Safeguarding
Adult
Review

Adult MR M

Stephen Cullen
Independent Reviewer

Note: Mr M is a pseudonym used for the purposes of this Report.

LIST OF CONTENTS

1. Glossary
2. Note of condolence and gratitude
3. Introduction
4. Supporting framework
5. Methodology
6. Limitations / parameters of the SAR.
7. SAR Process – Timeline
8. Confidentiality
9. Caldicott principles
10. Contributors to the SAR
11. SAR Panel
12. Professionals
13. Terms of Reference / Key Lines of Enquiry
14. Scope of Review
15. Parallel proceedings
16. Mr M as a person
17. Mr M's Medical history
18. Mr M's Home environment
19. Family perspective and involvement
20. Chronology – Key Events
21. Key Events within scope
22. Chronology of Events leading up to Mr M's death
23. Critical analysis
24. Effective practice
25. Conclusion
26. Multi-Agency Recommendations
27. Single Agency Recommendations
28. References
29. Appendix A Shropshire Council / MPFT Mental Health Assessment Pathway (2020)

GLOSSARY

30. A & E Accident and Emergency Department
31. AMHP Approved Mental Health Professionals
32. ASC Adult Social Care
33. CRHT Crisis Resolution Home Treatment
34. CQC Care Quality Commission
35. ED Emergency Department
36. ESWT Emergency Social Work Team
37. FPOC First Point of Contact
38. GP General Practitioner
39. ICS Integrated Care System
40. MHA Mental Health Act
41. MHAA Mental Health Act Assessment
42. MCA Mental Capacity Act
43. NHS National Health Service
44. SAR Safeguarding Adult Review

Note of Condolence and Gratitude

45. The experience and sad death of Mr M is the subject of this Safeguarding Adults Review (SAR).

46. As the author of this SAR, and on behalf of all the Shropshire Safeguarding Community Partnership, I would like to offer my sincere condolences to Mr M's family for their loss.

47. My appreciation is extended to the Professionals of the Agencies who also co-operated fully with this SAR, as well as the Shropshire Safeguarding Community Partnership (SSCP) Business Unit who supported the work required.

48. Particular thanks go to the SSCP Development Officer who has provided unstinting, and supportive, professional, and administrative support.

Confidentiality

49. Pseudonyms have been used in the report to protect the identity of the family and Professionals involved.

Introduction

50. Mr M was a a White British male born in 1945. Sadly, Mr M passed away at the age of 74 on 18th September 2020.

51. Mr M resided in Shropshire with his wife.

52. Mr M and his wife, had two children a an adult daughter, and an adult son who passed away in 2020.

53. This SAR is conducted on behalf of the Shropshire Safeguarding Community Partnership (SSCP).

54. SSCP is constituted as a combined multi-agency Safeguarding Arrangements for Children as defined in Working Together 2018, the Community Safety partnership as defined by the Crime and Disorder Act 1998 and the Safeguarding Adults Board as defined by the Care Act statutory guidance.

Supporting Framework:

55. Section 44, Safeguarding Adult Reviews:

(i) 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

(ii) Condition 1 is met if:

(a) the adult has died, and

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

(iii) Condition 2 is met if the adult has not died, but the SAB knows, or suspects the adult has experienced serious abuse or neglect.

56. Initial scoping of the case with the Agencies involved, and endorsed by the Independent Chair of the Shropshire Safeguarding Community Partnership, led to the view Mr M's case met the criteria for a Safeguarding Adults Review (SAR) in accordance with s44 (1 and 2) Care Act 2014 on the following basis:

1. Mr M was not receiving care and support from the Shropshire Local Authority at the time he died. It has been agreed on the basis of the information available Mr M had eligible needs for care and support

a) There are concerns, about how Agencies worked together to safeguard Mr M and
b) Condition 1 of the Safeguarding Adult Review criteria is met

2. Condition 1

a) Mr M has died, and
b) On the basis of the evidence provided by the Agencies involved, and the comments made in the Coroner's case summary; the Shropshire Safeguarding Community Partnership believe Mr M experienced self-neglect. There is also evidence, which requires further consideration as part of the review, as to whether there was also neglect, and acts of omission, by Agencies involved in providing him with medical treatment, care, and support.

Methodology:

57. This SAR takes into account the 6 safeguarding principles as set out in the Care Act Statutory Guidance 2014. They are:

1. Empowerment
   People being supported and encouraged to make their own decisions and informed consent

2. Prevention
   It is better to take action before harm occurs

3. Proportionality
   The least intrusive response appropriate to the risk presented

4. Protection
   Support and representation for those in greatest need

5. Partnership
   Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse

6. Accountability
   Accountability and transparency in safeguarding practice

58. The SAR has been conducted using a mixed methodology which is proportionate to the scale and the level of complexity of this case.

59. The aim of this review is to identify, and promote, effective Multi-Agency learning and improvement action to prevent future deaths or serious harm occurring again. The approach included:

- Agreeing Scope and Terms of Reference
- Participating Agencies preparing and submitting detailed chronologies using the SSCP Chronology Template; addressing the areas the SAR Panel wanted to explore (as outlined below) in their analysis
- Participating Agencies taking part in a Multi-Agency learning event, chaired by the Independent Reviewer
- Participating Agencies responding to further questions from the Independent Reviewer
- Participating Agencies providing relevant background information and documents
- Participating Agencies providing a context of the structures, processes, and procedures during this timeframe
- Engaging with key Professionals who have been involved in the case, to look at what was happening at the time, and understand more about why things happened as they did;
- A review of any background documents evidencing national and local policy, and where possible, any existing evaluations of practice in relation to the themes identified to inform the review
- The Independent Reviewer working alongside the SAR Panel in carrying out the review and analysing the findings

60. The review seeks to maintain a balance between the SSCP commitment to transparency and learning, on the one hand; and the need to respect certain elements of experience relating to Mr M and his family.

61. A strengths-based approach has been adopted in this review, where effective practice is recognised as per the Terms of Reference. The Independent Reviewer has sought to avoid hindsight bias. Any learning comes from the position, and the view Professionals had, at the time. This approach is more likely to embed learning into practice and support cultural change where required.

62. The SAR is devised primarily from the following sources of information:

- The initial scoping meeting
- Agency and combined chronologies
- A Professional learning event and follow-on contact with Agencies
- Follow up questions from the Independent Reviewer and responses from Professionals
- Meetings between SAR Panel and Independent Reviewer
- Feedback from the SAR Panel and Chair following submission of Draft Versions 1 to 3 of this report

63. Additional guidance, advice, and quality assurance has been provided by a dedicated SAR Panel, who has worked with the Independent Reviewer to ensure the report is balanced, references relevant guidance and legislation, and makes useful and constructive recommendations.

Limitations / Parameters of the SAR

64. There are a number of limitations or parameters around the SAR:

- Any Safeguarding Adult Review (SAR) will be enhanced with the involvement and insight from the person's family. They can provide a valuable insight into the person's life. The SSCP and the Independent Reviewer, did attempt to reach out to the family and explained their input and insights would be very much welcomed. Mr M's wife, and his daughter, have elected not to engage with this SAR.
- The main focus of this SAR is on learning i.e., it is not an investigation, nor a report, which seeks to attribute blame.
- Reviewing Mr M's life and the distressing events leading up to his death is challenging for all concerned. All parties may not agree with all aspects of the Independent Reviewer's assessment.
- The Independent Reviewer was provided with information as requested throughout.
- It is felt that a sufficient amount of insight was gathered to arrive at some informed findings.

Safeguarding Adult Review (SAR) Process – Timeline

65. A thorough, but proportionate, approach has been adopted in this SAR, recognising the requirement to submit the review within agreed time limits.

66. **22nd September 2020**
FALCK Patient Transport Services (FPTS) notified the Care Quality Commission (CQC) of their concerns regarding Mr M's care.

67. **28th September 2020**
FPTS raised an Adult Safeguarding Concern to Shropshire Council (SC).

68. **9th November 2020**
Shropshire Council Adult Social Care Safeguarding Team (SCC ASC) made a Safeguarding Adult Review referral to Shropshire Safeguarding Community Partnership (SSCP).

69. **28th January 2021**
An initial Multi-Agency scoping meeting took place, chaired by the Head of Strategic Safeguarding, from the Midlands Partnership Foundation Trust (MPFT). They recommended an independent SAR should be commissioned.

70. **26th February 2021**
The SSCP Independent Chair made the decision to support the recommendation and commission an independent SAR.

71. **27th May 2021**
The SSCP commenced the SAR process by co-ordinating an initial chronology.

72. **10th June 2021**
Independent Reviewer appointed.

73. **23rd August 2021**
A Practitioner's Learning Event was undertaken, chaired by the Independent Reviewer.

74. **September – December 2021**
SAR writing. Further communication between the Independent Reviewer, SSCP and the Agencies involved, to clarify issues or seek further information.

75. **31st January 2022**
Draft Version 1 SAR submitted to SAR Panel.

76. **10th March 2022**
SAR Panel met to review Draft Version 1.

77. **21st April 2022**
Draft Version 2 SAR submitted to SAR Panel.

78. **3rd May 2022**
SAR Panel met with Independent Reviewer

79. **13th May 2022**
Further meeting. SAR Panel and Independent Reviewer

80. **6th June 2022**
Draft Version 3 SAR submitted to SAR Panel

81. **20th June 2022**
Draft Version 4 SAR submitted to SAR Panel

Caldicott Principles

82. This SAR has been conducted in accordance with the Caldicott Principles.
83. The Caldicott Principles allow for the secure transfer of sensitive information across other Agencies, for example between Social Care and 'Health'.
84. There are 8 Caldicott Principles. The sharing of information in health and social care is guided by these principles:

1. Justify the purpose(s) for using confidential information
2. Use confidential information only when it is necessary
3. Use the minimum necessary confidential information
4. Access to personal confidential data should be on a strict need-to-know basis.
5. Everyone with access to personal confidential data should be aware of their responsibilities.
6. Comply with the law.
7. The duty to share information can be as important as the duty to protect patient confidentiality.
8. Inform patients and service users about how their confidential information is used

Contributors to the SAR

85. The following Agencies were identified as having contact with MR M and requested to contribute to this SAR:

- Midlands Partnership Foundation Trust (MPFT)
- Crisis Home Resolution Team
- Access Team
- Shropshire Community Health NHS Trust (SCHT)
- Shrewsbury and Telford Hospitals NHS Trust (SaTH)
- Robert Jones Agnes Hunt NHS Trust (RJAHT)
- Mytton Oak General Practice (MOGP)
- Shropshire Council
- Approved Mental Health Practitioner
- Adult Social Care
- Emergency Social Work Team
- Falck Patient Transport Service (FPTS)
- West Midlands Ambulance Service (WMAS)

86. West Mercia Police (WMP) were invited to the initial scoping meeting but had no involvement with MR M or his wife during the scoping period, but have remained involved to add their oversight as a member of the SAR Panel

SAR Panel

87. The SAR Panel comprises:

The three statutory partners of the Safeguarding Adult Board, namely

- Shropshire Council (Adult Social Care)
- West Mercia Police
- NHS Shropshire, Telford & Wrekin Integrated Care System (formerly the Clinical Commissioning Group)

This was augmented by a representative from the independent sector who works as part of the SSCP

Professionals

88. The supportive approach of Partners who participated in the SAR process is noted and appreciated. The daily pressures which organisations are under, particularly during the pandemic, is acknowledged as the context in which such positive responses were offered.

89. The focus of the SAR is on addressing organisational and individual learning. Openness, transparency, and candour was encouraged and consistently displayed by Professionals. The names of individual staff members are not included.

Terms of Reference / Key Lines of Enquiry

90. The Terms of Reference / Key Lines of Enquiry the SSCP / SAR Panel identified to support focussed learning for the review are set out below:

1. **It is accepted Mr M was the subject of self-neglect. In Mr M's case what evidence (if any) is there of:**

   Neglect and Acts of Omission by Agencies, in particular a failure to provide personal or health care and a failure to provide (privacy) and dignity.

2. **Mr M's relapse profile and concerns relating to self-neglect, and home conditions, were known to Agencies. Who (if anyone) was supporting/monitoring Mr M and his wife when at home? How effective was this support/monitoring in minimising the identified risks to Mr M?**

3. **What evidence is there staff involved in this case had knowledge of, and applied, the Shropshire Safeguarding Community Partnership (formerly known as Keeping Adults Safe**

in Shropshire Board) Responding to Self-Neglect in Shropshire Practice Guidance, and Local Process and Working with Risk Guidance; in their work with Mr M and his wife?

4. **What evidence is there of dissemination and leadership, by members of the Shropshire Safeguarding Community Partnership and the Keeping Adults Safe in Shropshire Network (formerly Keeping Adults Safe in Shropshire Board) into their organisations, and service areas, of the Multi-Agency guidance and process documents referenced in the point above?**

5. **How effectively were Mr M's wife's needs, as a Carer, assessed and met?**

6. **What were the outcomes of the 2 adult safeguarding referrals made by Adult Social Care on 1st October 2019 and 6th November 2019?**

7. **What was the outcome of the adult safeguarding referral made by West Midlands Ambulance Service to Adult Social Care on 15th June 2020?**

8. **How effective was the adult safeguarding response to Mr M and his wife?**

9. **Who was responsible for assessment when Mr M was discharged home from both the Redwoods Centre (in June 2019) and the Nursing Home (in July 2020) and were those assessments carried out?**

10. **Who is responsible for assessment of home/care at home, upon discharge from a nursing home/rehabilitation placement?**

11. **What are the areas of good practice, relating to the discharge of Mr M?**

12. **What observations were carried out, and to what extent did the ambulance crew examine Mr M on 16th September 2020?**

13. **Why did West Midlands Ambulance Service ask for a family member to contact their GP to request a mental health assessment when their service could have referred this request?**

14. **What were the disruptions/changes in practices for all Agencies involved due to the restrictions in place as a result of the Covid-19 restrictions? How did this have an impact on the response to Mr M?**

15. **Consideration should be given to how race, culture, ethnicity, and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management, including recognition of unconscious bias.**

Scope of the Review

91. The Scope of this SAR is from **1st of March 2019** to **18th of September 2020.**

Parallel Proceedings

92. The Shropshire Coroner examined the death of Mr M.

93. Within his summary the Coroner described the circumstances leading up to Mr M's death as follows:

94. "74-year-old with known psychotic depression, self-neglect, previous admission in June 2020 with fractures treated conservatively. Admitted following 2 days prior in kitchen, refused admission following fall but wife got GP and mental health involved. Treated for possible sepsis (raised inflammatory markers), acute kidney injury, self-neglect (Multiple pressure sores), frail with low albumin. Unexpected cardiac arrest in evening / resuscitation tried".

95. The Coroner also noted:

96. "Mr M's wife states her husband had 'given up on life' and she had witnessed him becoming increasingly frail, she does not want any further investigation".

97. The Coroner recorded the provisional cause of death as "sepsis of unknown origin".

98. There are no criminal proceedings, or any other parallel proceedings, associated with this SAR.

99. No disciplinary action has been taken against any employee who may have engaged with Mr M.

Mr M

100. Mr M was born in 1945. Mr M was 74 years of age when he passed away.

101. Mr M had a wife had an adult daughter.

102. Mr M and his wife had suffered the loss of their adult son around May 2020, about four months before Mr M passed away. The death is described "as having really knocked" Mr M.

Mr M's Medical History

103. Mr M was known to Mental Health Services since 2014 and had a diagnosis of 'psychotic depression'. His depression included features of physical self-neglect; this included placing himself on the floor, and becoming immobile, which led to pressure sores; cachexia (significant weight loss and muscle wastage), anaemia, urinary and faecal incontinence, and withdrawal of engagement from Services.

104. Mr M attended regular mental health reviews with his General Practitioner, in relation to his depression, up until April 2019. Mr M visited the GP practice about twice a year until he was

detained, under the Mental Health Act, in April 2019. Mr M had limited engagement with his GP after this time.

105. On 1st of April 2019, Mr M was taken by Ambulance to Shrewsbury and Telford Hospital Trust's Princess Royal Hospital for physical health issues, associated with the deterioration in his physical health as part of the impact owing to his low mood, and related self-neglect arising from his mental health difficulties.

106. On 18th April 2019; Mr M was discharged from Princess Royal Hospital and admitted to MPFT Redwoods Centre, under section 2 of the Mental Health Act 1983, before he was transferred to a Nursing Home. Mr M remained at the Nursing Home until the 10th June 2019, when he was discharged home.

107. During his psychiatric admission, Mr M received services from the Midlands Partnership Foundation Trust (MPFT) who provide mental health provision in Shropshire; who continued to work with him, beyond his discharge from Hospital on the 10th of June 2019, until 22nd January 2020; when his case was closed by the service. This was primarily due to the service not been able to find a way to engage with Mr M.

108. On 15th June 2020, WMAS received the call for Mr M who had fallen at home. An Ambulance attended the home address. Mr M had fallen the previous day and hurt his wrist, and had fallen again that day, but this time was unable to get up off the floor. A 'Care15-Welfare' referral was completed and submitted to Shropshire Council Adult Social Care, highlighting concerns as no support package was in place, and noting Mr M (and his wife) may be struggling to care for each other.

109. On the same day Mr M was admitted to Royal Shrewsbury Hospital, as a result of the fall, and treated for a fracture to the radial bone in his arm and acute kidney injury. Mr M was then discharged to a Nursing Home, where he received daily input from Shropshire Community Health Trust's Community Rehabilitation (Occupational Therapy) Team. They referred Mr M to Shropshire Council Adult Social Care to prepare for discharge. Mr M was discharged home on 20th July 2020.

Mr M's Home Environment

110. Mr M resided in his home, with his wife, in Shropshire. it is understood that they had lived in the same house for over 30 years.

111. A number of Professionals, at different times, raised concerns around the living conditions within the home.

112. On 7th June 2019, a home visit was carried out by the Social Work Mental Health Team. The Care Co-ordinator had also intended to visit, but Mr M's wife said "two people at the same time was too much". At this time, Professionals expressed concern around conditions of the home environment.

113. Professionals also identified there were no smoke alarms in the house, but Mr M's wife declined a referral to the Fire Service.

114. When Paramedics from WMAS attended Mr M's home in September 2020, they described the home as being in poor condition.

115. When Professionals, from the Crisis Resolution Home Treatment Team, arrived at the home during the same period, they noted a strong smell of faeces in the kitchen.

116. There was a clear consensus across Agencies, the living conditions of Mr M and his wife, during the scoping period (and possibly before), were poor and this may have been distressing for them.

117. Mr M's wife informed a Paramedic, that Social Workers had previously raised concerns around the conditions in her home. This may have influenced her unwillingness to engage with Adult Social Care.

Family Perspective and Involvement

118. There is recognition of the adverse impact Mr M's death will have had on his wife, his daughter, and potentially the wider family.

119. Their lack of engagement in this SAR has limited the opportunity to understand the impact of Mr M's death and provide support to his wife, and any wider family.

120. SSCP and the Independent Reviewer have tried to engage with Mr M's wife and his daughter. A social work 'safe and well' check was carried out with his wife after Mr M passed away.

121. However, his wife and her daughter are clear and consistent they do not wish to be involved in any way with the SAR. This is of course their right, and the Independent Reviewer and SSCP respect their decision

122. It is of note his wife stated, to the Coroner's office, her husband had "given up on life";

Chronology – Key Events

Key Events within scope - 1st March 2019 to 18th September 2020

123. **1st April 2019**
Mr M was taken by Ambulance to Shrewsbury and Telford Hospital Trust's Princess Royal Hospital for physical health issues, associated with sustained self-neglect due to his mental health difficulties.

124. **18th April 2019 – 10th June 2019**

Mr M was discharged from Princess Royal Hospital and admitted to MPFT Redwoods Centre, under section 2 Mental Health Act 1984, before he was transferred to the Nursing Home. Mr M remained here until 10th June 2019, when he was discharged home.

125. **10th June 2019 – 22nd January 2020**
During his psychiatric admission, Mr M was allocated to services from the Midlands Partnership Foundation Trust, who provide NHS mental health interventions, they continued to work with him beyond his discharge from Hospital on the 10th of June 2019 until the 22nd of January 2020 when his case was closed by the service due to a lack of engagement.

126. Shropshire Council Adult Mental Health Social Work Team were involved with Mr M, during his period of psychiatric admission, in order to complete an assessment of his mental capacity in relation to the decision to discharge home. Further Adult Social Care involvement was declined by Mr M's wife during a home visit, following Mr M's discharge, and the case was closed to Adult Social Care. Mr M did not reply to an invitation from his GP, for a mental health annual review, in September 2019. Subsequent follow up letters were not responded to.

127. **15th June 2020**
The MPFT Shropshire Access Team received a telephone call from his wife stating she was concerned for Mr M. His wife stated they had a bereavement (losing their son) and Mr M was very confused and 'hallucinating'. Mr M had fallen out of bed and hurt his wrist. Mr M's wife was advised to call the GP, or take Mr M to A&E, due to the possible physical injury to his wrist. During the call Mr M's wife stated Mr M was on the floor with only a T-shirt on. Advice was sought from Shift Co-ordinator and his wife was advised an ambulance was required. Due to the mental health concerns, a referral to Access was also completed. Mr M's wife requested the Professional make the 999 call while she made Mr M comfortable and this was actioned. His wife stated Mr M's speech was confused, that he had been getting better since his admission to the Redwoods Centre last June, but the death of their son had 'really knocked him'; stating the funeral was that Friday. Mr M's wife stated Mr M had not been eating or drinking, and not sleeping well.

128. On the same day, WMAS received the call for Mr M following his fall at home. An ambulance was dispatched and attended the home address. It was confirmed Mr M had fallen the previous day and hurt his wrist. Mr M had fallen again that day, but this time was unable to get up off the floor. Mr M was assessed, and had a potential fractured left wrist, bruising and deformity to the injured area. No other injuries were found however, Mr M was unsure of events of the incident; and his wife reported Mr M was more confused than usual. Mr M was taken to Hospital for further assessment and treatment. A 'Care15-Welfare' referral was completed and submitted to Shropshire Council Adult Social Care highlighting concerns as no care package was in place and noting Mr M and his wife may be struggling to care for each other.

129. On the same day Mr M was admitted to Royal Shrewsbury Hospital, as a result of the fall, and treated for a fracture to the radial bone in his arm and acute kidney injury.

130. **15th June 2020 to 20th July 2020**

Mr M was subsequently discharged to a Nursing Home, where he received daily input from Shropshire Community Health Trust's Community Rehabilitation (Occupational Therapy) Team. They referred Mr M to Shropshire Council Adult Social Care to prepare for discharge. His wife was contacted by Adult Social Care, and she advised she would provide care on his return home but did express concern about her husband's ability to climb the stairs. A referral was made to Occupational Therapy. Mr M was discharged home on 20th July 2020.

Chronology of Events leading up to Mr M's death

16th September to 18th September 2020

131. A number of Agencies were involved with Mr M and his wife in the days immediately prior to his death.

132. The chronology of events in the last four days of Mr M's life

16th September 2020

133. At 2.30am a 999 call was received by WMAS from his wife stating Mr M was lying on the floor, depressed and incontinent of urine. A telephone triage was completed. Following advice from WMAS, Mr M was reported to have to got himself off the floor during the call and sat himself in a chair. WMAS decided an ambulance was not required as there was no medical emergency and Mr M was able to self-mobilise.

134. At 4.15am the same day, the Shropshire Access team received a telephone call from a Mental Health Nurse via the 111 service. The Access Team then spoke with Mr M's wife who explained Mr M was lying on the kitchen floor and had been for the majority of the previous day (15th) and for some of the day before that (14th). Mr M was refusing to get up. Mr M's wife explained their daughter helped get him up earlier in the evening, but Mr M then put himself back on the floor. When his wife was asked about physical illness, she stated she was not aware of any other reason, or illness, other than depression as to why her husband was on the floor; stating Mr M had not fallen rather was reluctant to get up from the floor. Mr M's wife stated he had taken fluids earlier in the evening. The call taker placed his wife on hold and sought advice regarding the call. Contact was then made back with Mr M's wife, and it was agreed an ambulance would be called to have Mr M assessed physically. WMAS were called with an agreed time for arrival within one hour.

135. At 4.40am, a second 999 call was received by WMAS from Mr M's home. It is believed both Mr M and his wife spoke to WMAS. The Ambulance Crew were dispatched, and Mr M was still lying on the floor. The Paramedics noted several carpet burns to Mr M's legs where he has been rolling around on the kitchen floor. Mr M was able to get himself off the floor (as he had previously) but refused to do so. Mr M was described as 'alert' and 'fully coherent' and refused to attend A&E. The Ambulance Crew assessed Mr M and concluded he was medically stable and deemed to have capacity. The Paramedics considered that there was no requirement for hospital conveyance. Pathways were discussed with both Mr M and his wife. The GP and Crisis Team were contacted

and made aware of the situation and a mental health referral completed. A 'Care Welfare' referral was also submitted to Adult Social Care.

136. At 06.12 hours, the Access Team received a call from the Paramedic at the house stating all Mr M's physical checks were 'ok'. Mr M remained on the floor; he refused to get up or receive any intervention from the Paramedics. Mr M's wife did not want their daughter contacted at this point as she would be asleep.

137. The Paramedic stated to the Access Team the situation appeared to be a 'behavioural issue'. Mr M's wife requested a mental health assessment be carried out, as she felt this was not a physical issue but related to Mr M's mental health. As a result, a referral was made to the Access Team and passed to the Access Team Shift Co-ordinator.

138. The Paramedic noted the house appeared 'derelict' in appearance. The Paramedic also stated Mr M's wife was reluctant to contact Adult Social Care (ASC) as she didn't find them helpful. Mr M's wife said to the Paramedic she did not like a previous comment made about the condition of the house.

139. The Shift Co-ordinator triaged the referral at 08.43hrs on 16th September 2020 and flagged for urgent contact.

140. At midday, the Mytton Oak GP Receptionist relayed a message, from WMAS, to the GP asking if Mr M had been referred to the Crisis Team yet. The GP found the Ambulance report and noted Mr M had been seen out of hours and was found on the floor. Mr M had voluntarily put himself there but couldn't be encouraged to get up by the Ambulance Crew. Mr M was noted to be physically well and observations at the time supported this. The Paramedics reported they contacted the Shropshire Council Mental Health Team, after the Crisis Team advised Social Care should be contacted. The Paramedics advised Mr M's wife to contact her GP Practice in the morning.

141. However, for understandable reasons, given her husband was in distress, Mr M's wife didn't contact the GP; so, the first communication received by the GP was from the Ambulance Service (WMAS). The GP rang Mr M's home at lunchtime on Wednesday 16th and spoke to his wife; who said her husband had been deteriorating recently and had been on the floor since Monday evening; he hadn't fallen, was apparently in no pain and had no symptoms, but just chose not to get up. Mr M appeared to be more receptive to his daughter, who managed to encourage him to get up off the floor and take a drink the evening before. However, Mr M wasn't eating or drinking whilst on the floor. Mr M's wife asked for her husband to be admitted to Redwoods Centre. Mr M's wife stated she could not cope with her husband Mr M at home.

142. The GP stated she then rang the Crisis Team who advised they were aware and stated the Access Team had contacted Mr M and his wife that morning and planned to contact them again that afternoon. The Crisis team mentioned the Access Team had requested Mr M provide a urine sample. The GP again rang Mr M's wife who said she didn't recollect being asked to do this; and

said she couldn't do this anyway as Mr M was lying on the floor and unable or unwilling to co-operate.

143. The GP rang the Access Team back to say Mr M's wife couldn't obtain a urine sample. The Access Team said they would get in contact with the Lead Clinician who had been dealing with the case previously; and they would make a plan moving forward. The GP rang Mr M's wife back and reassured her the Access Team would be contacting her; and asked his wife to call the GP Practice (or the Access Team) if she needed any support or if anything changed dramatically.

144. At 15.45 hours, the Access Team telephoned Mr M's wife who reported Paramedics had taken bloods from Mr M, but they were unable to collect a urine sample due to his double incontinence. His wife stated that Mr M had declined in mood, presentation, and mental state. Mr M's wife reported her husband was apathetic, neglecting his basic needs, incontinent, not eating and only taking limited fluids.

145. The Access Team staff member attempted to talk to Mr M, but he was very difficult to understand and appeared to lack insight into his self-neglect and the concern his mental health was deteriorating. Mr M's wife again stated her husband required hospital admission. Support from the Crisis Resolution Home Treatment Team (CRHT) was offered but his wife refused stating she would be unable to cope with Mr M. Mr M's wife again requested a Mental Health Assessment. A plan for a referral to CRHT was made.

146. At 16.15hrs, the CRHT team received a request from the Access Team for an assessment of Mr M's mental health. A plan was made to contact Mr M's wife to clarify the situation and explore the options available - either CRHT support if suitable or an a MHAA (Mental Health Act Assessment) if not.

147. At 17.00hrs a CRHT Team Member contacted Mr M's wife. They attempted to speak to Mr M but he was incoherent and unable to provide any information. The notes taken suggest Mr M was relapsing and unable to engage with CRHT

148. Following information gathering by the Crisis Team it was deemed that Mr M would not be able to engage with them for home treatment as a less restrictive alternative to hospital admission.

149. Mr M's, wife agreed with this opinion and felt that an assessment under the Mental Health Act should take should place, she hoped that this could be facilitated the following day and not during the late evening / night as she and her daughter believed they could manage the situation until that point.

150. The Crisis Team contacted the Emergency Social Work Team (AMHP Desk) at 17.55 on 16th September 2021.

151. The purpose of the call to the Emergency Social Work Team (AMHP Desk) was to request that the Mental Health Act assessment be coordinated for the following morning and to make the

team aware of the current situation should any emergency / prioritised action be required during the night if JP's wife and daughter could no longer manage the situation as they planned.

17th September 2021

152. Following an urgent referral the Access Team made a telephone call to Mr M. His wife answered and reported Mr M was lying on the floor half asleep and unable (or unwilling) to engage with the call; she reported her husband didn't often present as well, and this had been the case for many years.

153. Mr M's wife stated:

- Mr M took to the floor on Monday night (14th) and had not voluntarily moved since
- Mr M had been incontinent twice, on the floor, where he lay
- Mr M's daughter had been round and helped her father into a chair and he had a drink
- Mr M then said he would go to bed, but returned to the floor instead
- Paramedics attended and referred him to the Access Team (as there were no concerns regarding him physically and Mr M had chosen to remain on the floor)
- Mr M's intake was minimal as he wasn't sitting up to eat or drink
- Mr M was not sleeping and often came out with confused, rambling speech during the night
- She (Mr M's wife) was staying with Mr M in the kitchen to keep an eye on him; she further stated:
- Mr M hadn't seen the GP for a long time
- Mr M was prescribed 4 tablets a day (prescription unknown) but he was very inconsistent in taking these
- Mr M had not expressed any suicidal or self-harm ideation

154. A home visit (following contact with Mr M's wife) was completed at 10.30am on the 17th September 2021 by a CRHT Professional. They noted:

- Wife reported her husband had remained on the floor
- Wife reported Mr M has been incontinent and not taken fluids since Tuesday night (15th September)
- Mr M was seen lying on the floor in the kitchen
- Mr M was wearing a shirt and what was described as an 'adult nappy', both appeared soiled
- There was a strong smell of faeces in the kitchen
- Mr M was spoken to and asked why he was on the floor, to which he initially responded he didn't know, but then went on to say it was due to his mood
- Mr M recognised he was struggling with his depression
- Mr M was asked if he was hungry - he said he was hungry and thirsty, but he couldn't eat as he was on the floor
- Mr M was asked about admission to Redwoods Centre - he replied it had helped him in the past so he would be willing to be admitted informally

155. As a result of this, the Shift Co-ordinator at MPFT was contacted, and a request for informal admission was shared for further assessment with the need to prevent further deterioration and

self-neglect. The Shift Co-ordinator stated they would discuss the situation with the Bed Manager at the Redwoods Centre. Both Mr M and his wife were made aware of the plan.

156. Following a call received from the CRHT, Falck Patient Transport Service (FPTS) attended Mr M's home address to transport him to Redwoods Centre. Mr M remained on the floor. FPTS were advised he had been there for 2 days.

157. They observed Mr M was in a poor physical condition. Mr M was not moving, he was curled in foetal position, wearing a soiled t-shirt, and they noticed multiple pressure sores some of which were infected.

158. The FPTS crew were informed that on 16th September 2020, WMAS attended the home address, and they were of the view Mr M had capacity, was able to mobilise and had refused to attend hospital.

159. The FPTS crew contacted their dispatch to raise their concerns with them. A call was made to the CRHT, who had attended the property earlier in the day. It was clarified that during the Crisis Teams visit they made the decision Mr M was required to attend Redwoods Centre via non-emergency Patient Transport.

160. In view of Mr M's condition, FPTS requested WMAS attend and transport Mr M to Royal Shrewsbury Hospital.

161. WMAS sent an ambulance to attend the property and met with the FPTS Crew. Mr M was positioned on the floor wet with urine with a strong smell, tachycardic and red flag markers for sepsis. WMAS noted Mr M had placed himself on floor and it was not a result of a fall. There had been other health care input, but no intervention had been put in place. Mr M had not been eating and was very low in weight. Mr M was changed out of his wet clothes, and incontinence pad and warming blankets applied, before WMAS transported him to hospital. Photographs of his pressure sores were taken to aid documentation and a safeguarding referral was completed. WMAS state Mr M's wife declined to complete a welfare or fire safety referral to the Fire service.

162. Mr M was admitted to Royal Shrewsbury Hospital at 22.00hrs on 17th September 2020.

163. The Doctor in A & E noted Mr M was "very frail, with smelly bedsores".

164. Mr M's records identify he was very unwell on admission with very high infection markers along with kidney damage.

165. Mr M was treated for sepsis and low potassium and the notes indicated he was probably end of life.

18th September 2020

166. At 22.03 hrs on 18th September 2020 Mr M suffered a cardiac arrest. Mr M was found unresponsive by staff on the ward at Shrewsbury Hospital.

167. At 22.30hrs a clinical decision was made to stop treatment and Mr M sadly passed away.

168. Subsequently, the Coroner noted cause of death was sepsis of unknown origin and frailty.

22nd September 2020

169. FPTS notified the Care Quality Commission (CQC).

170. FPTS state they did not receive a response from the CQC.

28th September 2021

171. FPTS raised an adult safeguarding concern via First Point of Contact on the basis Mr M had not received medical review, or treatment, for two days despite help being requested by his wife and contact with several Agencies.

172. The First Point of Contact or 'FPOC Team' are part of Shropshire Council's Customer Service Centre. The team of advisors take calls and emails from members of the public and professionals looking for support and assistance for adults in Shropshire.

173. During the initial scoping review meeting, into the events leading up to Mr M's death, Professionals raised the following concerns:

A. FPTS expressed concern Mr M's wife requested help on 16th September 2020 advising her husband was refusing to get up off the floor and yet, despite several Agencies being involved, Mr M did not receive a medical review until the 18th of September 2020?

B. Concerns were raised around WMAS assessment of Mr M's mental capacity to make decisions in relation to his care and support needs and possible need for hospital treatment. Although difficult to evidence, capacity could be questionable due to the description given of Mr M's poor physical condition. There was a capacity assessment completed by a Professional in 2019, but did Mr M have capacity in 2020 to decline treatment? Further, how could they conclude Mr M has fluctuating capacity when an assessment has not been done since 2019?

C. The Crisis Team did not carry out a home visit until 24 hours after the concerns raised. Concerns were raised as to whether this was an unnecessary delay.

D. A request for mental health assessment was not accepted by the Approved Mental Health Professional Service (AMHP) as they felt the Crisis Team should go out and review Mr M's physical health first. AMHP service previously stated they would make contact on the 16th September 2020 but was contact made? Questions were asked whether appropriate action was taken as no contact is evident from the AMHP Service?

E. Mr M's wife was asked to contact the GP and did not do so. A question was raised as to whether a Professional could have made contact with the GP on her behalf?

F. Concerns were also raised as to why the Crisis Team requested non-emergency transport, given Mr M had potentially been on the floor for over 2-3 days and was noted to be in poor physical health?

G. There is a clear request for a Mental Health Act Assessment under s13(4) of the Mental Health Act (1983) –which is a request from a 'Nearest Relative' (s26 Mental Health Act (1983). In this case Mr M's wife is the nearest relative. It appears that this may have potentially been over-looked.

H. There is concern in relation to the Crisis Team and Emergency Social Work Team agreeing a Mental Health Act Assessment could be convened for the next day. It is unclear as to why this was not considered on a more urgent basis, given Mr M had been lying on the floor in urine for 2-3 days and was noted to be incoherent?

All these concerns are explored further in the analysis below

Critical Analysis and the key lines of enquiry

174. The critical analysis specifically addresses the 15 key lines of enquiry set out by the SSCP. It will also identify related learning/actions.

Key Line of Enquiry 1 It is accepted Mr M was the subject of self-neglect. What evidence (if any) in Mr M's case is there of Neglect and Acts of Omission by Agencies, in particular a failure to provide personal or medical care and a failure to provide (privacy) and dignity.

175. On the basis of the evidence provided by a number of Agencies to the Shropshire Safeguarding Community Partnership (SSCP) and the comments made in the Coroner's case summary, it is clear that Mr M had a history of serious self-neglect over time.

176. To evidence the point, I detail below some of the significant incidents which support the fact that Mr M experienced some serious difficulties including self-neglect during the scoping period:

- When Mr M was admitted to the Royal Shrewsbury Hospital in April 2019 he was described as confused, unkempt with pressure sores and was described frail and malnourished. Mr M had hypothermia and he was treated for anaemia.

- On 15th June 2020 a 999-call received for Mr M who had fallen at home. An ambulance was dispatched and attended the home address. Mr M had fallen the day previously and hurt his wrist and had fallen again that day, but this time was unable to get up off the floor. Mr M was unsure of events of the incident and his wife reported Mr M was more confused than usual.

- When Professionals from CRHT, FPTS and WMAS attended Mr M's home address on both 17th September 2020 he was found in a distressing condition on the floor of his home, curled in a foetal position, wearing a shirt and a form of incontinence pad, which appeared soiled. Mr M had infected sores, smelt of urine and was not drinking or eating properly. His living conditions were described by WMAS as poor and CRHT describe a strong smell of faeces in the kitchen. This will have been extremely difficult for Mr M and his family.

- When examining the period between 2019 and 2020 it appears Mr M was suffering with multiple complex physical and mental health conditions and at times may have been in a great deal of pain.

177. There is also a consensus Mr M was living in unhygienic conditions, and his levels of personal care were poor.

178. Given the comments made by Mr M's wife to the Coroner, around her husband 'giving up on life', it is likely Mr M's health and living conditions deteriorated over this time.

The duty to promote the wellbeing of people experiencing self-neglect

179. SSCP Partner Agencies have a specific duty to support adults with care and support needs and this includes those experiencing self-neglect.

180. The Care & Support Statutory Guidance states self-neglect, 'Covers a wide range of behaviour - neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.'

181. Bray et al (2015) state self-neglect, 'Includes people, either with or without mental capacity, who demonstrate:

- lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- refusal of services that would mitigate risk of harm.'

182. Self-neglect poses particular challenges as it can result in conflict between values of rights to self-determination and a duty of care.

183. The current Working with Self-neglect in Shropshire Guidance does not provide explicit guidance on thresholds for intervention.

184. A number of other Adult Safeguarding Boards have introduced threshold guidance to support Professionals when considering all safeguarding matters not just self-neglect. Such guidance can play a crucial role in ensuring that safeguarding enquiries are undertaken for adults with care and

support needs. However, threshold documents cannot cover all situations and may be considered prescriptive and discretionary professional judgement is still needed.

Recommendation / Learning 1

185. **The SSCP may wish to review the decision not to introduce a threshold document (including self-neglect) to support the Working with Self-neglect in Shropshire Guidance**

186. It is noted that on Page 12 (point 4.20) of the Working with Self-neglect in Shropshire Guidance provides a helpful table of examples detailing how Professionals may intervene when people are self-neglecting. The Guidance also provides a link to the Local Government 'Making safeguarding personal toolkit'.

187. In this case, it is evident Professionals adopted the principles of the Care Act, and sought to make safeguarding personal, by considering and respecting the views of Mr M and his wife on a number of occasions. The couple's wishes were clearly heard.

188. However, this then invites the question as to whether Mr M was in a position to make fully informed decisions around his health and well-being and whether there should have been a more thorough assessment of his capacity to make specific decisions and proactive professional support put in place.

189. It is clear professional support was offered on several occasions, but Mr M was not always willing to accept it or engage with Agencies offering their services.

190. Mr M's wife had stated at times her husband did not want support but on other occasions she expressed a view that neither she nor husband could cope and requested interventions. Mrs M particularly requested help when in a crisis situation, such as the days immediately leading up to her husband's death.

191. Given the situation it is understandable Mr M presented in different ways at different times. This is not unusual. Mental health, vulnerability and resilience can fluctuate over time.

192. Further, it is not unusual for people in challenging situations to want to maintain their independence and privacy, when it is clear they may need professional support.

193. It seems the deteriorating situation, over a protracted period, had an adverse impact on Mr M's physical and mental wellbeing, as well as potentially the well-being of his wife.

194. Taking all of the aforementioned into account, I would suggest opportunities for stronger multi-Agency working, and proactive support for Mr M and his wife, were not always identified or taken.

195. Multi-Agency working is challenging, but critical. It is recognised there is always a raft of competing demands on Agencies. The pandemic would have presented additional challenges for

Professionals in the months leading up to Mr M's death. However, effective multi-Agency working can provide an enhanced response and protection to individuals with multiple and complex needs even in the most challenging context.

196. It appears several Agencies may have been working to support Mr M and his wife in isolation, as opposed to recognising their interdependencies, the importance of information sharing, and the added value of coming together, to support Mr M and his wife. Whilst it is evident Professionals had on occasions sought to support Mr M and his wife, this was often with limited understanding of what information and support other Agencies may hold, and what support they may, or may not have, been providing.

197. Given the complexities of the situation, and associated risk, I would suggest there would have been significant benefits in a calling for multi-Agency strategy meetings in order to share information, identify clear 'ownership' and collectively agree a way forward. Self-neglect cannot be addressed by a single Agency alone, and it is only by working together that the level of risk can be properly assessed, and a layer of support interventions put in place.

198. The guidance is clear. Any Agency may call for a multi-Agency meeting. Professionals at all levels should be encouraged to seek clarity, challenge decisions and to escalate issues of concerns within a well-defined process.

199. By following the guidance, a lead Professional could have been identified to coordinate and oversee the holistic management of the case.

200. It is accepted that designating patterns of behaviour, as a safeguarding issue alone, does not in itself make an individual safe. However, if Professionals and Agencies had come together to share their concerns there is a strong likelihood positive intervention would have followed.

201. It is of particular note the Working with Self-Neglect in Shropshire guidance states 'the risk to the adult and others is greater when they are refusing services that would mitigate the risk of harm to themselves or others'.

202. Enhanced Multi-Agency working may also have promoted more professional challenge and communication between Agencies, particularly where Professionals had not received a response from partner Agencies. Any proposals to close case files may also have been subject of professional challenge and a consensus reached.

203. Multi-Agency meetings may also have led to establishing what family support was in place or could have been provided to Mr M and his wife.

204. Mr M's daughter provided some support in the day's leading up to her father's death. There is a record of Mr M's daughter having a telephone conversation with Adult Social Care on 16th September 2020, where she expressed a concern around her father's condition and what support

he was receiving from Agencies. It may have been helpful to have sought the views of Mr M's daughter.

205. An earlier multi-Agency strategy meeting may have explored working with the daughter (and potentially other family members) in order to support Mr M.

206. The practice in this case, at times, seems at variance with the aforementioned Self-Neglect Guidance. Whilst there was liaison between Agencies, and a number of Professionals were involved with Mr M and his wife at different times, there is limited evidence of a clear, coherent multi-Agency approach for Agencies to deliver their services, in a collaborative and visible way, for Mr M.

Recommendation / Learning 2

207. **When presented with a challenging complex situation such as this, Agencies should call a Multi-Disciplinary Professionals meeting at the earliest opportunity, to ensure professional curiosity is exercised. This is particularly the case where agencies are struggling to engage adults with care and support needs.**

Recommendation / Learning 3

208. **The SSCP Partnership should promote relationship-based practice amongst professionals working with people who self-neglect.**

209. In examining the question what evidence (if any in Mr M's case) is there regarding whether neglect and acts of omission by Agencies, in particular a failure to provide personal or medical care and a failure to provide (privacy) and dignity; there are a number of concerns highlighted by Professionals.

210. One of the key questions is why MPFT decided that someone lying on the floor as described since they were first made aware at 04.15 on the 16th September 2020. -including information that he had been on the floor most of the 15th and some of the 14th as well - felt a home visit to assess his mental health needs could be left until the 17th September 2020.

211. Another key question is why the Crisis Team requested non-emergency transport, given that Mr M had potentially been on the floor for over 2-3 days and was noted to be in poor physical health.

212. Further, despite several Agencies being involved, Mr M did not receive a medical review until the 18th of September 2020.

213. Responses to these key questions are explored throughout this SAR.

214. Consideration has been given as to whether delaying the assessment of Mr M's mental health until the next day was influenced by 'system convenience'.

215. There is no evidence to suggest that 'system convenience' influenced the decision to delay the assessment of Mr M until the 17th September. It would appear MPFT Practitioners were satisfied that Mr M's wife could manage overnight, when they discussed the matter with her at 17.00 on the 17th September, and she would call for help as required. It is noted that the paramedics had completed a home visit shortly before and felt able to leave him at home for mental health services to respond. It would also appear that Mr M was satisfied with this arrangement.

216. Earlier in this review I have noted that the MPFT had marked the case as requiring urgent contact at 08.43 on the 16th September. When a representative from MPFT did visit on the 17th September they were able to make plans for an informal admission to the Redwoods Centre (mental health hospital) which raises the question that this outcome may have been executed earlier if this visit had taken place the day before.

217. There is consensus a number of Agencies, who had contact with Mr M could have displayed more professional curiosity.

218. Within a briefing document to Agencies and Professionals 'What is professional curiosity?' the Keeping Adults Safe in Shropshire Network state:

219. 'Professional curiosity is the skills used to explore and understand with what is happening with an individual or family. It is about managers and practitioners maintaining respectful uncertainty rather than making assumptions or accepting things at face value. It is about listening and exploring uncertain thoughts and feelings generating when working with an individual or family through critical enquiry and the evaluation of information'.

220. Professional curiosity or respectful uncertainty is particularly important when working with people who are displaying signs of vulnerability but are consistently stating they have no safeguarding concerns and are reluctant to engage.

221. There is a continuum of behaviours from people with full co-operation at one end of the spectrum and a clear reluctance to engage at the other. Many adults at risk seek to 'show their best side' or 'save face' which means Professionals are often working with limited or ambiguous information.

222. Professionals are required to rely upon guidance, their experience, and judgement to 'see beyond the obvious.'

223. It is recognised more enquiries could have been made around Mr M declining support. Questions could have included why this was the case, whether Mr M's wife had the appropriate support, as a carer, how might other family member's been sought and what other options may have been available to encourage Mr M and his wife to engage with Agencies.

224. As stated, at different times, Mr M and his wife declined support from Agencies.

225. On occasions, when Professionals tried to visit the home address, Mr M was reluctant to accept.

226. On other occasions, Mr M did engage with Agencies and permit Professionals and accept them in their home.

227. What is clear is that Mr M was an adult at risk.

228. Conversations with Mr M and his wife took place in their home and in the presence of each other, naturally may have reduced the opportunity to discuss any concerns with Professionals in confidence. Professionals may have considered how else they could have created an opportunity for Mr M and his wife to talk in confidence, for example was there an opportunity for such discussions when Mr M was in hospital.

229. Further, when engaging with Mr M and his wife, Professionals could have made more enquires as to whether more could have been done to establish the reasons why Mr M did not wish to receive support.

230. The Working with Self-neglect in Shropshire Guidance states 'an understanding an adult's life history and who is or has been important in their lives can help not only to develop a relationship with them but also make connections to patterns of self-neglect; and form hypotheses with the adult and those working with them about why and when they self-neglect. This can help to inform individualised interventions and safety strategies which might work for that adult to reduce their risk'.

231. The guidance goes on to say 'Finding' the adult is a key part of the assessment process to inform risk management and intervention, which should also involve appropriate others'.

Key Line of Enquiry 2

Mr M's relapse profile and concerns relating to self-neglect and home conditions were known to Agencies. Who / if anyone was supporting / monitoring Mr M and his wife when at home? How effective was this support/monitoring in minimising the identified risks to Mr M?

Recommendation / Learning 4

232. **Relapse signatures should be documented in MPFT clinical records and reviewed when someone is presenting in crisis. Professionals should give due consideration to relapse signatures and consider early review to determine what early support is needed and a mental health assessment, where a relapse signature is evident.**

233. A relapse signature is, in simple terms, the worsening of symptoms that may be experienced, or a return of symptoms, associated with illness. It can be used to develop awareness of the early warning signs to look out for when someone is starting to become unwell and can be used by the person, informal Carers and Professionals to plan responses.

234. Mr M's deterioration and placing himself on the floor was a pattern seen previously by Professionals. Mr M had previously elected to stay on the floor when low in mood and/or when his mental health was deteriorating.

235. For example, when admitted to Hospital on 2nd April 2019, Mr M was observed crawling on the floor. Further, when his wife contacted Adult Social Care on 15th June 2020, she described Mr M was sitting on the floor.

236. Experiencing a relapse in undoubtably an anxious time for those affected, those caring for them and families.

237. Early warning signs can vary between individuals but recognising triggers can help Professionals develop strategies to reduce further harm.

238. It is considered good practice, when completing care plans, to include information about any early warning signs a person exhibits when they are deteriorating, and how this can be used to inform the steps that may be needed to support the vulnerable person.

239. It is not clear in this case from the documentation received from MPFT whether Mr M's relapse signature was explicitly documented and shared with other Professionals. It is also not clear how much emphasis was placed on the relapse signature when Professionals attended the home address on the 16th and 17th September 2020.

240. When Mr M reverted to the floor on 14th September 2020, I would suggest this should have been viewed by Professionals as a clear relapse signature.

241. It was clearly repeated action which illustrated a deteriorating situation and a decline in Mr M's mental health. It is unclear if Professionals reviewed and communicated how Mr M presented when previously unwell to help inform responses this time.

242. The early identification of Mr M's actions as a relapse signature may have prompted earlier intervention, which meant he may not have been left on the floor for such a protracted period of time. Further, I would suggest the relapse should have prompted consideration for a mental health assessment when there is a history of relapse.

Key Line of Enquiry 3 What evidence is there staff involved in this case had knowledge and applied the Shropshire Safeguarding Community Partnership (formerly known as Keeping Adults Safe in Shropshire Board) Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance, in their work with Mr M and his wife?

243. The Care Act Statutory Guidance states that cases of self-neglect should be considered on a case-by-case basis and while these cases may not prompt a 'Section 42' safeguarding enquiry, it should

be remembered that there may come a time where the person who is self-neglecting may no longer be able to protect themselves.

244. The SSCP launched the 'Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance' in April 2019.

245. The guidance is highly relevant to this case. There was clear history of Mr M suffering psychotic depression, inconsistency in taking medication, and appearing confused and incoherent on different occasions.

246. Mr M was also suffering with his physical health. He was frail, malnourished and was suffering as a result of his poor hygiene. Mr M had a history of suffering falls.

247. There is a clear interdependence between physical and mental health. It is well documented and researched that people with long-term pain can find themselves struggling with low mood, depression, anxiety, and isolation – this can in turn make the pain worse. Therefore, it is accepted Professionals tackle these emotional impacts of pain as well as treating the pain itself.

248. Research often refers to three types of self-neglect:

- Lack of self-care
- Lack of care of one's environment
- Refusal of services that could alleviate issues connected to self-care or care of the environment

249. It is also important to understand poor environmental conditions, personal hygiene, or health may not necessarily always be the result of self-neglect. It could arise due to cognitive impairment, functional and financial constraints. In addition, many people, particularly older people who self-neglect, may lack the ability and/or confidence to come forward to ask for help, and may also lack the support of others who can advocate or speak for them. They may then refuse help or support when offered or receive services that do not actually adequately meet their needs.

250. Research conducted (Braye, S et al: 2015) with practitioners and people who use services, highlighted many different causes of self-neglect including:

- Past trauma or experience of loss
- A form of coping mechanism: to deal with experiences or emotions which feel overwhelming
- Low self-esteem and the adult's view that they are not worthy of help and/or do not deserve to live better
- Because of their current circumstances (homelessness, existing or deteriorating poor health)
- A result of previous and ongoing perceived or actual abuse or neglect by others (including services). Self-neglect can co-exist with other forms of abuse and neglect

251. Many of these behaviours were observed in this case. Mr M and his wife had lost an adult son, Mr M's wife described her husband as having 'given up on life' and he had deteriorating poor health.

252. The review indicates that not all agencies had fully embedded the knowledge of the self-neglect guidance across their organisation, in particular with their frontline workforce.

253. I offer this assertion based on some gaps in this case regarding important aspects of the guidance, including recognising the importance of the professional relationship, 'finding the adult', identifying creative interventions and ensuring cases are not closed where there is a perceived lack of engagement.

254. All agencies engaged in this SAR accept to a degree there were opportunities for more professional curiosity, Multi Agency working and proactive support with Mr M and his wife.

255. Embedding Multi Agency guidance across a range of Agencies and Professionals can be very challenging.

256. This can be due to range of reasons including the plethora of legislation and guidance Professionals are subject to, a changing workforce and the capacity to undertake professional development.

257. I understand that since these events, and the start of this SAR a multi-agency audit has been carried out by the self-neglect priority group about how agencies are embedding the self-neglect guidance.

258. I would propose that the findings from this multi-agency audit are brought forward and shared with from Professionals. This should be complimented with developing more awareness and understanding of the Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance.' The Partnership may consider undertaking a survey to further embed the guidance.

Recommendation / Learning 5

259. **The SSCP Partnership should continue to raise and understanding of the 'Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance.' In doing so, they should review the findings of the self-neglect priority group multi-agency audit and consider a survey to further embed the Guidance.**

Mental Health and Capacity

260. In addressing this question, whilst mental health is not explicitly referenced within the Terms of Reference, it is important to consider the issue of mental health and capacity, as it is a key aspect of this case. There is a clear link between mental capacity and self-neglect.

261. Further, we know in law that mental health problems do not necessarily equate to a lack of capacity to make certain decisions

262. The aforementioned Self Neglect Guidance states ‘Mental capacity is a key determinant of the ways in which Professionals understand self-neglect and how they respond in practice.

263. Learning from Safeguarding Adult Reviews (SAR) in general, but specifically in relation to individuals who self-neglect; has identified a need for improvement in the quality of direct practice in relation to Practitioner’s understanding and application of best mental capacity practice’ (Local Government Association. Preston -Shoot, M, Braye, S, (2019) Analysis of Safeguarding Adult Reviews April 2017 -March 2019)

264. The Mental Capacity Act empowers people, and places individuals at the very heart of the decision-making process. The Code of Practice sets out how the Act should be applied by Professionals.

265. The Mental Health Act 1983 Code of Practice states:

266. ‘It will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under this Act) without an understanding of key concepts in the MCA. In particular, they will need to be familiar with the principles and main provisions of the MCA to understand when a person may lack capacity to make a particular decision, to know when decisions can be taken in the best interests of people who lack capacity to take those decisions themselves, and the steps to be taken before doing so.

267. It is important to recognise an individual can be experiencing, or at risk of, self-neglect and have mental capacity. This is often a regular occurrence in cases of individuals who self-neglect, and who are refusing to engage with, or consent to, services or intervention; where the risk to themselves and/or others is likely or imminent. This reflects the challenge in this area.

268. Good practice would suggest mental capacity should be considered by Professionals:

- During any assessment
- Whenever a care plan is being developed or reviewed
- At other relevant stages of the care planning process, and
- As particular decisions need to be made

269. An understanding of the application of the Mental Capacity Act 2005 in practice underpins work undertaken with adults who self-neglect.

270. When examining how the Self Neglect Guidance and Mental Capacity Act was applied with Mr M, it is noted on 18th April 2019, Mr M underwent a Mental Health Act Assessment and was deemed to be detainable under Section 2 MHA.

271. Detention under the Mental Health Act does not necessarily equate to evidence that Mr M lacked capacity to make specific decisions (as the criteria for detention are not based on capacity) but it is an indication that he required mental health treatment.

272. Whilst in Hospital, Mr M was subject of further mental health assessments. On both of these occasions Mr M was deemed to have capacity regarding discharge planning.

273. Where appropriate, people should be allowed the time to make a decision themselves. The Mental Capacity Act and the associated Code of Practice provides detained guidance on the two stages of the capacity assessment which must be applied to a specific decision. This covers the diagnostic element pertaining to an impairment or disturbance in the functioning of the mind or brain which means the person cannot make the decision at the relevant time. The second stage is a functional assessment as to whether the person can understand, retain, weigh (or use) information and then communicate that decision

274. On 5th June 2019, Mr M agreed to completion of the Addenbrooke's Cognitive Examination and scored a total of 82 out of 100. This was still considered low but an improvement from his previous score of 58 on 26th April 2019. The Doctor completing the second assessment records the improvement was likely to indicate functional, rather than organic illness, due to the marked improvement from the previous scores.

275. It is also noted further consideration was given to Mr M's mental health and capacity at other times. For example:

- On 10th June 2019 when Mr M was discharged from Redwoods Centre, he was deemed to have capacity to decide whether to go home.

- On 15th June 2020 WMAS attended the home address and raised concerns as to whether Mr M may have dementia. This was part of a referral to Adult Social Care.

- On 20th July 2020 when Mr M was discharged from the Nursing Home, he was deemed to have capacity.

- On 16th September 2020 WMAS were of the opinion Mr M had capacity, which informed their decision not to take him to Hospital

276. Professionals recognised the significance of mental health in this case, in that formal mental health assessments were carried out within hospital settings, alongside further consideration by different Professionals around Mr M's capacity at different times.

277. However, there is a concern that Mr M's mental health, and capacity, was not fully considered consistently by all Agencies over time. There were occasions when a mental capacity assessment may have helped in addressing Mr M's self-neglect.

278. Mr M had suffered mental health crisis resulting in a psychiatric admission in the past. Mr M's was a man who on occasions was incoherent and difficult to understand.

279. Although difficult to evidence, Mr M's capacity could be questionable due to the poor physical condition he was described to be in. His living conditions were also poor, although it is accepted that Mr M's wife was also residing in the home.

280. Mr M appeared to be increasingly reliant on his wife and on a number of occasions (for example when declining care and support) appeared in agreement with her decision-making around his health and well-being. However, there are other examples, such as when Mr M, was unwilling to respond to Mr M's wife's requests to get up from the floor, where he did not appear to be in agreement with her.

281. In the days prior to Mr M's death, he clearly demonstrated a relapse signature, highlighting a deteriorating position.

282. When taking all this into consideration, I would suggest opportunities for further exploration and assessment around Mr M's mental capacity were not always taken. For example, when Mr M was lying on the floor for such a protracted period of time, earlier intervention and transfer to hospital would have benefited Mr M.

283. It appears collectively Professionals did not always recognise the need to fully explore whether Mr M had sufficient capacity to understand his physical and mental health challenges and make decisions for himself.

284. There are a number of occasions where professionals should have explored further Mr M's capacity to make specific decisions.

285. Mr M reported that he and his wife shared the domestic tasks, that he was independent with all self-care tasks and able to manage stairs without support. This was evidently not the case. Mr M appeared to have limited insight into his presentation at home.

286. Another example are Mr M's comments that he can manage his continence which was not evident in practice.

287. Further, it is noted that when in Hospital Mr M gained significant weight. This may have invited further exploration as to why he had lost much weight at home.

288. Whilst recognising that Mr M had on occasions declined support, they would have benefited from ongoing assessment required to achieve a holistic picture of Mr M's, capacity to decide on care and treatment.

289. A lack of cooperation may itself be indicative of making an unwise decision, which should warrant further probing to understand and explore the underlying issues.

290. Professional curiosity is key. An inquisitive approach is required in order for Professionals to question and challenge the information they receive, identify concerns, and make connections to enable a greater understanding of a person's situation.

291. It may be considered mental capacity has been ‘assumed’ but not explored in sufficient depth, particularly where the persistence of self-neglect was a factor.

292. Capacity decisions are specific to a certain issue. For example, in this case, one of the key questions is whether Mr M had sufficient capacity to make an informed decision about his desire to lay on the floor and the impact this would have on his physical and mental health.

293. In this case, it could be argued issues around capacity could have been explored further. Despite the challenges, Professionals could have gained a more thorough indication of how Mr M was living, by assessing the living environment and how this impacted on him; this may have given a different view of his capacity.

294. It is acknowledged that Mr M may well have had capacity to decline support at various intervals in time that he was known to services but given his very precarious position on 16th September 2020 any decision that he had capacity especially incorporating whether he had executive capacity would have needed a very robust assessment by WMAS and one which may have benefitted from exploration with specialist mental health services.

295. There was no evidence presented through this Safeguarding adult review process that West Midlands Ambulance Service did undertake a sufficiently robust assessment of capacity and one that would have included providing with information about the physical health implications of his “choice” to remain on the floor.

296. It is accepted a more thorough assessment of capacity would not necessarily have provided a means to secure more engagement and cooperation with Mr M but this would have enhanced the collective understanding of the situation, informed risk assessment, and potentially provide a basis for support and intervention.

Recommendation / Learning 6

297. **The SSCP Partnership should be assured that MCA training is accessible and being received by all partner agencies including WMAS.**

Interface between the Crisis Resolution and Home Treatment Team and the Approved Mental Health Professionals.

298. I will now examine the events between the 16th and 18th September 2020 with regard to the interface between the Crisis Resolution and Home Treatment Team and the Approved Mental Health Professionals.

299. A summary of events involving CRHT and AMHP is detailed as follows:

300. On 16th September 2020 Mr M's wife stated she could not cope and requested a Mental Health Assessment be carried out as soon as possible. This was her right as the nearest relative under section 13(4) of the Mental Health Act.

301. Mr M's wife spoke to the Shropshire Access Team and requested the Mental Health Act Assessment stating she is unable to cope with her husband.

302. At 16.15hrs on 16th September 2020, the CRHT received a request from the Access Team for a Mental Health Act Assessment. A plan was made to contact Mr M's wife to clarify the situation and explore the options available - either CRHT support if suitable or Mental Health Act Assessment if not.

303. At 17.00hrs on the same day CRHT contacted Mr M's wife. They attempted to speak to Mr M, but he was incoherent and was unable to provide any information. The notes taken suggest Mr M was relapsing and unable to engage with CRHT.

304. During a conversation with CRHT, Mr M's wife stated she was content to have a Mental Health Act Assessment completed the following day, with her husband remaining at home until then. Mr M's wife stated she had sufficient support to manage him until then, which is at odds with what she had initially stated to the Access team.

305. It was agreed between Mrs M and CRHT representative that a Mental Health Act assessment would be progressed the following day. It is recorded Mr M's wife was in agreement with this; and she would have help and support from her daughter in the meantime. It was agreed with Mr M's wife that she would make contact with CRHT if the situation became unmanageable overnight.

306. Contact was made with the Emergency Social Work Team to make them aware of the Mental Health Assessment. This was completed at 17.55hrs on 16th September 2021.

307. Mr M's wife reiterated her request for a Mental Health Act Assessment to Professionals the following day.

308. Mr M's wife stated that the situation appeared to be the same as 6 years prior when her husband required admission to the Redwood Centre for assessment and treatment of his mental health, she felt that the same response was required at this stage and supported further assessment under the Mental Health Act to allow for this to happen.

309. On 17th September a Professional from CRHT attended the home address to undertake an assessment. Mr M was seen lying on the floor in the kitchen, he was wearing a shirt and what was described as an incontinence pad, both appeared soiled. There was a strong smell of faeces in the kitchen.

310. Mr M was asked why he was on the floor, to which he initially responded he didn't know, but then went on to say it was due to his mood. Mr M recognised he was struggling with his depression. Mr M was asked if he was hungry; he said he was hungry and thirsty, but he couldn't eat as he

was on the floor. Mr M was asked about admission to Redwoods Centre, and he replied it had helped him in the past so he would be willing to be admitted informally.

Shropshire Council / MPFT Mental Health Assessment Pathway

311. The Shropshire Council / MPFT Mental Health Assessment Pathway was agreed by the MPFT and Shropshire ASC in April 2020.

312. The principles and guidance underpinning the Pathway state: 'only in exceptional circumstances should an individual go forward for a mental health assessment without an initial contact by a Professional to assess the risk'.

313. 13(4) of the Mental Health Act states: 'It shall be the duty of a Local Social Services Authority, if so required by the nearest relative of a patient residing in their area, to make arrangements under subsection (1) above for an approved mental health Professional to consider the patient's case with a view to making an application for his admission to hospital; and if in any such case that Professional decides not to make an application he shall inform the nearest relative of his reasons in writing.

314. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision, while at the same time preserving the patient's 'right to confidentiality'.

315. The right to request a Mental Health Assessment is reinforced in the Code of Practice to the Act.

316. The request from Mr M's wife for a Mental Health Assessment under the Mental Health Act of her husband was initially accepted by the Approved Mental Health Professional Service (AMHP) however they stated they would not undertake the assessment until Mr M had been seen by the CHRT and a Urinary Tract Infection ruled out.

317. The AMHP felt this decision was appropriate and that physical health needs should be ruled out before progressing with a Mental Health Act Assessment.

318. It is of note that the AMHP was not aware that a MHA assessment had been requested by Mr M's wife and if they had been aware they would have contacted her as the nearest relative directly to inform her of why assessment was being declined at that time."

319. The AMHP will say that even if they were aware that a request had been made by Mr M's wife the decision to defer any assessment would not have changed.

320. Once made aware, the AMHP noted that the Mental Health Pathway had not been followed, in that CRHT had not been out to see Mr M to see if a Mental Health Assessment was required.

321. AMHP will say they wouldn't ordinarily go out and assess someone under the Mental Health Act in a situation as presented in this case.

322. They describe a Mental Health Act Assessment as a ‘last resort’ and should not be carried out routinely.

323. This approach is primarily because AMHP will offer the view that given how complex Mental Health Act Assessments can be, the finite nature of resources and the Care Act principles it is felt it is appropriate to have a tiered approach where CRHT ordinarily undertake an initial assessment.

324. The Pathway clearly states the AMHP must 'consider' a request for mental health assessment. However, the Code is also clear Professionals should not subject someone to a mental health assessment unnecessarily.

325. AMHP’s should check who is making any referral and ensure the Nearest Relative is contacted in a timely way and informed in writing as to what the proposed course of action is and why this is the case.

326. AMHP service directed an assessment of Mr M’s physical health should be carried out before any mental health assessment. One of the specific reasons put forward was to rule out the possibility of a urinary tract infection, which is a common cause for confusion and deterioration in physical health.

327. This is recognised as effective practice as a urinary tract infection can greatly affect a person’s presentation.

328. AMHP will say in any set of circumstances they would expect all physical health issues to be checked and ruled out for why a person is presenting in a certain way. Depending on where the person is would depend on who does this – Hospital Avoidance, Crisis Team, Hospital wards, GP etc. AMHP’s point out that they are not health workers therefore cannot complete physical health checks, as they are not qualified to do so.

329. AMHP will say that ordinarily they will place weight on the physical checks carried out by other Agencies / Professionals as part of their overall assessment.

330. When the AMHP asked for physical health checks be carried out first, I understand they were aware WMAS had already undertaken physical health checks.

331. The AMHP was clear that the CRHT should undertake the physical checks without delay.

332. The AMHP was aware that Mr M had been placing himself on the floor during the current episode.

333. However, what is not explicitly clear is whether the AMHP was aware of the family view that Mr M had “given up” and lying on the floor had featured as part of his relapse signature. This was important contextual information. If not volunteered, the AMHP should seek such information in order they may make a fully informed decision.

Recommendation / Learning 7.

334. **When sharing information between agencies both the CHRT and the AMHP should ensure the information is sufficiently clear to help identify the level of risk and priority. A Joint audit between this teams should be carried out into the quality of the referrals and the finding reported to the Joint Case review group.**

335. When exploring the interface between CRHT and AMHP it appears that initially AMHP were apparently unaware Mr M's wife had requested a Mental Health Assessment. A Professional from AMHP states if he had been aware he would have contacted Mr M's wife directly to explain why a Mental Health Act assessment would not be carried out in the first instance but would have offered support from CRHT.

336. AMHP are of the opinion agreeing with CRHT for the latter to undertake the initial assessment was appropriate and in line with the Mental Health Pathway. AMHP are clear they believe Mr M's physical health requirements needed to be ruled out before progressing with any mental health assessment. AMHP specifically requested Mr M be examined for urine infection, which is common cause for confusion and deterioration in physical health.

337. However, Mr M's wife was also clear with Professionals her husband remained on the floor primarily due to a relapse in his mental health, as opposed to any physical barriers which affected his mobility. Mr M's wife's view was supported by WMAS in their assessment, who described Mr M's actions as a 'behavioural' issue.

338. That is not to say that Mr M was not frail, incontinent, and possibly in pain as a result of sitting on the floor for such a protracted period of time without properly eating or drinking.

339. His dignity may also have been adversely effected with a number of Professionals engaging with him whilst he remained on the floor. It cannot have been a comfortable position for Mr M to have different people in his home whilst he was in such a poor state.

340. Whilst it is difficult to definitively state the degree to which Mr M may have deteriorated during this period of time; I would suggest he would have benefited from an earlier intervention both in terms of physical and mental health. It is clear the risk of developing pressure ulcers would only increase the longer he stayed on the floor without any relief for his pressure areas.

341. There was approximately 40 hours between the initial contact from Mr M's wife on 16th September 2020 and the Ambulance being called on 17th September 2020. This would appear to be an unnecessary delay in Mr M receiving care for either his physical or mental health. It should be noted Mr M's wife apparently remained in the kitchen to care for her husband throughout, which clearly would have been distressing for her.

342. I would suggest further dialogue between the AMHP and CRHT have aided a clearer understanding of urgency and that physical health causation had already been ruled out.

343. It is also of note that following a home visit by CRHT there was limited further communication with AMHP.

344. I would also suggest consideration should have been given to an earlier admission to hospital for physical assessment and/or the assessment and treatment of his mental health. On balance, this would have been in Mr M's best interests.

345. There is a mental health pathway. The Pathway provides a framework of good practice, in that it follows the guiding principles of the Mental Health Act. The Pathway provides a mechanism to ensure that assessments are coordinated in a timely manner between the services and minimise delays.

346. The Pathway supports the principle that it's better for CRHT to go and initially assess the patient and then determine if a MHA assessment is required.

347. If CRHT are unsure if it's a MHA assessment or Professionals disagree then a joint visit with an AMHP and CRHT worker should be arranged.

348. I have been informed that there are now much more regular joint discussions, and incidents are escalated to the AMHP and CRHT managers where necessary. I understand where the AMHP Team can accommodate they will complete a joint visit with the CRHT, if they cannot agree a way forward.

349. AMHP will say they do apply some flexibility where they feel it's appropriate but ordinarily the Pathway will be followed.

350. When reviewing this case, some Professionals offer the view that a greater degree of flexibility and discretion could have been shown to reduce the delay in care and support for Mr M.

351. It could be suggested that there may have been a degree of uncertainty caused by the initial misunderstanding and subsequent communication between AMHP and CRHT. This may have been mitigated by more effective communication between the two Agencies.

352. It is recognised demand for health services is high, and resources are finite, and triage is an effective way of ensuring those at risk of highest risk of harm are prioritised. However, in this case, there is a vulnerable person with a history of mental health issues, evidence of a relapse signature and a deteriorating position and a clear request from the nearest relative for intervention. Earlier engagement and closer working may have allowed for a physical and mental health assessment sooner than when it was actually carried out.

353. In terms of the nearest relative right under section 13(4) of the Mental Health Act the SSCP Partnership may wish to request the two key Agencies review the Mental Health Pathway to ascertain if it ensures the timeliest assessment for people and the best utilisation of resources.

Recommendation / Learning 8

354. **The SSCP Partnership should give consideration to requesting that the MPFT and Shropshire Council review how the Mental Health Pathway is operating to determine is ongoing effectiveness. This to include whether or not Shropshire Council considers its legal duties under section 13(4) of the Mental Health Act are properly discharged by the agreed arrangements and that both services understand what may constitute a nearest relative 13(4) request and respond accordingly.**

Recommendation / Learning 9

355. **Agencies should seek to build upon ongoing professional development by undertaking:**

- **One to one conversation/restorative/reflective case supervision**
- **Practice observation**
- **Reflective practice**
- **Shadowing, mentoring, or coaching or e-learning**

Key Line of Enquiry 4 How effectively were Mr M's wife's needs, as a Carer, assessed and met?

356. Mr M and his wife lived alone in their home. Mr M's wife cared for her husband.

357. Mr M's wife shared the same GP Practice as her husband.

358. The GP confirmed Mr M's wife would attend the practice with Mr M for his appointments.

359. There is nothing mentioned in Agency files around Power of Attorney for Mr M.

360. The limited engagement means there are some gaps in our knowledge of Mr M's wife or any needs she may have had as a carer.

361. Mr M was discharged home from the Redwoods Centre on the 10th June 2019, and Professionals sought to help Mr M's wife in the days that followed. However, his wife cancelled follow up arrangements, meaning further support from Professionals was limited.

362. Mr M was discharged from the Nursing Home on 17th July 2020, without a support package. This again was primarily because Mr M declined any support and was deemed to have capacity relating to discharge arrangements.

363. A support package would ordinarily have included regular and consistent engagement with Mr M and his wife by Professionals. Together with Mr M and his wife any package would have sought to

identify and address specific physical and mental health needs such as incontinence or lack of motivation.

364. It is clear Carer's assessments (in line with the relevant legislation) should be offered to all identified Carers involved in providing support to vulnerable people who use services

365. There may be a range of reasons (explored earlier in this report) as to why Mr M's wife was reluctant to accept support for either herself or her husband. Further dialogue with her about her views would have been helpful.

366. Given the potential impact upon Mrs M's level of support to her husband, I would suggest more professional curiosity could have been shown by Professionals to understand any additional needs she may have had as a family carer.

367. I would also suggest greater consideration could have been given to Mr M's wife's needs with a comprehensive carers assessment, and a more robust support plan, when her husband was discharged from hospital.

Recommendation / Learning 10

368. **Agencies should identify informal carers and ensure they offered carer's assessments.**

Key Line of Enquiry 5 What were the outcomes of the 2 adult safeguarding referrals made by Adult Social Care on 1st October 2019 and 6th November 2019?

369. On 1st October 2019 and 6th November 2019 safeguarding referrals were made in respect of Mr M.

370. On 12th December 2019 a safeguarding enquiry was concluded by a senior safeguarding Professional. It was noted there was no evidence of abuse or neglect at this stage. The file was signposted to case management for further assessment and support, but no direct action was taken at this time.

371. Adult Social Care will say signposting following discussion with the Referrer was the correct action, as a 'Section 42' enquiry at this point would not be deemed a proportionate response. It was decided an urgent care assessment would be undertaken the following week and attempts made to assist Mr M to engage with Support Services should be actioned first. If Mr M declined this assessment, then a review would have ensued under Section 11 of the Care Act, which places a duty on the local authority to undertake an assessment when someone may be experiencing self-neglect. The safeguarding Professional also had the foresight to ask the Referrer to consider a Carer's Assessment for Mr M's wife.

Key Line of Enquiry 6 What was the outcome of the adult safeguarding referral made by West Midlands Ambulance Service to Adult Social Care on 15th June 2020?

372. On 15th June 2020, WMAS made a referral to Adult Social Care stating 'patient (Mr M) and his wife are struggling to look after each other – possible dementia - not been diagnosed. No care package in place and requires a full assessment'. It was identified that the Access Team were visiting the next day so the process was re-routed to that service for them to respond to the concerns.

373. On 30th June 2020 a '24 – 48 hour Review' was completed by an Integrated Community Service (ICS) Social Worker. It was reported Mr M was requiring full personal care, not getting out of bed, doubly incontinent, but eating and drinking fine. It was reported Mr M was not engaging in any conversation about his wishes /preferences. It was noted the GP was referring Mr M to Mental Health Services. It was recognised both Mr M and his wife would require support upon discharge. No concerns were recorded around safeguarding.

374. On 1st July 2020 an ICS Mental Health Nurse visited Mr M at the Nursing Home and she recorded Mr M and his wife informed her that they did not wish any further support from Mental Health Services. It was explained Mr M's son had died in May 2020 which had impacted on his mood, and a fall, resulting in a complex fracture of his left arm, also had an impact. A telephone conversation with Mental Health Services identified, contrary to what was previously believed, Mr M was not open to their services at this point.

375. Mr M remained in placement at the Nursing Home from 24th June 2020 until 17th July 2020. During this period OT assessments were carried out by the ICS OT community team and the ICS Mental Health nurse. As Mr M was not engaging with the Therapy Team it was initially thought a long-term placement might have been the way forward for him. The ICS Mental Health Nurse recommended a nursing placement to meet Mr M's needs.

376. From the evidence gathered, ICS processes have been followed and the allocated Social Worker recorded interventions with other Professionals, telephone conversations and gave a detailed account of her involvement with Mr M, his wife, the Care Providers, the Therapy Team, and ICS Mental Health Nurse. This demonstrated good practice, good communication skills and good recording management from the allocated worker.

377. However, Mr M was occupying a bed placement for a period of rehabilitation, and this provided opportunity for assessments to take place. There is evidence some assessments took place during that period (therapy and mental health assessments) however, there is no evidence demonstrating a social care needs assessment, according to the Care Act 2014, was completed.

Recommendation / Learning 11

378. **Shropshire Council should provide training about the effective use of section 11 of the Care Act**

Key Line of Enquiry 7
How effective was the adult safeguarding response to Mr M and his wife?

379. This line of enquiry has been explored previously in this Safeguarding Adult Review as per question 1a and 3 and in the conclusion.

380. Mr M presented complex physical and mental health challenges over time.

381. There is a pattern in the history of engagement from Mr M and his wife in a crisis situation, but a lack of acceptance of support on other occasions. It is acknowledged people with needs should be kept in sight, even when there is a lack of engagement.

382. As stated earlier, there were opportunities to improve key aspects of Multi-Agency working including sharing information, the identification of risk and needs, and a co-ordinated approach. Multi-Agency working is built upon the basis safeguarding is everybody's business and no single Agency can manage complex cases such as this one.

383. Whilst there are examples of Agencies seeking to support Mr M and his wife, and some liaison between Professionals, on a number of occasions a siloed approach was adopted towards Mr M's health and care needs.

384. On other occasions Professionals worked with sensitivity and flexibility to meet the needs of Mr M.

385. However, this seems to have been with only a partial shared understanding of Mr M's deteriorating physical and mental health, and home environment, and limited consideration as to the benefits of a Multi-Agency approach.

Recommendation / Learning 12

386. **The SSCP Partnership should reaffirm the importance of Multi-Agency working in complex safeguarding cases and undertake audit and in order to provide reassurance policy and practice has been followed.**

387. With regard to Mr M's family, it is of note on 16th September 2020 his daughter was advised the Access Team should be able to provide the support her father required following the referral from WMAS. Interestingly, Mr M's daughter said the family had been trying to get some form of support for Mr M for a long time, but nothing had been working. Without the opportunity to explore this further with his daughter (or Mr M's wife) it is difficult to understand what support she was referring to and why she considered it was not working.

Recommendation / Learning 13

388. **Agencies and Professionals should promote the importance of seeking to engage with families within the bounds of confidentiality in order to elicit a clearer picture of how things**

are for vulnerable people and what their needs, wishes, beliefs, priorities, and motivations are. This includes awareness that receiving information or eliciting information is not the same as sharing information without consent.

389. In this case, Mr M and his wife were offered statutory support, but on a number of occasions declined the offer. A different approach, involving an Advocate or Community Services may have resulted in a different response.

390. It is positive the GP Practice have advised in Primary Care they are now appointing Social Prescribers who will offer extra support, and contact, in order to get to know the patient. The GP Practice advise they are already seeing very good results from this initiative.

Recommendation / Learning 14

391. **Statutory Services should consider how they may work with Advocates and Community Services to engage individuals in accepting support.**

Key Line of Enquiry 8 Who was responsible for assessment when Mr M was discharged home from both the Redwoods Centre (in June 2019) and the Nursing Home (in July 2020) and were those assessments carried out?

392. I will initially explore the discharge from the Redwoods Centre in June 2019.

393. On 18th April 2019 Mr M underwent a Mental Health Act Assessment and was deemed to be detainable under Section 2 MHA. Mr M was transferred from Royal Shrewsbury Hospital to Redwoods Centre.

394. On 23rd April 2019, Mr M had time with a Staff Member at Redwoods Centre to discuss commencement of discharge planning. Mr M was reported to lack insight into the reason for his referral and stated he and his wife were coping fine. Mr M appeared to lack insight into his physical health condition and when asked if he would accept care at home on discharge, he accepted this stating that "if that was what it took to get him home" then he would. However, Mr M agreed to stay in hospital until deemed fit for discharge. Mr M was offered support to appeal his section but declined this and stated he did not wish to see an Advocate.

395. On 24th April 2019, Mr M was discussed in the ward Multi-Disciplinary Meeting. Action plans were agreed regarding management of both physical and mental health. An estimated date of discharge was agreed for 31st May 2019. A referral was made to the Community Interventions Pathway Shropshire West (CIP) requesting care co-ordination. A referral was also made to social work team for allocation of a social worker.

396. On 30th April 2019, Mr M was seen by the Occupational Therapy for initial assessment. Mr M reported he and his wife share the domestic tasks, he was independent with all self-care tasks and

was able to manage stairs without support. Occupational Therapy formed the view Mr M had limited insight into his presentation at home prior to admission to hospital. A plan for ongoing monitoring and assessment of needs, with encouragement to complete tasks independently, was agreed.

397. On 7th May 2019, Occupational Therapy asked Mr M if he would be willing to agree to a home visit to assess his needs, and identify required support, prior to discharge. Mr M's wife was subsequently contacted, and she stated she was not happy with the arrangement and asked for this to be completed on the ward. Further explanation was given regarding the need to assess Mr M at home to identify the required support for them. Mr M's wife refused to allow this to happen stating she felt no support would help Mr M.

398. On 10th May 2019, a family meeting was held between medics, Mr M and his wife. His wife explained Mr M is usually self-caring when well, but during last winter he did not want to eat much and hardly went out of the house. Mr M's wife put the decline in self-care down to a loss of confidence and motivation in carrying out his daily activities. Both Mr M and his wife declined any additional help in the form of a care package, with Mr M's wife saying she would not be keen for home visits. Mr M's wife agreed there had been an improvement in Mr M's condition since his inpatient stay. Mr M agreed to stay informally, as his Section 2 had now expired, resulting in a further MHA assessment not being required. The outcome was for the ward to continue to encourage physical mobility to build his confidence, continue medication and a further review meeting to be held.

399. On 5th June 2019, a Capacity Assessment was completed with Mr M. It was agreed Mr M has capacity to make a decision to return home on discharge, although it was suspected Mr M may be in denial regarding his abilities when he gets home. Professionals felt this was not a mental health issue preventing Mr M from addressing this, rather a wish not to think about it. Mr M continued to deny the need for care or support of any kind.

400. It was agreed with Mr M and his wife a Health Professional would visit the home address within two working days of his discharge; as seeing them at home enables a more accurate assessment of their abilities to manage.

401. On 7th June 2019, a Care Act Assessment was completed by the Mental Health Team at Mr M's home address. Professionals report, that whilst welcomed into the home, it was clear from Mr M's wife's language, and non-verbal communication, she was not happy for them to be there. Mr M's wife was insistent they did not need any help as they were both independent.

402. On 10th June 2019, Mr M was discharged home from the ward. It was agreed for a Social Worker to visit on 11th June 2019 and for the Care Co-ordinator to visit shortly afterwards. A copy of Care Plan and Discharge Plan was given to Mr M and his wife.

403. On 13th June 2019, Mr M was seen at home by the MPFT Care Co-ordinator. Mr M and his wife reported Mr M was doing well since discharge. Mr M reported his mood had improved, he

recognised he needed structure and that tending to his activities of daily living assisted in keeping him well, more effectively than medication alone. Mr M stated he was aware of contact numbers for help if required, and a further visit was agreed. This was planned for 12th August 2019.

404. On 8th of August 2019, Mr M's wife contacted the MPFT cancelling the planned visit for 12th August and stated Mr M did not want the appointment re-arranging.

405. When Mr M cancelled the appointment and refused support, Professionals may have given further consideration as to why further support was being declined and if services could have done anything else to encourage engagement.

406. I will now explore the discharge from the Nursing Home in July 2020:

407. Whilst admitted to the Nursing Home, records showed Mr M had been non-compliant with care. Reports indicate depression was a significant factor in this. A referral was made to the Senior Mental Health Practitioner for Shropshire Community Health Trust for urgent review.

408. On 30th June 2020 a '24 - 48 Hour Review' was completed by an ICS social worker. It was reported Mr M was requiring full personal care, not getting out of bed, doubly incontinent, but eating and drinking fine. It was reported Mr M was not engaging in any conversation about his wishes /preferences. It was noted the GP was referring Mr M to MH services. It was recognised both Mr M and his wife would require support upon discharge. No concerns were recorded around safeguarding.

409. On 16th July 2020, a telephone call was made to Mr M by SCHT Physiotherapist. His wife stated neither Mr M, or she, wanted a care package or equipment to support Mr M's return home and said they would manage. The Physiotherapist said she would assess Mr M the following day but did express concern he had been declining therapy input. Whilst Mr M's wife said she would talk to her husband, she was adamant they would manage the stairs at home, especially as they were being reviewed in Clinic a week on Monday, and hopefully, he will have his cast off then.

410. Mr M was discharged from Nursing Home care on 17th July 2020.

Key Line of Enquiry 9 Who is responsible for assessment of home/care at home, upon discharge from a nursing home/rehabilitation placement?

411. Once discharged home, there was limited engagement between Agencies and Mr M, and his wife.

412. On 12th September 2019, Mr M's Care Co-ordinator completed an unannounced home visit. The rationale for visit is due to concerns Mr M had not been seen and his wife has cancelled an earlier appointment on his behalf. There was no response at the front door and open access to the rear of the home. Mr M was observed through the window sat in the kitchen in incontinence pants only. Mr M came to the back door to speak to the Care Co-ordinator and when asked said his wife was

not at home. Mr M did not allow the Care Co-ordinator into the home. Mr M, when asked, said he was ok, but the Care Co-ordinator was not sure if he understood the questions being asked. Due to the ongoing concerns for Mr M and his care plan the Care Co-ordinator decided to call for an Mental Health Act Assessment.

413. On 13th September 2019 contact was made with Mr M's GP surgery, who reported Mr M had not attended for blood tests, for his current medication, but that either Mr M or his wife continued to collect the medication from pharmacy.

414. On 13th September 2019 AMHP service were contacted and the concerns shared. They stated they would call and possibly action on 16th September 2019.

415. On 26th September 2019, a Community Care Co-ordinator again requested an MHA for Mr M, as he had concerns about his welfare. It was reported Professionals had tried to get in to visit Mr M recently but had been prevented from doing so by Mr M and his wife. The Care Co-ordinator reaffirmed on a previous successful visit; Mr M was sat in the kitchen in nothing but an incontinence pad. The Professional also raised concerns Mr M's wife may have been having an undue effect on what Mr M can and cannot do. It was felt this pattern was similar to what the Care Co-ordinator observed from the couple in June earlier that year. The AMHP Professional was spoken who had previously worked with Mr M and he stated he planned to complete this on 30th September 2019. Further communication took place between the Council and MPFT and it was decided to further attempts to engage Mr M collaboratively.

416. The Care Co-ordinator continued to attempt to engage Mr M and his wife and on 6th December 2019; 90 minutes after the original attempt at an unannounced home visit a further attempt was made, and Mr M's wife answered the door.

417. Mr M's wife refused to allow access and stated the Professionals could only speak to Mr M from behind the door. When asked, Mr M stated he is ok, and he has no concerns, but it was difficult to determine whether he is in good physical health or not. Mr M's wife stated she did not want any more contact from the Mental Health Team for Mr M or herself; and Mr M said he was in agreement when asked. A plan was made to discuss the case further with the Social Worker who was based at the AMHP Hub as the Care coordinator believed that this professional was involved with Mr M's care following the previous request for an assessment under the Mental Health Act.

418. This was completed and then followed up on 20th December 2019 as there had been no response from the first request for contact made on the 6th of December 2019. The purpose of this was to advise of the lack of engagement with the Mental Health Team and follow up on the outcome of the adult safeguarding referral that the Social Worker working in the AMHP Hub had identified that he had made some days earlier.

419. A subsequent CPA Review was held on the 22nd January 2020 and at this point Mr M was discharged from the service.

Recommendation / Learning 15

420. **The SSCP Partnership should consider an audit of those people who have declined services despite concerns from the relevant agency about the impact of not accepting support to determine how effective risk mitigations plans have been.**

Key Line of Enquiry 10 What are the areas of good practice and improvement relating to the discharge of Mr M in this case?

421. In line with the Care Act and the principles of making safeguarding personal, it is clear Mr M's and his wife's voice was clearly heard, and taken seriously, by a number of Professionals and Agencies when they did not wish to engage with services.

422. When Mr M was at the Royal Shrewsbury Hospital, there were Professional discussions around his discharge, resulting in a transfer to the Redwoods Centre. There is positive evidence of information sharing, good communication, multi-disciplinary discussion, and appropriate well-informed decisions being made.

423. Mr M remained in placement at the Nursing Home from 24th June 2020 until 17th July 2020. From evidence gathered ICS processes were followed and the allocated Social Worker recorded interventions with other Professionals, telephone conversations and gave a detailed account of her involvement with Mr M, his wife, the Care Providers, the Therapy Team, and the ICS Mental Health Nurse. This demonstrated good practices, good communication skills and good recording management from the allocated worker.

424. On 26th September 2019, a MPFT Community Care Co-ordinator requested a MHA for Mr M as he had concerns about his welfare. It was reported Professionals had tried to get in to visit Mr M recently but had been prevented from doing so by Mr M and his wife. The Professional also raised concerns Mr M's wife may have been having an undue effect on what Mr M can and cannot do.

425. The Care Co-ordinator continued to attempt to engage Mr M and his wife and on 6th December 2019, 90 minutes after the original attempt at unannounced home visit a further attempt was made, and Mr M's wife answered the door.

426. Mr M's wife refused to allow access and stated the Professionals could only speak to Mr M from behind the door. When asked, Mr M stated he is ok, and he has no concerns but unable to determine whether he is in good physical health or not. it is noted however that Mr M was dressed, and there were no concerns about his mental state recorded. His wife stated she did not want any more contact from the Mental Health Team for Mr M or herself, and Mr M confirmed this when asked. A plan was made to discuss the case further with AMHP.

427. This level of Professional curiosity, resilience and continued concern displayed by the Care Co-ordinator represents good practice.

428. It is to their credit the Professionals from FALCK identified the need for Mr M to be taken to hospital without delay and also notified SSCP of their concerns around how Mr M had been cared for prior to their involvement. Further, FALCK reported their concerns to the First Point of Contact

429. Finally, it is positive Professionals have been open and candid in support of this SAR, in terms of identifying organisational and individual learning. For example, MPFT have already identified a range of improvement activity, which is detailed below.

Key Line of Enquiry 11 What observations were carried out, and to what extent did the Ambulance Crew examine Mr M on 16th September 2020?

430. WMAS will say paramedics would assume the patient to have capacity unless the patient gives them reason to believe there was an impairment.

431. When WMAS attended the home address on 16th September 2020, the Paramedics clearly state, within their contemporaneous documentation, Mr M was able to converse with the Crew, answered questions promptly and in normal tone. They did not feel there were concerns about Mr M's mental capacity and document this within their clinical findings.

432. WMAS carried out an assessment of Mr M on 16th September 2020, for 68 minutes, and during that time the following was completed:

- Medical/Medication history taken
- Respiratory Rate checked twice at different intervals
- Oxygen levels checked twice at different intervals
- Temperature, GCS, Blood Sugar levels checked once
- Pulse and Blood Pressure checked three times at different intervals
- Cardiovascular and Respiratory assessment completed with no abnormalities detected
- Mental capacity checked and confirmed (they did not document in the clinical notes the decision Mr M was deemed to have capacity to make).
- Body assessment completed – Multiple abrasion noted to legs believed to be from carpet burns caused when rolling around on the kitchen floor

433. The following day there was a different view with a marked deterioration in Mr M's health advised by WMAS. Indeed, the Paramedic who attended on this occasion was said to be 'shocked' at Mr M's condition and surprised WMAS had not been called earlier.

434. There is clearly a different interpretation of Mr M's physical and mental health by the Paramedics who attended the home address on the two occasions. It may be possible to see a marked deterioration in one day, particularly given Mr M had remained on the floor.

435. Whilst Mr M may have presented in a different way to different Ambulance Crews and people can deteriorate rapidly, the clear difference in how WMAS Professionals assessed Mr M's condition, within a relatively short period of time, is marked.

436. There is concern in relation to WMAS Paramedics initial assessment of Mr M's mental capacity to make decisions, in relation to his physical health needs, and the immediate need for hospital treatment. Although difficult to evidence further, due to assessments of this nature being time and decision specific, capacity could be questionable given Mr M's history, the relapse signature, and his poor physical condition. It is therefore important for WMAS to ensure staff are clear about the evidence and rationale to support their decisions

Recommendation / Learning 16

437. **Professionals should consider prioritising earlier intervention to people who are presenting clear physical and mental health needs.**

Key Line of Enquiry 12 Why did West Midlands Ambulance Service ask for a family member to contact their GP to request a mental health assessment when their service could have referred this request?

438. When WMAS attended Mr M's and his wife's home address on 16th September 2020, his wife raised concerns about her husband's mental health. Indeed, she requested he be assessed in Hospital.

439. WMAS will confirm they asked Mr M's wife to contact her GP the following morning. WMAS ensured a Mental Health referral, and a Safeguarding referral were completed.

440. Mr M's wife did not follow up with her GP the following morning, which is understandable given her own vulnerabilities, and the challenges she was facing with her husband remaining on the floor in a distressed state.

441. WMAS will say they made the appropriate referrals, and it would appear their direction to Mr M's wife to contact her GP was to ensure the GP helped her secure a Mental Health Assessment. However, it is questionable as to whether this additional responsibility should have been placed on Mr M's wife during such a distressing time.

442. Mr M's wife was vulnerable, dealing with a distressing incident in her own home and may have reasonably expected WMAS to contact the GP on her behalf.

Recommendation / Learning 17

443. **Professionals should carefully consider inviting people with needs to contact support directly when Professionals are in a position to make the referral themselves.**

Key Line of Enquiry 13
What were the disruptions/changes in practices for all Agencies involved due to the restrictions in place as a result of the Covid-19 restrictions? How did this have an impact on the response to Mr M?

444. The Covid 19 pandemic potentially impacted on services from March 2020 and continued through the six months leading up to Mr M's passing away and beyond.

445. It is important to acknowledge the context in which all Agencies were working during the latter part of the scoping period. Alongside increased demand and finite resources, the pandemic presented unprecedented challenges for vulnerable people, and the Agencies with responsibility for supporting them. It should be noted that Shropshire Council decided not to sue the Care Act easements that were available. The commitment displayed by Professionals to protect vulnerable people across all Agencies during this period was extraordinary.

446. There were concerns about the potential impacts on adults at risk or adults with care and support needs not having their needs met'.

447. It was the experience of many people they were unable to leave their home due to Government direction, and/or factors associated with their vulnerability. This may have led them to feel become more isolated with all its adverse effects.

448. Some adults with care and support needs may have needed more assistance with coping with day-to-day tasks; and may have become over reliant on others. Conversely, many vulnerable people may have withdrawn from the offer of support, believing Agencies may be prioritising the pandemic.

449. It is also possible that vulnerable people may have feared losing contact with relatives if admitted to Hospital.

450. However, it is important to note that Shropshire did not enact the Care Act Easements during the pandemic. Both demand for services and capacity to respond were within acceptable limits.

451. . It is not possible to say definitively if the Pandemic had a direct impact on the care and support provided to Mr M and his wife during the period under review or indeed on how they received it. However, given their age and the overall impact on COVID on society it would be remiss to say that it did not have an effect on them.

452. Further, without access to Mr M's wife expressing her own views, it is difficult to identify whether her contact with her GP, and other health services, reduced during the pandemic or otherwise.

453. With regard to recorded contact with Agencies, to my knowledge, Mr M's wife only sought Professional support during the pandemic between March 2020 and September 2020 on two occasions as follows:

454. 15th June 2020. WMAS attended the home address when Mr M suffered a fall. Mr M was admitted to Royal Shrewsbury Hospital as a result of the fall and treated for a fracture to the radial bone in his arm and acute kidney injury.

455. The key period between the 16th and 18th September 2020 when Mr M suffered a relapse and was ultimately taken to Hospital where he sadly passed away.

456. On both these occasions Professionals attended Mr M's and his wife's home address and provided in person care and support.

457. It is important to note when Mr M was in Hospital in June and September 2020, there were limitations as to who was allowed to visit patients in hospital due to Covid restrictions. Whilst engagement took place with Mr M's wife, it is not clear whether these restrictions limited the opportunity for Professionals to engage with Mr M's wife, or her daughter, in more depth or otherwise.

Key Line of Enquiry 14 Consideration should be given to how race, culture, ethnicity, and other protected characteristics, as codified by the Equality Act 2010, may have impacted on case management, including recognition of unconscious bias.

458. The Equality Act 2010 provides a general duty on Public Bodies to eliminate discrimination, to advance equality of opportunity and to foster good relations.

459. The Act makes it unlawful to discriminate against someone on the grounds of a number of characteristics, including age and disability.

460. Mr M and his wife were older people, which is the highest demographic in Shropshire.

461. Mr M in particular had a number of physical and mental health challenges.

462. Mr M's wife was an older lady who had the challenge of caring for her husband.

463. However, there is no evidence to suggest Mr M and his wife experienced discrimination due to their protected characteristics.

CONCLUSION

464. When examining the period between 2019 and 2020 it is clear Mr M had multiple complex physical and mental health conditions and may have in a great deal of pain at times.

465. There is also a consensus Mr M was living in unhygienic conditions, and his levels of personal care were poor.

466. Given the comments made by Mr M's wife to the Coroner around her husband 'giving up on life', it is likely that Mr M's health and living conditions deteriorated over this time.

467. In undertaking this Review there were some examples of good practice identified such as the Multi-Agency discussions that took place prior to Mr M's discharge from the Redwoods Centre and the Nursing Home.

468. There is good practice identified ahead of Mr M's discharge from the Nursing Home with the Social Worker, working in collaboration with Mr M, his wife, and other Professionals.

469. The level of professional curiosity, resilience and continued concern displayed by the Care Co-ordinator in visiting the home address, and trying to support Mr M and his wife, as he was so concerned around their welfare, is to be applauded.

470. However, taking into account the complex circumstances and range of needs, I would suggest professional practice was on a number of occasions reactive, rather than a proactive holistic assessment of Mr M' s and his wife's needs and risks.

471. This Review has identified a range of learning for Agencies and Professionals in supporting adults with care and support needs adults at risk who self-neglect. The learning includes:

- The importance of Multi-Agency working and the benefits of calling together a Professionals meeting at the earliest opportunity
- The importance of identifying a Lead Professional to co-ordinate and monitor a Multi-Agency response
- The requirement to be Professionally curious, particularly where the vulnerable person may be reluctant to engage
- The understanding and application of the Mental Capacity Act (MCA)
- The understanding and application of the Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance
- The requirement to explore Carer's needs and undertake robust and comprehensive discharge assessments, particularly when the carer themselves may be vulnerable themselves
- The importance of identifying family support and seeking to engage with them, in order to elicit a clearer picture of how things are for vulnerable people, and what their needs, wishes, beliefs, priorities, and motivations are
- A delay in responding to Mr M's considerable needs, when it was first reported he was lying on the floor, and was in an extremely vulnerable state
- Whether the request made by MPFT and AMPH staff for Mr M to undergo further physical health checks was fully cognisant of the fact WMAS had already concluded his needs were primarily relative to poor mental health
- If the section 13(4) AMPH duty is properly discharged by requesting MPFT review the situation
- Section 11 Care Act assessments are not always clearly understood and therefore utilised by professionals

472. Mr M was experiencing deteriorating physical and mental health.

473. The lack of engagement by Mr M, except when in critical need, reduced the opportunity for ongoing support and intervention.

474. There are a number of strategic considerations which the Partnership is invited to consider:

475. Do services or procedures need to be more focussed on engagement with people?

476. Are there discussions with people, about the outcomes they want, embedded in key processes at the beginning, middle and end of the process, so the service and procedures drive engagement with people?

477. How are Agencies addressing workforce development issues required to ensure people are skilled, and competent, in having difficult conversations with individuals at risk of harm or abuse?

478. Are Professionals equipped to work with families, and networks, to negotiate outcomes and seek resolution?

479. Do Professionals have skills, knowledge, and permission to use the full range of legal and social work interventions needed?

480. A Safeguarding Adult Review triggered by the death of an adult with care and support needs involving abuse or neglect person is, by its very nature, a reactive activity.

481. The key purpose of a Safeguarding Adult Review is to identify effective practice and learning for Agencies and Professionals.

482. The SAR also seeks to provide some insight and reassurance to the family of the deceased.

483. In common with many SARs, this SAR raises questions regarding Multi-Agency working, sharing of information professional curiosity, training, the balance between individual rights and duty of care, risk assessments, and family support.

484. Mr M’s death provides an opportunity for reflection and learning. There are lessons to be learned from these events. These lessons may help avoid similar distress for others in the future.

485. A critique of Safeguarding Adult Reviews over time will identify, despite the commitment of Agencies and Professionals to safeguard the most vulnerable, much of the learning in this review are repeated themes.

486. Determining how to create transformational sustainable change is a significant challenge for the Shropshire Safeguarding Community Partnership (SSCP). The relevant learning and recommendations from this Review should be disseminated and monitored to support this change.

Multi-agency Learning

Recommendation / Learning 1

487. **The SSCP may wish to review the decision not to introduce a threshold document (including self-neglect) to support the Working with Self-neglect in Shropshire Guidance**

Recommendation / Learning 2

488. **When presented with a challenging complex situation such as this, Agencies should call a Multi-Disciplinary Professionals meeting at the earliest opportunity. This is particularly the case where agencies are struggling to engage adults with care and support needs**

Recommendation / Learning 3

489. **The SSCP Partnership should promote relationship-based practice amongst professionals working with people who self-neglect.**

Recommendation / Learning 4

490. **Relapse signatures should be documented in MPFT clinical records and reviewed when someone is presenting in crisis. Professionals should give due consideration to relapse signatures and consider early review to determine what early support is needed and a mental health assessment, where a relapse signature is evident.**

Recommendation / Learning 5

491. **The SSCP Partnership should continue to raise and understanding of the 'Responding to Self-Neglect in Shropshire Practice Guidance and Local Process and Working with Risk Guidance.' In doing so, they should review the findings of the self-neglect priority group multi-agency audit and consider a survey to further embed the Guidance.**

Recommendation / Learning 6

492. **The SSCP Partnership should be assured that MCA training is accessible and being received by all partner agencies including WMAS.**

Recommendation / Learning 7

493. **When sharing information between agencies both the CHRT and the AMHP should ensure the information is sufficiently clear to help identify the level of risk and priority. A Joint audit between this teams should be carried out into the quality of the referrals and the finding reported to the Joint Case review group.**

Recommendation / Learning 8

494. **The SSCP Partnership should give consideration to requesting that the MPFT and Shropshire Council review how the Mental Health Pathway is operating to determine is ongoing effectiveness. This to include whether or not Shropshire Council considers its legal duties under section 13(4) of the Mental Health Act are properly discharged by the agreed arrangements and that both services understand what may constitute a nearest relative 13(4) request and respond accordingly.**

Recommendation / Learning 9

495. **Agencies should seek to build upon ongoing professional development by undertaking:**

- **One to one conversation/restorative/reflective case supervision**
- **Practice observation**
- **Reflective practice**
- **Shadowing, mentoring, or coaching or e-learning**

Recommendation / Learning 10

496. **Agencies should identify informal carers and ensure they offered carer's assessments.**

Recommendation / Learning 11

497. **Shropshire Council should provide training about the effective use of section 11 of the Care Act**

Recommendation / Learning 12

498. **The SSCP Partnership should reaffirm the importance of Multi-Agency working in complex safeguarding cases and undertake audit and in order to provide reassurance policy and practice has been followed.**

Recommendation / Learning 13

499. **Agencies and Professionals should promote the importance of seeking to engage with families within the bounds of confidentiality in order to elicit a clearer picture of how things are for vulnerable people and what their needs, wishes, beliefs, priorities, and motivations are. This includes awareness that receiving information is not the same as sharing information without consent.**

Recommendation / Learning 14

500. **Statutory Services should consider how they may work with Advocates and Community Services to engage individuals in accepting support.**

Recommendation / Learning 15

501. **The SSCP Partnership should consider an audit of those people who have declined services despite concerns from the relevant agency about the impact of not accepting support to determine how effective risk mitigations plans have been.**

Recommendation / Learning 16

502. **Professionals may wish to give earlier intervention to people who are presenting clear physical and mental health needs.**

Recommendation / Learning 17

503. **Professionals should carefully consider inviting people with needs to contact support directly when Professionals are in a position to make the referral themselves.**

Single Agency Recommendations

504. All Agencies are committed to continuous improvement and professional development. They have identified the following recommendations.

Midlands Partnership Foundation Trust (MPFT)

505. MPFT have carried out a serious incident review of this case which included specific recommendations. They identified the following learning points from the review:

- There was a delay in the assessment and clinical decision making
- There is reference to delirium and history of psychotic depression, so there were prominent signs of relapse
- There was no questioning around Mr M wearing the incontinence wear to find out who applied this, where he had this from, and how long he had been wearing it
- There is no firm information regarding Mr M eating or drinking whilst on the floor
- No formal mental capacity assessment was completed at the time

References

506. HM Government (2018) Working Together to Safeguarding Children

507. HM Government (1998) Crime and Disorder Act

508. HM Government (2014) Care Act

509. HM Government (2020) Caldicott Principles

510. Shropshire Coroner Summary Report 10877 reported 22nd September 2020

511. HM Government (2010) Equality Act

512. HM Government (2005) Mental Capacity Act 2005

513. HM Government (1983) Mental Health Act

514. HM Government (2022) Care and Support Statutory Guidance

515. Responding to Self-Neglect in Shropshire (2019) Practice Guidance and Local Process and Working with Risk Guidance

516. Braye, S, Orr, D, Preston -Shoot, M (2015) The challenges of self-neglect indicators of good practice

517. Local Government Association. Preston -Shoot, M, Braye, S, (2019) Analysis of Safeguarding Adult Reviews April 2017 -March 2019

518. Shropshire Council / MPFT Mental Health Assessment Pathway (2020)

519. Shropshire Safeguarding Community Partnership Strategic Plan and Priorities (2020)

520. SSCP Self-neglect group. Working with Adults who Self-neglect Volumes 1 and 2.

Appendix A. MHA adult assessment pathway ST&W

Source of referral
- Custody
- SW /AMHPs
- GP
- Nearest relatives
- MH wards / A&E
- Community Teams internal referral direct to CRHT

Offer of Training for CRHT & Liaison provided by LA MHA team

MHA assessment is requested / suggested

Refer/direct to Access Team (after 8pm CRHT) to gather information from referrer, family, RIO and social care- ring duty MH/family Connect /EDT (T&W) or Duty/EDT in Shropshire-

Triaged with information gained

Option 1
Signposted to other support services and refer back to GP

Option 2
Person known: Refer back to allocated Care Co or SW
Person not known: Progress referral for assessment

Option 3
Refer to CRHT
CRHT to gather further information and visit the person

NO - MHA Assessment required

Option 1 – continue with CRHT support
Option 2 Refer to the Pathway and /or MHSW
Option 3 – close and signpost

CRHT to pick up
and or
Refer to third sector for support

MHAA required refer to AMHP desk with copy of assessment

CRHT to attend all s136s

Referral received by duty AMHP who screens the referral and if appropriate coordinates MHAA.
AMHP to use s.12 Dr app.

Not detained under MHA

Least restrictive option available:

Refer back to CRHT or another team(s).
Assessing MHA Team to share details of support requested.

Decision made to detain.

Dr to confirm bed with CRHT
No bed available
CRHT, Dr(s) & AMHP to agree a shared risk management plan to support patient/family/carers.

Principles & guidance underpinning this pathway

1. Throughout the pathway the individual's ability to consent will be taken into account but the level of need and risk will override consent if required. The process will be followed despite any issues around the capacity or consent of the individual. *Risk overshadows consent. If it is felt person lacks capacity, following a Mental Capacity Act assessment, a Best Interest Decision can be made, following Best Interest Checklist and guiding principles of MCA and MHA.*

2. The Access Team will clarify what is required on referral, ensuring referrers understand the **difference** between a mental health assessment and MH Act Assessment.

3. Only in in exceptional circumstances should an individual go forward to a MHA assessment (MHAA) without being seen face to face by someone in the MPFT. In situations where this is not possible, CRHT should contact the AMHP to discuss this. Any difference of opinion should be escalated through the relevant line management structure.

4. Where possible, following good practice guidance in the MHA Code of Practice, 'a Dr who has previous acquaintance' with the individual should be approached first to complete the MHAA.

5. Professionals will all work to the MHA Code of Practice, in particularly giving careful consideration to the 5 Principles:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

6. Organisations will share information to reduce duplication, ensure there are no gaps and obtain an accurate picture of risk and the person's mental health.

7. All MHAA in the pathway, where possible, will be undertaken jointly with health and social care.

8. CRHT aim to be part of the individual face-to-face assessment where logistically possible regardless of the type or route to the MHA assessment.

9. We aim to reduce MHA assessments if not required and to support the person in the least restrictive way.

10. We aim to avoid admissions to beds if possible and to support individuals in the community where it is safe and effective to do so.

11. If someone is under a section 136, where possible the MHAA will take place at the designated Place of Safety at the s.136 suite at Redwoods.

12. AMHPs should not be relied upon to sit with people whilst waiting for a bed to be sourced. If the delay is unacceptable then a MDT risk assessment and management plan should be agreed. S140 responsibility sits with the CCG.