Essex Safeguarding Adults Board

ALAN

OVERVIEW REPORT

SAFEGUARDING ADULT REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF ALAN, A 58 -YEAR-OLD MALE WHO DIED IN DECEMBER 2018

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1. INTRODUCTION AND METHODOLOGY

Background

In May 2019, the Essex Safeguarding Adults Board considered the case of Alan who had been found deceased in his home. Alan was known to a number of services and was being supported at the time of his death. The safeguarding board recognised the potential to improve the way agencies worked together and commissioned this Safeguarding Adults Review (SAR)[1].

The review aimed to use the experiences of Alan to identify learning and to continually improve the way that agencies supported the wellbeing of adults at risk. A wide number of agencies from the safeguarding partnership took part and four key findings were identified. These are outlined in this report as follows:

a) Person centred approach to safeguarding.
b) Care Programme Approach processes.
c) Managing the risk of clinical disengagement.
d) Police welfare checks and safeguarding referrals.

Methodology

An independent lead reviewer was appointed to work alongside a panel of local professionals to undertake the review. Terms of reference were provided for the review, identifying the key date parameters as June 2017 to the date of Alan's death. Chronologies and single organisation reviews were provided by each agency, analysing practice events, and considering how changes to practice may deliver future improvement. The Mental Health Services provided a comprehensive Root Cause Analysis.

Practitioners and senior representatives from each agency met for the further analysis of events and to identify the systemic reasons as to why better outcomes were not achieved. All were then involved in identifying potential improvements for consideration by Essex Safeguarding Adults Board. Alan's family were provided the opportunity to be involved in the review but were not able to contribute. This overview report detailing the analysis and findings of the review panel was then prepared, having passed ESAB's quality assurance process.

About This Report

This report outlines the recommendations in a concise format. It is written with the intention of publication and as such does not contain information which may identify those involved. It aims to be a succinct and practical document as possible and therefore does not contain a detailed chronology of events, or the 'working out' process for the review findings. The detailed analysis of events and the evidence underpinning this report are held in additional documents retained by Essex Safeguarding Adults Board.

[1] Explanation and purpose of a safeguarding review - https://www.essexsab.org.uk/media/2493/safeguarding-adult-review-procedure.pdf

2. CASE SUMMARY & KEY EVENTS

Alan – An Overview

Alan was 58 years old at the time of his death, having attempted to take his own life whilst at home and later being pronounced deceased at hospital. He had lived alone and independently for a number of years, in accommodation provided by the local authority. He had a long history of poor mental health and had been supported by mental health services over a thirty-year period. He had a diagnosis of bipolar affective disorder, complicated by alcohol and drug addiction.

In 2004, he had been detained in hospital under the provisions of Section 2 of the Mental Health Act 1983 and at that time was diagnosed with drug induced psychosis. Whilst having a history of addiction, Alan was not believed to have used these substances for a number of years.

In 2015, Alan registered with his current GP practice and was seen on a number of occasions, mainly for events relating to his mental health. At the time of his death, he was being supported by mental health services provided by the Essex Partnership University NHS Foundation Trust.

Key Practice Events

a) In June 2017, Alan's GP identified that his mental health had deteriorated and referred him to the mental health services. He was accepted as an outpatient, however, was difficult for the services to engage with. He missed the majority of his appointments and was poorly compliant with his medication. He was last seen at an outpatients' clinic in November 2017.

b) In early September 2018, Alan was taken to the hospital Emergency Department following a mental health crisis event. He was subsequently detained under the Mental Health Act and admitted to hospital. He responded well to his treatment, although was reluctant to engage with ward activities and mainly confined himself to his room.

c) In early October 2018, his detention under the Mental Health Act concluded. A care coordinator from the community mental health team was appointed to support Alan and prepare for his return home with a care plan. This was in accordance with the Care Programme Approach (CPA) process[2]. Whilst the care coordinator introduced himself to Alan at the hospital, the care plan assessment process did not immediately commence. The coordinator was not involved in the planning process for Alan's subsequent discharge from hospital and did not meet with Alan again.

d) During early November, Alan was encouraged to take an increased amount of leave from the ward, in preparation for his discharge. He was however reluctant to engage with this, providing reasons as to why he was unable to leave the ward.

e) On the 8th November, Alan was discharged from hospital, having been given a day's notice to prepare. The discharge summary included a rationale that he had engaged well with his treatment and had engaged with an increasing amount of home leave. The subsequent root cause analysis review was unable to find any information to support this rationale, or how Alan's views had been captured. The community mental health team were not involved with the discharge process, which occurred before his care plan had been developed.

[2] Explanation of the Care Programme Approach - https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/

f) On the 9th November, the community mental health team met to discuss Alan's case and the process of commencing his CPA assessment. A risk assessment recorded the likelihood of Alan not engaging with services, which had been identified prior to his hospital discharge.

g) Upon returning home, Alan immediately disengaged from services. Despite repeated attempts he was not seen again by health professionals. As concerns for him increased, the police were asked to conduct a welfare check which was completed on the 12th November. Alan declined to allow officers into his home and he was only spoken to through a closed door. No concerns for his immediate safety were identified.

h) The first welfare check did not help the mental health team to initiate contact with Alan and on the 26th November the police were asked to conduct a second check. This was declined in accordance with policy, as there was no evidence that he was at risk of immediate and significant harm. It was recommended that the community mental health team apply for a warrant to conduct a mental health assessment[3], which the police could then support.

i) A decision was made to attempt further home visits before considering the issue of a Mental Health Act warrant. Two further visits were attempted and on the second (6th December), Alan was found at home having apparently died by suicide. His flat was found to be in a poor state, indicating that he had been struggling to live without additional support.

j) Upon attending the flat on the 6th December, the care coordinator had been able to gain partial access and had seen Alan inside with a ligature around his neck. The police attended and having forced entry checked Alan for signs of life. They found none and believing that he had been dead for some time did not attempt resuscitation. When the ambulance service attended, the paramedic determined that Alan had only recently tried to take his own life and commenced resuscitation. This was unsuccessful and Alan was later pronounced deceased at hospital.

3. CRITICAL ANALYSIS AND LEARNING

Finding 1 – Person Centred Safeguarding

Learning:

Many vulnerable people with complex needs find it difficult to engage with services. In order to support them a person-centred approach to safeguarding is required, finding ways to work with them and coordinate the work of the different agencies involved.

How agencies support vulnerable people who appear reluctant to engage with them, is a feature of many safeguarding reviews. This was a significant issue in Alan's case, who had difficulty in establishing and maintaining a relationship with the professionals supporting him. When additional support was provided to encourage this engagement, the efficacy of his care was improved. This was well evidenced through the personal approach taken by his GP surgery at the time of his registration in 2015. When this additional support could not be provided the quality of his engagement, and therefore the quality of his care, diminished.

Having been referred to the mental health services in 2017, Alan was assessed and then referred to a consultant psychiatrist as an outpatient. Alan missed his initial appointment on four occasions, eventually being brought on the fifth occasion by his son. He subsequently missed further

[3] Section 135 of the Mental Health Act - https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/#WhatIsSection135

appointments and was not seen again until his admission to hospital ten months later. The outpatient service does not include a care coordination function and therefore a plan to encourage his engagement with them could not be developed. This also meant that whilst written updates were provided to the GP, there was not a coordinated plan as to how the services would work together.

Alan was in need of considerable support to help him work with services, without which he would inevitably be seen as reluctant to engage with his treatment. His case highlights the need to consider how different agencies may be coordinated to support an individual with complex needs, rather than expecting them to fit in with the 'system'. A person-centred approach[4] to Alan's care may have offered the potential to improve outcomes, looking deeper into his life and understanding what could be done to improve his engagement with services. This may have improved his overall wellbeing, potentially preventing the deterioration of his health and his subsequent hospital admission.

In early 2021, new processes were introduced at GP surgeries in the Castle Point and Rochford CCG[5] area, improving the way vulnerable people are identified and cared for. These changes address the issues raised in this particular review finding. They include a strong focus on identifying individual need, involving partnership agencies in support planning, and coordinating activity. This change has been praised by the professionals involved in the multi-agency arrangements and whilst similar arrangements exist in other CCGs, this is not consistent in areas across NHS England.

Recommendation 1:	*The new arrangements introduced across the Castle Point and Rochford CCG, to identify and coordinate services for vulnerable people, have the potential to greatly improve the service provided to those who are hard to reach. This should be promoted as best practice with all Clinical Commissioning Groups.*

Finding 2 – Care Programme Approach

Learning:

When supporting people who have been admitted to hospital and who are in receipt of mental health services, the CPA assessment process should commence upon their admission. The care coordinator should be involved in the subsequent discharge planning meetings and the care plan should be developed prior to hospital discharge.

During the safeguarding review, it was explained that the health trust had a policy to commence the CPA assessment process before any hospital discharge. The practitioners involved in this review did not however describe that as common place. In Alan's case, the intention was to commence this process after he had returned home, despite the risk of non-engagement being fully recognised. By the time the community team met to discuss his case, it was already too late to engage with him.

Developing the care plan before his hospital discharge and involving the care coordinator in the discharge planning meetings would have provided three key advantages:

[4] Explanation of a person-centred approach - https://www.scie.org.uk/prevention/choice/person-centred-care

[5] CCG – Clinical Commissioning Group (https://www.nhscc.org/ccgs/)

a) It would have ensured that Alan's views were captured and considered in the discharge process. It was evident that he was concerned about leaving hospital, however this did not appear to be represented or considered in the discharge summary.

b) It would have provided time for a detailed person-centred assessment. This could have looked at all aspects of his life, understanding what he needed to effectively engage with professionals and identifying how partner agencies could form part of his care plan. Both the housing provider and adult social care may have provided key support in Alan's return home. In addition to supporting his living arrangements, this may have increased the opportunity for professionals to directly engage with him.

c) It would have allowed the development of a risk management plan. Maximising the chance of engagement at the time of discharge and to manage any subsequent disengagement from services. This could have included contingency planning with the other agencies involved in the care plan.

The Trust has a written CPA policy in place; however, this does not provide any guidance as to when the process should commence in respect of a person in hospital. It also does not provide any guidance as to the involvement of partnership agencies in the assessment process and care plan. There is no additional written guidance in place to address these two issues, although it is accepted that this may be included in training for those professionals involved in the CPA process.

This current policy is now due for renewal and it is therefore a good time to consider the development of new policy and procedure. The basis of any future guidance should be upon a person-centred approach to safeguarding and upon multi-agency working. The Trust has an excellent Clinical Disengagement policy which embraces both of these principles. This would be a useful place to start in the development of new CPA guidance.

The National Institute for Health and Care Excellence provides guidance in relation to a person-centred approach[6]. This is supported by the Mental Health Act Codes of Practice[7], which also outlines how CPA processes should commence at the point of hospital admission.

In July 2021[8], NHS England confirmed that during the period of 2021-2024, the CPA will be replaced with the Mental Health Framework for Adults and Older Adults[9]. This is a new community-based offer for mental health services, which supports the development of personalised and trauma informed care. It embraces multi-agency working and a personalised approach to safeguarding; and as such complements the recommendations identified during this review. Whilst implementing the new framework in Essex, this review recommendation should be considered and included in any procedures developed for professionals.

Recommendation 2:	*Whilst implementing the new Mental Health Framework for Adults and Older Adults, the Essex Partnership University Hospital NHS Foundation Trust should develop policy that is understood and consistently followed by staff across inpatient and community settings. The Trust should have*

[6] NICE Guidance - https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/1-delivering-services-that-are-person-centred-and-focused-on-recovery

[7] MHA Code of Practice – CPA found within Chapter 34, page 362. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

[8] https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

[9] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

	assurance mechanisms in place to monitor and oversee the application of this policy in its services.

Finding 3 – Managing the Risk of Clinical Disengagement

Learning:

As the risk increases for vulnerable people who disengage from services, the response should proportionately escalate. This should involve a multi-agency approach to safeguarding planning.

Following his hospital discharge, Alan completely disengaged from services. Despite numerous attempts the community mental health team were unable to contact him. The risk to Alan's safety was recognised and as concern increased it was discussed at a number of planning meetings. A key area of learning from this review is how escalating risk may be responded to.

Following the police welfare check, concerns should have escalated to a point where a multi-agency meeting would have been appropriate. Alan had declined to engage with the police, barricading himself inside the flat and refusing to be seen. A professionals' meeting could have allowed the development of a safeguarding plan to address the increasing concerns for his safety. In this case a joint visit with the mental health professionals and the police may have been considered. Had this not been successful then it may have provided additional grounds to obtain a warrant, enabling entry into Alan's flat to conduct a mental health assessment.

The Health Trust has an excellent Clinical Disengagement policy. It provides guidance to manage the risk of non-engagement and outlines the benefits of multi-agency strategy meetings. In Alan's case the policy was followed to a point, however there seemed a hesitancy to escalate to a professionals' meeting and for consideration of obtaining a Mental Health Act warrant.

The benefit of multi-agency working has been a consistent feature of this review and it now provides the opportunity to develop a greater culture of partnership working. This would improve services provided to vulnerable people and the ability of safeguarding partners to respond to risk. To support the development of this culture, it would be beneficial to hold multi-agency training for professionals in Essex. This should particularly consider how agencies can work together to safeguard service users who may be difficult to engage with.

It is also recommended, that managers and professionals working in the community mental health team receive additional training in the management of risk following clinical disengagement. The current policy should form the basis of this training and it should include the formal processes to engage with partner agencies and the chairing of strategy discussions. To cater for occasions where a partnership agency is reluctant to engage, this training should include use of the escalation policy and the statutory arrangements for safeguarding adult referrals[10].

Recommendation 3:	*Essex Safeguarding Adults Board should develop a programme of multi-agency training, focussing on how agencies work together to safeguard people who may be difficult to engage with.*

[10] Essex Safeguarding Adult Referrals Process - https://www.essexsab.org.uk/professionals/reporting-concerns/

Recommendation 4:	*Managers and professionals working in the Community Mental Health Teams, should receive additional training in the management of risk following clinical disengagement. This should include the coordination of partnership working through strategy and professional meetings.*

Finding 4 – Police Welfare Checks

Learning:

Professionals do not understand the role of the police welfare check, or its limitations as part of a wider safeguarding strategy.

During the review it was identified that uncertainty existed amongst professionals as to the purpose of the police welfare check. This includes when it would be appropriate for one to be requested and the information that should be presented to the police contact centre to support the request.

Essex Police has an established policy that outlines when it would be appropriate for them to conduct a welfare check. This outlines that it will only be appropriate where there is an immediate risk to life, or where a person is suffering from immediate and significant harm. This policy is supported by guidance from the College of Policing[11]. This explains the purpose as being limited to finding the person, calling for medical assistance where relevant, and feeding back information to the organisation requesting the check.

The welfare check is conducted by front line police officers, who only have limited skills in managing mental health issues and only have limited powers should the person choose not to engage with them. Whilst its purpose is useful to establish a person's immediate safety, its value in a wider strategy of developing engagement with a person is limited.

It would be beneficial for all agencies working within Essex safeguarding partnerships, to develop a wider understanding of this policy. This should apply to both adult and child safeguarding, as welfare checks are often requested in relation to young people at risk of exploitation.

It is recommended that Essex Police ensure that its Welfare Check policy is promoted widely across the safeguarding partnership. This should include its purpose, in addition to guidance as to the information they require to establish that the threshold to conduct the check has been met. In relation to the wider issue of how the police support multi-agency working and participation in strategy meetings, it would also be beneficial to clarify how specialist safeguarding teams are accessed. It would be useful to provide a single point of access for professionals.

The Health Trusts' Clinical Disengagement policy highlights the use of the police welfare check; however, it does not explain its purpose and what professionals will need to establish before a request is made. It is recommended that the policy is updated to include this information.

Recommendation 5:	*Essex Police should ensure that its Welfare Check policy is promoted with partnership agencies. This should further include how specialist safeguarding teams are accessed to support partnership working.*

[11] https://www.app.college.police.uk/app-content/mental-health/awol-patients/safe-and-well-checks/

Recommendation 6:	*Essex Partnership University Hospital NHS Foundation Trust should update its Clinical Disengagement Policy, to include specific guidance in the use of police welfare checks.*

4. PARALLEL REVIEWS

Whilst this review has focussed on multi-agency safeguarding arrangements, there has been a further two single agency reviews conducted which are relevant to this case. The first was a 'Root Cause Analysis Investigation Report' conducted by the Essex Partnership University Hospital NHS Foundation Trust. The second being an investigation conducted by Independent Office for Police Conduct (IOPC), examining the actions of the police on the 6th December 2018 and specifically the decision not to commence resuscitation.

Both of these reports make recommendations for those specific agencies and these are summarised at Appendix A of this report.

5. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Concluding Comments

The key learning from this review is the need to develop partnership working, to support the development of person centred and multi-agency care planning. Whilst this particular review examined the use of the Care Planning Approach, the learning is applicable to all safeguarding activity and support plans.

The Essex Safeguarding Adults Board should consider the recommendations outlined in this report and how they intend to deliver improvements to safeguarding practice. In addition to addressing the multi-agency recommendations it should hold individual agencies to account for delivering the single agency recommendations.

Summary of Recommendations

Recommendation 1:	The new arrangements introduced across the Castle Point and Rochford CCG, to identify and coordinate services for vulnerable people, has the potential to greatly improve the service provided to those who are hard to reach. This should be promoted as best practice with all Clinical Commissioning Groups.
Recommendation 2:	Whilst implementing the new Mental Health Framework for Adults and Older Adults, the Essex Partnership University Hospital NHS Foundation Trust should develop policy that is understood and consistently followed by staff across inpatient and community settings. The Trust should have assurance mechanisms in place to monitor and oversee the application of this policy in its services.
Recommendation 3:	Essex Safeguarding Adults Board should develop a programme of multi-agency training, focussing on how agencies work together to safeguard people who may be difficult to engage with.
Recommendation 4:	Managers and professionals working in the Community Mental Health Teams, should receive additional training in the management of risk

	following clinical disengagement. This should include the coordination of partnership working through strategy and professional meetings.
Recommendation 5:	Essex Police should ensure that its Welfare Check policy is promoted with partnership agencies. This should further include how specialist safeguarding teams are accessed to support partnership working.
Recommendation 6:	Essex Partnership University Hospital NHS Foundation Trust should update its Clinical Disengagement Policy, to include specific guidance in the use of police welfare checks.

6. Appendix A – Single Agency Review Recommendations

Root Cause Analysis Investigation Report – Summary of Recommendations

Recommendation: 1

The investigation team found that MDT review and CPA did not happen prior to the discharge in this incident therefore:

- The hospital consultant and ward manager/ charge nurse must ensure all discharges from the inpatient unit must have review and CPA prior to discharge.
- This should also address the risks that the patient may present following discharge and the plans
- This should be documented and communicated appropriately.

Recommendation: 2

The investigation team found that the documentation in the notes was inaccurate and not contemporaneous in this incident therefore:

- The ward manager must ensure the recording of the notes is accurate, clear, and contemporaneous. If required the agency and bank staff should be trained in making these notes

IOPC Report

Recommendation: 1

This related to a need to revise first aid training and the guidance provided to officers in respect of concluding that an individual was deceased. This recommendation was accepted by Essex Police which has resulted in the revision of this part of first aid training which is now delivered to all officers.

Recommendation: 2

This recommended a review of procedure in how Officers deal with incidents of hanging. The purpose of any such learning should be to ensure that officers are sufficiently well informed and trained to be able to fulfil their duty to preserve life as a first priority.