Bedford Borough and Central Bedfordshire Safeguarding Adults Board

Executive Summary of Safeguarding Adults Review Case A for the period of 29 December 2016 to 28 July 2017.

1. Introduction

This report provides a summary of a full report written for a Safeguarding Adults Review (SAR). The SAR was commissioned as a statutory review under Section 44 of the Care Act 2014 and in line with the Multi-Agency Safeguarding Adults Policy and procedure. The full report was written by an independent author – Pete Morgan

According to Bedford Borough and Central Bedfordshire Safeguarding Adults Boards Safeguarding Adult Review Framework (the SARF), a Safeguarding Adults Review Panel was formed and this panel agreed the following specific areas of enquiry in the terms of reference for the SAR in July 2017:

The SAR seeks to promote a culture of continuous learning and improvement across organisations that work together to safeguard and promote the well-being of adults. It is intended to identify opportunities to draw on what is effective, promoting good practice and recognising lessons to enhance partnership working and improve outcomes by considering:

How effective was the multi-agency involvement and contribution to assessment and understanding of risk,

- At key stages of Miss A's care and at the time of the decision to move Miss A to a residential unit.
- In the way information relating to risk and support needs was shared with staff directly responsible for Miss A's care and support?
- In the referrals to and responses from AMHP service

Are there lessons to be learnt from these experiences and from this case for future multi agency risk assessment work, and that will enable agencies to consider how they could do things differently in the future, to prevent similar harm occurring again.

The terms of reference also included involving and supporting Miss A's family and throughout the SAR the family were invited to contribute and the author of the report met with the family. The family were able to comment upon the Overview Report in draft form. These comments were, where appropriate, incorporated into the final version of the Overview Report; where the Independent Author did not support their comments, this disagreement was also acknowledged within the Overview Report.

Alongside the report it was also agreed by the Bedford Borough and Central Bedfordshire Safeguarding Board to publish an addendum in light of a difference in views between the family of Miss A and the independent author relating to the length of notice Miss A was given to vacate her placement.

2. Case Summary

Miss A was born on the 9th April 1981 in London. She was diagnosed with 'borderline hyperactivity' at the age of four. At primary school, she struggled to read and found it hard to form friendships. At the age of seven, she was diagnosed with Dyslexia and, at the age of eight, transferred to a specialist school, where she began to read within a term. At the age of ten, she returned to mainstream education at her old school. She attended an all-girls secondary school where she was academically successful but became isolated and ill through the increasing impact of her Anorexia.

Miss A, despite appearing unhappy and becoming obsessive about her weight and socially isolated, completed both her GCSEs and A levels. She completed a Foundation course at Wimbledon Art College but was too unwell to take up a place at university as she had planned. After several hospital admissions, Miss A subsequently completed, with a Distinction, a part-time creative writing course at Birkbeck College, London. This enabled her, at the age of 26, to read English at the University of Sussex.

Miss A could also be lively, funny, articulate and full of life. The artwork and creative writing she produced was very impressive and is an indication of what she might have achieved. The tension between the creative and the self-destructive in her life is clear to see and needs to be remembered.

Miss A had had contact with mental health services from the age of twelve and spent 5 years in the Maudsley Hospital for treatment of her Anorexia Nervosa. During this time she was placed under Section 3 of the Mental Health Act 1983.

She was further assessed under the Act in 2012 and 2014 but was not detained on either occasion. She was described as presenting with symptoms of Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Anorexia/Bulimia and personality difficulties that meet the diagnostic criteria for Borderline Personality Disorder. In 2014, Miss A was diagnosed with High Functioning Autism Spectrum Disorder, though Miss A disputed this, as she had most diagnoses.

Prior to her admission to the Milton Park Therapeutic Campus, Miss A was living in a residential hostel in Brighton, and was described as living a chaotic lifestyle involving the misuse of alcohol, illicit drugs and inappropriate sexual liaisons and abusive relationships with men. She was not cooperating with support services offered to her and a referral was made for a placement in a specialist locked rehabilitation facility, resulting in her placement at the Milton Park Therapeutic Campus as an informal patient, initially on two locked wards before she transferred to Pathway House, a residential home.

Miss A could be articulate and clear about her wishes and would often push any boundaries that might be imposed upon her. She could understand the need to change her behaviour and life-style, but was unable to make those changes. Despite increasing risks being identified about her behaviour, including one probable suicide attempt, Miss A remained a voluntary resident at Pathway House. She was offered an informal admission to the in-patient facility on the Milton Park Therapeutic Campus, but declined it. Three applications were made for an assessment under the MHA during June and July 2016, though none were actually carried out and at no time was Miss A made the subject of a detention order. There was also a fourth application in this period, but this was subsequently withdrawn at her parents' request in case it jeopardised a possible new placement.

On the 27th July 2016, Miss A left Pathway House in the morning to attend an appointment with her GP; she didn't return to Pathway House but was in regular telephone contact with staff during the day. Several times during the evening, she advised them she was about to return. She had also been in contact through the evening with her parents, who also encouraged her to return to the placement. Miss A's parents were also in contact with Pathway House and asked that they contact the Police, the final time at 11pm. They were advised that contact would be made at 1am if Miss A hadn't returned, which they considered too late.

At 2 am on the 28th July 2016, when Miss A had not returned and she had not been in contact for forty five minutes, the Police were alerted and she was registered as a Missing Person. At 5 am, the Police contacted Pathway House to advise them that Miss A had died in a traffic accident at 3 am.

The death of Miss A is the subject of a Coroner's Inquest; the first Pre-Inquest Hearing was held on the 8th December 2016 and the second on the 14th March 2017. It was planned to hold the Inquest in November 2017**,** but at the time this Report was written, it had been postponed until later in 2018.

3. Key Findings summary

Risk assessment and care planning

- The basis and expected outcomes of the placement at Milton Park were not clear, shared with Miss A or her parents, directly linked to her assessed needs or coordinated with her Care Programme Approach care plan.

- The process by which Miss A was assessed, offered a placement and admitted to Milton Park was ambiguous and lacking in detail and without a clear care plan with desired outcomes.

- There was no evidence of a formal or interim risk assessment being undertaken on Miss A's admission to Milton Park despite the concerns about her mental health and autism.

- That the provision of appropriate care and support services to Miss A on her discharge to the residential home was compromised by a lack of clarity between professionals and services involved as to its management including that within the Care Programme Approach.

Risk management and escalation

- Miss A was well-known to the Police, as were the increasing concerns about her behaviour and her placement but the police did not develop a strategy to manage the repeated contacts they received regarding Miss A.

- There appears to be no protocol within the Board's area to facilitate a single agency, such as the Police, raising concerns about adults with complex risk issues, such as self-neglect, in a multi-agency forum other than through a safeguarding concern.

- Despite increasing concerns about the viability of her placement and the ability of Tracscare to provide a safe placement for Miss A within the Milton Park Campus, nobody pursued alternative services local to Pathway House to support Miss A.

- The ability of Milton Park staff to question and challenge the AMHP Service, and the ability of the AMHP Service to accept professional questioning and challenging, would appear to have been limited, again to the detriment of the service provided to Miss A.

Use of the Mental Capacity Act 2005

- Despite professional concerns and having been assessed as meeting the first stage of the two stage functional test for capacity, at no point except at her point of admission, was a formal Mental Capacity Assessment undertaken despite increasing evidence that would suggest that she might lack capacity in some areas of decision-making; equally, at no stage of her placement was consideration given to action under the Mental Capacity Act 2005, all attention was focused on action under the Mental Health Act 1983.

AMHP Service involvement

- Serious concerns have been identified not only about the procedures, processes and systems operative within the Bedfordshire AMHP Service during the period of this Review but also about the professional performance of some members of staff. A referral for an assessment of Miss A by an AMHP was inappropriately screened out due to a lack of clear procedure to provide professional supervision and oversight to non-warranted AMHPs.

- The responses of the AMHP Service to the referrals for an assessment under the Mental Health Act 1983 failed to demonstrate a reasonable level of 'professional curiosity' and remained focused on a very limited understanding of the possible causation of Miss A's behaviour, one that reinforced the initial triage process undertaken by an unwarranted AMHP and not overviewed by a warranted AMHP.

Considering the diagnosis of Autism

- There is clear evidence throughout the period of this Review that the services offered and provided to Miss A did not consistently accord with the above principles of good practice of working with adults with autism

4. Recommendations

The recommendations below are based on the full report written by Pete Morgan. Bedford Borough and Central Bedfordshire Safeguarding Adults board will monitor the implementation of these recommendations by each agency involved.

Sussex Partnership NSH Foundation Trust:

- Sussex Partnership NHS Foundation Trust to review and, as necessary, revise its procedures for commissioning residential placements to ensure that all parties are enabled to be fully aware of the assessed needs of the person being placed, the expected outcomes of the placement and be appropriately involved in their identification and commissioning.

- Sussex Partnership NHS Foundation Trust to ensure they have robust quality assurance procedures in place to ensure that commissioned placements meet their contractual obligations and expectations through the development and maintenance of a skilled workforce and risk management, safeguarding and care management processes and procedures.

Tracscare

- Tracscare to review and, as necessary, revise its assessment and admission procedures to ensure that all parties are aware of the purpose, nature and intended outcomes of any service that is commissioned.

- Tracscare to review and, as necessary, revise its policies and procedures to ensure that assessments under the Mental Capacity Act 2005 are completed and reviewed effectively and appropriately.

- Tracscare to review and, as necessary, revised its policies and procedures to ensure that timely and effective Risk Assessments and Management Plans are developed, implemented and reviewed.

- Tracscare to review and, as necessary, revised their policy and practice with regard to those clinicians and staff responsible for all aspects of patients' treatment plans have sufficient and regular contact with those patients to fulfil their responsibilities effectively.

- Tracscare to ensure they have appropriate and effective escalation procedures in place where risk is high and there are concerns about other agencies' responses.

- Tracscare to address the proper implementation of the Care Programme Approach particularly when patients are discharged to the residential units.

AMHP service

- The AMHP Service to ensure it has been effectively reviewed and appropriate remedial action implemented and monitored to ensure that its procedures and practice are fit for purpose and in accordance with the requirements of the Mental Health Act 1983 and its subsequent revisions.

- The AMHP Service to follow internal procedures, with regard to the members of staff who were or should have been involved in the decision to screen out the referral from Milton Park and staff who should have been involved in decision making.

- The AMHP Service to ensure it has established robust procedures to ensure that decisions as to the management of referrals are considered in the light of previous contacts relating to their subject.

- The AMHP Service to review and revise its Practice Manual to ensure it provides robust and appropriate guidance.

- The AMHP Service to review and revise its processes and procedures to monitor staff's performance through professional supervision and system management.

Bedfordshire Police

- Bedfordshire Police to review and, as necessary, revised their policies and procedures for responding to adults with care and support needs who repeatedly come to their attention through actual or potential self-harm and accordingly liaise appropriately with neighbouring police forces.

Local GP practices

- Local GP practices to ensure they are implementing the Care Programme Approach correctly.

Multi agency recommendations

- Sussex Partnership NHS Foundation Trust and Tracscare to review and, as necessary, revised their policies, procedures and practice to ensure that all legal options, including those under the Mental Capacity Act 2005, are considered to appropriately safeguard patients/service users.

- Sussex Partnership NHS Foundation Trust and Tracscare to review and, as necessary, revise their policies and processes, re such as the Care Programme Approach.

- Tracscare and the Sussex Partnership NHS Foundation Trust to review and, as necessary, revised their processes for managing placements, particularly those that are exhibiting escalating risks and likely breakdown.

- Tracscare, the Sussex Partnership NHS Foundation Trust and members should develop and implement policies and procedures to consider all legal options, including the Mental Capacity Act 2005, the Court of Protection and the Inherent Jurisdiction of the High Court, to manage risk as part of an adult's care plan.

- The AMHP Service and Tracscare to review the nature of their relationship and put in place processes for the escalation of any concerns that arise in the future.

- All services for adults and children with a diagnosis/assessment of autism within its area are designed and delivered in accordance with the SPELL principles from the National Autistic Society.

- Tracscare and East London Foundation Trust to undertake a review with commissioners of the pathways into community mental health services for their residential placements.

Bedford Borough and Central Bedfordshire Safeguarding Adults board

- The board to establish a multi-agency protocol for identifying and responding to service users/patients with complex risk issues including a clear escalation process.