WALSALL SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

CLARA
(SAR 3)

OVERVIEW REPORT

Independent Reviewer: **Chris Brabbs**

Date of report: **2nd August 2019**

CONTENTS

1. The review process
2. Narrative of key events
3. Introduction to the review findings
4. Family involvement
5. Response to Clara's mental health and behaviours
6. Response to Clara's physical health Issues
7. Multi-agency working
8. Referrals and information sharing
9. Assessment and management of risks
10. Response to fire related incidents and risks
11. Response to formal safeguarding concerns submitted
12. Planned move to supported accommodation
13. Events during the last 24 hours preceding Clara's death
14. Examples of Good Practice
15. Summary of thematic learning points
16. Multi-Agency recommendation

Appendix 1: List of single agency recommendations

1. THE REVIEW PROCESS

Circumstances leading to the Review

1.1 This Safeguarding Adults Review (SAR) [1] was commissioned by the Independent Chair of the Walsall Safeguarding Adults Board (WSAB) following the death of Clara in July 2018 who sustained 90 degree burns from a fire incident at her flat.

1.2 Clara had been taken home in the evening by Police Community Support Officers after she had encountered her covered in faeces, dressed in her underwear under a coat. Home carers attended at the request of the police who helped Clara get clean and settle in bed. The carers left after a handover to paramedics who attended at the home carers request after a further episode of diarrhoea and vomiting. The paramedics' observations revealed the possibility of an underlying infection but Clara declined their advice several times to go to hospital and was deemed to have mental capacity to make that decision. Clara then asked the paramedics to leave.

1.3 Shortly after, West Midlands Fire Service responded to a call that Clara had been seen walking out of her house on fire, and then returning inside. Clara was taken to hospital with 90% burns and later died.

Background Information

1.4 Clara had a long history of mental health issues from her mid twenties with a diagnosis of bipolar disorder. [2] Following the death of her husband in 2015, there had been increasing agency involvement due to concerns in relation to her ability to look after herself both in terms of her physical and mental health. Clara had been admitted twice to a psychiatric hospital in 2015 and 2016 and after discharge continued to receive after care support from mental health professionals through the Care Programme Approach, and 3 x daily visits from home carers until her death. There continued to be numerous incidents which resulted in the involvement of the police, ambulance service, fire service, and community alarm to respond to physical health issues or concerns about her behaviour or presentation.

Parallel Processes

1.5 A Coroner's Inquest held in Autumn 2018 confirmed that the cause of death was burns and hypovolaemic shock due to fire. The Coroner recorded an open conclusion because it could not be known if Clara intended to set fire to herself, or whether it was accidental.

Time Period Covered by the Review

1.6 The SAR covered the period from December 2017 which was the point at which there were indications of Clara experiencing increasing difficulties in coping given the high number of occasions when she activated her community alarm pendant or made telephone calls to the emergency services.

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1 *Section 44 of the Care Act 2014 requires a Review to be carried out where "An adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"*

2 *Bipolar disorder is a long-term condition that involves periods of wellbeing that may end abruptly because of relapse into mania, hypomania or bipolar depression.*

Agencies Involved

1.7 The following agencies contributed to this SAR:-

Walsall MBC Adult Social Care
Walsall Healthcare NHS Trust
Dudley & Walsall Mental Health Partnership NHS Trust (DWMH)
Walsall Clinical Commissioning Group (CCG)
West Midlands Police
West Midlands Fire Service
West Midlands Ambulance Service
Accord Housing Association
Advance Healthcare
Tipton Homecare

Involvement of Family Members

1.8 Information about the SAR process was sent to Clara's son, daughter and son in law with an invitation to contribute their perspectives. There was no response to these letters and it was agreed that a further approach should be made prior to publication in order to try and share the review findings.

2. NARRATIVE OF KEY EVENTS

Explanatory Note

Until 31st March 2018, Clara's case was managed entirely by Dudley & Walsall Mental Health Partnership NHS Trust (DWMH) because of the Section 75 agreement between the local authority and DWMH for the latter to provide all mental health services, with local authority social work staff seconded and co-located within DWMH's Community Recovery Service. In April 2018, when the Section 75 agreement ended, the social work staff moved back to the local authority into a newly created Mental Health Team supporting service users under 65 years of age. [3] *The social worker and support worker were allocated to work jointly with DWMH in supporting Clara principally to focus on accommodation and care support issues.*

November / December 2017

2.1 At the Care Programme Approach (CPA) Review [4] at the end of November with her consultant psychiatrist and care co-ordinator, [5] the conclusion was that Clara's mental health was stable, and the only concern raised by Clara was the bowel problems for which she had been referred to hospital. It was agreed that 6 monthly reviews were appropriate with continuing community support.

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3 *For practitioners supporting service users over the age of 65, practitioners were assimilated into Adult Social Care Locality Teams.*

4 *The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.*

5 *The care co-ordinator had taken on this role with Clara a few weeks before in October 2017.*

2.2 In early December paramedics attended after a fall. Clara was distressed and said that she was not coping, had suicidal thoughts, and was experiencing an ongoing problem with her bowels. She was taken to hospital for further assessment but discharged herself before this could happen. Four days later, when Clara was again taken to A&E after falling out of bed, she was referred to the Psychiatric Liaison Team (PLT) [6] because of her agitated behaviour but declined to se them and was discharged home. A week later, the home carers raised concerns about Clara's mental health with her care co-ordinator who was assured by Clara that she was stable.

January 2018

2.3 At the start of January, Community Alarm informed Adult Social Care (ASC) that Clara had activated her alarm 91 times since mid December, often presenting as distressed and requesting support with her personal care. However, when the response carers attended it was found that Clara often did not need assistance. Community Alarm's request for a review was forwarded to the DWMH Community Recovery Service. Later that day, following concerns raised by the home care agency about Clara's behaviour, the care co-ordinator had 2 telephone calls with Clara who was described as being tearful, agitated and hyperventilating, saying she wanted to move back to Sandwell.

2.4 When the care co-ordinator visited to follow this up Clara explained that she was finding it hard to cope with the loose bowels. During the visit, Clara soiled herself and became agitated and frustrated whilst trying to change her clothing. Clara admitted that when she became angry she threw things around. The care co-ordinator made a further visit 4 days later after reports that she had been distressed but found Clara was calm and waiting to go out with her friend.

2.5 The following day at the Friendship Group, Clara informed a DWMH support worker that she would like to move to somewhere that could provide her with more support such as the housing scheme where her friend lived. Clara was advised to discuss this with the care co-ordinator. However, there was no reference to this being raised during the care co-ordinator's two further home visits during January.

February / March 2018

2.6 In mid February, it was agreed at a professionals' meeting attended by the care co-ordinator, Accord Housing and Walsall Council's Anti Social Behaviour Unit that an acceptable behaviour contract would be drawn up with Clara following an incident where she had dragged a clock into the communal area of the flats at 4.30 in the morning dressed only in her underwear, and was threatening to harm herself. A few days later, both Community Alarm and the home carers informed adult social care that Clara was regularly activating her alarm requesting help with continence care but when its response team attended no support was required.

2.7 A few days later, Clara was taken to A&E by paramedics following a fall and discharged the same day. Later that evening Clara was readmitted to hospital by paramedics because of she was experiencing abdominal pain. She was extremely agitated and verbally abusive towards the paramedics, and on admission was referred to the Psychiatric Liaison Team because of her continuing agitated

[6] *The Dudley and Walsall Mental Health Psychiatric Liaison Team is a service for adults aged 17 to 65 that offers assessment and advice for those who have attended the Accident and Emergency Department or they are a patient at the hospital experiencing mental illness or have issues such as: depression, anxiety, psychosis, self harm and suicide attempt.*

behaviour. Clara became tearful at times during that assessment stating she wanted to see her son and daughter whom she had not seen for a long time.

2.8 Clara remained in acute hospital for a month where she was treated for an acute kidney injury possibly due to chronic diarrhoea and poor oral intake, and received extensive input from therapists to improve her mobility with the use of a rollator frame. She was discharged in mid March 2018 after the ward checked that Clara's consultant psychiatrist was in agreement. However, the existing home care agency informed Adult Social Care (ASC) a week later that it could not continue because it felt unable to meet Clara's needs given the difficulties in providing care because of Clara's attitude and behaviour.

April 2018

2.9 From April, Adult Social Care (ASC) allocated a social worker for Clara, principally to focus on accommodation and care support issues. [7]

2.10 During a further 2 week hospital stay in the first half of April following a fall, a provisional diagnosis of collogenous colitis was made following a review by a gastroenterologist and arrangements made for out-patient follow up. During this admission, she was also seen by the PLT on 2 occasions because of her low mood and suicidal thoughts but their assessment was that Clara's mood was calm and stable, and there was no evidence of acute mental illness or risks.

2.11 A different home care agency commenced support following Clara's discharge from hospital and soon raised concerns that Clara was sleeping with a hammer under her pillow which resulted in ASC approval for two carers to carry out all visits to maintain carer safety pending a mental health review to be arranged by the care co-ordinator.

2.12 Over the following days, the carers experienced difficulties in providing care because Clara was often verbally abusive which culminated in the social worker carrying out a Care Act Review after agency 2 reported that Clara had chased the carers out of the flat. Although Clara's mood fluctuated during the visit, the assessment concluded that there were no concerns regarding her mental health. During this visit, Clara declined to consider moving into supported accommodation.

2.13 The following day, when paramedics took Clara to A&E for treatment of a swollen foot, Clara was agitated throughout. Following her return home, there were several incidents which resulted in concerns being raised by neighbours, home carers, and WMAS because she was acting strangely or appeared to be distressed. In addition, a neighbourhood police officer commenced proactive monitoring and liaison with other agencies after returning her home following reports that she had been walking the streets in her pyjamas and appeared distressed. This behaviour, and her fire alarm constantly bleeping were noted to be a regular occurrence.

2.14 At the end of April, the ASC Access Team considered a welfare concern referral made by WMAS to the emergency duty team, and an adult safeguarding concern form submitted by the home care agency in relation to two incidents. First during the morning call, Clara had lit some paper in an ashtray and threatened to burn down the flat with the carers inside, and later, Clara had been found sitting in the road, screaming and saying she wanted to "end it all".

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[7] *As per the earlier explanatory note at the start of the narrative of key events*

2.15 The outcome of the further information gathering by the ASC Access Team following discussions with the care co-ordinator, social worker and Clara was that the safeguarding concern would be closed and not proceed to section 42 safeguarding enquiries. Instead the concerns would be responded to through additional professional support as suggested by the care co-ordinator whose view was that the issues were "behavioural" rather than being due to any acute mental health concerns.

May 2018

2.16 During a visit made by the Care Co-ordinator the next day, Clara was unable to explain the reasons for her recent behaviour other than wanting to get out of the flat. She requested bereavement counselling and accepted the suggestion of a move to supported accommodation. On the same day, the neighbourhood police officer sent an email to the social worker about the recurring reports of Clara "wandering", presenting as distressed and appearing confused. The social worker replied to say that the care co-ordinator had visited that afternoon and found no acute concerns.

2.17 Two days later, Community Alarm requested a review because of the high number of activations in the past week when Clara had soiled herself which had resulted in the response team spending a significant amount of time with Clara. Visits were made by the care co-ordinator and the social worker - the latter recording that although Clara's moods were erratic, there were no acute concerns.

2.18 In mid May, the home care agency informed DWMH that Clara had burnt her hair, and a week later, the Fire Service responded to a 999 call to deal with a small fire in the duvet on the bed caused by a cigarette. An internal referral was made to a Vulnerable Persons Officer (VPO), and two "safe and well" follow up visits were made over the next 5 days when a fire retardant throw and mat were installed.

2.19 The following day, a professionals' meeting involving Accord Housing, the care co-ordinator and the neighbourhood police officer agreed that the involvement of the social worker was required to progress the supported housing plan. During a subsequent joint visit to Clara by the care co-ordinator and social worker a further professionals' meeting was arranged for early June.

2.20 Towards the end of May and in early June, there were further incidents when Clara was either distressed, or concerns about her behaviour were reported by the home carers which resulted in responses from the police, paramedics, the mental health crisis service and her care co-ordinator.

June 2018

2.21 At the start of June, the fire service made further safe and well visits. On the second visit Clara presented as agitated and confused and many cigarette burns were noticed in her dressing gown. The police also received calls from Clara saying that her husband, and then other people, were "out to get her". On the first occasion the police arranged for an ambulance to attend and on the second, the neighbourhood police officer was informed so he could follow this up.

2.22 There was no reference to any of these incidents when Clara was visited by the care co-ordinator shortly afterwards, or at the subsequent CPA Review with the Consultant Psychiatrist, care co-ordinator and social worker. The view reached at that meeting was that Clara's mental state had remained stable since the December review, and no new concerns had been identified other than the bowel problems.

2.23 Despite the loss of 4 stones in weight, Clara was described as being in good spirits. It was noted that she had remained compliant with her medication, was not experiencing side effects, and was also sleeping and eating well. It was agreed that Clara' needs would be best met within supported accommodation which she was enthusiastic about. Later that day, this plan was firmed up at a professionals' meeting with the existing housing provider tasked in identifying vacancies.

2.24 Following these meetings, there were further incidents when professionals responded to incidents where Clara appeared anxious or confused and provided reassurance. The first was her call to the police when Clara had stated that her four ex husbands were out to get her. The second was when Clara requested reassurance about fire safety. The impression gained by fire officers who attended was that Clara slept in her chair. The following day, the emergency duty team were advised by some home carers who used to visit Clara, that they had taken her home after finding her outside in her pyjamas. EDT arranged for the home care agency to visit who found her safe and well.

2.25 Two weeks after the professionals' meeting, the ASC support worker was finally able to complete the re-housing application forms after 2 unsuccessful attempts the previous week when Clara was not at home. These were submitted the following day when Clara was taken to view the housing scheme which she liked and expressed her desire to move there. Due to senior staff sickness at the unit, there was a delay before a visit could be arranged for Clara to attend an assessment visit which turned out to be the day after Clara died.

2.26 In the meantime, the episodes of diarrhoea continued to cause Clara considerable problems resulting in further paramedics' attendance, the home carers discovering her one morning naked and soiled in her chair, and 5 days later the carers reporting into the office that Clara had declined their contacting the GP despite having the problem continuously for several days.

2.27 The following day, near the end of June, after the police were contacted by a neighbour, Clara was taken to hospital by paramedics who found her outside shaking and possibly experiencing sceptic shock. She was discharged the following day after treatment for low potassium levels secondary to diarrhoea and vomiting. During this admission hospital staff concluded that there was no indication that a mental health review was required. The GP made a referral as requested for gastroenterologist follow up.

July 2018

2.28 The ongoing diarrhoea problems continued to cause Clara distress which resulted in two attendances by paramedics over a period of three days. After both visits, paramedics sent "adult care/welfare referral" forms [8] to the local authority's emergency duty social work team (EDT) because of concerns for Clara's safety and possible self neglect. On the second attendance, Clara was taken to hospital during the night but discharged herself early in the morning explaining that she did not wish to wait to see a Doctor, and felt well enough to return home.

[8] *Although the WMAS IMR described these as "safeguarding referrals" they were actually submitted using the forms to make adult care / welfare referrals. Irrespective of this, ASC clarified that it would have screened presenting concerns to determine how to respond and whether the threshold for initiating enquiries under Section 42 of the Care Act 2014.*

2.29 Later that day at 5pm, Clara rang the home care agency requesting an earlier call saying she was in a mess. On arrival, Clara appeared her normal self but denied she had called and said she did not require any help. At 21.15 hours, the carers were asked to re-attend by the neighbourhood police officer after 2 PCSOs had been approached by Clara for help, first asking for an ambulance and then repeatedly requesting the home carers be contacted. She was dressed in her underwear under a long coat and was covered in faeces and vomit. On the advice of the neighbourhood police officer, the PCSOs took Clara home where more faeces were observed on the door. The officers remained on the doorstep until the carers arrived at 21.55 and then left.

2.30 After cleaning Clara and the flat, Clara was settled into bed having declined the offer to see a doctor. Around 22.30 hours, the carers contacted Community Alarm to request an ambulance after Clara had another episode of vomiting and was shaking. There was a delay before the paramedics arrived at 00.45 hours because of the volume of calls that evening and the home carers were kept informed of this. After a handover, the carers left with the paramedics' agreement. Throughout the visit, the carers had been in frequent telephone contact with their on call supervisor.

2.31 Observations carried out by paramedics indicated that Clara might have an underlying infection and several times they explained to Clara it would best if they took her to hospital, and that if left untreated there was a danger of sepsis developing. However, Clara continued to decline this offer and started to become more agitated saying she did not want to wait at A&E for 5 hours to then be told she had diarrhoea and vomiting. The lead paramedic reached the conclusion that Clara had mental capacity to make this decision.

2.32 Clara said she understood that she could get worse at home, and ultimately die, and would be happy to die in her own bed if that was the case. Clara insisted that the paramedics leave saying she wanted to be left alone to go to sleep. After returning to the ambulance, the paramedics made telephone calls to NHS111 to request a follow up visit by Clara's GP, and to the Emergency Duty Team to raise a formal safeguarding concern

2.33 As they were doing this, the sound of a fire engine was heard but on looking outside there was no sign of any fire in the vicinity or anyone requiring help. The fire service had been despatched at 01.38 hours following a 999 call from a neighbour who had seen a person walking on to the main road with their top half covered in flames and then had run back inside the flats. On arrival the fire commander first assumed that the ambulance was there having been called to the same incident. The fire fighters found Clara on the bed and she was carried out of the property to the waiting stretcher and taken to hospital. Clara died later as a result of the burns suffered.

3. KEY FINDINGS AND LEARNING

Introduction

3.1 The report will now draw out the findings and learning covering the issues listed below. Within the coverage of each issue, the analysis of key events leads into exploration of the key issues arising from the analysis in order to draw out the learning and priorities for action:-

- Family involvement;
- Response to Clara's mental health issues and behaviours;
- Response to physical health issues;
- Multi-agency working and case co-ordination;
- Referrals and information sharing;
- Assessment and management of risk;
- Response to fire related risks;
- Response to safeguarding concerns;
- Planned move to supported accommodation;
- Events during the last 24 hours.

3.2 Drawing out the learning proved a more challenging task than was anticipated because of 2 factors. First, with some notable exceptions, the analysis in some IMRs was quite limited, with insufficient explanation of the evidence to support the findings. Second, was the lack of sign up to the 2 learning events which resulted in the late cancellation of the first, and limited attendance at the second. This meant it was not possible to achieve the planned full multi-agency exploration of how practitioners viewed the situation at the time, the rationale for actions taken, and any contributory factors for these.

4. FAMILY INVOLVEMENT

4.1 It is evident that most professionals had very limited knowledge about Clara's family and did not hold basic information about their names, addresses and contact numbers in their records. This lack of information created difficulties initially during the SAR in gaining the details of family members so information could be sent regarding the SAR, with an invitation to contribute.

4.2 The snippets of information in the IMRs reveal that Clara had a son who lived close by, whom Clara said she saw weekly and could contact independently when she wished. According to the social worker, they had a close relationship and Clara spoke highly of him. The only information picked up about Clara's daughter was that she lived in Berkshire and they had little contact. Clara also mentioned having a brother during a visit by the WMFS VSO.

4.3 None were contacted by professionals during the review period, or were involved in the case planning or CPA reviews. According to the ASC IMR this was because Clara consistently stated that she did not wish her relatives to be involved. Their lack of involvement was not seen as an issue because Clara was able to express her views in meetings with professionals, and had the mental capacity to make decisions about her accommodation, care and treatment. Accordingly it was also not considered necessary to appoint an independent advocate in accordance with section 68 of Care Act, 2014. [9]

4.4 However, although the social worker's perception was that Clara wished to keep her family life private, there had previously been occasions when Clara had referred in discussions with some other professionals about her lack of contact with her son and daughter. This appeared to be a significant issue for her, and caused her considerable distress. This was evident in January when Clara told the care co-ordinator that she had fallen out with her daughter again and was refusing to reconcile, and her upset during her hospital stay in February when she explained to

[9] *Sections 67 and 68 of the Care Act 2014 place a duty on the local authority to appoint an independent advocate to support and represent the person if it appears that a person with care and support needs may have substantial difficulty in being involved in decisions about their care, or where there are safeguarding concerns, in situations where there is not an appropriate individual to support them*

the PLT practitioner that she wanted to see her son and daughter whom she had not seen for a long time. However, neither professional explored these issues further because of either an explicit or implied signal from Clara that she did not wish to discuss these issues further.

Key Issues and Learning

4.5 The gap in knowledge in Clara's case highlights 3 learning points. First, on a practical level, it is essential that agencies have contact information for family members in the event of an emergency, or where the involvement of the family needs to be considered where a where a service user lacks capacity to make a decision about their care and treatment and a "best interests" decision process needs to be applied. In cases such as this where a service user has said they do not want their family involved, this issue needs to be explored sufficiently and explicitly to establish if the family should be contacted in the event of an emergency or if there was to be a time when she was unable to make decisions about her care and treatment.

4.6 Second, gathering information about the extent of any family support or other informal support networks is an important element in building up a picture of a service user's circumstances through a well rounded assessment.

4.7 Lastly, while it is important that professionals respect a person's explicit or perceived wish for privacy, this needs to be balanced against the importance of applying the necessary professional curiosity to explore issues around the family relationships where these may be having an adverse impact on a person's emotional or mental health, particularly where the service user is giving out clear signals that this is a stressful issue for them.

5. RESPONSE TO CLARA'S MENTAL HEALTH AND BEHAVIOURS

5.1 The analysis of issues relating to Clara's mental health during the review period is a key issue, and was explored at the inquest as to whether this was a contributory factor to the circumstances of her death.

5.2 The benchmark for considering Clara's mental health during the SAR review period is the November 2017 Care Programme Approach (CPA) review when it was concluded that her mental health was stable and that there was no evidence of neglect or psychotic symptoms. There was no reference to the fact that the previous day, paramedics had been mobilised by Community Alarm as Clara had been expressing suicidal thoughts.

5.3 Following this review, it is evident that Clara's mental health and behaviours fluctuated quite markedly, and on her own accounts her mood could change very rapidly. Some significant examples covered in the earlier narrative included:-

- The record of her telephone call with her care co-ordinator in early January when she was agitated and hyperventilating;

- the incident in mid February when she dragged a clock into the communal area of the flats during the night dressed only in her underwear and threatening self harm.

- the incident soon after during the paramedics' attendance when she was screaming, verbally abusive, and kept throwing herself back onto floor;

- the reports at the end of April that on 3 successive nights she had been at the door crying and asking for help, the "bizarre" behaviour when she had been

observed as unstable when sitting on a fence for 3 hours, and the home carers finding Clara sitting and screaming in the middle of a busy road;

- the report from the home carers at the end of May that Clara had been 'stripping off', kicking her legs up in the air and was then immediately low in mood, and the subsequent call she made to the mental health crisis number saying she was in a mental health crisis;

- the frequent records made by hospital staff during her admissions of her being agitated, including one incident of expressing suicidal thoughts, which resulted in referrals to the Psychiatric Liaison Team.

5.4 Yet set against this, the conclusion reached at the next CPA Review in June 2018 was that Clara's mental health had remained stable since the December review, and that there had been nothing about her presentation in the intervening period which had warranted an earlier review being held.

5.5 While the analysis of the gaps between her crisis calls to different services would suggest that there may have been brief periods where the situation was stable, the high number of these calls, sometimes several within a short time period, would suggest that Clara was finding it hard to cope, and her mental health was being affected.

5.6 Moreover, the frequent number of calls made by Clara during the night also casts doubt on the conclusion of the CPA review that she was sleeping well. This was an issue which had been noted in the initial assessment carried out by home care agency 2 in April 2018 which had recorded Clara's self reporting that broken sleep was an issue.

5.7 The conclusion that Clara was compliant with her medication is also questionable, and appears to reflect a lack of awareness of the several occasions when the home carers were uncertain whether Clara had taken her medication because she had thrown the tablets on the floor. In addition, the GP noted that Clara had not always taken the medication to combat the bowel problems.

5.8 These observations lend weight to the key finding in the DWMH IMR that the records did not include any clear indicator of what would constitute deterioration in Clara's mental health, and that the records could have been more consistent, detailed and reflective of her current presentation. The IMR makes the observation that this absence of a clear indicator of what could be viewed as a relapse in Clara's mental health was because her behaviour could equally be seen as her normal personality or a relapse in her mental health. However the nursing records did not reflect an understanding or any assessment of these differences.

5.9 This lack of clarity was apparent when this issue was explored during the SAR learning event where the mental health and social work practitioners' perspective was that all of Clara's behaviours stemmed from her personality, and she was able to control these. An example cited to support his view was an occasion when Clara had been agitated, but able to answer the telephone in a calm manner, before immediately returning to being agitated when the call was ended. This rationalisation appears a little one dimensional given the very different range of incidents where Clara's behaviour appeared to other professionals as being out of control.

5.10 In respect of both the six monthly reviews, and other contacts with mental health professionals, including the care co-ordinator, there appears to have been considerable reliance on Clara's self reporting. It is less clear as to what extent the observations and experiences of other professionals were sought to inform a rounded view. This is particularly evident on the occasions where Clara denied the description of events and her behaviour reported by the home carers.

Key Issues and Learning

5.11 The key issues and learning which flow from the above findings will be explored later when the report considers the issues in relation to risk management.

6. RESPONSE TO CLARA'S PHYSICAL HEALTH ISSUES

6.1 It is evident that the symptoms Clara experienced from the bowel problem had a major impact on not just her physical health, but also her mental health and behaviour. Therefore, professionals' response to this is one of the key issues in this case. Before exploring this, it will first be helpful to provide some explanation about the condition which affected her.

6.2 Clara was eventually diagnosed as having collagenous colitis which is a type of microscopic colitis. [10] The common symptoms include chronic watery, non-bloody diarrhoea often between 3 and 20 times daily, abdominal cramping and pain, dehydration, weight loss, nausea, vomiting, bloating, fevers, night sweats, anaemia and exhaustion. Faecal incontinence can be especially a problem at night. The severity, frequency, and duration of these symptoms can vary. While many people experience flare-ups that last a few days or weeks, other people have symptoms that last for months to years. A quick response is essential in the case of a severe, acute flare-up, which carries a small risk of death.

Investigation and treatment of Clara's symptoms

6.3 The GP notes and home care daily logs confirm that the bowel problem was causing Clara difficulties from October 2017. It was still a persistent problem at the point she died which led to the SAR exploring whether investigation and treatment could have been progressed quicker.

6.4 During October 2017, the GP arranged for repeat blood tests and faecal testing which resulted in a referral being made at the start of November for gastroenterology investigation. During this period, Clara made numerous calls to NHS111 because the problem was getting worse. After being seen by her own GP during an attendance at Urgent Care, a fast track referral was made at the start of November through the cancer pathway so that she would be seen in 2 weeks. However, Clara did not attend the subsequent appointment.

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10 *Collagenous colitis is characterized by a thick, non-elastic band of collagen [10] under the lining of the colon. It is described as a type of microscopic colitis because the inflammation it causes can only be seen under the microscope. Unlike most inflammatory bowel conditions, collagenous colitis is not considered a risk factor for colon cancer. It is estimated that 1 in 420 people having this condition amounting to approximately 146000 suffers in the UK.*

According to Crohn's & Colitis UK, microscopic colitis is most commonly diagnosed in people in their 60's, although the condition may begin at any age. Around one quarter of people are diagnosed before the age of 45 years old, and although rare, microscopic colitis has also been found in children.

6.5 Later in November, Clara made 3 calls to NHS111 over a period of four days which resulted in paramedics attending and information being sent to the GP. The following day, Clara was again seen in Urgent Care by her own GP who made a further referral. After a further six weeks when no appointment had been offered, Clara raised this with the GP receptionist who made three unsuccessful calls to the hospital to chase this outpatient appointment. [11] Clara was then seen by her GP the following day when she was told that she would have to wait for the Hospital to contact her.

6.6 It does not appear that the symptoms were assessed further until Clara's in patient hospital stay in April 2018 when a gastroenterology review identified that her symptoms suggested the possibility of collagenous colitis. Following discharge, Clara attended a surgical review at the colorectal outpatient clinic in mid April when a colonoscopy was carried out and the diagnosis confirmed. Clara explained that the medication prescribed had not improved her symptoms and a referral back to gastroenterology was made as they were best placed to manage the condition.

6.7 The follow up appointment was booked for later in June but in the event did not take place because Clara was in hospital on that date. Her symptoms were reviewed during this admission, which resulted in the GP making a referral for outpatient gastroenterologist follow up as recommended but to a different hospital at Clara's request.

6.8 The fact that 6 months elapsed after the condition was first reported and a colonoscopy being carried out led to the author raising the question as to whether investigation might have been progressed sooner. The GP's view shared with the CCG IMR author was that the referrals and time taken for Clara to be seen were within an acceptable level.

6.9 Further clarification of the waiting time issue was received from the CCG's deputy chief nurse that a person would be seen within 6 weeks if referred through the cancer pathway or otherwise within 18 weeks. It was confirmed that all referrals for colonoscopies are screened and prioritised including those referred through the cancer pathway.

6.10 In addition, waiting times will be affected if an appointment is missed or cancelled which was an issue in Clara's case. The CCG IMR referred to the challenges experienced by the GP practice in securing Clara's engagement with appointments and their going "above and beyond" in being flexible in seeking to meet Clara's needs. For example, the GP records in May and June refer to some non concordance with medication to treat the colitis, and not responding to an invitation for bowel cancer screening in May.

Professionals' response to Clara's experiences

6.11 Clara received prompt and sensitive care from her home carers and paramedics, although providing this was not always easy when Clara's frustration or embarrassment contributed to her agitation. The home care agencies were responsive in organising additional visits quickly when she reported that she had soiled herself and needed help. Similarly there were many visits by the Community Alarm Rapid Response Team. Both services raised concerns with ASC and / or DWMH that there were many occasions when visits resulted in the discovery that Clara was either not wanting or needing any help.

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[11] *The review was informed that receptionists would not routinely chase an individual patient's appointment but they made these calls because they knew Clara and wanted to help her.*

6.12 It is evident that the diarrhoea and vomiting caused Clara enormous distress and had a significant impact on her mental health and behaviour, and there were very few contacts with professionals where she did not voice her distress and frustration.

6.13 There are frequent references to Clara reporting the ongoing problem to mental health professionals including the CPA reviews, the visits made by her care co-ordinator, and the calls made to the mental health crisis number. However, although they gave her the opportunity to talk about her experiences, none took steps to support Clara with this problem by raising the issue directly with the GP. This would have been important in terms of explaining the impact the problem was causing and achieving the required degree of urgency to arranging investigation and treatment. For example, this information would have been important for the gastroenterology service to be aware of when making its decision on what priority should be given to arranging the colonoscopy.

6.14 Early examples include the advice given to Clara by the Mental Health Crisis Team in mid December to contact NHS111, and the visit by the care co-ordinator in early January when Clara had an episode of diarrhoea during the meeting which led to her becoming agitated and frustrated. The apparent primary focus remaining on Clara's mental health is revealed by the note made in the case record that there were no concerns with regards to Clara's presentation and no new risks identified during this visit.

6.15 According to the ASC IMR, the GP received updates on Clara's medical issues from the social worker, which together with information sent to the GP by other NHS services, enabled the GP to proceed with medical tests and reviews as required. There is no evidence in the GP chronology to support this assertion as there is no reference to any contact by either the social worker or the care co-ordinator. During the SAR process, ASC clarified that although the social worker said there had been periodic contact, this was not recorded. The issues around case recording are addressed within the ASC action plan.

Conclusions, Key Issues and Learning

6.16 The SAR findings reinforce the need for mental health professionals to maintain a focus on a service user's physical, as well as their mental health, even though the latter may be the primary reason for their involvement. The links between mental ill health and physical ill health are well documented. Research has shown that people with mental health problems have higher rates of physical illness, resulting in increased rates of morbidity and mortality - life expectancy among adults with bipolar disorder is estimated to be 15–20 years lower than for the general population. [12]

6.17 National guidance on the Care Programme Approach sets out standards for ensuring a holistic approach is adopted in looking at a person's needs and specifically refers to this needing to include consideration of their physical health needs. Assessments and care plans should identify where these are affecting, or have the potential to impact on, a person's mental well-being, and conversely take account of mental health symptoms or treatment programmes which might affect physical health. It will be important therefore that WSAB is assured that this fundamental requirement of the Care Programme Approach is being applied.

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[12] *Causes contributing to high morbidity and premature mortality among adults with bipolar disorder include cardiovascular disease, respiratory disease, diabetes and obesity.*

Annual Health Checks

6.18 In respect of persons with bipolar disorder, quality statement 7 [13] of the NICE quality standards referred to earlier, requires a full health assessment [14] to be carried out at least annually. A copy of the results has to be sent to the care coordinator and psychiatrist, and placed in the secondary care records. The NICE guidance describes how delivery of this standard requires the CCG to ensure there are protocols covering these arrangements, setting out the respective role of primary care and mental health teams.

6.19 However, during the SAR review period, there was no reference to Clara having an annual review in either the information provided by the CCG IMR, or the DWMH IMR coverage of the CPA Reviews where there appears to have been a reliance on Clara's self reporting of the ongoing bowel problems and the situation in terms of hospital follow up. WSAB should seek assurance that there is evidence that an annual health assessment is taking place, and there is an agreed process for the results to be acted on.

Impact of Inflammatory Bowel Disease (IBD)

6.20 Clara's experiences highlight the degree of stress and practical problems that IBD such as collagenous colitis can have, and how it is such a difficult condition to live with because it often follows an unpredictable course, which can affect all aspects of a person's life including personal and social relationships. The nature and unpredictable occurrence of the symptoms can have a profound psychological impact including low self-esteem, depression and anxiety. However, the earlier analysis suggests that the mental toll, and the physical impact of suffering diarrhoea on and off for probably 9 months, was not recognised sufficiently in Clara's case.

6.21 Getting the right information and support can make all the difference for individuals to enable them to manage their condition and their everyday life. Providing education support around self-management, and facilitating patients' access to the support from skilled IBD nurses at times of crisis to provide practical advice and reassurance, are key components in ensuring responsive and cost-effective care. In Clara's case, there was a high cost on the health and social care system because of the high number of responses by WMAS, home care agencies and community alarm that were directly related to episodes of diarrhoea.

6.22 The above observations underline the importance of multi-disciplinary team working and shared care protocols between primary and secondary to ensure effective co-ordinated shared care. Within these, the GP has a key role in the initial diagnosis, ongoing support, prescribing and monitoring of medication. Receiving information from other professionals who have more regular contact with the person is important in help the GP carry out these roles.

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13 *Recommendations 1.2.11 and 1.2.12 - Bipolar disorder (2014) NICE guideline CG185,.*

14 *The health check should include weight or BMI, diet, nutritional status and level of physical activity; cardiovascular status, including pulse and blood pressure; metabolic status, including fasting blood glucose, glycosylated haemoglobin (HbA1c) and blood lipid profile; liver function renal and thyroid function, and calcium levels, for people taking long-term lithium.*

6.23 The lack of any recorded contact with the GP by mental health and social care professionals is therefore a concern. This was in marked contrast to the picture prior to the SAR review period when there was good communication with both the mental health team and home care agencies. In exploring the reasons for this during the Learning Event, both the care co-ordinator and social worker explained that they did not see a need to contact the GP because action seemed to be in hand from the information Clara provided and the appointment letters she showed them. Equally, no concerns were brought to their attention by the GP.

6.24 This apparent passive response leads into the need for professionals to be reminded that referrals and timely updates to the GP are essential when the impact of a person's symptoms is having a serious impact. This will also enable discussions to take place on how other professionals can support the GP in achieving a service user's engagement with the required clinical help and treatment.

7. MULTI-AGENCY WORKING

7.1 The lack of liaison with the GP by the care co-ordinator or social worker, and visa versa, leads into consideration of the wider issues around multi-agency working and case co-ordination.

Lead agency and case co-ordination

7.2 The first significant issue relates to the significant differences in the perspectives of ASC and DWMH as to which professional held lead responsibility for oversight of Clara's case and co-ordinating action.

7.3 From 2016 Clara was receiving support from DWMH through the Care Programme Approach and had a care co-ordinator. Accordingly, given this statutory responsibility, ASC was clear that both before and after the ending of the Section 75 agreement, the CPA Care Co-ordinator was the lead practitioner. In support of this understanding, the ASC IMR cited the DWMH public information leaflet, [15] and that the home care support first agreed in 2016 was funded through Section 117 of the Mental Health Act (MHA) [16] when her discharge from psychiatric hospital was planned.

7.4 The following wording in the DWMH IMR on this issue suggests that there is not the same full acceptance of that ASC perspective:-

"From the documentation reviewed it would appear that mental health were perceived to play the lead role with this case, however due to the number of agencies involved there was little evidence to suggest that any one particular agency had been identified or reviewed as the lead provider."

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15 *"You will be allocated a care coordinator. This will be the person from the mental health team who is considered to be the most suitable to coordinate your needs and who you will see most often. …Once your care plan has been agreed, your care coordinator will oversee the care process".*

16 *Section 117 of the Mental Health Act places a statutory duty of aftercare on CCGs and the local authority in cooperation with voluntary agencies to provide, or arrange to provide, aftercare services free of charge for all clients who have been detained in hospital under certain qualifying sections of the Mental Health Act, 1983.*

7.5 The SAR established that one contributory factor for this apparent difference in view between the two agencies was the local organisational arrangements for the provision of mental health services which were explained earlier in the report that resulted in practitioners from both being involved from April 2018. The ASC IMR made the observation that there was then a joint responsibility for co-ordinating responses to any welfare or safeguarding concerns having regard to the statutory duty placed on the local authority by the Care Act 2014 in respect of these. Accordingly the ASC Access Team ensured that concerns were passed on immediately to both practitioners so that these could be responded to appropriately from a single and multi-agency perspective.

7.6 Both the DWMH and ASC IMRs arrived at positive findings about the effectiveness of joint working, and there were many examples in the chronology of good liaison, prompt information sharing and joint working. The ASC IMR refers particularly to the collaboration between the social worker and the care co-ordinator, the role of EDT in co-ordinating a response to crisis situations, and the Community Alarm's role in flagging up concerning patterns of alarm activation.

7.7 However, the ASC IMR also acknowledges that the experience of front-line staff initially was that the transition to the new service arrangements did impact on the support provided to Clara up to the end of May 2018, although this improved as time went on. Factors identified by ASC included the challenges in achieving effective communication through no longer being co-located, the lack of supervision, the lack of preparation for the change in role from essentially being care co-ordinators within the CRS to carrying out the full "traditional" social work role. In addition, the social worker's availability was limited because of being part time.

Conclusions, Key Issues and Learning

7.8 Clarity of roles and responsibilities are a pre-requisite for effective joint working where both the DWMH Community Recovery Service and ASC Mental Health Team are involved in supporting service users. Although both agencies referred to evidence of effective joint working, the SAR established that there continues to be some lack of shared understanding at practitioner level about these. This increases the chances of action not being taken to address a service user's needs, and compromises the ability of services to provide holistic and appropriately co-ordinated support.

7.9 In Clara's case this was evident in relation to the lack of proactive work to monitor and alert health professionals to the ongoing bowel problems which resulted in a lack of a cohesive approach. Another example, which will be explored later in the report, are the problems which arose in relation to information sharing and joint working in relation to the plan for Clara to move into supported accommodation.

7.10 During the SAR process, ASC shared its perspective that the lack of clarity was due to DWMH not ensuring that staff were discharging their responsibilities under the Care Programme Approach. Accordingly, the ASC single agency action plan sets out the need for senior managers from both agencies to jointly identify and resolve any continuing uncertainties, and provide the necessary clarification not just to their own staff, but also with other agencies that may need to share information about their involvement.

8. REFERRALS AND INFORMATION SHARING

8.1 The importance of that last observation is underlined by the SAR finding that the lack of a shared understanding across the wider partnership about who was the lead agency or professional had a knock on effect in terms of when referrals were made and to whom.

Referrals made by the Home Care Agencies

8.2 The ASC IMR highlighted how home care agencies frequently directed their concerns to their agency rather than the care co-ordinator despite this being made clear in Clara's care and support plans which were sent to the agencies when the support was brokered. However, the author's examination of the care records of both home care agencies does not entirely support ASC's observation. The only ASC plan in home care agency 1's file, which was dated 2016, did not include any specific direction about this. Notwithstanding this, there are entries in agency 1's records which show that concerns were raised directly with the DWMH community recovery service, and conversations held with the care co-ordinator.

8.3 Although the ASC brokerage team confirmed during the SAR that the support plan drawn up in April 2018 was sent to home care agency 2, the author did not find a copy of this in the latter's records. [17] In the absence of this, the agency's operations manager explained to the author that their understanding was that ASC was the lead agency to whom concerns should be reported. This was because ASC had commissioned the service, and also it is the agency to whom formal safeguarding concerns should be submitted.

Referrals made by crisis responder agencies (WMAS, WMP, WMFS, Community Alarm)

8.4 An important finding is that referrals were not always made, or information passed on by the various crisis responders, following their involvement.

Referrals made by Community Alarm

8.5 It proved difficult to gain full information about referrals made by community alarm because the service had been decommissioned prior to the SAR. It is clear however that there were a very high number of community alarm activations made by Clara. Although overall figures were not submitted within the SAR process, some idea of the scale is shown by the report made to ASC that there had been 91 activations over a two week period in late December, and similar concerns being raised in February and May.

8.6 The SAR heard that it would have been impractical to report each activation given the high volume, and ASC was only informed when there were concerns about a specific incident, or due to the pattern and frequency of the activations. While this pragmatic approach is understandable, it meant that ASC and DWMH did not always have an immediate picture of the extent Clara was seeking help.

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17 *ASC was unable to validate this because it would have been sent by secure email. These are deleted after 12 months in order to free up storage space which has a fixed capacity.*

Referrals made by the Ambulance, Police and Fire Services

8.7 The figures below show the extensive involvement of WMAS, WM Police and to a lesser extent, WMFS, in response to calls from Clara herself, or the home care agencies via Community Alarm:-

WMAS	33 incidents	26 attendances
WMP	18 incidents -	3 face to face contacts
WMFS	4 incidents	3 emergency attendances
		2 safe and well visits
		2 reassurance visits
		1 VPO visit

Of these, 23 were received out of office hours including 17 during the night after the home carers' final evening call.

8.8 Based on the information submitted during the SAR, the referrals made, or information shared by these 3 agencies during or post incident was as follows:-

WMAS	handover information to A&E	5
	mental health professionals	2
	contact with GP	1
	contact with home carer	1
	note left for home carers	3
	adult care/welfare concern referral	3
Police	Walsall Partnerships	1
	note left for home carers	1
	housing	1
WMFS	internal referral to VPO	1
	Contact with the care co-ordinator	1

8.9 It is possible that the agency chronologies and IMRs do not give a full and accurate picture, but on the basis of the above figures, it is apparent that in more than half the episodes of involvement, there is no reference to information being passed directly to ASC, DWMH or the GP. While there were some occasions when there was a clear explanation included in the records as to why this was not considered necessary, there were others where information sharing might have been expected or would have been important.

8.10 In exploring the contributory factors for the variations in whether information was shared, and with whom, the WMAS and WMFS IMRs made some important common points. The first is that they deal with each incident on a one off basis, and usually, it is different staff who attend. In this case, it was unusual that one of the fire fighters who attended in May and July 2018 had some previous knowledge of Clara through attending a call as a fire officer in 2016 which led to his observation that her mental health had declined over that period.

8.11 The second is that neither agency has a centralised system which holds information on the individual person, only whether the address has been visited before. The combination of both these factors is that crisis responders go into the situation with no knowledge of the service user from previous attendances, and whether health and social care agencies are involved. They are reliant in the first instance either on information provided by the service user, and / or the evidence of other agency involvement such as any log sheets in the home completed by home carers.

However, these are not always to hand if they have been put away to avoid the risk of these getting lost or damaged.

8.12 In Clara's case, they were usually able to establish that she was receiving home care support, had the community alarm service, and that mental health services were involved. On occasions there was liaison with the police, the local authority emergency duty team (EDT) Community Alarm, Street Triage or the mental health crisis service, to gain more information about the Clara's circumstances and support being provided, to inform a decision as to whether there was a need to pass information on.

8.13 On occasions, the discovery that support was being provided led to a decision that there was no need to share information. When information was shared, it appears that the wide variation in how this was done, or which service was contacted, stemmed from their not having specific information as to which agency or professional was co-ordinating her care and should be notified. A key point here made by WMFS is that crisis responders are not involved in the health and care network on a day to day basis, and therefore they are not familiar with the details of how services are organised.

8.14 The SAR Learning Event confirmed that a consequence of referrals not being made was that there were occasions when the care co-ordinator and ASC staff were not immediately aware of the involvement of crisis responders, particularly where the outcome was that Clara remained at home. DWMH and ASC staff expressed surprise when the total number of call outs was shared at the event. Similarly, the GP would not have been aware of this involvement unless it resulted in hospital attendance or the involvement of NHS111 through the standard reports sent to the GP. This meant that the professionals responsible for monitoring Clara's situation lacked a full picture of the extent, and the patterns, of the crises Clara was experiencing.

Conclusions, Key Issues and Learning

8.15 The SAR findings reinforce the importance of crisis responders sharing information about their involvement so that all relevant professionals can determine whether immediate follow up action is required. The implications of this have already been acknowledged by the police and fire service and the SAR was informed of a number of initiatives to address this.

West Midlands Police

8.16 WM Police has taken steps to ensure that information is shared direct with relevant professionals / agencies rather than relying on other agencies to do this. This reflects their own findings in this case that there were many occasions when "vulnerable adult" referrals were not made.

8.17 To address this, a new electronic vulnerability form was introduced from December 2018 which is accessible on police officers' force issue mobile devices. This enables them to make referrals immediately in the presence of the individual to ensure their consent is obtained. Previously, referrals could only be made when an officer returned to the station. The drawback of this was that often attending several incidents, which inhibited the opportunity to make notes at the time, meant they had to try and recall events when they had returned to base. Police officers have also been reminded through force message systems that they must make a referral to mental health services where their staff are not already in attendance, regardless of any assurances made by partner agencies that they will also make a referral.

West Midlands Fire Service

8.18 The Fire Service is also implementing changes to their arrangements. Although there was a prompt response in carrying out a number of follow up visits to assess the risks, provide fire retardant items, give advice on prevention and evacuation, WMFS acknowledges that prompt liaison with other relevant agencies is vital to explain steps they have taken and ensure a shared understanding of the risks and how these might be minimised.

8.19 Consequently, WMFS is in the process of strengthening its arrangements following a review of the VPO process. This is resulting in VPOs receiving a higher level of training and becoming part of a Complex Needs Officer (CNO) Team to promote a consistent approach across the brigade, and a robust follow up process. In addition, current updating some of its IT based systems are planned to address the current difficulties which arise from:-

- VPOs/CNOs not being able to access their own closed cases;

- systems not allowing automatic notifications to be made to the assigned VPO/CNOs when incidents occur at properties which are on their caseload, or repeat referrals are received about a person they have visited previously;

- fire crews carrying out a safe and well visit not automatically being provided with information from any previous engagement with the person/property.

Help required from other agencies to assist crisis responders make appropriate referrals

8.20 Although these welcome initiatives will have a positive impact, crisis responders will need help from other agencies in two ways to maximise the benefits. First, is to ensure that there is a shared understanding of when crisis responders should make referrals, and the agencies which need to be informed depending on the situation and the issues identified. This is particularly important where either there is no current agency involvement, or existing involvement cannot be established at the time. Where this is not covered by existing local guidance, additional inter-agency and multi-agency protocols may need to be considered. The SAR heard that ASC are liaising with WMFS to enable CNO's to seek support and advice from experienced ASC staff around potential safeguarding issues to assist how they respond to situations.

8.21 The second is to address a key challenge faced by crisis responders which is the lack of information about which agencies or professionals are involved, and ways must be found to make the correct contact information easily accessible. This will require a greater level of ownership and problem solving by senior managers in DWMH and Adult Social Care in exploring possible solutions than that displayed at the practitioners' learning event.

8.22 One option where a person is already in receipt of support, would be for the lead agency co-ordinating support to take responsibility for a sheet being left in the home listing the agencies involved, together with the designation and contact details of the professionals involved. This will make it more likely that referrals will be directed referrals to the appropriate person / service. The only practical issue would be the need for inter-agency agreement on how this would be updated when there are changes to the services or personnel involved.

8.23 A second option might be to take this a stage further and also leave a “professionals log” in the service user’s home, which would be separate, and additional, to the daily log sheets completed by home carers. This would enable visiting professionals to record the time and date of any visit, their contact details, the reason for attending, and the names of any professional or service that information has been shared with. This would be additional to the normal recording in agency’s case recording systems.

Feedback to referrers

8.24 This case has also reinforced the need for WSAB to seek assurance that agencies’ quality assurance processes ensure that feedback is provided to referrers. Lack of feedback was an issue raised by several agencies as a potential area of risk because they did not know what action had been taken in response to concerns raised, and whether any further action was required on their part to either support that response, or to re-refer their original concerns. Examples cited included the frequent lack of feedback from DWMH on action taken to respond to referrals passed through by the ASC Access team or Community Alarm, and the lack of feedback to the home care agencies by adult social care and DWMH.

Reliance on service users to self refer

8.25 There were occasions where agencies, including NHS111, WMAS, and mental health professionals, advised Clara to self refer to the GP the following day. However, the chronology suggests that she did not always do this. The learning from this is that when dealing with service users who are distressed, professionals need to take into account whether it is realistic to expect the service user to take on board the advice at the time, and well enough to follow this through. Where there are doubts, professionals must take responsibility for making direct contact with the relevant agency with the service user’s consent unless the criteria is met for sharing information without consent.

Triggers for Information sharing by home care agencies

8.26 During the SAR, ASC made the observation that it was not always aware of the distress Clara was experiencing because of the ongoing bowel problem or the difficulties experienced by the home care agencies in providing the full package of care because of Clara’s behaviour towards the carers.

8.27 Given the other ASC observation that information shared by home care agencies was not always directed to the appropriate agency, this suggests that at the point that home care support is brokered, there is a need to ensure there is a shared understanding of what should be reported by home care agencies, when and to whom. For example, when home care agencies encounter difficulties in providing the service, should this be reported on each occasion or just when there is a pattern developing? Similarly when do home care agencies report any health issues which are causing the service user difficulties? The SAR heard that ASC intend to address these issues through discussion with home care agencies at the care provider forum later in 2019.

9. ASSESSMENT AND MANAGEMENT OF RISK

Assessment of risk

9.1 Mental health professionals maintained a clear focus on the risk of suicide or self harm to either to Clara herself or to others. The checks of Clara's mood, and concordance with her medication, is well documented in the IMR, particularly by the CPNs from the Psychiatric Liaison Team, showing the rationale for the conclusions reached through their assessments.

9.2 Based on the information provided by DWMH, it is sometimes less clear what the basis was for the conclusions reached by the care co-ordinator at the end of most visits that no new risks had been identified. More explanation would have been expected when the visits were made following a "crisis" situation reported by another agency. This was touched on earlier in the analysis of professionals' response to Clara's mental health issues.

9.3 The ASC IMR established that the risk assessment completed by the social worker in early May demonstrated a good understanding of the risks, particularly the high risk of self-neglect should Clara not co-operate with the support offered with her personal care, preparation of meals to meet her nutritional needs or with taking her medication. The assessment noted that her behaviours also placed her at risk when her mental health deteriorated.

9.4 However, neither of the ASC and DWMH risk assessments was updated to reflect the concerns raised by the home care agencies, or the urgent situations which resulted in the involvement of crisis responders. This may have brought greater focus on the risk factor related to Clara's loneliness at night which was often been referred to by professionals as a possible factor for her calls to the mental health crisis service, and the reports of her being out in the street, or on her doorstep, appearing distressed and asking for help.

Risk management in relation to home care support

9.5 Rapid action was taken by ASC to source a new provider when home care agency 1 concluded that it could no longer meet Clara's needs. In addition approval was given to a doubling up of the carers when Clara was discharged from hospital in April 2018 because of the difficulties reported by home care agency 1 related to Clara's verbal aggression and the discovery that she slept with a hammer under her pillow. The existence of the hammer had previously been reported to the care co-ordinator by Agency 1 in late January with a request to double up the staffing but this information had never been shared with ASC by the care co-ordinator.

9.6 The SAR established that neither DWMH nor ASC provided a copy of its written risk assessment to the home care agencies to supplement the information provided verbally when the service was commissioned. The SAR heard that the ASC Brokerage Team do not send these to home care agencies unless this is specifically requested.

9.7 However, both home care agencies applied their usual practice in carrying out their own written risk assessments, and it is evident that they were alert to any emerging risks. The logs maintained by office managers, and the "on call" manager out of hours, show that carers routinely reported in any concerns about Clara, or difficulties in providing the full service because of Clara's mood swings which could result in her declining help, making sarcastic remarks, or being verbally abusive. Although this resulted on occasions in Clara insisting they leave, to their credit, the logs show that more often than not, they were able to defuse the situation. However, as outlined previously, DWMH and ASC were not always informed of these difficulties

9.8 Equally, managers were proactive and supportive in maintaining regular telephone contact with carers to check how situations that had been reported in were developing, and offering appropriate advice on action to be taken. Agency 2 also operate a quality assurance system whereby at the end of each week, the manager checks the daily log sheets completed by the carers, and records on a control sheet any significant developments during that period and what action had been taken.

Conclusions, Key Issues and Learning

9.9 One issue which stands out from the narrative is that many of the occasions where mental health professionals concluded that there were no new risks were sandwiched between serious concerns being raised by other agencies or members of the public. This raises the question as to what extent there is a shared understanding of how risk is viewed by mental health professionals.

9.10 Risk management is a core component of mental health care and requires the development of flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. The best practice guidance published by the Department of Health, [18] which sets out a framework of principles covering violence, self-harm / suicide, and self-neglect, provides a list of tools that can be used to structure the often complex risk management process.

9.11 A key difficulty in exploring this question in Clara's case, is that neither the DWMH IMR, nor the learning event, provided a clear explanation of what constituted the term "stable" from their perspective, or any analysis of what evidence they drew on to support the positive conclusions about Clara's mental health and there being no new risks.

Personalised Care Plans

9.12 These observations highlight the importance of adherence to the quality standards for management of bipolar disorder in adults published by the National Institute for Health and Care Excellence (NICE) in 2015 [19] which are underpinned by the comprehensive guidance published earlier in 2014. [20]

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18 *"Best Practice in Managing Risk - Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services" – first published in 2007 by the Department of Health and updated in 2009*

19 *"Bipolar disorder in adults" - Quality standard published by the National Institute for Health and Care Excellence (NICE) 23rd July 2015*

20 *"Bipolar disorder: assessment and management" - clinical guideline first published by the National Institute for Health and Care Excellence (NICE) 24th September 2014 and updated in April 2018*

9.13 Quality Standard 2 explains that adults with bipolar disorder should have a personalised care plan which is focused on maintaining wellbeing, preventing relapse and achieving recovery goals. [21] In addition to specifying the care they want to receive, particularly in a crisis, the plan should include the early warning symptoms and triggers which allow practitioners and carers to be alert to these, and to intervene early to prevent or prepare for a crisis. These indicators provide clarity about the differences in a person's behaviour and level of functioning both when mentally well, and unwell.

Updating and sharing of risk assessments

9.14 All risk management plans should include an awareness of the potential for changes in the level of risk, and the need for these to be updated both in response to crises and other developments, as well as the agreed schedule for review meetings. From discussion with the service user, it is also essential to anticipate what circumstances would trigger a review outside the normal timetable and what times in the year are particularly difficult. In Clara's case for example, the anniversary of her husband's death was one which proved problematic for her.

9.15 The Department of Health best practice guidance makes the point that a risk management plan is only as good as the time and effort put into communicating it to others so that it can be used as the basis for joint action. The service user's consent for sharing of information in this way should be sought, although the duty of confidentiality can be overridden if there is a clear risk of harm to the service user or others. Although the DWMH risk assessment completed in November 2017 was shared with ASC in early April 2018 when the social worker was allocated, the ASC IMR stated that no further documentation was supplied by the care co-ordinator after that date.

9.16 WSAB should seek assurance therefore that agencies' quality assurance systems provide the necessary checks that risk assessments remaining current, and these are being shared with other agencies involved to ensure that risk management strategies are appropriately robust, comprehensive and co-ordinated. The SAR noted that ASC has already commenced its work on this as set out in its single agency action plan.

Arrangements to discuss escalation of concerns

9.17 Despite a number of agencies raising concerns that Clara's behaviours might indicate a possible deterioration in her mental health and an increase in associated risks, no multi-agency meetings were held until later in May 2018. There was therefore no opportunity provided for agencies to share perspectives, evaluate that information, and agree whether there was a change in the level of risk and how this might be minimised.

9.18 None of the 3 "professionals" meetings held were full multi-agency meetings. During the SAR, home care agency 2 shared its disappointment that it had not been involved in risk planning, and WMFS's view was that it should have been involved given that Clara had a tendency for fire setting, whether deliberate or accidental, so that it could try to engage with her to offer preventative solutions to try to keep her safe and prevent future fires. The involvement of both agencies would have been important in agreeing a multi-agency plan to address the ongoing risks pending resolution of the issue around her future accommodation.

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[21] *Bipolar disorder (2014) NICE guideline recommendations 1.3.2 and 1.9.4.*

9.19 The issue of home care agencies not being routinely being invited to meetings was a pattern raised by all 3 home care agencies. The SAR panel agreed that it will be important to find a way of harnessing their experience and insights, preferably through attendance, or at a minimum through some discussions prior to the meeting and feedback afterwards. Facilitating their involvement has become all the more important because home carers have increasingly become the “eyes and ears” for statutory agencies in monitoring a service user’s situation and reporting any changes in levels of functioning and risks.

9.20 This leads onto the issue as to which agencies can take the initiative for arranging multi-agency meetings to discuss concerns which do not meet the criteria for raising formal safeguarding adults concerns. In this case, the police were a prime mover in the convening of the May professionals’ meeting. However, the SAR discussions established that some agencies, such as home care agencies and the fire service, are uncertain about the process to be followed for arranging meetings, or if indeed there is “legitimacy” within the multi-agency arrangements for them to do this. It also appears that there continues to be a lack of awareness of how WSAB’s multi-agency escalation policy can be invoked to escalate concerns or challenge decisions made by other agencies which have not been resolved through local discussions.

9.21 It will be important therefore that WSAB seeks assurance that the triggers and arrangements for convening “concerns” meetings and the processes for escalating concerns are understood across the wider partnership, and are being applied to respond to emerging risks.

Risk Management and Mental Capacity Issues

9.22 During the Review period, there were several occasions when Clara chose not to act on advice from paramedics to go to hospital. Respecting a person’s right to make what appears to be an unwise decision is at the heart of the empowering ethos of the Mental Capacity Act, but brings challenges for professionals in balancing this with their professional duty of care to keep people safe where the consequences of the decision could have serious adverse effects on a person’s health. In Clara’s case, on the last evening, paramedics advised her that not going to hospital had the potential to be life threatening because of the possibility of sepsis developing if she had an underlying infection which was not treated.

9.23 The approach taken to risk management by the paramedics during that final attendance provides demonstrated good practice which should be shared as a reminder that where professionals consider a person is making an unwise decision, it is essential that a mental capacity assessment is carried out and a detailed record made of the steps taken to consider whether a person has capacity and the reasons for the conclusion reached. In addition, the paramedics demonstrated the required dynamic management of risk [22] which was an area of learning from a previous Walsall SAR. [23]

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22 *The definition of dynamic management of risk is that decisions are based on a continuous process of identifying hazards, assessing risk, taking action to eliminate or reduce risk, monitoring and reviewing, in the rapidly changing circumstances of an operational incident.*

23 *Walsall Safeguarding Adult Review regarding “Andrew” published 2018*

10. RESPONSE TO FIRE RELATED INCIDENTS AND RISKS

10.1 The risk of fire incidents first emerged in October 2015 when an ASC Neighbourhood Community Officer reported there were cigarette burns on the bed sheets and recommended a risk assessment which was passed on to DWMH. About a year later in September 2016 the Community Alarm Service reported that one of the many alarm activations included one where Clara requested an ambulance as “she was going to set herself on fire’. Shortly afterwards, WMFS attended in response to Clara setting fire to some used incontinence pads on the bathroom floor which she explained to the fire officers was because of her embarrassment about having to use pads. Fire retardant items were installed immediately afterwards to reduce the risk. When the home care agency also reported this incident, it also added that that Clara was putting cigarettes out on the living room carpet.

10.2 The ASC electronic case record shows that in April 2015 a referral had previously been made to WMFS for a home safety check. However WMFS had no record of that referral being received. It was not possible to reconcile this because the ASC electronic record did not provide any details of how the referral was made and any supporting documentation regarding this was no longer available. [24]

10.3 The SAR heard from ASC that there was an assumption that this referral initiated regular involvement from the fire service. However, after WMFS’s attendance in 2016 to deal with the fire in the bathroom, the service had no further involvement until May 2018. WMFS explained that no further safe and well checks were carried out in the intervening period because when the fire officers attended the 2016 incident, they were informed by Clara and her mental health worker that she would shortly be moving to new accommodation, and WMFS was not notified when this did not go ahead.

10.4 During the SAR, WMFS expressed concern that it was not informed about the incident at the end of April 2018 when Clara set light to paper in an ashtray and threatened to burn the house down with the carers inside, the occasion in May when she burnt her hair, or that police officers around that time had noted that Clara’s smoke alarm was constantly bleeping. These all occurred before their emergency attendance to extinguish the fire in the duvet in May 2018 which led to the internal referral to the Vulnerable Persons Officer (VPO) and the safe and well visits.

10.5 WMFS made the observation that had it been informed of these previous incidents either at the time, or post event, it would have increased their assessment of the risk in relation to that attendance, and would have been taken into account by the VPO in terms of considering what further steps might be taken to reduce the risk, including liaison with other agencies.

10.6 Not being aware of these previous incidents, the VPO did not make an immediate approach to inform the care co-ordinator or ASC Access Team of the risks these visits had identified and the preventive action taken. A month elapsed before the VPO made a telephone call to the care co-ordinator in late June. [25] The information was shared with another member of the mental health team, and a call back requested

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[24] *ASC explained that the referral was made in April 2015 when it was using the “Paris” recording system. In November 2015 ASC began the switch to the “Mosaic” electronic record system and not all information held was migrated across.*

[25] *The information regarding this call was included in the original WMFS report for the scoping of the SAR but was not included in the WMFS chronology or IMR.*

from the care co-ordinator when she returned from annual leave. Neither agency has a record that a return call was made.

Conclusions, Key issues and Learning

10.7 The lack of inclusion of the potential risk of fire related incidents in the risk assessments is a concern given the several incidents referred to above. It is also a concern that the Fire Service was never approached by any agency from 2017 onwards for advice or to request a fire risk assessment. All the visits made by WMFS to mitigate the risks stemmed from their own internal referral procedures. There were numerous opportunities for agencies to alert WMFS to the continued and seemingly heightening fire risk which would have resulted in a Safe and Well being carried out or another visit from a VPO.

10.8 This lack of contact was despite the Fire Safety Guidance for Health and Social Care Practitioners which had been developed and issued by WMFS following the recommendations of 2 previous SARs. [26] This guidance supports practitioners with the identification of evidence of fire risks in a property, and details the need for these to be reported to WMFS so that ongoing support can be offered to the occupier to minimise the risks. This includes situations where a property has working smoke alarms, but a continuing fire risk has been identified.

10.9 This document had been updated and re-circulated to all local authorities in the West Midlands region within the last 2 years with the offer of training. It is unclear from the IMRs whether the front line practitioners in Clara's case had undertaken the training, but the lack of focus on the fire risks, or referrals to WMFS would suggest that there was insufficient awareness or application of this guidance. This is surprising given that one of the drivers for producing the guidance involved a previous Walsall SAR.

10.10 It is positive therefore that the SAR received confirmation that all Adult Social Care staff have now attended mandatory briefings delivered by WMFS since this case, and that the guidance and referral forms are available through the Adult Safeguarding intranet pages. The SAR also established that in addition to its own training, DWMH have placed links to the WMFS guidance and referral process on its website and all staff have been made aware of the availability of these.

10.11 The SAR was informed by WMFS that an e-learn package will be available in the coming months which is suitable for all professionals that go over the threshold into a person's home. This may help over come the difficulty that has been encountered so far in engaging with home care agencies who have found it difficult to free up carers' time to attend training events. Given that WMFS view that home carers are a crucial cohort in being well placed to identify potential fire risks, WMFS have raised the issue of whether completing the fire risk e-learn package should be a mandatory requirement when home care agency contracts are awarded.

10.12 It will be important that WSAB seeks confirmation of the arrangements within other agencies and the steps taken to promote awareness of the WMFS guidance, and that this covers all relevant groups of existing staff, and is included in the induction of new staff. The aim should be for a consistent approach to be applied across the wider safeguarding partnership.

10.13 As with any training, it will be important that WSAB seeks assurance that that this is achieving the required impact and that there is evidence that fire risks are being included in risk assessments, professionals are applying the triggers for initiating contact with the fire service, and this is leading to effective liaison and joint working of

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[26] *(Coventry Miss G 2013 and Walsall JG 2014)*

all agencies involved in individual cases. This liaison needs to cover situations where consideration may need to be given to a further fire risk assessment either where a service user moves to new accommodation, or someone moves into the household who has a known history of possible fire risk factors.

11. RESPONSE TO SAFEGUARDING CONCERNS SUBMITTED

11.1 There was one formal safeguarding concern raised via an Adult Safeguarding Concern Form which was by home care agency 2 following the fire in the ashtray incident. Following discussion with the care co-ordinator and social worker to gather more information, [27] the rationale for the decision made by the ASC Access Team not to proceed to Section 42 enquiries is understandable given the high level of existing agency involvement. The decision was also reached following discussion with Clara and reflected her expressed wishes and desired outcomes. This contact with Clara demonstrated good practice in ensuring adherence to the principle of making safeguarding personal (MSP).

11.2 However there was no reference in the discussions with the social worker and care co-ordinator to the previous and recent fire setting incidents, or the several observations of burns in Clara's clothing, carpets and furniture. Consideration of these might have led to more weight being given to the potential significance of the latest incident.

Conclusion, key issues and learning

11.3 The above analysis highlights two issues.

Decision-making process when considering safeguarding concerns

11.4 The first is to ensure that when additional information is being gathered to consider the response to formal safeguarding concerns that have been raised, and whether the criteria for section 42 enquiries are met, the views of all relevant agencies are taken into consideration. In this instance, consultation with WMFS would have been important, and a more detailed discussion with the home care agency who raised the concern.

Recognition and response to self neglect

11.5 Although a number of "care concerns" were reported by WMAS and the home care agencies, the ASC IMR raised the question as to whether there was sufficient understanding of self-neglect being a safeguarding issue, and action required to respond to this. ASC has taken steps to raise awareness through the dissemination of new Adult Safeguarding Practice Guidance via a series of mandatory briefing sessions, and providing links on its intranet to the regional adult safeguarding procedures and self neglect best practice guidance. In addition, all its teams now have a nominated Adult Safeguarding Champion to help support the quality of adult safeguarding practice responses and ensure awareness of safeguarding policies and guidance.

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[27] *During the SAR ASC was able to confirm that discussion had taken place with the social worker. There had been some doubt regarding this in the light of the social worker's evidence at the inquest that's she was not aware of this safeguarding concern having been raised. This led to the Coroner requesting further enquiries to be made by the local authority. ASC subsequently clarified that the confusion arose from the social worker not having the case records to refer to during the inquest.*

11.6 In addition work has started work within WSAB on developing a Self Neglect Pathway which includes a risk assessment tool which provides a safety net for situations where practitioners are not achieving the necessary engagement from service users or other agencies.

11.7 It will be important that WSAB seeks assurance that across the partnership, initiatives such as these are making a difference, and that professionals are applying the local and regional guidance to improve recognition and are confident about when, and how, formal safeguarding concerns should be raised.

12. PLANNED MOVE TO SUPPORTED LIVING

12.1 In response to the increasing risks, the plan for Clara to move into supported accommodation was developed as a possible solution. Although arrangements were well advanced for Clara to move at the point she died, examination of the agency chronologies suggests there were missed opportunities to progress this earlier.

12.2 Following the death of Clara's husband in 2015, professionals had been continually advising Clara to consider the benefits of supported accommodation both in terms of practical support and reducing her social isolation. When the option was raised, at the CPA review in November 2017 Clara rejected this despite being "strongly advised" which was respected as Clara was deemed to have the mental capacity to make that decision. According to the DWMH IMR this remained her stance until early May 2018.

12.3 However, as early as January 2018, there were indications that Clara wanted to move because she was lonely and finding it difficult to cope. First, she explained to paramedics that she was not sleeping well and did not want to be on her own. A week later, at the friendship group, Clara told a DWMH support worker that she wanted to move to somewhere that could provide her with more support such as the unit where her friend lived.

12.4 Although Clara was encouraged to raise this with her the care co-ordinator, there is no record of her doing so. During the Learning Event, the care co-ordinator confirmed she was unaware of this and it appears therefore that the support worker did not feed this information back or ask Clara's permission to do this. This feedback would have been important given the significance of this development, and would have enabled the care co-ordinator to open up the issue in her next contacts. This was a missed opportunity therefore for the accommodation issue to be explored at a point where Clara appeared to be more receptive to a move to a more supported setting.

12.5 The social worker told the ASC IMR author that she raised the option of moving during the Section 27 Care Act Review at the end of April 2018. However, Clara clearly articulated her opposition to this and her written contribution in the review document stated that *"My current place of residence is important to me, I like living in my own bungalow. I do not want to move."*

12.6 Clara's stated preference appears somewhat at odds with the observation of a neighbour around the same period who reported that Clara had been at her door crying, and stating that she did not wish to be there. Moreover, just five days after the ASC assessment, Clara told the care co-ordinator that she was agreeable to moving - even acknowledging that she might have to reduce her smoking for this to happen. Three days later, she asked the care co-ordinator when she would be moving.

12.7 Action to progress this resulted in a professionals' meeting later in May involving the care co-ordinator, neighbourhood police officer and housing association, when it was agreed that the social worker would be approached to become involved. It is not clear why the social worker was not invited to this meeting which clearly contributed to a delay in the process to facilitate the move. Two days later the social worker and care co-ordinator made a joint visit to Clara when Clara agreed to the plan to hold a professionals' meeting in early June to follow on from the CPA review.

12.8 According to ASC, the social worker was not informed by the care co-ordinator during that visit about Clara's agreement to move, and that the social worker only became aware of this at the professionals' meeting in June. That being the case, this was a missed opportunity to engage the social worker earlier to progress this.

12.9 A month had therefore elapsed since Clara first indicated her willingness to move before the detailed plan was firmed up at the June meeting. It is evident that the ASC support worker was very proactive in trying to progress the plan following this. Unfortunately, her efforts were hampered by the various difficulties covered in the narrative around submission of the application and Clara's suitability being assessed by the unit.

13. EVENTS DURING THE LAST 24 HOURS

13.1 According to the WMAS IMR, when Clara was brought into A&E in the early hours of the morning following a severe episode of diarrhoea and vomiting, paramedics shared the information that Clara had said she had not been coping and had expressed suicidal thoughts. These concerns were subsequently included in the "safeguarding referral" submitted by WMAS that day.

13.2 During the time Clara was at A&E, it was recorded on several occasions that she would not remain in the cubicle as had been requested for infection control reasons. When she discharged herself, this was accepted because she was deemed to have mental capacity to make this decision. It does not appear that consideration was given as to whether any agency should be alerted to this. Given the concerns shared by WMAS, and the previous history of mental health issues in her hospital record, consultation with the PLT, or direct referral to the mental health team or crisis team might have been expected.

Events later that evening

13.3 The inquest heard evidence from the police community support officers who took Clara home, one of the home carers, and the lead paramedic. The consistent thread running through the evidence was that although Clara became agitated at times when discussing the advice to go to hospital, she did not display any mental health issues which would warrant formal assessment under the Mental Health Act.

13.4 In addition, she demonstrated throughout that she had mental capacity to make decisions about her medical treatment and to decline hospital. The paramedics explained to Clara several times that if the possible infection was left untreated there was a danger of her developing sepsis. Clara demonstrated that she had capacity in respect of the two stage test set out in the Mental Capacity Act. She was able to repeat back what information had been provided, demonstrate that she could use and weigh the information about the risks of this being left untreated in reaching her decision, and able to communicate this.

13.5 The conclusion that Clara had capacity to make this decision left the paramedics with no choice but to act on Clara's request for them to leave. Although the paramedics rang NHS111 and the Emergency Duty Team to advise them of the situation, and started to complete a formal safeguarding concern immediately on leaving the flat, there was nothing in her behaviour which led them to believe there was a risk in leaving Clara alone.

14. GOOD PRACTICE

14.1 The SAR has identified a wide range of good practice.

Person Centred Assessment and Support

- There were several examples of professional interventions by social work staff and the care co-ordinator being person centred to support Clara in achieving her desired outcomes and respecting her right to self-determination;

- The Section 27 care and support plan review in April 2018 was person centred, person led, outcome focussed and strengths based;

- the proactive efforts made by social work staff to expedite the planned move to supported accommodation following the June professionals' meeting;

- Clara was able to see the same GP for most of her consultations;

- Application of core principles of the Mental Capacity Act 2005;

- The flexibility shown by the GP practice in arranging appointments and not letting Clara's sometimes aggressive behaviour affecting how they treated her.

Risk Assessment and Management

- The internal referral to the VPO, and the several prompt safe and well / reassurance visits and provision of fire retardant equipment;

- Immediate approval for 2 home carers to carry put all visits after the home care agency 2 raised safety concerns.

Reporting and response to welfare concerns

- The referrals made by the home care agencies and community alarm;

- The quality assurance processes within home care agency 2 for review of the daily carers' care notes by the office manager at the end of each week to check that the necessary action has been taken in respect of any significant issues recorded by the carers;

- The occasions when WMAS sought to further support when hospital treatment was either not required or declined by Clara herself;

- The immediate forwarding of concerns received by the ASC Access Team to both the social worker and the care co-ordinator to enable them to provide an appropriate response;

- The rapid follow up visits made by the social worker or care co-ordinator to follow up concerns reported by other agencies or Clara herself;

- The mobilisation of WMAS visits and / or the Street Triage Team by police call handlers in response to calls suggesting difficulties in relation top Clara's mental or physical health;

- The reassurance given to Clara by police call handlers in the several calls when she presented as distressed;

- The proactive action taken by the Neighbourhood Police Officer in maintaining a non crime vulnerable adults log, monitoring the situation and liaising with other agencies to organise support and longer term solutions.

Liaison between hospital staff and the Psychiatric Liaison Team,

- The referrals made by nursing staff to the psychiatric liaison team when there were any concerns about her mental health and agitated behaviour;

- The prompt response, and quality of the assessments, carried out by members of the PLT to support medical and nursing staff's efforts to provide the required care and treatment;

- The maintenance of behaviour monitoring charts by nursing staff to monitor Clara's behaviour following discussion with the PLT about recognition of the possible triggers for an increase in agitated behaviour.

Provision of personal and medical care

- The persistence shown by the carers from all the home care agencies in seeking, and mostly managing, to engage Clara to accept the care offered on the many occasions when she was agitated and initially refusing to accept care. This included the challenging circumstances when Clara was sarcastic, verbally abusive, and on occasions telling the carers to leave;

- The sensitive care provided by the home carers and paramedics in helping Clara to get clean and changed when they found she had had an episode of diarrhoea;

- Responsiveness of the Community Alarm Service in responding to Clara, both over the telephone, and through prompt visits when she was either distressed or required assistance to meet her intimate hygiene needs;

- The clinical and nursing care provided to Clara in sometimes challenging circumstances because of her agitation.

15. SUMMARY OF THE SAR LEARNING

Introduction

15.1 At the request of the WSAB Independent Chair, the summary of the key findings are presented as thematic learning points rather than as specific recommendations. These will then be integrated into WSAB's existing work streams, and action plans from other recent SARs, which are currently being updated. Accordingly there will be just one formal multi agency recommendation to support this requested approach.

15.2 This key learning covers the following 6 themes:-

1. SAR learning process;
2. Multi-agency Working
3. Case co-ordination;
4. Risk assessment and management;
5. Referrals and information sharing;
6. Family involvement

THEME 1: SAR LEARNING PROCESS

There is a need for WSAB to ensure there is full commitment by agencies to all elements of the SAR learning process.

15.3 The rationale for this stems from the author's observations in section 3. The lack of engagement with the learning events was cited as an issue in another recent safeguarding adult review, [28] and is in said to be in marked contrast to the reported high level of engagement with children's serious case reviews.

15.4 It will be important that WSAB address this issue at board level to secure the necessary "buy in" from all agencies to support all elements of the agreed SAR process so that practitioners and their managers are clear about the requirement to participate, their attendance at learning events is facilitated, and they receive the necessary support throughout the process.

THEME 2: MULTI-AGENCY WORKING

WSAB should seek assurance that agencies are applying an inclusive approach to multi-agency working to ensure that all relevant agencies are involved in case planning who can either contribute direct knowledge of the service user's situation and / or who can offer specialist advice and support.

15.5 The rationale for this key message flows from the following SAR finding that there were never any multi-agency meetings which included all relevant agencies, and gaps in liaison which should have been expected, for example:-

- the home care agencies not being invited to attend any of the professionals' meetings or provide their experiences and perceptions to inform the CPA Reviews;

- the social worker not being invited to the May professionals' meeting to discuss the move to supported accommodation;

- the Fire Service not being invited to professionals' meetings despite the increasing incidences of fire related risks;

- the lack of liaison with the GP Practice by the care co-ordinator or social worker

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28 *Walsall Safeguarding Adult Review regarding "Andrew" published 2018*

15.6 Similarly it is important that all relevant agencies are approached when the local authority carries out lateral checks to gather additional information to determine the response to formal safeguarding concerns, and whether the criteria for section 42 enquiries are met. In this case, consultation with WMFS would have been important given the safeguarding concern included a fire incident, and more detailed discussion would have been expected with the home care agency who submitted the concern.

There is a need to raise awareness across the wider partnership of the processes which can be invoked by agencies to escalate concerns which do not meet the criteria for raising formal safeguarding adults concerns, or to challenge decisions made another agency.

15.7 The SAR findings raise the question as to whether Walsall's partnership arrangements provide legitimacy for any agency to take the initiative in convening multi-agency meetings where there are concerns. Although the neighbourhood police officer was proactive in this respect, it appears that the home care providers and Community Alarm looked to either DWMH or Adult Social Care to decide how concerns should be addressed.

15.8 During the SAR discussions home care agency 2 shared its perception that on occasions it did not feel that their concerns about Clara's behaviour and associated risks had been given sufficient consideration, but did not know how to press these further. It also appears that fire officers may not be aware of the processes to be followed when they consider a multi-agency meeting is required. There also seems to be limited awareness of WSAB's escalation protocol.

THEME 3: CASE CO-ORDINATION

Where both Adult Social Care and DWMH are involved in providing support to a service user, there should be an explicit agreement at the outset about their respective roles, the focus of their involvement, and triggers for information sharing which reflect the statutory responsibilities of the care co-ordinator through the Care Programme Approach. The agreed arrangements and information sharing pathways should be shared with other agencies who are involved.

15.9 The importance of ensuring clarity of roles stems from the SAR findings that:-

- although ASC was clear that DWMH had lead responsibility for co-ordinating Clara's care by virtue of the statutory responsibilities through the Care Programme Approach, the perspective of DWMH was that there was little evidence to suggest that any one particular agency had been identified as the lead agency.

- some other agencies were unclear as to which was the lead agency when there was a need to share information..

The SAR findings reinforce the need for mental health professionals to ensure that they apply the national guidance on the Care Programme Approach by adopting a holistic approach in assessing a service user's needs including a focus on their physical as well as their mental health needs

15.10 The expectation of ASC was that delivery of the Care Programme Approach would focus on not just Clara's mental health, but also her physical health issues. When this did not happen, Clara did not receive appropriate support around the latter from either agency, which could have included ensuring the GP Practice was aware of the ongoing distress that Clara was experiencing in relation to the bowel problem.

THEME 4: RISK ASSESSMENT AND MANAGEMENT

Agencies should strive to achieve a shared understanding of what changes in behaviour may indicate deterioration in a service user's mental health and consequent possible increase in the level of risk.

15.11 This stems from the SAR finding of an apparent "perception gap" between mental health specialist practitioners and other professionals around these issues when concerns were raised by the latter that Clara's behaviour suggested that her mental health was deteriorating but the former concluded that her mental health remained stable and there were no new risks.

15.12 This underlines the importance of personalised care plans for people subject to the Care Programme Approach providing clarity about the differences in a person's behaviour and level of functioning both when mentally well, and unwell in order to provide professionals to spot the early warning signs of a possible deterioration in a person's mental health.

Risk assessments must be robust, comprehensive and updated in response to crises and other developments, and shared with all agencies which have ongoing involvement to provide the basis for joint monitoring and action.

15.13 The SAR heard that DWMH and ASC risk assessments were not updated to reflect information received about the incidence of Clara wandering the streets, sometimes exhibiting distressed behaviour, or the increasing incidences of possible fire risks. Their risk assessments were also not shared with the home care providers.

Where a professional considers a person is making an unwise decision about their care or treatment, a record should be made as to why the person was assumed to have mental capacity, or setting out the conclusions reached following assessment where capacity has been called into question.

15.14 This reminder stems from the several instances where Clara declined to act on advice to be taken to hospital for further assessment, or for the home carers to contact her GP when she was experiencing prolonged episodes of diarrhoea. It is important that professionals can produce evidence of steps that were taken and defendable decision-making in the event of such situations resulting in adverse consequences for the service user.

This review has demonstrated the need to increase the ability, and focus, of professionals on identifying indicators of possible fire risks, ensuring their inclusion in risk assessments, and reporting these to the Fire Service to seek their advice and involvement to identify ways of minimising the risks

15.15 With the exception of the fire service, the SAR has established that there was insufficient focus by professionals on potential fire risks, and no contact with the fire service in relation to these, or actual incidents.

15.16 It is essential that WSAB seeks assurance that there is a consistent approach across the partnership and that all agencies are adhering to the guidance issued by WMFS on how to identify and report potential fire risks, and are taking up the offer of training including the e-learning package when it becomes available.

THEME 5: REFERRALS AND INFORMATION SHARING

Agencies that are providing ongoing support, either directly, or through commissioned care providers, must ensure that crisis responders are able to immediately access information about which agency / professional referrals should be directed to.

15.17 The need for action around the above stems from the SAR findings that there were many instances when crisis responders did not share information about their involvement. Where information was shared, there was a wide variation in which agencies this was provided to.

15.18 A key issue which needs to be addressed is how to make it easier for crisis referrers to direct information to the appropriate agency given that crisis responders most usually go into situations with little or no previous knowledge of the service user. They are therefore unaware of which agencies are involved in providing support, and do not have easy access to contact details for the key professionals who need to be contacted. Consideration should be given to exploring the feasibility of information being made available within the service user's home that provides contact details for professionals who have lead responsibility for co-ordinating support.

Where an agency identifies that a service user is in urgent need of help from another agency, but have doubts about a service user's ability to act on advice to self refer, it must take responsibility for making direct contact with the relevant agency, subject to securing the service user's consent unless the criteria is met for sharing information without this

15.19 This stems from the number of occasions when it does not appear that Clara followed through on advice from paramedics, NHS11 1 or mental health professionals to seek help from the GP.

Agencies which commission home care support must ensure that their expectations are clear as to when, and to whom, care providers should report any difficulties in delivering the commissioned service, or have concerns about the physical and / or mental health of the service user.

15.20 This stems from the finding that home care agency 2 and Adult Social Care did not have a shared understanding that concerns should be reported to the care co-ordinator. Second is observation made by Adult Social Care confirming during the SAR that it was not always aware of the difficulties being experienced by the home care agencies, or by Clara when she had been having episodes of diarrhoea over a 2 week period in June – the implication that it should have been informed.

THEME 6: FAMILY INVOLVEMENT

Agencies should strive to ensure they maintain up to date contact details of relatives in the event of an emergency, and that assessments establish the extent of their involvement, or that of other significant people, in order to gain a well rounded assessment of a service user's situation, needs and informal support networks.

15.21 The need for this reminder stems from the SAR finding that the main agencies involved could not readily provide the contact details for Clara's son and daughter, and appeared to have little information about the extent of her daughter's contact which emerged at the inquest.

Practitioners should apply the necessary professional curiosity to explore any issues about family involvement and relationships which appear to be having an adverse impacting on a service user's mental health and emotional well-being.

15.22 While acknowledging the need to respect a service user's wishes if they do not wish to discuss issues relating to the family, there will be occasions as in Clara's case, where practitioners need to probe further and suggest there might be benefits in talking about family issues which appear to be causing distress.

16. MULTI AGENCY RECOMMENDATION

16.1 It is recommended that WSAB assures itself that the thematic learning points from this SAR summarised in Section 15 of this report are integrated into the work to update its strategic priorities, action plans and associated work-streams.