The Case of X

Case brought by TVP to the SAR Panel on 31 Jan 2017

Summary of the Case of X

The case of X was presented to the SAR Panel on 31 January 2017 by Thames Valley Police for consideration under the SAR criteria.

X appeared have some degree of Learning Disability and lived a chaotic lifestyle. He had Warnings on PNC for mental disorder, self-harm, weapons and drugs. He had 17 convictions and two cautions between 1985 and 2015 for offences including criminal damage, theft and related offences, drugs and firearms. A Criminal Behavioural Order was applied for in relation to Anti-Social Behaviour (March 2015).

X attempted suicide in April 2015 by jumping out of a window and received serious injuries, including injury to his brain. A referral was made to the Community Mental Health Team and he spent two months in hospital. He was made subject to Section 136 after a disturbance in a chemist and taken to Prospect Park Hospital. A further referral was made to CMHT.

There were complex relationships, interdependencies and possible domestic abuse / coercive control between X and his two brothers. This was felt by the Panel to be an important factor in the case.

On 6th October 2016, X was interviewed by Thames Valley Police on a voluntary basis in relation to an allegation of historic sexual abuse. The first interview was suspended when it became apparent X needed an Appropriate Adult. The Investigating Officer contacted Divert Mental Health Services in Berkshire, the Crisis Team and the National Crime Agency to arrange an Appropriate Adult but was not able to secure the services of an intermediary so the interview was delayed and not able to take place before X was found dead.

The coroner ruled that in the absence of any evidence of injury, acute natural disease or other factor, the probable cause of death was: 1a) Methadone and Diazepam toxicity.

Panel decision

The Panel considered further information at an exceptional SAR Panel meeting on 27 March and concluded that although, technically, the case met the criteria for a SAR, a SAR would not be a proportionate response and would be unlikely to produce new learning. The Panel agreed to look at learning that was already available from local and national cases so as not to duplicate efforts. In particular, the case of Mr I completed in 2016 was noted as containing similar themes.

On 3 May, the Panel considered a summary of learning from previous reviews of cases involving individuals with similar needs e.g. chaotic lives, complex needs, substance misuse and sporadic engagement. A summary of learning from other reviews including links to the cases is attached as Appendix A.

This summary of learning was considered in conjunction with a combined chronology based on records from Reading BC, Berkshire Healthcare Foundation Trust, the GP Surgery and Thames Valley Police. The combined chronology indicates that X received adequate services and that practice was followed; at the point of the safeguarding referral he was made safe. The Panel agreed that it would be unlikely a thematic or partnership review would produce any further learning to that which is already available from similar, recent cases.

Themes

The following themes have arisen from this case and are apparent in other national cases. Learning from other national and local cases shows that processes are in place but are not necessarily working. Work is already under way locally to address some of the issues, as indicated in the third column.

Theme	The issue	Work underway / action required
1. Capacity assessments	No one formally considered X's mental capacity. Viewing behaviours as anti-social or as life-style choices, may have resulted in underestimating the significance of his underlying mental health issues.	Workers need to be able to identify the requirement for a capacity assessment and make appropriate referrals.
2. Advocacy / Appropriate Adult	The support of an Appropriate Adult could not be secured, delaying the police interview which could not be completed prior to X's death.	Partnership agreement is required for a pathway to secure support for an Appropriate Adult
3. Management of complex cases / Risk management / Engagement / Hard to reach	The association of substance misuse with brain injury and suicide is well documented. Do practitioners have sufficient opportunities to discuss complex cases? Chaotic lifestyles and inconsistent compliance can result in people being described 'hard to reach' which may not be relevant to the urgency of people's deteriorating circumstances.	Board agenda item to raise awareness of suicide prevention – Sept 2017. Effectiveness Subgroup has reviewed the Board's Multi-Agency At Risk Pathway and produced a guidance document to help raise awareness of opportunities for practitioners to discuss complex cases within each agency.
4. Multi agency, coordinated working	Like other people with support needs arising from mental health problems, homelessness and substance misuse, X was in contact with a wide range of services. Arrangements for managing complex, multi-agency cases need to be promoted. There needs to be clear escalation protocols in all agencies for the resolution of conflicts or stuck situations.	Effectiveness Subgroup has produced a briefing note to help raise awareness of complex case panel arrangements in each area.
5. Cohersive control	Interdependencies and possible domestic abuse / coercive control between X and his brothers were an important factor in the case.	Domestic Abuse event planned for October / November, to include presentation to raise awareness of cohersive control.

Appendix A

1. Summary of learning from previous, similar case reviews

The SAR Panel considered a summary of themes and findings from previous reviews of cases involving individuals with similar needs e.g. chaotic lives, complex needs, substance misuse and sporadic engagement:

NB. no commentary on the Case of X is included in the following section.

Advocacy

Policy and practice guidance needs to promote the involvement of advocacy services.

Learning Disability

In view of the continuing national evidence about the disadvantage experienced by adults with a learning disability, the SAB will seek assurance that an effective learning disability liaison service is in place across the hospitals that routinely receive residents.

An annual health check should be provided for all people with a learning disability.

Management of complex cases / Risk management

Arrangements for managing complex cases need to be reviewed to ensure:

- allocation of a case co-ordinator
- firm expectations of multi-agency decision-making
- clear escalation protocols in all agencies for the resolution of conflicts or stuck situations.

Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together.

People with support needs arising from mental health problems, homelessness and substance misuse are likely to be in contact with a wide range of services. However, public services may exclude people if they do not meet rigid or complicated access thresholds.

Without effective help, some clients and patients inadvertently take up a phenomenal amount of professionals' time over long periods of time. Commissioners and public services are not currently thinking creatively and ambitiously enough about delivering credible support to people with long-term, complex support needs.

The association of substance misuse with traumatic brain injury and suicide is well documented. It was his family who correctly anticipated that he would take his own life. The review's findings make it clear that working more closely with families could improve suicide prevention.

There was variable understanding and use across agencies of the Safeguarding Adults at Risk Policy revealed during the review, with a common view that the formal procedures did not apply in this case.

The individual's mental ill health and the way it manifested itself, together with his lack of willingness to engage, posed risks to him and to others. However, whilst each agency recognised those risks no agency took the lead in developing an overall risk mitigation or management plan.

Agencies including Adult Social Care, focussed mainly on the risks posed by to himself, and underplayed the risk to others, which meant that decisions were made predominantly on the basis of his willingness to comply, or assumptions about his capacity to make choices about how he lived. Whilst Housing was more alert to the risk to others, staff did not know how best to use other services to help mitigate this risk. Fire officers too highlighted the risk to others.

Capacity assessments

Supervision processes are not supporting practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours, with the result that assessments of capacity are made but practitioners act as though capacity is lacking.

His circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity. An assumption of mental capacity is risky because a person's severe brain injury usually results in a degree of cognitive impairment.

Describing his behaviours as anti-social or as life-style choices, may have resulted in underestimating the significance of his underlying chronic mental health issues, or recognising the escalation of his behaviours as evidence of deteriorating mental health.

His mental capacity was formally assessed but despite his history of serious mental illness, and current behaviours and rationalisations, he was assumed to have capacity. Workers assumed capacity on the basis of his verbal reassurances and did not take into account the context of his serious mental health history. Because he was articulate and resistant to receiving help, staff seem to have taken his reassurances at face value, but greater knowledge and understanding of capacity issues may have given staff greater confidence to try to work around his resistance. Mental capacity as an issue is mentioned, but understanding of the complexities of the concept appears underdeveloped.

Multi agency, coordinated working

Agencies were in touch with each other during crisis periods, but there is no evidence of overall analysis or planning to inform a shared strategic approach. Each episode or incident tended to be viewed in isolation and not in context, either of the individual's previous history, or of other agencies' experience of him.

There appears to have been no proactive input from the GP throughout the period under review, which is a concern given the key role of GP's in the continuing care of all people who experience serious mental ill health and the NICE clinical guidelines (CG185) on Bi-polar Disorder. Equally, there is evidence that the GP was not involved in the individual's discharge from mental health services.

Looking at the whole narrative it appears that for much of the time Housing Officers were working alone and were not able to rely on consistent help from other agencies. This meant that they were not always aware of the most effective referral route to find the help they thought he needed.

None of the agencies saw it as their role to provide a leadership or coordinating function across all partners. This meant for example that information was not shared when one partner decided to discharge, was not taking up a referral, or was passing it to another agency. When referrals were passed on from one agency to another, there was no follow up to see what had happened as a result of the referral.

The lack of consistent joint working meant that frontline staff did not have the opportunity to learn about the way that other agencies work, how to target referrals or what their duties or powers are.

This lack of understanding also meant that agencies were unable to escalate their concerns effectively when they identified deterioration in his situation.

Strong multi-agency protocols for working with people who self-neglect are needed with a view to promoting robust and consistent joint agency work, with action plans/strategies, and programmed follow-up when working with an individual who has a chronic mental health condition and who self-neglects, and with whom it is difficult to engage.

Although no single agency could address his support needs, it appears that nothing impelled or required health and social care services to work collaboratively within and across their provision to provide direction and resolution.

There were missed opportunities to initiate a coordinated, multi-agency approach. As a result, his difficulties were perceived in a fragmented way.

He required a professional-led, multi-agency approach. Gatekeeping criteria or service 'thresholds' should not allow a vulnerable man to remain "in harm's way". Negotiating shared solutions has to be actively facilitated.

Inter-Agency Communication and Information Sharing: care was shared between specialist mental health providers (both inpatient and community services), and generalist services. This created significant challenges for ensuring good communication, which was not always achieved.

Issues identified by the review included lack of appropriate information sharing between agencies which led on occasion to the inadvertent undermining of the community management plan and lack of clarity about how to respond.

Implementing risk management protocols was complex due to the demands made on the wide range of agencies involved, including out of hours services. The agreed management plan reduced but did not eliminate risk and it was challenging for all agencies to understand and consistently implement the agreed plan. Considerable efforts were made to achieve this but there were examples of poor or missed communication, as well as a lack of understanding about the role and powers of the police service, which increased risk.

Engagement / Hard to reach

The Multi-Agency Pathway for non-engagement is not consistently followed, with the consequence that multi-agency perspectives and resources are not brought to bear when previously-managed risk becomes less controllable.

Chaotic lifestyles and inconsistent compliance can result in people being described 'hard to reach' or perceived as 'someone else's problem' – neither of which are relevant to the urgency of people's deteriorating circumstances.

Organisational change

The Mental Health Partnership and Adult Social Care underwent major restructures around this time. No agency has identified organisational capacity per se as an issue in relation to its support of the individual, but it must be noted that both these organisations went through a period of great change.

2. Summary of other cases explored in this report:

Bristol – Mr C

Mr C, aged 61, died in a fire at his flat in Bristol in September 2014. He had been known to a variety of agencies. From 1997- 2011 Mr C was admitted to psychiatric in-patient services on eight occasions, twice under Section 3 MHA, and four times under Section 2 MHA. He was discharged in September 2010 from secondary mental health services. Nowhere in the records is it recognised that he continued to be covered by Section 117 (Aftercare) of the Mental Health Act. He was open about his drug use and firmly believed that this had no negative impact on his mental well-being. In the light of Mr C's unwillingness to engage with services, the decision was taken in 2012 to discharge Mr C from mental health services. An ASB tag was added to police records, which coupled with the recent discharge from AWP services, meant that his behaviour was seen by agencies as primarily being anti-social, exacerbated by his use of drugs. In this context, his long history of mental health issues seems to have been underestimated or discounted. He invited commercial sex workers and drug dealers into his flat, who stole from him. Avon Fire and Rescue was called to attend a 'barbecue' fire on Mr C's balcony. Fire Officers noted the cluttered state of the flat and gave fire safety advice. There were signs of self-neglect. Joint visits by housing officers and social workers took place but Mr C declined to have a community care assessment and said he did not need any support. Adult Social Care closed the referral as the social worker concluded that the state of his flat was a lifestyle choice and he had capacity so his wish would be respected. On 3rd September the Housing officer and ASB officer agreed to visit jointly the following week on the 8th September to agree an action plan with Mr C to clear the property. Two days before the planned visit, a fire broke out in the flat in which Mr C died.

https://www.bristol.gov.uk/documents/20182/354651/BC+Executive+summary+final+-+Publication+-+v1_03.pdf/86c32318-326f-44af-ad8a-75009683afe3

Hampshire - Ms B

Ms B was a 46 year old woman who had a mild learning disability, personality disorder and epilepsy. She died in 2014 aged 46, with the cause of death recorded as (a) heart failure and (b) obesity and depression. Ms B's care and support in the last weeks of her life had involved a complex mix of physical and mental health and care services. Her behaviour had changed significantly and different approaches to respond to this were attempted, but with limited success. Finally her physical health required her admission to hospital and was found to have deteriorated so substantially that little effective treatment was possible.

http://www.hampshiresab.org.uk/wp-content/uploads/Ms-B-Safeguarding-Adult-Review-Executive-Summary-December-2015.pdf

West of Berkshire - Ms F

Ms F was a young woman who died of sepsis. With the exception of her GP, her case was not open to any service until just before her death, when she was referred to Adult Social Care by the Police. Other members of the household were well known to many services in Reading including Antisocial Behaviour and the Police, both as victims and perpetrators.

http://www.hampshiresab.org.uk/wp-content/uploads/Ms-F-Safeguarding-Adult-Review-executive-summary.pdf

West of Berkshire - Mr I

Mr I had suffered a brain injury and had a lower leg amputation. He was prone to depression and developed an increasingly severe dependence on alcohol. He resented contact from the services and was aggressive to visitors including the regular care staff; keyworkers struggled to develop a working relationship with him. The daily carers continued to call but often did not manage to see Mr I, so the police would occasionally be asked to undertake welfare checks. The case was transferred between teams within the council. During a significant re-structure of the Local Authority teams, a period of confusion and increasing frustration between teams followed, with a lack of clear accountability for the case. During this period the teams were unaware that Mr I's physical health was significantly deteriorating. He died unexpectedly in June 2015 and was found in his home several days later by the police.

http://www.hampshiresab.org.uk/wp-content/uploads/SAR-Mr-I-Final-Report-2016v4.pdf

Somerset – Tom

The review concerned a man who in his early twenties sustained a traumatic brain injury in a road traffic accident. He took his own life in 2014.

http://ssab.safeguardingsomerset.org.uk/wp-content/uploads/Tom-Practice-Briefing-Note-FV.pdf

Dorset – LW

LW was 26 year old woman who had a long and extensive psychiatric history. She had a diagnosis of Borderline Personality Disorder. She had a difficult early family life, she was diagnosed with Attention Deficit Hyperactivity disorder at the age of seven, she spent periods in care, and she committed a number of criminal offences and spent nine months in prison. She had numerous admissions to psychiatric hospital between 2004 and her death in February 2011. Her condition was characterised by frequent episodes of self-harm and substance misuse and difficulties in engaging with the psychological interventions offered. There was an increase in her distress and an escalation of her disturbed behaviour prior to her death. She was admitted informally to psychiatric hospital on 17 February 2011 during the night, saying she was low in mood and planning to kill herself. She was detained under section 5 (2) of the Mental Health Act and this was subsequently converted to a section 2 on 22 February. On 25 February in the context of LW appearing to be more settled and relaxed, she was allowed two towels and went to take a bath. She was found collapsed in the bathroom twenty five minutes later, with a ligature around her neck and an injury to her head.

http://www.hampshiresab.org.uk/wp-content/uploads/2012-SCR-regarding-LW-Dorset.pdf