Safeguarding Adults Review

Learning from the circumstances around the death of Mr S

8th November 1942 - 20th October 2021

Lead Reviewer: Kate Spreadbury

Date: November 2022

Contents

Glossary

ASC - Adult Social Care

CCG – Clinical Commissioning Group

CPA – Care Programme Approach

COPD – Chronic Obstructive Pulmonary Disease

CPN – Community Psychiatric Nurse

ECMHTOA - Enhanced Community Mental Health Team – Older Adults

ED – Emergency Department

HCP – Health Care Practitioner

ICB – Integrated Care Board

ICS – Intermediate Care Services

SAR - Safeguarding Adults Review

SCF- Social Care Facilitator

WHT - Walsall Healthcare Trust

WMAS - West Midlands Ambulance Service

WMFS - West Midlands Fire Service

WSAB – Walsall Safeguarding Adults Board.

1. Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Walsall Safeguarding Adults Board (WSAB) in response to the circumstances surrounding the death of Mr S on 20th October 2021.

1.2 Mr S, a white male UK citizen, was 78 years old when he died in hospital on the 20th October 2021. He lived in social housing; his flat was in a general needs housing scheme.

Mr S had lived in Walsall all his life. It is reported that he had six sisters and three brothers but at the time of these events only had contact with his brother X who lived a few miles away. Mr S was a Wolverhampton Wanderers supporter and enjoyed watching football on the television. He liked to discuss politics which he followed on the news.

Mr S had worked in engineering jobs, but his mental health needs made it hard to maintain employment. He had a long-term diagnosis of paranoid schizophrenia, experiencing distressing auditory hallucinations and feeling suspicious and mistrustful of people.

Mr S described himself as a private person. He struggled to form relationships with others but appeared to enjoy a level of social contact once he became familiar with a person and knew he could trust them. Mr S said that maintaining his privacy, being independent and having contact with his brother were key to his well-being and peace of mind. Being able to come and go from his home as he pleased was particularly important to him. He hoped to live closer to his brother and welcomed help to explore this.

Mr S registered with a GP Surgery on the 5th March 2015 and remained with the same practice until his death. He had a number of physical health issues including Chronic Obstructive Pulmonary Disease (COPD), Hyponatremia (low sodium levels), iron deficient anaemia diagnosed in Feb 2021, and angina pectoris diagnosed in August 2006. Mr S smoked around 20 cigarettes a day. He was significantly hearing impaired, to the degree that this impeded communication with him.

1.3 This review is conducted in accordance with section 44 of the Care Act 2014 and the Walsall Safeguarding Adults Board Procedures.

The decision to commission this SAR was made in December 2021. The lead reviewer was commissioned in February 2022 and terms of reference were agreed in early March 2022.

Under section 44 of the Care Act 2014 a Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there

- is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,
- and the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

2. Terms of Reference

2.1 **Timeframe**: The timeline for the SAR is **February 2021 to October 2021**

Rationale for the timeframe: Mr S was admitted to hospital in February 2021, care arrangements were put in place to support his discharge and a significant period of multi-agency working began at this point**.** Mr S died in October 2021.

2.2 The **specific areas of focus** for the SAR are:

- How agencies worked together, including sharing information and making referrals.
- How risks posed by Mr S' self-neglect were understood by all agencies, and what actions were considered or taken to prevent harm.
- How Mr S' physical and mental health needs were understood together with the impact of these on his engagement with services and ability to self-care. How were his needs understood during transitions, for example discharge from acute or mental health care or between providers?
- Whether Mr S' family or social networks were engaged in planning his care or engagement.
- How practitioners and systems can be developed to improve our response to others in similar situations.
- Good practices and systems as well as those that need development. Both aspects will contribute to the learning from the SAR.

3.Methodology

3.1 This Safeguarding Adults Review was undertaken using a hybrid methodology to analyse the complex circumstances that practitioners work in and provide opportunities for shared learning. The key lines of enquiry were developed by a Panel of involved

organisations and also informed by initial learning from other SARs currently being undertaken in Walsall.

The agencies involved completed a chronology and analysis which focused on the actions and decisions of their own agency. Initial themes arising from these reports were explored in a reflection and learning workshop with the practitioners and first line managers who worked with Mr S. Individual interviews were also held with some of the involved practitioners.

3.2 The following agencies have contributed to the Review:

- Accord Housing
- Adult Social Care (ASC)
- Black Country Healthcare Foundation Trust
- Care XY
- NHS Walsall Clinical Commissioning Group (who compiled the GP Report)
- In Mind Care
- Walsall Healthcare Trust (WHT)
- West Midlands Ambulance Service (WMAS)
- West Midlands Fire Service (WMFS)

4. Family involvement

4.1 Mr S's family were invited to participate in the SAR on two occasions, when terms of reference were agreed and after the draft report was signed off by the Practice Review Group. No response was received to these invitations. Should Mr S's family wish to comment on the SAR in the future they will be welcome to contact the Walsall Safeguarding Adults Board.

5. Time in scope – key episodes and analysis

5.1 **Key Episode 1: 1ST February until 12th February 2021**

5.1.1 During this period Mr S was open to the Enhanced Community Mental Health Team – Older Adults (ECMHTOA). He had been on the Care Programme Approach (CPA) since 2011. He was seen by a mental health trust Health Care Practitioner (HCP) and a Community Psychiatric Nurse (CPN) regularly. He was also open to Walsall Council Adult Social Care (ASC), his CPN had referred him for support with his neglected home environment, ASC were arranging cleaning for his flat.

5.1.2 During January 2021 Mr S appeared unwell. On the **29th January** the ASC social worker alerted the GP that Mr S was breathless with rapid breathing. COVID Hub staff attempted to visit but found him not at home. West Midlands Ambulance Service (WMAS) attended that evening, Mr S declined conveyance to hospital and was thought to have the mental capacity

to do so. The following day he went to the GP surgery himself and was prescribed antibiotics, blood tests were also undertaken, examination was suggestive of bronchiectasis.

5.1.3 Mr S met with his ASC social worker and a charity on the **2nd February** to plan the clean of his flat which was scheduled for the 6th February. He has previously paid for a clean himself in 2019 when the carpets in his property were removed. He is reported to have owed money to this cleaning company, something which worried him.

5.1.4 Mr S's blood test results were concerning, he had low sodium levels in his blood. A GP left repeated messages on Mr S's telephone and also tried to contact Mr S's HCP. The GP surgery were under the impression that Mr S lived in a warden controlled flat but that they did not have contact details for the warden. The GP booked an ambulance which conveyed Mr S to Hospital. In the Emergency Department Mr S presented with '*confusion, agitated and verbally and physically aggressive to staff'.* The Walsall Healthcare Trust (WHT) report writer has noted that although Mr S was described as refusing care and treatment and having episodes of agitation, there was no evidence of a Mental Capacity Act (2005) assessment being undertaken to establish if he lacked capacity to understand the risks associated with his refusal.

5.1.5 After admission WHT began to plan for Mr S' discharge, recognising that he would need support to return home. The cleaning of his property had been postponed as he would not be present. A discharge plan was led by Intermediate Care Services (ICS) and involved ASC, the Mental Health team, the cleaning support charity and latterly Accord housing. Mr S was consulted as part of the planning, in particular about the property cleaning which now needed to go ahead before his discharge. Mr S was medically fit for discharge on the 8th February. His landlord, Accord, arranged for key safes to be installed and ICS arranged a care package in order to both support Mr S and assess his needs in his home after discharge. Mr S returned home on the **11th February** having agreed to have two domiciliary care visits per day to assist him with personal hygiene, meal provision, domestic support and to oversee Mr S self-administering his medication. This is believed to be the first time that Mr S was supported by a care provider.

5.1.6 Mr S's GP surgery recorded that having written to him to offer a COVID vaccine on several occasions (in the context of the review between 29/1/2021 and 11/02/21), further invitations would not be offered. Mr S is recorded as 'declining' a COVID vaccine whilst accepting flu vaccines.

5.2 Analysis

5.2.1 Mr S was medically fit for discharge on the 8th February but remained in hospital whilst his flat was cleaned. During this phase of the COVID pandemic there were increased resources to fund discharge from hospital, the flat cleaning could be arranged and funded quickly. Funding was also available to address contingencies post discharge to avoid re admission.

5.2.2 The discharge to assess[1] pathway in Walsall is reported to be well-established and to work well for patients. Some participants at the Learning Event were concerned that Mr S may have benefitted from a 'step down' bed in a care home to ensure his health was stabilised, it is unknown if this option was offered or indeed whether Mr S would have accepted this. Mr S had not had the support of carers before and is described as very independent, assessing his needs in his own home would give a better picture of what support he needed to remain independent for as long as possible. WHT, the ECMHTOA and Intermediate Care Services worked together effectively to arrange a safe discharge. Mr S's discharge took place when all was in place to support him, the ward ensuring that he would not go home until key safes had been installed.

5.2.3 Mr S was severely hearing impaired, so much so that the Social Care Facilitator (SCF1) who supported him post discharge found that communication was better when they wrote notes to each other. His hearing impairment isolated him. He could not hear a knock at the door or the phone ringing. Mr S did not open letters and had no-one to open letters for him. His communication preferences were not noted in his GP notes until a GP visited on 11th March. *(See section 5.3.10 below*). The assumption that he was 'declining' a COVID vaccine, vital for a person with chronic respiratory disease, was not robustly followed up via any of the organisations working with Mr S. Mr S would have met the criteria of 'clinically vulnerable' [2] in 2020 – 2021. In the light of his physical and mental health issues organisations needed to be aware of his vaccine status and prepared to work with primary care to support Mr S's informed consent and possibly a primary care home visit to administer the vaccine.

5.2.4 The GP surgery were flexible in their responses to Mr S, during the time in scope his habit was to attend the surgery without an appointment, he was always seen and examined, contrary to NHS guidance in place at the time but in recognition of his need and engagement.

5.2.5 Mr S was described as '*confused and agitated*' and '*refusing care and treatment*' at WHT Emergency Department but there is no record of a mental capacity assessment being considered or undertaken. Mr S' capacity to make decisions could be affected by his illness, his mental health issues which made him fearful and suspicious of others, and/or his great difficulties in hearing people. On what legal basis Mr S was admitted and initially treated is therefore unclear. Mr S is later described as participating in his discharge plan. After treatment for the acute phase of his illness Mr S may have regained capacity, but there is no record to substantiate this.

[1] Find out more at LGA (accessed on 25062022) *Home First/Discharge to assess* at https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess

[2] https://www.gov.uk/government/news/clinically-extremely-vulnerable-receive-updated-guidance-in-line-with-new-national-restrictions

5.3 **Key Episode 2 12th February – 21st March 2021**

5.3.1 Mr S's care was now being coordinated by an ICS Social Care Facilitator (SCF1) and he was therefore closed to his previous ASC social worker. SCF1 demonstrated excellent person-centred practice, establishing the best way to communicate with Mr S and, realising that he had barely any possessions or clothing, attempting to find useful items that were acceptable to him to improve the quality of his life. Care provider 1 also sourced socks and clothing for him, Mr S had very few possessions at home.

5.3.2 In the early days of contact Mr S and the care agency struggled to work together. On the day after discharge, **12th February,** one carer thought that Mr S was going to hit her. Mr S said that he did not know what carers were doing in his flat and asked her to leave. After that incident the support plan was changed to enable two carers to visit each time, morning and evening. ASC asked the mental health team to give carers advice on how to work with Mr S as the interim discharge plans did not contain specialist knowledge from a Community Psychiatric Nurse (CPN) regarding how best to approach and engage with Mr S. The CPN thought that Mr S's responses were due to his mental health condition. The care agency later reported back that a different approach had enabled Mr S to be comfortable in the carers' presence and to begin to engage with them during visits. The care provider agreed to report any concerns to SCF1 and Mr S's CPN. The need for two rather than one carer was not discussed with Mr S.

5.3.3 Mr S went to his GP surgery on the **15th February**, he was agitated and out of breath. He was sent to ED where he was treated for confusion and hypernatremia (high sodium levels in his blood). Later that day he returned home where his carers report that he was '*aggressive*' toward them.

5.3.4 Mr S' care and support needs were reviewed with him in a joint visit with the HCP and SCF1 on the **22nd February**. The outcome of this review was that he needed long term domiciliary support, with four visits per day with two carers. A rat infestation throughout the complex was identified, this was reported to the nuns who, because of a historical agreement, lived in the property and reported repairs to the housing association. It was also agreed that an application for rehousing for Mr S would be explored and a referral to be made to West Midland Fire Service (WMFS) for an urgent home safety check as Mr S lived alone and smoked heavily. The care provider was not invited to participate in the Review despite a 'discharge to assess' model being used.

5.3.5 The next day SCF1 contacted the GP surgery to request a medication review. An application for a change of accommodation was sent to the HCP to finalise with Mr S and submit to the Housing Association. A GP telephoned Mr S and on the **24th February** wrote to him asking him to attend the surgery for the medication review. Mr S did not know how to use his inhalers which involved inserting a capsule. This exacerbated his breathing difficulties. Mr S did not respond to the GP letter.

5.3.6 SCF1 and care provider facilitated a WMFS safe and well check to Mr S on the **24th February**, various items of fire prevention equipment were provided. WMFS noted that Mr S smoked in bed, that he had a hearing impairment and would also require assistance to get out in the case of fire. The care provider later encouraged Mr S to use the fire prevention equipment.

5.3.7 ICS asked the GP to provide easier inhalers and for a referral to wheelchair services on the **26th February**. Mr S wanted to be independent, and it was thought that a wheelchair would help carers to get him out of the property so that he could go to the post office with them to get his money. The GP wrote to Mr S again on the **2nd March** to arrange a medication review but received no response. ICS asked again for a wheelchair services referral on the 19th March. There is no evidence that a referral to wheelchair services was made. Learning event participants reported that waiting times for a wheelchair assessment nationally was and currently is around 18 weeks, a referral may not have been immediately responded to.

5.3.8 By the **9th March** Mr S's care and support plan had been completed with him. The plan consisted of two carers to visit four times daily to assist Mr S with hygiene needs, domestic support, laundry, medication administration and nutritional needs. There was also additional support to assist with shopping. This was anticipated to be needed for the long term. Mr S's care provider did not have the capacity to continue to work with him and so another care provider needed to be found.

5.3.9 SCF1 requested an urgent GP home visit due to concerns regarding Mr S's increased confusion and reduced dietary/fluid intake, as well as to ensure that a COPD nurse could visit him at home due to his increased frailty. Mr S did not have a visit from a COPD nurse. He had been referred previously but did not respond to letters inviting him for an appointment and was closed to the COPD team on 22nd February 2021. COVID had a great impact on the COPD team who were also experiencing a staff shortage and were unable to respond to requests at this time.

5.3.10 In response to SCF1's request a GP visited Mr S on the **11th March** and, after being admitted by the nuns as Mr S did not hear the door, found him asleep on the couch with food and drink beside him. The GP described the flat as very untidy with '*an element of self-neglect*'. A full patient examination was undertaken; Mr S agreed to a further blood test. The GP recorded that Mr S did not answer the phone or open his mail and was therefore unaware of his appointments. This was recorded in his GP notes. The GP referred Mr S to community phlebotomy for a blood test.

5.3.11 The HCP visited Mr S on the **10th and 12th March**. His flat looked clean although Mr S was described as '*agitated*' and worried about the debt for the 2019 clean up of the flat. Mr S' Olanzapine was reviewed, he had forgotten to pick the prescriptions up. It was unclear whether Mr S had been taking his medication since his discharge from hospital or when he

had last had a medication review. Mr S carried his medication around with him in a plastic bag and was unwilling to let others see what was in the bag which made assessing his compliance very difficult for the care providers. SCF1 had seen inside the bag and thought that the medication was old and out of date.

5.3.12 Across this week Mr S appeared unwell and unhappy, he shouted at the carers, he did not want to wash or eat and dropped food across the flat, '*his place was a mess'*. The care provider called 999 on the **19th March** as Mr S was breathless and had been vomiting. Although agitated when the ambulance arrived Mr S calmed quickly. He did not wish to go to hospital, so the crew spoke with his GP who arranged a domiciliary blood test and enquired after Mr S's living conditions, checking whether he still had the appearance of someone who was self-neglecting. WMAS had found the flat clean and had no concerns.

5.3.13 Mr S continued to be unhappy and angry with carers. During the last contact he had with care provider 1 he ordered them out of the house. It is not known if Mr S was told his care provider was about to change. Now that the 'discharge to assess' process had finished Mr S was also no longer seen by SCF1 but transferred to a team in ASC.

5.4 Analysis

5.4. 1 Practitioners who attended the learning event thought that the nuns who lived in the flats were also wardens. The housing association reports that the role of the nuns is to arrange repairs and organise activities, but they are not employed by the Housing Association to provide any service to tenants. Misunderstanding about the status of Mr S accommodation may have obscured the lack of support he had there. Participants reported that there are so many different types of housing that this creates confusion about what support is actually available.

5.4.2 Prior to cleaning Mr S property was described as uninhabitable, a safety risk and fire hazard. These concerns were being addressed via support and monitoring by ICS and the mental health team, but Mr S was still self-neglecting in terms of his health, medication needs and acceptance of support. Practitioners attempted to resolve these concerns with variable success. The fire and rescue service was facilitated by ACS and the care provider to attend and advise, but the GP surgery and primary care services struggled, either being unable to make contact or being under pressure and unable to respond. Mr S was often unwilling to allow care providers into his flat or accept support from them. Care providers report that Mr S' property would quickly deteriorate without carers having access and being able to clean. He would drop food everywhere and move items around at night when he was most active and alert.

Mr S's continuing self -neglect was not focused on as a safeguarding concern as arrangements to support him at home were continuing to develop. The SAR Panel has also advised that agencies in Walsall do not share a commonly agreed and understood definition of self-neglect and this can obscure the true extent of potential harm.

5.4.3 Whilst the impact of Mr S' mental health needs were acknowledged by all involved, the discharge support plan focused only on his physical needs. Care providers report that this is not uncommon in the context of discharge to assess, there is little information about the person or their home circumstances. Their mental health needs are not referenced and may not have been fully understood whilst they were in the acute hospital trust.

Both care provider 1 and care provider 2 were given telephone advice by the mental health trust on how to engage and work with Mr S. However this specialist advice needs to be recorded on the person's support plan and where possible discussed with and supported by a face to face meeting with a mental health practitioner. When care providers accept the commission to work with an individual their key source of information is the support plan. Information about how a person's mental health needs can be met must be included there.

Examination of a Walsall Council support plan shows that the domains of the form could be used to record needs arising from mental health needs. Domains could be used flexibly to record engagement needs, and indeed to record more information about a person's wellbeing. This may require further guidance and case examples to support staff to use the plan to give care providers the information they need to engage with and support the person to maintain their overall wellbeing, including access to primary care.

Care provider 1 was not invited to contribute to the review of Mr S care and support needs. They had a different view of his needs based on their daily contact with him and thought that he needed much more support via an extra care scheme. His acceptance of care was so intermittent and unpredictable, they thought that he needed accommodation with support available all day.

Whilst the care provider found ICS very responsive to the difficulties they were experiencing in initially engaging Mr S, they felt that they wanted an opportunity to try to think through why he might be behaving in this way. This opportunity could have been provided by meeting with members of the mental health team who knew Mr S and understood his feelings of mistrust and suspicion, his paranoid thinking and the impact of his hearing impairment on his ability to communicate.

5.4.4 SCF1 and the HCP worked together well, Mr S was familiar with the HCP and SCF1 built on this familiarity to engage with him. The presence of the care provider during the WMFS Safe and Well visit meant that the use of the equipment and advice could be reinforced by them on a daily basis.

5.4.5 Organisations needed to work with Mr S' GP to try to enable Mr S to engage with the surgery's attempts to meet his needs. Mr S was on a range of medication which had not been reviewed, he was not getting blood tests, he was at times ill and distressed, he had not had a COVID vaccine. These were concerns which, had they been identified as self -neglect, could have resulted in a coordinated approach to ensure he was getting appropriate health support. All organisations had difficulty in engaging with Mr S, but none had a holistic view

or plan regarding his communication and engagement needs and what the barriers were for each organisation.

5.4.6 Mr S' hearing impairment was continually noted but no referrals or attempts to support him to access a hearing assessment or hearing aids were made. Hearing loss can increase anxiety and depression[3] and in Mr S' case his feelings of suspicion about other people. Mr S is reported to have been particularly worried about neighbours breaking into his house, how much did this fear, together with anxiety and incomplete communication about support changes, influence his wish for people to leave his flat?

5.4.7 Working together is supported by sharing information about how the person is responding to support, learning event participants reported that ICS can access both health and social care systems, this has only been a fairly recent development. Finding out which services are involved and who to talk with is still difficult for all organisations. It is reported that Walsall is piloting an information sharing system (MAST)[4] which will enable easier identification of which organisations are involved with a person so contributing to prevention of crises. Partners include Adult Social Care, Children's Social Care, Public Health; Walsall Healthcare NHS Trust; West Midlands Police; West Midlands Fire and Rescue. This approach will support multi-agency working. Panel members also report that work is being undertaken to enable a shared health and social care basic record sharing system. This may provide another avenue to share the person's specific communication and engagement needs.

5.4.8 Mr S did have face to face visits from the practitioners involved, including joint visits, and was also able to see his GP face to face in an emergency. He urgently needed a review of his respiratory needs and medication, but respiratory nurses appeared to be unavailable to him. Mr S saw many different GPs who did not have a common understanding about his communication needs. Although the visiting GP recorded his communication preferences in his notes these did not influence the surgery's practice, letters continued to be written and to be unopened. There does not appear to be a facility to record communication preferences in a patients notes. SAR Panel members suggested that an agreed 'one page plan,' for people who agencies will experience barriers to communication and engagement, would be a useful document. The plan, similar to those in use for people with dementia or learning disability,[5] can be completed with the person by any agency and shared electronically with primary care and other colleagues with the person's consent, or, if they lack capacity to make this decision, in their best interests. It could form part of a shared health and social care record.

[3] https://rnid.org.uk/wp-content/uploads/2020/05/Hearing-Matters-Report.pdf page 32
[4] For further information about MAST go to https://policyinpractice.co.uk/mast/

[5] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/24-thisisme.pdf

5.4.9 COVID restrictions during 2020 and early 2021 may well have impacted on Mr S mental health. He liked to go out, to visit shops and be around people without interacting with them. These opportunities were reduced during lock down periods which would have left Mr S isolated and lonely.

5.5 Key Episode 3 22nd March – 27th July 2021

5.5.1 On the **23rd March** the new care provider telephoned ASC advising that Mr S had become verbally and physically aggressive to staff upon arrival. ASC asked for liaison between the provider and CPN in '*the form of a joint visit to enable care provider transition*'. A joint visit did not take place, but a mental health practitioner telephoned the care provider on the **27th March** to advise on coping strategies. There was no plan in place to facilitate the transition between care provider 1 and 2.

The new care provider took time to build up a rapport with Mr S. He refused personal care but allowed the care staff to encourage him to change his own clothes which he did daily and eventually at times unprompted. He also refused meals some days but 'made it up' other days, particularly liking fish and chips from the local shop. The provider tailored the care package to suit Mr S who was more responsive to their visits in the afternoon, the morning visits became a 'welfare' check, with more activity e.g. changing clothes being undertaken in the afternoon. Mr S could still be volatile and difficult to engage at times. Different teams attended the three calls, but these teams were stable at the time, Mr S may have recognised the carers after regular attendance over a few weeks. The care provider was also concerned about the lack of carpets in the flat but discovered that replacing the carpets was Mr S responsibility as a general needs housing tenant.

5.5.2 By the **24th March** the CPN was concerned that Mr S was not taking his medication, the GP surgery was asked to provide medication in blister packs. Mr S was noted by the mental health team to be frail. ASC made a referral to Accord Housing for a move to sheltered housing to better cater for Mr S health needs. SCF1 and the HCP had already supported Mr S to complete a referral form and he is reported to have been keen to move nearer to his brother.

5.5.3 On the **30th March** the HCP was again concerned about Mr S's medication compliance but was unable to contact a GP. On the **14th April** the mental health team emailed Mr S's GP seeking clarification on the prescribing of Olanzapine, the GP responded offering a medication review. The mental health team became concerned that Mr S had not picked up Olanzapine prescriptions since January 2021. However both ICS and the care providers were able to confirm that he had been discharged from hospital with Olanzapine in blister packs and also had the drug in blister packs in the community. Because Mr S was so guarded about his drugs it was difficult to determine what medication he was taking and when he took it.

5.5.4 Mr S is recorded to have 'refused' to allow the community phlebotomist to take his bloods at home on the **31st March**. His GP wrote to him to arrange a telephone conversation, perhaps unaware that Mr S did not respond to letters and could not hear well enough to use the telephone.

5.5.5 Mr S became very breathless on the **14th April**, he told the care staff to leave his flat when he was told they had called 999. The care staff met the ambulance crew outside. Mr S was agitated with the ambulance crew and refused assessment but said that he had run out of inhalers. The crew called the GP surgery and arranged a prescription which was delivered by the local pharmacy.

5.5.6 The HCP visited on the **15th April**. Mr S appeared agitated and said that he no longer wished to move house. The flat appeared untidy with signs of self-neglect. Mr S said that he was unhappy with the carers visiting, it was noted that this was concerning as there was a risk of self-neglect and deterioration in his health if he disengaged with carers. His medication had been delivered and the previous day's tablets had been taken, but the risk of Mr S' noncompliance was still noted. The care provider told the HCP that Mr S could be verbally abusive and would sometimes allow carers to visit, sometimes not. The care provider agreed they would contact ASC should Mr S decline care.

5.5.7 A new SCF was allocated to Mr S to review his care and support needs. On the **10th May** SCF2 and the HCP reviewed Mr S's care and support needs with him. The HCP noted that Mr S was 'greatly improved' since the last visit. He was compliant with medication and using a dosette box correctly. The move to supported living was discussed with Mr S and he was now more willing to contemplate this.

It was agreed that the '*care and support arrangements to remain in place, with reduction of bespoke domestic support hours, as domiciliary provider 2 are able to complete tasks within daily allotted support hours'*. Mr S is reported to have participated in the review, asking SCF2 to sit closer to him so that he could hear her. His flat looked tidy and he had a pile of clean laundry. He said that he was accepting of the carers. Care Provider 2 was not invited to the review and does not appear to have been consulted as part of the review process.

5.5.8 By the **18th May** it was known that the proposed supported accommodation scheme near Mr S' brother was unwilling to offer Mr S a tenancy. The housing association said that they would explore alternative accommodation. The HCP is reported to have agreed to continue to support Mr S with this process. Now that a review had taken place and Mr S appeared to be 'stable' he was no longer allocated to SCF2 but remained open 'to the team' in ASC.

5.5.9 By the **20th May** the visiting HCP found Mr S '*greatly improved*'. He had been taking his medication and was accepting of care and had no paranoid thoughts. There are no more reports from the mental health team between the 20th May and the **12th July** when a Care Programme Approach (CPA) review was held. A mental health team care coordinator, two

HCPs and Mr S attended the CPA review. Mr S was noted to have the mental capacity to consent to the review, he engaged well and, although he was 'defensive' about sharing the contents of his bag of medications, he did so. Mr S reported that he was accepting visits from carers three times a day and 'was happy' with the carers. He liked them to make him a drink and sandwich but also preferred to go out to buy a cake and sandwiches. He preferred to self-medicate. Mr S did not want to move from his flat if he could not move to accommodation near his brother.

On the CPA records the entry under 'triggers/early warning signs' says that Mr S '*is currently engaging well with the carers and has built up a therapeutic relationship with the carers, that support him daily. (He) is able to independently seek help when required. and is now able to use his mobile telephone'* Mr S is recorded to be most responsive to **'***care agency, staff at (the) housing complex'***.** Recorded contingency plans were for Mr S to contact the mental health team should his mental health decline as well as a review of his physical health and the possibility of a placement in a care setting. The box asking if Mr S has a social worker was ticked as a yes. The CPA reviewer appears to believe that there were 'staff' at the flats.

Mr S was recorded as agreeing to the plan to discharge him from the mental health team as his mental health was stable. On the **27th July** after a team discussion and agreement Mr S was discharged from mental health services. ASC did not know of the case closure, and by this point Mr S had no allocated worker in ASC. The GP surgery and care provider were informed, and the care provider given advice on 'further coping strategies' and to refer back to the mental health team should Mr S deteriorate. The care provider has no written record of the advice on further coping strategies.

5.6 Analysis

5.6.1 Any learning from Mr S's reaction to carers in February 2021 was not bought forward to support him and his new carers to get to know each other in March 2021. The first visit from his new carers was not supported by any other agency. There was no written advice on the support plan as to how to engage with Mr S, what the impacts of his mental health and hearing loss might be and how to mitigate these. Care providers report that this is not uncommon, attention is paid to physical, not mental health needs in support planning**.**

5.6.2 After dedicated attempts by the agencies involved with Mr S his mental and physical health improved as he became more compliant in taking his medication and accepting of support. He appeared more able to engage in conversation and was reported to be more accepting of his carers and able to use his inhalers regularly. The review of his care and support needs on the 10th May did not involve his carers who may have presented a different view about the stability of the arrangements. They would have perhaps had the opportunity to explore what 'declining care' meant, Mr S' pattern of not always allowing carers into his flat or of tolerating them only for a few minutes was evident throughout his

time with all care providers and had become normalised. If he did not allow carers in on one occasion he usually would at the next.

5.6.3 The CPA review of the 12th July took place after a gap of two months in visits from the mental health team. This was due to staff absence. Mr S was still presenting as well, and his situation was stable. The CPA review was an opportunity to discuss and document what Mr S relapse indicators were as well as the risks arising from relapse. There were no triggers or early warning signs recorded on the CPA notes. However the risks to Mr S from disengaging with his carers were recognised. After both the CPA review and the care and support needs review a clear plan could have been shared with the care provider as to how to recognise relapse or when to be concerned about disengagement. Involving the care provider could have also enabled carers to share their concerns about Mr S. After Mr S' reaction to the carers calling an ambulance on the 14th April they may have been wary of doing so again without his consent.

5.6.4 It is unclear as to whether either ASC or the mental health team realised that neither organisation was still involved with Mr S. The CPA review also refers to 'staff' at the flats, giving an idea that there was some secondary oversight of Mr S wellbeing. The GP was unable to engage with Mr S, his medications remained unreviewed. At the end of this period Mr S was frail, was taking his anti-psychotic medication, but was not always engaging with his care provider. This period of stability had lasted two months. Any deterioration in his physical or mental health was likely to end this period of stability. The only organisation working with him was the care provider who had not been involved in any meetings and had no written advice or as to what to look out for in terms of a deterioration in his mental or physical health and how to summon help quickly.

5.7 Key Episode 4: 4th October 2021 – 21st October 2021

5.7.1 On the **4th October** the local authority Emergency Duty Team was telephoned by Mr S' brother, Mr S had visited and appeared to have lost weight, was unclean and was extremely paranoid. He thought that others were attempting to poison him. His brother agreed to contact the Mental Health Team about Mr S's deteriorating mental health. EDT reported the call onto the ASC duty team.

5.7.2 On Friday **8th October** the ASC duty team followed up the situation with Mr S' brother who advised that he had been unable to contact the mental health team. The duty worker telephoned the mental health triage team and discovered that Mr S had been discharged on the 27th July. An urgent response was requested from mental health triage regarding concerns about the deterioration in Mr S's mental health.

5.7.3 Over the following weekend the mental health team spoke with the care provider twice who reported that they were visiting Mr S three times a day, he appeared to be in good spirits and with no agitation reported and no concerns raised. The care provider report that it was not unusual for Mr S to have a reduced appetite for a few days and then to

significantly increase his food intake. They had not noticed a significant weight loss, although they knew that he did have a history of this. The mental health team also tried to contact Mr S by telephone but had no response.

5.7.4 On the **12th October** the ASC duty worker followed up the referral to the mental health team and recorded that mental health were now working with Mr S in response to concerns. However by this stage Mr S had not yet been seen.

5.7.5 The ASC duty worker requested management consideration to undertake a review of Mr S care and support needs given the change in his circumstances. However the primary issue was thought to be the change in Mr S mental health presentation, urgent action from the mental health team was thought to be the appropriate response to Mr S's presenting behaviours and risks. The idea of a joint visit with mental health colleagues was not considered.

5.7.6 On the **14th October** the mental health team tried to gather further information about Mr S. They contacted the care provider but had no immediate response. They contacted Mr S' brother who had Covid and was unwell, his wife advised the practitioner that they were concerned for Mr S and that he was not being looked after properly in independent living. The HCP planned to await responses from the care provider and do an unannounced visit to complete an assessment.

5.7.7 The care provider reports that in the week leading up to his death Mr S remained independent and was going out to the shops. Carers did not raise any concerns in relation to self-neglect. On the **16th October** Mr S did not want the care staff to prepare him a meal as he was going to the chip shop. He appeared agitated and unwell, and carers offered to call the ambulance, but Mr S adamantly refused, and they decided not to call an ambulance without his consent.

5.7.8 A CPN visited Mr S at 11.30 am on the **18th October**, gaining access via the nuns as Mr S did not answer the door. Mr S looked dishevelled, and he was not wearing trousers. The flat was cold and the toilet was blocked. The CPN was concerned to see no carpets, there were bodily fluids on the floor. The nuns were concerned that Mr S health was deteriorating and that he appeared helpless. The CPN made a safeguarding referral regarding Mr S self-neglect, and requested a rapid physical health review, this was accepted by the Rapid Physical Health Team. The CPN also requested a hearing assessment via the GP.

5.7.9 ASC have noted that the adult safeguarding concern raised by the mental health team was about the self-neglect of Mr S' property and hygiene needs and his poor nutritional intake. '*Referrer requesting urgent respite due to (Mr S) not eating, drinking or taking medication.'* ASC also recorded that '*Referrer advises that he feels that (Mr S) requires a MH assessment but cites difficulties with hearing as a barrier to such.'* The CPN does not share this recollection, the main concern was Mr S' physical health needs at that point.

ASC discussed the referral with the mental health team and recorded that '*Due to (Mr S)'s presentation, it was ultimately determined that he required urgent medical attention due to appearing unwell, refusing food, fluids and medication, pending urgent mental health assessment in line with CMHTNP recommendations'.*

5.7.10 The safeguarding concern was 'screened' by the ASC Access Team. The team concluded that an appropriate and proportionate response was for Mr S to receive '*urgent support from ASC and health*' to respond to immediate physical and mental health needs, and therefore the S42(2) (Care Act, 2014) criteria was not met as the necessary actions had been decided upon. The ASC author has noted that information gathering gave limited consideration to Mr S's mental capacity to make decisions about his own health and wellbeing, '*thus limiting the ability to definitively determine whether S42(2) (Care Act, 20145) criteria was met*'.

5.7.11 At 4.30pm Rapid nurses attended Mr S who was sitting on his sofa smoking with his coat on and appeared pale in colour, he was coughing and very chesty. Mr S was agitated and shouting that he did not trust the nurses. He told them to get out and threw things at them. The nurses spoke to 'the warden' who is reported to have said that '*she informed mental health nurse this morning that paramedics would be best to come as he trusted them, and they would most likely be able complete assessment.* The nurses called an ambulance who said they would try and make Mr S a priority. Ambulance control was given the nun's mobile number and the nun was advised that if Mr S deteriorated to ring 999 again.

5.7.12 WMAS attended on the evening of the **18th October.** The crew recorded that:

'*Patient was sat back in armchair, airway clear, breathing on his own. Patient is coughing and producing mucus so query a chest infection, but patient is talking in full sentences. Patient refused further assessment, so GP records accessed with patient permission to gain a history, patient then refused any further assessment as WMAS do not carry the cough medicine he wanted. Patient asked for further observations to be stopped and refused all further assessment asking the crew to leave.*

No shortness of breath, no difficulty in breathing, blood pressure in normal parameters and no signs of respiratory distress. Clinicians gave the patient a glass of water at his request and then he told them to leave and stated 'why bother' he would call his GP in the morning to obtain the cough medicine he wanted. Patient had capacity and was able to make decisions for himself. Worsening advice explained and told plenty of rest and fluids and again he wanted the crew to leave and said he would (missing) his GP in the morning. There are no concerns noted around the ability of him being able to retain, repeat or comprehend information, he was able to make his feelings known and plan actions for the following day in respect of calling the GP to gain his cough medicine at no time was his capacity in question with the attending clinicians in relation to this incident'.

At the learning event practitioners involved with Mr S thought that he would have been too unwell to assess his capacity at this point. WMAS left a record with Mr S to say that he had full capacity and detailing what they had done.

5.7.13 On the 19th October at 12.40 the WHT clinical intervention team recorded that a 2-week course of Doxycycline was delivered to Mr S. Mr S was described as very non-compliant by the nurses, they spoke with a nun who felt '*she hasn't seen Mr S this bad and is very concerned for his health and welfare'*. Mr S would not let the nurses approach him at all without becoming agitated. He was coughing up very green sputum onto the floor. The nurses spoke with the mental health team who advised that they would be reviewing today with a view to admitted him into hospital 'in his best interests'.

5.7.14 On the **19th October** lunch call carers worried that Mr S did not seem well, he was shouting and swearing, refusing food saying wasn't hungry. By the evening call there was 'mess' on the floor, Mr S was shouting and refusing assistance.

5.7.15 The Rapid team attended Mr S again that day, but he would not allow them into the flat. They reported back to the CPN that Mr S had refused to allow the rapid team to complete an assessment and that he had refused to take oral antibiotics. Due to concerns regards his history of poor mental health, and obvious poor physical health, advice was given by CPN that in the best interest of Mr S he must be admitted to hospital.

5.7.16 The CPN wrote an email to ASC stating that he did not believe that Mr S should be discharged from hospital before he had a mental health and social care assessment to prevent the same concerns happening again. A response was received via email confirming that the concerns were being addressed by the South Locality team.

5.7.17 An ambulance was called and attended at around 7pm. The WMAS crew recorded that *'Mr S had difficulty in breathing with low oxygen saturations. Currently on doxycycline.? whether Mr S is compliant with meds. Mr S was agitated and became combative and aggressive, he was confused and possibly hypoxic. A safeguarding referral was submitted by the crew, 'due to evidence of self-neglect. Poor state of habitation with urine and faeces on the floor. Little evidence of food. Poor physical condition, and lacking executive and functional capacity'.*

Mr S was assessed as lacking mental capacity to make the decision to be conveyed to hospital and all subsequent actions were undertaken as a best interest decision.

5.7.18 In hospital Mr S was diagnosed as having '*type 2 respiratory failure secondary to community acquired pneumonia, patient would need intubation but given current presentation (pneumonia and sepsis) would not be a suitable candidate for ITU, a discussion with the ITU consultant confirmed ward-based care and anticipatory medication'*. The RESPECT documentation was completed documenting that CPR attempts would not be recommended. The correct mental capacity related documentation was completed, these

decisions were made in his best interests. It was thought that Mr S had no next of kin, he had always refused to give his brother's contact details. Mr S died on the 20th October at 1.24pm. The cause of death was documented as Sepsis.

5.8 Analysis

5.8.1 EDT were told of concerns regarding Mr S's situation on Monday 4th October and passed these onto ASC duty, ASC duty contacted the mental health triage team on the 8th October. Mr S was not seen by anyone but the care provider until the 18th October, some two weeks after his brother raised the concern. What impeded a response to the deterioration in Mr S health? Between the 4th October and the 18th October there were opportunities to identify the deterioration in Mr S health and initiate preventative action.

Organisations had no risk indicators or agreed contingency plan in place to use when Mr S' health declined. Mr S was highly likely to experience a decline in physical health which would then impact on his mental health and ability to engage with support. This was not an unlikely occurrence.

Mr S' behaviour was not seen as unusual by the care provider. They had potentially begun to 'normalise' his behaviour and did not pick up the early signs of ill-health or relapse. He was his 'usual self'. No indicators had been documented to prompt the care providers awareness. Learning event participants shared details of the new Care Navigation service which can advise professionals including care providers who may be uncertain as to who and when to report health issues.

The care provider became aware of Mr S' ill health on the 12th October but did not call an ambulance as he had not consented to this and had previously evicted them from the flat when they had called an ambulance against his wishes. This was against the care provider agency expectations, but the agency staff did not appear to have had access to management support to advise them on a course of action.

There was no consideration of a joint visit between ASC and the Mental Health team in the ASC management discussions on the 12th October. The ASC duty workers request for management consideration of allocation for a S27 (Care Act, 2014) review in light of change of circumstances was declined. Mr S was seen as having mental health needs as his 'primary presentation'. The connection between Mr S physical and mental health was not understood.

5.8.2 In keeping with the trend of population aging, the number of older adults with schizophrenia and associated disorders is increasing[6]. There is still little research on the needs of people who live with schizophrenia in older age. Older people with a life- long psychosis are more likely to be socially isolated, to struggle with everyday tasks and to

[6] .Berry, K and Barraclough, C *The needs of older adults with schizophrenia Implications for psychological interventions in* Clinical Psychology Review Volume 29, Issue 1, February 2009, Pages 68-76

experience cardiovascular and pulmonary health issues[7]. It is important to understand the interaction between mental and physical health in this age group. NICE guidelines (2014)[8] emphasise the importance of an annual health check for people with schizophrenia, particularly those who have used anti-psychotics over a long period.

5.8.3 There was some discussion at the learning event as to whether Mr S had met the criteria for the local authority use of the Care Act s42. The mental health team and the ambulance crew had both submitted adult safeguarding referrals in relation to Mr S' self-neglect. The ASC report writer has commented on the lack of robust information gathering during s42(1) as only the mental health team and care provider were consulted. They have also commented on the lack of consultation with Mr S himself as directed by the Making Safeguarding Personal[9] approach. Given the situation it is understandable that information gathering was more confined than expected. The decision on both referrals appears to be that the criteria for use of s42 was met, but that 'a proportionate response' would be for Mr S *to 'receive urgent support from ASC and health to respond to immediate physical and mental health needs, and therefore that S42(2) (Care Act, 2014) criteria was not met'.*

After the immediate safety and wellbeing needs of a person have been met an enquiry under S42(2)[10] enables the facts in the situation, in Mr S case the circumstances that gave rise to his self-neglect, and the possibility that his needs were also being neglected unintentionally, to be fully understood. Once Mr S had regained capacity the enquiry could ascertain his views and wishes and make these central to what happened next, it determines what further action should be taken to prevent further self-neglect and protect the person. Most importantly, an enquiry can coordinate all organisations involved, producing shared risk assessments and risk planning. Had Mr S survived his illness this would have been an extremely important step in maintaining his safety and wellbeing.

5.8.4 Walsall SAB launched a 'Self-Neglect' Pathway in August 2019[11]. Learning Event Participants in 2022 were aware of the Pathway but could not recall being aware of or using it in 2021. Dissemination and implementation of the Pathway may have been impeded by

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5.Berry, K and Barraclough, C *The needs of older adults with schizophrenia Implications for psychological interventions in* Clinical Psychology Review Volume 29, Issue 1, February 2009, Pages 68-76 and https://www.guidelinesinpractice.co.uk/mental-health/gp-early-referral-and-ongoing-health-checks-are-key-in-psychosis/348609.article

[8] NICE. *Psychosis and schizophrenia in adults: treatment and management*. NICE Clinical Guideline 178. NICE, 2014. Available at: www.nice.org.uk/guidance/CG178

[9] LGA Making Safeguarding Personal Resources at https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/making-safeguarding-personal

[10] Care and Support Statutory Guidance Chapter 14 paragraph 14.94. access at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[11] https://go.walsall.gov.uk/Portals/37/Walsall%20SAB%20Self%20Neglect%20Pathway_1.pdf

COVID response in early 2020 onward. The risk assessment tool within the Pathway guidance provides useful indicators that would have assisted the identification of Mr S as a person who was self-neglecting. These indicators could be developed to inform a shared and commonly understood definition of self-neglect in Walsall.

The Walsall self-neglect pathway does not reference the Care Act s42 duty but proposes a route where people who are still self-neglecting after agencies have exhausted all 'usual' routes to refer to a Hoarding and Self Neglect Panel for advice and/or a multiagency discussion. This may raise the profile of self-neglect in Walsall. However it may also serve to obscure when the s42 duty is a more appropriate route when needs ae complex and impact on life likely to be severe. The statutory guidance[12] on self-neglect states

'*It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'.*

This can lead to a preoccupation with the 'ability to protect oneself' as a determinant of the criteria for use of the duty. What this 'ability' is has not been defined in statutory guidance. Local guidance [13] (West Midlands 2021) defines it as

'*where an adult is engaging with and accepting assessment or support services that are appropriate and sufficient to address their care and support needs (including those needs relating to self-neglect), then the adult is not demonstrating they are "unable to protect themselves" from self-neglect or the risk of it*'

In terms of this definition, Mr S was unable to protect himself from self-neglect.

Learning event participants also indicated the idea that self-neglect does not always need an enquiry because there is no third party involved. This view, that self-neglect is somehow different from other forms of abuse, can impede well- coordinated responses to self - neglect.[14]

5.8.5 An immediate focus on self-neglect can also obscure the neglect of a persons' needs. The organisations working with Mr S were challenged by various factors, including their understanding of Mr S' disabilities, frailty and communication needs. His health needs were neglected by primary care, the deterioration in his physical and mental health was not identified by the care provider at an earlier stage, organisations did not enact their duty of care toward him despite having every intention of doing so. Primary care interventions

[12] Ibid. Chapter 14 paragraph 14.17

[13] West Midlands Adult Safeguarding Editorial Group (2019) *Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands*. Page 4 available at https://www.safeguardingwarwickshire.co.uk/wmadultdocs

[14]

were impeded by the pressures caused by COVID, but also by a lack of appreciation of Mr S' specific engagement and communication needs.

5.8.6 Mr S' mental capacity to make decisions about his own care and treatment was a factor on occasion during the SAR timeframe. A key issue in October 2021 may have been the interaction between Mr S' mental health and physical health. He was adamant that he did not want an ambulance to be called or to be examined despite the evidence of his own deteriorating health. What motivated his decisions was not understood and his presentation was taken at face value by the ambulance crew of the 18th October in the absence of any other information. We have little insight into how Mr S perceived the world when mentally unwell. He told his brother he was being 'poisoned', did this belief relate to his refusal to eat at times or his preference for a known and trusted fish and chip shop?

5.8.7 During the nine month timeframe of this SAR Mr S had two care providers, was transferred from ICS team to a locality team and lost his relationship with SCF1, lost his relationship with the HCP who had regularly visited and was seen by several different GPs. When he was in crisis he was seen by professionals he was unfamiliar with. He had a longer relationship with care provider 2, but this involved up to six different members of staff on a daily basis. Mr S had no consistent person who could explain his need and preferences to others. He was thought not to need a statutory advocate during reviews and assessments, but could have benefitted from an on-going relationship with an advocate to connect him with those who offered support to him.

5.8.8 Mr S would have also benefitted from a 'person-centred' approach to his care and support needs. We discussed various approaches at the learning event. A direct payment may have provided consistent personal assistants who could spend time getting to know him and understanding his needs. He may have struggled to manage a direct payment without support however. He may have benefitted from support from a care agency who had specialist understanding about working with people with severe and enduring mental health issues.

6.Findings and Learning Points

6.1 Introduction

It must be remembered that these events took place during the second year of the COVID pandemic. After careful risk assessments organisations did maintain face to face contact with Mr S. The GP surgery was flexible in seeing him whenever he attended the surgery with no appointment, contrary to the NHS Guidance at the time but in recognition of his need. Whilst an increased resource to support discharge from hospital was available, there was extreme pressure on services, particularly respiratory services, through COVID related demand and staff sickness. Mr S' reported refusal to have a COVID vaccine does not appear to have either been known or to be of concern to the agencies working with him, and multiagency support to enable him to make a considered choice about this lacking.

Findings in this SAR are set against the questions posed in the SAR Terms of Reference below. The learning points below include how practitioners and systems can be developed to improve the response to others in similar situations, recognising good practices when they were evident.

- How agencies worked together, including sharing information and making referrals.
- How risks posed by Mr S' self-neglect were understood by all agencies, and what actions were considered or taken to prevent harm.
- How Mr S' physical and mental health needs were understood together with the impact of these on his engagement with services and ability to self-care. How were his needs understood during transitions, for example discharge from acute or mental health care or between providers?
- Whether Mr S' family or social networks were engaged in planning his care or engagement.

6.2 How agencies worked together, including sharing information and making referrals.

6.2.1 Whilst planning Mr S discharge the involved organisations worked together to undertake actions and facilitate each other's involvement. ICS and the mental health team continued to work together to promote Mr S's wellbeing and safety once he was back in the community. After reviewing and noting that his situation and mental and physical health appeared stable, ASC were able to de-allocate and the mental health service close his case. By July 2021 Mr S was supported only by his care provider and GP. Workload pressures mean that organisations cannot keep people allocated indefinitely, however in the knowledge that people in Mr S's position can deteriorate quickly, a number of steps can be taken to continue to promote multi-agency working. These steps are described in this section and in section 6.3 below.

6.2.2 The involvement of care providers in multi- agency working is essential in maintaining stability and safety for a person in Mr S' situation in the community. Care providers see the person on a daily basis and are well placed to reinforce advice given by other organisations (in this case WMFS) and to share pertinent information about the person and their daily lives. Care providers were consistently not involved in reviews regarding Mr S. They had no opportunity to discuss the difficulties they were experiencing in supporting Mr S with the mental health team or ASC. They had no opportunity to reflect on and understand Mr S' presentation, wishes and fears etc. Commissioners of social care providers may wish to ensure that attendance at reviews is expected as part of the providers contract.

6.2.3 When several agencies are working with a person regular reviews should be multi-agency, the involvement of primary care as well as specialist services needs to be sought.

Learning Point 1: Consideration should be given to involving care providers in reviews of care and support plans and CPA reviews. Care providers see the person on a daily basis and have information to share as well as the need to understand the person's and other organisation's plans and perspectives on the situation. Care providers need to share in the opportunities to discuss concerns and problem solve offered by a review. The need for care providers to be involved should be reflected in commissioning arrangements and in all review procedures. Reviews are opportunities for all agencies working with the person to review and revise plans together and with the person involved.

The key vehicle for information sharing with care providers is the person's Support Plan. This is often the only information the provider has before seeing the person for the first time. The support plan needs to contain information about communicating and engaging with the person, as well as information on how to support their mental, emotional and physical needs (see 6.4.3 below). Considering a person's communication needs should also prompt referral for hearing assessments etc.

Learning Point 2: Support plans should include a section on how to support a person's emotional and mental health needs, and how to engage and communicate with the person, as well as detail on their physical and support needs. These support plans can be informed by the person's mental health worker as needed together with the person themselves. These support plans become particularly important during transition between services and/or practitioners.

6.2.4 Primary care teams struggled to communicate with Mr S and as a result were unable to meet his health needs. Agencies continued to make referrals to the GP service but appeared unaware of the problems primary care services were experiencing.

6.2.5 Multi agency working is not just about sharing information and making joint visits. Mr S communication and engagement needs could have been documented and shared with all agencies working with him, including primary care. The GP surgery needed to record details of Mr S communication needs and preferences visibly on his records, involved agencies could have also offered a contact to facilitate primary care visits to Mr S. These details could be captured by any agency as part of a 'one-page' communication and engagement plan and shared with all agencies including primary care.

Learning Point 3: Communication and engagement needs should be part of shared multi-agency plans with consideration given to contacts who can facilitate engagement. Communication and engagement needs and supports can be captured as part of a shared 'one page plan'. GP surgeries need to record communication needs and preferences visibly on the patients records.

6.3 How risks posed by Mr S' self-neglect were understood by all agencies, and what actions were considered or taken to prevent harm.

6.3.1 Individual agencies appreciated the risks of Mr S neglecting his health needs, his medication and nutrition. This appreciation was not translated into a shared risk assessment or risk mitigation plan, well understood indicators of relapse or health deterioration or shared contingency plans. Mr S health was highly likely to deteriorate with a severe impact on his life, but no planning for this contingency was undertaken prior to case closure by either ASC or the mental health team. The absence of these impeded the recognition of Mr S illness and need for urgent help in October 2021. The care provider had no written information to use to judge the situation and failed to appreciate the early signs that Mr S was unwell.

6.3.2 Actions to prevent harm can be based on a shared risk assessment. If the risks following disengagement are likely and of high impact, efforts must be made and robust plans put in place to support continued engagement and work with the care provider. Formulating such a risk assessment and plan should be part of all multi-agency meetings including care and support needs reviews and CPA reviews. All agencies involved with the person must be made aware of the closure of the case to an allocated worker or to the agency itself.

Learning Point 4: A shared risk assessment, a risk mitigation plan, well understood indicators of relapse or health deterioration and shared contingency plans are at the heart of multi- agency working with people who are at high risk from self-neglect and have multiple needs. These must be shared with care providers. Multi-agency approaches post case closure can still be facilitated by the creation of a shared plan to inform the consideration of new referrals or other agreed actions. However all agencies involved must be aware of the closure of a case either to an agency or to an allocated worker.

6.3.3 Because actions were being taken to support some of Mr S' needs, his unmet health needs and inconsistent acceptance of support was not identified as self-neglect. The possibility of neglect was also not considered. The use of the Walsall Pathway self-neglect checklist may serve to identify self -neglect in areas where an otherwise engaged person is still struggling to engage with support. This may also counter any 'normalisation' of the person's situation and prompt consideration of factors that can quickly turn what is 'normal' into a life- threatening situation. Efforts are needed to promote a common shared understanding of self-neglect in Walsall, the self-neglect checklist may support these efforts.

Learning Point 5 Practitioners must have a shared and common understanding of the indicators of self-neglect across all aspects of a person's life. Professional Curiosity about a

person's situation can counter the risk of 'normalisation' and can be promoted through reflective conversations or supervision, including the use of self-neglect indicator tools in conversations.

6.3.4 The s42 duty to enquire should be considered when a person is self-neglecting with the potential for likely and high impact harm. A s42 enquiry has the legal mandate to quickly involve all organisations in co-operating in the development of shared risk mitigation/contingency and communication/engagement plans. Information gathering under s42(1) should consider whether the situation is one of self-neglect or whether other factors or potential abuses may also be occurring.

Learning Point 6: The self-neglect pathway should also emphasise the use of s42 enquiry in high-risk situations where urgent information sharing and coordination is needed.

6.4 How Mr S' physical and mental health needs were understood together with the impact of these on his engagement with services and ability to self-care. How were his needs understood during transitions, for example discharge from acute or mental health care or between providers?

People who have a life-long experience of psychosis are ageing, and along with the general population are more likely to live into their 70s and 80s. Organisations need to understand the needs of this group who may use social care and health care services as they age. Strong partnerships between mental health and other organisations will help to develop pathways and ways of working to support this small but complex group of people.

6.4 1 Mr S physical and mental health needs interacted, if physically unwell his mental health deteriorated and vice versa. This made it hard for him to trust services wanting to help him address his physical health. He could not be seen as needing either a 'mental health' response or a 'physical health' or a 'care and support 'response, all were interrelated and needed careful multi-agency planning and communication.

6.4.2 Mr S physical needs were well understood in hospital. Learning event participants told us that the mental health needs of physically unwell patients were often not considered.

Learning Point 7: Mental and physical health are strongly connected in older people who have life-long experiences of psychosis and are physically frail. Consideration is needed for a pathway to support the health needs of this group whilst in hospital and in the community.

6.4.3 Mr S' physical health and care and support needs were considered in his post discharge support plan and in the support plan given to care provider 2. There was no

consideration of how care providers could meet his needs arising from his mental health issues, his suspicion of new people, his distress at having people in his flat, his worries about the security of his medication or of the safety of his food. Mr S had no opportunity to inform this element of his support plan, something which may have helped him prepare for engaging with care and support. There was no planning for the transition between care providers which took account of Mr S' specific needs.

See learning point 2.

6.4.4 Mr S mental capacity was not assessed in the Hospital Emergency Department in February 2021 despite his agitation and confusion and refusal to accept treatment.

His capacity was presumed by the ambulance crew attending him on the 18th October although earlier that day the mental health team found him too unwell to assess his capacity.

Learning Point 8: A mental capacity assessment determines the steps that can be taken to address the urgent needs of a person who is refusing treatment but appears confused. **Assessing the mental capacity of a person who is experiencing paranoid thoughts or other effects of psychosis can be complicated. The acute trust and ambulance trust may need to consider whether clinicians are confident and capable of assessing capacity in those circumstances and if needed, where they can access support to enable them to do so.**

6.4.5 Older people who have experienced long term psychosis are often isolated and un-befriended, they have no-one to represent them. They may need an advocate to support them to engage with a range of services and to represent their thoughts and wishes about their own lives.

Learning Point 9. Advocacy can play a useful role in ensuring person centred care for people who are fearful of interactions, mentally unwell and isolated. An offer of advocacy should be considered in pathways to support the health of this group as well as during engagement with other social or health care services.

6.4.6 Mr S had many different people offering support in his life. As workflows or teams changed he lost staff who understood him and had to start again. This must have been extremely difficult for a man who found it difficult to trust others. Mr S care and support needed to be consistent and person-centred. How this can be achieved requires thought, it may be that for some a direct payment is appropriate, for other who have life-long mental health issues an agency with mental health support skills may be useful. There may be other useful approaches to be considered.

Learning Point 10: Person centred care is supported by consistency in supporters as well as skilful and knowledgeable support. Assessments which consider all domains of a person's wellbeing can inform arrangements which are as responsive as possible to the person's needs.

6.5 Whether Mr S' family or social networks were engaged in planning his care or engagement.

6.5.1 Mr S had no social network but was in contact with his brother. In the past he had not wanted his brother to know about his life and did not want to name him as a contact in emergencies. As Mr S became frailer this wish could have been discussed with him again, he may have changed his mind.

Learning Point 11: As a person moves through the life course their wishes may change. Opportunities should be taken to review previous decisions with them.

7. Other SARs in Walsall.

The lead reviewer has noted findings and recommendations from other SARs commissioned by Walsall SAB, in particular SAR 3, 'Clara', and SAR 7. The findings of SAR 7 have been considered in formulating recommendation 8.1 below.

SAR 3, 'Clara'[15], published in 2019, has very similar findings to this SAR. Specifically:

The interaction between Clara's mental and physical health.
No clear indicators about what would constitute a deterioration in her mental health which resulted in a normalisation of her behaviour.
Intermittent engagement with carers and uncertainties about medication compliance.
No involvement of care providers in reviews.
Joint working did not result in a holistic plan and coordinated support.
A need for a shared understanding about what should be reported by care agencies, when and to whom. This included dilemmas about when difficulties in providing a service should be reported - on each occasion or when a pattern developed?
The need for regularly updated risk assessments, informed by care providers as well as emergency services and shared with all involved organisations.

[15] Available at https://go.walsall.gov.uk/Portals/37/WSAB%20SAR%20-%20Clara%20-%20Final%20Overview%20Report%20%2802_08_19%29%20v4.pdf

Key messages included:

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.

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.

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.

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 concerns about the physical and / or mental health of the service user.

8. Recommendations to Walsall Safeguarding Adults Board

8.1 The Safeguarding Adults Board is recommended to consider how to further develop multi-agency collaboration in Walsall. This recommendation has been informed by the Findings of SAR Clara and SAR 7. This will include considering[16]:

How the SAB can create and lead a strong expectation of multi-agency collaboration in operational as well as strategic work with adults at risk of abuse or neglect, including self-neglect.

How the SAB will promote parity of esteem between all organisations working with adults at risk in Walsall, this includes providers of care and support.

[16] Further information on approaches can be taken from:
LGA (2020) A supportive safeguarding adults board: what can a SAB, alongside leaders from the range of sectors do to support collaborative working at all levels? in '*Understanding what constitutes a safeguarding concern and how to support effective outcomes*. Page 39-40 at https://local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes and
LGA (2020) Summary of what needs to be addressed by cross sector leaders to support acting on the messages in this framework in '*Understanding what constitutes a safeguarding concern and how to support effective outcomes*. Page40-41 at https://local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes

What the SAB expects from partner organisations, including commissioners, to evidence a focus on collaboration throughout all aspects of their work. This will include how services are commissioned and quality assured, policies and procedures and supporting documentation.

How the SAB will develop and disseminate a shared and commonly understood definition of self-neglect with associated risk indicators.

These approaches will be supported by focusing on multi agency collaboration as a theme throughout SAB audits and quality assurance activities.

Learning points 1,3, 4,5, and 6

8.2 The Safeguarding Adults Board is recommended to undertake assurance activities regarding the use of professional curiosity in adult safeguarding, and to ensure the approach is promoted across all agencies in Walsall, including care providers.
Learning Point 5

8.3 The Safeguarding Adults Board is recommended to request that any audit or review of the Walsall Self Neglect and Hoarding Pathway considers whether the s42 criteria has been considered and applied when indicated.
Leaning Point 6

8.4 The Safeguarding Adults Board is recommended to receive assurances from the named partner agencies below that actions arising from the recommendations below have been completed.

9. Recommendations to individual agencies:

9.1 Walsall Council commissioners, Adult Social Care and the Black Country Healthcare Foundation Trust are recommended to consistently involve care providers in reviewing Support Plans under the provisions of the Care Act or the Care Programme Approach or similar arrangements. The involvement of care providers should be reflected in a) commissioning arrangements and b) in review procedures. Involvement of other agencies, including GP surgeries, should also be considered as part of any individual's multi-agency review.
Learning Point 1

9.2 Walsall Adult Social Care are recommended to include information in support plans on how to support a person's emotional and mental health needs, and how to engage and communicate with the person.
Learning Point 2

9.3 Adult Social Care and the Black Country Healthcare Foundation Trust are recommended, as part of review processes including CPA, to ensure that multiagency plans are made with people who are self-neglecting with the likelihood of a serious impact on their wellbeing should they disengage with support. These plans should contain:

- a communication and engagement plan
- a shared risk assessment and risk mitigation plan
- specific indicators of relapse or health deterioration and contingency plans.

These plans must be shared with care providers and must be in place before cases are closed to the local authority or mental health trust.
Learning Points 3 and 4.

9.4 The Black Country ICB is recommended to advise GP surgeries to record a patients communication needs and preferences visibly on their records. All relevant agencies are recommended to ensure that details are available to GP surgeries.
Learning Point 3

9.5 Walsall Council and the Black Country Healthcare Foundation Trust and all other relevant organisations are recommended to develop and consistently use a personal 'passport' (similar to 'This is Me'[17]) that all agencies can use to support a person-centred approach to communication and engagement.
Learning Point 3

9.6 Walsall Council and the Black Country Healthcare Foundation Trust and all other relevant organisations are recommended to ensure that there are procedures in place to inform the other agencies involved with an individual of case closure or de-allocation from a specified worker. Managerial oversight is recommended to ensure that these procedures are adhered to.

Learning Point 4

9.7 Walsall Healthcare Trust, Walsall Council and the Black Country Healthcare Foundation Trust are recommended to develop a pathway to support the needs of frail older people with life-long experiences of severe and enduring mental health issues whilst in hospital and

[17]Example: https://www.alzheimers.org.uk/sites/default/files/2020-03/this_is_me_1553.pdf

in the community. Use of advocacy and person-centred support arrangements should be considered as part of the pathway.
Learning Points 7, 9 and 10

9.8 Walsall Healthcare Trust is recommended to assure the Walsall Safeguarding Adults Board that arrangements are in place to support mental capacity assessments in the Emergency Department.
Learning Point 8

9.9 Organisations who record emergency contacts are recommended to be mindful of the need to review the person's wishes with them or request that other involved agencies do so as the person moves through the life-course.
Learning Point 11