GP in October 2015.

2.4 By December 2015, Adult Q had suffered a fall and had been admitted to hospital. He was discharged back home with an increased care package of 4 visits a day.

2.5 During March 2016 a pattern of behaviours started to occur and referrals were made to various agencies, until a Mental Health Act Assessment was requested on the 21st March 2016, however at the same time due to concerns for his safety the police carried out a 'safe and well' check and broke into his house and he was taken into the acute hospital. He was discharged from hospital on the 29th March 2016.

2.6 On the 5th April 2016, Adult Q was found dead at home. The Coroner recorded his death as due to bronchopneumonia and associated severe kyphosis, secondary to that ankylosing spondylitis.

3. Key Findings of the Review

3.1 The Review Panel considered each of their findings in line with the Terms of Reference:-

I. The circumstances and events surrounding Adult Q's death

The report found that it was not possible to identify a direct causal link between deterioration in Adult Q's mental state with his death. However the relapse of his mental state may have played a significant part in how Adult Q responded to the offers of support from both the professionals working with him and the informal support network, prior to his death. It was concluded that it was not possible to say if the death of Adult Q was preventable or not but the circumstances of his death did highlight a number of concerns about the way agencies worked around Adult Q, including responses to his mental health and self-neglect.

II. If there were ways agencies could have worked more effectively with regard to Adult Q to safeguard him and others.

It is clear from the findings that there were several agencies who were working with Adult Q towards the end of his life and that there was communication between different agencies. However no one agency appeared to hold the full picture of his care needs and what was happening at any one time.

The Panel also found that there was a lack of recognition of the value of the support provided by Adult Q's friend Ms Y as well as the role of the Church in his life. So that when his friend was removed from his support network due to an allegation of financial abuse, there was a significant gap in the level of support he was receiving which was not recognised by services.

III. How legislation, policy and guidance informed the provision of care provided to Adult Q, including duties and powers under the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 1983.

The report looked at which pieces of legislation could have been utilised when supporting Adult Q, in particular the Mental Health Act in relation to Mental Health Act assessments, one of which was requested near to the end of his life, but was not undertaken.

Then secondly around the Mental Capacity Act, where there is evidence that although these were carried out sporadically that there was no consistent application of the Act. This is particularly the case in relation to his finances. In the past he had had an appointee for his finances but lately allowed to manage his own money with no evidence of why this change had occurred.

Also, considering legislative provisions for carers and the people they care for together, a holistic view of Adult Q's needs with his main carers would have been preventative and protected against the risk of self-neglect.

IV. How learning from previous related case reviews impacted on the care provided to Adult Q.

A range of other Safeguarding Adult Reviews including the Thematic Review carried out by Buckinghamshire Safeguarding Adults Board were analysed as part of this review. It was agreed that the impact of learning captured in previous case reviews should be evaluated and monitored as part of the learning from this Safeguarding Adult Review.

At the stage of the review it was apparent that Practitioners remain unaware of the Self-Neglect toolkits available, or are unsure as to when they should be used.

V. Information sharing, communication and coordination of multi-agency care, including referrals, assessments, discharges and transitions.

In the case of Adult Q information sharing and communication was at times an issue. Information was held by various agencies but not equally shared with all agencies providing care and support to Adult Q. There also appeared to be a lack of clarity around roles of certain agencies and lack of understanding about how teams functioned.

The two major failings in relation to communication appeared to occur: first when a Mental Health Act assessment was requested but a mental health assessment was conducted and secondly when Adult Q was discharged from Wexham Park in the week prior to his death there was a lack of communication from the hospital to agencies in the community, therefore the GP and other agencies were unaware that he was being discharged.

VI. Management of Adult Q's physical and mental health conditions.

In relation to his mental health, Adult Q had a long period of stability without the need of the intervention of mental health services. However in March 2016 his mental health started to deteriorate and a referral was made for a Mental Health Act assessment. At this time, Adult Q was not well known to mental health services and he did not know them well either. He was known to be fearful of services in that he was concerned that he might end up in a care home or hospital.

The Panel found that there was no relapse plan available for Adult Q, had there been a plan this could have been put into action.

RECOMMENDATIONS

The report contains a number of recommendations, which can be seen in full in the main report but are summarised below:-

- 1) Multi-agency working – That the Board should carry out an evaluation and efficacy review of the RAMP process.
- 2) Legislation, Policy and Guidance –
 - A) That the Board should obtain quantitative and qualitative data on needs assessment and carers assessment to ensure that professionals understand the duties placed on them by the Care Act 2014, and are meeting expected practice standards for holistic working.
 - B) That relevant agencies should publish and disseminate, to potential referrers, clear information about the options available to individuals experiencing deterioration in their mental health and the difference between a mental health assessment and a Mental Health Act assessment.
 - C) That agencies responding to referrals about individuals experiencing deterioration in their mental health should ensure that appropriate Feedback is offered including where appropriate the planned intervention and role the referrer could play in supporting the individual.
 - D) The Board needs to assure itself that the level of expertise and knowledge of staff across health and social care in relation to assessing capacity and carrying out best interest decision-making is sufficient, and take any action to remedy skills and knowledge deficits.
- 3) Information sharing, communication and the coordination of care – The Board should consider the role of the Lead Professional/Communicator in the context of multiagency self-neglect intervention and how the identification of a lead professional may be able to act as a conduit of information to facilitate multiagency decision-making.
- 4) Physical and Mental Health Conditions – The Board should consider how a recovery-focused approach to mental health service treatment and support could be used to ensure that services users with long-term conditions who are discharged from services have a complete discharge plan including a summary of relapse indicators, a crisis and contingency plan and information on re-referral pathways.
- 5) Individual Management Reviews – The board should consider, in future reviews, a pre IMR briefing so that IMR authors are aware of the methodology being proposed by the independent author and can be reminded of what is expected of the organisation involvement and IMR analysis.

There were additional lines of enquiry that developed as the Review continued which included:

- Cross Boundary Hospital Admissions

- Risk Management in relation to Self-Neglect
These areas are discussed in more detail within the report (page25)

Summary

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

The Board accepted the Report at an Extra Ordinary 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.