Safeguarding Adult Review in respect of 'Charles'

Contents

1. Introduction, Background & Circumstances Leading to the Review

1.1 Charles is a 52-year-old man who has a diagnosis of Schizophrenia. He was born in Pakistan where he grew up before moving to England. Charles has an older brother and younger sister. On moving to England Charles lived in the former family home in Dawlish with his mother Liz. His father lived elsewhere having separated from Liz. In November 2012 Liz was evicted from the former family home by her husband, the owner of the former family home, and was placed in emergency accommodation by the local housing authority. Charles reportedly declined to complete any documentation and therefore spent a period of time sleeping 'rough' on the streets.

1.2 Liz later moved in to one bed rented accommodation through Teign Housing. Charles moved in with his mother and was sleeping in the living room on the sofa. The home environment was described as very poor and having a significant odour. The fridge wasn't working and there were hardly any working lights. The drain in the shower was blocked and the bathroom was said to be filthy.

1.3 Charles is a sibling of a patient detained at Langdon Hospital under section 3 of the Mental Health Act (MHA). Concerns regarding Charles' physical and mental health were first raised by clinicians at Langdon Hospital, although he was not their patient, in January 2018. At this time no one had met Charles, but Langdon Hospital had received reports from Charles' mother that she was worried about Charles' physical health and mental health. During a visit to the home to assess the suitability of home leave for Charles' brother in March 2018, clinicians at Langdon Hospital raised further concerns with the GP surgery regarding Charles' physical and mental health. They described the home situation to be "incredibly poor", that Charles appeared to have not washed for a significant period of time and concerns that Charles was self-treating a suspected leg infection on both legs with talcum powder, this was to absorb the puss and weep from the wounds. Clinicians at Langdon Hospital reported that Charles' mother raised her own concerns around the safety and the deteriorating health of her son. Charles' mother told clinicians at Langdon Hospital that Charles would not engage with health professionals and get treatment for his legs.

1.4 Between January 2018 and June 2018, it was difficult to persuade Charles to engage with services and treatment for his leg ulcers given his reluctance to trust professionals. Liz described Charles as being an introvert and a person who liked to keep himself to himself. Liz stated that "Charles had always been quiet and wasn't one to converse unnecessarily. He is polite when spoken too and is a kind man."

1.5 Clinicians at Langdon Hospital raised a safeguarding concern in September 2018 for both Charles and Liz in respect of concerns about their safety and wellbeing in the community. In the referral, clinicians at Langdon Hospital described the difficulty from their perspective, in seeking support for Charles regarding his physical and mental health. Charles was at that time known to a number of agencies:

- Devon County Council, Coastal Community Health and Social Care Team (CHSCT)
- Devon County Council, Safeguarding Adults Team
- Devon Partnership Trust, AMHP Service
- Devon Partnership Trust, Langdon Hospital
- Devon Partnership Trust, Crisis Team
- Primary Care, Barton Surgery, Dawlish

1.6 Charles was detained on Haytor Ward under the MHA in August 2018, having been admitted to the General Hospital for medical and nursing care due to possible infection of leg wounds. On admission to Haytor Ward, it was reported that Charles had ulcers on his legs that were of 2-3cm deep. At the time of this review Charles is said to be making positive progress.

1.7 Devon Safeguarding Adults Board (DSAB) received a referral for consideration of this matter for a Safeguarding Adults Review (SAR) on 27 August 2018 in respect of Charles. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect[1]. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

1.8 The Safeguarding Adults Review Core Group (SARCG) reviewed the referral for Charles and it was determined that the above criteria for a SAR was met.

[1] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

2. Methodology

2.1 The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a SAR[2].

2.2 The Care Act 2014 Statutory Guidance states that the process for undertaking SAR should be determined locally according to the specific circumstances of individual cases[3].

2.3 The SARCG resolves to consider how reviews can be more effective in terms of balancing the time that agencies are involved in such reviews, timeliness of reviews and learning outcomes that can improve the service provided as partners. The methodology selected was therefore based on a proportionate reflective learning review model that would produce a concise report focused on key learning and recommendations. It is intended that this will inform an action plan to inform and improve future practice and partnership working.

3. Process and Scope

3.1 Full Terms of Reference and a Reflective Learning Event plan were agreed on 23 October 2018 and are included in Appendix 1. It was agreed that the scope of the review would take account of events in the life of Charles in the year prior to his admission to hospital under s3 Mental Health Act in August 2018.

4. Adult and Family Engagement

4.1 The Clinical Specialist for Safeguarding, Devon Partnership Trust met with Charles on 30 August 2018 and informed him of the decision to undertake a SAR. Charles agreed to allow a review of his care prior to his admission to hospital. The Clinical Specialist for Safeguarding deemed that Charles at that time had the capacity to agree to the review.

4.2 The DSAB Safeguarding Practice Lead and DPT Clinical Specialist for Safeguarding met with Liz on 3 December 2018, at her home address, to discuss the safeguarding concern. It was intended for the meeting to establish Liz's preferred outcomes; to discuss the

[2] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[3] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

decision to undertake a SAR in respect of Charles, and to agree how she wished to be involved. Liz did not perceive herself to have been a victim in any way. She talked positively of her relationship with Charles and of the support, she personally, received from different agencies. Liz did not feel that any further action was warranted under safeguarding in respect of herself. Liz described how concerned she had been regarding Charles' physical health. She described how upsetting it was to see Charles "taken" from the home and in to hospital. She stated that she did not believe Charles needed treatment or support in relation to his mental health but stated that she was relieved that he was now receiving treatment for his legs and that he would not have consented to this support otherwise. Liz was supportive of a learning review being held to establish whether there are any lessons to be learnt from Charles' circumstances about the way in which local professionals and agencies work together to safeguard adults at risk. The DSAB Safeguarding Practice Lead and DPT Clinical Specialist for Safeguarding agreed to meet again with Liz once the review had taken place to share the learning.

5. Areas where Learning has Occurred

5.1 Communication and Coordination

5.1.1 Between January 2018 and June 2018 there were number of attempts made by agencies to encourage Charles to engage with health professionals and get treatment for his legs and professionals were communicating with the various agencies who had expressed concerns about his physical and mental health. The learning identified was not that agencies and organisations were not communicating rather that there was no one lead person or agency who was coordinating that communication.

5.1.2 In May 2018 there was an informal discussion between the Approved Mental Health Professional and Langdon Hospital Doctor in relation to potential routes forward for Charles and it was proposed that a 'risk management' meeting should be convened. As communication was outside of usual channels and not recorded there was no clear indication of who would be responsible for coordinating this and the 'risk management' meeting was never arranged.

5.1.3 In June 2018 the Community Health and Social Care Team convened a Safeguarding Enquiry Meeting in respect of Liz due to safeguarding concerns for Liz regarding Charles' relationship with Liz, the impact of Charles' health on Liz's wellbeing and the condition of the home, the risk of eviction due to Charles not letting in the Gas Service to complete a

gas safety assessment and concerns that Charles is not allowing Liz to take her medication as prescribed. The meeting was attended by the Community Health and Social Care Team Manager, Community Health and Social Care Team Social Worker, Liz's GP, a Mental Health Crisis Team Worker, a Forensic Social Worker from Langdon Hospital, an Occupational Therapist from Langdon Hospital, and a Support Worker from Intermediate Care. A representative from the Approved Mental Health Professional Hub was invited, but unable to attend. There was confusion as to the purpose of this meeting with other professionals believing this to be the 'risk management' meeting for Charles that had been proposed. The confusion around the purpose and focus of the meeting meant that professionals attended with different agendas. Despite the focus of the meeting being on Liz it appeared to take a 'think family'[4] approach considering the needs of Charles as well as Liz. What it was unable to achieve was a focus on the specific risks pertaining to Charles' physical and mental health. It was unfortunate that the AMHP service could not attend this meeting. There was no plan agreed at this meeting regarding how Charles needed support and how it would be delivered.

5.1.4 Professionals reflecting at the learning event agreed that the cumulative impact of Charles' physical health was not fully understood. Agencies had bits of information that if shared might have changed the assessment in terms of the level of risk and rationale for decision making. Many professionals felt that their voices were not being heard or listened to and reflected that in multi-agency meetings where there is challenge it can be difficult to maintain objectivity.

Learning Point 1: *Earlier multi-agency approach for both Charles and his mother would have created an opportunity to share information in order to assess risk.*

Learning Point 2: *Critical practice is important as is listening to the views and expertise of other professionals both of which provide a vehicle for professional curiosity and challenge.*

Learning Point 3: *There needs to be a common use of language and terminology across the system i.e. Multi-Disciplinary Team meeting, Risk Management Meeting, Safeguarding Enquiry Meeting etc.*

Learning Point 4: *Communication and coordination is key to ensuring that the risk and the plans around these are understood by all.*

[4] Think Family is supporting whole families as well as individuals through better information sharing, more collaborative interventions and the right level of priority given to the most vulnerable members of the group promoting a holistic approach to managing risk.

5.2 Safeguarding and Self-Neglect

5.2.1 The Care Act 2014 brought in self-neglect as a category of abuse in April 2015. Self-neglect covers a wide range of behaviours neglecting to care for one's personal hygiene, health or surroundings. Section 14.17 of the Care Act Statutory Guidance August 2016 notes that self-neglect may not prompt a section 42 enquiry[5]. An assessment should be made on a case by case basis. A decision whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

5.2.2 In this case there was more than one safeguarding concern. There was concerns for Liz in relation to neglect through deprivation and physical-psychological abuse from Charles who was considered as being obstructive to health and care support for Liz. There was evidence that Liz was not taking her prescribed medication for blood pressure or pain relief which would ease the arthritis and potentially allow for greater mobility. Liz had complained of chest pains and had agreed to see her GP however Charles maintained that Liz did not need a GP. There was also concerns for Charles in his own right as there was evidence of self-neglect.

5.2.3 Safeguarding was only considered in relation to concerns over Charles' relationship with Liz and not in relation to his self-neglect. As Charles' physical health was deteriorating his behaviours surrounding this were becoming of increasing concern to his mother and professionals. There had been a number of attempts to engage Charles by the GP, and although the GP undertook several home visits and arranged for a Doctor with Islamic faith, to visit as this had been an expressed preference by Charles, Charles did not allow the GP in the home and refused to accept any form of support in relation to the treatment of his legs. Charles' self-treatment of his legs was of great concern. He was reported to be using talcum powder to pack the fluid leaking from his legs. He was observed to pick at his legs and there was skin residue and blood in front of and on the chair where he sat. His toenails were 4 inches long.

5.2.4 Professionals who visited the property described its condition as extremely poor and dirty. There was no working fridge in the kitchen and few working lights. The drain in the shower was blocked and the bathroom was said to be filthy. The home had a significant

[5] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

odour and due to the skin and talcum powder residue the floors of the kitchen and bathroom were extremely slippery. There were additional concerns that Liz's tenancy was at risk as she had received a letter threatening court action due to Charles blocking a gas safety assessment at the flat. The Community Health and Social Care Team were working with Liz in order to find the most appropriate way to improve the home situation.

5.2.5 Professionals reflecting at the learning event agreed that a safeguarding referral should have been made for Charles in relation to self-neglect. They stated that their focus had been on building a relationship with Charles to encourage him to engage and receive treatment for his physical health. Professionals were mindful of the fear from mother that Charles might also be 'taken away' and this was a contributing factor to wanting to take a slow approach and build a relationship.

Learning Point 5. *There was a missed opportunity to work in a collaborative way in relation to Charles through using the legal framework of safeguarding.*

5.3 Multi-Agency Referral Processes and Criteria

5.3.1 The Approved Mental Health Professional (AMHP) Service received three referrals in relation to Charles during the timeframe specified in the scope of review: 24 January 2018, 29 June 2018 and 30 July 2018. A referral was also made to the Mental Health Assessment Team on 12 March 2018.

5.3.2 The decision as to the outcome of the first referral to AMHP Service on 24 January 2018 was made without a face to face assessment, relying on discussions with Liz and the GP to make the clinical decision in respect of Charles. The approach was considered on the basis of the report of risks to Liz from Charles and the uncertainty around the nature and degree of any mental disorder. Liz denied any evidence of odd/delusional beliefs in Charles and confirmed her primary concern is his legs and the condition of the property as a result. The outcome of this referral was that not enough evidence existed for statutory mental health intervention at that time. The GP agreed to continue to attempt engagement on physical health needs (along with consideration of mental health needs).

5.3.3 Professionals report that Liz gave a different account of her situation to different professionals. Given that the AMHP Service were aware of concerns that Liz was at potential risk from Charles, albeit these had not been clearly defined; this should have been explored more explicitly. The AMHP Service held a team reflection meeting, where

it was noted that potentially too much weight had been given to the reports from family members and that application of more in-depth professional curiosity with a 'cold call' approach would have been a good step to take.

5.3.4 The referral made by GP to the Community Mental Health Team on 9th March 2018 was not accepted as Charles was not consenting to the referral. This was a possible missed opportunity.

5.3.5 Referrals to agencies did not necessarily provide an accurate reflection of the situation. It is possible that assumptions were made about the level of knowledge agencies had around Charles' situation. The second referral to the AMHP service on 29 June 2018 reported a clearer picture of Charles' psychotic beliefs and ideation and arrangements to set up a Mental Health Act Assessment were made. The outcome was s.2 MHA detention.

Learning Point 6. *Consideration needs to be given in terms of follow up on agreed actions when referrals are closed.*

Learning Point 7. *Clarity of concerns and nature of risk in terms of what is being referred / nature / details.*

Learning Point 8. *Consideration needs to be given about challenging the information provided by family members, application of professional curiosity, particularly where there is a potential difference of view being expressed.*

5.4 Application of the Mental Capacity Act

5.4.1 The Mental Capacity Act was not properly considered or applied. The GP stated in the Safeguarding Enquiry Meeting in respect of Liz that he believed Charles to lack capacity in relation to his physical health. However, professionals did not explore this further in terms of the actions that could be taken in his Best Interests if he lacked capacity in this regard.

5.4.2 Application of the Mental Capacity Act may have been fundamental in understanding if the issues that appear to be self-neglect are in fact due to a person lacking capacity; to understand the impact that their behaviour is likely to have on their health and wellbeing. In Charles' case there were grounds for the professionals involved to questions their presumption of Charles mental capacity in relation to managing his physical and emotional health and care needs.

5.4.3 Professionals reflecting at the learning event questioned whether Charles' age affected their response. On exploring how a similar situation would have been responded to for an older person it was acknowledged that the Mental Capacity Act would have been considered.

Learning Point 9. *Mental Capacity Act assessment should have been considered by professionals at various stages throughout involvement.*

6. Good Practice

6.1 Professionals who attended the learning event were asked to identify areas of good practice from their own and other agencies' involvement. Evidence of notable practice included:

- There was a focus on proportionality and relationship-based practice.
- There was consideration of cultural influences.
- There were proactive approaches by professionals. The GP for example, undertook several home visits in relation to Charles' legs. He also arranged for a Doctor with Islamic faith, to visit as this had been an expressed preference by Charles.
- Adult Social Care did more than what was/is expected. in terms of arranging and funding a deep clean of the property.
- The AMHP service kept the door open in terms of re-assessing.
- There was evidence of Adult Social Care management oversight and support to their staff.
- Despite the safeguarding meeting in respect of Liz being challenging, professionals felt the meeting was chaired well and there was a 'think family' approach considering the needs of Charles as well as Liz.
- Langdon Hospital were advocates for both Charles and his mum.
- Professionals persevered with Charles to encourage him to engage and receive treatment for his physical health albeit unsuccessfully.

7. Learning and Recommendations

7.1 Recommendations were made by the group based on the learning points identified. These will inform the overall action plan.

1. Ensure staff have effective awareness of services available along with threshold levels.

2. Provide clarity in terms of the role of consent when referring an adult to mental health services when a serious mental health illness is being considered.

3. Ensure staff can identify concerns in relation to self-neglect and have the confidence to act on their levels of concern knowing what to do about this.

4. There needs to be development of a protocol for cross system lead roles which links to risk management. There needs to be a common use of language and descriptors for meetings and processes across the health and social care system and across the County, in general, in respect of risk management meetings and safeguarding meetings.

5. Develop risk assessment tools for professionals to use to assist them in assessing risk and impact.

6. Increase staff knowledge of Mental Capacity Act (2005). If there is reason to be concerned that an individual's capacity for a specific decision may be affected staff need to ensure that consideration of this is recorded and assessment outcomes are clearly evidenced.

7. In multi-agency meetings where there is challenge it can be difficult to maintain objectivity. Promote staff awareness of the potential impact on professional practice and the importance of critical practice.

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