Teeswide Safeguarding Adults Board

ADULT D

A Safeguarding Adults Learning Lessons Review (LLR)

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1. INTRODUCTION

1.1. Adult D was a 62-year-old gentleman who died in hospital from pneumonia. Adult D had spent the previous 18 months being treated for mental and physical health illnesses. Concerns had been raised by the Acute Hospital Safeguarding team in relation to Adult D's treatment and whether his placement in a Primary Care Hospital could provide for his increasing physical and mental health care needs. Concerns had also been raised that he had been sectioned under the Mental Health Act, but his detention had been to the Primary Care Hospital where it was later advised that the hospital is not registered with the Care Quality Commission to detain individuals who are sectioned under the Mental Health Act.

1.2. It was recorded in the Safeguarding Adult Review decision making meeting, and therefore within the terms of reference for the review, that Adult D had a nasogastric (NG) tube[1] and was fed against his wishes and that he had a Deprivation of Liberty Safeguards (DoLS)[2] placed upon him albeit that he retained capacity to make his own decisions regarding care and treatment.

1.3. Prior to his admission to hospital, Adult D was reported as being homeless and had been placed into a Bed & Breakfast (B and B) following a lengthy period in a Mental Health Hospital.

1.4. A Safeguarding Adult Review (SAR) notification was submitted for consideration following concerns raised in a safeguarding strategy meeting.

1.5. Adult D passed away the day after the strategy meeting from natural causes.

2. PROCESS AND SCOPE

2.1. The decision making, scope and Terms of Reference for the LLR can be found in Appendix 1. These were amended following restrictions placed on agencies due to the Covid-19 pandemic response; the proposed methodology was changed after a period of inactivity with the review.

2.2. The review covers the six months prior to the death of Adult D.

2.3. There are three main geographical areas covered by this review depicted in the table below.

Area 1 : Area of Residence at time of review	Area 2: Larger town with specialist services	Area 3: Area that Adult D had previously lived in with partner
Housing	Mental Health Inpatient Services	Previous GP
Locality Social Work	Locality Social Work	
Primary Care Hospital	Acute Hospital	
GP		

[1] A **nasogastric** (**NG**) **tube** is a flexible **tube** of rubber or plastic that is passed through the nose, down through the oesophagus, and into the stomach. It can be used to either remove substances from or add them to the stomach.

[2] **Deprivation of Liberty Safeguards (DoLS)** protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things. https://www.pohwer.net/deprivation-of-liberty-safeguards-dols

3. THE REVIEWER

3.1. TSAB commissioned an independent reviewer to chair and author this LLR. Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in Safeguarding roles in the NHS for a number of years. Karen is completely independent of TSAB and its partner agencies.

4. FAMILY INVOLVEMENT IN THE REVIEW

4.1. The lead reviewer contacted Adult D's partner and she was keen to be involved in the review. The details, thoughts and observations of Adult D's partner have been included throughout the review, as appropriate. Adult D's partner was in touch with his children and ex-wife and was able to feedback progress with the review to them.

4.2. The reviewer also contacted the manager from the Bed and Breakfast accommodation that Adult D had stayed at. His thoughts are also included, as appropriate.

5. ADULT D RELEVANT HISTORY

5.1. Adult D was a retired nursing lecturer who had lived with his long-term partner for 14 years; he had two children from a previous marriage. Adult D had a previous history of two incidences of bowel cancer and related pancreatic malabsorption otherwise known as Pancreatic Exocrine Insufficiency[3]. Adult D displayed a deterioration in his mental and physical health over an 18-month period prior to his death. It appears that the ongoing physical health problems resulted in a deterioration in his mental health presentation that led to a first referral to mental health services ten months prior to the timeframe for this review. Adult D was then admitted to inpatient mental health services eight months later; this admission continued into the time period of the review. Adult D's deterioration and unwillingness or inability to care for himself led to a decision by his partner that he could not go back to live with her as she was unable to care for his complex needs as well as work full time. Carers had been visiting but his needs outweighed the service that they could offer.

6. ADULT D KEY EVENTS/TIMELINE

Part One- Inpatient Mental Health Hospital

6.1. At the start of the review period Adult D was an inpatient in a Mental Health Hospital. Plans were underway for his discharge. In order to preserve his independence and to prevent building a dependence on others, the Occupational Therapy assessment had led to a recommended discharge to independent living. This, along with other assessments and observations, led to the Multi-Disciplinary Team (MDT) decision that Adult D could live independently.

[3] **Pancreatic exocrine insufficiency (PEI)** means the pancreas does not produce enough digestive enzymes to digest food properly. This means that [the] body does not get all the nutrients it needs, especially fat-soluble vitamins. This is called malabsorption. If malabsorption is not treated it leads to malnutrition. PEI is treated by taking medication containing the required enzymes with food. https://www.jpaget.nhs.uk/media/408365/Diabetes-and-Pancreatic-Exocrine-Insufficiency.pdf

6.2. Concerns regarding this arrangement were expressed by the Area 1 locality social worker and Adult D's partner due to issues regarding his management of self-care which had been an ongoing issue. There had been a discharge planning meeting to which the social worker and Adult D's partner were not invited.

6.3. A homeless application was submitted by the social worker as well as an application to a reablement centre to support Adult D prior to being rehoused. Adult D would need an address at the end of that placement as it would only be for six weeks.

6.4. A further discharge planning meeting to which the social worker and Adult D's partner were invited (Adult D declined to attend) agreed that Adult D's homeless application should continue, that reablement or care home were not options as Adult D did not have needs for care and he did not have any motivation to work with reablement services.

6.5. Although supported living options were looked at, Adult D could not be accepted to a specialist housing association. As Adult D had not had access to benefits, his income was not maximised and there were concerns regarding a shortfall to self-fund this placement. Adult D had access to a significant private pension so would be self-funding. Plans were therefore made to discharge as homeless to Bed and Breakfast (B and B) accommodation; other provisions were not available.

Part Two- Discharge to Bed and Breakfast

6.6. On the day of discharge, Adult D was accompanied to the homeless team offices by a member of staff from the ward. He was accommodated in Area 1 in B and B accommodation.

6.7. The social worker was on training for two days so was not available. Adult D received a follow up visit from the mental health crisis team the next day as per policy and planning. There was no reported evidence of mental illness. Adult D had indicated that he had no idea how he was going to structure his day. Adult D told the team that his partner was holding his money and had provided some food. Adult D declined any further follow up and so was discharged from mental health services.

6.8. On return from study leave the social worker visited Adult D and had telephone contact with Adult D's partner. Adult D's partner had reiterated that she was not able to support Adult D and was not prepared to visit the B and B. Adult D's partner told the social worker that it would upset her too much to visit with a risk she would want to have him back home. During the social worker visit there was evidence of food eaten but not any medication being taken. Adult D was advised of the importance of his medication. Adult D's medication was to support his nutritional status post his bowel cancer surgery and to manage his diarrhoea. The social worker gave Adult D their contact number and also left this with the B and B manager.

6.9. Adult D's partner was then in a position where she needed to provide money and food for Adult D, despite having said that she could not do this. She had stated that she could not have Adult D back to live with her unless he could evidence that he could care for himself. Long term housing options were still being explored.

6.10. One week after discharge, Adult D was refusing to take medication, had diarrhoea, was walking around naked; he was covered in faeces. The B and B manager called NHS 111 with the details of the concern. The

manager reported that this was ongoing for a few days; he had cleaned one room and offered Adult D another room. This was now contaminated with faeces too. NHS 111 agreed to send an ambulance. The mental health inpatient team agreed to review Adult D on the crisis assessment suite. On the way to the hospital, Adult D changed his mind as he stated that he would not be able to get home. Despite reassurance by ambulance staff that transport could be arranged, Adult D still declined to be taken to hospital. The ambulance crew formally assessed Adult D who was found to have mental capacity for this decision and so was returned to the B and B. The ambulance crew updated the social worker.

6.11. The social worker visited the next day. The social worker contacted the GP in Area 3 to request a GP to visit to assess Adult D's mental and physical health. Adult D had been placed in a B and B away from Area 3 and therefore the GP could not visit as it was out of their area. The social worker completed a temporary registration form for a local GP and took it to the surgery. The social worker also contacted the mental health crisis team, but the triage indicated that it was Adult D's physical health that was the main issue. Adult D stated that he was sick of taking medication but did take it during the visit and also made a sandwich. Adult D agreed to a referral to MIND[4].

6.12. Efforts continued to secure long term accommodation and ensure his income and access to any benefits had been assessed.

Part Three- Admission to the Acute Hospital

6.13. Six days after the previous visit by the social worker a further visit was attempted but Adult D refused to let the social worker in, so the visit was carried out the next day. Adult D was found incontinent and ill having not eaten, not passed urine and had swollen hands. He was conveyed to hospital by ambulance.

6.14. Adult D was admitted to hospital with Acute Kidney Injury[5] and noted to be dehydrated, malnourished and underweight. Adult D reported wanting to die. Adult D declined full mental health assessment and support from mental health services; he was assessed as having capacity to make this decision. Adult D was discharged five days later; he declined rapid response social care support.

Part Four- 2nd Discharge to Bed and Breakfast and Readmission to Acute Hospital

6.15. Adult D was visited by the social worker over the next few days with limited engagement; the social worker was purchasing food items. A joint visit took place with the Social Worker and Transformation Challenge Team (CT)[6] Adult D was assessed by the CT team; there was evidence of odour indicating incontinence again.

[4] MIND is a charity proving advice and support to empower anyone experiencing a mental health problem. MIND campaign to improve services, raise awareness and promote understanding. https://www.mind.org.uk/about-us/

[5] **Acute kidney injury (AKI)** is where your kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure. Common causes include severe dehydration.
https://www.nhs.uk/conditions/acute-kidney-injury/

[6] **Transformation Challenge Team** of community key workers provide intensive support to adults with a range of difficulties through a model of respectful engagement and by working with local specialist services to effect and sustain positive changes in and adult's life. The Service is commissioned by the local authority.

6.16. Five days later Adult D was again taken to hospital after having been lying in faeces and in a very neglected state. On arrival at hospital a safeguarding referral and incident form were completed. Adult D was admitted to hospital but was reluctant to be examined.

6.17. Again, Adult D was expressing a wish to die and although at first, he declined a mental health assessment, he later agreed. Adult D's mental health at the point of admission was one of low mood and symptoms of depression. Admission to a mental health ward was discussed but Adult D improved in mood over the next few days. Records at this time show that Adult D was to be treated under the Mental Capacity Act[7] if non-compliant with treatment.

6.18. Adult D's engagement with hospital staff, investigations and treatment remained minimal. He had refused to eat. His mental health mood deteriorated significantly, he was assessed and detained under Section 2 of the Mental Health Act.

Part Five- Transfer to Mental Health Hospital and back to Acute Hospital

6.19. Adult D's physical health improved following treatment and at that point it was felt that his greater need was his mental health; he was transferred to the mental health ward of the Mental Health Trust.

6.20. His physical health was managed by the physical health care nurse along with the physiotherapist, dietician, and occupational therapist of the Mental Health Trust.

6.21. Adult D's mental health responded well to the mental health treatment and his mood improved. Adult D's engagement with the physical health care team and therapists was intermittent and he soon started to refuse to eat and drink. He started to lose weight and his physical health declined rapidly. A week later Adult D was transferred back to the Acute Hospital on Section 17 leave[8] as his Mental Health Act section was still in place.

6.22. A week later, Adult D's Mental Health Act section 2 was allowed to lapse, and he was to be treated under the Mental Capacity Act and DoLs if necessary. A week later, social work responsibility was transferred to the mental health team as it was recognised that the support Adult D needed was outside of the remit of locality social work.

6.23. Four weeks after the admission back to the Acute Hospital, Adult D had gradually improved. His compliance with treatment, including use of nasogastric feeding had been mixed but he had started to gain weight and take oral diet. During this time Adult D was diagnosed with a large pulmonary embolus[9] and

[7] **The Mental Capacity Act 2005** came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future .https://www.scie.org.uk/mca/introduction

[8] **Section 17 MENTAL HEALTH ACT** section applies when a person is detained under the Mental Health Act. This section gives the responsible clinician power to grant leave for a specified period of time from the ward and the hospital. There are usually conditions attached such as returning on a certain day or at a certain time or staying at a particular place or in the care of a particular person. https://www.mind.org.uk/information-support/legal-rights/sectioning/about-sectioning/?gclid=CjwKCAjwxev3BRBBEiwAiB_PWFzk7Y_P19BStfhl6tk88qFd0J7Ip-ORk2DN3T-0rORJ0J8RzkQEoxoClykQAvD_BwE#collapse0df37

[9] **A pulmonary embolism** is a blocked blood vessel in your lungs. It can be life-threatening if not treated quickly. https://www.nhs.uk/conditions/pulmonary-embolism/

treatment was started. The safeguarding concern was closed as there were plans in place to keep him safe from self-neglect whilst in hospital.

6.24. Adult D was still weak and frail and often needed prompts for self-care, but plans were underway to assess the type of ongoing care and housing Adult D would benefit from. Assessment for NHS Continuing Healthcare and NHS Funded Nursing Care[10] was commenced.

6.25. Adult D was offered the services of an advocate to support him with his decision making; he declined stating that he felt able to make his own decisions and to voice concerns if he had them.

Part Six- Transfer to Primary Care Hospital

6.26. Five and a half weeks after being transferred to the Acute Hospital, Adult D was assessed as well enough to continue assessments for his future needs in a Primary Care Hospital 'discharge to assess' bed. Adult D had initially refused to leave the Acute Hospital but did agree to move later on the same day. The Primary Care Hospital was the same Hospital NHS Trust as the Acute Hospital but was in Area 1. It was recognised that this was not an appropriate bed type due to being covered by therapy staff and not medical staff; Adult D was moved to an older person's medicine bed with medical consultant cover.

6.27. Adult D continued to fluctuate in mood, self-care, eating and drinking. He had several visits from various teams, i.e., mental health affective disorders team, social care transformation challenge team as well as the mental health social worker. During this time the social work responsibility switched to the older people's mental health team who also visited Adult D.

6.28. A potential housing placement was found that would offer supported care. Adult D and his partner felt that residential care would be required to prevent the self-neglect that occurred before.

6.29. Concerns again turned to Adult D's weight loss and his frailty. Adult D was eating on and off and had been seen by the dietitian and prescribed supplements, but he refused them.

6.30. The chronology for this review shows that Adult D underwent a neurological CT scan. The senior psychiatrist felt that there were indications of a degenerative brain disorder[11] from which Adult D would not recover. The senior psychiatrist told Adult D that he had brain shrinkage and was possibly suffering from a type of dementia affecting his physical and social functioning. Adult D was 'very shocked'.

6.31. The senior psychiatrist spoke to the medical consultant regarding the potential diagnosis and physical health care that may be required. The medical consultant reviewed Adult D and planned to take over as lead for physical health care. Following this a Do Not Attempt Resuscitation order was applied. Two days later the ward staff discussed this diagnosis with Adult D's partner.

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[10]The Continuing Healthcare Checklist and the Decision Support Tool form part of the National framework for NHS continuing healthcare and NHS funded nursing care https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

[11] **Degenerative brain diseases** are caused by the decline and death of nerve cells called neurons. These diseases are progressive, meaning that the condition worsens over time as greater numbers of neurons in the brain die. As the brain gradually deteriorates, the patient loses intellectual function in key areas like speech, memory and spatial skills.

6.32. Adult D started to refuse all meals and interventions including insertion of a NG tube; he later did agree to the tube feeds. Adult D was also now doubly incontinent.

6.33. The neurological review, seven days after the scan, identified that Adult D's symptoms were not indicative of a degenerative condition but that it was his severe depression that was driving his current behaviour and presentation. The Do Not Attempt Resuscitation order that had previously been put in place was rescinded at this point. The senior psychiatrist apologised to family and other staff for the misdiagnosis.

6.34. In the absence of a degenerative brain condition diagnosis and affirmation that it was Adult D's mental health that was causing his presentation, he was assessed and detained under Section 3 of the Mental Health Act. The Primary Care Hospital is not registered by the Care Quality Commission for assessment or medical treatment for persons detained under the Mental Health Act 1983. When this was highlighted a week later, Adult D was reassessed and it was found that further detention was not necessary.

6.35. Adult D continued to refuse all oral intake and was fed and medicated by NG tube. His frailty and increasing physical health decline were considered to be so severe that transfer to the mental health or Acute Hospital was not possible and that he could receive the required care where he was.

6.36. The situation continued with no real improvement in Adult D's physical or mental health. The NG tube came out and Adult D refused to have it reinserted. He started to eat some food, but this was sporadic and of minimal amounts. Adult D told the social worker that he knew that he would die if he did not eat and that he was happy with this as he was exhausted.

6.37. A Safeguarding Concern was raised by the safeguarding lead in the Acute Hospital regarding the care and treatment that Adult D had received. A safeguarding meeting was planned regarding whether Adult D was in the right place, as well as a closer look at the circumstances that led to the detention. The safeguarding meeting took place four days later where it continued to be agreed that Adult D was too ill to move to the Acute Hospital.

6.38. Despite that meeting and discussions, the next day there were further discussions regarding the need for a Mental Health Act assessment. Adult D's physical health was deteriorating leading to a decision with Adult D he would receive active treatment, but that invasive resuscitation would not be in his best interests.

6.39. Later that morning, after breakfast, Adult D requested to return to bed, he was assisted to do this. Adult D collapsed, deteriorated and died. The coroner recorded a verdict of death from natural causes.

7. AREAS FOR LEARNING AND IMPROVEMENT

7.1. In considering areas for learning and improvement, questions and considerations were explored using the framework identified in Appendix 2. Four virtual small group multi-agency workshops were facilitated, each concentrating on one theme. The stage one report offered hypotheses for each theme to enable wider exploration within the workshops. The discussions resulted in analysis of strong practice leading to identification of where areas of practice need further strengthening.

Assessment Care and Review

7.2. It appears that staff across several agencies knew Adult D very well. They were aware of his background and therefore knew that the person they were offering care and services, to be a very different man from the one that they would have seen 18 months previously. This was strong practice and meant that staff understood the nature and complexity of supporting and caring for Adult D.

7.3. Adult D was assessed, treated and cared for by both the Mental Health Trust and the Acute Hospital Trust. He was also assessed and supported by Adult Social Care. The evidence for this review suggests that the assessments undertaken were good and in line with what would be expected. How these three services interacted and worked together will be analysed in this section.

7.4. Adult D was admitted to the Acute Hospital on several occasions during the timeframe of the review due to physical health concerns and presentations suggesting self-neglect. The review has identified that Adult D had significant physical health issues that were exacerbated by his seeming lack of motivation to self-care, and not taking his medication, so much so that self-neglect became the biggest issue that brought him to hospital. It became apparent that Adult D's physical health issues impacted on his mental health. On his first admission to the Mental Health Hospital, Adult D improved. He was noted to be able to self-care and the formulation[12] at that time was that he had choice and control over his self-care and plans were made for discharge. It was noted that Adult D's diarrhoea stopped when he took his medication appropriately, therefore not taking his medication suggested that he knew this would lead to diarrhoea.

7.5. Adult D's partner told the author that, having been told by mental health staff that he had some control over his behaviour and that she needed to step back, doing so is now a huge regret for her. There were several formulation meetings regarding a diagnosis of Adult D's mental health presentation. It was discussed that Adult D appeared to have a reliance on others, increasing the speculative formulation regarding personality disorder. This was not applied as a definitive diagnosis. On second admission to the Mental Health Hospital, Adult D's mental health had deteriorated, and he was diagnosed with a significant depression.

7.6. Adult D's lack of willingness to self-care due to his mental health issues led to detention under the Mental Health Act to enable assessment and treatment. Adult D's depression in this period required extensive treatment in order for him to improve.

7.7. On each admission episode and particularly the last one, it was Adult D's physical health care needs that were the most pressing with physical health care and treatment given. Following improvements in physical health it was then Adult D's mental health that took over as being the priority need. This led to him being transferred to the Mental Health Hospital. Physical health care continued to be given within the Mental Health Hospital by the mental health team that included a physical health care nurse, occupational therapist, physiotherapist and dietician who all supported Adult D, albeit that he was refusing mostly to

[12] **Formulation** is a way of understanding mental health difficulties. While diagnosis has traditionally been viewed as an essential concept in medicine, particularly when selecting treatments, we suggest that the use of diagnosis alone may be limited, particularly within mental health. The concept of clinical case formulation advocates for collaboratively working with patients to identify idiosyncratic aspects of their presentation and select interventions on this basis. Identifying individualized contributing factors, and how these could influence the person' s presentation, in addition to attending to personal strengths, may allow the clinician a deeper understanding of a patient, result in a more personalised treatment approach, and potentially provide a better clinical outcome.

engage with those professionals.

7.8. Ultimately, Adult D's mental health would improve with treatment, and it was then physical health that deteriorated to such an extent that this again became the priority need and he was transferred back to the Acute Hospital. Adult D then progressed to be well enough for plans to commence regarding his discharge, to consider ongoing support and accommodation needs. Adult D transferred to a Primary Care Hospital bed where assessment could continue, and accommodation be sought.

7.9. A decision was made that Adult D required a community mental health team in preparation for discharge and he was duly accepted by the Affective Disorders Team who saw Adult D in the Acute Hospital. This was evidence of good practice in order use the best fit team, albeit that Adult D was an inpatient and was also being reviewed by liaison psychiatry.

7.10. Adult D and his partner were then told of the degenerative disease diagnosis; this had a negative impact on him as he thought that his death was approaching. It appears that the senior psychiatrist had discussed the potential diagnosis with ward staff and suggested that a treatment plan would be needed if the diagnosis was confirmed. The senior psychiatrist informed Adult D of the brain scan showing 'brain shrinkage'. It had been agreed that it would be ward staff that would inform the family of the diagnosis. A Do Not Attempt Resuscitation order was immediately agreed with Adult D. This diagnosis was then not confirmed by the neurologist, but the impact on Adult D along with his prior tendency for lack of motivation to self-care again took over and he deteriorated mentally and physically. The Do Not Attempt Resuscitation order was rescinded.

7.11. Throughout all of this time, Adult D was seen by several physical health care consultant teams, and mental health teams and his social work support passed from locality adult social care, to mental health social work and then to the older persons team. He was also known to other social work teams from Area 1 and 2 as identified in Section 5.

7.12. Throughout the review period, there was good use made of multi-disciplinary team meetings and liaison together in order to plan jointly and share assessments. Ultimately though, with the needs of Adult D escalating and changing regularly, it was difficult for all professionals to keep updated, particularly those that were in the community setting.

7.13. Each organisation working with Adult D had access to their electronic recording systems, so each professional was able to view inputs from other professionals within their agency. When Adult D moved to be a patient in the Acute Hospital it would be the liaison psychiatry team attached to the hospital that would take over his mental health care. This worked well from the professionals' point of view because of access to the electronic records that covered all of Adult D's mental health input.

7.14. When Adult D was a mental health inpatient, however, although contact was made with the Acute Hospital consultant teams, they did not see him in the Mental Health Hospital.

7.15. Social work teams have reflected that they should have reduced the need for change of social worker as often as they did for Adult D. Following transfer from the Mental Health Hospital to the Acute Hospital in phase five he was referred from the locality social work team to a mental health social worker. Later, he was transferred to an older person's mental health team in phase six. In hindsight it would have been

better for Adult D to have been transferred straight to the older persons mental health team as this would have reduced number of changes in social work.

7.16. The review has identified learning for improvement that would have made practice stronger that can be applied to future practice. In cases such as this, it is important to consider having regular Multi-Disciplinary Team meetings that include as many professionals involved as possible so that all thoughts and support can be shared widely. It means that the team of professionals build strong working relationships enabling question and challenge of each other. This should also include appropriate family members and carers and identified advocates. Currently, as professionals as well as families have got used to video technology for meetings, this could also be utilised to ensure wide attendance without the need for travel from site to site.

7.17. When there was a suspected diagnosis of a degenerative brain disorder, it would have been stronger practice for the key consultants and professionals to meet together to formulate a plan that would include, confirming diagnosis and care and treatment in a coordinated way. This information could have then been delivered to Adult D and his partner and family in a way that recognised the impact that such a diagnosis may have on a person who is frail and vulnerable. There should be recognition that the suspected diagnosis could have been made very clear i.e. that this was only suspected and would be further confirmed by a neurologist and when the neurologist would undertake a review. In that way care would have been transparent but clearly only a working diagnosis that could have then been given as good news when it was not confirmed. As it was, the immediate discussion with Adult D and the application of a DNAR gave a very grave message to Adult D.

7.18. The potential diagnosis was given in good faith and it is important not to apply hindsight bias to this situation. Had the diagnosis been confirmed then the open and honest approach would have been strong practice. It should also be noted though that the review from the neurologist with the confirmation that Adult D's presentation was not one of a degenerative brain condition was only six days later. There is further learning applied here that at least the DNAR should have not been made so swiftly.

7.19. The Social Care Institute for Excellence (SCIE) warns against use of hindsight bias stating that it is an obstacle to learning[13]. Knowledge of the outcome biases our judgment of the process that leads to the outcome. That leads us to oversimplify the situation confronting the professionals at the time. SCIE also identifies that decisions or actions that are followed by negative outcomes are judged more harshly than those with a neutral of more positive outcome. In this case, however, the assessment made on the day was that there was no risk from mental health illness. Adult D had support from a locality social worker whose role it was to support his social needs in the community.

7.20. There is learning regarding GP visits when a patient is housed away from their original area of residence. When Adult D was resident in the B and B, a social worker requested for a GP to visit to see Adult D as there was a concern regarding his condition; the practice in area 3 stated that as he was no longer resident in their area that a visit could not be undertaken. On discharge, it was not recognised that his old practice would not visit and that he would need to be registered with a new practice. This should have been part of

[13] **SCIE:** Safeguarding Adults Reviews (SARs) under the Care Act https://www.scie.org.uk/safeguarding/adults/reviews/care-act#:~:text=Hindsight%20bias%20poses%20a%20great%20obstacle%20to%20learning%20through%20SARs.&text=Knowledge%20of%20the%20outcome%20biases,were%20involved%20at%20the%20time.

the discharge plan and been undertaken as soon as he was discharged and may have prevented emergency services being required on some occasions within the time he was at the B and B. Temporary registration forms were completed for a local practice which the social worker took to the practice, but this was after the area 3 practice had declined to visit. At a further call to 111 that resulted in paramedics attending, the paramedics questioned why the GP had not been called. The social worker stated that there was no GP and having called NHS 111, the decision had been for paramedic response.

7.21. There is learning here for agencies in that the social worker could have called the GP that had received the temporary registration forms as that had been nine days previously. Adult D could have been visited by the Area 1 GP practice as a temporary patient; the practice, have stated that they have no record of Adult D. It has not been possible to understand why the GP practice had no record of Adult D. It appears that as forms are paper forms, they may go astray before being processed.

7.22. The continual move between hospitals and organisations caused discussion within the review. There is work underway within the Acute Hospital and Mental Health Trust to offer more holistic care under the 'Parity of Esteem'[14] initiative called 'Treat as One'. The author has seen initial work and notes that it should strengthen practice. Additional strengthening would need to consider how Adult Social Care can be involved. Assurance will be needed, that where mental and physical health are causing significant issues for a person, one is not prioritised over the other. Consideration must be given to ensuring that a person does not necessarily need to continue moving between hospitals where it is at all possible and that both physical and mental health can be managed in one bed/unit with all specialisms working more cohesively.

7.23. During the workshop and within investigations that have been undertaken by agencies following the death of Adult D, it was agreed unanimously that the transfer to the Primary Care Hospital was not the right decision. As Adult D deteriorated, his physical health care needs were more than the Primary Care Hospital were used to managing. When Adult D's mental health deteriorated, he was assessed and detained under the Mental Health Act to the Primary Care Hospital. Both of these situations should have been managed within the Acute Hospital.

7.24. Improvements have already been made to ensure only those with needs that can be met by the Primary Care Hospital are transferred there. These include that a consultant from the older persons team at the Primary Care Hospital will assess all patients that have been referred for transfer to ensure their needs can be met.

7.25. The Primary Care Hospital is not registered for the regulated activity of administering the Mental Health Act meaning that it cannot be used to detain patients to. There were ongoing debates between

[14] **'Parity of esteem'** is defined as 'valuing mental health equally with physical health', which would result in those with mental health problems benefitting from:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users
- equal status in the measurement of health outcomes.

The term is used primarily in England and isn't commonly in use outside the UK. The previous government's 2011 mental health report *No Health Without Mental Health* included reference to parity of esteem for the first time, and following on from this, it was enshrined in the Health and Social Care Act 2012. https://www.mentalhealth.org.uk/a-to-z/p/parity-esteem

professionals regarding this with some believing that all hospitals would be registered for this activity.

7.26. The registration details on the Care Quality Commission website for the Acute Hospital Trust (who the Primary Care Hospital belongs to) are clear that the Primary Care Hospital does not have administration of the Mental Health Act as part of its recorded regulated activities. The Primary Care Hospital staff did not know that they could not care for a detained patient and accepted the Mental Health Act detention paperwork, adding to the belief by the Mental Health Act assessing professionals, that the detention was in line with usual processes. As the paperwork had been accepted by a professional who did not know the process and was not trained in the administration of the Mental Health Act, the paperwork was not scrutinised for possible errors and Adult D was not read his rights, both of which are requirements of the Act as set out in the Mental Health Act Code of Practice[15]. When the mistake was recognised, Adult D was reassessed as required under the Act and Code of Practice.

7.27. Approved mental health practitioners indicated during this review, that there has been a lot of learning across their service regionally with regard to hospitals that may not be registered for administration of the Mental Health Act. This message will need strengthening as part of the learning from this review. The Acute Hospital Trust have investigated and shared learning with regard to this issue to ensure that the Primary Care Hospital is not used as a detaining hospital again.

7.28. The review was informed that, on this occasion, Adult D was sectioned under the Mental Health Act in order to feed him; this detention did not continue past seven days. The review has not found recorded evidence that Adult D was fed or medicated against his wishes per se. The tube was used to feed overnight prior to the Mental Health Act Assessment and there was no evidence that Adult D had stated that he did not want the tube to be used for feeding or for medication post assessment. He was aware of why the tube was being inserted and he agreed to have it inserted. When the tube then came out, he did ask for it not to be reinserted and he did start to eat small amounts.

7.29. There were questions raised within the review regarding how Adult D was assessed as requiring detention within the Primary Care Hospital and why seven days later, when it had been recognised that the hospital was not appropriately registered for this, his further assessment deemed that he was no longer detainable and could therefore stay within that hospital. This was looked into in depth to ensure that on both occasions the Mental Health Act assessment had been administered appropriately based on Adult D's presentation each time. Adult D was not taking any oral food and had refused medication on the first occasion as his mental health was deemed to be impacting on his motivation to eat. On the second occasion Adult D was in agreement with eating and tube feeding where he could not eat, hence no longer detainable to be fed.

7.30. The Mental Health Trust have identified learning in recording more details of the rationale for detention or no detention rather than just the outcome of the assessment. This will help others reviewing detentions in understanding the rationales rather than a merely factual perspective.

7.31. With regard to the scans that had showed that Adult D's brain was shrinking, there was no clarity as to the cause and diagnosis. There were differing thoughts regarding possible causes expressed i.e. starvation or a

[15] Department of Health (2015) Mental Health Act (1983) Code of Practice TSO available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

type of dementia. Adult D's partner told the author about some of the behaviours that could have been indicative of dementia. A consultant psychiatrist attending the workshop indicated that severe depression could also cause a person to display dementia type behaviours in forgetting how to undertake simple tasks. It was accepted that this could be confusing for professionals and families and required clearer communication. There was a general agreement within the workshops that professionals could have worked differently. More opportunities to share their thoughts, including that Adult D was approaching end of life (not withstanding that the diagnosis of brain degeneration had been excluded), could have supported greater partnership working. In attempts to ensure that Adult D had all the mental and physical health care that he could be given in order to preserve life, an objective view that Adult D was going to die was not the overarching picture. This meant that end of life care planning (even as a parallel plan) was not put in place until it was too late for Adult D and his family to prepare for his death. It was felt on discussion in the workshops that this was more evidence for mental and physical health care teams alongside social workers, to work more closely together. Adult D's family told the author that they needed longer to prepare for his death. This will be further discussed later in this report.

Points for stronger practice:

- Regular MDTs that draw in other agencies can enhance multi-agency working, communication and challenge. Use of virtual meeting technology can facilitate and enhance attendance.
- Incorporating question and challenge into MDTs leads to stronger working relationships and shared understanding of care, issues and diagnoses.
- The 'Treat as One' model could provide assurances that where mental and physical healthcare needs are of equal issue, a person can be managed in a person-centered collaborative team approach. Caring for patients in the right place at the right time should mean that one element of care does not get treated at the expense of another. E.g. mental and physical health care
- Recognition that not all hospitals are registered for the purposes of administration of the Mental Health Act needs strengthening to ensure that the Mental Health Act is administered appropriately.
- Sharing detail of assessments and observations that lead to formulations may help other professionals and families to accept a view about working or speculative diagnoses.
- Potential life limiting diagnoses should always lead to careful consultation and planning regarding imparting this information to patients and families if this is to be done before diagnosis is confirmed.

Mental Capacity Act

7.32. This section will address application of the Mental Capacity Act when working with Adult D. This theme cuts across all other sections and was a complex area for professionals in discerning whether to use the Mental Capacity Act or the Mental Health Act in order to ensure that Adult D was able to receive life preserving treatment.

7.33. There appeared to be clarity as to when Adult D's mental health was the driver in his refusal of treatment. It is also true that Adult D's decisions to refuse treatment or that his lack of motivation to self-care, was mostly deemed to be capacitous.

7.34. It can be understood how difficult it is for practitioners who find themselves in these situations. Those who work in health and social care are caring professionals who want to be able to treat and care for people, putting their clients'/patients' health and well-being as of utmost importance at all times. The Mental Capacity Act upholds that people with capacity should be able to make their own choices, with support if necessary, even if those choices are deemed unwise by others.

7.35. Difficulties in this case arose because the situation would vary from hour to hour and day to day. For example, one day Adult D wanted to be left alone and refused to eat or be fed by tube, then later would change his mind. In exploring this at the workshops, it was identified that there was a general understanding of the Mental Capacity Act, as issues related to whether Adult D had the capacity to refuse food or medicines was recorded. This was strong practice. It is the case however, that there was very little recording of formal mental capacity assessments.

7.36. Practitioners work from the presumption of capacity, as required by the Act. When so many decisions appear to be 'unwise', capacity should not always be assumed without assessment. Therefore, to strengthen practice in this area, there should be a focus on the recording of formal assessments of mental capacity, particularly in complex cases. It may also be beneficial to draw together a summary of the number of unwise decisions being made for discussion in MDTs or other appropriate forums e.g. Supervision. This may provide an overview as to whether the number of unwise decisions is significantly increasing risk and necessitating a formal review of mental capacity exploring both decisional and executive capacity.

7.37. There is also some evidence of statements such as 'has capacity' without it being clear what decision the statement was made in relation to. The Mental Health Trust has identified this as learning for their organisation.

7.38. The Ambulance Service has put in considerable resources to ensure that staff have clarity regarding the requirement to formally assess and record capacity assessments appropriately. An ambulance service audit had shown that there were too many assessments being submitted without correctly applying the legislation. Following an extensive training programme, a subsequent audit showed a reduction in the quantity but an increase in the quality of the submissions. Other agencies have stated that they do not see these assessments recorded in handover documents or onward referrals. This will be subject to a single agency recommendation.

7.39. The issue as to whether Adult D had ever been fed against his wishes also caused debate in the workshop in relation to his capacity to decide to eat or not. The outcome of this was a recognition that Adult D did not want to eat for varying reasons. One was that because food went straight through his body and increased his incontinence, another was that he stated that he did not want to continue living and knew that if he did not eat, he would die. A further reason was that Adult D found the NG tube uncomfortable and that he could not swallow well or enjoy food with it in place. Not wanting to eat or be fed by NG tube could have been seen as making an unwise decision, professionals at the workshop reflected that his decision may have been understandable but was not formally assessed and recorded with Adult D's rationale for not wanting to eat.

7.40. The chronology provided for this review, suggests that when Mental Health Act sections lapsed or were discharged, that the Acute Hospital staff were advised by mental health staff to use the Mental Capacity

Act, Deprivation of Liberty Safeguards (DoLs) in order to ensure that treatment could continue. The review did not find evidence that there was an application for a DoLs although it was included in plans, as a suggestion, if required. Given that Adult D was mostly deemed to have capacity regarding the decisions he was making, it would not have been possible to apply for a DoLs as that is only legal for a person who lacks capacity.

7.41. More formal mental capacity assessments may have identified that, on occasion, Adult D did not have capacity to decide on his care and treatment. It seems that Adult D had fluctuating capacity and wishes and feelings which made the situation difficult. In Adult D's case, it would be unlikely that a DoLs would have been appropriate. In cases of fluctuating capacity, DoLs is only appropriate when there is a general lack of capacity that only returns momentarily.

7.42. It can be seen that when Adult D's mental health illness was severe that he may not have had capacity or understood reality or made decisions that he would when he was otherwise well. The Mental Capacity Act states that you should not make decisions to treat someone that they would not usually make when they had /have capacity. This does not preclude proceeding in best interests. This means that even when someone has severe mental health illness that is affecting their decision making, that you should not ordinarily be giving treatments that they would have refused when they were mentally well and had capacity unless it can be carefully assessed and recorded that it would be in their best interests to proceed. It can be suggested therefore that it was important to know what Adult D really wanted to happen at a point when he had capacity so that there was clarity regarding his capacitous wishes and feelings. At the point that this review was undertaken, no one really understood why Adult D did not want to self-care, refused to eat and was reluctant to be tube fed. Latterly, when he was suffering a considerable depressive illness, it was felt that the reason for the continued self-neglect was down to this.

7.43. The Mental Health Act only allows a person to be treated for mental health illness and not physical health illness. The Mental Capacity Act therefore always has to be followed when treating a person for their physical health when they are physically unwell. In the case of Adult D, however, it was his mental health that was preventing him from eating and causing physical health symptoms, therefore the Mental Health Act was appropriate to use under those circumstances. (Considerations of further use of legal routes are discussed in the 'Safeguarding' Section)

7.44. Other provisions of the Mental Capacity Act include the support of an Independent Mental Capacity Advocate (IMCA). Adult D was offered advocates on two occasions (not IMCAs); both of these were refused. It was very clear however, that although Adult D's partner told the author that she often felt not listened to, that she was his advocate and therefore a formal IMCA was not appropriate. Even when Adult D's partner was advised to step back to encourage Adult D to do more for himself, she continued to advocate for him during her contacts with agencies. All professionals noted that Adult D was happy for his partner to undertake that role.

7.45. When discussing this with Adult D's partner during the review process, she stated that although she was able to challenge and advocate for Adult D, she did not feel well supported in her own right as a carer. Adult D's partner requested that consideration is given to this issue. Adult D's partner told the author that she was articulate and able to challenge any issues that she was not comfortable with. Adult D's partner felt, however, that it would have been helpful if she had been signposted to carer support networks and that those less able than herself would definitely need this type of support. The Care Act is clear regarding

the support that carers are entitled to. It may have been that as Adult D's partner was able to articulate her concerns that support networks were not thought to be necessary. This leads to learning and a recommendation.

7.46. When complex situations arise, it is advisable for professionals to seek support from senior managers, safeguarding leads and legal professionals to ensure that all avenues have been explored and to make sure that actions remain lawful and that any legal options can be explored. There is no evidence within the chronologies that this input was sought on further use of the Mental Capacity Act nor was there a full assessment of whether Adult D had the capacity to decide that he did not want to accept treatment. His decision appeared to be that he did not want to continue living but again this fluctuated and there was no clarity that Adult D was intending to end his life by refusing to accept care. There is evidence that he knew that he could die if he did not eat. On occasions he did talk about the future and talked about wanting to feel better but often presented as exhausted with life. Professionals needed to explore whether there were legal grounds to treat him against his wishes. Advice of this nature was sought much later and very close to the time that Adult D died.

Points for stronger practice:

- The Mental Capacity Act assessments provide the rationale for respecting the wishes of people who retain capacity albeit they are consistently acting in ways that others may deem unwise.
- Mental Capacity assessments must be carried out formally and recorded robustly to comply fully with the Mental Capacity Act**.**
- Where ongoing concerns or issues of capacity and unwise decisions are being made, gathering summaries of the quantity of those, early support and legal advice sought can support professionals who may be struggling to understand their role in preserving life or when someone is self-neglecting.
- All carers, regardless of their apparent skills in supporting the person they care for, benefit from signposting to support services, particularly those who are advocates for the person.

Discharge Planning and Housing

7.47. Prior to the timeframe for this review, Adult D had been admitted to the Acute Hospital following concerns for his physical health. He was living with his partner at that point who stated that she was not able to have him home as he had become difficult to manage, not self-caring, up often in the night and incontinent at times. Whist his partner had been on holiday, Adult D was cared for in a care home but had returned to live with his partner on her return. During Adult D's admission, the hospital social worker was exploring housing solutions.

7.48. As Adult D was ready for discharge from the Acute Hospital, various discharge options were discussed with him which included a flat with 24 hour supported care. Adult D, however, was very low in mood and was seen by the mental health team and offered admission to a mental health inpatient bed for assessment and care. Adult D and his partner were in agreement with this and he was transferred where he remained until his discharge within the time frame of the review.

7.49. Once in the Mental Health Hospital, immediate work started to find suitable accommodation options. These were led by the Mental Health Hospital social worker whose role was to support patients in addressing their housing needs. The 24-hour supported living option found when Adult D was in the Acute

Hospital was cancelled when the decision to admit to the Mental Health Hospital had been taken and was no longer available.

7.50. Various options were explored including care home and privately rented accommodation. Once a referral was received by locality social work, and a needs assessment was undertaken it was identified that a care home would not be suitable as Adult D did not meet the criteria for needing a care home and that he needed to be encouraged to self-care rather than be cared for.

7.51. Adult D only sporadically engaged in discharge assessments. Adult D was not able to access reablement services as it was deemed that his non-engagement would make any work futile.

7.52. A discharge planning meeting attended by the social worker had agreed that a further meeting would be held to update everyone on plans for discharge. A 'duty to refer'[16] referral had been sent by the ward to housing services. This was good evidence that new housing legislation was embedded and being actively applied. It was recognised that Adult D had limited day to day support in the community, and that for access to any supported housing he would need his benefits and finances assessing to enable funding decisions. Adult D's partner reiterated that he could not return home.

7.53. At the further meeting there was no invitation for the social worker or Adult D's partner. Adult D's discharge was agreed; as he was homeless, this was known to be likely to be to B and B accommodation. Adult D was not deemed as having a need for community mental health services but would have the follow up visit undertaken as is required practice. A further meeting was convened to finalise all arrangements with the social worker and Adult D's partner present following concerns expressed by Adult D's partner and social worker that they had not been at the previous meeting. It appears that there was a fine balance in that continued hospitalisation was seen as harmful by the psychiatry team, as at that point Adult D had been assessed as being able to self-care when he chose to, but the social worker and Adult D's partner were expressing concerns about his level of motivation to self-care.

7.54. Housing services were receiving information updates via the social worker and alternative housing options were being explored. It seems that the Multi-Disciplinary Team (MDT) decision to sanction a B and B was not the best option for Adult D. During the workshops the role of housing was considered. It became apparent that housing colleagues felt that they could have been involved much sooner when it was realised that at the point of discharge, it was known that housing solutions were needed for Adult D. As a result of the workshop, the Mental Health Trust inpatient services where Adult D was a patient, were going to be identifying a system to resolve this and ensure that housing were involved in MDT meetings where housing was a likely issue. This is strengthening practice as part of the review process.

7.55. It was identified at the later stages of this review that there is a new pathway, Provision of Accommodation for Homeless People with Mental Health Needs, that would seem to provide a solution to the involvement of housing much sooner and requires MDT meetings. It has only just been launched at the time of writing

[16] **Duty to Refer**: Under section 213B of the **Homeless Reduction Act (2017)** the public authorities specified in regulations are required to notify a housing authority of service users they consider may be homeless or threatened with homelessness (i.e. it is likely they will become homeless within 56 days). Before making a referral, a public authority must:
(a) have consent to the referral from the individual;
(b) allow the individual to identify the housing authority in England which they would like the notification to be made to; and,
(c) have consent from the individual that their contact details can be supplied so the housing authority can contact them regarding the referral.

this report. Audit will be required to judge professionals' knowledge and use of the process alongside its efficacy. If it appears successful, this model will benefit other areas of the Teeswide Board area.

7.56. The 48-hour follow-up visit by the crisis mental health team identified that, although Adult D stated that he had no idea how he was going to structure his day and had no support, his mental health was assessed as not at risk and he was discharged from mental health services. It was debated that this decision was premature as it was very early days for Adult D in the B and B. The author would consider that this would be another occasion that could be application of hindsight bias and therefore the decision should not be necessarily seen as premature.

7.57. As described in Section 5 of this report, Adult D's self-care quickly deteriorated as did his mental health. Despite the efforts of the social worker who visited Adult D regularly to try and identify other services that could support and encourage him to wash, eat and take his medication, his self-care was very erratic.

7.58. Adult D's partner was left in a situation where she was having to support him albeit that she stated that she could not do this if he was in B and B accommodation as it would be emotionally difficult to see him in such circumstances.

7.59. Plans to discharge to specialist supported housing had not been possible due to Adult D having a substantial pension income. This meant that Adult D would not be able to access usual benefits and would have to pay for the placement. Due to the expense of this provision, Adult D would eventually run out of funds.

7.60. There was a possibility of Adult D claiming Personal Independence Payment (PIP)[17] but the process was not started as Adult D had already been discharged when the Mental Health Trust social worker attempted to visit Adult D on the ward to start the process. Welfare rights had a conversation with the Local Authority social worker on the same day as discharge but again, as Adult D was discharged the process was only started once in the B and B when it became apparent that supported housing was possibly still the best option for Adult D. At that point Adult D had become too unwell to speak to the Department of Work and Pensions to start the process, which is a requirement for the claim to be started. Ultimately Adult D was readmitted to hospital and was not discharged again so the PIP was no longer required.

7.61. It does not appear that there was any resolution to the impasse between Adult D's improved mental health, meaning he was no longer benefitting from hospital admission, and the fact that Adult D had limited motivation to self-care, take medication etc. This seemed compounded in a B and B situation where there were limited facilities and no one to prompt self-care and taking of medication. This was explored during the workshops and as previously stated, assessments had identified that Adult D did have the ability to self-care.

7.62. This review raises concerns regarding the impact Adult D's stay had on a B and B and the manager. The manager was given contact numbers for social work and on two occasions was required to call services after having found Adult D needing support. The first occasion was just 8 days after discharge. The landlord had already deep cleaned one room and given Adult D another because of faecal contamination. Now a

[17] **Personal Independence Payment (PIP**) can help with some of the extra costs if a person has a long-term ill-health or disability.

second room had become contaminated. Adult D refused admission on this occasion. Each time a room was cleaned, Adult D's partner paid the costs of this.

7.63. On the second occasion an ambulance was called, Adult D was discharged six days later back to the B and B. Each time the landlord called services the situation was worse than the one before, leading to the final admission when Adult D was significantly unwell both mentally and physically.

7.64. The author spoke to the manager of the B and B who stated that the B and B was used to taking homeless people and providing support. Rooms at the B and B have sinks, shared bathroom facilities and access to kitchens to cook meals. The manager felt that services responded well when he asked for help for Adult D but did feel that there needed to be support 24 hours a day as he had to stay and watch Adult D out of hours some of the time as he was worried. The manager stated that they have no information provided to them regarding homeless people they are taking and said that some limited information before a person arrives would be helpful. This review would suggest that consent to share relevant information with managers of B and B's should be sought as part of the discharge planning process; housing officers could then share this information when the tenancy starts. As there was a social worker in this case, that information could have been shared in that way too.

7.65. The author would suggest that professionals did not appear to be able to manage the situation and that the final admission was inevitable as the issues that Adult D faced and presented with did not improve; they got worse. During the workshops, it was recognised that wider MDT meetings may have addressed the housing needs of Adult D more collaboratively.

7.66. It was agreed during workshop discussions that one of the issues was that there was no suitable step-down provision between acute mental health inpatient beds and discharge to community, especially where there are care and support needs that have not been addressed. In the case of physical health care, such beds exist providing a place of safety and support whilst alternative accommodation and care packages are sought. This prevents Acute Hospital beds from being used for those who no longer have the need for Acute Hospital healthcare but are not ready for discharge. No such provision exists for mental health. If Parity of Esteem is truly to be met, then this gap should be explored in more detail and solutions found. It is a known fact that there is a national shortage of mental health inpatient beds; situations like the one that Adult D found himself in, mean delays in discharge. Although mental health colleagues state that they would not discharge someone without suitable provision, there were those that expressed concern regarding the decision to discharge to the B and B.

Points for stronger practice:

- Involvement of Housing Colleagues in MDT meetings from an early stage may improve discharge planning options.
- Sharing and embedding new processes for housing solutions for mental health inpatients may improve access to appropriate housing that meets a persons' needs.
- There would be a benefit from exploration of stepdown provisions for mental health patients where housing and other social issues need resolution before a safe discharge.
- Early assessment of financial position could improve understanding of access to housing solutions.
- Sharing information with housing provider managers may help to support people who are likely to have some care needs.

Safeguarding and Self Neglect

7.67. There were many aspects in the last 18 months of Adult D's life that indicated self-neglect. Self-neglect is defined in the Care and Support Statutory Guidance[18] as:

> 'a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

- Lack of self-care (e.g., neglecting personal care, hygiene and health; poor diet and nutrition) and/or,
- Lack of care of their domestic environment (e.g., neglecting home environment, hoarding and excessive clutter) and/or,
- Refusal of services that could mitigate the risk to safety and well-being (e.g., lack of engagement with health and/or social care staff and other services/agencies)

7.68. This identifies that Adult D fitted the criteria of self-neglect; he was at risk of harm because of his lack of self-care for his physical and mental health needs. The guidance mentioned above also states that:

> 'It should be noted that self-neglect may not prompt a Section 42 Enquiry[19]. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'

7.69. This paragraph describes the elements of self-neglect that this review and the workshops focussed on:

- Was Adult D's behaviour seen as self-neglect?
- How much control did Adult D have over his behaviour?
- Why did a person with Adult D's background choose to self-neglect in this way?

7.70. During Adult D's mental health inpatient stay at the start of the review period, Adult D was not recognised to be self-neglecting in a way that required a safeguarding response. The formulation, as previously discussed, was that he was able to demonstrate choice and control regarding his behaviours. Not all agencies agreed with the view that he would be safe in a B and B and choose to care for himself; Adult D's partner felt that he would self-neglect in a B and B. These issues were not successfully escalated in a timely manner. The local authority social worker had expressed concerns that Adult D would self-neglect in a B and B and did later send a retrospective safeguarding referral related to an unsafe discharge. This was not a safeguarding self-neglect referral. This was referred to the Area 2 social work team as it related to an organisation in Area 2.

7.71. On receipt of the referral, the Area 2 social worker liaised with the Mental Health Trust to undertake some enquiries. The outcome was that the discharge was not up to the usual standards and learning by the Mental Health Trust to improve standards of discharge has been implemented. By the time the concern was submitted Adult D had been sectioned under the Mental Health Act and was deemed safe.

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[18] **Care Act Guidance: Care and Support Statutory Guidance** (2016) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Updated 2018 with no changes to Chapter 14 Safeguarding

[19] **The Care Act 2014 (Section 42)** requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

7.72. A recognition of self-neglect risk and the differing views being expressed could have been resolved and planned for using a safeguarding approach. This would have highlighted Adult D and his difficulties to safeguarding leads within organisations and may have brought in an expert safeguarding view earlier in the case.

7.73. As discussed earlier, albeit that there were internal MDT meetings on a daily basis, some wider meetings on the ward that drew in more agencies, may have created space for more challenge of the views that were formulated. This does not mean that those formulations were not the right ones, but it may have resolved the differing views by sharing the assessments and observations of Adult D's behaviours that had led to the formulation. It was suggested in the workshops that staff were respectful of each other's roles, however more challenge does not have to mean disrespect if disagreements are addressed professionally. The TSAB Professional Challenge Procedure, although specifically a safeguarding tool, can be utilised more generally for guidance on this issue.

7.74. It should be noted that self-neglect does not necessarily mean that someone does not have capacity, but it does mean a difference in response. i.e. a Section 42 enquiry may not ensue for someone with capacity, but it does not prevent a different level safeguarding response where safeguarding is used in its broader meaning. At the very least the concerns of those who considered self-neglect would have been recorded.

7.75. No formal safeguarding referrals were sent until Adult D's final admission. Adult D had been taken to A and E by ambulance from the B and B when he was in a very self-neglected state. The A and E nurse made a safeguarding referral in respect of self-neglect which is strong practice to be noted.

7.76. The decision-making manager in Area 1 made the decision not to progress the safeguarding concern at this point. The manager spoke to the ward staff who indicated that as Adult D was in hospital and getting all the support required to manage self-neglect; that he was safe. It was also noted that there would be an MDT meeting prior to discharge. This decision did not receive any challenge from other professionals who were concerned. Adult D was very unwell at the time albeit he was spoken to about the concern being raised. Both Adult D (when his health had improved) and his partner should have been spoken to about the referrals in order to apply a 'making safeguarding personal approach' and understand their wishes and feelings regarding the self-neglect.

7.77. It was agreed at the workshop that there is learning for stronger practice here that the safeguarding enquiry should have continued and dovetailed with any future discharge planning. It was noted that there were legal frameworks to protect him e.g. the Mental Health Act and the Mental Capacity Act, however, Adult D continued to self-neglect in hospital and died from complications of long-term issues related to not engaging with healthcare advice; he was not safe from self-neglect when he was in hospital.

7.78. A broader safeguarding response such as the Team Around the Individual (TATI)[20] multi-agency approach

[20] **The Team Around the Individual (or TATI)** panel is a Multi-Agency High Risk Panel which was developed in response to the need to establish a multi-agency way of supporting work on complex and/or high-risk cases. This includes, but is not limited to chaotic lifestyles, self-neglect hoarding, fire risk, alcohol and substance misuse. https://www.middlesbrough.gov.uk/community-support-and-safety/domestic-abuse/one-minute-guides/team-around-individual-tati-panel

could have ensured that there was a central safeguarding plan that could be applied to all those involved if a Section 42 enquiry was not progressed. Adult D would have met the criteria for a TATI panel; however, it was not in use in Area 1 at the time of this case. An audit and survey on TATI have recently taken place and provides assurance to the Board that the process is working well to improve outcomes for people.

7.79. It is recognised in research[21] and Safeguarding Adult Reviews[22] that working with cases of self-neglect can be particularly complex. The research [(ibid)] recognises that there is a need for practitioners to understand self-neglect and to develop skills in effective interventions. There are some key elements to best practice approaches to working with people who self-neglect:

- Importance of relationships
- Understanding the person
- Legal literacy
- Creative interventions
- Effective multi-agency working

7.80. The key in managing self-neglect in the case of Adult D was the need to build a trusting relationship and get to the root cause of why he self-neglected. Adult D's case was complex with significant mental health physical health illness. Recognition of self-neglect and earlier safeguarding referrals may have been a way to refocus concerns to understand Adult D's limited and sporadic engagement with healthcare. As Adult D's condition deteriorated many professionals thought that he was dying. Adult D was still minimal in his engagement. With wider MDTs or a safeguarding approach, it is likely that more senior managers would have been involved (TATI) as well as legal advice possibly leading to an application for an inherent jurisdiction[23] in the High Court regarding the case and ways forward.

7.81. There is a fine line between ensuring the Human Rights Act requirements are adhered to and intervening into someone's life where they have capacity to refuse treatment. A discussion within the workshops included a debate regarding the use of legal advice. There were beliefs that the Mental Health Act was the legal framework that was being used and was the most appropriate therefore not needing an inherent jurisdiction. However, after the Mental Health Act section was rescinded there was no legal framework to keep Adult D safe. Earlier legal advice may have provided opportunities to explore which legal framework was the most appropriate and aid decision making with legal support.

7.82. This review has led to a recognition that self-neglect is still not well understood in cases of this nature where there are significant complexities in understanding that self-neglect can cover those with mental ill health and physical ill health especially where a person is assessed as having mental capacity or where

[21] Braye, S. Orr, D. & Preston-Shoot, M. (2015) Self-neglect policy and practice: key research messages. Social Care Institute for Excellence available at https://www.scie.org.uk/publications/reports/report46.pdf

[22] Braye, S., Orr, D. and Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews', *Journal of Adult Protection*, 17, 1, 3-18

[23] Before the implementation of the MCA, the means for the High Court to intervene in the life of a mentally incapacitated adult was founded upon the Court's inherent jurisdiction. **The inherent jurisdiction** is a doctrine of the English common law that a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal.…….. the High Court has gradually extended the use of the inherent jurisdiction to the group of vulnerable adults – adults who possess capacity but still require protection for certain reasons. https://autonomy.essex.ac.uk/resources/vulnerable-adults-and-the-inherent-jurisdiction-of-the-high-court/ The concept of 'inherent jurisdiction' says that a higher court (i.e. the High Court or above) has jurisdiction to deal with almost any matter that comes before it. Inherent jurisdiction is, in effect, a 'cover all', entitling the court to make a decision, where there is no existing law available, and where it is clear that the decision of a court is required.https://www.stowefamilylaw.co.uk/blog/2019/11/04/what-is-inherent-jurisdiction/

capacity is fluctuating regularly.

7.83. The final safeguarding referral came as a result of concerns regarding Adult D's care and treatment. This did lead to a Section 42 enquiry and safeguarding meeting. Unfortunately, Adult D died before the enquiry was concluded and led to the referral for a Safeguarding Adults Review.

7.84. It is of note that the review heard that as a result of recent SARs, the increased training and awareness raising with regard to self-neglect has resulted in an increase in Safeguarding Concerns being raised. There has been public engagement linked to self-neglect through a recent radio interview and some awareness raising in resident magazines. This is positive evidence and learning from SARs and should be celebrated.

Points for stronger practice:

- TATI has been an agreed process across the TSAB area with learning from other SARs to enhance its use and understanding more broadly.
- In depth understanding of self-neglect in complex cases is required, particularly where a person is deemed to have capacity.
- Use of legal frameworks and legal advice may be necessary in complex cases
- Professionals should be encouraged and have confidence to professionally challenge
- Decision making in safeguarding cases must be transparent and outcomes carefully recorded and shared

8. CONCLUSION

8.1 This review has highlighted much strong practice with practitioners who were dedicated to trying to improve and preserve the life of Adult D. The review has also highlighted some systemic barriers to improvement that the recommendations will seek to address along with areas where practice could be strengthened.

8.2 The review evidenced some very good multi-agency working with the involvement of health organisations and social care as well as housing. What may have strengthened this working would have been for that to have been more collaborative. There were several examples of good communication, however each agency largely kept within their remit and did not challenge or push beyond this. Whilst this respectful way of working is comfortable, it has been highlighted in many SARs and children's safeguarding reviews, that professional challenge can be positive. Being challenged by other professionals ensures that professionals are able to take a step back and review issues from another perspective. If a culture of challenge is embedded and expected it enhances multi-agency working making it truly collaborative. Analysis of what works in self-neglect identifies that this collaborative approach allows for reflection and shared decision making.

8.3 The review also identified some systemic barriers to supporting people such as Adult D. He had complex mental and physical health problems and it seemed that one or other had to take paramountcy. He moved between two hospitals with transfer of care from physical health care teams to mental health care teams. His final move was to a hospital that was not equipped to deal with either of the complex issues that he was presenting with, learning having already taken place from internal organisational investigation.

8.4 Key in this element of learning was affording Adult D true parity of esteem in that both his physical and mental health needs should have at all times been of equal importance. It seems that when mental health was at its worst, physical health care was not a priority and therefore this then declined. Albeit that, when it was the other way round, Adult D did come under the care of the mental health liaison psychiatry team who became responsible for his mental health care, the environment of an Acute Hospital may not have been the best for motivating Adult D to self-care. Throughout the review timeframe there was no one key allocated coordination role, this could have been the social worker; the barrier to this was that it was the health issues' both mental and physical that were the main presenting factors.

8.5 The review also highlighted the lack of GP involvement when requested when Adult D had moved area. It does not appear that this was resolved during the timeframe of the review. There was no input or communication from a GP during this time.

8.6 The reason for Adult D being placed in B and B accommodation was because he was homeless, and no other suitable placement could be found. Adult D would not have been discharged had he not been fit for discharge. In hindsight, this was not a suitable placement for Adult D who struggled to keep motivated when he was on his own. It seems difficult to understand why Adult D having a reasonable income appeared to be a barrier to expensive supported living. Options were still being sought but Adult D deteriorated in the B and B and was readmitted before anything more suitable could be found. A mental health step down provision is not available and is a gap in the system.

8.7 The safeguarding system was not effective for the reasons identified. It is not unusual for professionals to struggle with the management of self-neglect where a person largely retains capacity. The fact that Adult D was in hospital should not have been a reason to end the safeguarding involvement. He was still self-neglecting in hospital and at times it was not possible to use the Mental Health Act to safeguard him. It is possible for Care Act safeguarding provisions to run alongside Mental Health Act management in order to support a person who is self-neglecting. As discussed, an earlier recognition of self-neglect and a safeguarding approach may have been beneficial and leads to learning.

8.8 The information discussed in the meeting for decision making following the referral for consideration of a SAR had identified that a DoLs had been placed upon Adult D despite the fact that he was deemed to have capacity and that he had been fed against his wishes. These issues were therefore included within the terms of reference for the LLR. There was no evidence found by the review that confirmed these issues to be factual.

8.9 Finally, it would have been beneficial to have had legal advice regarding how much interference professionals could have had in Adult D's life when he was assessed as having capacity. Albeit that the Mental Health Act could have been used more effectively towards the end of his life, Adult D's behaviour in refusing care and food led to his death. Ultimately professionals needed to ensure that they had exhausted all avenues to preserve Adult D's life. This could then have led to an end of life pathway that would have ensured that he and his family could prepare for his death.

9. RECOMMENDATIONS

9.1 The findings identified above have been included in learning points throughout this report and lead to

recommendations for improvement.

9.2 Where agencies have made their own recommendations TSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

9.3 The following multi agency recommendations are made to the TSAB as a result of the learning in this case:

Assessment Care and Review

1. All agencies who are arranging multi-disciplinary team meetings for any reason, must ensure that there is guidance/documentation that includes a note to ensure all professionals who are involved with a person are invited. Use should be made of virtual meeting technology where time/distance is a barrier to attendance. Production of a "What a Good MDT meeting looks like" would be useful. MDT meeting effectiveness can be tested out in future Multi Agency Case File Audits.

2. TSAB should relaunch the 7-minute briefing No 1 "Professional Challenge and Professional Curiosity". Progress against this learning should be evidenced in Multi Agency Case file audits.

3. Parity of Esteem
    - TSAB to request information and progress against the Treat as One policy.
    - TSAB should ask for an 'options appraisal' for the Acute and Mental Health Trusts to consider what can be done to prevent patients 'see sawing' between hospitals for those who have both significant mental and physical health needs.

4. TSAB to seek assurance that all relevant agencies have guidance and processes in place to ensure that no person is detained under the MHA to a place that is not registered for such purposes. Assurance should include that all elements of the process are undertaken in line with legal duties under the Act.

5. TSAB should seek assurance from those who deliver life limiting diagnoses and DNARs that they are being delivered appropriately and that practice in this case was unusual. The NHS Trusts could review their complaints to determine if there are any linked to this subject. NHS Trusts may undertake appreciative enquiry stories to present to TSAB that show excellence in end-of-life care planning.

Mental Capacity Act

6. TSAB should refresh the Mental Capacity Act policy and add a guidance section to ensure that multiple apparently unwise decisions lead to assessment of capacity under the Act.

7. TSAB should ask single agencies to review their guidance in light of the learning from this review.

Discharge Planning and Housing

8. TSAB should assure itself that due consideration is given to undertaking or adopting the 'MBC Provision of Accommodation for Homeless People with Mental Health Needs' guidance (or similar) across all Teeswide areas.

9. TSAB should write to commissioners raising concerns regarding the lack of provision for inpatients who are ready for discharge from Mental Health beds where housing needs have not been addressed.

Safeguarding and Self Neglect

10. TSAB should incorporate the learning from this SAR into the self-neglect awareness campaign (linked to a previous SAR).

11. TSAB should ensure that the recording of the rationale for decision-making in safeguarding cases is incorporated into Multi Agency Case File Audit questions.

12. TSAB, in the learning briefing for this review, should include the requirement under the Care Act to offer all carers signposting for support.

Appendix One: Terms of Reference

Learning Lessons Review
Case 3/19
Adult D

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

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

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

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and

empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

Adult D was a gentleman in his early sixties who died in hospital from pneumonia. Concerns were raised by the Acute Hospital Safeguarding team in relation to Adult D's treatment under the Mental Health Act (MHA). The individual was an inpatient at a Primary Care Hospital and sectioned under the MHA, he had a gastric tube and was fed against his wishes. It was advised that the Primary Care Hospital is not registered with the Care Quality Commission to detain individuals who are sectioned under the MHA and so the detention was not valid.

A number of other issues were raised regarding his care including a Deprivation of Liberty

Safeguards (DoLS) being advised to enable treatment if refused, yet it was deemed he had full capacity.

Prior to his admission to hospital the gentleman was reported as being homeless and had been placed into a Bed & Breakfast by the Mental Health Trust following a lengthy period as an inpatient. A safeguarding strategy meeting was held however it was considered that this was not a forum for multiagency learning, and it was requested that a SAR notification was submitted for consideration.

Adult D had a previous partner who supported him who had some involvement with professionals.

Adult D passed away the following day from natural causes.

3. Decision to hold a Learning Lessons Review

The Safeguarding Adult Review Subgroup of the Safeguarding Adults Board met on 25th September 2019. It was agreed that the criteria for a Safeguarding Adults Review were met and made a recommendation to the TSAB Independent Chair that there was likely to be learning in the way that agencies worked together to safeguard Adult D. Following further discussions with the Independent Chair of TSAB, it was agreed that a learning lessons review would be undertaken as the cause of death was not thought to be related to the alleged abuse. Due to the National Response to Covid-19, it was not possible to progress the review until July 2020 when an alternative methodology was agreed (see below)

4. Scope

The review will cover the period six months before the date Adult D died. Key background information will also form part of the review that will inform the more contemporary elements of Adult D's life.

5. Method

In determining the methodology to be used for this Learning Lessons Review the TSAB considered the Care Act 2014 Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

Following delays incurred by Covid -19, TSAB chose to amend the initial methodology to continue to engage with frontline practitioners and their line managers through a series of workshops undertaken using virtual meeting technology. Each workshop will focus on one or two themes and be set the task of exploring the themes and answering questions. The themes will be identified from the chronologies and other reports that have been undertaken by agencies. This will lead to identification of areas for learning and improvement.

Themes will include the following agreed areas

- **Assessment**
- **Mental Health Act**
- **Mental Capacity Act and DoLs**
- **Discharge planning and housing**
- **Support and Guidance**
- **Effectiveness of the Safeguarding System**
- **Family Involvement**
- **Documentation**
- **Good Practice**

6. Independent Reviewer and Chair

The named independent reviewer commissioned for this Learning Lessons Review is **Karen Rees.**

7. Organisations to be involved with the review:

- The Mental Health NHS Foundation Trust
- Area 1 Borough Council
- Area 2 Borough Council
- Clinical Commissioning Group
- Acute Hospitals NHS Foundation Trust
- Ambulance Service
- Area 1 Council Housing Team

8. Family Involvement

A key part of undertaking this Learning Lessons Review is to gather the views and experiences of the family and share findings with them prior to finalisation of the report. Adult D's partner, family and other relevant persons will be contacted to inform them of the review and invite them to meet with the author.

9. Project Plan dates:

1.	**Re Scoping Meeting (Governance Group)**	**08/07/2020**
2.	Terms of Reference updated	08/07/2020
3.	Additional Info for Stage 1 Report	14/08/2020
4.	Stage 1 Report Submitted	01/09/2020
5.	Distribution of Report and associated documents to all Learning & Reflection Workshops attendees	03/09/2020 (approx. but at least one week ahead of workshop)
6.	Learning and Reflection Workshops	15/16/23/24/09/2020
7.	Stage 2 V1 SAR Report to all Workshop Attendees & Panel	23/10/2020
8.	Panel Meeting	W/C 2nd November (Allowing for half term)
9.	Stage 2 Report V2 circulated to panel	W/C 16/11/2020
10.	2nd Panel Meeting/Gov Group to Review Recommendations	From Tuesday 1st December
11.	Final Draft Report to board	10th December
12.	Presentation to TSAB	Extraordinary meeting TBC after 10th December

Appendix Two: Framework for Learning