Wiltshire Safeguarding Adults Board

Learning Briefing

Safeguarding Adults Review - Adult C

Adult C

Adult C, aged 74, had been diagnosed with Paranoid Schizophrenia in 1989. Although he was supported to live independently, he was very reluctant to engage with professionals and Community Treatment Order ensured that he received anti-psychotic medication. The Court of Protection Team were given a Deputyship Order in 2012 to manage his finances.

However, after concerns were raised about Adult C's behaviour and physical health, he was recalled to a mental health hospital for assessment. Adult C waited a week for a bed and, on admission, a physical examination revealed he was emaciated and starved. Adult C was then admitted to hospital where he died eight days later as a result of community acquired pneumonia and paranoid schizophrenia.

After his death, Adult C's family found that payments to his personal account had been stopped and there were only a few pounds in the account. Adult C had not received regular physical health assessments and assessment of his capacity to make decisions in his own best interest were not sufficiently evidenced.

The complexity of Adult C's case, his reluctance to engage and a failure to work effectively across agencies increased the risks to Adult C's health.

Our Review

This learning briefing summarises the key themes and recommendations from a Safeguarding Adults Review (SAR), undertaken in 2018/2019. The Care Act (2014) states that Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or is thought to have suffered, abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively to protect the adult. The purpose of the SAR is to promote effective learning and improve action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and applied to future cases. We encourage all managers and staff working with vulnerable adults to read this briefing, and ask that you take time to reflect on the issues discussed here, considering together with your team/s, how you can challenge your own thinking and practice to improve outcomes for vulnerable adults. This document includes a feedback sheet which we kindly ask you to complete and return, to capture how you have used this learning.

Key Themes and Learning Points

Good practice

All the professionals working with Adult C wanted the best for him and tried to let him live his life in the way he wanted, evidencing a person-centred approach.
The CPN evidenced flexibility to try and catch Adult C at home for his injections.
There is evidence that professionals did know and understand Adult C, and they worked hard to engage with him.
Police officers who engaged with Adult C recognised him as a person with vulnerabilities. They shared information with the Mental Health Street Triage Team rather than criminalise him.
There was some evidence of professionals working together to co-ordinate their visits to cause less disruption to his life.
Adult C was recognised as a very vulnerable man who professionals worked with for six years to help him live independently in the community.
When Adult C was admitted to hospital, staff there assessed he did not have capacity to make decisions for his care and treatment. They used the Mental Capacity Act best interest decision making process to carry out medical healthcare interventions to try and treat Adult C.
Adult C's family spoke very highly of some of the professionals involved in the care of their brother.

Application of the Mental Health Act

Although a Community Treatment Order was successfully used, other areas of the Mental Health Act could have been applied more effectively. Under the Act, a more formal 'nearest relative' is appointed rather than a general 'next of kin' and, where there is no spouse or children, the oldest sibling is automatically given this role. Adult C's older brother and then sister took on the role, however his younger brother was the main family contact. This caused confusion about who to contact when Adult C was admitted to hospital. It is crucial that roles are clear to all, especially in large families.

"The family … had no idea about the care plans, or some of the issues that had arisen, until after the death of Adult C". p11

Adult C's daily care was managed through the Care Programme Approach (CPA), but this could have been applied more robustly. Whilst Care Plans were reviewed and shared with the GP, they were not shared with Adult C's family. Multi-agency reviews can involve family members, particularly in complex cases. As there were increasing difficulties with Adult C's behaviour, CPA reviews could also have happened more often. This opportunity to share information may have resulted in a multi-agency plan, involving family members. Large caseloads and the case's long-term nature may explain why this was not considered, and why the case did not receive a fresh and objective view.

- Involving families in multi-agency reviews provides opportunities to share more information. **Do multi-agency reviews you conduct routinely include family members?**
- Clarity of family roles ensures better communication. **How does your organisation ensure that this happens?**

Parity of Esteem and use of the Mental Capacity Act / Care Act

Parity of esteem means giving mental health equal value to physical health. However, in Adult C's case, it appears that assumptions were made because of his mental ill-health, about his physical health treatment. For example, although it was thought Adult C may have a hearing problem, the assumption that he would not agree to be tested meant an appointment was not pursued.

When professionals made referrals to the GP about Adult C's weight loss, it was not clear what they were asking for. Letters to GPs should be as clear as possible - with requests set out clearly at the start of a document rather than the end, a technique known as 'BLUF' (bottom line up front).

"… in a practice that receives hundreds of letters regarding many patients… it is crucial that any action required of the GP is clearly highlighted." p12

Adult C did not present as a typical case of self-neglect. His appearance and living conditions gave no cause for concern. Despite that, the Mental Capacity Act could have been applied when Adult C refused physical health interventions. This would have meant his capacity to make decisions about his health was assessed and a multi-agency plan, perhaps with a Court of Protection application, could have been put in place if not.

When Adult C received his medication by injection five weeks before death, he had enough muscle mass for a normal needle to be used. At that time, the mental health professional who saw him had no concerns about significant or sudden weight loss. However, as there was no post mortem or report to the coroner, it is not known if Adult C had underlying medical conditions or how quickly his weight loss progressed.

Hospital staff should have reported Adult C's death to the coroner as:

- there was a question of self-neglect, and
- he was being treated under the Mental Health Act.

The hospital and the coroner together decided that the coroner referral was not required, but this conversation was not recorded. It can only be assumed that the points above were not made sufficiently clear to the coroner.

- Robust communication and clarity of actions can ensure appropriate responses. **What could your organisation do to improve its communication with other agencies?**
- Including other agencies in CPA reviews can ensure a holistic approach to risk and care planning**. Does your organisation routinely involve all other relevant agencies in its CPA reviews?**
- How does your organisation ensure that Mental Capacity Assessments are carried out when needed, particularly around refusal of physical health treatment?
- **How confident are staff in your organisation about identifying self-neglect, especially where this may not be evident in the person's appearance?** Safeguarding processes need to be applied when there are any concerns that a patient may have been neglecting their own care.
- How does your organisation ensure that coroner reports are made, and what the requirements for this are when a patient is treated under the Mental Health Act?
- Where a patient is under the Mental Health Act or there are other situations that require a report to the coroner upon death, it is important to document decision making. **How does your organisation ensure that record keeping in these circumstances is accurate and comprehensive?**

Managing the resistant yet vulnerable person

When new professionals tried to engage with Adult C, they did not always request support from the professionals who knew him well. In addition, Adult C's family were not made aware that he was avoiding professionals. By working with those professionals who knew him best and with Adult C's family, the chance that Adult C agreeing to visits, assessment and treatment may have increased.

Adult C was well-known in the community. He was familiar to the police, with increasing frequency. Police knew Adult C was vulnerable and when they were contacted about his behavior, instead of criminalising him they sought to help him.

However, this approach meant multi-agency meetings that would have been organised if the police had taken a more traditional approach, did not happen.

"A person who is treated more liberally and sensitively because of their mental health condition receives a less robust intervention". p17

Supervision is crucial in supporting professionals working with people like Adult C, who have enduring mental ill-health and are resistant to services. When someone has been known to services for a long time, sometimes it takes a fresh pair of eyes to see what could be done differently.

- **How effectively does your organisation consult with others to work with people who are difficult to engage?**
- Information coming from Street Triage Teams may evidence the need for a multi-agency review. **Do you have a process through which this would happen?**
- **Do the supervision processes in your organisation allow for appropriate objectivity and reflection in long-term cases?**

Office of the Public Guardian and Finance Deputyship Order

Adult C was known to spend only around £100 a month. This low amount was not questioned although, alone, the amount seems unlikely to have been sufficient to cover his basic living costs. Eventually Adult C's regular payments were suspended when the amount in his account had built up significantly. This seems to have been the right decision at the time and his finances were managed by a Deputyship Order made to the Local Authority from that point.

However, that decision should have been reviewed regularly. For a number of reasons, that did not happen and this meant that no-one realised Adult C had limited funds until after his death. Those reasons were that:

- Adult C did not engage with some visits.
- Adult C did not know about the funds' suspension, nor did his family or mental health worker.
- Adult C did not discuss his finances with family or with professionals that saw him - the mental health professionals that saw him would not have been aware of the way his finances were managed
- There was no trigger to managers in the Court of Protection team about outstanding annual reviews or visits.
- Deputyship Officers were not involved in CPA meetings.

Significant changes have since been made to the managing of Deputyship Orders in the Local Authority and Mental Health Trust.

- **How does your organisation ensure the Court of Protection Team are included in multi-agency reviews, where they hold a Deputyship Order?**
- **How does your organisation ensure families views are included in multi-agency reviews, where there is a Deputyship Order?**

Feedback

To further help us share this learning, please complete the short form below and send back to us at lsab@wiltshire.gov.uk.

Name		**Date**	
Job title			
Agency			
Who was this briefing cascaded to (e.g. District Nurses, Social Workers)?			
Where was this briefing used (e.g. 1:1/group supervision, team meeting, training event with X number of staff)?			
Changes to your organisation's practice following the learning:			
1. **2.** **3.** **4.** **5.**			
Other feedback:			