Southampton
Safeguarding Adults Board

Multi-Agency Review
Brenda

Overview Report

Independent Reviewer

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Contents

1. Introduction

1.1 For the purposes of this review report and in order to protect the identities of those involved the subject will be known as Brenda.

1.2 It is easy for Learning Reviews and Overview Reports to focus on events and the involvement and actions of a number of agencies. It is important that this Review and this Report recognise that, at their centre, is a human being, who should be treated with respect, and likewise their family members.

1.3 Brenda was born on the 23rd October 1949 in Calcutta, India and was 69 years old and living on her own in a supported tenancy at the time of her hospitalisation.

1.4 Brenda was the eldest of two children, her brother was also born in Calcutta where their father was a broker dealing in jute and tea. Her brother describes them as having a very privileged lifestyle with servants and a chauffeur, enjoying sports such as golf, swimming and horse-riding.

1.5. When she was 10 years old, both children were sent to boarding schools in England as their parents considered the education available in India to be inadequate; they returned to India during the summer holidays but spent other school holidays with their maternal grandparents. Both children found this separation traumatic and Brenda hated her school, where she was bullied because of her darker skin caused by her time in India.

1.6 Her parents returned to England in 1964 and settled in Southampton, where her brother still lives. Brenda went to the Southampton Technical College, where she studied a secretarial course; there she met her future husband, who introduced Brenda to drugs, LSD and hashish. Heavy drug misuse continued throughout their relationship. Both sets of parents disapproved of the relationship, and Brenda's parents sent her to America one summer in an attempt to break it.

1.7. This was unsuccessful, and, on her return, they married and moved to London in the late 1960s, where Brenda worked using her secretarial qualifications. They moved back to Hampshire in the early 1970s, living in a cottage owned by her husband's family. At this time, her brother was travelling abroad a lot and while they had been a very close, they began to drift apart.

1.8 In 1974, their mother died after a year-long illness with cancer and Brenda's marriage started to fall apart and she moved back with her father. She was admitted to a local psychiatric hospital for the first time after jumping from her first floor bedroom window. Around this time, she started talking about her husband telepathically manipulating her, but they did get back together for a period of time. They eventually separated and divorced – he has subsequently died and there were no children from the relationship.

1.9 After the separation, Brenda lived in various places, including the YWCA, with friends and rough on Southampton Common, and returned to live with her father in the early 1980s. By this time her brother had also returned to live in Southampton, having been living in Wales.

1.10 Brenda's relationship with her father is described by her brother as being a difficult one – she would call him 'a murderer' – and, in the words of her brother, she was often 'in another reality'; he attributes her mental health issues to 'a perfect storm' of drug misuse, the death of their mother and the break-up of her marriage, resulting in her having a diagnosis of paranoid schizophrenia.

1.11 Eventually, Brenda's unpredictable behaviour forced her father to have her legally evicted from the family home; she was accommodated in supported housing in Southampton, initially by Stonham Housing, supported by the local Community Mental Health Team. In 1995, Brenda was the subject of a Guardianship Order, but it would appear that this was allowed to lapse.

1.12 She was given a tenancy in a flat close to the town centre on the understanding that it was a long-term tenancy; over time, her landlord changed several times and ultimately the tenancy became part of a 'move-on' project, which Brenda found hard to accept and which compounded her alienation from the services intended to support her.

1.13 For a period of time, Brenda's support was coordinated via the Care Programme Approach, (the CPA) which included the involvement of her brother. When the CPA was closed is not clear, but her brother's involvement ceased in the early 2010s when Brenda stopped opening the door when he visited. She withdrew her consent to information being shared with him and she withdrew from engaging with support services, with the exception of the support worker who stayed with her despite the contract for the support service being transferred to different agencies.

1.14 Brenda continued to manage her own finances and her mental health was described as 'stable' though she had stopped being prescribed any medication. Her flat deteriorated as she became more and more isolated and had her gas and electricity supplies capped, leaving her with no cooking facilities and limited heating. She was sleeping on the floor, had no furniture and ate out as she was unable to cook at home and it is suspected she lost a lot of weight though she had always been slight in build and wore baggy clothes that would have disguised any weight loss.

1.15 In November 2018, her support worker became so concerned for her when her physical health suddenly dramatically deteriorated, that he contacted her GP Surgery; a Community Matron visited the following day and Brenda was admitted to hospital and treated for a suspected infection. When she did not respond to her treatment, further tests were carried out and she was diagnosed with stage 4 lung cancer with distant metastasis. She died on the 20th December 2018, sadly without her brother being informed as the hospital were unaware of his existence. He only found out she had died when he was contacted by a specialist tracing company after she was declared 'in testate'.

1.16 The case was referred to the Southampton Safeguarding Adults Board (the Board) for consideration for a Safeguarding Adults Review (SAR) in December 2018 and the referral was passed to the Case Review Subgroup (the Subgroup).

1.17 The referral was considered in January 2019, when the Subgroup agreed the criteria for a discretionary Safeguarding Adults Review (SAR) had been met and therefore recommended to the Board's Independent Chair that a multi-agency review be undertaken.

1.18 In March 2019, the Board's Independent Chair confirmed that a multi-agency review (discretionary SAR) should be undertaken.

1.19 This Report was authored on behalf of the Board by Mr Pete Morgan, an Independent Consultant.

1.20 The administration and management of the Safeguarding Adults Review Procedure has been carried out by the Southampton Safeguarding Partnerships Team

1.21 This Review was commissioned under Section 44 of the Care Act 2014; its commissioning will be reported in the Board's Annual Report for 2018-19 and its findings and their implementation will be reported in the Annual Report for 2020-21 as required by the Act.

1.22 The Report was ratified by the Southampton Safeguarding Adults Board in December 2020.

2. The Case Review Group

2.1 The Case Review Group (the Group) oversaw the process of the Review and acted as the Review panel, on behalf of the SAB. The Group was comprised of representatives from statutory, independent and voluntary sector agencies and its Terms of Reference are included as Appendix A

2.2 The Group met on the 4th July 2019, the 7th November 2019, the 17th December 2019 and the 4th February 2020.

2.3 The business of the Group was conducted in an open and thorough manner. The meetings sought to identify lessons and recommend appropriate actions to ensure that better outcomes for adults with care and support needs in similar circumstances are more likely to occur as a result of this Review having been undertaken.

3. Terms of Reference and Scope of Review

3.1 The meeting of the Case Review Group, held on the 7th November 2019, confirmed the Terms of Reference for the Review but agreed they would be regularly reviewed as the Review progressed to ensure they remained fit for purpose.

3.2 The finalised Terms of Reference for the review are to be found in Appendix B.

3.3 The scope of the SAR was initially set as the period from the 1st January 2013 to the 21st December 2018.

3.4 The reason for this was that it would enable the review to focus on the period of time immediately prior to Brenda's hospitalisation and death but with an understanding of the context of her involvement with local health and social care services. It was agreed that the SAR would not consider the medical treatment provided to Brenda after her admission to hospital on the 27th November 2018.

3.5 Agencies were asked to include a summary of any earlier information about their involvement with Brenda if they considered it to be of particular relevance to the Review.

4. Information Searches

4.1 Information searches were completed by partner agencies to identify which agencies had had relevant contact with Brenda during the period of the Review.

4.2 These enabled appropriate Independent Management Reviews (IMRs) and chronologies to be requested to enable the Group to ensure the Review was in possession of all relevant information about single and multiagency support offered and received by Brenda and her family.

4.3 The Group considered at each of its meetings whether further IMRs or other reports were required; in the event, the Group decided that none were.

4.4 IMRs were requested from the following agencies with regard to their involvement with Brenda and her family:

- *Southampton City Council Adult Social Care*
- *Southampton City Council Integrated Mental Health Team*
- *Hampshire Constabulary*
- *Primary Care - GP Practice*
- *Richmond Fellowship*
- *Home Group*
- *University Hospital Southampton NHS Foundation Trust*

4.5 Agencies were required to make recommendations within their IMRs as to how their own performance could be improved. These were accepted and adopted by the agencies concerned. The recommendations are supported by the Independent Reviewers.

4.6 On the 21st November 2019 a Practitioners' Learning Event was held. This enabled practitioners who had had direct contact with Brenda to consider how they had been able to work together to support her and her family; what had worked well and where practice and processes could be improved to raise the quality of services.

4.7 A full and comprehensive review of the agencies' involvement and the lessons to be learnt was achieved.

5. Family liaison and involvement

5.1 Contact was made with Brenda's brother through the Home Group. He was offered the opportunity to meet or speak to the Independent Author and they met on the 7th November 2019.

5.2. The Independent Author explained the legal basis and purpose of the review, namely, to gather any learning from the case to improve practice and procedure in the future, not to apportion blame or culpability. He also explained the reasons for meeting with him, namely, to gather his perception of the services and support provided to his sister and their family and to seek clarification of some areas of biographical detail.

5.3 In order to preserve her anonymity, his sister is being referred to as 'Brenda' during the Review, but should he have any preference for how she should be referred to in the Overview Report, the SAB would take this into consideration but the final decision is the SAB's.

5.4 Prior to the meeting the Independent Author had asked her brother to provide a brief biography of Brenda, which he had done; he was thanked for it and clarified some points it contained. Elements of the biography have been included in this Report

5.5 He had not been advised of his rights as Brenda's Nearest Relative under the Mental Health Act (MHA), nor had the Mental Capacity Act (MCA) been explained to him and its implications for assessing Brenda's capacity to make specific decisions – in his words, he considered she had lacked the capacity to some decisions relating to her health and welfare for up to 20 years, caused by her drug misuse (LSD and hashish) when she was younger.

5.6 He had attended CPA meetings until 2010 when he ceased being invited. He assumed because Brenda said she didn't want him involved. He had continued to try to see her, but she would either not answer her door or would be out when he called.

5.7 He had particular concerns that he only found out about Brenda's death when he was 'cold-called' by an agency seeking the Next of Kin of someone who had died 'in testate'; it took them less than 24 hours to find him while agencies who knew of his existence and his name and, in some cases, his contact details from when he was attending CPA meetings, failed to do so.

5.8 The length of time it took for him to be informed of Brenda's death meant that he was unable to attend, let alone help arrange her funeral. He finds it difficult to understand why, if the Heir-seeker service could identify him so quickly, it wasn't possible for an agency in Southampton involved in her care if not the Hospital to do so.

5.9 He confirmed that Brenda managed her own benefits and finances with some support; there was no Appointee with the Department of Work and Pensions (DWP) or any Power of Attorney in place.

5.10 He was not aware that any safeguarding concerns had been raised about Brenda at any stage.

5.11 He had not been aware of any signs of Brenda self-neglecting when she was younger beyond her substance misuse before she left the family home – see 1.11.

5.12 He was aware, and had copies of the relevant paperwork, that she had been made the subject of a Guardianship Order under the MHA in 1994, but that it hadn't

been renewed. Included in the paperwork was a copy of the information leaflet relating to Brenda's rights under the MHA but not of the Nearest Relative's rights, despite him being named as the Nearest Relative on the leaflet.

5.13 He was not aware of any formal assessments taking place of Brenda's care and support needs under the Care Act 2014 or previously and had not been offered a Carer's Assessment at any stage.

5.14 It was discussed that the cause of Brenda's death was cancer rather than self-neglect; it may not have been prevented if earlier action had been taken re her self-neglect but her quality of life at the end of her life could have been improved.

5.15 He was advised that it was the SAB's decision whether or not to publish the Overview Report, but that he would be given sight of it before it was published and that he would be offered the opportunity to meet the Independent Author again to discuss the findings and recommendations and to check for any factual errors or omissions in the report. While editorial control of the report remained with the Independent Author, it would be either amended in the light of any comments he might have or they would be acknowledged in the final version.

5.16 The Independent Author was unable to meet Brenda's brother due to the Covid-19 restrictions, but did speak to him by telephone. He welcomed and agreed with the Report's Recommendations, expressed his appreciation of the quality and depth of the Review and hoped that it would lead to improvements in service delivery and a reduced likelihood of any such case occurring in the future. To that end, he wished the Report to be published in full.

6. Liaison with the Police

6.1 There had been no prosecutions relating to this case and there were therefore no issues regarding disclosure at the commissioning of the Review. The Police were represented on the Group.

7. Agency involvement prior to the Review period

7.1 As has been mentioned previously, agencies providing IMRs were able to include brief details of any particularly relevant involvement they had had with Brenda prior to the Review period.

7.2 Information was provided that Brenda had been open to the Community Mental Health Team (the CMHT) from the 31st October 2007, though no details were provided of the reasons for the initial referral to the CMHT. She had been supported by the Richmond Fellowship from August 2010, having been resident at her address at the time of her death since 2006 supported directly by the NHS.

8. Key Events and Analysis

The purpose of this Review is not to consider the medical care Brenda received once she had been admitted to hospital in November 2018; it is to consider the care and support offered and provided to Brenda and her family prior to her admission to hospital and the implementation of the safeguarding procedures after her admission.

8.1 In 2013, the CMHT records that Brenda was visited by the allocated Community Psychiatric Nurse (CPN) between one and four times a month, albeit with variable degrees of success and engagement. The purpose of the visits was to encourage Brenda to be more independent in collecting her prescribed medication, to review her weight and to liaise with her support staff.

8.2 On the 22nd March 2013, Adult Social Care (ASC) Contact Centre record a contact from a First Wessex Housing Association, who were then Brenda's landlord, expressing concerns about the state of her tenancy and that others appeared to be living in her flat. ASC requested that the Richmond Fellowship, the Housing Support Provider convene an urgent multiagency meeting. There are no records of that meeting taking place. It has been suggested, but not supported by the chronologies submitted to the Review, that a review of Brenda's situation under the Care Programme Approach was brought forward from May 2013 to the 16th April 2013. The concerns that others were living in Brenda's flat were found to be groundless

8.3 On the 25th October 2013, the Southampton City Council Supported Housing Commissioning Service record First Wessex repeating their concerns for Brenda; the record states that a safeguarding meeting had been held but that First Wessex considered no progress had been made and were requesting escalation.

8.4 On the 5th December 2013, the GP Practice records that Brenda failed to attend an appointment and a letter was sent asking Brenda to inform staff if she is unable to attend in future.

Finding 1:
At this stage, Brenda's care and support was being managed under the Care Programme Approach (CPA), but no meetings are recorded as being held under the CPA

Finding 2:
There was clear evidence of Brenda not engaging with the CPN, but there was no evidence of any escalation or convening of a review under the CPA

Finding 3:
There is a lack of clarity as to whether or not a multi-agency meeting had been held, what its status was, what its outcomes were and a request to escalate the concerns due to a lack of progress resulted in no action

Finding 4:
Although the GP Practice implement its Did Not Attend (DNA) procedures when Brenda failed to attend an appointment, it did not do so in a manner likely to result in her engagement in the future

See Recommendations 1, 2, 3 and 4:

8.5 During 2014, the CMHT records thirteen attempted contacts with Brenda or contacts with her support staff, with her being seen or spoken to through the door to her flat on five occasions. It is recorded that there 'were no obvious signs of deterioration in Brenda's mental health'.

Finding 5:
It is difficult to reconcile eight unsuccessful attempts to see Brenda and five 'successful' attempts – which include only speaking to her through her flat's door – with there being 'no obvious signs of deterioration' in her mental health. It is a mental health professional's duty to assess an individual's mental health, not a support worker's.

See Recommendation 5

8.6 Although it falls outside of the Review period, Brenda's brother was unaware of his right as her Nearest Relative to request an assessment under the Mental Health Act 1983 - see 5.12 above. Had he been made aware of his right, he would have done so; this may or may not have resulted in Brenda being admitted to hospital, and may have further alienated her from him, but it would have required an assessment to be completed and, if no admission occurred, for him to be provided with a written explanation why not.

8.7 Brenda may have had the right to request that her brother was not informed of her situation; however, this does not amount to revoking his rights as her Nearest Relative, which requires action via the Courts.

Finding 6:
Brenda's Nearest Relative, as defined by the Mental Health Act 1983, was not advised of his rights under the Act; had he been, he would have requested that she be assessed under the Act.

See Recommendation 6

8.8 Twice during January 2014, Brenda did not attend appointments at her GP Surgery; on both occasions, letters were sent, the latter being a 'final letter'.

See Recommendation 4

8.9 On the 19th May 2014, the CMHT records show a CPA Review was held; the main concern documented was the unsuitability of Brenda's accommodation, despite the lack of success in engaging with her and her not keeping GP appointments. A week later, the CMHT records show a CPA review was held: Brenda was reported to shop regularly, that her weight was stable and despite having stopped taking her medication as she didn't think she needed it, that her mental state was stable.

Finding 7:

There is a lack of clarity about when the CPA review was held and who attended, the rigour of any scrutiny given to information presented to the review, what the outcome of it was and the lack of any escalation or reconvening of the review when the Safeguarding Adult Referral Form was received and concerns arose about Brenda being evicted.

See Recommendations 1 and 2

8.10 During 2015, the CMHT record Brenda being seen four times by the Team; there is no record of any unsuccessful attempts to see her. It was noted on the 13th March 2015 that she is not unwell enough for the CMHT to be able to treat her but 'due to risk of vulnerability she will remain under (CMHT) to support her needs'.

8.11 On the 28th January 2015, the GP Practice records sending a letter offering Brenda a 'routine appointment'; it is not stated what the appointment was for, whether she attended or what action ensued.

See Recommendation 3

8.12 On the 20th April 2015, Brenda was reported to the Police by a member of the public as she was standing, shaking, on the street in the early hours of the morning; the Police attended, and Brenda told them her bag had been stolen. She was offered but did not participate in a Vulnerable Witness Interview but provided a short statement; they then escorted her home. Brenda's diagnosis of schizophrenia was noted and a Safeguarding Adult Referral Form was submitted to ASC with the suggestion she required support from her housing provider.

8.13 The Police contacted the Richmond Fellowship, requesting a copy of any relevant care plan to enable the Police to support her appropriately should she come to their attention again. The outcome of this request is not recorded.

8.14 On the 28th April 2015, ASC record receipt of the Safeguarding Adult Referral Form from the Police and the concerns for her welfare are noted and that these were passed on to Brenda's Care Coordinator under the CPA process (CCO), her allocated CPN in the CMHT. The CMHT has no record of receiving this information.

8.15 On the 8th May 2015, Southampton City Council's Safeguarding Adults Team (SAT) record being contacted by Brenda's support worker with the Richmond Fellowship to raise a safeguarding concern about her self-neglect and that she had been given notice of her possible eviction. This latter was due to her non-engagement with the support services and a plan to move her to more suitable accommodation. He was advised to contact the CMHT; when he expressed his concern at the lack of effective action from the CMHT, he was advised to escalate his concern with the CMHT management and that the Safeguarding Enquiry criteria had not been met. The SAT was also contacted by Brenda's CCO in the CMHT and also advised him that the Safeguarding Enquiry criteria were not met. It is not recorded how these criteria were not met.

Finding 8:

It was good practice for the Police to both raise a Safeguarding Adult Referral Form and to seek advice from the Richmond Fellowship on how to best to support Brenda in the future; it would have been even better practice if the Richmond Fellowship had responded or if the Police followed up the lack of response.

Finding 9:
It is not clear how Brenda failed to meet the criteria for a Safeguarding Enquiry under s42 of the Care Act 2014 which was enacted as of the 1st April 2015.

See Recommendations 2 and 3

8.16 On the 15th June 2015, ASC record receiving a notification from the Police of their attending Brenda's flat at 1am on the 12th May when Brenda was locked out; they had concerns about the state of the flat and her mental health. This was referred on to Adult Mental Health, Access and Assessment Team (AMHAAT). The Police have no record of either attending Brenda's flat or of contacting ASC and the AMHAAT have no record of receiving the concerns. The record is that this was referred on to the Adult Mental Health Access and Assessment Team but they have no record of its receipt.

Finding 10:
This was a month after the previous concern was raised about Brenda's tenancy with ASC, but the two incidents do not appear to have been linked, nor the fact that Brenda was still, at this time, subject to the CPA process.

See Recommendation 7

8.17 On the 19th July 2015, Brenda was visited at home by a Consultant Psychiatrist; it is suggested that it was a result of a multi-disciplinary team meeting held on the 29th May 2015 at which self-neglect issues were identified but no such meeting was referred to in any of the chronologies submitted to the Review. The Consultant Psychiatrist noted the squalid condition of her flat, that she looked thin, that she mumbled and behaved in a manner consistent with continuous auditory hallucinations and refused to engage with any discussion of moving from her flat. She had failed to visit five possible alternative flats during the year. He noted the long-term diagnosis of schizophrenia and the severe deterioration in her self-care skills resulting in self-neglect and consequent infections. It is recorded that her CCO advised that she had been like this for some time and had 'always resisted attempts at rehabilitation and treatment'. The proposed plan was 'to reassess in a lucid day to see whether she does have capacity if this fails then consider Section 2 under the MHA to admit her that she can regain some self-care ability and the capacity to decide where to live'. There is no recorded follow-up to this visit and assessment. Brenda's GP was notified of the outcome of the visit.

Finding 11:
It is good practice that Brenda was seen by the Consultant Psychiatrist though the lack of any record of how it was requested is of concern; it is also good practice that the Consultant Psychiatrist recognised the chronic nature of Brenda's situation and the need to re-assess her at a time when she might be

more lucid to determine her capacity to make specific decisions and whether she might meet the criteria for action under the MHA.

Finding 12:
It is unclear why the Consultant Psychiatrist referred to Section 2 of the MHA as Brenda had a diagnosis of schizophrenia of which he was aware and therefore an admission for assessment would have been inappropriate unless there were grounds for reviewing her treatment plan.

Finding 13:
It is poor practice that the plan outlined by the Consultant Psychiatrist was not followed up by either the GP or the CMHT or reviewed via the CPA process.

See Recommendation 1

8.18 In 2016, CMHT record four contacts with Brenda between May and November, including a multi-agency agency meeting held on the 11th May 2016 to discuss future accommodation options for Brenda; this means a maximum of three direct contacts with Brenda during the year.

8.19 On the 11th January 2016, the GP Practice records show a letter was sent to Brenda giving an appointment with the Practice Nurse; there is no record that she attended or cancelled the appointment or that any follow-up action was taken.

8.20 On the 15th March 2016, the GP Practice records show an update was made to Brenda's Summary care record.

8.21 On the 11th May 2016, Richmond Fellowship record a 'Multi Agency Meeting' attended by Brenda's CCO, her support worker and his manager, a manager from First Wessex and staff from ASC. Brenda's lack of engagement was noted as was her choice of a 'bohemian lifestyle', her poor personal hygiene and very long toenails requiring oversize shoes. It was agreed she would benefit from an advocate.

8.22 On the 30th September 2016, the Fire and Rescue Service (FRS) was called to a neighbouring flat to Brenda's; they made safety checks to the other flats in the premises and contacted the Local Authority Out-of-Hours Service due to concerns about the state of her tenancy and that she had no electricity. This was triaged by the ASC Contact Team on the 4th October 2016 as a safeguarding concern due to possible self-neglect; the outcome was that it was passed on to CMHT for a response.

8.23 On the 5th November 2016, the Police records show that Brenda was found walking the streets at 2am; they managed to persuade her to let them escort her home. A Safeguarding Adult Referral Form was submitted to ASC that Brenda required support from her housing provider. A follow-up visit by the Neighbourhood Police Team (NPT) liaised with the Richmond Fellowship and requested by email that they provide a copy of any relevant care plan to enable them to appropriately support Brenda in the future. There is no record of the outcome of this request.

8.24 On the 5th November 2016, ASC Contact Team record receipt of the Safeguarding Adult Referral Form from the Police and that it was passed to the CMHT.

8.25 On the 15th December 2016, the GP Practice records show a routine appointment letter to see her GP was sent to Brenda; there is no record of whether she attended or cancelled the appointment or if there was any follow-up action.

Finding 14:
Despite her care and support needs still being managed under the CPA process, there is no record of any CPA review being held, the safeguarding concern did not generate either a s42 Enquiry or a CPA Review and her apparent failure to respond to the two letters from the GP Practice did not lead to any contact being made with the CMHT.

See Recommendations 1, 2, 3 and 4

Finding 15:
Despite the ongoing concerns that had been raised about the state of her flat, possible self-neglect and lack of engagement, there is no evidence that any professional working with Brenda demonstrated any 'professional curiosity' into the causation of her behaviour, what could be seen as a deterioration in her mental health or questioned her mental capacity.

See Recommendations 8 and 9

8.26 During 2017, the contract for housing-related support was transferred from the Richmond Fellowship to a new provider, the Home Group; as part of the transfer, Brenda's support worker was TUPE'd across to the new provider. Brenda received two to three visits a week, these were primarily welfare checks as she continued not to engage with any further support. The records state that she had historically refused any medical interventions, had chosen to have her gas supply capped in 2013, chose not to have any furniture or many possessions, refused to give any contact details for a Next of Kin although she did say she had a brother. While the new provider were aware that Brenda was allocated to a mental health worker, they are not clear on how much contact they had with Brenda.

8.27 In the first three months of 2017, the GP Practice sent three letters to Brenda giving her appointments to see her GP for a review; there was no response to any of the letters.

8.28 In May 2017, the CMHT records liaison with the Richmond Fellowship and the ASC Contact Team regarding safeguarding concerns around possible cuckooing and HFRS being called to a pan boiling dry. These appear to be the same concerns identified in 8.29 below.

8.29 On the 23rd June 2017 the ASC Contact Team record a referral from the Home Group requesting a safeguarding assessment of Brenda 'due to the build-up of concerns about her welfare'. This was prompted by a fire alarm going off in her flat when a pan boiled dry; a Fire Safety Officer from the Fire and Rescue Service was

surprised it hadn't caused a fire. The referral noted Brenda's resistance to any changes in her way of life. The safeguarding concerns were not triaged within the Contact Team but were passed to Brenda's CCO in the CMHT to 'consider the need to triage under s42 criteria' and ASC closed the contact. There is no recorded outcome to the request to the CMHT.

8.30 On the 15th August 2017, the ASC Contact Team record a referral from VIVID, the new landlord of Brenda's property about the state of Brenda's tenancy, repeating much of the information and concerns in previous referrals about Brenda from a variety of sources. The referral was again passed to the CMHT requesting they consider the need for a Section 42 Enquiry.

8.31 Although it is not contained within the chronologies or the IMRs provided to this review, the Independent Author understands that, when the contract for the supported accommodation was transferred to the new landlord, the nature of the service changed. Brenda had moved into her property on the understanding that it was a long-term tenancy. The new service was a 'move-on' service, with an understanding that tenants would progress to less supported accommodation within an agreed period of time. This change further alienated Brenda from those services supporting her, particularly so the Independent Author understands, the CMHT who changed the focus of their support accordingly.

Finding 16:
During 2017, agencies have continued to withdraw from contact with Brenda without working to support her to engage with services. There are no recorded contacts between the CMHT and her or any reviews under the CPA process. The GP Practice contacts her only by letter, despite her never responding to letters. There is no consideration given to either assessing her mental health or her mental capacity. ASC do not triage the safeguarding concerns raised with them despite a legal duty to do so – they can delegate the undertaking of Section 42 Enquiries but not the decision as to whether or not any action is required as a result – although the CMHT is integrated during this period under a section 75 agreement and therefore contained an ASC manager who could supervise the triage process.

See Recommendations 1, 2, 3, 4 and 9

Finding 17:
During this year, Brenda had a change of both of landlord and housing support provider; it was good practice that the landlord raised a concern with ASC and that Brenda's support worker was TUPE'd across to the new provider, ensuring consistency of support to Brenda. It is of concern that the new housing support provider, the Home Group, was not provided with a clear handover from the Richmond Fellowship or from the commissioner when they took on responsibility for supporting Brenda.

See Recommendation 10

8.32 In the first three months of 2018, the GP Practice contacted Brenda three times by letter to remind her of having a flu jab, smoking cessation and a health check; there is no record of any response from Brenda.

See Recommendation 4

8.33 On the 15th March 2018, the CMHT records show a multi-disciplinary team meeting was held that highlighted that Brenda had not been seen for eighteen months, did not want any input, was not on any medication and was not engaging. A historic risk of self-neglect was noted but with no current risk. The outcome was that Brenda was discharged from the service back to her GP, who could re-refer as required. Both the GP and Brenda were informed of the above by letter.

8.34 This would appear to be the closure of the CPA process for Brenda by an internal meeting within the CMHT as no other agency records the meeting; the plan required the agreement of the GP who did not attend the meeting and Brenda was informed by letter, when it was well-known that she didn't open let alone respond to letters.

8.35 It is unclear how someone diagnosed with paranoid schizophrenia who is not complying with a prescribed medication regime and is not engaging with services can be appropriately discharged from a service without being seen and her mental health assessed; it is also unclear how any statement about the level of risk of self-neglect could be made if she hadn't been seen for eighteen months.

8.36 The CPA process is meant to coordinate both the mental health and social care and support needs of adults in the community. Brenda was clearly at a high risk of self-neglect and not engaging with services and should therefore have been seen as a high priority for support within the CPA process. For the process then to be closed and the her case to be closed to mental health services without an assessment or a review of her social care and support needs under s9 of the Care Act 2014 is a serious concern as it ignores a major component of the support services available to her. This is particularly true given the change in the nature of the supported housing tenancy Brenda was living in in August 2017 and therefore the likely change in her desired outcomes and support needs – see 8.31 above.

Finding 18:
The decision to close the CPA process for Brenda appears to have occurred within the CMHT without input from all the relevant agencies including an assessment under Section 9 of the Care Act 2014 or support from an Independent Advocate under Section 67 of the Care Act 2014.

See Recommendation 11

8.37 During the summer of 2018, the Home Group record that Brenda's mental capacity was assessed in the light of her continuing self-neglect /life-style choices by her CCO. The assessment was that she had capacity, though it is not recorded as to which decisions.

8.38 On the 5th August 2018, the GP Practice records note a notification of the CMHT's intention to discharge Brenda back to the GP's care as her mental health is 'relatively stable and she doesn't take any medication.' Brenda is stated to remain in supported accommodation, which is currently secure, though her 'engagement with staff there is minimal despite their best efforts'.

8.39 This is five months after the multi-disciplinary meeting that had closed CMHT's involvement with Brenda, doesn't make any recommendation as to her ongoing support and leaves open what 'relatively stable' means or how her accommodation was 'currently secure'. The GP Practice was expected to accept responsibility for Brenda with no hand-over and no agreed plan for her on-going care and support.

Finding 19:
The closure of the CPA process for Brenda by what is recorded as a 'Multi-Disciplinary Team meeting' within the CMHT is an example of poor practice with no coordination with the GP Practice for her care and support

See Recommendation 12

8.40 On the 19th November 2018, the ASC Contact Team record receiving an anonymous e-referral raising concerns about Brenda's home conditions; no action is recorded as being taken nor any explanation of the decision to take no further action. The Review has been advised this was due to the level of referrals being received; by the time the referral was triaged, Brenda had been admitted to hospital.

Finding 20:
The lack of a response to the anonymous referral, which was in effect raising a safeguarding concern, is an issue, given the referrals, albeit of a low-level, that had been made to ASC about Brenda over the Review period.

See Recommendation 13

8.41 Compounding the above is the failure of all agencies to refer Brenda to the Multi-Agency Risk Management process (MARM) that coordinates the response to cases of self-neglect that do not meet the criteria for other multi-agency processes such as safeguarding or CPA.

Finding 21:
Despite a number of agencies being aware of Brenda's self-neglecting behaviour, there was a lack of awareness of the MARM that had been developed to enable them to share information and to coordinate their responses to cases such as hers, which are deemed to be low-level risk.

See Recommendation 14

8.42 On the 20th November 2018, the ASC Contact Team record receiving a referral from the Home Group raising a safeguarding concern from her support worker about her living conditions and her physical health. Records from the Home Group show that their staff were continuing to make regular visits to Brenda and that she very unwell but

continuing to decline any further interventions. There is no recorded response to the safeguarding concern.

8.43 On the 26th November 2018, the Home Group records state that the support worker rang 111, due to his increasing concerns for Brenda's deteriorating health. He was advised not to call 999 but to contact her GP. This he did and the GP subsequently arranged for a home visit the next day.

8.44 The GP Practice records state that the support worker advised that Brenda had refused any help or care in the past but had gradually deteriorated, that he would need to be present at any home visit and, although she had agreed to see someone, asked for it to happen the next day so he could be there as she would not let anyone in to her flat. He described Brenda as having toenails about eight inches long, very matted hair, having been incontinent and soaked in urine but she would not let him clean her. He said the smell in the flat was very strong.

8.45 On the 27th November 2018, Brenda was visited at home by an Advanced Nurse Practitioner with her support worker. They described the flat as squalid, with no heating, dark and cold with a smell of urine. There were 3 areas of bedding, all of which were dirty and stained. Brenda was thin and said she hadn't eaten for four days; she refused any observations or physical assessment. She was advised that, though she was asking for help, this couldn't be provided at home and she would need to go to hospital for assessment with a view to returning home with appropriate support.

8.46 Brenda asked for time to think about being admitted to hospital; she was advised that, due to the significant risks posed by her staying at home, this was not possible and that the alternative to her agreeing was for her mental capacity to make that decision being assessed. After discussion with the support worker, who said he would ring for an ambulance if the Advanced Nurse Practitioner didn't but who felt he could persuade Brenda to go to hospital, the Advanced Nurse Practitioner made a Best Interests Decision and rang for an ambulance to transport Brenda to the hospital.

8.47 The Advanced Nurse Practitioner contacted the Emergency Department at the hospital to advise them of Brenda's arrival and to alert the social worker in the ASC Hospital Discharge Team (HDT) responsible for hospital discharge planning and specialist nurses of her pending admission. The UHS records do not note this contact.

8.48 On admission to UHS, Brenda refused any clinical observations or personal care and was estimated to have a Body Mass Index of 15. A Safeguarding Concern should have been raised by the Hospital on Brenda's admission but this did not occur until the 29th November 2018, a delay of approximately forty eight hours.

8.49 On the 29th November 2018, UHS notes record a review by the Older Persons Mental Health Consultant which noted 'Chronic schizophrenia, not grossly psychotic, chronic self-neglect with new acute confusion, safeguarding concern …. Patient doesn't want anti-psychotics and no legal framework to give covertly or IM *(intra-muscularly)* … Refer to ESCT *(Enhanced Care and Support Team)* Confusion screen. May need visit to ensure home environment is safe for her to return to.' While the above is correct with regard to the giving of anti-psychotic medication, the Older

Persons Mental Health Consultant should have considered the need for a capacity assessment given Brenda's recorded acute confusion but her not being actionable under the MHA. The capacity assessment would have been the responsibility of the staff meeting her medical needs.

8.50 On the 30th November 2018, the Hospital notes record a discussion with ASC HDT of safeguarding concerns re Brenda; it was agreed ASC HDT would liaise with the CMHT and supported living teams for further information.

8.51 On the 3rd December 2018, the Hospital records note a safeguarding team review which states that Brenda was medically unwell, reported as actively confused 'Consider DoLS. Will require social service assessment prior to discharge'

Finding 22:
The handover of information on Brenda's transport to hospital was an example of good practice; however, given her lack of compliance and the fact that she was admitted under a Best Interests Decision, it is of concern that no capacity assessment was carried out when she refused treatment or before reference is made to DoLS (Deprivation of Liberty Safeguards)

See Recommendation 9

8.52 On the 5th December 2018, Hospital records state there was a Discharge Officer review where the Social Worker advised that there was an 'open safeguarding' to be resolved and that they would be dealing with discharge planning for Brenda – see 8.48 above.

Finding 23:
It was good practice that arrangements were put in place at an early stage of Brenda's hospital admission to plan for her discharge; the lack of clarity of terminology around safeguarding which is apparent throughout the period of the Review is a concern, e.g. safeguarding alerts, safeguarding referrals, safeguarding concerns, an open safeguarding

See Recommendation 15

8.53 On the 6th December 2018, Hospital records note an Occupational Therapy (OT) review which questioned Brenda's mental capacity re health and welfare decisions, her eight- to ten-inch toenails, chronic schizophrenia and need for 'a deep clean' of her flat before an access visit undertaken. On the 7th December 2018, a formal assessment of Brenda's mental capacity was requested by the Ward Sister. It was not recorded which decision the assessment was to relate to. ASC have no record of this request.

8.54 On the 11th December 2018, Hospital records note that Brenda was deemed medically fit for discharge and referred to the discharge planning team within UHS; this despite her continued lack of co-operation with any treatment regime or with the social worker to discuss her self-neglect. This was also before any formal assessment of Brenda's mental capacity or her nursing needs had been completed.

Finding 24:
Although this review is not considering the medical treatment Brenda received in hospital, it is of some concern that she could be deemed 'medically for discharge' without her mental capacity or nursing needs being assessed and while she continued to refuse medication – if she needed medication and wasn't taking it, it would suggest the medical need for the medication hadn't been met.

See Recommendation 16

8.55 On the 12th December 2018, a Social Worker from the Complex Care and Hospital Discharge Team visited Brenda with her support worker; she stated Brenda did not have capacity although neither a formal capacity assessment nor the relevant decision is recorded. She also stated Brenda would be remaining in hospital over Christmas pending a discharge package being arranged but expressed concerns as to whether Brenda would agree to a care package and the suitability of her flat, given its condition.

8.56 On the 13th December 2018, Hospital records note a further Occupational Therapist review was completed; an orientation assessment was completed - not a capacity assessment – and Brenda was not orientated re time and date but did know where she was but not why.

8.57 Brenda continued to not co-operate with any treatment or being provided with personal care; there is no record of a formal capacity assessment being completed despite 10.53 above, though on the 15th December 2018 the UHS records refer to a capacity assessment being completed on the 10th December 2018 'by the team'; which team is not made explicit, but it was most probably the medical team responsible for Brenda's care.

8.58 On the 16th December 2018, Hospital records note an Oncology review identifying 'Radiological lung cancer and probable cord compression. Too unwell/unstable for radiotherapy'; the referral to the Oncology service had been made earlier that day in the light of investigation results. A referral is made to the palliative care team. It is suggested that Brenda 'may benefit from IMCA as she may not have capacity and has no identified NOK'. At this stage there is still no formal assessment that Brenda lacks capacity for any specific decision.

8.59 On the 18th December 2018, Hospital records state that a referral should be made to the IMCA service regarding further decision making about stopping the antibiotics, stopping IV fluids and a possible move 'to hospice for on-going care.' The Home Group records state that the hospital was advised that Brenda had a brother but that they had no contact details.

8.60 Hospital records note that Brenda continued to refuse food and drink much of the time but was comfortable and in good spirits, though drowsy. On the 20th December 2018, she died.

Finding 25:

Brenda's death was not directly linked to her self-neglect nor to the care and treatment provided to her at UHS; the diagnosis of the lung cancer was delayed, it would appear, due to the masking of its symptoms by the impact of her self-neglect

Finding 26:
The lack of any recorded formal assessment of Brenda's mental capacity is a concern, as is the consideration of referring to the IMCA service without such an assessment or a Best Interests meeting, raising questions about the Hospital's staff awareness of the Mental Capacity Act 2005 and its implications for their practice .

See Recommendation 9

Finding 27:
The 'open safeguarding' referred to in 9.51 could relate to the concern raised by the support worker before Brenda was admitted to hospital; a further safeguarding concern should have been raised when she was admitted to hospital on the 27th November 2018 – rather than two days later - and appropriately triaged as a s42 Enquiry not transferred to the Hospital Discharge process

See Recommendation 2 and 3

8.61 Although it falls outside of the Review period, Brenda's brother only became aware of her death when commercial companies managed to identify and locate him within 24 hours of her being declared 'in testate'. By this time, she had already been cremated.

8.62 The Review understands that staff at UHS followed their normal procedures in their attempts on her death to establish whether, or not, Brenda had any family. The fact remains that some agencies knew that she had a brother and some would have had his contact details from when he was involved in the CPA process.

Finding 28:
The failure to identify and locate Brenda's brother caused him unnecessary pain and distress, which was only exacerbated by the speed with which commercial organisations were able to do so.

See Recommendation 17

9. Key Themes and Recommendations

9.1 This review is focused on the care and support services offered and provided to Brenda between the 1st January 2013 and her death on December 20th 2018; it does not consider the medical care provided to her after her admission to hospital on the 27th November 2018.

9.2 The Findings identified in Section 8 of this report and the recommendations that follow for them can be grouped under the following Themes: Mental Health Act 1983; Care Programme Approach; Care Act 2014; Safeguarding; Mental Capacity Act 2005; Self-neglect; Adults who do not engage with services; Professional Practice and Good Practice

Theme 1: The Mental Health Act 1983

Findings 5, 6, 12 and 16

9.3 Brenda had a long-standing diagnosis of paranoid schizophrenia, yet at no stage during the review period was her mental health formally assessed; there are statements that her mental health was stable but she did not engage with mental health services and would often not open the door to CMHT staff who visited her.

9.4 Brenda's lack of engagement and reported self-neglect should have been sufficient to lead staff to question her mental health. Speaking to her through the front door to her flat does not constitute interviewing her in an appropriate manner to enable an assessment to have been carried out. This being the case, how to gain access to her to enable a mental health professional to asses her mental health should have been considered.

9.5 With her diagnosis and behaviour, an application to a magistrate for an order under Section 135 Mental Health Act 1983 should have been at least considered; as it is, it would appear that information obtained from her support worker was used to assess her mental health.

9.6 When Brenda was seen by a Consultant Psychiatrist, it was appropriate that their assessment was deferred to a later date in order to establish whether her behaviour was due to a temporary lack of mental capacity or a mental health issue. However, given her diagnosis, it is not clear how a Section 2 admission for assessment and treatment would have been appropriate, unless the admission was not due to her diagnosis of paranoid schizophrenia or there was an identified need to review her treatment plan.

9.7 It is sometimes argued, although not in this Review, that a Section 2 admission is a less restrictive option than a Section 3 admission on the basis that one lasts for 28 days and the other for 6 months. This is erroneous as both orders can be ended earlier if the person no longer meets the criteria for the order and an admission under s3 entitles the person to Section 117 Aftercare. Therefore not using a Section 3 order when no assessment is needed could be seen as potentially denying the person access to additional support services on discharge.

9.8 In 2017, there are no recorded contacts between the CMHT and Brenda, raising the question of how any decision could have been made as to what action might be appropriate under the Mental Health Act 1983

9.9 The Mental Health Act 1983 grants certain rights to a person's Nearest Relative. Once Brenda's husband had died – there is no reference to any divorce having taken place – and her parents having also deceased, her brother became her Nearest Relative as defined by the Act. The CMHT had his contact details from when he attended the CPA meetings – he hadn't moved during this period – and should therefore have advised him of his resulting rights. Had they done so, he would almost certainly have requested an assessment of Brenda under the Act; this might have enabled services to support her in a way that would have provided a degree of oversight and management of her self-neglecting behaviour.

Recommendation 5:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that adults at risk are seen appropriately, their mental health assessed adequately to ensure the effective assessment and management of any risks and concerns are escalated when this is not possible

Recommendation 6:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring that Nearest Relatives are correctly identified and appropriately advised of their rights under the Mental Health Act 1983 and supported in exercising them

Theme 2: The Care Programme Approach:
Findings 1, 2, 7, 13, 16, 17, 18 and 19

9.10 At the beginning of the Review period, Brenda's care and support needs were being managed via the CPA process and her brother reported attending CPA reviews. There is no CPA review detailed in the chronologies or IMRs provided to this Review where the decision was made to close the Approach and no reviews recorded that were convened because of concerns about Brenda's mental health or her self-neglect.

9.11 Due to the lack of recorded reviews, it isn't possible to know who was involved in the CPA process, but it should have included her GP Practice who would then have had the opportunity to raise concerns about her situation and her non-engagement with them.

9.12 The CPA process should coordinate the support provided by both health and social care services; the closure of the process should therefore be informed by a review or reassessment of the care and support needs of the person to determine that they are now better met outside of the CPA process, to identify how they will continue to be met and who will do so – assuming they are assessed as still needing support.

9.13 In Brenda's case, the above did not happen; there is no record of any such review or re-assessment taking place and only a reference to care being transferred to her GP Practice and a reference to the GP Practice being informed of this some three months after the decision was taken. This lack of any formal review of Brenda's care and support needs was echoed in the lack of any such review when the contract for her

housing support was transferred to a new provider and the remit of the housing provider changed from long-term tenancies to short-term 'move-on' tenancies.

Recommendation 1:
The SAB should seek assurance that Adult Social Care and the relevant health agencies are effectively monitoring the CPA process to ensure it is being implemented and recorded correctly

Recommendation 11:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that, when the CPA process is closed for an individual, that decision is taken within a properly convened CPA Review and that it is supported by a review of the individual's care and support needs under the Care Act 2014.

Recommendation 12:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that adults leaving the CPA process are appropriately transferred to alternative care and support services in a planned and coordinated manner

Theme 3 - The Care Act 2014:
Findings 7, 14, 18, 20 and 24

9.14 Brenda was entitled to an assessment under Section 9 of the Care Act 2014 as she had care and support needs as identified by her care and support being coordinated via the CPA process. Equally her brother may have been entitled to an assessment under s10 of the Care Act 2014, dependent upon when he withdrew from contact with his sister. It may be that this was prior to the Care Act being enacted in 2015.

9.15 Given Brenda's history of not engaging with services, and the likelihood of her refusing a Section 9 assessment as she was legally entitled to, the local authority had a duty to provide her with an Independent Advocate under Section 67 of the Care Act to facilitate her involvement in the assessment. This duty did not need her to be assessed to be lacking the capacity to make the decision to refuse the assessment; it would, however, have enabled a capacity assessment to have taken place re that specific decision so that an Independent Mental Capacity Advocate could be commissioned if necessary.

9.16 When a service is recommissioned with a new service, those who are receiving the service should be given the opportunity to either agree to continue to receive the service or to make their own arrangements via a Direct Payment. This would also require a review or re-assessment of their care and support needs to determine whether and what level of service was required. This did not happen in Brenda's case either when the housing support provider changed – which it did at least twice – or her housing provider.

9.17 Planning for discharge from a hospital should, ideally, start as soon as possible after admission in order to coordinate the person's health and social care needs and how they will be met. Brenda was deemed 'medically fit for discharge' on the 11th December 2018; this was while she was refusing treatment, food and drink and personal care and had not had a capacity assessment or an assessment of her nursing needs. While this might appear to be a correct decision in the sense that no further need for inpatient- treatment was identified, the diagnosis of lung cancer five days later would suggest the opposite.

9.18 The Care Act 2014 lays a mutual duty to cooperate on local authorities and a range of agencies including health agencies to meet their respective duties under the 'Act; this would suggest that, where a safeguarding concern has been raised, that decisions about hospital discharge should be joint, involving medical, nursing and social care staff.

Recommendation 7:
That the SAB seek assurance that Adult Social Care, as part of its triage processes to identify those who should be offered assessments of their care and support needs under the Care Act 2014, checks to see if adults referred to it are known to other multi-agency forums and procedures

Recommendation 10:
That the SAB seek assurance that Integrated Commissioned Services have reviewed and revised as appropriate their procedures and practice when transferring a service to a new provider, including ensuring a review of individual service users' care and support needs.

Recommendation 16:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring patients are fully and appropriately assessed before being deemed 'medically fit for discharge'

Theme 4: Safeguarding Practice:
Findings 3, 7, 9, 14, 16, 23 and 27

9.19 Safeguarding concerns were raised about Brenda on several occasions by the Police and her support worker with ASC and were passed to the CMHT to triage and decide how to respond. The Care Act 2014 places a clear duty on local authorities to undertake or cause to be undertaken whatever enquiries it – the local authority - thinks necessary for it – the local authority – to decide what any action if any needs to be taken in possible safeguarding cases. The local authority can therefore delegate the triaging of the safeguarding concern but not the decision as to whether or not a Section 42 Enquiry should be undertaken and by who. The Review is aware that the current section 75 agreement integrates the CMHT into ASC with an ASC manager supervising the triage of safeguarding concerns.

9.20 At no stage was any attempt made to discuss with Brenda the safeguarding concerns or how they might be responded to.

9.21 Self-neglect is included in the list of types of abuse contained in the Statutory Guidance supporting the Care Act 2014. However, not all cases of self-neglect will meet the criteria contained in Section 42 of the Care Act 2014 and therefore will not come under the safeguarding procedures. That doesn't mean that they don't require a response from the local authority and other agencies with a responsibility to 'promote' the wellbeing of its residents. Agencies did not know, and still didn't at the Practitioners' Learning Event held as part of this Review, of the alternative forums that could consider and coordinate responses to such cases

9.22 There is a lack of consistency in the language used around safeguarding activity; for example, there are safeguarding concerns and safeguarding referrals. This may be linked to the Review period beginning before the Care Act 2014 received the Royal Assent but can only have caused some confusion amongst agencies as to the implementation of the multi-agency safeguarding policies and procedures.

Recommendation 2:
The SAB should seek assurance that safeguarding concerns are being recorded, triaged and responded to in accordance with the Care Act 2014, its supporting Statutory Guidance and Making Safeguarding Personal

Recommendation 3:
The SAB should seek assurance that the multi-agency Safeguarding Adults Procedures are being monitored effectively and that appropriate escalation processes are in place

Recommendation 14;
That the SAB seek assurance from other local partnerships that Southampton has fully implemented the MARM process and forum to identify and coordinate a multiagency response to cases of self-neglect that don't meet the criteria of Section 42 Care Act 2014

Recommendation 15:
That the SAB seek assurance that member agencies are consistent in their usage and understanding of the terminology relating to the safeguarding procedures in order to prevent confusion.

Theme 5 - The Mental Capacity Act 2005:
Findings 15, 16, 22 and 26

9.23 Until the day she was admitted to hospital, no formal assessment had been made as to whether or not Brenda had the capacity to make decisions about her health and welfare. Her capacity to make decisions about financial matters had been managed by her support worker assisting with benefit claims etc.

9.24 There is often confusion amongst professionals caused by the principles contained in the Mental Capacity Act 2005 (the MCA) that adults must be deemed to have capacity until it is proven that they don't, that they have the right to make Unwise

Decisions and that capacity is time and decision specific. This can result in a decision about their having capacity being made on the basis of each instance a person comes to their attention rather than considering any patterns or trends in their behaviour and decision-making: essentially on a photograph rather than a video.

9.25 Brenda demonstrated behaviour over a number of years that should have led to her mental capacity being questioned and formally assessed. The Code of Practice that supports the MCA in Section 2.11 makes it clear that if someone continues to make the same Unwise Decision and doesn't learn from experience then it doesn't mean they lack capacity to make that decision but that their capacity should be further investigated.

9.26 It might be argued that Brenda would not have met the first stage of the Two Stage test for capacity contained in the MCA, namely having an impaired functioning of the mind or brain. However, this doesn't only mean having a learning disability/ difficulty or an organic mental health issue such as dementia; someone assessed with high-functioning autism, for example, can lack the capacity to make certain decisions; Brenda, with her history of substance misuse and a diagnosis of paranoid schizophrenia, could certainly have been considered to have met the first stage or at least it should have required further investigation.

9.27 There is no record of Brenda ever having a formal assessment of her capacity, though there are references to such assessments and statements that she lacked or lacked capacity at different times during the Review period.

Recommendation 9:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring that their staff, and those in services they commission, are appropriately trained and their practice monitored to ensure they practice in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice, particularly, in self-neglect cases, 2.11 of the Code of Practice

Theme 6 - Self-neglect:
Findings 20 and 21

9.28 That Brenda was self-neglecting as defined in the Statutory Guidance that supports the Care Act 2014 is beyond doubt: she was 'neglecting to care for (her) personal hygiene, health or surroundings'. The Guidance continues 'It should be noted that self-neglect may not prompt a section 42 enquiry…… whether a response is required *under safeguarding* will depend on the adult's ability to protect themselves by controlling their behaviour. There may come a point when they are no longer able to do this, without external support.' (Italics are the Independent Author's)

9.29 Even if, at some stage, Brenda had been able to control her behaviour, she was clearly not able to do so throughout the Review period. There was a duty on the local authority to respond to Brenda's self-neglect either via the safeguarding procedures or through some alternative such as an assessment under s9 of the Care Act 2014 and s6 of the Care Act 2014 places a similar duty on partner agencies through the duty to cooperate.

Recommendation 13:
That the SAB seek assurance that Adult Social Care has reviewed, and where necessary revised, its policies, procedures and practice in triaging repeated low-level concerns re self-neglect, particularly in cases of known mental health or learning disabilities.

Recommendation 14:
That the SAB seek assurance from other local partnerships that Southampton has fully implemented the MARM process and forum to identify and coordinate a multi-agency response to cases of self-neglect that don't meet the criteria of Section 42 Care Act 2014

Theme 7 – Adults who do not engage with services:
Findings 4, 14 and 16

9.30 Brenda consistently did not engage with services other than her support worker: she did not attend appointments with her GP or respond to any contacts from the Practice, she did not answer the door to her allocated mental health worker, she did not attend any meetings convened by the CMHT, assuming she was invited. If she wasn't, that raises further concerns about the practice within the CMHT in implementing the CPA, supporting staff working with adults who do not engage with services or triaging safeguarding concerns at the request of ASC.

9.31 In fairness, the GP Practice did implement its Did Not Attend Policy, but only by writing to Brenda; this to a person with a longstanding known diagnosis of paranoid schizophrenia and with a history of not responding to letters. It would appear that the Policy was implemented without any consideration of good or person-centred practice.

9.32 Policies should provide parameters within which professionals exercise their professional judgement, not be a strait jacket that prevents professional good practice.

Recommendation 4:
The SAB should seek assurance that member agencies and those services they commission have policies and procedures such as DNA and support systems for staff in place that are sufficiently flexible in their implementation to enable them to encourage those patients or service users who are not engaging with services to do so

Theme 8 - Professional Practice:
Findings 15, 17 and 28

9.33 Running through this Review is a recognition that staff dealt with the presenting issue rather than taking an overview of Brenda and situation across a period of time – what was referred to earlier as looking at photos rather than a video. It is also the case that the quality of information exchange when Brenda was transferred between providers when services were re-commissioned was poor and not questioned effectively by the new providers.

9.34 This lack of ‘professional curiosity’ resulted in Brenda’s behaviour becoming accepted as the norm and not questioned. However, professionals practice within an organisational and management culture.

9.35 The Care Act 2014, when it was enacted, was seen by the Department of Health as requiring a change of culture on behalf of professionals to become more person-centred and outcome focused. It was recognised that such a change of culture could only happen if there was a change in organisational culture too. Prior to the Care Act 2014, the Association of Directors of Adult Social Services and the Local Government Association had launched a joint initiative, Making Safeguarding Personal, to support such cultural changes and to promote person-centred practice that is relevant across all social and health care settings, not just safeguarding – see Recommendation 2 above

9.36 These two cultural changes can only come together if professionals are provided with opportunities to reflect on their practice in formal and informal supervisory situations. These would enable them to challenge organisational structures and procedures that prevent them practicing as the Care Act 2014 requires.

Recommendation 8:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring their staff, and staff in services they commission, are receiving appropriate professional supervision and support to enable them to reflect on their professional practice, particularly in cases of possible self-neglect, and adults who are difficult to engage with

Recommendation 17:
That the SAB seek assurance that member agencies, particularly Adult Social Care and University Hospital Southampton, have reviewed and revised their policies and practice, in cases where patients die ‘in testate’, to maximise the opportunities to identify Nearest Relatives/ Next of Kin.

Theme 9 - Good Practice:
Findings 4, 8, 11, 17, 22 and 23

9.37 There are examples of good practice with Brenda throughout the Review period.

9.38 The GP Practice did have and implement its Did Not Attend Policy when she did not respond to letter inviting Brenda to appointments with her GP.

9.39 The Police did raise Safeguarding Adults Referral Forms when they had concerns for Brenda and did follow them up with requests for information from the Richmond Fellowship to enable them to better support Brenda if they had any further contact with her.

9.40 When Brenda was visited at home by the Consultant Psychiatrist, it was good practice to defer their assessment of her until a later date to see if Brenda was more lucid in order to pursue the least restrictive option in providing her with support.

9.41 It was good practice that her new landlord raised a safeguarding concern with ASC when they took over responsibility for her tenancy

9.42 When Brenda was transported to hospital, the information supporting her admission from the Advanced Nurse Practitioner was full and timely, containing the basis of her Best Interests Decision to make the admission.

9.43 It was good practice that arrangements for planning for her discharge were put in place soon after her admission; given the circumstances of her admission and her concern about the permanency of her tenancy, doing so should have provided her with some assurance of the reasons for her admission.

9.44 A consistent figure in Brenda's life for most of the Review period was her support worker; he was the only person who appears to have had regular and frequent contact with her and from whom she was willing to accept support. He also appears to have been the primary source of information that other agencies relied upon to inform their own decisions about Brenda's care and support needs. His commitment to her went beyond what was required of him or could have been reasonably expected; this is acknowledged by the Independent Author and by Brenda's brother.

Recommendation 18:
That the SAB formally recognise the good practice of the agencies and individuals identified above

10. Conclusions

10.1 As has been identified during this Report, there are numerous discrepancies between agencies recordings with regard to the dates events happened, whether certain events did occur and instances of incomplete recordings – see 8.2; 8.9; 8.14; 8.15; 8.16; 8.17; 8.22; 8.23; 8.29; 8.47 and 8.53 above. While these discrepancies may not have had any direct impact on the care and support provided to Brenda and the resulting quality of her life, they do raise concerns about the quality of multi-agency working that is possible if those agencies have differing knowledge and understandings on which to base their assessments and interventions.

10.2 On the basis of the above, it would appear that the following conclusions can be appropriately drawn in response to the four questions contained in the review's Terms of Reference.

10.3 The level of self-neglect experienced by Brenda was predictable; she had a long history of mental health issues, failure to engage with services and self-neglect. Recent research has shown that much self-neglect can be linked to issues relating to loss or bereavement. At no stage was there any evidence of any attempts to actively seek Brenda's engagement other than by her support worker or to work with her to identify the causation of her self-neglect.

10.4 Brenda's history of not engaging with services or even recognising the need to so engage would suggest that the chances of working with Brenda to change her

behaviour were very limited. This may have been due to the impact of her mental health issues on her behaviour – paranoid schizophrenia may have made Brenda suspicious of those who tried to engage with her. Even with radical interventions in her life such as admissions to hospital under the Mental Health Act 1983 or the continuation of a Guardianship Order with requirements to manage her behaviour, it is not necessarily the case that her self-neglect could have been prevented or even reduced in its deterioration.

10.5 Having said the above, Brenda's care and support needs were not appropriately assessed or responded to. In fact, there is no record of any assessment of her care and support needs under the Care Act 2014 nor of the involvement of a Section 67 Independent Advocate to support her.

10.6 Equally, there is no evidence that Brenda was referred into the multi-agency self-neglect procedures. In fact, some agencies were not aware of them.

10.7 Brenda was referred into the multi-agency safeguarding adult's procedures but these were not implemented or coordinated appropriately. In fact, it would appear that the safeguarding adult's procedures were not actually implemented at all beyond the safeguarding concerns being referred to the CMHT for consideration until after she was admitted to hospital.

10.8 However, it is unlikely that her self-neglect, lack of engagement with services or the failures to implement the multi-agency self-neglect and safeguarding adult's procedures had any causal effect on her death, which was due to lung cancer. She does not appear to have complained of or exhibited any symptoms that might have led to an earlier diagnosis.

10.9 What would also appear to be the case is that Brenda's quality of life could have been improved if agencies had worked together better to assess and offer to meet her care and support needs and thereby assess and manage the attendant risks to her health and wellbeing; her brother could and should have been given the opportunity to exercise his rights to seek support for his sister. This might have led to him being able to be involved in her last days, arrange for her funeral and to grieve her properly.

10.10 She would still have most probably refused any support or service that was offered, but that doesn't excuse the failure to offer them.

11. Recommendations

Recommendation 1:
The SAB should seek assurance that Adult Social Care and the relevant health agencies are effectively monitoring the CPA process to ensure it is being implemented and recorded correctly

Recommendation 2:

The SAB should seek assurance that safeguarding concerns are being recorded, triaged and responded to in accordance with the Care Act 2014, its supporting Statutory Guidance and Making Safeguarding Personal

Recommendation 3:
The SAB should seek assurance that the multi-agency Safeguarding Adults Procedures are being monitored effectively and that appropriate escalation processes are in place

Recommendation 4:
The SAB should seek assurance that member agencies and those services they commission have policies and procedures such as DNA and support systems for staff in place that are sufficiently flexible in their implementation to enable them to encourage those patients or service users who are not engaging with services to do so

Recommendation 5:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that adults at risk are seen appropriately, their mental health assessed adequately to ensure the effective assessment and management of any risks and concerns are escalated when this is not possible

Recommendation 6:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring that Nearest Relatives are correctly identified and appropriately advised of their rights under the Mental Health Act 1983 and supported in exercising them

Recommendation 7:
That the SAB seek assurance that Adult Social Care, as part of its triage processes to identify those who should be offered assessments of their care and support needs under the Care Act 2014, checks to see if adults referred to it are known to other multi-agency forums and procedures

Recommendation 8:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring their staff, and staff in services they commission, are receiving appropriate professional supervision and support to enable them to reflect on their professional practice, particularly in cases of possible self-neglect, and adults who are difficult to engage with

Recommendation 9:
That the SAB seek assurance that Adult Social Care and relevant health agencies are ensuring that their staff, and those in services they commission, are appropriately trained and their practice monitored to ensure they practice in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice, particularly, in self-neglect cases, 2.11 of the Code of Practice

Recommendation 10:

That the SAB seek assurance that Integrated Commissioned Services have reviewed and revised as appropriate their procedures and practice when transferring a service to a new provider, including ensuring a review of individual service users' care and support needs.

Recommendation 11:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring that, when the CPA process is closed for an individual, that decision is taken within a properly convened CPA Review and that it is supported by a review of the individual's care and support needs under the Care Act 2014.

Recommendation 12:
That the SAB seek assurance that ASC and the relevant health agencies are ensuring that adults leaving the CPA process are appropriately transferred to alternative care and support services in a planned and coordinated manner

Recommendation 13:
That the SAB seek assurance that Adult Social Care has reviewed, and where necessary revised, its policies, procedures and practice in triaging repeated low-level concerns re self-neglect, particularly in cases of known mental health or learning disabilities.

Recommendation 14:
That the SAB seek assurance from other local partnerships that Southampton has fully implemented the MARM process and forum to identify and coordinate a multiagency response to cases of self-neglect that don't meet the criteria of Section 42 Care Act 2014

Recommendation 15:
That the SAB seek assurance that member agencies are consistent in their usage and understanding of the terminology relating to the safeguarding procedures in order to prevent confusion.

Recommendation 16:
That the SAB seek assurance that Adult Social Care and the relevant health agencies are ensuring patients are fully and appropriately assessed before being deemed 'medically fit for discharge'

Recommendation 17:
That the SAB seek assurance that member agencies, particularly Adult Social Care and University Hospital Southampton, have reviewed and revised their policies and practice, in cases where patients die 'in testate', to maximise the opportunities to identify Nearest Relatives/ Next of Kin.

Recommendation 18:

That the SAB formally recognise the good practice of the agencies and individuals identified above

Recommendation 19:
That the SAB seek assurance from ASC and relevant health agencies that they have developed and implemented effective monitoring systems to ensure that multi-agency working is accurately and consistently recorded.

Appendix A

Terms of Reference for Southampton Safeguarding Adults Board Case Review Group

Aims

To enable the Local Safeguarding Adults Board (LSAB) to undertake timely reviews of cases that require lessons to be learned, including Safeguarding Adults Reviews (SARs) as detailed in Care Act 2014 and to provide a mechanism for the LSAB to deliver reviews of cases that do not meet the threshold for a SAR. It also aims to ensure that lessons learned from SARs and other reviews are shared and acted upon as follow up to the work of case review panels across the multiagency partnership.

Functions of the Group

1. Receive referrals of cases to be considered as Safeguarding Adults Reviews.

2. Identify the scope of agencies involved in cases subject to review

3. Consider these cases against the statutory criteria for Safeguarding Adult Reviews as detailed in Care Act 2014. **The Chair of the Group will have the casting vote as to whether the case proceeds for recommendation for a SAR (statutory or discretionary)**

4. Refer cases that are deemed by the group to meet the definition of a SAR to the LSAB chair for the final decision

5. Ensure proportionality of these reviews in the methodology that is adopted

6. Lead the initiation and delivery of reviews (including Thematic reviews) of cases that do not meet the criteria for a SAR.

7. Monitor progress and review timelines of commissioned reviews to ensure timely delivery of report, learning and recommendations.

8. To be responsible in ensuring a SAR is fit for purpose, robust quality assurance of the final report and that terms of reference for a review is fulfilled.

9. To recommend publication arrangements and agree communications plans for reviews.

10. Oversee and monitor actions coming from these discretionary reviews.

11. Monitor progress of actions to completion to ensure lessons learned from reviews once the panel has completed its role and the number of actions is manageable by this means.

12. Once actions are completed to pass information to 4LSAB Quality Assurance Group for monitoring of ongoing impact and audit of practice improvement.

13. Link with the LSCB as necessary and Safe City Partnership, the Coroner, other groups and stakeholders as relevant

14. Work with 4LSAB Sub Groups to ensure multiagency activity is co-ordinated and business plan activities are delivered.

15. The group will ensure that it is aware of, and consider, any other investigations or processes that are running in parallel (eg. DHR, MMHR), to ensure relevant information is shared without delay and duplication is minimised.

Membership

- Southampton City Council Adult Social Care
- Southampton City Council Housing Services
- Southampton City Council Legal Services
- Southampton City Council Local Safeguarding Boards Team
- Southampton City Clinical Commissioning Group
- University Hospital Southampton NHS Foundation Trust
- Southern Health NHS Foundation Trust
- Solent NHS Trust
- Hampshire Constabulary
- National Probation Service and Hampshire Crime Rehabilitation Company
- Southampton Voluntary Services
- LSAB Lay Member
- Other LSAB members may be invited to attend as necessary.

Chair

Chair – Carol Alstom, Associate Director of Quality, Southampton City CCG
Vice Chair – TBC

Reporting and Accountability

The group will report to the LSAB chair on recommendations made and on progress against delivery of reviews and business plan priorities. The group will raise issues that need resolution beyond the remit of its members to the Independent Chair of the LSAB if these cannot be resolved. The CRG will hold partners to account and escalate issues with regard to compliance of information sharing when requested for the purpose of case review work.

The CRG group will be quorate for recommendations and decision making as long as 2 out of 3 funding partners (**Southampton City Council, Southampton City CCG** and **Hampshire Constabulary)** are represented at meetings.

Frequency of Meetings
The group will meet 6 to 8 weekly.
To be reviewed July 2020.

Appendix B

Terms of reference for Multi-Agency Review – Brenda

Introduction:

1. The purpose of the Discretionary Review re Brenda is to:

    a. Establish whether there are lessons to be learnt from the circumstances of Brenda and the context of her death about the way in which local professionals and agencies work together to safeguard adults at risk
    b. Review the effectiveness of procedures (both multi-agency and those of individual organisations)
    c. Inform and improve local inter-agency practice
    d. Improve practice by acting on learning (developing best practice)
    e. Commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2. The Case Review Group (CRG) did not consider that Brenda's case met the criteria contained in s44(1) of the Care Act 2014 that would place a duty on the Southampton Safeguarding Adults Board (SSAB) to commission a SAR but agreed that a discretionary review be commissioned under power contained in s44(4) of the Care Act 2014.

3. The CRG will consider any lessons learnt by each agency in conjunction with the findings of the Review re Brenda to develop a single inter-agency action plan for implementation. Responsibility for driving through any required process improvements will sit with the Chair of the SSAB.

Terms of Reference for the Review Panel

4. For the purposes of the Review, the CRG will act as the Review Panel (the Panel). The Panel is responsible for:
    a) Ensuring the Review is completed within the agreed timescales
    b) Reviewing the Terms of Reference of the Review to ensure they remain fit for purpose
    c) Ensuring that relevant agencies are informed of the requirement to complete a Chronology and Analysis
    d) Ensuring that each organisation is aware of its own responsibility to implement single agency lessons to be learned, in accordance with their internal quality assurance and governance arrangements, to ensure adults at risk are safeguarded
    e) Arranging a Practitioners' Learning Event to inform the Overview Report
    f) Making recommendations to the SSAB for a multi-agency Action Plan, ensuring that there is no delay in the implementation of actions which will safeguard adults at risk
    g) Ensuring that the Overview Author has all the relevant documentation
    h) Making any decisions on if/how to involve any wider family or significant others in the review

i) Tabling the Overview Report and Action Plan to the SSAB for ratification

Terms of Reference for the review

Scope

5. The Review will cover the period **1st January 2013 to 21st December 2018.**

6. The Review will specifically consider the following questions:
   - Was the level of self-neglect experienced by Brenda predictable?
   - Was the level of self-neglect experienced by Brenda preventable?
   - Were the care and support needs of Brenda assessed and responded to appropriately and effectively?
   - How well were the single and multi-agency self-neglect and safeguarding adults procedures implemented and coordinated?

Timetable

7. The Review will follow the following timetable:

Activity	**Date**
SSAB Case Review Group to confirm draft Terms of Reference and methodology	12.8.19
Deadline for agencies to submit chronologies with analysis and action plan	30.8.19
Overview report author to submit first draft	29-30.10.19
Panel Meeting to consider 1st draft overview report and questions (reviewer to be invited, Chair from Southampton City CCG)	7.11.19
Multiagency review practitioners learning workshop	21.11.19
Overview report author to submit overview report final draft	January 2020 (TBC)
The panel to agree overview report and multi-agency action plan	January 2020 (Date TBC)
SSAB Case Review Group to review and agree report	February 4th 2020
Sign off of the overview report and action plan at Southampton LSAB	March 2020 (Date TBC)

8. All chronologies and analyses' are to be submitted electronically to the Safeguarding Board's Business Office via secure email by the deadline dates.

Terms of Reference for Overview Author

9. The Overview Author will be asked to focus on the following:

   a. What were the lessons learnt by each agency?
   b. Consider the effectiveness of the work of the various agencies involved with both the individuals
   c. Consider the role and purpose of each agency's involvement and how well the agencies shared information
   d. Consider the quality of the work of different agencies and the quality of their management of the case
   e. Establish how well Mental Capacity was understood by the various agencies at each point of contact and whether a Best Interests decision was considered at any point
   f. Establish the extent to which the involved agencies adhered to local policies and procedures relevant to this case
   g. Explore the quality of risk assessments and how these were undertaken.

Appendix C Independent Overview Report Author

1 Mr Pete Morgan has been the Independent Chair of the Worcestershire and Hertfordshire Safeguarding Adults Boards, having retired as the Head of Service – Safeguarding Adults with Birmingham City Council. In the above roles, he has

commissioned Serious Case Reviews as well as participated in them and their ratification by the relevant Safeguarding Adults Board. He has chaired and co-authored a Domestic Homicide Review for the Safer Wolverhampton Partnership, a Serious Case Review for the Walsall Safeguarding Adults Partnership Board, Safeguarding Adults Reviews for the Bedford Borough and Central Bedfordshire Safeguarding Adults Board, the Leicestershire and Rutland Safeguarding Adults Board and the West Sussex Safeguarding Adults Board, was a member of an Independent Joint Serious Case Review Team for Newcastle Safeguarding Children and Adults Boards and was authoring an SAR for three other Safeguarding Adults Boards. He was a member of the Department of Health's Safeguarding Adults Advisory Group and is the Chair of the Board of Trustees, the Practitioner Alliance for Safeguarding Adults and the Independent Chair of the Safeguarding Panel for Advance, a charity that provides accommodation and support for adults with care and support needs.

2 He had had no involvement, directly or indirectly, with any member of the family concerned in this Review or the commissioning, delivery or management of any of the services that they either received or were eligible for prior to being commissioned to write this Report.

3 He had no involvement, directly or indirectly, with any of the agencies contributing to this Review prior to being commissioned to write this Report.

Appendix D

Glossary

SAB	**Safeguarding Adults Board**

CPA	**Care Programme Approach**
CMHT	**Community Mental Health Team**
SAR	**Safeguarding Adult Review**
IMR	**Internal Management Review**
CRG	**Case Review Group**
MCA	**Mental Capacity Act**
MHA	**Mental Health Act**
DWP	**Department of Work and Pensions**
ASC	**Adult Social Care**
CCG	**Clinical Commissioning Group**
CPN	**Community Psychiatric Nurse**
DNA	**Did Not Attend**
SAT	**Safeguarding Adult Team**
SCC	**Southampton City Council**
CA12	**Police Safeguarding Adults Referral form - now known as a PPN1**
FRS	**Fire and Rescue Service**
DoLS	**Deprivation of Liberty Safeguards**
OT	**Occupational Therapist**
TUPE'd	**…For the Transfer of Undertakings (Protection of Employment) (TUPE) Regulations. This is relevant to any redundancy decisions where a business or part of it is transferred from one owner to another.**
DHR	**Domestic Homicide Review**
Mental Health Review	**MHR**