Cornwall and the Isles of Scilly Safeguarding Adults Board

Safeguarding Adults Review in respect of

'Peter'

who died in 2023

Executive Summary

prepared by

Barrie Crook, Independent Lead Reviewer

1. Background to the Safeguarding Adults Review (SAR)

1.1 Peter died in 2023 at the Royal Cornwall Hospital Trust (RCHT). He had been compulsorily admitted to hospital later that year under section 2 of the Mental Health Act (MCA) for depression, risk of suicide and self-neglect.

1.2 A referral for a Safeguarding Adults Review was made to the Cornwall and IOS SAR sub-group in 2023. The following case characteristics were cited:

- Domestic abuse
- Mental health
- Self-neglect
- Serious illness and
- Discrimination

Peter

1.3 It is well documented that Peter's upbringing and family life was marked by experiences of trauma and domestic abuse. His mother died when he was a young child. It is recorded that she died by suicide. Peter's brother died in an accident. His father's controlling behaviour involved him in making decisions about Peter's life and not enabling him to develop the skills to be more independent of him.

1.4 In the late 1990's Peter first came to the attention of Social Services when he was excluded from a Special Needs Unit at a local College for numerous incidents of aggressive and disruptive behaviour, especially towards staff and students.

1.5 Between 1998 and 2021 Peter appeared in criminal courts on a number of occasions. The majority of these convictions were for assault and harassment, including three assaults on the Police and harassment of a former girlfriend. In 2007 a MAPPA[1] panel meeting registered him as being a risk to the public at level 1, i.e. able to be managed by a single agency.

1.6 He served five separate custodial sentences, the two most recent being in 2021. Restraining orders were imposed at different times on account of domestic abuse towards his father. In March 2021 the Probation Service assessed Peter as posing a medium risk of serious harm to the public, known adults, i.e. his father, and staff/arresting officers.

1.7 He is described as a man with neurodevelopmental needs that are not well understood and having a possible learning disability. In other reports he has been referred to as having a background of autistic spectrum disorder, suspected ADHD (Attention Deficit Hyperactivity Disorder) or a dissocial personality disorder.

[1] Multi-Agency Public Protection Arrangements are designed to manage the risk of harm from potentially dangerous offenders

Events leading to the death of Peter

1.8 Adult Social Care (ASC) became involved with Peter in October 2020 when his father went into hospital. He had felt that his son would not be able to cope independently. From this point until his death there were three critical incidents which adversely affected him.

1.9 In 2021 a MARAC[2] determined that he should no longer live at his father's house after he committed offences against his father and the property. There were 5 temporary accommodation placements arranged for him until in late 2021 he moved to a self-contained flat.

1.10 This proved to be a settled period for him and he enjoyed living there until April 2022 when allegations were posted on social media against him. This had a significant psychological impact upon him as well as leading to him being homeless again.

1.11 There were further attempts to find accommodation with short stays at temporary placements disrupted by Peter causing damage and being in conflict with staff.

1.12 Further to an incident where Peter sustained serious injuries, he was discharged from hospital to extra care housing with a package of care commissioned by Adult Social Care. There followed a further sequence of movements between temporary addresses with concerns expressed by practitioners that he was becoming increasingly depressed and self-neglectful. He was detained under the Mental Health Act in late 2023. He died in hospital 3 weeks later.

1.13 This review has been informed by the results of a Patient Safety Incident Investigation (PSII). HM Coroner has conducted an Inquest and determined that Peter died from natural causes.

[2] The Multi-Agency Risk Assessment Conference is the partnership arrangement for assessing and managing the risk of domestic abuse.

2. Analysis and Findings

2.1 This section focuses upon the Key Lines Of Enquiry set by the SAR subgroup.

Care and treatment for physical conditions

2.2 Decisions how to treat Peter's injuries took into account concerns about Peter's likely level of compliance post-surgery given his agitation whilst in the hospital ward. It was considered that physiotherapy was the better option. Following discharge he was visited by the physiotherapist from the LD team. In spite of a detailed exercise plan to improve his mobility, Peter continued to believe that he needed surgery. His GP arranged for him to have X-rays to confirm that the injuries had healed. This issue became a further obstacle to engaging with him and influenced his emotional wellbeing. He wanted to be able to return to his previous physical state and was fixated in his desire for surgery.

Care and support provided by independent providers

2.3 On discharge from hospital Peter was accommodated with a package of care of 1 hour per day commissioned from care provider 1. This ended when this provider withdrew from the contract in January 2023 because of an assault on a staff member who was driving at the time.

2.4 A much expanded service was then commissioned with the care agency/provider 2 and began in February 2023. The agency was the only bidder for the package. This provided for daily 3 hour visits for outside activity, shopping, meal preparation, 15 hours per week flexible support and 24/7 cover. Peter was evicted from his accommodation following assaults on staff and another resident. There followed a series of temporary placements when self-neglect in respect of nutrition became an increasing concern and during which it became clear that the provider was not equipped to support him. Communication was a significant issue as many of its staff did not speak English as a first language. Attempts to commission a provider with specialist skills in learning disability and autistic spectrum disorder were unsuccessful, indicating a shortfall in appropriate provision in the market at the time. The care agency was later involved in an organisational safeguarding enquiry.

Self-neglect

2.5 Peter’s personal care was a constant theme throughout 2023 following discharge from hospital. There were steps that Peter could have taken to meet his own care and support needs but chose not to. Towards the end of his life he was able to do much less for himself. Initially he would allow the outreach worker from the Learning Disability team to cook him a meal but would often refuse food. He had a diet based upon chocolate bars and coca cola. When his social worker visited they often went out for a drive, which provided the opportunity for a burger to be purchased. Peter was reluctant to spend money on food. In May 2023 a psychiatrist assessed that his

restrictive eating was a consequence of his neurodevelopmental needs and social situation rather than a depressive illness. When he was admitted to hospital in September the care agency reported that he had not changed his clothes for 8 months.

2.6 This review predates the development of a more comprehensive policy in respect of self-neglect by the Safeguarding Adults Board. However, it is clear that Peter's social worker and outreach worker recognised the risks of self-neglect, had built a supportive relationship with him and tried whenever they visited to induce him to eat more and better food.

Mental capacity

2.7 Peter was assessed as lacking capacity on several occasions. A Deprivation of Liberty Safeguard (DOLS) was in place during his admission to hospital in 2022 as he was assessed as lacking mental capacity in relation to his treatment and any decision to self-discharge against medical advice. In early 2023 his GP assessed him as lacking capacity to make decisions around his mental or physical health. A formal Mental Capacity Assessment was completed by Adult Social Care and an Independent Mental Capacity Advocate (IMCA) assigned to support Peter. A Best Interest decision enabled Peter to be referred to other services including mental health. His social worker completed a second assessment in respect of his finances and made an application the Court of Protection for authority to sign a tenancy agreement on his behalf. Both assessments were exceptionally detailed and thorough.

2.8 It is accepted that later in 2023 when there were frequent crises the audit trail was not always formalised. A consultant psychiatrist found difficulty in assessing Peter because of his reported unwillingness to engage. Peter was not prescribed medication for his low mood but such decisions were not formally documented.

Mental health

2.9 From December 2022 until his admission in September 2023 a number of requests were made by practitioners working with Peter for a Mental Health Act assessment or specialist support. The use of the MHA was not considered proportionate or necessary on each occasion. However there was no alternative treatment plan or pathway set out to support workers managing him in the community. In September as Peter's emotional and physical state deteriorated further, his social worker was advised to take him to Accident and Emergency. Once there he was assessed as having depression with secondary anger issues. It was believed that he would kill himself if left in the community and that treatment could only be provided within a hospital setting. He was detained in hospital until his death.

Accommodation

2.10 From January 2021 until September 2023 Peter moved between twelve different temporary placements. Some lasted several months, others a matter of days. Only one placement was in any way successful or satisfactory to Peter. This was ended in a way that was significantly detrimental to his wellbeing. However many other placements were terminated because of his own disruptive or aggressive behaviour. The frequent moves, whilst often unavoidable, would have created added stress for someone with a neurodivergent condition such as Peter's. There was positive joint working with Housing during this period and later his social worker tried many avenues to find a suitable social care placement for him.

Safeguarding and multi-agency working

2.11 Numerous multi-agency meetings were held during the period in scope and were a positive indicator of partnership working. Most were called as MDT (Multi-Disciplinary Team) meetings with three under the heading of a Blue Light meeting. There were no safeguarding conferences although section 42 enquiries and concerns are recorded on seven occasions.

2.12 Risk assessments relating to Peter were well documented. These included a communications profile by a speech and language therapist, a crisis plan by Peter's social worker and the outcome of a MARAC meeting.

2.13 A MDT in February 2020 recorded a high likelihood of assaults on his father, a risk to staff with a high probability of stalking. Peter had a preference of being more accepting of white middle-aged male workers. It was difficult to challenge his attitudes without running the risk of losing the level of engagement that had been achieved. It was concluded that he should not be seen by a lone female worker. Two of the temporary accommodation placements to which Peter was referred were hotels. Whilst at one of these Peter threatened to kill a female receptionist. Whilst systems have since changed, Housing has no record of whether known risks were conveyed to temporary providers during this period as communication was only managed verbally.

MARAC

2.14 A high-risk DASH[3] was completed following offences committed at Peter's father's home in January 2021. Measures were taken to support his father and to protect the property. At the same time it was recognised that Peter was himself a vulnerable person and actions to support him were agreed. It was good practice for the MARAC to have considered the wider needs and risks of Peter if he lost contact and accommodation with his father. There was intermittent contact between them until

[3] The Domestic Abuse, Stalking and Honour-based abuse risk checklist for assessing the likelihood and risk of domestic abuse.

his father died in 2023. Their relationship, though important to Peter, remained fractious. A safeguarding referral of psychological abuse was made in November 2022 when his father was observed shouting aggressively at Peter when he visited him.

Examples of good practice

2.15 The consistent patient approach of Peter's social worker over a three year period is noteworthy. He is described by one partner as 'outstanding'. He acknowledged that he felt well supported by his line manager. His outreach worker and social worker visited Peter alternately and worked as a team to support him. They were each creative in trying to find different ways to engage him and adopted a trauma informed approach. Credit should be given to each agency in enabling both workers to devote so much time to Peter throughout this period. However this situation also created pressure on the workers, especially during times of annual leave, as they cared about what happened to Peter and had no one else to hand over to.

2.16 There was good preparation to receive Peter as a vulnerable patient when admitted to hospital in 2022. Similarly it was a positive decision to admit him in September 2023 as this acknowledged his acute mental health needs in spite of reservations that a mental health ward was not the best option for him.

3. Recommendations

3.1 Peter had complex needs given that he was neurodivergent, had experienced childhood trauma and may have had a learning disability. His own behaviour often undermined the best efforts of practitioners to support him. This review has however highlighted areas for improvement which could have longer term benefits for other service users with similar complex needs.

3.2 The commissioning of the care agency to work with Peter was inappropriate given his complex behaviour and specific needs and the workforce profile of the provider i.e. having a number of staff whose lack of fluency in English raised communication barriers. The care agency also failed in its duty to feed back issues of concern to commissioners. However no other provider had bid for the contract specified. Commissioning indicate that there are now contracts in place which specifically allow the procurement of providers which have been assessed as being able to offer support to working age adults with complex support needs.

3.3 *Recommendation 1*

The Safeguarding Adults Board should assure itself at least annually (a) concerning the availability of suitable accommodation and homecare services for adults with neurodivergent and mental health needs and (b) that the quality of care providers are delivering is satisfactory.

3.4 Peter's mental health diagnosis required a partnership approach involving specialist mental health input to support practitioners engaging in direct work. This was not always evident.

3.5 *Recommendation 2*

Cornwall Foundation Trust and the Integrated Care Board should regularly update the SAB on the development of a Greenlight liaison service and the benefits this will provide in future partnership work with clients who experience both learning disability and mental health problems.

3.6 Mental Capacity Assessments were not formally documented and kept up to date especially in respect of Peter's capacity in relation to medication which could have alleviated his low mood/depression. The SAB requires ongoing assurance and oversight in relation to the assessment and review of mental capacity to ensure decision-making is lawful, timely and responsive to fluctuating or deteriorating presentations.

3.7 *Recommendation 3*

(a) The Community Forensic Team should ensure that the statutory principle of assumption of capacity is applied correctly and does not result in the absence of a formal Mental Capacity Assessment where there is reasonable cause to doubt capacity.

(b) Adult Social Care should ensure that Mental Capacity Assessments are time- and decision-specific and are kept under regular review, particularly where there is evidence of deterioration, repeated crises or changes in circumstances.

3.8 Peter was assessed as posing a risk to women. It was recommended that he should not be seen by lone female workers. He was referred to hotels when his accommodation needs were acute. It is not clear if known risks were shared with these and other temporary accommodation facilities. The Council now has an agreement not to refer 'Dangerous Offenders' to hotel 1 and no longer uses hotel 2.

3.9 *Recommendation 4*

As part of the SAR action plan Housing Options should provide (a) an account of current practice in sharing information about risk[4] with providers of temporary accommodation and (b) a review of the effectiveness of the agreement with hotel 1.

3.10 It was not always clear when a section 42 safeguarding enquiry had been closed nor whether feedback concerning the outcomes had been given to the referrer.

[4] Risk in this context refers to the assessment of potential risk of harm to staff and other residents.

3.11 *Recommendation 5*

Adult Social Care should ensure that for each section 42 safeguarding enquiry outcomes are specified and clearly communicated within an agreed timeframe following the completion of the enquiry.

3.12 Peter was discussed at regular multi-agency meetings (MDTs) and three Blue Light meetings but not at a safeguarding conference. There are a number of meetings in Cornwall and the IOS designed to manage risk and safeguarding concerns. However there is ambiguity in relation to the purpose and powers of different meetings, how minutes/actions should be recorded and disseminated and who should be present. Guidance for professionals concerning participating in and leading multi-agency meetings is currently being produced.

3.13 *Recommendation 6*

The Safeguarding Adults Board and Safer Cornwall should prepare guidance and learning resources clarifying all the issues outlined and how meetings relate to one another and to the adult safeguarding procedures.