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A matter of life or death: a rapid review assessment of London's safeguarding adults reviews to inform the future of mental health adult social care under a new Mental Health Act

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A Report for London ADASS

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Foreword

The public's understanding of mental health has increased recently with more high profile and other individuals opening up about their personal struggles with their mental health. This increased profile has not yet fully translated into improved responsiveness of social care mental health services to meet needs and we still hear stories about people with mental health problems receiving *no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths*[1] .

The current debate around mental health continues to focus on how the NHS can meet these needs and the voice of social care needs to be strengthened further in this space. It is often thought that NHS spending on mental health services far outweighs that of Local Authorities. This remains a misconception because when Local Authority spending on social workers, commissioned care services, substance misuse services and supported housing are considered, the difference in spending is small.

This emphasises the important role of Local Authorities in meeting the needs of people with mental health problems and preventing such problems arising where possible. At a time when new mental health legislation is expected, the role of social care services in supporting people with mental health needs will need clarity and resourcing.

Within London ADASS, increasing awareness of mental health problems and identifying evidence-based services to effectively meet needs remain a priority. During Race Equality Week (2021) we ran a series of luncheons (virtually) where we created a safe space to discuss issues related to race.

During the session dedicated to mental health participants noted that *'listening is the key - not necessarily with comments that have to substantiate what is being shared' and 'relationships with authentic communication and connection is key'*. Following Race Equality Week, we launched our Big Promise which included a commitment to develop a suite of resources to support strategic and operational staff http://londonadass.org.uk/wp-content/uploads/2021/02/2021.02.19-Race-Equality-week-Our-Big-Promise-v16.pdf

We welcome this timely report (the first of the resources we committed to producing within our Big Promise action plan) that reviews, through a social care mental health lens, a set of Safeguarding Adult Reviews published in London and London's Reports to Prevent Future Deaths (PFDs) relevant to social care mental health services published on the Chief Coroner's Office website.

This report is the first of its kind to use these two data sources together to identify recommendations to improve the wellbeing of those with mental health problems in London and to highlight that safeguarding must be part of social care support for people experiencing poor mental health. Any new mental health law must include safeguarding of the rights of people with mental health problems from neglect, abuse and exploitation.

[1] Mental Health Five Year Forward View, London, NHS England

We look forward to championing implementation of the recommendations and feeding back progress during Mental Health Awareness Week 2022.

Elaine Allegretti, Director of People People & Resilience, London Borough of Barking and Dagenham, LondonADASS (Association of Directors of Adult Social Services) Mental Health lead.

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Summary

Mental health social care supports individuals with mental health problems on their road to recovery and wellbeing. Distinctive from NHS clinical care and treatment, it is still part of a wider system of mental health care so does not operate in isolation. People with mental health problems need services that work in partnership. This can be a matter of life or death, especially when they are living at home or in the community.

In this report we use the term mental health social care to refer to services provided by local councils and social care providers supporting adults with their mental wellbeing. Relevant social care services include local council's assessments, care planning, and support and the services provided by private and not for profit organisations ranging from care homes, home care, day services, and community services such as befriending, group activities, advocacy and therapy.

Safeguarding Adult Reviews (SARs) can be a valuable source of learning to improve mental health care (Local Government Association, 2020) by taking on board the lessons learned when things go wrong in working together between agencies for people with care and support needs. In light of the government's commitment to reform the Mental Health Act 1983, this report summarises the qualitative learning from 77 SARs published across 24 London boroughs covering the period January 2017 to November 2020.

The premise of this report is that the reform of the Mental Health Act will also prompt a 'wake up' of the entire mental health system in London and the rest of England in which parity of social care with health care becomes the 'new normal'. This report seeks to make a contribution to this and highlights that legal reform must include attention to adult safeguarding. It also adds to the growing body of analyses of national, regional and thematic SARs.

The SARs analysed for this report tell the stories of Londoners who experienced mental health problems and came to harm or died as a consequence of their condition despite having been in contact with mental health social care services and others. From the rapid analysis of the SARs **case clusters emerged**, with similarities in the individuals' stories and outcomes. **These clusters show that there might be groups of people who require particular attention when it comes to reforming the Mental Health Act – and with it the mental health social care 'offer'.**

The stories of these individuals also raise some concerns around human rights, equality and inclusion with the question: Is enough being done to protect the rights of vulnerable people with mental health problems who receive mental health social care and who may rely on social care to respect these rights?

The analysis further suggests that there are **two major problem areas** across virtually all the cases and clusters – **professional knowledge and usage of the Mental Capacity Act 2005 and inter-agency working and communication.** We uncovered that in most SARs mental capacity legal processes were not used at all or appropriately and that often people living in the community with mental health problems sometimes fell under the radar of the services that are supposed to help

them, in these cases often with devastating results. **These findings are in line with other similar reports, which indicates a systemic, nationwide problem that is not limited to London** (see Analysis of Safeguarding Adult Reviews, Preston-Shoot et al., 2020) but which London could take on board and become a leader in change.

Findings quick overview

Finding point	Theme	Frequent learning points/ recommendations in the SARs relating to theme
Overarching theme 1	Keeping people on the radar – continuity of care, collaborative multi-agency work and individual responsibility	Improved collaborative working across agencies and organisations, including Adult Social Care, Community Based Mental Health Services, hospitals, the Police and Fire Brigade, where applicable, to support and protect adults with mental health needs
		Shared risk and escalation procedures and pathways to respond to changes in an individual's circumstances
Overarching theme 2	Knowledge and applicability of mental capacity and mental health legislation land policies	Improvement across organisations and agencies in the understanding and use of the Mental Capacity Act 2005
Cluster 1	Older people who died at home	Ensure that multi-agency discharge procedures from hospital are person- and needs-centred
		Involve GP/primary care practices more in identifying isolated older people
Cluster 2	Adults who died at home after a fire	Care pathways to include London Fire Brigade
		Self-neglect policies to include risk of fire and other similar hazards
Cluster 3	Adults with learning disabilities	Not specified in this report

Cluster 4	Adults who refused care and treatment	Provide support to health and social care professionals to balance rights to make treatment decisions with mental health and capacity laws and policies
Cluster 5	Young adults (18-25) who died by suicide	Ensure the embedding of suicide prevention strategies in practice
		Existence and dissemination of guidance for managing complex cases
Cluster 6	Adults who died by suicide	Increase professional curiosity about people who are in contact with services on several occasions
Cluster 7	Adults who died or came to harm in care homes	Improved multi-agency risk assessments
Cluster 8	Adults experiencing or at risk of homelessness	Homelessness strategies that include adult social care/ mental health social care
		Training on equality, diversity and biases towards people experiencing homelessness and drug abuse
Cluster 9	Adults living with dementia	Improved application of the Mental Capacity Act for people living with dementia
		Identifying and managing risks affecting people living with dementia
Cluster 10	Adults who were detained for assessment/ treatment under the Mental Health Act	Improved system of person-centred, holistic risk assessment/ treatment sharing

Implications and suggestions from the findings in the context of a new Mental Health Act

● Start an early countdown to the new legislation. Is there a named person in each borough to take the lead? Are they meeting together pan-London?

● Consider asking the London Safeguarding Adults Board to circulate Safeguarding Adults Reports covering mental health (with their summaries and action points) to all boroughs and Mental Health Trusts and arrange learning events.

● Seek agreement that all SARs will consider their recommendations using an approach to identify the level of urgency and potential effectiveness or reach of their suggested changes.

● Seek agreement from London's Safeguarding Adults Boards (SABs) that they will review their SARs' action points within an agreed timescale.

● Seek agreement, pan London, that all SARs will contain details of ethnicity, religion if any, and sexual orientation (and consider other relevant protected characteristics) or note that these details were not known to agencies so that equalities can be better addressed.

● Agree a London-wide approach to the new mental health legislation. Set out an early road map for training on the new Mental Health legislation and include Mental Capacity Act learning and discussion. Plan training with NHS secondary and acute Trusts and primary care services. Where training is shared with NHS partners ensure that it highlights social care roles and responsibilities. Consider how such training will also be made available to other parts of boroughs' services and providers of social care and draw on their strengths and experiences.

● Consider pan-London discussion of training for mental health practitioners working in adult social care on human rights, equality and inclusion as part of their safeguarding work and in line with their professional standards if applicable.

● Establish the interest among NHS partners, London Mayor and borough legal services and mental health service user groups in developing good practice in mental health social care services in the light of relevant articles in human rights legal instruments (e.g. right to health; right to be free from inhumane and degrading treatment; right to housing) and the United Nations Convention on the Rights of Persons with Disabilities.

● Audit Adult Mental Health Professional (AMHP) training, current and proposed, to assure Mental Capacity Act coverage reflects AMHPs' own practice and ability to challenge others' decisions where appropriate. Consider if the training content is sufficient to provide AMHPs with expertise on the interface of mental capacity and new mental health legislation.

● Audit practice (peer audits) in mental health social care on use of the Mental Capacity Act 2005 especially in relation to the Mental Health Act as it stands and as the new law is implemented.

● Work with London hospital discharge planning services to consider mental health needs in new Discharge to Assess and Recovery procedures proactively.

● Ensure mental health social care is involved in initiatives on tackling and preventing loneliness.

● Seek suggestions and agree actions from staff and other stakeholders of practical steps to improve the capacity of mental health social care to promote continuity of care – so that fewer people fall under the radar. These steps could include: cross-borough analysis of good and poor practice in inter-agency communication and exchange as well as auditing of cases. Establish a 'task and finish' inspiration group to seek ideas for improvements of how organisations (including NHS, mental health social care providers, adult safeguarding, London Fire Brigade and Metropolitan Police) can better work together to support and protect people with mental health problems. Share improvement ideas in high profile events, eg with support of the Mayor.

● Promote recognition of pressure ulcer prevention as part of adult safeguarding in mental health; for example, by safeguarding services' engagements in Stop the Pressure annual events.

● On a pan London basis share the Reports to Prevent Future Deaths issued by London's Coroners and discuss wider implications within SABs and in mental health social care and NHS services. Consider sharing action points and auditing them.

● Work with London care homes to learn more of the lessons from SARs; perhaps by engaging with LondonADASS provider networks.

● Develop ways to highlight and publicise what is working well and not so well in implementing policies on suicide prevention, risk assessment and escalation, self-neglect and hoarding behaviour by listening to public and staff perspectives; and prioritise actions. Canvass ideas for awards, prizes and celebrations to promote good practices; potentially using Proud to Care London's networks.

1. Background

Mental health social care – the difference it makes

High-quality mental health social care helps individuals experiencing mental health problems on the road to recovery. For some it can make the difference between life or death; for others it can help rebuild connections and wellbeing. Mental health problems including depression, anxiety, suicidal thoughts, addictions, self-harm, bipolar disorder and schizophrenia are a major public health concern throughout the United Kingdom (UK) but disproportionately affect poorer communities, among which are many parts of London.

The Care Quality Commission (CQC) in its State of Care annual reports and others has highlighted poor access to mental health care, especially inpatient care, for several years. This means that people who urgently need mental health care may hit a crisis point before receiving any help, if at all. The Covid-19 pandemic has increased the numbers of people with mental health problems who might benefit from treatment and care (Public Health England, 2021).

The improvement of mental health social care is therefore vital in responding to the pandemic over the long-term. This can be accelerated by learning from past poor and good practice examples (see Preston-Shoot, 2019 on the value of Safeguarding Adult Reviews (SARs) for building good practice around self-neglect).

The government has recently consulted on a White Paper that contains proposals to reform the Mental Health Act 1983, following on from an independent review of the Act, which reported in 2018. The Mental Health Act 1983 sets out when and how an individual may be detained in an inpatient setting for assessment and treatment for mental health conditions, as well as other provisions. One declared aim of the White Paper is to improve the experience of mental health service users, including people using mental health social care services.

The government proposes a human rights-based approach, with the protection of the equality and dignity of service users at the heart of the changes. Under the Human Rights Act 1998, public bodies including the NHS and local authorities are required to respect and protect the human rights and freedoms of service users contained in the European Convention on Human Rights.

Other laws, including the Equality Act 2010 and the Care Act 2014, also oblige public services for people with mental health conditions to further, protect and respect fundamental human rights. The pressure arising from the increasing awareness of the United Nations Convention on the Rights of Persons with Disabilities, which the UK ratified over a decade ago, is also relevant here. High-quality mental health social care, in line with such rights, can thereby help ensure that these obligations are met.

Mental health problems – it's complicated

Mental health problems are often complex, with individuals sometimes affected by more than one condition at a time, often over long time periods and/or various episodes. The Mental Health Foundation, a leading sector charity, estimates

that for example 7.8% of Britain's population experiences mixed depression and anxiety (Mental Health Foundation, 2021). This can lead to other mental health problems if left untreated, such as addictions and vice versa.

Mental health problems are also often linked to socio-economic factors and inequalities. People from an ethnic minority or LGBTQ+ background are more likely to experience mental health problems, as are people from poorer backgrounds and people requiring social care and support. In London, for example, in 2017/18 over 55% of social care users have anxiety and depression (Public Health England, 2021).

Risk factors for developing a mental health crisis include experiencing poverty, having a learning disability or dementia, being an unpaid/family carer or survivor of domestic abuse.

Currently about 1 in 8 people with mental health problems receive care and treatment. Most commonly, NHS treatment involves medication but psycho-social care is increasingly important – talking therapies, peer support, behavioural change techniques, art therapy of different sorts, group work and counselling. Beyond the NHS, mental health social care often supports people who have a diagnosed mental illness and social care needs. This may be offered by multi-disciplinary teams, including nurses, social workers, GPs, community services, by care home staff, by one-to-one support or by staff working in day services, at different stages or times.

Increasingly, early help and prevention services are delivered by the voluntary sector and commissioned by local authorities and/or the NHS. Delivery of services for people with high level needs for care and treatment is complicated by funding and other arrangements, between NHS mental health services and local councils' adult social care, with local agreements about roles and responsibilities such as Section 75 agreements between local councils and NHS Mental Health Trusts, with health staff sometimes carrying out social care functions, mainly for people aged under 65 years of age.

Because everyone with mental health problems is different and has their own history and needs, people working in mental health social care need to be particularly person-centred, responsive, aware and connected to their colleagues in their own agencies and others. Mental health social care does not operate in a vacuum; it is part of a wider system of care which needs to work smoothly to be effective. It is in this context that this report is set; although the impact of Covid-19 on mental health is only just emerging in the UK and internationally.

> ### Box 1 | Mental Health in London
>
> **The population of Greater London before the COVID-19 pandemic disproportionately suffered from mental health problem compared to the rest of England:**
>
> ■ **19.3 Londoners out of a 100 aged 16+ experienced a common mental disorder compared to the national average of 16.9/100. this rate varied across London boroughs.**
>
> ■ **In the year of 2018/19 at least half of London's boroughs saw rates higher than the national average in depression and anxiety amongst its populations, according to Public Health England's crisis care profiling tool.**
>
> ■ **In Hackney, Camden and Islington, for example, between 15% and 15.8% of their population had been diagnosed with anxiety and depression. The national average is 13.7% (Public Health England, Crisis Care Profile).**
>
> ■ **The prevalence of severe mental illness is at least 1.12% of Londoners, compared to 0.98% in the rest of the country.**
>
> ■ **Whilst in England an estimated 8.9 people out of a 1000 are addicted to crack, opiates or cocaine, this applies to 9.3 out of a 1000 Londoners**
>
> ■ **However, the suicide rate in London is below the national average.**

Summary of London specific findings of the National SARs Review

In 2020, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) published the report "Analysis of Safeguarding Adult Reviews: April 2017 – March 2019" (Preston-Shoot et al., 2020). This was the first sector-led national analysis of SARs and adds to other thematic, national and regional SAR reviews (see Manson, 2017; Preston-Shoot, 2018; Martineau et al., 2019; Alcohol Change UK, 2019). From this national SAR analysis, several London-specific findings emerged, which help put into context this current report. Some cornerstone findings are the following:

● The most common types of abuse and neglect investigated by SARs in London were self-neglect (44% of London based SARs/45% of national SARs) and neglect/omission (30% of London based SARs/37% of national SARs). Whilst London was roughly in line with other regions regarding the types of abuse and neglect investigated, it differed significantly regarding the type of abuse by age, with the cases of Londoners aged between 60-80 disproportionally being the subject of self-neglect and omission/neglect SARs compared to other regions.

● As in other regions of England, equality markers including ethnicity, religion, sexual orientation were surprisingly not recorded in the large majority of London-based SARs. However, virtually all the SARs in London recorded a range of mental and physical health conditions affecting the individual concerned, particularly mental health and long-term physical ones.

● Londoners whose case set in motion a SAR were mostly living alone and in their own accommodation. They were highly reflective of the national profile. Circumstances of self-neglect were often apparent (48% of all London based SARs/ 46% of national SARs) or the omissions or commissions of care providers (33% of all London based SARs/30% of national SARs).

The national SAR analysis follows a thematic logic of the four key domains of the safeguarding system (direct work with individuals; inter-agency practice; organisational themes and SAB governance) to draw out and systematically report on the most commonly mentioned poor/good practice points. Inadequate or missing mental capacity and risk assessments as well as care support assessments were most commonly linked to poor practice (theme 1: direct practice), as were insufficient inter-agency coordination and information sharing (theme 2). These findings mirror a review of London SARs published in 2017 (Braye et al. 2017) and the national pictures of reviews that covered people living with dementia and also people who were homelessness (Manthorpe and Martineau, 2016 and Martineau et al., 2019).

2. About this report

This report documents the findings from a rapid review assessment of 77 Adult Safeguarding Reviews (SARs) published across 24 London boroughs (no reviews were identified in the remaining 8 boroughs, either because they had not produced any or because they were unpublished) between 1 January 2017 and the 4 December 2020. The main part of this report derives from a search of the webpages of all the London Safeguarding Adults Boards conducted on 4 December 2020.

All SARs were retrieved from these pages and subject to analysis. In addition, London Reports to Prevent Future Deaths (PFDs) published in the same period were searched for on the Chief Coroner's Office website within the following categories: mental health related deaths (n=19), and care home health related deaths. In the latter group, nine PFDs were related to mental health and included in our review (see Box 2 for details of the PFDs). It is important to note that, with greater resources, a more thorough search could have been conducted, with our findings being highly dependent on the categorisations made by the Office of the Chief Coroner.

Most SARs in this report tell the stories of individuals with mental health problems who suffered serious abuse or neglect despite virtually all of them having been in close contact with mental health social care teams prior to the event that lead to harm or their death.

Table 1 summarises the stories of 10 individuals who were in direct contact with mental health social care teams across various boroughs in London prior to coming to serious harm or dying. It puts 'names' to these cases (where these are in the public domain) – rather than merely becoming another statistic – and highlights the wide range of individual circumstances involved in provision or receipt of mental health social care. It is important to recognise the lives of these Londoners are much more than the events discussed here and that they left grieving family and friends behind. For many people working in services that knew them, often over many years, the events discussed will be sad and regretted.

This report was commissioned by the London ADASS (Association of Directors of Adult Social Services London Region). The aim of the analysis was to identify shared learning points and recommendations across the SARs to inform thinking

about and planning for the new Mental Health Act. To do so, the SARs were scanned and compared for case summaries, lessons learnt and recommendations. From this exercise, 10 case clusters emerged of individuals (all adults) with mental health problems who came to harm or died under similar circumstances, often with similar learning points and/or recommendations. These clusters are:

1: Older people who died at home (18)

2: People who died as a result of a fire, often caused by smoking (11)

3: People with a learning disability (excluded from this report as requested by London ADASS) (9)

4: People who died apparently because they refused treatment (5)

5: Young people (aged 18-25) who died by suicide after experiencing mental health problems (5)

6: People who died by suicide (6)

7: People who came to harm in care homes (7)

8: People experiencing homelessness (reported separately, Martineau et al., 2019 and added to by the report authored by Preston-Shoot et al., 2020)

9: People living with dementia (9)

10: People detained ('sectioned') under the Mental Health Act 1983. (15)

In the findings section of this report, key characteristics of individuals in each cluster are briefly outlined together with examples of shared learning points/ recommendations (illustrated with an illustrative quote from a SAR). The method of a rapid review assessment, which does not envisage an in-depth qualitative analysis of the data, means that the findings of this report are indicative only. Some shared learning, which could have possibly emerged after a more thorough qualitative analysis, may have been missed.

But this report offers various starting points for more in-depth analysis in the future and considerations for the new Mental Health Act. It was not the priority of this study to analyse the quality, process and formats of the SARs included here, including lengths of investigations, family involvement or inclusion of methodological notes. But, we still took note of how learning points were presented and this is reported in section 3.

Table 1: Putting 'names' to mental health social care contacts in Safeguarding Adult Reviews

Name	Age	Gender	Specificities	Mental health problem	Outcome
Ms A	28	Female	Diabetes	Bulimia, anxiety, depression	Death after refusing healthcare
Ms Taylor	71	Female	Multimorbidity multiple long-term conditions	History of depression, alcohol dependency and suicide attempts	Death caused by fire at home
Mr C	Late 70s	Male		Parkinson's Disease and dementia, 'aggressive anti-social' behaviour	Death after a fall in a care home
Sahara	33	Female	Pregnant in her third trimester with second baby	Anxiety and depression with insomnia	Death by suicide
CM	93	Male	Multimorbidity	Depression	Death by suicide
Drina	35	Female	Victim of trafficking and modern slavery/ learning disability	Severely neglected state	Fate unknown after deportation to Romania
Ms AB	45	Female	Recently homeless/ victim of domestic abuse	Drug and alcohol addiction	Death by drug overdose
LP	Working age	Male	Detained under the Mental Health Act	Various mental health problems	Death during a police chase after fleeing from a hospital when no inpatient bed was available on a secure psychiatric ward
Cedric Skyers	70s	Male	Disabled and using wheelchair; unable to move limbs or call or call for help	Schizophrenia	Died after cigarette caught in clothing while left smoking unattended in a care home
Mrs AM	80	Female	Multimorbidity	Dementia	Suffocated in her care home bed after having been left unattended

3. Findings: Learning from the past to build the future of mental health social care

3.1 Format and publication of the SARs

Despite a common aim of the SARs identified for this study – namely to draw learning points and recommendations for practice change from the cases of people who came to harm or died whilst in contact with services – the presentation of the reports differed significantly in length and structure. But, this is in line with statutory guidance (Department of Health and Social Care, 2020) which is usefully summarised in a national SARs review:

> "Statutory guidance gives SABs discretion as to what type of review process is most likely to promote effective learning and improvement action. The same guidance advises that reviews should be proportionate to the scale and level of complexity of the case. Similarly, the quality markers advise that consideration should be given to the appropriate size and scope, form and focus of the review given the case and its context." (Preston-Shoot et al., 2020, p.27)

In some cases, executive summaries of main reports were published, but most were full-length reports with or without additional executive summaries. At times, recommendations and learning points were summarised in a box or table but in others it required a thorough read of the entire report to identify the learning points/recommendations. For a few reports, easy-read versions were available, which is important in terms of accessibility.

Summaries, sometimes described as 7-minute briefings (meaning they should take about 7 minutes to read), were published for 10 reports. Again, these were of differing quality, some of which succinctly described the main learning drawn from the case. Other learning materials, like PowerPoint presentations, action plans or family statements were available for 9 reports. Five thematic reviews were published across 4 boroughs, one of them commissioned by several boroughs.

In this study we did not look for information to tell us what learning events have or have not taken place after the SARs were published. We also do not know which actions were taken or recommendations realised by the several organisations involved or subject to the reviews.

But from systematically searching and scanning the recommendations and learning points in each of the SARs, it became apparent that often there were no timescales given by when to realise or act on recommendations identified in the reports. The recommendations often did not note the level of urgency to act on them in order to avoid future comparable cases, nor did they include a reflection on the potential effectiveness and/or reach of the suggested changes.

3.2 Equality and Inclusion – findings

People may experience discrimination or have specific needs in terms of protecting their human rights based on their personal characteristics and background. As in similar overviews, not all the SARs we covered included

descriptions of the individual that were enough to be able to record relevant factors for an equality and diversity analysis. Also, the number of SARs analysed for this report is not large enough to be statistically relevant. Nevertheless, this review still uncovered the following points, which may contribute to a bigger picture in terms of equality, diversity and human rights within adult safeguarding:

● Out of 34 cases where ethnicity was recorded, 10 people had a white British and 14 had an ethnic minority and/or migration background.

● At least 39 individuals had a physical or learning disability or disabling health condition, including multimorbidity/multiple long-term conditions in addition to their mental health problem – the majority of the cases.

● At least two of the individuals belonged to the LGBTQ+ community.

● At least 10 people had either been diagnosed with or were suspected to have dementia.

● The Reviews were undertaken in respect of roughly an equal number of males to females and older people (aged 65+) to working age and younger people (18-65)

● Several cases touched on equality matters including homelessness, literacy and numeracy, and poverty.

A small number of the SARs referred to the Human Rights Act 1998 and the duty of local authorities to protect the rights and freedoms of people who are in need of care and support. These cases told the stories of individuals who were known to adult social care teams to have mental health and care needs but were sometimes left without support which could amount to a violation of basic human rights under national and international law.

3.3 Overarching themes

Across the majority of the SARs, two overarching themes emerged that could be applied to many other of the cases discussed within the reports. The first theme concerns inter-agency work and collaboration to ensure provision and continuity of high-quality, person-centred care. The second theme revolves around professional knowledge of and ability to apply mental capacity and mental health legislation. This second theme is highly pertinent in the present context of legal change.

Theme 1: Keeping people on the radar – continuity of care, collaborative multi-agency work and individual responsibility

The SARs studied for this report suggest that a majority of individuals concerned fell 'under the radar' of mental health social care provision. **This especially applied when people received care in the community, often after having been discharged from acute care settings.** Care in these instances can be described as interrupted and/or non-integrated or unresponsive. This is not to say that individuals never received consistent care in their histories of mental health social care contact but that the events leading up to the point of serious harm as reported in the SARs often point to such circumstances just before coming to harm. In these cases, individuals did not receive:

● the right amount of care (for example, no or not enough visits by care workers or social workers, no beds available for inpatient treatment, etc.) and/or

● care that was timely enough (e.g. emergency interventions, equipment) and/or

● care that was tailored and responsive to their individual needs.

In various instances this may have contributed to a mental health problem either escalating to crisis point or to the risk of serious harm and death staying undetected or inconsistently managed.

The data point to three major root causes for interrupted and non-integrated care before harm. In various cases these root causes were interrelated and complementary. **The first major root cause was a lack of communication, clear responsibilities and exchange of information between agencies and/or organisations**, as the following quote highlights:

"Adult B had very complex physical and psychological problems. It was clear during the process of this review that agencies did not understand the level of involvement by partner agencies and did not fully use opportunities to share information and arrive at a multi-agency plan to address the issues which were arising."
(Adult B, Southwark)

A second root cause was **a gap in continuity of service provision or unresponsive care**, as outlined in this quote:

"The failure of Michael's own GP to act on family information received on 29th February 2016 delaying treatment for the deterioration of his mental state which could have possibly prevented his death."
(Michael Thompson, Lewisham)

A third, commonly mentioned root cause was **a lack of risk assessment or escalation procedures:**

"It is apparent that agencies were aware of, or had a duty of care to be aware of, information on increased needs and risks. However, this information was not sufficiently recognised or shared between agencies, particularly in the year leading up to the incident, and this presented a missed opportunity for multi-agency risk assessment and management in a case involving complex needs and risk circumstances."
(SU, Kingston)

To ensure that people are kept 'on the radar' of inter-agency work and provided with the right care and support, the learning points and recommendations of a majority of reports suggest the need for the following measures:

● Improved collaborative working across agencies and organisations, including Adult Social Care, Community-Based Health Services, hospitals, the Police and Fire Brigade, where applicable, to support and protect vulnerable adults with mental health needs

"Organisations should ensure collaborative working across Adult Social Care, Children's Social Care and Community Based Health services (including: GPs,

District Nurse, and Physiotherapists), agreeing Joint Referral Pathways and Information Sharing Protocols."
 (Mr K, Bexley)

● Shared risk and escalation procedures and pathways to respond to changes in an individual's circumstances

"Policies and procedures regarding actions to be taken to understand and assess risks to a person's vital interests are needed, together with an agreed process to follow if urgent multi agency coordination is indicated. Without an agreed process and understanding of potential multi – agency actions it is unlikely that a confident response will be made to a situation similar to Martin's in the future."
(Martin, Lambeth)

Theme 2: Knowledge and applicability of mental capacity and mental health legislation and policies

The learning points and recommendations across virtually all the case clusters include reference to how social and health care professionals work, or do not work, with mental capacity legislation – the Mental Capacity Act 2005. Indeed, from the reports it became apparent that many professionals do not undertake mental capacity assessments, cannot agree on the outcomes of assessments of decision-making capacity or do not keep adequate records of their assessments, or decision making.

Difficulties in balancing some of the fundamental human rights of people, including the right to privacy, correspondence and family life, the right to non-discrimination and the right not to be treated in inhumane and degrading ways were less often mentioned. This theme will be picked up on several times in the case cluster reports below. A shared learning point and recommendation across the SARs included the following and this reflects much other commentary and research:

● Improvement across organisations and agencies in the understanding and use of the Mental Capacity Act 2005

"No mental capacity assessment was undertaken at any time. Mrs. K was very unwell during her second hospital admission. Given the concern regarding cognitive impairment, the presumption of mental capacity without an assessment was therefore of concern… Health and social care commissioners [are] to offer the SAB assurance on compliance with training on the Mental Capacity Act and involvement of the person."
(Mrs K, Wandsworth)

3.4 Case clusters and recommendations from the SARs

Cluster 1: Older people who died at home

Out of 77 SARs, 16 were about one or more older people (aged 65+) who died in their own homes or in hospital after having lived at home. Individuals in this cluster were **older, living on their own or with limited informal or family care, isolated from the wider community, with multiple health needs having had several previous stays in hospital and care packages being in place for some**.

In most of these reported cases the older person was unable to look after their own needs (a form of self-neglect) and/or their home but was deemed to have capacity to make their own decisions or had not been given a mental capacity assessment. Due to their isolation and physical and/or mental health needs that may prevent them from leaving their homes and participating in the community, people in this cluster were at times defined as "hard to reach" and dependent on local authority adult services "picking up" on them either by being told about them in the first instance or monitoring their care.

Common causes of deaths in this case cluster were infection resulting from pressure ulcers or other, mostly preventable conditions, or falls at home without anyone checking on them for several days. The pain experienced here is not always made explicit in the SARs but is likely to have been considerable.

The learning points across this cluster shared recommendations included:

● Ensure the existence of multi-agency discharge procedures from hospital that are person and needs-centred

"In complex cases, particularly where there has been a long stay in hospital there should be a multi –agency pre-discharge planning meeting for Vulnerable Adults. This should ensure all necessary arrangements are in place including care at home and medication." (Mrs Q, Tower Hamlets)

● Involve GP practices more in identifying isolated older people

"Catherine's GP acknowledges receipt of the ASC (Adult Social Care) referral in December 2016. They recorded that the referral did not raise any safeguarding concerns. There is no evidence that the GP practice made any attempts to contact Catherine. Given that the Practice had not seen Catherine since 2014 and they had received concerns about her behaviour in June 2016, it is surprising that a review of her health and wellbeing was not undertaken…GP practices [are to] review the use of letters when they have had no contact/response from elderly individuals with a recorded mental health history."
(Catherine, Croydon)

Cluster 2: People who died at home after a fire

Ten people who were the focus of a SAR died as a result of a house fire. Characteristically, SARs in this cluster concerned people (50-80 years old), who **had multiple long-term conditions such as long-term disabling physical health conditions eg multiple sclerosis, as well as a long-term mental health condition, including depression and anxiety. Self-neglect and hoarding behaviour as well as social isolation and lack of informal care structures** were identifiable in most of these cases, similar to the cases in cluster 1. Virtually all the individuals in this cluster were deemed to have capacity or were not assessed for their capacity to make choices that posed significant fire hazards, such as smoking in bed or using electric heaters in a way that led to heightened risk. Many of the reports concluded that the causes of these fires were predictable and preventable.

The analysis of learning points and recommendations brought up the following themes specific to this cluster:

● **Care pathways should include the London Fire Brigade (LFB)**

"Prior to the fatal fire, Mr A had not been subject to a fire risk assessment or referred for a LFB Home Fire Visit that, in all probability would have highlighted that he was at high risk of a fire occurring at his home address. This would also have meant that additional measures could have been considered to reduce the fire risks or to provide additional care planning or support measures."
(Mr A, Enfield)

● **Self-neglect policies should include risk of fire** and other similar hazards

"There is no evidence that Ms Taylor's decisions on smoking was construed as self-neglect and therefore as a safeguarding issue, although in her rejection of safe smoking strategies she was neglectful of her own health and safety."
(Ms Taylor, Haringey)

Cluster 3: People with learning disabilities

Nine people (aged between 30 and 64 years) with learning disabilities, including Down's syndrome, were the focus of SARs in London during the review period. London ADASS decided to leave the analyses of this sub-group of SARs to a later date.

Cluster 4: People who apparently refused treatment

Six people (aged 28 – 63) with **serious underlying health conditions as well as mental health problems, including depression, psychosis and addiction, were reported to have died as a result of refusing medical treatment**. Refusal of treatment is broadly defined and may include self-discharge from hospital, not taking medication, refusing to have necessary interventions in hospital administered, and not attending doctors' and/or hospital appointments (there may of course be a good reason for this). In the UK, informed consent is needed for most treatment and this poses dilemmas in practice at times. Accordingly, a learning point and recommendation along the following lines was common in the relevant SARs:

● Provide support to health and social care professionals to balance rights to make treatment decisions with mental health and capacity laws and policies

"There were consistent misunderstandings related to self-neglect and mental capacity. Agencies were aware that GC was self-neglecting, however they also assumed that GC had mental capacity, and consequently (and erroneously) decided that an intervention was not possible."
(SAR GC, Havering)

Cluster 5: Young people (18-25) who died by suicide

The SARs included the cases of six young people (aged 18-25) who died by suicide after having been known to mental health social care services and actively receiving (mostly extensive) treatment for mental health problems. Commonly, the young people had experienced complex difficulties in their family lives, together with problems around housing, alcohol and drug abuse. Two of the individuals were care leavers and two had a diagnosis of autism. Like other clusters, each review has its own learning points that were not necessarily transferable to other cases. But, in virtually all the reports, learning points and/

or recommendations spoke about the need for suicide prevention strategies and improved guidance for managing complex cases:

● Ensure the existence of suicide prevention strategies

"A key finding was the absence of a self-harm and suicide prevention strategy, translated into a framework for frontline staff to use when assessing risks and deciding how to respond."
(Ms L, Tower Hamlets)

● Guidance for managing complex cases

"Arrangements for managing complex cases concerning young people and young adults could be reviewed to ensure that active consideration is routinely given to situations where services are struggling to meet an individual's needs."
(Ms A, Havering)

Cluster 6: People who died by suicide

Seven of the SARs provided accounts of multi-agency contacts with people between the ages of 33 to 93, who died by suicide while being known to the NHS, social care and/or mental health services in the community. Some striking similarities between the cases emerged from the analysis of SARs. For example, all these individuals at the time of their death were **facing extraordinary, often acute stress factors that fed into their pre-existing mental health problems**, including:

– bereavement
– homelessness or facing a real risk of becoming homeless
– insomnia during pregnancy
– negative outcomes of immigration status applications
– debt collection letters
– awaiting a trial on bail
– having a child removed from their care under child safeguarding procedures.

Furthermore, they had made or attempted to make contact on several occasions with GPs, hospital emergency departments and/or mental health crisis telephone lines in the weeks and days before taking their own life. Often, the contacts with the individuals did not seem to prompt professional curiosity to engage with the person's situation in any depth, which in various cases could possibly have contributed to saving their life. A shared learning point was thus:

● Increase professional curiosity for people who are in contact with services on
  several occasions

"When adults with vulnerabilities come into contact with health and social care professionals, these interactions present crucial opportunities for assessing risk. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm; maintain an open stance of professional curiosity (or enquiring more deeply) and understand one's own responsibility and know how to take action."
(CM, Havering)

Cluster 7: People who died or came to harm in care homes

Another cluster of cases concerns six older people (aged 70+) who died or came to harm in a care home. The circumstances of the cases do not seem to connect beyond the care settings in which they took place. For example, one SAR concerned a care home resident who became victim of financial abuse before he died. Another care home resident died from suffocation because she was unable to move, whilst one individual died by suicide.

But many of the SARs highlight failures in risk assessments of individuals that engage with a number of agencies and people outside the care home. This seemed to contribute in many cases to the individuals not receiving the care and support they required.

● Improved multi-agency personalised risk assessments

"Given the level of multi-agency input and concern from July 2015, there were sufficient grounds for involved agencies to trigger a multiagency assessment, close communication and coordination in addressing high dependency care needs and risks. Agencies appeared to practice within specialist areas and largely in isolation."
(Mrs AM, Richmond)

Cluster 8: People experiencing or at risk of homelessness

Three SARS told the stories of vulnerable people of working age who had histories of sleeping rough or being at risk of homelessness. In two cases the adults died following a drug overdose. They had been known to mental health social care services, each of them with complex and multiple mental health problems and histories of experiencing abuse, addiction and neglect. One of the cases triggered a cross-borough SAR because of the level of vulnerability of the person with complex mental health problems and his history of sleeping rough. The SAR highlighted how this person in particular fell through the gaps of the adult social care system and led to a multi-agency failing to provide the care and support this person was entitled to receive. Unconscious bias towards homeless people was mentioned in all the relevant reports.

● Homelessness strategies that include adult social care/mental health social care

"One key interface where partnership working is required is that of Housing and Adult Social Care. Section 23 Care Act 2014 covers the boundary between care and support and housing legislation. The statutory guidance (…) that accompanies the Act, Chapter 15, provides further detail. The lack of suitable accommodation puts health and wellbeing at risk"
(Ms H and Ms I, Tower Hamlets)

● Training on equality, diversity and biases towards people experiencing homelessness and drug abuse

"Focusing on Ms I, the section 42 enquiry concludes that the Senior Practitioner seems to have lacked professional confidence and clarity in her decision-making, referring the matter back to a Senior Practitioner who had worked previously on the case. The divided state of the case record may have aggravated confusion

here. The [Internal Management Review] observes that staff must be aware of conscious and unconscious bias regarding homeless people with addiction issue" (Ms H and Ms I, Tower Hamlet)

Cluster 9: People living with dementia

Out of the 77 SARs, 9 included cases of older people with a diagnosis of (5) or suspected (4) dementia. About half lived in care homes and the other half at home, either alone or with family members. Most of the relevant SARs identified learning points and/or recommendations regarding the application of the Mental Capacity Act in supporting individuals living with dementia to make decisions. These points mainly highlighted that the principles of the Mental Capacity Act had not been followed by one or various agencies involved in the cases and that greater understanding and improved application of the principles must be achieved. Various SARs also mentioned mostly sub-optimal practice in identifying and managing risks.

● Improved application of the Mental Capacity Act in regarding people living with dementia

"Where changes are made to existing arrangements around adults with care and support needs and opportunities for interaction and observation may vary, it becomes more incumbent on all agencies to ensure strict compliance with the Mental Capacity Act and Best Interest. MCA is time and decision specific. (Mr A, Enfield)

● Identifying and managing risks affecting people living with dementia

"Where risk assessments are undertaken these should record actions that mitigate the risk and the contingencies that should be put into place should these actions fail or not be available. Risk assessments should also have a time frame for review and record what other factors may trigger a review." (Mr C, Greenwich)

Cluster 10: People who were detained under the Mental Health Act

The reports included the cases of 16 people (aged between 19 to 92) who were subject to the Mental Health Act (MHA). In 11 cases, death occurred after individuals had been detained under the Act but had returned to stay and receive treatment and care in the community. In five cases individuals died during their hospital stay. The cases were analysed in sub-clusters accordingly. Few made reference to the MARAC (Multi-agency Risk Assessment Conferences) system.

Regarding the individuals who died while detained in hospital under the MHA, some similarities emerged. The cause of death was by suicide in most of these cases. Limited holistic understanding and management of risks (e.g. suicide, absconding), with effective information sharing, was a major connecting theme here.

● Improved system of person-centred, holistic risk assessment and information sharing

"It was the general panel view that the step-down risk assessment reflected the presenting circumstances and was proportionate. The Reviewer held a

different view, that the decision to transfer LP to an unlocked unit did not give sufficient weight to the risk presented by a history of fluctuating mood, previous withdrawals from support and previous attempts at absconding. The panel recognised that the assessment tool did not include the risk of absconding and, for LP, was not signed by an appropriate level manager. The risk had been addressed following the incident by the immediate provision of locks to the exit doors on the unit, the inclusion of absconding in the assessment tool and an escalation policy". (LP, Wandsworth)

Regarding people who had been previously detained under the MHA but were receiving treatment in the community at the time of death, cases differed substantially. Individuals died by suicide, from self-neglect, were killed, abused, or neglected by family members. One connecting theme across many of the relevant SARs focused on safeguarding procedures and practice. In many cases learning points and recommendations mentioned the need to improve safeguarding procedures and practice, whilst in some reviews good safeguarding practice was lauded.

● Improved understanding in safeguarding procedures and practice

"The records suggest that CCO2 questioned the point of a safeguarding referral, due to AA's behaviour involving illicit drug use. There was a significant delay before any discussion took place with the borough safeguarding team and when the safeguarding team advised that further exploration was needed in relation to AA's consent to proceed further, no further action was taken to explore this." (AA and BB, Hillingdon)

Box 2 below covers our findings about Reports to Prevent Future Deaths that were issued by coroners across the period covered by the SARs we reviewed. These are not generally included in analyses of SARs or discussions about adult safeguarding but we suggest that they are important in terms of wider adult safeguarding learning as well as their express purpose which is to prevent future deaths and so recommend more attention to them.

When an inquest reveals circumstances that create a risk of future deaths, coroners are under a duty to make a report to those who may have power to take preventative action (Coroners and Justice Act 2009). Recipients of these Reports to Prevent Future Deaths (PFDs), also known as Regulation 28 reports, must respond, usually within 56 days (The Coroners (Investigations) Regulations 2013). PFDs, then, share with SARs the goal of seeking to apply lessons learnt to potential future cases (Care Act 2014).

Running alongside our analysis of SARs, we conducted a review of London PFDs related to mental health, published over the same period (January 2017 – November 2020 inclusive). We focused on those which involved adult mental health social care services. Using the indexing system of the Office of the Chief Coroner (2021) website, we isolated 19 PFDs classified as 'mental health related' and nine classified as 'care home health related' which had a mental health component (looking in the latter category in order to capture dementia cases).

None of the 19 mental health related PFDs were sent to adult social care departments or social care providers. Nearly all involving cases where the person had taken their own life, these reports were predominantly directed at NHS Trusts (16 of the reports). Other recipients were the police service (4), the Department of Health and Social Care (2), NHS England (1), a GP practice (1), the Prison service (1), and a local authority housing department (1). The majority of concerns expressed by the coroners related to the quality of risk assessments, mostly at discharge from hospital, but also around unescorted leave.

In one instance, although the PFD was sent to the housing department at the Royal Borough of Kensington & Chelsea (as well as the local Trust), it was responded to jointly by Housing and Adult Social Care. In the case of Georgia Nelson who, at 21, had stepped into the path of a train, the coroner was critical of the hospital discharge planning, but also of the lack of availability of supported accommodation in the Borough (Georgina was reported to have treatment-resistant schizophrenia).

According to the PFD, she had been placed in supported housing for young people which was not designated as suitable for people with severe and enduring mental illness. Plans were afoot for her to move on, but with an absence of long-term supported housing '[t]here was simply no suitable place for her to go', according to the coroner, who also criticised the lack of rehabilitation placements. These concerns drew assurances from Housing and Adult Social Care in the Borough that improvements would be made, even if it meant, in the case of long-term (possibly life-long) supported accommodation, this had to be purchased out of area (Georgia Nelson, ref: 2019-0140).

We reviewed PFDs regarding care home related deaths (a separate category on the Chief Coroner's Office website). Among nine cases where mental health was a concern, six involved dementia (the remaining cases involving suicidal behaviour, complex mental health problems, and acquired brain injury). In three of the dementia cases the coroners' concerns centred on inadequate responses after the person had fallen, in another it was a matter of poor medical record keeping, in another it was a question of the fluids regime, and the last related

to bad treatment received from someone with overseas convictions for assault not picked up at recruitment. Except for this latter case, where the report was directed at the Disclosure and Barring Service alone, all the PFDs were made to the care providers (and often copied to the Care Quality Commission).

In two of the care home related deaths the PFDs were also made to Adult Social Care. Pamela Craigie, who had dementia, died as a result of a fall, her fourth at the nursing home in Hounslow where she lived. Her being at high risk meant that 1:1 care might have been appropriate.

The coroner was concerned that applications to the local authority for this change to her care plan were not being made because of past funding refusals. She also noted that urgent multi-disciplinary team meetings at Adult Social Care could take between two and three weeks to arrange. The provider responded that there would be clarification of the criteria for 1:1 care in the face of fall risk, that where such care was indicated applications to the local authority would indeed be made, and that it would ensure a risk management protocol would be in place in the interim. Hounslow's response is not available on the website (Pamela Craigie, ref: 2017-0279).

The second PFD that was sent to Adult Social Care (as well as the provider) concerned Yong Hong, an asylum seeker living in a Croydon care home with a history of self-harm and suicidal behaviour. The PFD outlined how the close observation regime recommended by his GP was not implemented and the care home staff were insufficiently trained in carrying out risk assessments themselves. Yong Hong hung himself with the call bell in his room.

The coroner also highlighted that Hong's social isolation was worsened by his very poor English and that no interpreter was sought to assist in the assessment of his needs 'due to issues of confusion between the social work team and the care home about responsibility for funding'. There is no response on the website from either the provider or Croydon Borough Council (Yong Hong, ref: 2019-0130).

PFDs' extension of the inquisitorial process beyond the coroner's court gives rise to evidence for researchers not dissimilar to that reported by SAR authors. Indeed, though not apparently the case among this small sample, PFDs and SARs can be done in relation to the same events, just as there can be overlap with Root Cause Analysis investigations (often undertaken by NHS Trusts).

An important point of distinction with SARs is that, at least formally, a PFD only 'raises issues and is a recommendation that action should be taken, but not what that action should be' (Chief Coroner, 2020: para 27). This is why it is particularly useful when responses are posted on the Chief Coroner's Office website, to see the nature of the action taken or proposed. However, while the Chief Coroner has asserted that there is a presumption in favour of publication of PFDs (Chief Coroner, 2020: para 61), the same presumption does not appear to apply to responses.

We are aware of two other analyses of PFDs of interest here. Leary et al. (2021) conducted a thematic analysis of PFDs in healthcare (England and Wales, 2016-19), identifying five themes and 53 sub-themes across 710 reports. They argue that the emergence of these themes makes for a 'substantial opportunity for learning from PFD reports' (p. 20). However, none of their findings focus

explicitly on mental health social care. The second analysis is a thematic one of PFDs involving mental health services done by the Care Quality Commission (CQC) (not limited to London, apparently for the year 2014-15). This seems to be only available as a result of a Freedom of Information Act request made by Minh Alexander and only on her website. We mention it here as potentially useful context for our findings (CQC, 2016).

4. Implications of findings for the proposed Mental Health Act and recommendations

This review was commissioned with a view to learning from the past of mental health social care for the future under a new Mental Health Act and for mental health social care particularly. Generally, the SARs highlight the importance and use of inter-agency work and communication, including shared guidelines, action plans and clarity around who is responsible for what and in which organisation.

As a first recommendation, **it would be reasonable to start a countdown to the new legislation coming into play, appointing a named person from adult social care in each borough to bring forward conversations with peers on how to inform and ultimately put into practice the new legislation in the current context. This could include a London-wide plan of action to disseminate information and series of training/learning initiatives on the new Act aimed at NHS secondary and primary care Trusts.** Within these action plans, the role of social care amongst NHS partners should be clearly highlighted to foster inter-agency work and collaboration whether this is through Section 75 agreements or otherwise.

General recommendations

The SARs for this review provided rich data and potential for future learning and thus a real improvement in practice and systems. **In terms of communication and improved learning from SARs (as much as can be said about this within the remits of this study) the London Safeguarding Adults Board could have a general commitment to circulate SAR reports covering mental health (with summaries and action points at the beginning to promote the accessibility of report) to all boroughs and Mental Health Trusts and organise learning events, with the aim to encourage inter-agency work and cooperation; and also to note good practice.** New relationships with Integrated Care Systems are developing and safeguarding will have to feature in these partnerships' plans and commissioning.

To maximise the potential for change from SARs, **recommendations and action points could include an assessment of the level or urgency of each of them as well as of the potential effectiveness or reach of their changes**. This could help to prioritise and plan concrete actions. **London's Safeguarding Adults Boards could encourage actions within a reasonable timeframe and monitor their progress. A review of how the SARs were disseminated and what actions have been taken and to what effect could follow after specific times, post-publication.**

Recommendations for equality/inclusion and human rights

This study found little mention of equality and inclusion markers within the reports, in line with other comparable reports. Yet, the findings suggest that the individuals who have come to harm often experienced at least one protected characteristic under the Equality Act 2010 (e.g. physical/mental disability). The clusters of comparable cases also indicate that there are certain groups of people and certain factors, such as unwanted social isolation and loneliness, that require particular attention from Adult Social Care and the London Safeguarding Adults Board to ensure they are discharging their duties under the Human Rights Act 1998, the Care Act 2014 and international human rights law.

A first step to improved practice here would be for those commissioning SARs to oblige reviews to include equality and inclusion markers (e.g. ethnicity, religion, migration status, sexual orientation) into all SARs to enable future overviews to understand how these characteristics are possibly playing a role in current mental health services. London-wide training on human rights and equality, including awareness on human rights issues such as human trafficking and modern-day slavery, for NHS and social care partners in mental health could contribute to improved practice in adult safeguarding. Good practice in mental health and social care could be analysed in the light of human rights instruments and specific articles, including the right to health and the right to housing.

Isolated older people and others often seem to be 'hidden in plain sight' and the pandemic has thrown new light on the potential for mutual aid and neighbourhood support to assist people who are lonely and isolated but also the increased prevalence of social isolation and loneliness.

This can be framed as a rights issue under the right to health but also as part of efforts such as making London an age and a dementia friendly city. There is much room for local data sharing about risks of loneliness and of poor health, including mental health. **SABs need to be included in such conversations. The creation of new systems to identify people who may need support in any future crisis should include debates about the substantial numbers of people who are referred to adult safeguarding services – as an enquiry or a concern – and whether this data may provide useful information about levels of need or opportunities for prevention of harm.**

Mental capacity law and assessment

As outlined above, the understanding, applicability and use of mental capacity law were SAR-wide problem areas. A common theme within these SARs was the extent of dilemmas faced by health and social care professionals in balancing the respect for people's right to make decisions with the complexities surrounding assessments under the Mental Capacity Act, the role of the Mental Health Act and the potential for compulsory treatment. The reports suggested that professionals in different care settings are sometimes not clear about the role of the Mental Health Act when capacity has been assessed (Gilburt, 2021). Different opinions about mental capacity assessment may at times hinder a constructive way forward.

Action to address this theme could be taken within the training that will be necessary in the implementation of a new Mental Health Act and training could be commissioned to cover the interface of the new Act and the Mental Capacity Act. Training has to be put in practice, of course, and, as the pandemic subsides, there may be fresh opportunities to conduct audits and peer or inter-local authority audits of cases as previously promoted by the Local Government Association for adult safeguarding. Opportunities for refresher training on the use of legislation could be promoted by Safeguarding Adults Boards and uptake collated in their annual reports.

The replacement of the Deprivation of Liberty Safeguards by the Liberty Protection Safeguards (due April 2022) provides other opportunities for refresher training. Pan-London training using webinars and other virtual designs

would seem to be worth developing in partnership with the new Integrated Care Systems and the secondary NHS Mental Health Trusts covering London. Such training could be evaluated as it will need to be effective in changing practice or sustaining good practice and inter-agency working.

Another way to address this theme could be to audit practices (peer audits) in mental health social care on the use of the Mental Capacity Act 2005 as it stands and as the new law is implemented.

Other recommendations following on from this study

In the study some particularly pertinent topics emerged for recommendations:

● Hospital discharge

Most commonly, the reviews picked up on the discharge procedures in acute hospital settings. They found several shortcomings that at times contributed to individuals not receiving the care and support that they needed. Learning points suggested the need for multi-agency discharge procedures that allow an effective, person-centred handover from acute to primary healthcare.

As such, these should include multi-agency discussions and information sharing between hospitals with the GP, social and mental health care teams and others who may be needed to provide high-quality care to a vulnerable adult. It should ideally also engage family and others in the community (including home care providers) and teams that may be tasked to deliver care equipment or environmental services. Multi-agency discharge procedures (now modified to Discharge to Assess and Recovery) should include an update on care packages. The procedures must have mechanisms in place to ensure continuity of care and support on bank holidays and weekends.

The widespread introduction of Discharge to Assess (assessments being conducted at home or in a temporary care setting rather than in hospital) during the Covid-19 pandemic (as from Spring 2020) should benefit some situations, since such those doing such assessments should increasingly see home circumstances. However, they will also need to engage with people who may be reluctant to have help at home and be cautious about relying on remote assessments (online or telephone communications only) if the home circumstances are unknown or appear to present risks. **SABs could seek information from their local hospitals about how such assessments are being undertaken and what is the threshold or risk assessment process for making a visit to assess the person at home.**

● Pressure ulcer prevention

Pressure ulcers are a serious concern for the health and wellbeing of vulnerable adults, as the review of this study highlighted again. **There may be the potential to ensure that pressure ulcer prevention and recognition are highlighted in commissioning of home care agencies, that good training is freely available on the subject and that NHS professionals are encouraged to share their skills and experience with care workers and family members. These are often seen as physical health problems but this study has illustrated the presence of mental health and physical health problems that can potentially exacerbate each other. London local authorities may wish to mark international Stop Pressure Ulcer**

Day (18 November 2021 this year) with local communities, employers, care users, carers, disability groups and older people's groups. This could be co-ordinated across London and involve all local SAB partners especially NHS colleagues and care providers.

● Learning from good practice

SARs throw light on problems but learning from past events can also be provide opportunities for reflection on good practice or 'appreciative enquiry'. Some SARs provide opportunities to highlight and publicise what is working well and not so well, for example, in suicide prevention, risk assessment and escalation, responding to self-neglect and hoarding behaviour and of listening to service users and carers; and prioritising actions. In mental health social care there may further be room to canvass ideas for awards, prizes and celebrations so that positive practice is celebrated. LondonADASS' commitments to mental health practice made during Race Equality Week 2021 could be drawn upon here.

5. Conclusion

This report has considered SARs that are relevant to mental health social care in London in the context of planned new mental health legislation. Our focus is on adult mental health social care services but several of our findings are more widely applicable.

Several points are directed to the London's Safeguarding Adult Boards and to local authorities both about the content of the SARs they commission and also their dissemination, usage and follow up.

We suggest that consideration is also given to Reports to Prevent Future Deaths from local coroners, Mental Health Homicide Reviews, Domestic Homicide Reviews and Serious Untoward Incident Reports produced by Mental Health Trusts and others to ensure that London benefits from their analyses. New mental health legislation will need the support of mental health social care to promote Londoners' wellbeing and its safeguarding implications need to be highlighted.

References

Alcohol Change UK (2019) Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017. London: Alcohol Change UK.

Braye, S. and Preston-Shoot, M. (2017) *Learning From SARs: A Report for the London Safeguarding Adults Board.* London: ADASS. http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

Care Quality Commission (2016) Thematic Analysis of Prevention of Future Death (PFD) Reports involving mental health services. Available at: https://minhalexander.files.wordpress.com/2017/08/cqc-foi-20160517-coroners-reports-mh-sector-thematic-analysis-final.pdf

Chief Coroner (2020) Revised Guidance No. 5. Reports to Prevent Future Deaths, London: Office of the Chief Coroner. https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/guidance-no-5-reports-to-prevent-future-deaths-4/

Gilburt, H. (2021) A tale of two Acts: the Mental Health Act, the Mental Capacity Act, and their interface. London, The King's Fund, https://www.kingsfund.org.uk/blog/2021/02/tale-two-acts-mental-health-act-and-mental-capacity-act

Leary A., Bushe D., Oldman C., Lawler J. and Punshon G. (2021) 'A thematic analysis of the prevention of future deaths reports in healthcare from HM coroners in England and Wales 2016–2019', *Journal of Patient Safety and Risk Management,* 26(1), 14-21. https://doi.org/10.1177/2516043521992651

Local Government Association (2020) Analysis of Safeguarding Adult Reviews: April 2017 – March 2019, https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019#sab-governance-of-sar-decision-making

Manson, S. (2017) *Report from a Thematic Review of Safeguarding Adults Reviews Within East Midlands.* East Midlands ADASS. http://www.nottinghamshire.gov.uk/media/132275/emsanthematicreviewsars.pdf

Manthorpe,J. and Martineau,S. (2016) Serious Case Reviews into Dementia Care: An Analysis of Context and Content, *The British Journal of Social Work,* 46(2), 514–531, https://doi.org/10.1093/bjsw/bcu135

Martineau, S. J., Cornes, M., Manthorpe, J., Ornelas, B., & Fuller, J. (2019). *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews.* NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-006

Mental Health Foundation (2021) Mental Health Statistics: Most Common Mental Health Problems https://www.mentalhealth.org.uk/statistics/mental-health-statistics-most-common-mental-health-problems

Office of the Chief Coroner (2021) Reports to Prevent Future Deaths. https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/https-www-judiciary-uk-subject-community-health-care-and-emergency-services-related-deaths/

Preston-Shoot, M. (2020) 'Safeguarding Adults Reviews: informing and enriching policy and practice on self-neglect.' *Journal of Adult Protection*, 22 (4), 199-215.

Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20 (2), 78-92.

Public Health England (2021) COVID-19: mental health and wellbeing surveillance report available at https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/2-important-findings-so-far