SAFEGUARDING ADULTS REVIEW:

DECLAN

'SOMETHING HAS TO CHANGE'

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Acknowledgements

Governance

The author can declare that he has no conflict of interest in completing this review, and that he is independent of all the agencies involved in the review. He is the Independent Chair to the Cambridgeshire and Peterborough Safeguarding Partnership. The report has been commissioned by, and written for, the Partnership and overseen by a multi- review panel of local senior managers and practitioners from the following agencies:

- CPFT
- GP
- Learning Disability Partnership – health and social care
- Placement 1
- Placement 2
- Police
- Cambridge University Hospital
- East of England Ambulance Service
- Integrated Care Board formerly Clinical Commissioning Group – s117, Mental Health & Learning Disability commissioners and complex cases
- Multi Agency Safeguarding Hub
- Cambridgeshire County Council – Brokerage, contracts and Commissioning
- Advocacy

The details of the adult, on the wishes of the family, have not been anonymised. They wish for Declan to be remembered.

Contents

1.0 Introduction

1.1 This review focuses on the life and tragic death of Declan. When he died Declan was 26 years of age. He had a severe learning disability and autism. Declan required full time support and care. He was largely unable to communicate by usual means. Some of those able to get to know him were able to understand and interpret some of his wishes.

1.2 From December 2014, Declan lived with and was supported by a service providing personal care. In June 2019, a review between Declan's social worker and support provider concluded that the environment was not suitable for his needs. The provider followed this up by serving notice on Declan's placement. Another placement was sought, and this took some time to achieve. This move was not supported by Declan's family. The rationale for this placement withdrawal forms part of this review.

1.3 In May 2021, Declan moved to a residential care home. Following the move there was a short period where he seemed to have settled well but quite quickly staff at the care home raised concerns that they felt that they could not safely care for him. Alternative provisions were sought but not found.

1.4 Declan's behaviours at the new setting became increasingly challenging and manifested in various ways including him repeatedly attempting to abscond from the premises.

1.5 In March 2022, there was a serious incident where Declan became very distressed and assaulted a number of staff. Police were called and a number of officers became involved in assisting staff to restrain him. As a last resort Declan was detained under section 136 Mental Health Act[1]. He was conveyed to hospital for his safety and assessment. It had been originally planned that Declan would be transferred to the s136 suite whilst still under the provision of the s136 however due to the examination and sedation he remained overnight in hospital, during which time his s136 expired.[2]

1.6 The following day Declan was assessed under the Mental Health Act (MHA), and the recommendation was for detention under section 2 Mental Health Act[3], however, there was no identified bed, as he required a single service user environment. It was agreed to admit Declan into the S136 Suite as a temporary holding action as it was deemed less inappropriate than the hospital emergency department, and safer for others.

1.7 During his admission to the s136 suite a suitable placement was sought, one could not be identified and as a result Declan spent an extended period of time, 10 days, within the confines of the s136 suite, a purpose for which it is not intended. During his admission to this provision he was seen to present some self-injurious activity, namely climbing and running into walls.

1.8 In the early hours of the 10th day of Declan's admission he was found to be breathing loudly. He was not responsive, and a doctor and emergency services were called. He was conveyed to hospital where it was established, he had acquired a head injury, causing an

[1] S136 Mental Health Act – give the police emergency powers to detain a person where it appears they have a mental disorder and are in need of care or control - https://www.legislation.gov.uk/ukpga/1983/20/section/136 (accessed 10/01/23)
[2] CPFT IMR
[3] S2 Mental Health Act - https://www.legislation.gov.uk/ukpga/1983/20/section/2 (accessed 10/01/23)

intracranial bleed. Declan remained supported in hospital until 2nd April 2022 at which time his family agreed that care should be withdrawn, and he passed away.

2.0 Why a review

2.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively.
- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults partnership in Cambridgeshire and Peterborough to improve its services and prevent abuse and neglect in the future.
- Agree how this learning will be acted on, and what is expected to change as a result.
- Identify any issues for multi or single agency policies and procedures.
- Publish a summary report, which is available to the public.

2.2 The Cambridgeshire Safeguarding Adults Review sub-group considered a referral for a SAR in March 2022. The Review Group was constituted from agencies with responsibility to make determination on the necessity of a SAR. The decision was that there was valuable learning to be understood and presented.

2.3 A SAR panel was formed for this review and developed terms of reference (full details at Appendix A). The agencies identified as having involvement in the case provided a report which focused on the key lines of enquiry identified by the terms of reference.

2.4 All agencies involved were asked to provide staff for a facilitated reflective workshop. This was attended by most agencies and where there was not representation the author spoke to representatives in separate interviews. Professionals engaged particularly well in the workshop and the discussion added value to the review, which is reflected in this report.

2.5 The timeframe the review considered is from the beginning of December 2020 to March 2022. Agencies were requested to consider significant events or information outside of this time period which influence the decisions made during the period in its scope.

3.0 Background

3.1 Declan was a young man of 26 years (born 1995) at the time of his death. He was recorded as being diagnosed with autism and associated severe learning disability, bipolar disorder and Attention Deficit and Hyperactivity Disorder (ADHD). Records from the provider of his support from 2006 state that on occasions he could display challenging and self-injurious behaviour. This was mainly by biting his hands, banging his head and scratching his arms, back and chest. He did on occasions also display faecal smearing.

3.2 Declan was non-verbal, and it was important that he was supported by those that knew him well and were able to understand his behaviour and through this gain an understanding of his needs.

3.3 Declan was born in Canterbury, Kent, where he was diagnosed with autism at a very young age. Soon after Declan moved to Cyprus, as his father served with HM Forces, and lived the early part of his life there. On returning to the UK, he initially attended a general SEN school in Cambridge, but the school excluded him, as it was unable to meet his needs. In 2003, a placement at a residential school in Kent was found, but out of term Cambridgeshire services were unable to meet his respite needs. This resulted in in Declan being placed full time out of county again, in Lincolnshire.

3.4 Declan arrived at placement 1 in October 2003, which was for a 52-week placement for both accommodation and education. He remained with this provider until his transition to adulthood. This care involved 1:1 care during waking hours and shared support through the night. For care and community appointments he was afforded 2:1 support. The provision was commissioned by Cambridgeshire County Council (CCC) to provide accommodation via a tenancy and to deliver 24-hour care. As a young adult Declan resided in a supported living service, which provided personal care and support in one of four houses which provide supported living.

3.5 Contextually it is important to note that between 2018 and 2019 the placement was being closely monitored due to institutional safeguarding concerns, which included: -

- Inability to provide individual and personalised care.
- Poor recruitment and retention of staff.
- Inability to apply routine and structure and implement robust care and support plans.

3.6 A programme of support was put in place by the Intensive Assessment and Support Service (IASS) of the Learning Disability Partnership (LDP), which included both planned and unplanned visits by the Contract and Commissioning Teams.

4.0 Review time period

4.1 **Episode 1 – Placement 1 – June 2020 – May 2021**

4.1.1 In June 2019, there was a review between Declan's social worker and the provider, that concluded that the provision was no longer suitable for Declan. There had been numerous complaints from neighbours regarding him causing noise and throwing items over the fence. He was also recorded as removing his clothes and faecal smearing. It is not clear to what extent Declan's family were consulted and involved at the discussion at this stage. The provider attempted to resolve the situation by convening meetings with the local community, police and local district councillors.

4.1.2 In July 2019, the review was followed up by a Mental Capacity Act (MCA) assessment to establish if Declan understood his care and support needs. This assessment was undertaken over several visits, facilitated by staff who were familiar to Declan. The

assessment established that he lacked capacity in this respect. The records indicate that his parents were involved in this best interest decision being taken on his behalf.

4.1.3 Throughout July and August 2019, there continued to be concerns raised by neighbours about Declan and other residents at the provision. In July a medications review was undertaken by the psychiatrist and Lisdexamfetamine (a central nervous system stimulant for ADHD) was added to Declan's prescription, after one week this prescription was increased to 50 mg per day.

4.1.4 At the beginning of August 2019, three neighbours raised concerns regarding Declan's behaviour. He had been seen outside of his property in a distressed state. As a result, a section 42[4] (safeguarding) enquiry was raised. This enquiry was found to be unsubstantiated with no evidence of Declan being distressed on the given dates.

4.1.5 During August, September and October 2019 there continued to be activity to find a new placement for Declan. The search was broadened and taken outside of the Approved Commissioning Framework due to the lack responses from local providers. During this time the LDP continued to support the placement provider to improve the quality of outcomes for Declan.

4.1.6 During September 2019, a potential new placement was identified, and the potential new provider visited placement 1 on two occasions. Placement 2 were confident that they would be able to meet Declan's needs. They would be able to provide a large open outside space, although the interior space was regarded as smaller than that Declan had been used to. The LDP records show that Declan's family were consulted on the potential move to placement 2 in early October 2019. It is recorded that the family concurred that Declan found living with others difficult and that he would benefit from a large outdoor space.

4.1.7 In mid-October 2019, placement 1 carried out a re-assessment of Declan's needs. This concluded that he required single service accommodation, with a minimum of 2:1 staffing. It was recognised that a single person service without close neighbours would reduce the number of restrictions that were in place to keep him safe.

4.1.8 At the end of October 2019, a safeguarding concern was raised because of a neighbour reporting that they had witnessed Declan being assaulted by a member of staff. Declan was reported to have been in a high state of agitation, vocalising loudly and throwing items over the fence. The matter was reported to police and Declan was examined for any marks and the only one found was described as a mark on his lower back. The member of staff involved who was employed by an agency was removed from the service.

4.1.9 Throughout October and November 2019, discussion on the suitability of placement 2 continued and it was put forward by the commissioners that the placement would not be suitable due to the proximity of neighbours who had previously complained about residents.

4.1.10 In mid-November 2019, Declan's family were consulted on his care and support plan. They were informed that the next step would be to apply to the Court of Protection (CoP) due to the restrictions that were in place to ensure Declan's safety. This was the first reference to

[4] Section 42, Care Act 2014 - A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse.

consideration of Deprivation of Liberty (DoL). The family are recorded as agreeing to this application.

4.1.11 There was a further medication review by the psychiatrist at the beginning of December 2019. The family were recorded as being involved in this review. It was recorded that the introduction of ADHD medication had led to improvements in Declan's *'health and wellbeing in domains of focus, concentration and hyperactivity'*. No acute physical health issues were noted. The family did highlight that there was a history of bipolar and affective disorder in the family, and they had noted that Declan's behaviour appeared to have a seasonal presentation with more extreme behaviour noted in the winter months. It is of note that at this time the records show a new behaviour of head butting on a few occasions had occurred.

4.1.12 Through the remainder of 2019 and the beginning of 2020, staff from the LDP raised concerns regarding the lack of activities being provided to Declan and the failure to develop and adhere to an activity plan. The placement had difficulty meeting these needs as there were issues regarding staff retention and the reliance on agency staff. The LDP continued to support the placement provider.

4.1.13 At the beginning of March 2020, Declan's parents contacted placement 1 provider and the social worker to inform them that they no longer supported Declan's move from placement 1. The family, having viewed the suggested new placement (placement 2) felt that the best option for Declan was to remain in his current setting, which they considered both appropriate and viable for his needs.

4.1.14 On 23rd March 2020, the first national lockdown due to the covid pandemic was put in place and this was to have a significant impact on the plans and delivery of service to Declan and all service users in his position.

4.1.15 On 27th May 2020, the placement 1 provider contacted the LDP to inform them that they wished to advise them of the termination of the contract to deliver services to Declan, this notice period was 28 days, expiring at the end of June 2020. The conversation with the provider was that they would, despite the serving of notice, support a smooth transition between services.

4.1.16 At the beginning of June 2020, Declan's mother requested an update on the application to the CoP, she was informed that the application was currently with the CCC legal team and once Declan's move had been arranged it would be submitted to the court.

4.1.17 The discussions over the transition to placement 2 continued through July and August, this included a joint visit by the social worker and Declan's parents to view the new setting and to discuss the building alterations that were required.

4.1.18 Over the following months there were meetings to discuss the transitions and the family undertook a further visit to the new placement. Due to restrictions and challenges presented by the covid pandemic there were problems in recruiting and training staff for the new setting and this extended the transition plan. This transition plan included visits by staff between the new and current placement and when the move occurred staff who were familiar to Declan moving with him by way of introduction. Due to the difficulties, there was only one staff visit to placement 1 and one visit by a behavioural expert. The planned staff move with Declan did

not happen due to the transition date being rearranged. This followed discussion between the LDP, Placement 1 and Placement 2.

4.1.19 In January 2021, a safeguarding concern was raised by a staff member at placement 1. These surrounded mistakes made in Declan's medication in November 2020 and covid practices. This concern was opened as a s42 safeguarding enquiry. There is a record that the family were made aware of the concern. The s42 was forwarded to the team responsible for Declan as part of ongoing concerns and was closed on the basis that it did not meet the criteria for a s42 enquiry. There was a focus on the medicine error, which was deemed to have caused no harm and the practice during covid but it did not consider the ongoing concerns regarding the ability of the setting to meet Declan's needs and the overriding problem concerning recruitment and retention of staff.

4.1.20 In February 2021, the provider at placement 1 raised concerns that Declan's behaviour was deteriorating. This was manifesting in him biting himself and staff members, and faecal smearing. It was recorded that this behaviour had been ongoing for some weeks. A medication review was undertaken by the psychiatrist, but this was not until the end of February, and was undertaken on the phone. The psychiatrist noted that there was an absence of core staff and new staff had not been following guidelines, and behavioural charts not being completed as being possible contributory factors. The review stated that if there were medical concerns the GP should be contacted.

4.1.21 There continued to be discussions regarding the transition, the move was further delayed after placement 2 needed the accommodation that had been identified for Declan for use as an emergency placement for some months. At the end of March 2021, concerns were raised regarding the space for staff at the new setting. This required addressing and would further delay the move. Despite this the transition plans continued with appropriate training being delivered to placement 2 staff. A staff member from placement 2 also spent 3 days at placement 1 to become familiar with Declan.

4.1.22 Declan moved to the new setting on 18th May 2021, this was just under 12 months after the provider at placement 1 served the 28 days' notice of termination of contract. Through May 2021, prior to the move, there continued to be an escalation in Declan's behaviour. He was vocalising and seeking to leave the premises late at night and jumping the perimeter fence on a daily basis. There was discussion with LDP over least restrictive measures that were necessary to keep Declan safe. This included locking doors and gates during the night to prevent Declan having access. There was no DoLs in place and the discussion had agreed that this could not be achieved before Declan's imminent move.

4.2 Episode 2 – Placement 2 – May 2021 - March 2022

4.2.1 The move to placement 2 is said to have gone well and initially the provider at the new setting would say there was a 'honeymoon period' where Declan seem to settle well and appeared content in his new environment. Declan was to receive 1:1 care for 24 hours a day and 2:1 for 8 hours per day, although additional hours were allocated for the transition period. It was recognised at this stage that placement 2 was registered with CQC as Residential Care and therefore the provider should submit a standard DoLs application to the Local Authority.

This was again referred to at the end of May 2021, when the LDP reviewed Declan's care plan.

4.2.2 The family made contact with the LDP and commented favourably on the move but made the point that Declan would have less disposable income due to the change in calculation of contribution and the family would be seeking advice on whether the changes made were in Declan's best interests.

4.2.3 Within one week the provider at placement 2 started to record challenging and agitated behaviour being displayed by Declan. There were complaints made by neighbours regarding items being thrown over boundaries by Declan and he pulled the bath from the wall in his accommodation.

4.2.4 Towards the end of June 2021, concerns were raised by placement 2 with the LDP. These involved Declan vocalising loudly at night, complaints from neighbours and Declan throwing items over the fence. They were concerned that the PRN[5] medication was not having an effect. Declan had started to jump the fence at the placement giving him access to other areas and the exit point for the placement. The placement requested a Multi-Agency Team meeting (MDT) to discuss these issues.

4.2.5 The day following this request a referral was received in the Multi Agency Safeguarding Hub (MASH) from an advocacy service. They had been visiting another resident at the placement and became concerned about Declan's behaviour and support. The advocate reported seeing Declan in the garden naked and without staff support. It was acknowledged that this was known behaviour for Declan but questioned the level of support. The advocate questioned Declan's safety should he leave the premises, whether he was in pain which required attention and whether there should be a Care Review. A call was made to the placement manager. These concerns were to be discussed at the planned MDT.

4.2.6 The psychiatrist undertook a telephone mental health review and made some adjustments to the timings of Declan's medication and advice to staff on managing his behaviour. This was followed up by an MDT at the end of June 2021. Concerns regarding Declan's behaviour were discussed, and actions set, which included the psychiatrist liaising with the GP over an increase in antipsychotic medication to assist Declan with his sleep. This was undertaken by email. There is no evidence that the concerns raised by the advocate were discussed or addressed at this meeting.

4.2.7 The changes in medication and other actions taken regarding the physical aspects of the environment did not appear to reduce the concerns. Declan was jumping the perimeter fence on a regular basis, and it was reported that it was sometimes taking staff several hours to re-direct him to his property. Declan's behaviour was also noted as having an impact on other residents as he was entering other parts of the setting. An increase in hours of support was agreed to manage the increasingly challenging behaviour. Many of the behaviours being seen at the new setting were those as witnessed at Declan's previous placement.

4.2.8 A further MDT took place in mid-July 2021, which included professionals involved with Declan and family members. Declan was still displaying anxious behaviour and spent most of the time naked. Overall, the view was that Declan was more settled, particularly at night.

[5] PRN medication - pro re nata,' which means that the administration of medication is not scheduled.

Around this time LDP records show that DoLs was again considered, and it is recorded that the provider was asked to submit a request to the Supervising Authority for a DoLs Standard Authorisation. There is no record of this being done.

4.2.9 Declan had access to a small self-contained flat, the living room had been adapted to provide a separate staff observation area. The flat gave access to large outside space which was surrounded by a 6-foot wooden fence. Declan would easily climb this fence and throw items over it. Measures, such as netting were put in place to try to mitigate this, but they were immediately removed by Declan. He appeared to want to explore other parts of the premises and wanted to gain access to his vehicle which was parked just outside.

4.2.10 By August 2021, the provider recorded that Declan had destroyed his bathroom, mattress (replaced twice), sofa, fire alarm, tables, chairs and windowsills. It was difficult to make repairs to the flat while Declan was on site and due to the re-occurring nature of the damage. Declan's accommodation became increasingly unfit due to the inability to repair it.

4.2.11 There were attempts by the behavioural expert, Occupational Therapist (OT) and Speech and Learning Therapist (SALT) to provide remedies for Declan's behaviour and sensory needs but these were rejected by Declan and seemed to overwhelm him. The placement provider stated that they found it very difficult to adhere to the Positive Behaviour Support Plan (PBS).

4.2.12 In August 2021, there was a well-attended MDT meeting. There is no evidence of the family being invited but were contacted shortly after the meeting. The meeting followed further complaints from neighbours regarding loud night-time vocalisation. The family were recorded as being content with Declan's care at placement 2 but wished to view the PBS.

4.2.13 During September 2021, Declan became more fixated on his vehicle. He started to cause damage to his vehicle, and this was something that had been positive for him previously. Some of his behaviour was noted as banging his head repeatedly on the window. It became increasingly difficult to move him from the vehicle following his daily drives, on occasions taking 5 to 6 hours before he would leave the car. Management at the placement raised concerns with the LDP that staff were unable to understand Declan's wishes. They requested a review of his PRN medication and stated an intention to raise a safeguarding concern on the physical state of the property.

4.2.14 The psychiatrist undertook a medicines review. This again this was by phone and email to the GP. There was a change of psychotic medication.

4.2.15 In September 2021, there was a further MDT, professional staff attended but there is no record of family being invited, although they were updated the following day. The physical living conditions were discussed and how improvements could be made. Declan's physical health was discussed and the need for a health check, to include dental health and the necessity to sedate Declan for this. The placement manager spoke to the GP regarding this and was informed that this would need to be arranged by the LDP. The family were contacted and fully supported sedation for a full medical examination, they also requested that the psychiatrist contact them to discuss the changes made in medication. It is recorded that the LDP were unable to take this examination forward as they were unable to secure a suitable location for this to take place.

4.2.16 In mid- September there was an incident where Declan attacked a member of staff, and it took some time to get him to release the staff member. There was a virtual review of Declan's Care and Support Plan by the LDP, there is no reference to the family being part of this review, but it notes that Declan's father now has Lasting Power of Attorney (LPA)[6] for Declan's health and wellbeing. This in fact was not correct and the family held Deputyship[7] for Property and Financial affairs only. The review reported that placement staff believed that Declan was much more settled but noted the assault to staff and that staff were now more anxious about supporting him. The review acknowledged that there were a number of outcomes not being met. The placement requested that an interim setting be found to allow necessary remedial work to Declan's flat.

4.2.17 The placement continued to raise concerns and these included an increase in Declan jumping the fence and this occurring between 20-30 times daily. As well as the risks that this presented to Declan the behaviour was also causing distress to other residents and neighbours. On many occasions Declan was naked as he refused to wear clothing.

4.2.18 In September 2021, the manager of the placement communicated to the regional manager and through MDT, that they felt unable to keep Declan safe and were concerned about the wellbeing of other the other setting residents.

4.2.19 In mid-September Declan's case featured for the first time on the Dynamic Support Register[8] (DSR). These are in place as part of the Care and Treatment Policy to identify people with learning disability and autism, who are at risk of hospital admission due to challenging behaviour or mental health. The cases are graded as green, amber or red depending on the level of need and response. Declan's case was reported as red in September and the level then fluctuated between this and green until the end of January 2022 when the rating returned to being red.

4.2.20 In Mid- October 2021, a safeguarding report was made to the MASH by the placement that Declan had vaulted the fence and caused considerable damage to another part of the property. Other residents needed to be moved to what was deemed a safe location. An MDT was planned to take place within the next two weeks.

4.2.21 During October 2021, Declan continued to jump the fence on a regular basis. At the beginning of November 2021. There was an MDT involving professionals and Declan's father was present. The opportunity for remedial work to the flat was discussed and alternative accommodation, although none was identified.

4.2.22 Over the next four weeks there were further reports about Declan leaving the property naked and running down an adjacent track. One complaint was made by a neighbour

[6] Lasting Power of Attorney - A lasting power of attorney (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

[7] Deputyship - Deputyship is a way that someone becomes legally allowed to make certain decisions on another person's behalf, if: the person no longer has the mental capacity to make those decisions for themself and the person has not made an LPA or EPA, which is still valid.

[8] Dynamic Support Register – There is a requirement for integrated care boards (ICBs formerly CCGs) to develop and maintain registers to identify people with a learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission.

regarding Declan being naked in the garden. The other involved the police being called after a member of the public had seen Declan, whilst naked being restrained by a staff member. Every day there would be numerous occasions where Declan jumped the fence taking 3 or more staff to re-direct him to the property.

4.2.23 In early December 2021, Declan pulled the bath from the wall and damaged the toilet to make it unserviceable. There was a crisis MDT to try to find alternative accommodation, which was unsuccessful. The social worker was able to visit the placement for the first time since Declan had moved (6 months). The psychiatrist agreed a further change in medication, advising 25 mg of Promethazine daily. This review was again conducted on the phone. Declan's father was advised of the current position and he raised a concern that the placement was not able to meet Declan's needs and they had not set firm enough boundaries.

4.2.24 There continued to be concerns over Declan's behaviour on a daily basis through December. Enquiries continued to be made to try to find an alternative placement, but nothing could be sourced to meet his needs. There was an MDT in December which considered options and agreed that attempts should also be made on an out of county basis. Declan's family were updated with these discussions and again voiced concerns that, in their view, boundaries had not been set by the provider for Declan and the approach had not been consistent. Some of the incidents involved Declan displaying head banging behaviour and he had to be confined to his flat.

4.2.25 The staff and management at placement 2 were becoming increasingly concerned that they were unable to safely support Declan. There was further conversation with the psychiatrist and alterations made to the timing of Declan's PRN medication but there was no face-to-face visit to see Declan or further consideration of whether there could be other health matters which were impacting on his behaviour. In an MDT meeting at the end of December, all professionals present agreed that placement 2 was the wrong placement for Declan but despite efforts no alternative could be sourced.

4.2.26 Over the Christmas period the placement called on duty psychiatrist for advice on PRN medication as they felt the medication was having little effect and more PRN medication was being given. There was a request from the management at the placement for an urgent consultation with Declan's psychiatrist but there is no record of this conversation taking place.

4.2.27 The MDT continued to try to support the placement but there was no consideration at this time of initiating a Care Treatment Review (CTR)[9]. It is clear that there was consideration of a hospital admission being a possibility and therefore a CTR should have been considered.

4.2.28 On 17th January 2022, the manager of placement 2 notified the LDP of what they considered to be more significant issues. Declan had presented heightened anxiety over the weekend, and this culminated in him whilst naked leaving his flat in the early hours, jumping the fence and entering another service user's accommodation. Declan then accessed cleaning products, which he smeared on himself. Declan had also caused extensive damage to his own

[9] Care Treatment Reviews (CTR) - CTRs were developed as part of NHS England's commitment to improving the care of people with learning disabilities, autism or both in England with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities. CTRs bring together those responsible for commissioning and procuring services (this will include nurses, social workers, education commissioners and other health, education and social care professionals alongside strategic commissioners where appropriate) with independent clinical opinion and the lived experience of people and families from diverse communities with learning disabilities, autism or both.

flat and was seen to throw himself off a table headfirst to the floor. The placement considered that they were unable to keep Declan safe and conveyed this to the LDP.

4.2.29 The GP was contacted regarding advice on the cleaning fluid getting into Declan's eyes and in turn there was discussion with a specialist in hospital regarding treatment. Declan was not seen by a clinician.

4.2.30 On the same day a Care Treatment Review (CTR) was convened with the Clinical Commissioning Group (CCG now ICB), staff from the LDP and psychiatrist. It does not appear that management from placement 2 were at this meeting. There was discussion regarding an admission to a local inpatient unit and a bed being available 4 days' time. The meeting felt that this admission should be avoided as it would be more restrictive and not in Declan's best interests. Other placements were still being considered.

4.2.31 Two days following the CTR Declan's family contacted the LDP and stated that they did not support the move to an inpatient unit without a formal rationale being provided. They also stated they would not support a full time out of area placement. They described the move from placement 1 to placement 2 having a catastrophic impact on Declan. The family raised concerns regarding Declan's care and treatment and requested a second opinion. This request was also made again in a following conversation.

4.2.32 The CCG Senior Clinical and Nursing Lead visited the setting in January 2022 to gather more information and context. The lead found that the setting was not suitable to meet Declan's needs and that robust behaviour plans were not being followed. The CCG recorded that staff felt they could not meet Declan's needs and were 'burnt out'. Feedback was offered to the LDP, but the CCG records would indicate that they were not asked for further assistance at this stage although Declan remained as priority case on the DSR. The LDP records would indicate that the CCG agreed to follow up on the inpatient admission. During the visit Declan's behaviour of being naked and jumping the fence was witnessed. During the visit placement 2 stated an intention to serve a 28-day notice to terminate the placement.

4.2.33 A potential provision had been identified in the Kent area and efforts continued to try to source this. The family visited the placement, requested details of the recent safeguarding incidents and the recent CCG/LDP visit. In a follow up call from the LDP the family again requested a review/second opinion on Declan's care, medication and treatment. The social worker said they would take this forward. The family were to visit the potential setting in Kent, but the family were informed that the MDT didn't feel that the local in-patient unit would be the right setting for Declan either.

4.2.34 The LDP continued to try to support the placement with the behaviours being presented. The placement recorded that they had a difficulty in introducing strategies and using the PBS as they had a significant staff shortage and were at that time running at 40% down on staff cover.

4.2.35 At the end of January 2022, the psychiatrist visited the placement spoke to staff and saw Declan. This was the first face to face visit since Declan had been at this placement. Declan was described as being calm during the visit.

4.2.36 Declan continued to jump the fence on a daily basis and some instances were reported as safeguarding concerns by the placement, this was generally when a member of

the public witnessed the activity or where Declan caused a minor injury to himself. Towards the of February 2022, there was a significant incident. Declan managed to jump the fence and run naked to the village before he was caught up with by staff. The police attended this incident and submitted a safeguarding referral making it clear that Declan presented a continued flight risk, a risk to himself and from others who may not understand his circumstance. After information gathering the MASH deemed that this did not reach the threshold for a safeguarding enquiry but was referred to the LDP for continued complex case management.

4.2.37 At the end of February the LDP reviewed Declan's needs and the outcome was that placement 2 was not an appropriate setting for Declan and the placement have stated they cannot meet his needs and are at a point of burn out. The was an increase from 12 hours to 14 hours daily 2:1 staffing.

4.3 Episode 3 – Detention under S136 and admission under section 2 MHA - 8th March 2022 – 18th March 2022

4.3.1 In the early hours of 8th March 2022, Declan suffered an episode of significant heightened anxiety. Declan jumped the fence and gained access to another resident's property. When staff attempted to remove him, he assaulted staff by biting, strangling and hitting them. Police were called for assistance. On arrival of police Declan was back in his flat, he was naked but at that stage calm but displaying extreme behaviour. Police established that there had been a pattern of escalating behaviour and that staff had been assaulted. The staff at the placement said they were unable to safely care for Declan. Police liaised with the social care Emergency Duty Team (EDT) who informed them that there was no secure accommodation available. A decision was made to detain Declan under section 136 Mental Health Act 1983[10]. An ambulance was called to convey Declan to hospital.

4.3.2 On trying to get Declan clothed he is reported as becoming agitated and started hitting out and spitting at officers. Hand and leg restraints were used to detain him, and this involved eight police officers. Officers are recorded as using proportionate force and removing restraints when Declan's behaviour allowed it.

4.3.3 At 8.45 a.m. the same morning Declan was conveyed to hospital by ambulance accompanied by police and a member of the placement staff. The suite that is used to accommodate persons detained under section 136 of the Mental Health Act (the 136 suite) was occupied at the time, so Declan was taken to the hospital Emergency Department (ED).

4.3.4 Declan was examined by a clinician, and it was noted that there were no bruises or injuries. Declan was calmer and cooperative with staff. The Mental Health Act dictates that a person detained under the act should be mentally assessed within 24 hours of their arrival at the place of safety (ED). This period can be extended by up to 12 hours with the authority of

[10] S136 MHA 1983 - If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons— (a) remove the person to a place of safety (b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety

the relevant medical practitioner, if they feel the assessment is not practicable at that time. The assessment is undertaken by an Approved Mental Health Professional (AHMP) and a minimum of one registered psychiatrist.

4.3.5 Late in the evening of 8th March 2022, it was recognised that blood had not been taken from Declan as part of a medical assessment. Declan was taken to the resus room and sedated so that blood could be taken and his heart checked (ECG). Due to there being other mental health cases for the AMHP to assess and Declan's sedation his assessment for the purposes of the MHA was delayed. The medical examination found that there were no medical issues and it was not necessary for Declan to be admitted to hospital on a medical basis. The following morning the hospital learning disability nurse advised staff on the Mental Capacity Act and the need to record best interest decisions and to consult with his parents and care team.

4.3.6 At 8.45 a.m. on 9th March 2022, the 24-hour period for mental health assessment expired. There was an urgent MDT held at 12.30 p.m. this meeting created actions for alternative accommodation to be sourced and for the psychiatrist to undertake the mental health assessment. At 3.26 p.m. the hospital recorded that the consultant psychiatrist had agreed that Declan could be admitted to hospital for treatment and assessment of his mental health under section 2 MHA.[11]

4.3.7 The LDP updated the family who stated their view was that Declan should not return to placement 2 and that at this time Declan required an inpatient admission to hospital. The family also again requested a review of Declan's medication and treatment. There is no evidence that their previous similar requests had been progressed.

4.3.8 At 2.00 p.m. the CCG and LDP met to discuss accommodation options for Declan, enquiries with providers had been unsuccessful. The Hollies provision had been considered but discounted due to staff skills and current client profile. It was agreed that a request would be made to use the 136 suite as a short-term accommodation option. Senior executives from the Clinical Commissioning Group, CPFT and Learning Disability Partnership met at 4.00 p.m. and whilst they acknowledged that the 136 suite was not a ward, they agreed that the suite should be used to accommodate Declan as a temporary holding action as this location was deemed more suitable than the emergency hospital department.

4.3.9 Declan arrived on the s136 suite just before 8.00 p.m. on 9th March 2022, the report for this review from the health trust indicates that a robust risk assessment was put in place. Declan was under constant CCTV observation and there would be 15 minutes physical checks on him. Declan arrived in his private vehicle accompanied by staff from placement 2, which is unusual as this would usually be by ambulance and at the time Declan was under a section 2 admission.

[11] Section 2 Mental Health Act - A patient may be admitted to a hospital and detained there for the for assessment where (a) they are suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and (b)he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons. - https://www.legislation.gov.uk/ukpga/1983/20/section/2 (accessed 10/01/23)

4.3.10 Over the following days it can be seen that the LDP attempted to source a single bed unit which would be suitable for Declan, but nothing could be located on a local or national basis.

4.3.11 Placement 2 provided staff during the day to support the s136 suite staff. This was put in place to provide Declan with some familiarity and assist the s136 suite staff as they were not trained in dealing with Learning Disability. This support was during the day hours and not at night. This was challenged by the family as they believed that the support would be 24 hours. The LDP stated this was not required as Declan was more settled at night. The records would appear not to support this, and Declan was just as likely to be agitated at night.

4.3.12 Declan was reported to be calm during the first few days in the s136 suite, although he was pacing around the suite. On 13th March 2022, Declan flooded the suite bathroom, he was agitated and running, jumping and climbing on an anti-ligature door on the bathroom. During this Declan was seen to slip and fall and as a result had a bump on his head. Staff cleaned some blood from his head and arm. A duty doctor was called to examine him but due to his demeanour was unable to undertake a physical examination but did undertake a 'gross' examination[12]. No significant injury was detected, and no vomiting reported.

4.3.13 On 15th March 2022, the Independent Mental Health Advocate (IMHA) visited Declan on two occasions. The IMHA was immediately concerned about Declan's situation. This concern was founded on the time that Declan had spent in the 136 suite. The IMHA was also concerned that Declan's admission fell within the guidance for long term segregation (LTS)[13]. The IMHA was also concerned about Declan's presentation when seen. He was naked and at the time no staff were interacting with him. The IMHA was informed that it had been a difficult weekend and Declan had destroyed furniture and demonstrated head banging behaviour. The IMHA raised a number of concerns which included - the environment, lack of LTS plan, the hospital responsible clinician was Declan's community psychiatrist and therefore there could be a lack of clinical oversight, concerns about Declan's presentation and the lack of outside space and stimulation. The IMHA raised these concerns with Declan's psychiatrist the next day who stated they would review his care.

4.3.14 On 16th March 2022, the responsible clinician for the admission, which was Declan's psychiatrist completed a review of his care. It was recorded that Declan spent most of his time sleeping and waking only for food. There had been two periods of challenging behaviour, including running, jumping and headbanging, leading to a bruise on his body and eye. The clinician reduced the daily sedation medication and introduced medication to manage the headbanging behaviour (Lorazepam). The clinician expressed a view that Declan was at risk to himself and others if allowed to mix freely on a ward and would present a high likelihood of harm. They stated the LTS was proportionate and the 136 suite provided the best option for accommodation for Declan until a suitable placement could be found, which was being actively sought by the MDT.

[12] Gross examination – medical term which means that the patient is examined with the naked eye to obtain diagnostic information.

[13] Long Term Segregation (LTS) - a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.

4.3.15 The same day the staff from placement 2 who were assisting with Declan's care raised concerns with their manager that bruises were now apparent of Declan, which had not been there on his admission. They were concerned about his medication management and whether staff at the S136 suite were aware of Declan's intolerances to nuts and soya. The manager raised these concerns with the staff at the s136 suite.

4.3.16 The IMHA followed up their concerns by contacting the suite and speaking to staff. The IMHA also made arranged for a Mental Capacity assessment and a solicitor to be allocated to Declan under the terms of the MHA. The IMHA also initiated an application for a Mental Health Tribunal.

4.3.17 Both the LDP and CPFT record that following the input from the IMHA, a LTS plan was put in place although there remained some conjecture as to whether one was required. There continued to be daily MDT meetings but there was no success in achieving a suitable placement. The CCG at one meeting raised a concern that more senior representatives needed to be present to move things forward. It was confirmed that an MHA tribunal had been set for 25th March and a CTR for 21st March 2022.

4.3.18 On the evening on 17th March 2022 Declan started to display agitated behaviour. He was observed throwing himself on the floor and climbing furniture. More staff were called to assist, and PRN medication was given and accepted (1 mg Lorazepam and 50 mg Promethazine). This did not appear to have an impact on Declan's behaviour. The duty doctor was called to examine Declan but again a physical examination was not possible, but the doctor reported '*grossly no indication of significant injury and he was mobilising well, moving all 4 limbs without holding self in pain.'*

At 10.10 p.m. the same day it is recorded that Declan vomited a small amount, this had been seen previously particularly if Declan had consumed something that he should not have. Declan then went to bed.

At 2.30 a.m. the following morning Declan started to run around his bed area, this behaviour continued, at 3.05 a.m. the duty doctor was contacted and attended. The purpose was to sedate Declan so he could get some rest.

At 3.30 a.m. staff went to see Declan in his bed to provide fresh bedding and remove bedding which he had torn. Staff noted that Declan was breathing heavily and there was a secretion around his mouth. The doctor undertook an examination, an ambulance was called, and Declan was conveyed to hospital.

4.3.19 On admission it was recorded that Declan was covered in bruises. Declan had a CT scan which revealed an acute large left sided subdural haematoma. He was taken to theatre and a procedure to evacuate the subdural haematoma. He was then treated in the critical care unit. Declan at the time of admission was noted as being admitted under section 2 MHA. This was later rescinded on 22nd March 2022, in consultation with Declan's family whilst treatment was ongoing.

4.3.20 The Critical Care Team met with Declan's family. Attempts to remove the breathing tube had shown that it was clear that Declan's mental state was not alert enough to keep his airways open. If Declan was able to survive it was highly likely that Declan would be in a vegetative minimally conscious state. The family expressed a view that they had discussed

the options and realised that the chances of recovery were slim, and they would not wish Declan to have a poor quality of life.

4.3.21 Declan passed away on 2nd April 2022.

5.0 Discussion

The discussion on the various themes presented from this case will be structured under the key lines of enquiry within the terms of reference for the case (appendix A).

5.1 What were the difficulties in finding Declan suitable supported accommodation, be that in the community or in a hospital provision? Is this a local or wider issue?

5.1.1 The reason why this theme has been addressed first within this report is it is apparent that many of the decisions made, which will feature within this discussion, were predicated on the fact that there was a lack of appropriate accommodation to meet Declan's needs and at every stage decisions, on occasions decisions that did not concur with legislation or guidance, were made on a 'there is no alternative' basis. This premise disadvantaged Declan, his family and those professionals left with a situation where they felt they had no alternative. The lack of available accommodation to appropriate care and support for Declan and other people with learning disability and autism requires urgent attention. It cannot be the case that situations are endured until they meet crisis point and are then addressed with legislation and frameworks, which were not intended for this purpose.

5.1.2 The lack of provision for persons requiring a single service crisis provision and long-term care in the community with clinical support is lacking and the current plans have resulted in a closure of mental health inpatient beds without an infrastructure in place to provide a safe environment for an individual's needs to be met in the community[14].

5.1.3 In 2012, the then Government made a commitment that anyone with learning disabilities or autism inappropriately placed in hospital would be moved to a community-based setting by June 2014.[15] In January 2015, the Government acknowledged that the target not been met. [16] In October 2015, NHS England, in partnership with the Local Government Association and the Director of Adult Social Services announced a plan to reduce inpatient occupation for people with learning disabilities and/or autism by 35 to 50 percent over the following three years.[17] Funding was made available to support the 'Building the Right Support Plan'.

5.1.4 The Government's 2018/19 mandate to NHS England set a target of March 2019 to achieve the 35 to 50 percent reduction in inpatient care set out in Building the Right Support Plan.[18] The 2019 NHS Long Term Plan set a new target of a 50 percent reduction of use of inpatient beds for people with learning disabilities and/or autism on the March 2015 levels by

[14] Cambridgeshire Learning Disability Partnership agency report
[15] Department of Health, 2012, Transforming Care, A National Response to Winterbourne View Hospital.
[16] Department of Health, 2015, Winterbourne View, Transforming Care two years on.
[17] NHS England 2015, Building the Right Support
[18] Department of Health and Social Care, 2018, The Government's Revised Mandate to NHS for 2018/19

2023/24.[19] In 2021, the Government established a "delivery board" to oversee progress of the 2015 Building the Right Support plan, as well as a "stakeholder update forum". The building the right support delivery board include representatives from the Ministry of Housing, Communities and Local Government, the Ministry of Justice, the Home Office, the Local Government Association, the Association of Directors of Adult Social Services and NHS England, as well as representatives of users.[20]

5.1.5 The 2021 report stated in the introduction '*Throughout our inquiry, we have had a clear focus on how best autistic people and people with learning disabilities can be supported to live independent, free and fulfilled lives in the community. The evidence we received demonstrated that current levels of provision for community services are totally inadequate.'*

5.1.6 The Government has said that it intends to bring forward legislative reforms to reduce the number of autistic people admitted to inpatient mental health settings. The Government's National Strategy for Autistic Children, Young People and Adults: 2021 to 2026, published in July 2021[21], said these changes would mean that autism alone is no longer a lawful basis for ongoing detention in inpatient care. These legislative changes are set out in the Government White Paper in August 2021[22], which includes proposals that detention is only appropriate when it can be demonstrated that the purpose of care and treatment is to bring about a therapeutic benefit and care and treatment cannot be delivered to the individual without their detention and appropriate care and treatment is available.

5.1.7 It is entirely appropriate that the proposals of Building the Right Support sought to ensure that people with Learning disabilities and autism received the appropriate care in the community. It focussed on closing inpatient provision with an increase of provision in the community. The targets for inpatient closure have been driven but it is apparent that this is not matched by the availability of appropriate community care, particularly for those with more severe learning disability. The cited House of Commons Health and Social Care Committee, 2021 stated,

'Autistic people and people with learning disabilities have the right to live independent, free and fulfilled lives in the community and it is an unacceptable violation of their human rights to deny them the chance to do so. It is also more expensive to detain autistic people and people with learning disabilities in inpatient settings and this takes up resources that are not then available for more humane community care. We are therefore deeply concerned that community support and provision for autistic people and people with learning disabilities, and financial investment in those services, is significantly below the level required to meet the needs of those individuals and to provide adequate support for them in the community. Fixing this must be a greater priority for both the Department of Health & Social Care and NHS England & Improvement.'

[19] NHS,2019, The NHS Long-Term Plan
[20] House of Commons Health and Social Care Committee, 2021, The Treatment of Autistic People with Learning Disabilities (Fifth Report of the Session 2020-21)
[21] HMG,2021, The National Strategy for Autistic Children, Young People and Adults 2021-2026
[22] HMG,2021, Reforming the Mental Health Act, A White Paper

Recommendation 1
That the Chair of the Cambridgeshire and Peterborough Safeguarding Adults Board highlights this case and the deficiencies in suitable accommodation for those with severe learning difficulties to The Health and Social Care Committee, All Party Parliamentary Groups on Learning Disability and Autism and NHS England, requesting a response on how this deficiency is being addressed.

5.1.8 In 2019 the BBC broadcasted a programme to expose the practices at Whorlton Hall, an independent hospital in Durham. The Durham Safeguarding Adults Partnership commissioned a Safeguarding Adult Review. This review was undertaken by SCIE and used the review to give a 'window' on the system. The review identified seven headline findings.

Two of these were Finding 6 – No clear National approach to absorb learning, coordinate, and resource action to transform care and Finding 7 – There is no evidence base for what made a CCG effective at 'micro' commissioning and Quality Assurance of service for people with learning Disabilities and/or who are autistic, to inform ICS's.[23]

5.1.9 In Cambridgeshire and Peterborough the Integrated Care Board (ICB formerly the Clinical Commissioning Group) holds a Section 75[24] agreement with Cambridgeshire County Council to ensure that services are commissioned and funded to meet the health and social care needs of adults with a learning disability. A requirement of the agreement is that the Council will maintain a level of audit and act on any findings as appropriate. The delegated commissioning responsibility is delivered through the LDP, who in turn have a management agreement with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The agreement will be updated as part of the transition to the Integrated Care delivery model.

5.1.10 At every stage of this case the lack of suitable provision for Declan impacted on the decisions being made and action taken. Placement 1 was deemed not suitable, and no provisions could be identified. After some time, Placement 2 was identified but required building work and adjustment, this move took nearly one year to facilitate. Within a short period of time Placement 2 was recognised as not being suitable for Declan but an alternative could not be sourced. This continued until the situation reached crisis in March 2022, when Declan was detained under the MHA. Again, no provision could be sourced, and Declan spent over 10 days in a 136 suite which is intended for short term mental health assessments.

5.1.11 The complete lack of appropriate care provision caused Declan distress and anxiety, it was stressful for his family, and it impacted on the staff who were working hard in sometimes an impossible situation to care for Declan and find him the best provision.

5.1.12 This situation has a very negative impact on the workforce and in turn exacerbates the situation where there is a high turnover of staff and an over reliance on agency staff. Again,

[23] SCIE, Safeguarding Adult Review on Whorlton Hall,2022

[24] Section 75 NHS Act 2006 - allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

this is circular as the lack of familiar and consistent staff had a negative impact on those relying on it.

5.1.13 As part of the work undertaken to find a suitable local provision for Declan a specialist 10 bed unit Assessment and Treatment Unit (ATU) was identified as a possibility of for him. This was deemed not viable as it has shared facilities and to make it viable for Declan effectively half of it would have to be closed and residents moved. Since Declan's death the provider, CPFT, have developed plans to make changes to the floor plan of the unit to include two separate single resident units. Whilst this was considered positive it has transpired that the funding for this initiative has not been secured and therefore no work has commenced.[25]

Recommendation 2
The Cambridgeshire Learning Disabilities and Autism Programme (formerly The Transforming Care Programme), The Integrated Care Board and NHS England should provide the Safeguarding Adult Board reassurance that there are local plans in place to address the local deficit of suitable accommodation and support for those with severe learning disability and autism.

5.2 When it was apparent that placements were breaking down what was done to prevent this?

Was the level of support appropriate at various stages? Were Care Treatment Reviews (CTRs) considered and undertaken?

5.2.1 The first placement was being closely monitored and supported by the Council due to institutional safeguarding concerns, which included: -

- An inability to provide individual and personalised care.
- Poor recruitment and retention of staff resulting in high use of agency staff.
- An inability to apply routine and structure including implementation of robust care plans and recommended approaches from MDT including Positive Behaviour Support Plans.[26]

5.2.2 Despite this support placement 1 stated in June 2019 that they were unable to meet Declan's needs. This was formalised in an assessment in October 2019, which concluded that Declan would benefit from a single service accommodation with greater support and no close neighbours. An enduring problem with Declan's accommodation at placement 1 was complaints received from neighbours regarding his behaviour. This was addressed by numerous meetings with neighbours, local police and district councillors. It is the view of Declan's family that the move from placement 1 was not driven by Declan's needs but by the reports and complaints by neighbours. This was explored at the reflective workshop for this review, and it was agreed that the issue with neighbours was a major contributory factor.

[25] As of panel meeting 04/03/24
[26] Learning Disability Partnership IMR

Although Declan would be unable to remain if he could not maintain a tenancy if the impact on neighbours continued and the provider felt they could not meet his needs.

5.2.3 The family withdrew support for the move from placement 1 and made this known to the Learning Disability Partnership. At this stage or earlier the role of an advocate could have been considered to help to reflect and support Declan's position. According to the Challenging Behaviour Foundation, independent advocacy is a "crucial resource" that "can ensure choice, well-being and enable person-centred care.[27] The panel felt that the use of advocacy could have considered the cumulative impact over time on Declan and adopted a trauma informed approach to assist in representing him.

Recommendation 3
The Cambridge and Peterborough Leaning Disability Partnership should ensure early consideration is given to the use of advocacy services where it would assist to support the person with learning disability.

5.2.4 Once notice had been served by placement 1 there were real difficulties in sourcing another suitable placement. After many attempts placement 2 was agreed. The accommodation space at the new placement was recognised as being smaller and there were known sensitivities from neighbours at the new placement, due to this there was every likelihood that the new placement would encounter problems.

5.2.5 It was not long before problems with complaints from neighbours and concerns regarding safeguarding were received at the new placement. The family, prior to the move had voiced their concerns about it and had in fact formally withdrawn their support. As the situation at placement 2 became more acute the family requested a review of Declan's care on a number of occasions, but this was not progressed.

5.2.6 It soon became apparent that placement 2 was not appropriate for Declan's needs as articulated on the previous section another suitable placement could not be found. Declan's increasingly anxious behaviour was not sustainably managed by medication despite numerous attempts. It should have been apparent that Declan's situation would meet crisis point at some stage and that would inevitably result in an inpatient admission. For this reason and the requests by the family for a review, a Care Treatment Review should have been convened at an earlier juncture. It is the strong view of the family that Declan's behaviour was linked to his medication, which they feel was increased without proper review. They feel that this should have been peer reviewed at intervals and there is evidence that they requested this. CPFT would refute this contending that there were regular medication reviews, accepting that these were mostly undertaken by phone, this was in line with the guidance in place at the time due to covid.[28]

5.2.7 The family feel that there should have been more consideration of the family medical history when Declan was first diagnosed with ADHD and started on medication for this

[27] https://www.challengingbehaviour.org.uk/wp-content/uploads/2021/03/Advocacy-guide-for-commissioners.pdf

[28] National NHS policy as part on Covid response (CPFT)

condition (Lisdexamfetamine Dimesylate 70 mg). At this time Declan was on the maximum dose of mood stabilisers and antipsychotic medication. The Consultant Psychiatrist states Declan *'was started on a low dose of ADHD medication, carefully cross-titrating with mood stabilisers and antipsychotic medications.'* He further states that the family history was collected and considered when ADHD was diagnosed and medication for this started.

5.2.8 The family are also concerned that the use of ADHD medication was not independently or peer reviewed. The NICE guidance on Learning Disability: behaviour that challenges (Quality Standards)[29] indicates that people with a learning disability and behaviour that challenges have a multidisciplinary review of their antipsychotic medication 12 weeks after starting treatment and then at least every 6 months. The NICE guidance Quality Standards for Autism[30] (QS 51) state that if antipsychotic medication is prescribed it should be monitored by an expert. CPFT would contend that this did happen during MDT's but concede there is no clear documentation to show that the medication was reviewed.

5.2.9 Care Treatment Reviews (CTRs) are part of NHS England's commitment to transforming services for people of all ages with a learning disability and autistic people. CTRs are for people who have been admitted to a mental health hospital or for people who are at risk of admission. They are undertaken by commissioners to ensure that people are only admitted to hospital when absolutely necessary and for the minimum amount of time possible.[31]

5.2.10 A CTR in the community would have involved a review panel made up of the responsible commissioner and two independent expert advisers, one expert by experience and one clinical expert. The person being reviewed should be consulted and if this is not possible after consideration to the Mental Capacity Act, the family involved.

'The CTRs were designed to bring an additional challenge and scrutiny to existing review processes and an alternative perspective and 'second opinion' which, in part, is achieved by the inclusion of an expert by experience (a person with learning disabilities, autism or both or family carer of someone with a learning disability, autism or both who has relevant experience) and the additional input of an independent clinician.' [32]

5.2.11 The LDP records that a CTR took place following a significant safeguarding incident in January 2022, but the ICB record that there was no CTR requested until March 2022, following Declan's admission under s136. If the meeting recorded in January 2022 was a CTR it does not appear that the CTR guidance was followed. It is clear that this case would have benefited from a CTR before the circumstances reached crisis point. It is also recognised that a CTR could have been considered when Declan was admitted to hospital to allow wider considerations than the convened MDT did. It is the view of CPFT that an emergency CTR should have taken place at this point.

5.2.12 In March 2022, a CTR was requested and scheduled for 23rd March 2022, but this date was rescheduled at the request of Declan's parents to allow a IMHA to attend the meeting. Unfortunately, Declan suffered the injury and died before this meeting.

[29] Learning Disability: behaviour that challenges (2015) NICE Quality Standard 101. Last updated July 2019

[30]

[31] NHS England - https://www.england.nhs.uk/learning-disabilities/care/ctr/ (accessed 10/01/23)

[32] NHS England - https://www.england.nhs.uk/learning-disabilities/care/ctr/ (accessed 10/01/23)

5.2.13 There is evidence that there were regular MDT meetings in both placement 1 and placement 2 but these tended to be based around safeguarding concerns or when Declan's situation was reaching crisis point.

Recommendation 4
The Cambridge and Peterborough Integrated Care Board and The Leaning Disability Partnership should ensure that the Care Treatment Process is considered in a timely fashion to assist in preventing inpatient admission and that these reviews follow the NHS England guidance.

Recommendation 5
CPFT and the Learning Disability Partnership should work together to agree the level of adherence of the Learning Disability provision against the NICE Guidance for Learning Disability and Autism in Cambridgeshire and agreement on the Commissioning of this service.

5.2.11 There is a requirement for integrated care boards (ICBs formerly CCGs) to develop and maintain Dynamic Support Registers (DSR) to identify people with a learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission. Those who are at risk of admission should be offered a CTR.

5.2.12 Declan was placed on the DSR in September 2021 and the priority fluctuated between then and January 2022. The DSR cases are reported by the then CCG to NHS England. The cases that are red and amber were discussed at the Transforming Care Delivery Board. There is no evidence that the case being rated as red led to any consideration of a CTR or that this was escalated by NHS England.

5.2.13 Each of the agencies involved in this review have made appropriate recommendations on developments within their own organisation (full details at appendix 2). The ICB at recommendation 8 has made a recommendation of action on the DSR, which will not be repeated here. The ICB also made suggested developments with regard to developing escalation processes across the system (recommendations 11 and 12 - appendix 2). To assist with the near impossible situation for professionals in trying to source appropriate accommodation, demonstrated in this case with LDP staff contacting over 30 providers, the ICB suggest the development of a directory.

Recommendation 6
NHSE England should develop a directory of Learning Disability hospitals across the country and maintain vacancy information.

5.2.14 The ICB agency report for this review articulates that there needs to be local, regional and national work to develop the career pathways for people working in health and social care in the area of learning disability and autism. Developments are required in this area.

The Health and Care Act 2022 introduced a requirement that providers registered with the CQC must ensure that each person working for the purpose of regulated activities carried on by them receives training on learning disability and autism which is appropriate to the person's role.

Recommendation 7
NHS England should consider work with the Department of Health and Social Care to develop career pathways for health and social care to support people with a learning disability and or autism, and across health and social care as a whole.

Recommendation 8
The Cambridgeshire and Peterborough Safeguarding Adults Board should seek reassurance that the Oliver McGowan mandatory training on learning disability and autism is appropriately being implemented.

5.3 Is there evidence of decision making and care being person centred and was Declan's mental capacity and best interests considered?

What were the arrangements Power of Attorney for Declan? Were these arrangements well understood and adhered to?

5.3.1 Declan was supported by the providers of placement 1 for over 14 years. During this time he was educated and there is evidence to support that his welfare was central to the support and decisions made in his best interests. Providers in 2019 decided that the placement could not meet Declan's needs, but this seems largely based on the proximity to neighbours and the complaints coming from them. An assessment of Declan's needs found that he required a single service accommodation setting without close neighbours to reduce the number of restrictions in place to keep Declan and neighbours safe.

5.3.2 A suitable placement could not be sourced despite tenacious attempts for reasons already discussed and placement 2 was identified as the best alternative. There was a mental capacity assessment as part of the assessment and confirmed that Declan lacked capacity to understand his care and support needs, and it was in his best interests to continue to receive the level of support being commissioned. At the time of placement 2 being identified, whilst there were no safeguarding concerns at the time, placement 2 was rated as requiring improvement in two domains, following an inspection by the CQC. It noted that care plans were not up to date and consistently used and there was a high use of agency staff.

5.3.3 The areas of improvement and the fact that placement 2 was close to neighbours were issues which add to the view that placement 2 was not the ideal setting for Declan and his needs but there was no alternative. Added to this Declan's family felt that placement 2 was

not a good alternative and withdrew their support. For these reasons it is difficult to see whether the consideration of the options to try to sustain the placement at placement 1 until a single service provision could be sourced versus moving to placement 2 were weighed up using the best interest process.[33]

5.3.4 In November 2019, as part of a care plan meeting and in consultation it was agreed that placement 1 would make an application for a DoLs. It became necessary to restrict Declan's access by locking doors and gates and this was considered again in May 2021, but not taken forward as Declan's move was imminent. An application was not progressed for over 18 months despite an increase in the use of restrictive measures. When Declan moved to placement 2 it was again identified that a DoLs was in place but again this was not progressed.

5.3.5 Whilst placement 1 was supported living, a community DoLs should have been applied for and Placement 2 being a registered care home, should have had a DoLs in place from the time that Declan arrived, in particular as there was an extensive transition period to allow this. The DoLs would have also given the family the role of relevant persons representative.[34] The IMR from the LDP for this review identifies the gaps in the use of DoLs and makes some recommendations to address these within LDP. It should also be the responsibility of all those involved in a person's care, the MDT, to review and challenge whether a DoLs is required.

Recommendation 9
All agencies who are responsible for applying for Deprivation of Liberty Safeguards to review their polices and ensure that the roles and responsibilities are clearly defined and that applications are made in a timely manner. Agencies should have measures in place oversee this process.

5.3.6 There was an assumption by some agencies that Declan's parents had a Lasting Power of Attorney in place for Declan for decisions regarding health and welfare. This was not in fact the case and the family only had a Deputyship for matters of finance and property. When someone is receiving the level of support that Declan was there should be a clear picture of the legal status for decision making on the person's behalf. There was a lack of this being part of agency records.

Recommendation 10
All agencies involved in Multi Agency Teams Meetings to support a person should ensure that there is a clear understanding and clear policies in place of what the legal basis is for relatives to make decisions on the person's behalf and that this is recorded clearly on records.

[33] LDP IMR (page 33)

[34] The role of a Relevant Person's Representative (RPR) is to maintain contact with the person and to represent and support them in all matters relating to the deprivation of liberty safeguards (DoLs)

5.4 Were the Care and Risk plans for Declan appropriate and reviewed as the circumstances changed?

5.4.1 The provider at placement 1 for this review has concluded that care and risk plans were in place and they were appropriate to meet Declan's needs. The LDP report that the provider was being monitored and supported due to what is termed as institutional safeguarding concerns, which included the inability to apply routine structure including the implementation of robust care and support plans.

5.4.2 When visits were made to provider 2 there was a recognition that robust care plans in place were not being adhered to. It is recognised that Declan posed a significant challenge to carers to support but that routine and structure were not established. This must be partly due to the high use of agency staff and the lack of familiar carers being present. The family raised on more than one occasion that they felt there had been a lack of early boundary setting and as time progressed it became impossible to impose these.

5.5. Was Declan's detention under section 136 of the Mental Health Act 1983 appropriate and did it comply with guidance?

What was the legal framework for Declan being detained in the S136 suite?

Was Declan's detention appropriately reviewed?

Whilst Declan was accommodated in the s136 suite how was he supported, who was involved in that support and was it appropriate?

5.5.1 Police were called to assist staff in placement 2 in the early hours of the morning. When they arrived Declan was calm, but the officers were made aware that he had caused damage to his and another's flat and had assaulted members of staff. Although calm, Declan was displaying what was described as extreme behaviour. The staff at placement 2 stated that they could not safely care for Declan any longer. The officers liaised with the social work Emergency Duty Team (EDT) and no other accommodation could be identified for Declan.

5.5.2 The police felt that they had three options, to do nothing, to arrest Declan for the criminal offences or to use s136 of the Mental Health Act to detain Declan to a place of safety for assessment. To do nothing was not a viable option and it was considered that an arrest would be inappropriate and likely to cause Declan significant anxiety and distress. In any case it was unlikely that Declan would have been deemed fit to detain in custody and would have been transferred to hospital. The officer felt the best option in the circumstances was to detain Declan under s136, recognising that this was a less than ideal solution.

5.5.3 Declan was detained, and an ambulance was called to convey him to hospital. During the wait it was necessary for eight officers to become involved in restraining him and handcuffs and leg restraints were used. The officers again felt they had no option but to use proportionate force to protect themselves and others present.

5.5.4 Section 136 MHA allows police to detain a person where they appear to be suffering from a mental disorder and it is necessary to protect that person or others. The person should then be taken to a place of safety. The police power cannot be exercised in any house, flat or room where that person or any other person is living, or any yard, garden or outhouse that is

used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

5.5.5 There is a lack of clarity where Declan was actually detained with police stating it was in the outside garden, which they firmly believed to be a communal garden and staff that it was within Declan's flat. Clarity on this has been sought but the officers body worn camera footage has been destroyed. The police are reviewing their policy on the retention of camera footage in circumstances where there has been a death. In any case it is apparent that S136 of the act was not applicable in these circumstances and there was not at that time a power to detain Declan using this section. That said the only alternative was to defer to s135 of the act, which allows a constable or an AMHP to apply to a court for a warrant to enter and detain a person under the act. In these circumstances this was neither possible nor practical.

5.5.6 Although the use of s136 was not within the act due to the location it was used, the power was used with Declan's best interests being considered. The officers and placement staff felt that Declan could not remain at the setting, and he had to be removed for his and others safety. This is another instance where professionals felt they had to resort to the least restrictive available option, recognising it was not ideal due to there was no suitable accommodation or support for Declan.

5.5.7 The s136 power would not allow police to detain a person if the person was trespassing in living accommodation or where they are there with consent and the consent is withdrawn. This is recognised as a limiting factor.

Recommendation 11
Department of Health and Social Care consider within the Mental Health Act Review amending s136 Mental Health Act to allow the power to be used where a person is trespassing on premises where a person lives or where a person entitled to withdraw consent for that person to be there does so to a police constable.

5.5.8 Declan was conveyed to hospital where it was necessary to sedate him to examine hm and take bloods. Having been detained under s136 it is necessary for Declan to be assessed by a doctor designated by section 12 of the act and an Approved Mental Health Professional (AMHP). This was arranged but did not take place due to Declan being deemed not fit to be assessed under the Mental Health Act at the time. As a result, the 24-hour period for examination expired before the assessment was undertaken and Declan spent 46 hours in the Emergency Department of the hospital.

5.5.9 Some considerable time before the assessment took place the clinician dealing with the medical examination advised that there was no evidence that Declan had any acute medical condition. The clinician also determined that there was no need to admit Declan to hospital. The only reason for Declan's continued detention was for the purposes of an assessment under the mental health act. The CPFT records show that from the time of the expiry of the s136 detention to the time of the assessment Declan was admitted in hospital under the Mental Capacity Act.

Recommendation 12
Cambridge University Hospitals University NHS Trust and Cambridgeshire and Peterborough NHS Foundation Trust use this case to facilitate a learning event to discuss processes and policies to ensure they are relevant and robust.

5.5.10 The Mental Health Assessment was carried out by Declan's community psychiatrist and an AMHP, the decision of the assessment was a recommendation that he was detained under section 2 MHA. This section is for detention to a hospital as opposed to a bed. There were at the time ongoing enquiries to find a suitable location for Declan to be accommodated. All options were being considered but nothing could be sourced.

5.5.11 MHA Codes of Practice states a person can only be detained under section 2 if they are suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) and the person ought to be detained in the interests of their own health or safety or with a view to the protection of others. If a suitable placement could have been sourced Declan would not have been detained and there was no evidence of further on-going assessment. For this reason, the use of section 2 in these circumstances is questionable. If the circumstances made the Mental Health Act not appropriate to use, then Declan's care would have reverted to the Mental Capacity Act with decisions made on a best interest basis and consideration of putting DoLs in place. This is another example of a decision made resulting from a lack of suitable accommodation and support provision. The MHA Codes of Practice advise that other options including the MCA should be considered before detaining a person under section 2 MHA.

5.5.12 Meetings at a high level of the agencies involved agreed that the s136 suite could be used to detain Declan whilst enquiries continued to source a placement. This was viewed as the best available option. The s136 suite is a bespoke unit to accommodate persons who the police feel may be in an acute mental health crisis so that they can be assessed by suitably qualified practitioners. It is not intended for longer term accommodation and due to risks presented by those detained there the environment could not be described as being sensory friendly or suitable for persons with severe learning disability and autism. This was recognised but again it was deemed there was no suitable alternative.

5.5.13 The staff in the s136 suite are not trained in managing persons with learning disability and autism so some staff from placement 2 were allocated but only during daytime hours. It is notable that when the crisis incidents occurred it was at nighttime. Declan remained in the s136 suite for ten days. This was being reviewed on a daily basis by MDT meetings, but no suitable accommodation was sourced despite enquiries being made on a national basis. This has to be seen as a totally unacceptable position. Where a person remains detained in the s136 suite for more than 24 hours the CFPT policy on bed management[35] states that they should be reviewed by their responsible clinician on a daily basis. There is no clear documentation to show that the Responsible Clinician made contact with the people caring for Declan on a daily basis.

[35] CPFT,2020, Adult/Older People Bed Management Protocol

5.5.14 During his stay in the s136 suite there were two main episodes where Declan displayed anxious behaviour, he was described as headbanging, running into walls, climbing and jumping. On one occasion he was seen to bump his head and there was blood present. He was examined by the duty clinician on two occasions after this behaviour was witnessed. Both of these examinations were described as 'gross examinations'. The second of these was before the episode which resulted in his emergency hospital attendance and discovery of the subdural haematoma. Shortly before this he had been seen to vomit, whilst this could have been due to a number of factors it may also have been an indication of a head injury. It is difficult to see how a sense of definitive reassurance regarding a head injury was achieved from these examinations.

Recommendation 13
Cambridgeshire and Peterborough NHS Foundation Trust should review their policies, procedures and practices in responding to persons with potential head injury, in particular when the person through disability is not able to verbalise.

5.5.15 After Declan had been detained for two days in the s136 suite he was seen by an IMHA, who immediately raised concerns. One of these concerns was the use of Seclusion/Long Term Segregation, the IMHA raised this concern with Declan's responsible clinician, the community psychiatrist.

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.[36]

Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. [37]

5.5.16 The rationale for Declan's detention in the S136 suite was the lack of suitable accommodation and it was also noted that he required single bed accommodation. For these reasons it would appear that he was being secluded from others. The CPFT policy of Seclusion and Long-Term Segregation[38]states that seclusion should never be a planned response. It would therefore be the case in these that Long Term Segregation (LTS) should have been considered.

5.5.17 Both seclusion and long-term segregation are only relevant when a person is detained under the mental health act. If it were held that Declan should not have been held under

[36] Department of Health, Mental Health Act 1983, Codes of Practice
[37] Department of Health, Mental Health Act 1983, Codes of Practice
[38] CPFT,2020, Policy of Seclusion and Segregation Policy and Practice

section 2 MHA and the MCA was more appropriate, then a DoLs would have had to be considered rather than LTS.

5.5.18 When the issue of LTS was raised by the IMHA with CPFT there was some discussion as to whether a LTS should have been considered and the necessary measures complied with. It was agreed that due to lack of clarity a LTS would be put in place and the required plan was commenced.

5.5.19 Had LTS been considered at an earlier stage the various stages within the policy and Mental Health codes of Practice would have to have been complied with, which included an MDT decision, plan and review process.

5.5.20 On the day that the decision was made to use the s136 suite to detain Declan there was a meeting of executive leads from CPFT and the use of the s136 suite was agreed. There is no evidence that seclusion or LTS were considered. There does not appear to be any separate records of that meeting held regarding Declan's accommodation to substantiate if there was consideration of LTS.

5.5.21 It is CPFT's position for this review that LTS was not a consideration in this case as Declan was not being held to segregate him from others but being held as there was no other suitable accommodation. It remains that Declan was being detained under the mental health act and it was deemed that he was not able to be held in an environment where he could mix freely with others. This is another example of a decision being determined by a lack of suitable resource.

Recommendation 14
Cambridgeshire and Peterborough NHS Foundation Trust should ensure that their annual Mental Health training is revised to ensure that learning from this review is embedded with regards to consideration to seclusion and long-term segregation.

5.5.22 It is apparent that this is not the only case where the s136 suite has been used as a longer-term provision for people that could not be accommodated in a setting suitable for their needs. As previously mentioned, the suite and the way that it is configured is not intended for this purpose and therefore not suitable for longer term detention or accommodation. The use of the suite for this purpose also means that it is not available for emergency cases and the purpose for which it was intended.

Recommendation 15
Cambridgeshire and Peterborough NHS Foundation Trust monitor and report to commissioners and the Safeguarding Adults Board occasions where there are detentions or accommodations in the s136 suite under provisions other than s136.

5.6 What medical conditions did Declan have and did these effect Declan's behaviour and presentation?

5.6.1 A person with learning disability over the age of 14 should have an annual health check arranged by their GP. There is a record of Declan having an annual health check in November 2020, whilst at placement 1. When Declan moved to placement 2, he registered with the new GP in May 2021. There is no record of any further health check for him. Overall, there seems to have been little engagement with the GP. The GP practice have weekly virtual rounds with the placement but there are no records that Declan was discussed. There are four records of where the GP was consulted for specific concerns (detailed in previous narrative). It would seem appropriate that where a person with severe learning disability transfers to a new placement there should be a review of their health which should involve an introduction and briefing of relevant information to the GP, including areas such as Lasting Power of Attorney.

5.6.2 There are references in the history of the case that some of Declan's more extreme behaviour could have been attributed to him being in pain. He displayed headbanging and chewing hard surfaces, which could have been indications that he was uncomfortable. There are records (December 2019) that Declan was demonstrating being in pain, but this at placement 1. When this was discussed at the reflective event it was felt that those who knew Declan well may have been able to interpret behaviour as an indication of pain but there was in both settings a reliance on agency staff, which lacked consistency.

5.6.3 In September 2021 at an MDT, sedation was discussed to undertake a full examination of Declan's health needs. This was also discussed and agreed with the family. This did not happen. Investigation into why this was not progressed would indicate that there was a lack of ownership as to how this would be taken forward and it effectively became too difficult.

5.6.4 When Declan was taken to hospital in March 2022, he was sedated and examined for the purposes of potential admission. Consideration could have been given at this stage to use as opportunity for a wider health examination. It is accepted that this may have been difficult to coordinate in an urgent care setting, but consideration may have at least eliminated or established health issues, which could have been contributing to his behaviour and anxiety.

5.6.5 Overall whilst Declan was at placement 2 there was a lack of face-to-face contact from all professionals. This was in part due to the restrictions of the covid pandemic but at the time Declan moved to placement 2 (May 2021) restrictions were easing with step 4 of the Covid Recovery Roadmap being implemented in July 2021. Of particular significance was the lack of face-to-face contact with health professionals, Declan's GP and his designated clinician. The consideration of a medical condition or changes in his medication should have warranted more contact.

Recommendation 16
General Practitioners should ensure that there are annual health checks, that any relevant information from the health checks is integrated into the care plan. Where possible these health checks are face to face.

5.7 Did the Covid pandemic and associated issues impact on Declan and the service he received. How did it impact on agencies delivering the services?

5.7.1 There is no doubt that the covid pandemic and the associated restrictions had a significant impact on services and plans that were made for Declan. This was not only for the agencies involved who had to alter the way in which they delivered services but also for commissioned care providers within the market and the challenges they faced with staffing, recruitment and retention of staff and their ability to take on new care packages during the pandemic.

5.7.2 The move between placements 1 and 2 was delayed and this was in part due to the covid restrictions but also due to the alterations that had to be established at the new placement.

5.8 Are there areas of good practice that should be highlighted to develop learning points and recommendations?

5.8.1 There is evidence that professionals generally worked hard to provide support and care to Declan but there were issues which have been highlighted in this report. Areas of good practice have been mentioned in the narrative of the report but there are some instances of practice which particularly stand out. The IMHA immediately raised concerns on Declan's behalf and they sought to ensure that the areas that had been raised had been progressed.

6.0 Conclusion

6.1 This is a particularly sad case which leads the review to the conclusion that the system in place to support Declan failed him. There is evidence that professionals involved with Declan tried hard to provide him with the care and support that he needed but this was not available, not locally, not regionally and not nationally. This left professionals with decisions to make on the 'best alternative' basis, inappropriate and sometimes questionable decisions coerced by circumstances.

6.2 The reality is that there is not suitable accommodation and support for people in Declan's circumstances and this situation continues to exist today. This has been recognised in national reviews and discussion. Declan's case was moved closer and closer to crisis but still there was no solution. It was then left for the emergency measures of policing, emergency mental health and hospital care to intervene. It is impossible to put oneself in Declan's shoes and understand the frustration, anxiety and fear he must have experienced.

6.3 The situation as it is today is not fair on Declan, his family and those professionals who everyday are having to make difficult decisions in impossible situations. Something has to change.

7. Recommendations

Recommendation 1

That the Chair of the Cambridgeshire and Peterborough Safeguarding Adults Board highlights this case and the deficiencies in suitable accommodation for those with severe learning difficulties to The Health and Social Care Committee, All Party Parliamentary Groups on Learning Disability and Autism and NHS England, requesting a response on how this deficiency is being addressed.

Recommendation 2

The Cambridgeshire Learning Disabilities and Autism Programme (formerly The Transforming Care Programme), The Integrated Care Board and NHS England should provide the Safeguarding Adult Board reassurance that there are local plans in place to address the local deficit of suitable accommodation and support for those with severe learning disability and autism.

Recommendation 3

The Cambridge and Peterborough Learning Disability Partnership should ensure early consideration is given to the use of advocacy services where it would assist to support the person with learning disability.

Recommendation 4

The Cambridge and Peterborough Integrated Care Board and The Learning Disability Partnership should ensure that the Care Treatment Process is considered in a timely fashion.

Recommendation 5

CPFT and the Learning Disability Partnership should work together to agree the level of adherence of the Learning Disability provision against the NICE Guidance for Learning Disability and Autism in Cambridgeshire and agreement on the Commissioning of this service.

Recommendation 6

NHSE England should develop a directory of Learning Disability hospitals across the country and maintain vacancy information.

Recommendation 7

NHS England should consider work with the Department of Health and Social Care to develop career pathways for health and social care to support people with a learning disability and or autism, and across health and social care as a whole.

Recommendation 8

The Cambridgeshire and Peterborough Safeguarding Adults Board should seek reassurance that the Oliver McGowan mandatory training on learning disability and autism is appropriately being implemented.

Recommendation 9

All agencies who are responsible for applying for Deprivation of Liberty Safeguards to review their polices and ensure that the roles and responsibilities are clearly defined and that applications are made in a timely manner. Agencies should have measures in place oversee this process.

Recommendation 10

All agencies involved in Multi Agency Teams Meetings to support a person should ensure that there is a clear understanding and clear policies in place of what the legal basis is for relatives to make decisions on the person's behalf and that this is recorded clearly on records.

Recommendation 11

Department of Health and Social Care consider within the Mental Health Act Review amending s136 Mental Health Act to allow the power to be used where a person is trespassing on premises where a person lives or where a person entitled to withdraw consent for that person to be there does so to a police constable.

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Cambridgeshire and Peterborough NHS Foundation Trust monitor and report to commissioners and the Safeguarding Adults Board occasions where there are detentions or accommodations in the s136 suite under provisions other than s136.

Recommendation 16

General Practitioners should ensure that there are annual health checks, that any relevant information from the health checks is integrated into the care plan. Where possible these health checks are face to face.

Recommendation 17

Cambridgeshire and Peterborough Safeguarding Adults Board should gain assurance that the recommendations identified by agencies in this review for their own agency are completed.

Addendum

Cambridgeshire and Peterborough NHS Foundation Trust have asked for the following to be addedWith reference to Recommendation 13 page 29 section 5.5.13

'Where a person remains detained in the s136 suite for more than 24 hours the CFPT policy on bed management[35] states that they should be reviewed by their responsible clinician on a daily basis.'

[35] CPFT,2020, Adult/Older People Bed Management Protocol

The document referred to at [35] is the CPFT Adult/Older People Bed Management Protocol approved in August 2022. There was no policy or protocol in place during March 2022 for the Responsible Clinician. Reference number 35 is incorrectly dated.

Appendix A – Terms of Reference

SAFEGUARDING ADULTS REVIEW (SAR) TERMS OF REFERENCE
In respect of Declan

BACKGROUND

Declan had been supported by various agencies since he was a child.
Declan's Learning Disability and associated Autism as well as his communication difficulties are such that he does not have the capacity to understand the experience of abuse and neglect, nor be able to self-protect himself from these experiences. Declan does not have the capacity to correlate the impact of his outwardly presentation upon himself or others, nor understand the consequences of actions and how this could harm him. Declan is reliant on the care and support of others to maintain his wellbeing.
Declan had previously been in a supported setting but moved in May 2021 due the placement breaking down. Declan moved to Placement 2, where he received 24/7 care. In September 2021 this placement started to breakdown.

In December 2021, Placement 2 advised the Learning Disability Partnership (LDP) that they were not able to meet Declan's needs, the LDP therefore referred to CCC brokerage who then commenced a search for an alternative provider, following an initial call out to the market it was clear that a local provision could not be found, at which point an exemption was agreed for the search for a new placement to be widened to include national / off framework placement options. The request for bespoke accommodation was also escalated to Commissioning (CCC) for any options available with housing providers both in the immediacy as an interim and longer-term option given the lack of single service accommodation available locally. No suitable options were identified despite the placement search being broadened. To support the provider whilst the placement search was ongoing the LDP provided intense support from the community team.

On 9th March 2022, there was an incident where Declan became agitated and had bitten, punched, and attempted to strangle female care staff. Police attended and Declan was detained under section 136 Mental Health Act 1983. He was conveyed to hospital and on 10th March 2022 Declan was transferred to the section 136 suite at the hospital under section 2 of the Mental Health Act 1983.
Suitable accommodation either in the community or in a hospital provision could not be located for Declan and he remained accommodated in the section 136 suite.
On 18th March 2022 Declan was found unresponsive and admitted to Addenbrookes Hospital where he underwent emergency operation due to a Subdural Hematoma.
Declan died on the 2nd April 2022.

TIME PERIOD TO BE COVERED BY THE REVIEW:

From 1st December 2020 to 18th March 2022
If the author recognises events that they consider relevant or potentially relevant to this review that fall outside of the dates above, they are asked to highlight in their report.

Areas to be considered:

1) Is there evidence of decision making and care being person centred and was Declan's mental capacity and best interests considered?
2) When it was apparent that placements were breaking down what was done to prevent this?
   Was the level of support appropriate at various stages? Were Care Treatment Reviews (CTRs) considered and undertaken?
3) What were the arrangements Power of Attorney for Declan? Were these arrangements well understood and adhered to?
4) Were the Care and Risk plans for Declan appropriate and reviewed as the circumstances changed?
5) Was Declan's detention under section 136 of the Mental Health Act 1983 appropriate and did it comply with guidance?
6) What was the legal framework for Declan being detained in the S136 suite?
7) Was Declan's detention appropriately reviewed?
8) Whilst Declan was accommodated in the s136 suite how was he supported, who was involved in that support and was it appropriate?
9) What were the difficulties in finding Declan suitable supported accommodation be that in the community or in a hospital provision? Is this a local or wider issue?
10) Did the Covid pandemic and associated issues impact on Declan and the service he received. How did it impact on agencies delivering the services?
11) What medical conditions did Declan have and did these effect his behaviour and presentation?
12) Are there areas of good practice that should be highlighted to develop learning points and recommendations?

PANEL MEMBER AGENCIES

Police
CCG
Hospital
Ambulance
Local Authority Adult Social Care
CPFT
Learning Disability Partnership
NHS England and Improvement

METHOD

Agencies will be asked to provide (in accordance with Section 45 of the Care Act 2014) detailed chronologies about their involvement in the care and services provided to Declan; the author may request further information if required.

Agencies will also be requested to complete a report that addresses and analyses the 11 "areas to be considered" detailed above. A report template will be provided for agencies to complete. The review will also seek to identify any early learning from the review and whether there has already been organisational remedial action taken or whether the issue remains

unresolved. The review will also consider if the principles of Making Safeguarding Personal were applied when professionals worked with Declan. We would ask that this is included within your agencies report.
The review will seek to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time and avoid the use of hindsight. The methodology will reflect a systematic approach, drawing on the requirement to consider strategic and organisational learning and improvement, as well as learning from practice at the frontline.

CHRONOLOGY
Chronologies to be requested from:

- CPFT – Report from health and mental health
- GP
- Learning Disability Partnership – health and social care
- Placement 1
- Placement 2
- Police
- Cambridge University Hospital
- East of England Ambulance Service
- Clinical Commissioning Group – s117, Mental Health & Learning Disability commissioners and complex cases
- Multi Agency Safeguarding Hub
- Cambridgeshire County Council – Brokerage, contracts and Commissioning
- Advocacy

TEMPLATE FOR CHRONOLOGY
A chronology template will be provided. All agencies are requested to use the template and ensure that this is version controlled.

FAMILY or OTHER SIGNIFICANT PERSONS MEETING
The review will seek to include the views of the family and/or other significant persons as appropriate.

Parallel Processes:

The SAR will maintain contact with other identified reviews to avoid duplication and distress to the family.
The Coroner's inquest is suspended pending further information from the police investigation.
Learning Disability Review (LeDeR)

MEDIA
Any media activity or responses on this review should be led and coordinated through the review panel.

Appendix B – Single Agency Actions

Declan Recommendations as identified by agencies.

Placement 1	
1	Develop and roll out a specific handover document to be completed and shared at the point that any people we support transition to an alternative service, outside of the organisation
2	Implement RADAR across the organisation
Cambridgeshire Learning Disability Partnership	
3	A review of the placement finding process to ensure that CQC Inspection Reports are checked, and any providers rated as Inadequate or Requiring Improvement are highlighted
4	A review of the process in place to monitor Community DoLs to ensure that cases highlighted on the DoLs register are kept under review
5	A review of the current arrangements and implementation of a process when a placement is commissioned within a Residential Care setting
6	Lessons learnt in respect of decision making, risk analysis and ensuring this is well evidenced in case records where a decision is made in an individuals' best interest
7	Lessons learnt from this SAR in respect of the lack of local specialist single service provision, and the development of community 'crisis' facilities to be shared with Commissioners and Partner Agencies within the Transforming Care Partnership (now known as the Learning Disability and / or Autism Leadership Group), with a view to such service developments being expedited
8	Lessons learnt from this SAR in respect of the lack of local and national Specialist LD Mental Health Provision, it's impact and risks when an individual requires a clinically appropriate admission for the purpose of assessment and treatment, to be shared with the NHSE Regional Collaborative
Integrated Care Board	
9	NHS Cambridgeshire and Peterborough ICB should Review and implement the Need to Know process to strengthen internal information sharing of significant and relevant information and incidents
10	NHS Cambridgeshire and Peterborough ICB should implement Action trackers within TC Delivery Board meetings and included in the terms of reference (ToR).
11	NHS Cambridgeshire and Peterborough ICB should Implement information sharing between the local authority contracts team and the CCG/ICB to ensure appropriate oversight even though responsibility is delegated. This includes offering support to the local authority where appropriate.
12	NHS Cambridgeshire and Peterborough ICB should work in partnership with local authority commissioners and co-commission services where this is appropriate to allow the ICB to input skills and knowledge to support the commissioning process which will benefit local people using community services.

13	NHS Cambridgeshire and Peterborough ICB should develop KPIs for the Section 75 agreement to ensure clear roles and responsibilities and robust information and data reporting to retain appropriate oversight even though commissioning responsibility is delegated
14	NHS Cambridgeshire and Peterborough ICB should co-commission a community crisis provision with the local authority
15	NHS Cambridgeshire and Peterborough ICB should support CPFT with their development plans for the local ATU ward
16	NHS Cambridgeshire and Peterborough ICB should Review the DSR across Cambridgeshire and Peterborough and: a. identify clear and robust criteria for rating individual risk and ensure this is consistent across the footprint. b. ensure there is clear guidance as to what work should be completed when someone is highlighted on the DSR. c. consider whether there needs to be escalation points built in if someone is on the DSR for more than 3 months, more than 6 months etcetera. d. consider having someone to administrate the DSR to prevent duplicate entries and ensure there are regular updates to make the DSR a meaningful working document.
17	NHS Cambridgeshire and Peterborough ICB should work with system partners to find a solution and build contingency plans and processes for when there is no accommodation and or no staffing available to meet someone's needs
18	NHS Cambridgeshire and Peterborough ICB should make available a list of those professionals who can cover for the CTR coordinator should they be unavailable
19	Cambridgeshire and Peterborough Integrated Care System (ICS) should Consider implementing a shared escalation process across the system partners, including nominating a lead for each organisation
20	Cambridgeshire and Peterborough Integrated Care System (ICS) should develop system wide contingency plans and processes for when there is no accommodation and or staffing available to meet someone's needs. This will enable extraordinary measures to be taken such as utilising available provider staff from a different organisation on a closed ward
Cambridgeshire and Peterborough Foundation NHS Trust	
21	Development of Standard Operating Procedure (SOP) to support the use of the S136 Suite outside of its normal remit. This will include medical cover and support for the S136 Suite including clear lines of responsibility and support from appropriate directorates in the event it is used as an alternative to ward and the use of a full NEWS2 which included and body map
22	S136 Suite environment, review of use of the anti-ligature door to the en-suite facilities as opposed to no door or full door
23	CPFT to ensure that the Oliver McGowan training package is rolled out across the Trust to increase knowledge and skillset for all staff
24	Proposal for development of single service user provision within CPFT at The Hollies (this has now been agreed and is in the initial development stages).

25	CPFT to write a protocol to support staff with assessment and actions to be taken when a physical injury has occurred including but not exclusively head injury
Multi Agency Safeguarding Hub	
26	Direct MASH leads where there is no safeguarding concern, but action required by the allocated team that the information gathering outcome must be to send a MASH recommendation as the next mosaic work step.
27	Review of adult safeguarding fact sheets around mosaic process, that includes mash recommendation work step
Cambridgeshire Constabulary	
28	PVP management to ensure there is regular input at frontline staff training days for dealing with Adults at Risk
29	Consideration to be made for a bespoke policy for dealing with Adults at Risk
30	Consideration to be made for a process to be put in place with partner agencies regarding feedback and action to be taken following police MASH referrals
31	Cambridgeshire Constabulary to review the arrangements for the retention of body worn video in circumstances where this relates to a death
Voiceability	
32	Improving Voiceability knowledge and understanding based on the learning from this SAR