LEARNING BRIEFING

Learning Lessons Review Adult D

Teeswide Safeguarding Adults Board

1 Background

Adult D was in his early sixties, had a long-term partner and two children from a previous marriage. Adult D had ongoing physical health problems which led to a decline in his mental health resulting in admissions to and between hospitals where he sadly died of natural causes. This Learning Lessons Review looks at how services worked together to support Adult D and specifically considers how services responded to the following key issues: self-neglect, application of the Mental Health Act, communicating an unconfirmed diagnosis of a terminal illness, safeguarding, housing, and transfers between hospitals. Adult D's partner was consulted throughout the review which highlighted learning around support for carers. The review also highlighted good practice including; good communication and strong multi-agency and partnership working.

2 Theme 1: Assessment, Care and Review

Adult D and his family were informed that he had a terminal illness which later proved to be an incorrect diagnosis; this had a significant impact on Adult D's physical and mental health. Careful consultation and planning should take place before giving this information to patients and their families, particularly when a diagnosis has not yet been confirmed.

Adult D was transferred to a Primary Care hospital which was not registered for detaining patients under the Mental Health Act. There must be recognition that, in order to legally detain a patient using the Mental Health Act, the hospital must be specifically registered to do so.

Adult D was supported at 3 different hospitals and by 3 different social work teams as his physical health, mental health needs and location changed. Although there was good multi-disciplinary working across these services and teams, the review identified that stronger working practice would include arranging regular multi-disciplinary meetings to draw in workers from all relevant agencies, and family/ carer/ advocacy representatives to provide a forum for communication and challenge.

3 Theme 2: Mental Capacity Act

Mental capacity assessments could have been strengthened in the case of Adult D. He frequently declined food and medicines and appeared to understand that he may die because of these decisions. Practitioners worked on the basis of presuming capacity and when faced with a number of unwise decisions did not consider carrying out formal mental capacity assessments to determine decisional and executive capacity. This approach may have determined that Adult D had fluctuating capacity and considered how Adult D's health conditions may have also impacted upon his decision making.

Adult D's partner was a strong advocate and able to challenge professionals and act on Adult D's behalf. However, she felt that she was not well supported as a carer and it would have helped her if she had been signposted to carer support services as set out by the Care Act 2014.

When practitioners have ongoing concerns about mental capacity and unwise decisions being made they should seek early support from their managers to ensure they have access to legal advice at a time when they may be struggling to understand their role in preserving life when someone is self-neglecting.

4 Theme 3: Discharge Planning and Housing

Prior to Adult D's discharge from the Mental Health hospital several housing options were explored, including residential care, supported living and rehabilitation services; none of these were a viable option which resulted in his discharge to B&B accommodation. This solution was in place for a matter of days prior to his return to hospital. There was no 'step down' provision for mental health patients prior to discharge into the community which may have better met Adult D's needs.

Involvement of Housing Colleagues in multi-disciplinary team meetings from an early stage could improve discharge planning options.

5 Theme 4: Safeguarding and Self-Neglect

There were many aspects in the last 18 months of Adult D's life that indicated self-neglect as defined by the Care Act 2014. Practitioners could have raised a self-neglect safeguarding concern sooner; 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.

The discharge to B&B accommodation was thought to be inappropriate by Adult D's partner and his social worker who both felt he would continue to self-neglect his personal care; a safeguarding concern was raised by the social worker relating to their opinion of an unsafe discharge but did not indicate self-neglect; by the time the concern was picked up Adult D was back in hospital and felt to be safe and so the concern did not progress to investigation.

On reflection of this case practitioners agreed they need to have more confidence to professionally challenge decisions they do not agree with albeit in a respectful way.
Safeguarding enquiries should not stop just because someone is in hospital and deemed to be safe.

The Local Authorities in the Tees area have now adopted the Team Around the Individual (TATI) approach which is wholly appropriate for people who self-neglect and disengage with services, this provides individuals with complex needs (like Adult D) with an extra layer of support.

6 What to do now

- Reflect on how the above themes link with your direct practice with adults, families and practitioners.
- Think about what changes you can make to your practice in similar cases.
- Share within your team and explore any training needs you may have.

7 What to do next

- Read the full Adult D Report.
- Check out these resources:

https://www.centreformentalhealth.org.uk/parity-esteem

https://www.carersuk.org/

TSAB resources including Self-Neglect Policy and Guidance, Mental Capacity Guidance, Team Around The Individual (TATI) Guidance and Carer's support.

Professional Challenge and Professional Curiosity - 7-minute briefing

- Implement any identified changes required to your practice.

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