Michael Murphy Associates

Safeguarding Adult Review Summary: Mairead

Independent Review for the Hillingdon Safeguarding Partnership

Introduction

Hillingdon Safeguarding Partnership commissioned Michael Murphy Associates to undertake this Safeguarding Adults Review. The purpose of this SAR has been to identify systemwide learning in respect of the death of Mairead, following concerns about unmet care needs and delays in access to clinical care.

Context

The circumstances, concerns and events giving rise to this SAR are highly similar to those which prompted the Thematic Self-Neglect SAR 'Angela and Chris' published by the Hillingdon Safeguarding Partnership in September 2022. Five key themes were identified that contributed to the response of local services:

- Community mental health service responses to patients' physical health needs
- Diagnostic overshadowing
- Recognition and response to self-neglect (including refusal of medical assessment/treatment) where someone is believed to have mental capacity.
- Triage of safeguarding concerns within Adult Social Care led Multi-Agency Safeguarding Hub.
- Collaboration between primary care services and secondary mental health services.

Following preliminary analysis, these same areas of learning are applicable to service responses to Mairead.

Methodology

Hillingdon Safeguarding Partnership commissioned an independent reviewer with extensive relevant experience to undertake the review. The Terms of Reference for the SAR were agreed between the SAR Panel

- Family views about how safeguarding partners worked together to safeguard Mairead.
- Any learning that can be identified, through review of partner's responses to Mairead, that has *not already been identified* through the Thematic Self Neglect SAR September 2022 and the section 42 enquiry.
- Reflections on the responses of services after Mairead's death.
- System-change recommendations not covered in the Thematic Self Neglect SAR or the section 42 enquiry.

Hillingdon Safeguarding Partnership will develop an action plan to ensure dissemination and embedding of learning, including consideration of any recommended system changes.

Circumstances of Concern

Mairead was a 70-year-old white female open to secondary mental health services with a diagnosis of schizophrenia. Mairead attended a CNWL run clozapine clinic and had a package of support in place from a floating support service attached to her housing association tenancy, which was one of several supported accommodation 'group homes' in Hillingdon for people with severe and enduring mental illness.

The Lead Professional was the Consultant Psychiatrist who saw her as an outpatient. There was an assessment pursuant to s.9 Care Act 2014 documented in July 2020. No previous nor subsequent Care Act assessment or review was undertaken.

Throughout May and June 2021 Ability workers and Clozapine Clinic nurse documented recurrent concerns about deteriorating mental state and difficulties engaging her in face-to-face contact.

CNWL's community health service Rapid Response Team visited Mairead in early June 2021 but did not provide ongoing support.

On 11th June Ability documented *"During the visit I told Mairead she will be referred to the Mental Health Team for an assessment as I had concerns for her well-being."* There is no evidence of this happening.

On 25th June 2021 a neighbour raised concerns about Mairead's mental health and her safety. London Ambulance Service were called and found her extremely mentally unwell, screaming, naked, confused and throwing things out of the window. Mairead was conveyed to Hillingdon Hospital under the Mental Capacity Act 2005. Mairead later died following cardiac arrest in hospital. Adult Social Care triggered a s.42 enquiry.

Key Areas of System Learning

In order to avoid duplication of the Thematic Self-Neglect SAR and the section 42 enquiry, this SAR was tightly focused on learning not already identified in the Thematic Self Neglect SAR or the Safeguarding Enquiry. However, the learning from the Thematic Self Neglect SAR is directly relevant to this person. Mairead's sister raised concern about the long-term impact of shared supported living arrangements on Mairead.

Recommendation:

- **SAB to seek assurance from ASC that duties of assessment and review of support provision are being discharged for people in receipt of supported accommodation and floating support.**

There were no further attempts to assess Mairead's needs or review the support provision from June 2020 onwards despite clear evidence of deterioration in her ability to cope and her engagement in support offered by Ability.

The CMHT, Ability and CNWL's Community Health services made no referrals to Adult Social Care to convey concerns about her deteriorating anxiety, difficulty accessing food, difficulty going out, and then a fall in May 2021.

Recommendation:

- **SAB to seek assurance that support providers for mental health service users are aware of their expectations to alert Adult Social Care to changes in need, levels of engagement or difficulties meeting needs.**

On 1st May 2021 an ambulance attended Mairead's home following a call to NHS 111 about pain following a fall 12 days prior. The paramedics documented a disclosure of a history of abuse and associated nightmares which had recently increased, and that Mairead had not been eating properly since the fall. They noted a shortage of food in the house. The paramedics telephoned the CNWL Mental Health Single Point of Access while in attendance. Their concern was conveyed to the CMHT by Single Point of Access. NHS 111 then submitted a safeguarding concern containing the concerns of the paramedics to Adult Social care, which reached Adult Social Care on 4th May 2021.

The Multi Agency Safeguarding Hub identified appropriately that the concerns indicated a need for an assessment of need. However, the referral was unintentionally closed, the referral never reached the mental health social work team so no further action was taken at the time. This was a missed opportunity to discharge Care Act duties.

On 21st June there is a request to the undertake an assessment of need for Mairead, but the records do not explain why this was requested. The manager concerned is no longer available to consult. There was no contact with her, her family, nor Ability to gauge urgency or gather any information prior to her subsequent admission to hospital on 26th June. No assessment was initiated prior to the hospital admission.

Quality of Assessment – Holistic, Proportionate and Supported by Partnership Working

Multiple professionals had responsibilities for assessing and reviewing Mairead's care, support and treatment needs as stipulated in section 7 Care Act 2014.

However, evidence indicates that all involved organisations were largely working in isolation from each other, and this impaired the quality of all agencies' assessments and interventions. Mairead's sister expressed the view that if Mairead had had the right support in the community she would not have become so unwell or had to go to hospital

Recommendation:

- **SAB should seek assurance that informal carers and concerned family members are involved in assessment and reviews by Adult Social Care and under the new Community Mental Health Framework.**

Mairead's sister expressed concerned that quality of assessments of Mairead's needs by all involved professionals had been low for years prior to June 2020. She has previously written to CNWL previously to express concern.

Her sister's view is that Mairead was incapable of managing her finances or speaking up for herself when she was being treated unjustly or had unmet needs. She found changes of key support professionals in her life very difficult, and it took time to develop trust.

Care and Support Needs

Mairead had an assessment of her care and support needs in June 2020, pursuant to section 9 of the Care Act 2014, by a social worker within Adult Social Care, by telephone. The assessment concluded:

"No social care needs identified during the assessment. Mairead should continue to work with her GP to manage her diabetes and medication. She should continue to engage with her CMHT to monitor her mental state and current medication and identify any signs of relapse."

Whilst the records on SystmOne were reviewed by the social worker in preparation for the assessment, there was no consultation or communication between the social worker and the Ability support worker or their manager, nor Mairead's brother who was acting as an informal carer at the time. Nor her sister who had acted as an informal carer for years previously. The nature of the support being provided by family was unknown to any services other than Ability. This should have been explored as part of the assessment.

The assessment states that Mairead needed no help with shopping for food, and yet the records from Ability indicate that at this time Mairead's brother was undertaking online shopping orders for her from France, and when he was unable to, she was asking Ability floating support workers for support with this.

The social worker explained, during a reflective discussion, that this assessment took place at the tail-end of the first Covid 19 national lockdown and all assessments and reviews were being undertaken remotely unless there were significant reasons for doing otherwise. However, remote assessment increases the importance of partnership working with any other services involved, family members and informal carers. The social worker acknowledged that, on reflection, it would have been best practice to contact the other people involved.

Assurance has been provided to the SAR that such an assessment undertaken now would adhere to much higher standards and mental health social workers are now more confident and supported to undertake quality assessments and reviews.

Recommendation

- **Adult Social Care to consider an audit to evaluate partnership working and involvement or family carers in assessments and reviews pursuant to the Care Act of adults with mental health needs.**

Mental and Physical Health Needs

The Care Programme Approach policy in place at the time of Mairead's passing was approved by CNWL in 2015. Care plans must be reviewed whenever necessary, and at least every 12 months.

Mairead was subject to LPC, rather than CPA, and her lead professional was her consultant psychiatrist. The reviews, documented by the Lead Professional, of her care plan, from 2019 until her death, made no mention of the role or presence of Ability in Mairead's life, nor the support she was receiving from her family.

Reviews of her mental health care plan only appear to take account of her engagement with medication, and varying prescriptions. There was no review undertaken by the lead professional which took account of the increasing concerns around her increasing physical health concerns, and deteriorating mental health and overall functioning identified by the Clozapine Clinic Nurse, the District Nurse, the London Ambulance Service nor Ability throughout May and June 2021.

Recommendation:

- **The SAB should seek assurance from CNWL about how reviews of care plans are quality assured and what standards they are held to.**
- **The SAB should seek assurance from partners that professionals undertaking direct work are working in a trauma informed way.**

Responding to Disengagement from Services

Mairead's had very little face to face engagement with outpatient appointments and with Ability Floating Support throughout 2020 and 2021. There were frequent non-attendances, cancellations of appointments and refusal to allow access to her home, including for necessary repairs.

The Community Mental Health Service *Did Not Attend/Clinical Disengagement Standard Operational Procedure* sets out expectations on the lead professional when someone does not attend, which includes the following:

- *Attempt to contact them by telephone and/or if appropriate, undertake a home visit.*
- *Liaise with family and other agencies involved to gather information as appropriate.*
- *Document any concerns, the reasons for them, and any attempts at contact.*

The SAR posits that this policy was not followed.

Recommendation:

- **The SAB to seek assurance from CNWL that the Did Not Attend processes are being followed for people using their services.**

Application of Section 42 Care Act 2014 When Adult at Risk has Died

After Mairead passed away a Safeguarding Enquiry pursuant to s.42 ran between 8th July 2021 and 20th February 2023. It was concluded temporarily during this period and reopened to take account of the findings of the Coroner's Inquest. The Safeguarding Enquiry was very detailed and made several recommendations relating to the way that services had worked to safeguard her in the last 2 months of her life, with a focus on the cause of death.

An adult at risk is defined by section 42 Care Act 2014 as an adult who:

- has needs for care and support
- is experiencing, or at risk of, abuse or neglect, and;
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

However, an adult who is deceased is no longer experiencing, nor at risk of, abuse or neglect. The purpose of a safeguarding enquiry is to enable the Local Authority to decide whether any action should be taken in the adult's case. After Mairead had passed away there was no action the Local Authority could take *in her case*. Given the purpose of a safeguarding enquiry, it is disproportionate to wait for and incorporate the coroner's findings. Section 44 of the Care Act 2014 explicitly concerns itself with people who have died and where there are concerns about the ways in which safeguarding partners worked together to safeguard them.

Section 42 enquiries are led by Adult Social Care. It is arguably unreasonable and unrealistic to expect Adult Social Care staff to fully scrutinise and challenge practice by themselves, peers and managers within their department.

There is a requirement on the SAB to commission a suitably *independent* reviewer for a Safeguarding Adults Review. This makes sense in light of the high sensitivity of a review following a death.

Recommendation:

- **The SAB should review the application of section 42 Care Act 2014 where there is good reason to suspect that the s.44 criteria might be met.**

Impact of Shared Supported Living Arrangements

During consultation with Mairead's family there were serious concerns expressed about the experiences Mairead and the family had had trying to safeguard Mairead from distress and harm from fellow supported housing tenants over many years. The family posit that a long-term detrimental impact to Mairead's mental health from the way the supported housing scheme was managed expedited her mental and physical deterioration culminating in her death. She said of the group home scheme: *"it ruined people's lives. It wasn't managed correctly"*. Mairead's sister said she repeatedly complained to CNWL about the way that tenants were identified for the group home. She said, "*it was like talking to a brick wall*".

In 2020 a multiagency action plan was completed to provide assurance that the recommendations from the AA BB SAR had been actioned to ensure that the same issues of incompatible co-tenants would not recur.

Recommendation:

- **SAB to consider responding to Mairead's sister to acknowledge her concerns, answer her outstanding query as to how decisions about allocating tenants had been made for Mairead, and provide assurance about changes in practice.**

Recommendations

Recommendation 1:

- SAB to seek assurance from ASC that duties of assessment and review of support provision are being discharged for people in receipt of supported accommodation and floating support.

Recommendation 2:

- SAB to seek assurance that support providers for mental health service users are aware of their expectations to alert Adult Social Care to changes in need, levels of engagement or difficulties meeting needs.

Recommendation 3:

- SAB should seek assurance that informal carers and concerned family members are involved in assessment and reviews by Adult Social Care and under the new Community Mental Health Framework.

Recommendation 4:

- Adult Social Care to consider an audit to evaluate partnership working and involvement or family carers in assessments and reviews pursuant to the Care Act of adults with mental health needs

Recommendation 5:

- The SAB should seek assurance from CNWL about how reviews of care plans are quality assured and what standards they are held to.
- The SAB should seek assurance from partners that professionals undertaking direct work are working in a trauma informed way.

Recommendation 6:

- The SAB to seek assurance from CNWL that the Did Not Attend processes are being followed for people using their services.

Recommendation 7:

- The SAB should review the application of section 42 Care Act 2014 where there is good reason to suspect that the s.44 criteria might be met.

Recommendation 8:

- SAB to consider responding to Mairead's sister to acknowledge her concerns, answer her outstanding query as to how decisions about allocating tenants had been made for Mairead, and provide assurance about changes in practice.