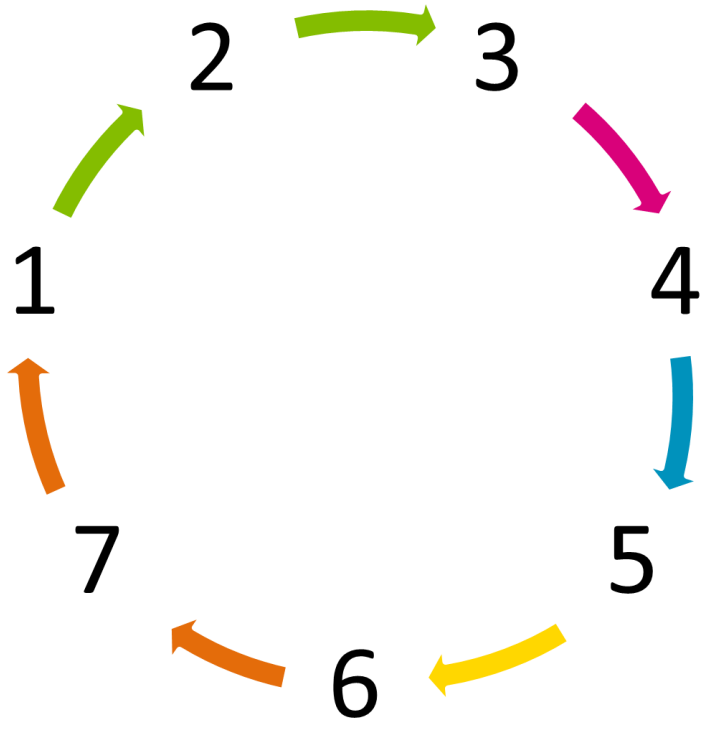


7 Minute Briefing: SAR ADULT 28

Safeguarding Adult Review (SAR): ADULT 28

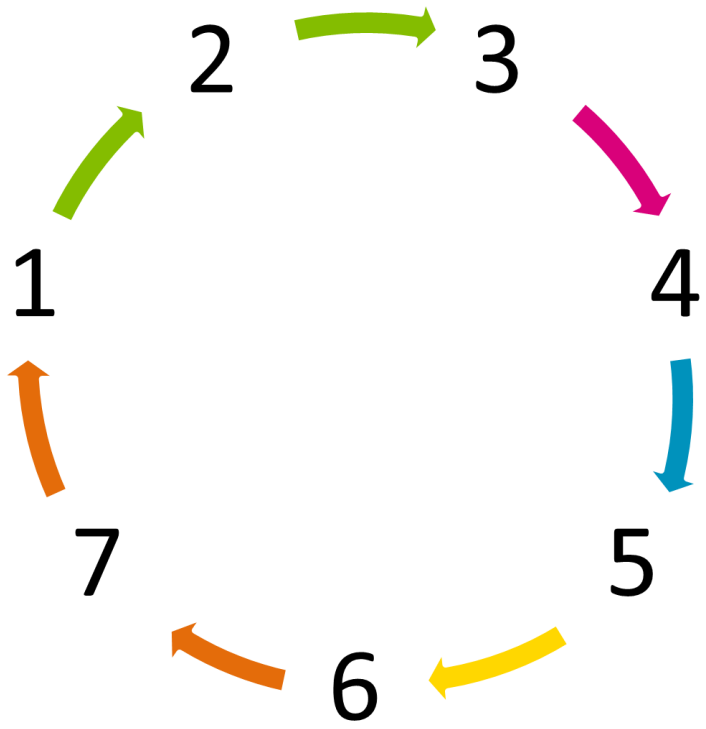
Wigan Safeguarding Adults Board

Methodology

The WSAB Independent Chair is consulted on the methodology utilised in any given SAR and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of **ADULT 28**. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon. An immediate family member was also consulted regarding the case review.

Background



Background

Adult 28 was a male who had a diagnosis of heart condition**,** suspected brain injury affecting his higher level functioning and paranoid schizophrenia. He was known to use drugs and alcohol, and he had been a dependent user for the last 30 years. He did not believe he had any problems with his mental health and whilst detained under Section 3 of the Mental Health Act, Adult 28 would abscond from his placements in hospital. His presentation was often complex and challenging on ward with incidents of aggression and as a victim of aggression.

On discharge to a specialist care home from a period as an inpatient under the Mental Health Act, he continued to abscond. The first incident was while he was on Section 17 leave to the home where he was missing for two days and subsequently found in a town in Wales. A second incident occurred just over a week later when two days later he attended a police station in a neighbouring town.

Following this second incident a safeguarding alert led to a safety plan being implemented to address this risk, including a specific plan regarding his drug use, aggressive behaviour and also addressing security factors such as fence height at the care home.

Furthermore, a missing report was logged following his arrest at the home (and removal to custody) due to threatening behaviour; he was released from custody on his own and did not return immediately to the care home voluntarily presenting himself at a police station in a neighbouring authority two days later.

The safety plan put in place after the second abscondment (and focused on his risk regarding this) appeared to be successful until a few weeks later, when he absconded a third time due to a failure by Care Home staff to follow the safety plan regarding bedroom checks.

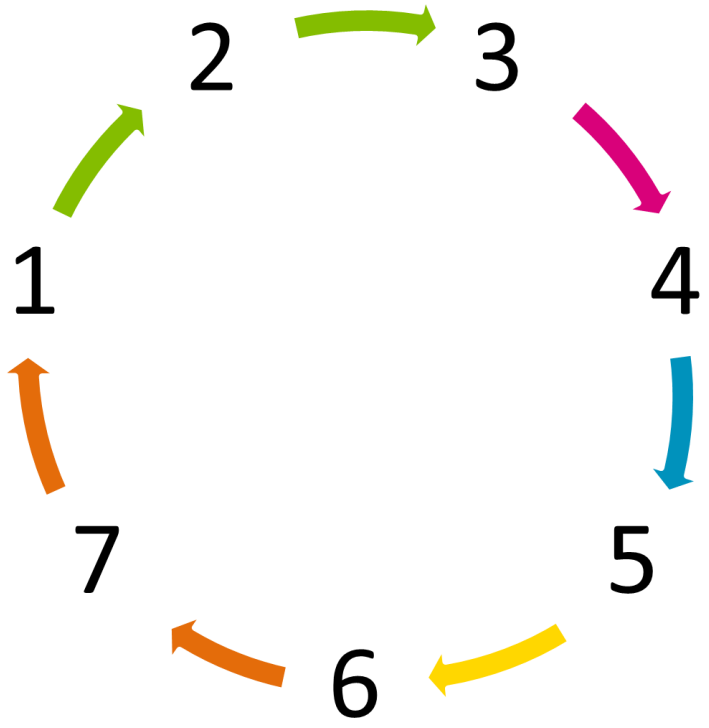
An initial police enquiry into the circumstances of the incident resulted in no further criminal investigation although an internal investigation followed.

The main themes within the case are:

- Risk Management including Drug and Alcohol Treatment and co-occurrence with Mental Health / long term dependency.
- Hospital Discharge / Legal Frameworks
- DoLS

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Risk Management / Drugs and Alcohol



Risk Management

- Overall, Adult 28's discharge lacked a co-ordinated approach to using partner agency information within appropriate legal frameworks to put in place plans that robustly managed risk in relation to absconding. This is explored further in Section 3 of this report. This section provides an overview of the potential root causes regarding his absconding, how the risks were mitigated and linked to his long-term dependency of drugs.

Adult 28 absconded from the care home where he was residing on three occasions with a further missing episode as well:

- The first incident was on the 2nd full day of residency in his new care setting. A safeguarding alert was raised at this point and systems noted that there were open safeguarding steps and had been passed to that social worker to assist in establishing a risk plan, the alert was then closed noting the work taken to establish the risk plan.
- On the second occasion, ten days after the initial incident ADULT 28 was found after accessing a police station in Manchester. He was returned on this occasion by police officers.
- Records from the care home show that a risk plan was signed off that day after ADULT 28's return and based on both episodes of absconding.
- A third missing report was logged when Adult 28 was arrested for threatening behaviour at the home, detained and then released the following morning from custody with no charge

and based on the custody officer's assessment of his presenting behaviour and attitude. Although the presumption at this time was that a standard DOLS was in place (the emergency 14 day one having run out) police staff did not speak to the care home regarding this or his risk of absconding and he failed to return home (he subsequently presented himself to a police station in a neighbouring authority two days later).

- Staff on duty during the time when Adult 28 absconded for the third time did not adhere to the risk plan. Crucially they did not carry out observations as required within the risk plan. The safeguarding enquiry concluded that records appeared to be falsified regarding checks, this was considered by the police but did not result in any further charges.

- A safeguarding police enquiry under a Section 42 safeguarding process was undertaken to ascertain the level of acts of omission, however this did not proceed to criminal investigation or reach criminal threshold.

Drug and Alcohol Use

- Through conversations with Adult 28's family they felt that his absconding incidents were based mainly on the motivation to purchase drugs, and the fact that he was in a secure unit with high levels of monitoring would have made him feel controlled and with little choice. Family also encouraged Adult 28 to not abscond. The absence of capacity assessments to capture his understanding of the risks he was taking are noted within this report.

- Adult 28 had absconded from acute mental health services most recently just over a week before transition to the new care home. It was known by professionals that he used amphetamines whilst absconding from acute mental health services. Although there is evidence that conversations around his drug use had taken place, it was not evident that he was receiving support in relation to this abstinence, or that it was considered by clinicians that this was a driver for his absconding risk.

- The support regarding help with this never moved beyond an assumption that Adult 28 did not want to engage with drug and alcohol services though there was no evidence of a capacity assessment regarding this. His risk profile at discharge therefore appeared to not consider that he would likely continue to abscond in order to obtain drugs without support around his dependency (noting that whilst he appeared to not have accessed services regarding this, Adult 28s life was changing and his dependency and offers around this could have been improved and focused on co-occurrence practice – see below).

- Furthermore, Adult 28 was known to have a high intake of caffeinated energy drinks. It was considered that this was potentially a substitute for his amphetamine habit, however this connection was never made, nor did it trigger consideration for support in relation to Adult 28's abstinence whilst in the care home setting in response to what were entrenched drug and alcohol dependency issues.

- The panel discussed and agreed that patients with long term dependency would benefit from a different approach to addressing the issue of co-occurrence (with mental health issues). Greater Manchester Mental Health Trust are currently refreshing their Co-occurrence Policy and Process, alongside further work to embed a refreshed approach regarding person centred, trauma responsive methods. In Adult 28's case, and through discussions with his immediate family, this may well have assisted in supporting him regarding his long-term dependency.

Making a Difference:

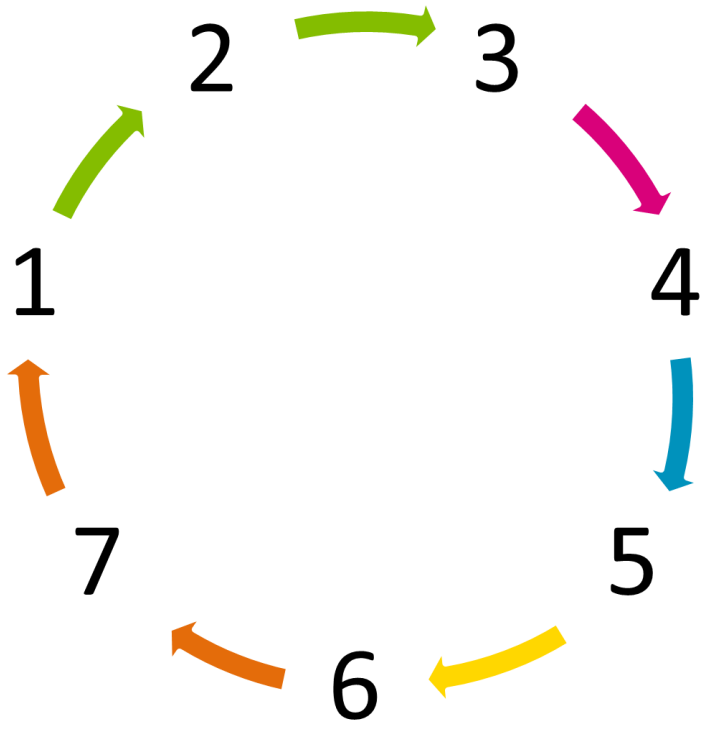
1> Police to update custody release protocols to include conversations with providers for individuals whose residence is a care home to check the nature of the service and what legal frameworks are in place for the individual to ensure appropriate return home is arranged

2> Safer Employment whole system work stream (and based on embedding the PRISIM model) within Organisational Safeguarding Delivery group to ensure that an approach to agency staff is incorporated

3> Further understanding of caffeinated energy drinks in relation to medication to be circulated to health and care providers with guidance on how to support individuals when the intake is detrimental to an individual's medication

4> *The ICB, public health and GMMH should review the current harm minimisation support available to in-patients. For patients with co-occurring conditions, harm minimisation approaches should be incorporated into risk management and discharge procedures to enable adults at risk (and their informal support network) to work with practitioners on safety plans adopting a recovery concept model*

2. Hospital Discharge / Legal Frameworks



Hospital Discharge

- The discharge process was disjointed with poor information sharing between key agencies regarding his needs and risks. There were missed opportunities to use tools and processes under the legal framework of discharge. The panel considered the following key points regarding this issue:
    - Adult 28 was an inpatient in a mental health hospital under Section 3 of the Mental Health Act. Whilst he was considered for discharge under a Community Treatment Order (CTO) whilst an inpatient, ultimately this did not happen with no rationale within clinical records as to why. This would have provided a vehicle to recall back to inpatient if there were risks / issues on placement. The care home raised concerns in respect of this prior to the move and on his move to the provision.
    - Adult 28 was eligible for aftercare under Section 117. Whilst there was evidence of multi-disciplinary discharge meetings with both the provider and adult social care present whilst an inpatient, this was not undertaken under the Section 117 legal framework; risks could have been reflected in this documentation and resulting care plans.

- Whilst there was a 117 document completed by social care after discharge to the care home, this was in retrospect, and this was a single agency document not a partnership plan – the panel noted that going forward there is provision to establish robust 117 care plans that will capture all partner information (including known risks) in the local Section 117 Memorandum of Understanding which is being implemented.
- Adult 28 was discharged under Section 17 leave to the care home provider where he immediately absconded. There was also poor recording on adult social care records regarding his transition from ward to care home which explains the gap in social care input until the first abscondment from the provider and the raising of a safeguarding alert. Additionally, Section 117 Care Plans should ensure information is collated in one place for patients transitioning with onward risk.

- A better co-ordinated approach would have clarified the appropriate legal frameworks and responsibilities of agencies involved (relating to DoLS / CTO / Guardianship, and Powers to Return) and ensured the appropriate framework and risk management was in place prior to discharge. Whilst it's acknowledged these were subsequently put in place (following the second abscondment), addressing these known risks could have been improved.
- The understanding of Section 117 discharge being applicable is not consistent across services. Furthermore, the Section 117 process for Wigan Health and Social Care agencies is not agreed in policy, which results in a lack of clarity of responsibility and prevents the accountability of agencies to be upheld. The application of Section 117 aftercare is not consistent with discharge meetings and annual reviews not being routinely completed.
- There was no evidence of the use of advocacy. At discharge Adult 28 was un-befriended and so legally should have been appointed an advocate whilst an inpatient (this was addressed by the allocated social worker following the first period of absconding from the home regarding contact with family)

Making a difference:

5>Develop and implement a Wigan S117 Memorandum of understanding between GMMH and Adult Social Care to establish robust aftercare arrangements for patients.

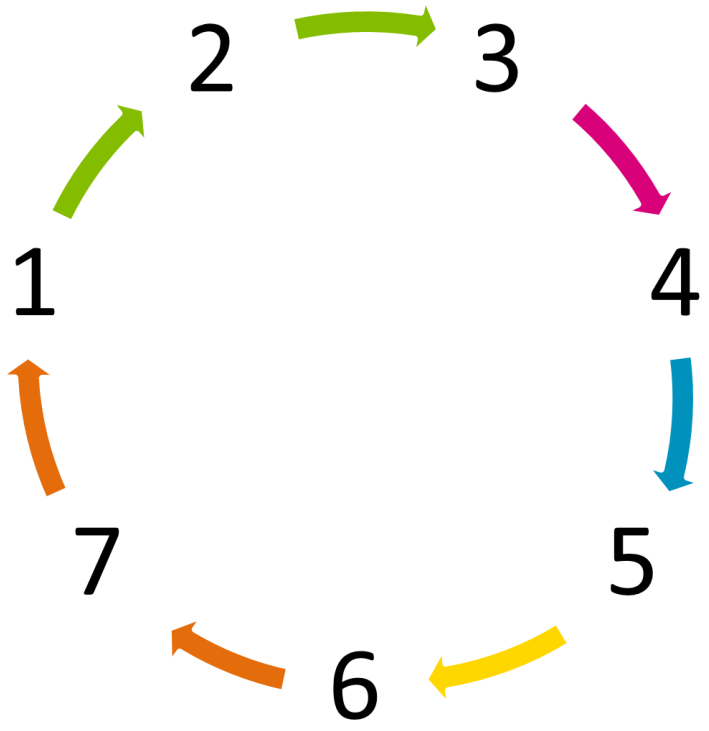
6> Learning and Quality Assurance Delivery Group to develop, undertake and report on a S117 effectiveness audit incorporating a measure of co-production and recovery based practice.

7> Implement Wigan Adult Social Care transformation plans ensuring that hospital social workers retain cases at discharge from mental health acute settings into community to the point of (and including) the first review, ensuring continuity of care across the initial period of transfer. (Keep as action update - Social workers now retain cases for 6 weeks post discharge from all hospital settings and to assist the provider and service user with settling in new settings (dependent on S117 in place).

8> Wigan Safeguarding Adults Board oversight of Advocacy key performance indicators regarding appropriate and timely offer of Independent Mental Health Advocates in acute settings.

9> Implement changes that improve the capture and use of key information regarding patients detained under the Mental Health Act and who require social care support within Mosaic the social care case management system.

3. DoLS



Adult 28was transferred from acute mental health services to a Care Home that provided secure mental health care and support.

The care home requested a 7-day urgent DoLS extension from the local authority in respect of Adult 28.

This form also automatically puts the need for a DOL authorisation into a waiting list in order to receive a "standard" authorisation. The urgent referral was received and held in the priority work tray for the DoLS team, however it was never allocated due to team resources and backlogs at the time. This resulted in Adult 28 not being subject to an authorisation on the third abscondment.

It is unknown if Adult 28 had capacity, and specifically capacity in relation to the risks of absconding, because no capacity assessment took place at discharge from acute mental health services (due to discharge taking place whilst Adult 28 was absconding whilst on Section 17 leave) and no capacity assessment took place for the DoL authorisation (due to being overdue).

Because of this, executive functioning capacity was not considered – this was particularly relevant to Adult 28 as it is known that drug and alcohol misuse can affect a person's executive functioning capacity to plan ahead and meet goals, display self-control with obvious links to increased risk factors linked to decision making.

Adult 28 absconding from the care home could have been considered as it not being his wishes to reside there, emphasising the requirement for mental capacity assessment, DoL authorisation/ assessment, and advocacy.

Making a difference:

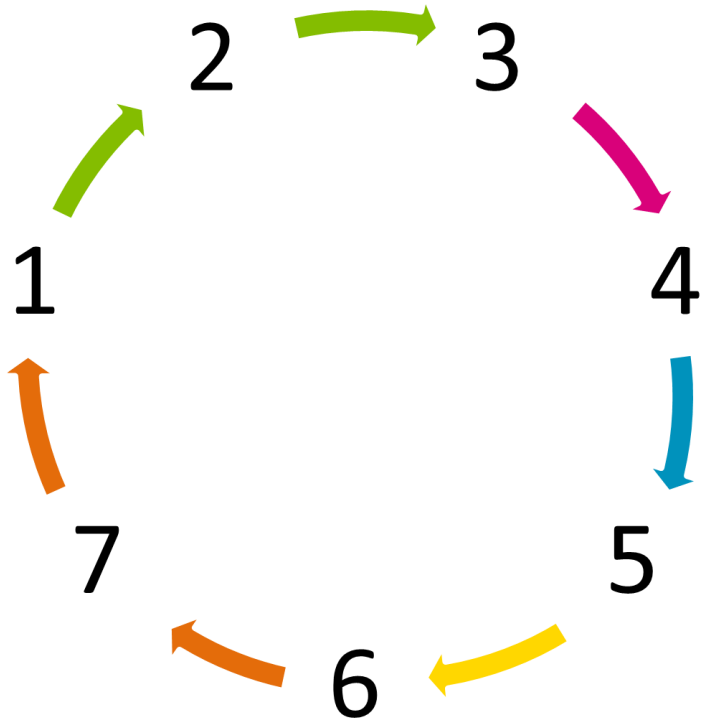
10> The DoLS Team in the Local Authority should implement a new triage process to mitigate risk in the system during timeframes awaiting a DoL authorisation:

- *Referrals are triaged at point of receipt and prioritised following the ADASS screening tool*
- *DoLS referral Form 1 to be updated to capture a wider checklist of risks (including un-befriended, attempts to leave etc.)*
- *Additional Advanced Practitioner Social Worker resource to be recruited to the DoLS Team*
- *The backlog of referrals should be screened and prioritised accordingly*
- *A project team of 5 Best Interest Assessors (BIAs) should be allocated to reduce the backlog of referrals*
- *The DoLS Team should be alerted to any Safeguarding referrals received for an individual referred for assessment*
- *There should be weekly and monthly performance reporting for oversight and management of timescales and activity*
- *The process should be able to demonstrate Improved communications with referrers to gain more information for the DoLS Team and provide timescales to the referrer, this should include information from Best Interest Assessors (which in this case had a Section 117 process taken place would have had this assessment to draw on for information)*

11> Wigan Safeguarding Adults Board should have oversight of DoLS key performance indicators

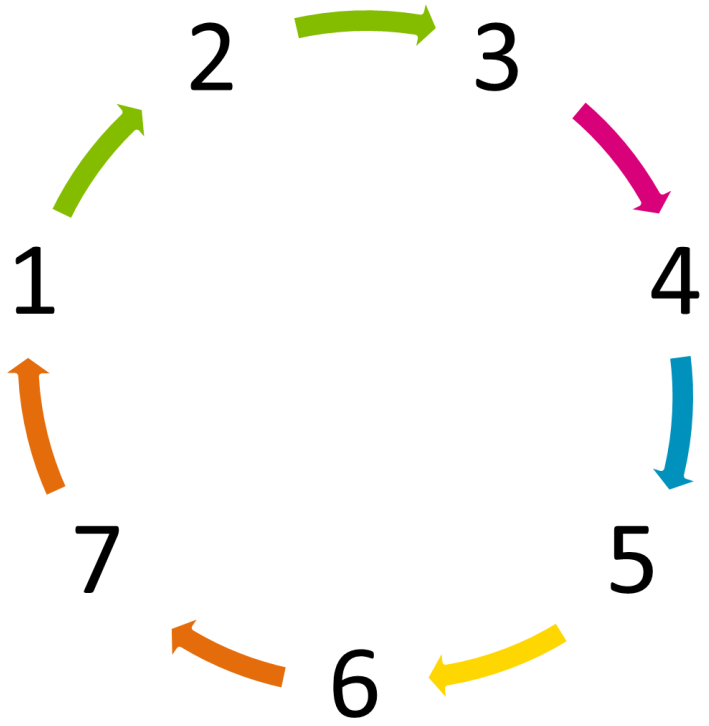
12> Wigan Safeguarding Adults Board should have oversight and assurance regarding improved and robust use of Mental Capacity Assessments (within hospital discharges regarding mental health acute settings to community and the appropriate legal frameworks.

Practitioner questions to consider



1. *Are you confident in the legal literacy of the Mental Capacity Act?*
2. *Have you considered referral to advocacy (and at the earliest point of contact)?*
3. *Does your organisation have effective support mechanisms in place for employees well-being that extends to agency staff?*
4. *Are you aware of the risks of caffeinated energy drinks on medications?*
5. *Have you considered a person's drug addiction within care plans for mental health recovery?*
6. *Have you made a referral to WithYou (drug and alcohol services) for individuals who require support, allowing the service to make attempts to engage the individual? CONSENT?*

Want to learn more?



Case Law:

A Primary Care Trust v LDV & Ors | [2013] EWHC 272 (Fam) | England and Wales High Court (Family Division) | Judgment | Law | CaseMine

Evidence Led Practice:

https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/

Further information:

Danger: Don't mix these 8 meds with coffee - MDLinx

SCIE Training

E-Learning - MCA: Mental Capacity Act (MCA): e-Learning course | SCIE

WSAB Training:

WSAB Training Brochure 2021 (wigan.gov.uk)