Wolverhampton Safeguarding Adult Board

Safeguarding Adult Review (SAR)

ADULT C

Overview Report

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Presented to Wolverhampton Safeguarding Adult Board (WSAB) 10 October 2018

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1. Introduction and Circumstances Leading to the Review

1.1. The following information formed the basis of what was known at the commencement of the review process. During the review, it became apparent that some of these details were not accurate. The inaccurate elements are identified within this report.

1.2. Adult C was 39 years old and admitted to a Hospital Trust following an epileptic fit. Adult C suffered from severe epilepsy and schizophrenia. Adult C wore a helmet to prevent head injuries should there be a seizure and was cared for at home by next of kin (Partner) and a dog trained to place Adult C in the recovery position in case of a seizure. Adult C's main carer i.e. the Partner was also in hospital at this time undergoing surgery. At the time of admission, Adult C expressed many concerns of not being able to cope at home alone whilst the Partner was in hospital. Adult C referred to command hallucinations of a suicide nature. Adult C underwent various assessments and was discharged home. The day following discharge Adult C took an overdose, called The Mental Health NHS Trust to report this and advised that ambulance staff would not be let in when they called. There was significant delay in ambulance staff requesting Police attendance. When ambulance staff gained entry, they attempted resuscitation without success and Adult C died.

2. Methodology

2.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR). Full details related to the Terms of Reference for this SAR can be found in Appendix 1.

2.2. The Care Act 2014 Statutory Guidance states that the process for undertaking SAR should be determined locally according to the specific circumstances of individual cases.

2.3. Agencies involved in the care of Adult C (See Appendix 1) provided Agency Review Reports to provide information and analysis of their own individual agency practice in respect of the care they delivered to Adult C.

2.4. Practitioners and their line managers, report authors and safeguarding leads came together for a Learning and Reflection Workshop. Attendees at the Learning and Reflection Workshop had an opportunity to review the written material prior to and during the workshop. In line with Care Act statutory guidance, the Learning and Reflection Workshop ensured full engagement from agencies who had provided care to Adult C and attempted to understand the systems that practitioners were working within to understand why practitioners practiced in the way that they did and how they made decisions. The Learning and Reflection Workshop gave opportunities to understand how agencies worked together to identify effectiveness of multiagency working. Areas for learning and improvement were identified in collaboration with the attendees at the Learning and Reflection Workshop leading to recommendations where appropriate.

3. The Reviewer

3.1. Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in Safeguarding roles in the NHS for a number of years and is completely independent of WSAB and its Partner agencies.

4. Process and Scope

4.1. Full terms of reference and project plan were agreed on 21.03.2018 and are included in Appendix 1. It was agreed that the scope of the review would take account of agency involvement from the period six months prior to admission until the date of death.

4.2. Agencies who provided information and were involved in this review are included within the Terms of Reference in Appendix 1.

5. Family Engagement

5.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. The author made contact, via a suitable professional, with Adult C's Partner. The Partner told the author something of the issues as they were seen from the partner's perspective. These are included within the report where appropriate.

6. Background Prior to Scoping Period

6.1. Adult C lived with a Partner in a bungalow rented from The Housing Agency. The bungalow had been adapted for their needs following their move four months prior to the scoping period. The Partner confirmed that they had met in a pub and had been together for 18 years.

6.2. Adult C had been known to the Mental Health NHS Trust for a number of years. Adult C had been diagnosed with a personality disorder following assessment for hallucinations and possible psychosis. It is of note that Adult C preferred to refer to the diagnosis as one of schizophrenia. This issue will form part of the analysis later within this report.

6.3. Adult C also had a diagnosis of epilepsy and was under the care of a neurologist at the Hospital NHS Trust. It was understood that there was an assistance dog that was trained to put Adult C in the recovery position should a seizure happen. This is discussed later in the analysis.

6.4. Adult C referred to the Partner as carer to all the professionals, informing them of a dependency on Partner for support. It is understood that Adult C's Partner also had some physical and mental health issues but without consent, this review has not looked at the records of the Partner. It is therefore only where this may have impacted on Adult C, that this review references this issue.

6.5. Adult C had been known to other services of the Local Authority. Adult C was known to The Independent Living Service who provided occupational therapy services to assess the need for supportive equipment. It was known that Adult C used a wheelchair on occasions. Adult C was also known to the Telecare Service who provided falls sensors in case of epileptic seizures. Initially these alerted Adult C's Partner and more latterly were connected to a 24-hour monitoring and alert service.

6.6. It was reported that Adult C had a good insight into diagnoses and maintained full mental capacity to make decisions regarding care and treatment throughout the scope of this review. Adult C was always able to articulate needs and concerns and continued to so this throughout the period covered by this review.

7. Key Phases

7.1. For the purposes of this review Adult C's story during the scoping period will be highlighted using relevant information in key phases that inform the areas for analysis in section eight of this report.

7.2. This review has identified that mental health support services were offered by both the Local Authority and the Mental Health NHS Trust. The table below provides and overview of which services were provided by which organisation:

Local Authority	Mental Health NHS Trust
Mental Health Social Work Team and Manager/Duty Manager	Complex Care Team (Operates during normal working hours)
Mental Health Outreach Team	Crisis Resolution & Home Treatment Team (CRHT)(offers access out of hours to patients known to other teams)
Emergency Duty Team (not just for Mental Health)	Psychiatric Liaison Team (based at The Hospital Trust) to assess patients in the Acute Hospital NHS Trust.
Hospital Social Work Team (based at The Hospital Trust- Generic Team not just for Mental Health)	

Key Phase 1: Pre-first admission of Adult C's Partner to hospital (6 months)

7.3. Adult C's main contact with services in this phase was related to mental health needs. Adult C was under the care of the Complex Care Service[1] of the Mental Health NHS Trust as a non-CPA[2] patient, as it was identified that the criteria for CPA was not met. Adult C's main care was provided via outpatient appointments with a consultant psychiatrist. Along with the guiding principles for person centred care[3], Adult C had a care plan with planned reviews. Adult C's care plans were shared with

[1] Complex Care Service - This service provides community support to people in the locality with severe and enduring mental health problems such as schizophrenia and bipolar disorder.

[2] The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx.

[3] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care#guidance Accessed 23 May 2018

Health Innovation Network What is person-centred care and why is it important? https://healthinnovationnetwork.com/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf Accessed 23 May 2018

2014 Health Foundation. Person-centred care made simple What everyone should know about person-centred care

the GP.

7.4. During this phase, Adult C was seen on two occasions and made telephone contact on three occasions. The consultations were to review Adult C's care plans and medication. One of these appointments was brought forward because of a request for more urgent review from Adult C and the GP. It appears that Adult C often questioned medication and asked for changes. This was also true in contacts Adult C had with the GP practice in this phase.

7.5. One appointment was a home visit as Adult C had not been able to attend outpatients. The consultant with whom Adult C had a good relationship moved to a new catchment area. This led to Adult C requesting a change of consultant; this could not be facilitated. An offer of transport to attend future appointments was accepted by Adult C. Towards the end of this phase, Adult C was referred to the Well Being Service for psychological support. This had been previously declined but now Adult C had agreed to this support. There was a waiting list for this service.

7.6. A GP visited Adult C to give a flu vaccination and noted that Adult C stated that the epilepsy was poorly controlled and that there were 6-8 seizures a day being experienced. Adult C had also informed the Complex Care Service of this level of seizure activity.

7.7. Towards the end of this phase there is an indication that Adult C was feeling increasingly stressed. Adult C contacted the GP requesting a medication increase and a referral for anger management. This referral was made the same day but Adult C died before an appointment could be arranged. On checking with the Complex Care Service, Adult C's request for an increase in medication was declined.

7.8. The following day, Adult C contacted the GP out of hours' service. Adult C informed them that the underlying diagnosis was bi-polar disorder/personality disorder, Adult C stated feeling drained and stressed and that this was impacting on mental health. Adult C stated that a GP had been out in the early hours of the morning. The GP practice had no record of this. Later that day Adult C called the GP practice informing them of several fits overnight. Adult C had been in touch with the Complex Care Service. The GP contacted the Complex Care Service. As a result of this and Adult C's contact, the appointment was brought forward (as described in 7.3 above).

7.9. GP records show that in this phase, a carer identification form was completed by Adult C confirming that Adult C was the Partner's carer. No other professionals recorded that Adult C was the Partner's carer.

7.10. The Telecare Service received several calls in this phase with concerns that equipment was not working correctly. On each occasion the Telecare service responded in a timely manner to reassure Adult C and correct any issues.

https://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf Accessed 23 May 2018

7.11. The Occupational Therapist from the Independent Living service was also attempting to contact Adult C to review needs and ensure that all was well. Adult C died before contact could be made.

7.12. On the final day of this phase, Adult C contacted the Complex Care Service to inform them that the Partner had gone into respite. Adult C stated that being alone would mean an inability to cope without additional support. Further checks during this review suggest that Adult C's Partner was taken to hospital by ambulance and was seen in the Urgent Care Centre; the Partner was not admitted nor in respite.

7.13. The duty community psychiatric nurse within the complex Care Team made an urgent referral to the mental health social work team of the local authority for social support. It was recorded that a referral was also made to a third sector organisation who support people with mental health issues.

Key Phase 2: First Admission of Adult C's Partner – day before admission of Adult C (17 Days)

7.14. It is of note that this phase covered an extended bank holiday period when routine services were not open; emergency and crisis services were covering mental health and social care as is usual out of normal office hours.

7.15. The referral to mental health social work team was loaded onto the social care database the next day. The information in the referral indicated that Adult C had Bi-polar disorder, psychosis, epilepsy, and an emotionally unstable personality disorder. The referral also stated Adult C was a wheelchair user, was catheterised and without a carer due to the hospitalisation of the Partner. The referral was not authorised by a manager in the social work mental health team until ten days later.

7.16. Eight days after the initial referral, Adult C telephoned the mental health social work team to ascertain when a social worker would be allocated. Adult C furnished the duty social worker with more information about needs, stating that help and support with meal preparation, food shopping and going out of the bungalow was needed. Adult C informed the social worker that the Partner was now home from hospital. Adult C's Partner now had needs and could no longer offer Adult C the support that Adult C needed. The duty social worker contacted the Complex Care Service and added more information to the referral which included the need for a carer's assessment.

7.17. Due to misunderstandings and errors in Adult Social Care, the referral was sent to the Physical and Sensory Disability Team by the Mental Health Team Duty Manager. The bank holiday period then followed so it was not until four days later that the referral was sent back to the mental health team for allocation. It was a further six days (and within the next phase) before the case was allocated to a student social worker who was going to be supported by a manager. During this time, Adult C phoned on numerous occasions seeking confirmation of when a social worker would be allocated.

7.18. Adult C made a self-referral to the Meals on Wheels service of the local authority. The daily delivery consisted of a hot meal for lunchtime and an afternoon tea.

7.19. Over the bank holiday period, Adult C contacted the Adult Social Care Emergency Duty Team to inform them that the Partner had again been admitted to hospital. Adult C stated that additional

support may be required if the Partner remained in hospital. The duty worker agreed to call Adult C the following day to see how things were.

7.20. When a duty worker made contact the following day it was agreed that Adult C was struggling and would be a benefit from a safe and well check by a mental health outreach worker. The mental health outreach team visited Adult C for the next three days until services were open again. They undertook some tasks to support Adult C which included visiting Adult C's Partner to drop off medication and to collect a garage key. Adult C was reminded that there was also support for mental health by using the Mental Health NHS Trust CRHT.

7.21. On the final day of these visits, Adult C informed the duty worker that the Partner was due to be discharged that day. Adult C's Partner had been in hospital a total of 4 days. Adult C phoned the ward on several occasions asking when the Partner would be discharged.

7.22. During this period, Adult C made numerous calls to the CRHT in the Mental Health NHS Trust. Adult C was concerned for the wellbeing of both Adult C and the Partner. Adult C stated the Partner was unwell leading to anxiety about this. Adult C indicated the struggle to get support for the Partner's ill health and that this was adding to the feeling of stress. This resulted in a telephone call by the duty psychiatric nurse to the social work team to expedite the social work assessment.

Key Phase 3: Admission of Adult C to hospital – Death of Adult C (3 days)

7.23. This key phase covers the three days leading up to Adult C's death.

7.24. Adult C's Partner was taken via ambulance to the Hospital NHS Trust Emergency Department for a physical health condition. Just over one hour later, Adult C called an ambulance. Adult C stated that a seizure had happened and that the Partner had been admitted to hospital earlier. Adult C informed the ambulance service that the Partner was Adult C's carer. Adult C indicated an inability to cope at home without a carer. Adult C stated hearing voices telling Adult C to commit suicide.

7.25. Adult C had also called the Mental Health CRHT at roughly the same time as the call to ambulance, telling them that being at home on alone was not possible. The duty worker discussed coping strategies with Adult C. This information was not shared with the Complex Care Service.

7.26. Whilst in the Emergency Department it was agreed that Adult C could not go home until an assessment by the Psychiatric Liaison Team of the Mental Health NHS Trust. Adult C was assessed by the hospital doctor with the Partner present who was already a patient in the Emergency Department.

7.27. Assessment was undertaken by Psychiatric Liaison Team and agreed that it was the lack of carer input and social needs that were impacting on Adult C's mental health. A recommendation was made for an onward referral to the hospital social work team for assessment. This was duly completed by the Emergency Department staff.

7.28. Adult C was then transferred to the Clinical Decision Unit in the hospital overnight to await social work assessment. Adult C's Partner was admitted to the same unit an hour and fifteen minutes later. There is nothing within the hospital records for the Clinical Decision Unit that recognised Adult C and the Partner as a couple.

7.29. The next morning both Adult C and the Partner were seen by two hospital social workers. The couple were seen together and then individually. The outcome of this assessment was that Adult C did not have an eligible need for care and support. Adult C was fully mobile and able to meet personal care needs. The hospital social work team contacted the mental health social work team manager. It was a belief at the time, that as Adult C had seen the Psychiatric Liaison Team earlier, there was no pressing need for Adult C to be seen that afternoon. It was identified that a social worker was to be allocated and that Adult C would receive contact to be seen later that week. Adult C was insistent that there was a need to get home to care for the dogs who had been left alone all night. At that point, Adult C did not know that the Partner would not be going home.

7.30. Transport was arranged and Adult C was discharged that afternoon. The Partner remained on the Clinical Decision Unit. Adult C's Partner was seen separately by one of the social workers. The Partner disclosed a fear about going home as the Partner could not cope any longer with the level of care that Adult C stated was needed. The Partner stated that Adult C shouted at the Partner. The Partner informed the social worker that the level of hoarding of memorabilia by Adult C had led to the Partner having to sleep on the sofa as there was no access to the bedroom that the Partner slept in. It was assessed that Adult C's Partner needed a further period of assessment and would be eligible for a seven-day bed. This was to allow the Partner to consider next options. The Partner declined to consider safeguarding support regarding the disclosure.

7.31. Adult C's Partner was discharged to an 'up to seven-day bed'[4] in a nursing home much later that evening.

7.32. Coincidentally, allocation to the student social worker happened on that day. However, it would be a further 4 weeks before assessment could be undertaken. Adult C's care was therefore handed back to the mental health social work duty team.

7.33. The next day was the day that Adult C died and the events that unfolded are summarised but timed to aid analysis and learning.

7.34. **9.51 am** the student social worker had spoken to Adult C on the telephone to make an appointment to commence the assessment. Adult C expressed concern that the Partner who was Adult C's carer had been taken into a care home and would be there for another week or possibly longer. Adult C listed problems that mental health was taking a dive, felt depressed, felt suicidal and was hearing voices indicating harm to self and others. Adult C stated that an inability to shower without the Partner there in case of a fall. Adult C said meals on wheels were not suitable and Adult C did not

[4] seven day beds are an initiative to provide care home beds for up to seven days to those not ready for discharge where an acute hospital bed is not needed.

have the ability to cook. Adult C stated an inability to manage the dogs and they had trashed the house when Adult C was not at home.

7.35. **11.06am** the Mental Health Duty Officer rang Adult C, there was no answer.

7.36. Mental Health Duty Officer telephoned the Mental Health CRHT regarding the current situation. Both teams had received several calls from Adult C indicating distress and suicidal thoughts over the last few days. It was agreed that Adult C's medication needed reviewing as a priority. The Mental Health Duty Officer then referred to the Mental Health Outreach Team for support until the social work assessment could be carried out.

7.37. At some point in the next 20 minutes, the Mental Health duty officer spoke to Adult C but there was no indication of expression of any thoughts of immediate self-harm. Adult C was given contacts for who could be called if there were any further suicidal thoughts. Adult C was expecting a visit that day but it was not clear who this was from.

7.38. **11:30hrs**: Adult C contacted the duty nurse at Complex Care Service to state an intention to take an overdose of all the medication. Adult C repeated to the Complex Care Service the inability to cope alone because the Partner was in respite. Adult C was informed that an ambulance would be called. Adult C stated that the door would not be answered to the ambulance crew.

7.39. **11:33** The Ambulance service received a 999 call from the Complex Care Service who stated Adult C had advised an overdose of medication had been taken.

7.40. **11:40** The ambulance crew arrived, Adult C was verbally abusive to the crew and declined to put the dogs away. The crew withdrew from the house and requested Police assistance.

7.41. **11:50** The Ambulance crew called for Police assistance.

7.42. **11:50hrs:** The ambulance service contacted the Complex Care Service to inform them of the situation. The ambulance crew were given more information regarding Adult C's diagnosis.

7.43. **11.52** Police received a call from Ambulance Service indicating assistance required and that Adult C was being abusive to ambulance crew and refusing to put the dogs away. The call was graded in such a way as to note that Police were required to attend.

7.44. **11.54** Police log indicated a proposal that the police sergeant allocated to the mental health triage team should liaise directly with officers at the scene; at that point, there was no officer on scene so this did not happen.

7.45. **11.58 & 12.16** Police note that no officers were available from the force support unit in the locality so requested assistance from another force support unit at **12.17**

7.46. **12.00pm** Adult C rang the mental health duty officer wanting to speak to the social worker, stating that an overdose of medication had been taken. Adult C stated feeling drowsy. Adult C's speech was

difficult to understand. The mental health duty officer stated that the call was going to be ended so that an ambulance could be called.

7.47. **12:12** 999 call received by the Ambulance Service from mental health duty social worker. The caller was not aware that there was already an ambulance at the house.

7.48. **11.45 – 12.15hrs** Meals on wheels delivered Adult C's meal as usual. Adult C answered the door and accepted the meal. The meals on wheels' delivery driver did not recognise that there was an ambulance at the house. The ambulance crew did not alert the situation to the meals on wheels driver.

7.49. **12.29** Police and Ambulance recorded a further request from Ambulance Service to Police seeking and estimated time of arrival. The Police were informed that Adult C was now sounding drowsy. The call was upgraded indicating that a faster response was required.

7.50. **12.31** Police force support unit asked for information regarding the dogs and if they were a known threat. The operator viewed previous incidents and noted that there was no reference to any dogs on previous attendances.

7.51. **12.39** Police were diverted from another incident to attend Adult C.

7.52. **12:41** Ambulance crew attempted to make a further evaluation of Adult C. There was no answer from door.

7.53. **12:42** Police and Ambulance recorded a further telephone call from the ambulance service to the Police chasing estimated time of arrival as Adult C was no longer answering the door.

7.54. **12:55:** Police arrived but unable to gain access as the 'keysafe' code was not known. It was noted that the dogs included a large dog and two other dogs that were growling. The ambulance crew attempted to contact Adult C by telephone; there was no answer. Police requested a dog handler. There was no dog unit available. Initial attempts to gain access failed.

7.55. **13.24** A Police sergeant attended the incident and requested a dog unit from another force. A request was also made for firearms support as it was likely that the dog unit was not going to be able to be at the incident very quickly given the distance, as it was there was no dog unit available.

7.56. **13.39** Officers tried alternative methods of entry using shields and captor spray. This took some time as it was not possible to identify which rooms the dogs were in as all the internal curtains were drawn. Firearms and dog units did arrive at the address but were no longer required.

7.57. **13:53** Entry gained to property. On entry into property Adult C found to be in respiratory arrest and then further deteriorated into cardiac arrest. Attempts at resuscitation were unsuccessful.

7.58. **14:34** Adult C's death was confirmed.

8. Thematic analysis

8.1. The analysis section focusses on areas where learning has occurred

Understanding the person, diagnosis and treatment

8.2. This section of analysis identifies the importance of ensuring that those working with a person understand their needs and presentation to offer the best service that they can in accordance with the ethos of person-centred care and the Equality Act (2010).

8.3. Adult C had been known to NHS Mental Health Services for many years. In the material that was gathered for this review, it has become apparent that the diagnosis of Adult C's mental health issues was not well understood and communicated to all those that were offering care and support. It is recorded by all agencies that Adult C had a diagnosis of epilepsy. It was also noted that Adult C had schizophrenia which in fact, was incorrect. Indeed, the original referral for Adult C's death to be considered for a SAR appears to have been based on incorrect information but was not challenged within the scoping period. This leads to the first point for learning.

> Learning Point 1: When Safeguarding boards are scoping cases that are referred for a SAR, it is crucial that factual accuracy is assessed. Agencies who hold information that may appear to contradict facts within a referral should update the board in order that decision making can be effective and terms of reference robust. Recommendation 1

8.4. The issue of impact and treatment for mental health diagnoses has been identified in a recent (yet unpublished) Children's Serious Case Review in a neighbouring authority. From that review, it has become apparent in discussions with mental health colleagues, that it is not unusual for initial symptoms suggestive of psychosis, to be assessed to identify whether they are due to schizophrenia. It is therefore sometimes the case that diagnosis may change following a period of assessment. In the case of Adult C, this was clearly so; the definitive diagnosis became one of personality disorder.

8.5. NICE guidance[5] in relation to personality disorder indicates that drug treatments should not widely be used to treat the personality disorder but that some drug therapy may be useful in treating associated conditions such as anxiety and depression.

8.6. Records within agencies indicate that Adult C was on many medications to treat symptoms of psychosis, anxiety, pain and epilepsy as well as medications for vitamin deficiencies and medication to manage side effects of medications. It appears that Adult C was repeatedly asking for medication to be increased both by the GP and the mental health team. It is not clear why this was. Records suggest that these requests were listened to and that there was communication between the GP and the Psychiatrist where appropriate. During mental health consultations, it is recorded that

[5] Borderline personality disorder: recognition and management Clinical Guideline Published: 28 January 2009 https://www.nice.org.uk/guidance/cg78/resources/borderline-personality-disorder-recognition-and-management-pdf-975635141317 accessed 17 May 2018

medication treatments were discussed with Adult C and there was a belief by some, that Adult C did understand the prescribed medication.

8.7. On this issue one consultant psychiatrist explained not being comfortable with the number of psychiatric medications that Adult C was taking. The consultant told the review that Adult C was very assertive but that Adult C probably did not fully appreciate the reasons and logic in context of the prescribed medications. The consultant felt that these medications were not achieving their desired objectives but that there was possibly some psychological satisfaction. This may go some way to explaining why there was a consistent challenge to medication. It is, however, reported that this is not an unusual scenario in mental health services. This situation did not lead to any further action, the consultant in question had only seen Adult C on one occasion. This is discussed further in Section 8.60. It is not recorded by any health agency that Adult C fully understood that the personality disorder would not improve with treatment.

8.8. The other interlinking factor related to medication was the prescribing of medication to control the epileptic seizures. At a GP home visit in key phase one, the notes indicate that Adult C's epilepsy is poorly controlled and that maximum medication is prescribed. The GP that undertook this visit no longer works at the practice. It is believed that this indicates Adult C's self-report to the GP of the level of seizures. This did not lead to any communication by the GP to the Neurologist.

8.9. Indeed, most of the care needs that Adult C's was reporting (discussed in the next section) were identified by Adult C as related to epilepsy. Albeit that there were letters to the GP following mental health consultations with copies to the neurologist, there was no active communication between the GP or the Mental Health Team and the neurologist. It is of note that the neurology department did offer an appointment based on the information that they read in these letters, but Adult C died before the appointment date.

8.10. It was identified at the workshop that psychosis symptoms can be linked to epilepsy and epilepsy medication. It is known that anti-psychotic medication can reduce the efficacy of anticonvulsant medication for epilepsy and this may increase the risk of seizures. The psychotic symptoms that Adult C experienced were not related to a mental disorder, but to the epilepsy and therefore the demands for treatment of 'hearing voices' would not benefit from antipsychotic drugs. This was explained to Adult C by the psychiatrist.

8.11. This is a complicated issue and although professionals reported that Adult C had good insight, it is not clear that Adult C really understood.

8.12. Adult C told professionals that 6-8 grand mal seizures a day were being experienced and that they were having a severe impact on life. Professionals were not able to identify that this level of seizure activity was factual. There were no 999 calls for assistance for seizures apart from on the final admission to hospital in key phase three. Discussions at the workshop would suggest that the level of grand mal seizure reporting would generally bring a person to the attention of emergency health services more often.

8.13. When in hospital in key phase three, Adult C told staff that several blackouts had been experienced whilst there. Staff did not witness any of these. Adult C's partner told the author that he saw Adult C have up to three seizures a day.

8.14. It has come to light in gathering information for this review that in fact Adult C's diagnosis of epilepsy had been questioned by the neurologist several years previously. A diagnosis of 'non-epileptic attack disorder'[6] was considered. This disorder may have been linked to the mental health issues or due to other organic causes. Adult C had been referred to and initially seen by a specialist neurologist and tests were commenced. Adult C declined further test appointments and defaulted appointments for repeat Electroencephalogram (EEG)[7]. The diagnosis update does not appear to have been pursued. Information was passed to the GP in a letter following this; Adult C's GP records do not show this question of diagnosis; this review has found that no other agency was aware of the question surrounding epilepsy diagnosis.

8.15. Communication was required to understand the level of seizure activity, its nature and impact. This is discussed below in 8.31-33 & 8.59.

8.16. Adult C is recorded as being a wheelchair user by many of the professionals who knew Adult C. Some recorded that Adult C had poor mobility. It was this poor mobility that led to home visits as it was believed that Adult C found it difficult to get to appointments. When this was discussed at the workshop it was agreed that Adult C did not have mobility problems. The reason for using a wheelchair was largely because of the fear of having a seizure when out and therefore the use of the wheelchair was to guard against falls. In fact, all the input from the Independent Living Service and the Telecare service was to ensure that Adult C felt safe and confident, should there be a fall from a seizure either at home or when out. This issue was also a large factor in the expressed need for care that is discussed in section 8.26-29.

8.17. The GP practice has found that a previous GP in another area had referred Adult C to the continence service several years earlier. The new practice continued to prescribe the incontinence device. It was assumed by the practice that the continence service would continue to monitor. The referral to Adult Social Care indicated that Adult C was catheterised. Records at the Hospital NHS Trust indicate that Adult C had told staff about the incontinence product that would need changing the following day, but this was not an indwelling catheter. Professionals at the workshops were asked if the incontinence worries could have been linked to fear of incontinent episodes during seizures in a similar way to the wheelchair was used to prevent falls during seizures. It was agreed that in the absence of any other evidence, this may well have been the case. No one appeared to question Adult C regarding this or offer further assessment or support. Adult C was not known to the continence service locally.

[6] Non-epileptic seizures (NES) or dissociative seizures are different from epilepsy as they have a different cause. Non-epileptic seizures (NES) are not caused by disrupted electrical activity in the brain and so are different from epilepsy. They can have a number of different causes. Non-epileptic seizures (NES) can be divided into two types: organic non-epileptic seizures and psychogenic seizures. https://www.epilepsysociety.org.uk/non-epileptic-seizures?gclid=EAIaIQobChMIh5ultvzN2wIVFZ7VCh01ZgbzEAAYASAAEgIOOvD_BwE#.Wx-n5DNKjJw Accessed 12 June 2018

[7] **Electroencephalogram (EEG)** is a recording of brain activity.

8.18. Despite this apparent mobility issue and a report of urinary incontinence in such a young person, alongside the reported high level of seizures, Adult C's physical healthcare did not receive the assessment, support and follow up that it might have done. There was not a clear picture within records that these issues were well understood or addressed.

8.19. Mental Health services do have access to a physical health care team for annual health checks for some patients. Adult C did not meet the criteria for this service and therefore was not subject to physical healthcare checks. The mental health team can refer patients to the GP if they are not able to access the physical health care service. This did not happen as it was not seen that Adult C had physical healthcare needs. It is not clear that there was an understanding of why Adult C used a wheelchair and suffered urinary incontinence. These issues were not followed up.

8.20. When the author talked about Adult C's physical healthcare needs with the Partner, it was not clear that the partner fully understood these but did say it was because of the fits.

8.21. It is not clear that those working with Adult C were able to put together the mental health diagnoses with a view to understanding the person and how Adult C might present in crisis and show distress. Adult C was described by all as being very able to articulate needs and to communicate and demand services. This is evident in Adult C's ability to access meals on wheels and to chase referrals and appointments and challenge medication. This appeared to lead to a reliance on self-referral and self-seeking of further support by some agencies; Mental health services had initially recorded that Adult C was referred to a third sector support agency, this turned out to be incorrect and in fact Adult C was given a leaflet to enable a self-referral. Adult C was also given information about meals on wheels' services and dog walker services whilst at the hospital.

8.22. This is generally good practice as it promotes self-reliance and self-determination for patients. There are times, however, when more support and direct referrals on behalf of a patient, provided consent is given, maybe what is required. It could be argued that, with an understanding of Adult C's rising stresses and worries that this may have been one of those times. It appears that the reason that Adult C was seen in this way was because of the level of functionality may have masked the real need and dependency that had been developed by Adult C.

8.23. Adult C had told professionals within the Mental Health NHS Trust and Adult Social Care that voices were often heard that these were linked to stress. Adult C said that the voices increased when anxiety and stress increased.

8.24. Adult C's calls to services increased in key phase two and three. Adult C was articulating the need for care and telling professionals about the voices indicating serious self-harm. Professionals did appear to recognise that this was a person with personality disorder who was in crisis. This should have led to a coordinated assessment and response that is discussed later.

Learning Point 2: When sending letters to consultants and GPs specific instructions as to what is expected on receipt of information may lead to a more proactive response. Recommendation 2

Learning Point 3: Formal referrals made to other services over the telephone are more robust if they are followed up in writing within a reasonable timescale. This ensures accurate transfer of information and a clear audit trail of the referral made. Recommendation 3

Learning Point 4: Understanding mental health diagnoses is key to understanding the person. Recommendation 2

Learning Point 5: Understanding the severity of physical healthcare conditions requires effective two-way communication between key clinicians. Recommendation 2

Learning Point 6: Promotion of self-reliance and self-determination may need to be set aside when a patient is experiencing increasing stress and crisis. Recommendation 2

Understanding need for care and carer needs

8.25. It was well documented in most agency records that Adult C's carer was the Partner. On completing a form for the GP practice, Adult C indicated being a carer for the Partner.

8.26. Adult C's Partner told the author that, at first, caring for Adult C was not difficult. As time went on though, caring for Adult C became increasingly difficult and the Partner stated that there needed to be more support for Adult C. This overall issue only seemed to have been acknowledged to professionals when the Partner went into hospital.

8.27. What was not clear was what Adult C's care needs related to. Some agencies believed that this may be help and support with personal care particularly in relation to the fact that Adult C was a wheelchair user. This issue led to the referral into Adult Social Care from the Mental Health Team, being sent to the Physical Disability Team. There was no recognition that it was possibly the mental health issues that were having the biggest impact.

8.28. During the review, it became apparent that it was the epilepsy that was Adult C's biggest concern. This led to the expressed need for care. The adaptations to the home and provision of equipment were focussed on Adult C's expressed need to keep safe in the event of a seizure.

8.29. It was also reported that Adult C had an assistance dog trained to put Adult C in the recovery position should there be a seizure. This was included within the referral for this review. It is now believed that this was a dog that Adult C had bought alongside the other dogs who had been trained

by Adult C. This was not a professionally trained assistance dog. It is of note that professionally trained assistance dogs for epilepsy do not put patients into the recovery position. They are trained to recognise early signs of seizures and lead a person to safety, retrieve the phone or access a person's lifeline pendant.

8.30. The fear of seizures appeared to become all-encompassing for Adult C. It led to a feeling of fear of being left alone, unable to leave the house unattended and becoming totally dependent on the Partner for tasks that Adult C considered risky if there was any seizure e.g. meal preparation, shopping, being present always etc.

8.31. Albeit therefore that this could be viewed as care for a physical health condition, it was the impact of the personality disorder on the day to day confidence of managing epilepsy that appeared to be the overriding factor in Adult C's expressed need for care.

8.32. There are several areas for consideration in this regard.

8.33. It is not clear exactly what the updated neurology view was regarding the level of seizure activity that Adult C was reporting and why there was no question posed to the neurologist as to further treatment and support options. Adult C was not referred to any specialist nursing services and it did not appear that there was very regular input from the neurologist. Given the number of reported seizures and the impact, it was difficult to understand why. It is noted in 8.14 that a neurologist had questioned the epilepsy diagnosis.

8.34. Reasons were given that professionals assumed that the neurologist would make contact if there were concerns. There was also a belief that as all mental health consultations resulted in a letter to the GP and copied to the neurologist, that if anyone had a concern then they would make contact. The author would argue that this is a dangerous assumption but one that is seen in reviews of this nature and leads to learning. It is not unusual for GPs to believe that being routinely written to following a consultant appointment as a courtesy and not one that requires any action on receipt, unless it is explicitly stated so.

8.35. Had there been active communication with the neurologist there may have been an understanding of level of seizure activity and the diagnosis question. This may also have led to a better understanding as to whether the reported number of seizures and level of care required was more to do with Adult C's mental health needs and understanding of these behaviours. It is acknowledged that an appointment had been arranged with the neurologist, however it was at the very end of the scoping period and Adult C died before the appointment date.

8.36. NICE Guidance[8] for epilepsy management indicates that all patients with an epilepsy diagnosis are offered a referral to a nurse specialist. It is also recommended that:

[8] NICE 2012 Epilepsies: diagnosis and management
https://www.nice.org.uk/guidance/cg137/resources/epilepsies-diagnosis-and-management-pdf-35109515407813

"All children, young people and adults with epilepsy should have a comprehensive care plan that is agreed between the person, family and/or carers where appropriate, and primary care and secondary care providers. This should include lifestyle issues as well as medical issues."

8.37. It is not apparent that the basis of Adult C's expressed need for care was understood. What this meant was that when Adult C's carer was no longer available to undertake care, the enormity of the implications for Adult C were not fully appreciated. The possible reasons for this are related to a lack of coordinated assessment and are discussed in the next section.

8.38. Notwithstanding what is stated above, when Adult C made contact to say that the Partner had gone into hospital, the duty nurse within the mental health team made a referral to Adult Social Care for an urgent assessment of care and support needs. This was responsive and led to Adult C becoming known to adult social care services. When this was received by Adult Social Care, it was not clear what the care and support needs were specifically related to and there was some incorrect information (i.e. that Adult C suffered from bipolar disorder). This referral did not lead to any urgent assessment. In fact, there were delays caused by the bank holiday, the referral being sent to an alternative team and an allocation to a student social worker who had no capacity to take on any work at that time.

8.39. This referral was made over the telephone and was not followed up in writing to confirm the details of what was specifically being referred and for what reason. There is no requirement for this type of referral to be followed up in writing. If it had been, it may have led to more accurate information being transferred in the referral and therefore leads to learning previously identified.

8.40. Adult C then spent the next few days constantly contacting both mental health services and Adult Social Care. These phone calls were all responded to and there is evidence of some very good proactive practice in Adult Social Care with various teams offering support and an unusual response by the Emergency Duty Team to ask the Mental Health Outreach Team to visit.

8.41. Whilst this was a very good response it did not lead to an understanding that this activity was indicative of rising stress levels and associated augmentation of the voices that Adult C reported to be hearing.

8.42. Whilst the Care and Support Statutory Guidance[9] gives details of how the Care Act should be implemented in relation to assessment of care and support needs, there is no defined timescale for this:
"An assessment should be carried out over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs."

8.43. It could be argued that the reasons that there was a delay in assessment was because the urgency of the needs were not understood and the fluctuation in those needs as Adult C's Partner was in an out

[9] Care and support statutory guidance **Updated 12 February 2018 available at** https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance Accessed 17 May 2018

of hospital were not recognised.

8.44. Adult C's Partner was well known by all to be Adult C's carer. It does not appear that anyone considered that the Partner may also have needs for care and support as a carer. It is acknowledged that a carers assessment was going to be part of the social work role following the referral for assessment of Adult C. No one, however, considered an earlier discussion with Adult C's Partner about whether there was support needed as a carer. This is particularly concerning given that the Partner was also a patient of the Mental Health Team and also had physical health care needs.

8.45. Whilst it could be argued that the Care Act places a duty on local authority to assess the needs of carers, it is reliant on partner agencies recognising carers and making appropriate referrals or giving details to allow self-referral if appropriate.

8.46. The GP in fact did record that it was felt that Adult C and the Partner were carers for each other. The GP believed that he was not able to refer for a carers assessment at that time but that they are now able to use a 'social prescription for referral'. This was a misunderstanding as GPs have always been able to refer. There has been a recent initiative whereby social workers have spent time in GP practices and will see patients that the GP believes would benefit from social care support and advice. It is believed that is the reason that the GP stated that they are now able to refer.

8.47. It is of note that on several occasions, Adult C referred to the fact that that the Partner had gone into respite. This is not evidenced in records as each time these were attendances to hospital and not any form of respite. It is not clear why Adult C referred to these occasions as 'respite' and professionals did not display any professional curiosity to understand what and why the Partner was in respite.

8.48. During the assessment by Hospital Social Workers Adult C's Partner disclosed feelings about being a carer. Adult C's Partner stated no longer being able to cope with the demands of Adult C. The Partner indicated not feeling safe to return home with Adult C. The Partner reported how Adult C's hoarding of memorabilia had now encroached on the bedroom used by the Partner forcing the Partner to sleep on the sofa. Adult C's Partner also indicated that Adult C shouted at the Partner constantly which could have been indicative of domestic abuse.

8.49. Adult C's Partner did not want to progress this disclosure along a safeguarding route but did accept offer of admission to an up to seven-day assessment bed whilst considering available options. This information differed from the information in the original referral for a SAR in that this admission was not for surgery.

8.50. It can be seen therefore that the outcome for the Partner was positive but left Adult C facing the biggest fear of being left alone.

8.51. Had there been an earlier carer's assessment the issues that the Partner was facing might have been known earlier. This could have led to more preventative action to address the relationship issues and identify any violence and abuse that was emerging before a crisis point was reached.

Learning Point 7: Clarity is required regarding the basis of care needs Recommendation 4

Learning Point 8: Carers Assessments should always be offered to those who are in identified caring roles. Offers that lead to refusals should be documented. Further offers should be made. Recommendation 4

Learning Point 9: All professionals have a responsibility to offer a referral for Carers Assessments Recommendation 4

Learning Point 10: NICE Guidance provides important best practice information Recommendation 5

Coordinated, person centred assessment

8.52. In order to offer analysis of what may have made a difference to Adult C and the Partner and taking into account analysis in the previous sections brings the consideration of assessment.

8.53. In both health and social care providers there is a requirement to ensure that delivery of services to be person centred. The Care Act also identifies the need for any care and support assessment to be person centred. This means that the person should be at the heart of assessment, planning and intervention. It requires that services should be cognisant of what is important to the person from their perspective. Therefore, it is important to understand the person as identified in Section 8.2-23 above.

8.54. Adult C did not meet the criteria for CPA so although Adult C did have a care plan that was shared with the GP, it did not cover all the areas that a full CPA care plan would have done. The Mental Health NHS Trust have indicated that the risk assessment tool that should have been completed during out patients' appointments and updated as required was not done and a single agency recommendation has been made regarding this.

8.55. Adult C did not benefit from a Care Coordinator (as required by CPA) within the mental health team and remained under routine outpatient review. This review has not found that Adult C should have been subject to CPA throughout the scope of this review. It is however, a consideration that at the point where Adult C's distress was increasing that CPA should have been considered. CPA eligibility criteria include the following:

- are at risk of suicide, self-harm,
- have a severe mental disorder including personality disorder
- non-concordance with treatment plan
- are vulnerable
- rely on a carer, or are a carer
- physical health problems

Other reasons for requirement of CPA can be if there needs to be a coordinating role where there are several agencies involved.

8.56. If Adult C's eligibility for CPA had been reviewed this would have led to a more coordinated approach and it would have been clear who was coordinating care. If Adult C's needs had been fully understood it would have been noted that needs were escalating and that the criteria for CPA was now met.

8.57. A review of CPA status could have led to a multi-agency review and would have led to a framework for coordinating all assessments and information sharing. It may have also led to expediting the social care assessment.

8.58. The Mental Health NHS Trust has indicated that the review of CPA status did not happen because it was not seen that Adult C met the eligibility criteria within their policy and that the needs escalated quite rapidly. The Mental Health NHS Trust is currently reviewing the CPA Policy. It has made a single agency recommendation to ensure appropriate review of CPA status from Non-CPA to CPA at times of increased need.

8.59. On referral for assessment of care and support needs to Adult Social Care, there was limited clarity of what the issues were. The referral was not followed up in writing and led to wrong information being recorded. Some of this impacted on the timeliness of the allocation and assessment. Adult Social Care should be able to respond to urgent need. For the reasons stated previously, this urgent referral did not result in a crisis response. In the end the referral did not result in an assessment before Adult C died.

8.60. It is of note however, that many services were responding to Adult C's calls for help and many of these responses are recorded as good practice in Section 9. It was a feature though, that all of these services were working in isolation and there was not a coordinated response. Had Adult Social Care had resources and information to lead to an earlier assessment or Adult C been subject to CPA, the coordination and understanding of Adult C and the care needs may have led to a more effective response.

8.61. A third layer of assessment and coordinated care could have been through the Epilepsy Care Plan. Despite the level of seizures that Adult C reported, the neurology team did not have a large involvement. Had there been more attempt by others to proactively involve the neurology team, an Epilepsy Care Plan would have been shared with others involved in Adult C's care and may have led to a better understanding of the epilepsy management. This was especially important given that the stated care needs were because of the epilepsy.

8.62. It is of note that one consultant had questioned the efficacy and interactions of all the medication that Adult C was prescribed. The author would argue that use of an epilepsy care plan, CPA care plan or alternative joined up assessment and coordination may have led to a review of the polypharmacy issues. There may have been opportunities to seek clarification from the prescribers regarding medication. There is no record of either the pharmacist attached to the GP practice or the dispensing pharmacist questioning the level of medication. A coordinated approach could have also

provided an opportunity to set out for Adult C what each medication was for and why adding more medications would not be beneficial.

8.63. The fact that none of these assessments and care plans were in place was not picked up by management oversight or supervision and was not challenged or escalated. Care was delivered as a response to crisis rather than as part of a coordinated assessment and care plan. These would have needed to incorporate how Adult C might respond in a crisis and times of stress and what responses were best able to meet needs.

8.64. Learning from SARs nationally[10, 11] has identified similar themes regarding communication and coordinated assessments. These reports identify that work is often undertaken on 'multiple parallel lines' with no identified key worker/coordinating role and no multidisciplinary forum to bring all professionals together. In this case, there were possibilities to use a coordinated multidisciplinary approach as discussed above, but these were not utilised for the reasons stated.

8.65. The SAR Learning documents [IBID] as well as a recent Learning Lessons Briefing locally, also identify many recommendations made to support multiagency pathways or forums to bring agencies together in complex cases where there is no other identifiable alternative process. This is a debate within many Safeguarding Adult Boards that the author is aware of. Those who work across adult and children's safeguarding services often liken this to being able to offer 'Early Help' in children's services for families where concerns fall below the threshold of children's social care intervention.

8.66. It is noteworthy that there is a piece of work underway by the Safeguarding Adult Board partners to develop a pathway for communication and coordination where a case falls below the safeguarding threshold. It is proposed that in cases where there are increased vulnerabilities and a person is often in crisis, that a multi-agency coordinated response will be utilised. Notwithstanding the quoted mechanisms that could have been applied, this case is further evidence that such a pathway is required when other frameworks may not be applicable.

8.67. Other issues found in the above reports identify how the absence of shared records leads to difficulties in information sharing. Whilst in this case there was some shared records in mental health services, it was not possible for all professionals to see each other's records and led to delays in communication and miscommunication of Adult C's needs.

8.68. It is pleasing to note that there is a project currently underway locally to deliver a shared record across various health and social care providers. This will allow access for clinicians to view integrated digital care records via a clinical portal. As this develops it will be possible to share assessments, care plans in current interventions in other agencies. This positive step could provide a vehicle to shared care plans in complex cases.

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[10] Braye, S. & Preston-Shoot, M. (2017) **Learning from SARs: A report for the London Safeguarding Adults Board**

[11] Preston-Shoot, M. (2017) **What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews. A report for south west region safeguarding adults boards**

8.69. The Mental Health NHS Trust are also planning to ensure that there is a shared electronic record across all its services and has made a single agency recommendation to ensure that the Safeguarding Adult Board receive updates on this issue.

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> Learning Point 11: A review of circumstances may lead to a change to CPA status; CPA aids communication and coordination in complex cases. Single Agency Recommendation.
>
> Learning Point 12: Exploring and utilising mechanisms for multidisciplinary communication of care assessment, planning and delivery provides individualised safe and effective care Recommendation 2,5,6 & 7
>
> Learning Point 13: Shared records and access to information held by other agencies can aid communication and coordination Recommendation 6.

Emergency Response

8.70. The final section of analysis spends some time considering the responses on the final day to identify learning. The events that unfolded link to learning in other sections above but it is pertinent to discuss these in the context of the response on the final day of Adult C's life.
The original referral for a SAR indicated that ambulance staff did not call for Police assistance in a timely manner. It is now known that was not the case.

8.71. There was a time lapse of two hours 13 minutes from the time that the ambulance crew arrived until the time that they were able to gain access to treat Adult C. For this reason, it is important to analyse why this was the case and identify any specific learning.

8.72. Between the first call to Adult C at 9.51 and 11.06, there was activity to identify if Adult C had thoughts of immediate self-harm. At this point it was identified that this was not a concern.

8.73. As soon as Adult C indicated that an intention to take an overdose, a call was made immediately for ambulance support. The ambulance arrived 7 minutes after the call. The ambulance crew could not gain access so called for Police assistance.

8.74. The Police grading for the call was based on the fact that assistance was required but that this was not an immediate danger to life. This grading was questioned by the review. The police knew Adult C had taken an overdose of medication but was answering the door and talking to the ambulance crew. Adult C was also talking on the phone to others so the need for immediate assistance was not obvious to the Police. Mental Health colleagues involved in this review, argued that the immediate risk to life could not be ascertained at that point as it was not clear how long it would be from taking medication to collapse and death; it was not known what and how much medication had been taken.

8.75. The initial call made by the Complex Care Team to the ambulance service had not contained very much detail of Adult C's diagnosis or that this was out of character behaviour for Adult C.

8.76. When the ambulance service could not gain access, they contacted the Complex Care Team and explained the situation. At this point, the Complex Care Team gave the ambulance crew more information about Adult C and that this was a new presentation and out of character (i.e the verbal abuse and aggression as well as attempts at suicide). This information was not transferred to the Police. Police indicated that even if this information had been known, it would not have made a difference to their response grading at that point. Mental health practitioners involved in the review indicated that, this is indeed an issue of greater concern and 'out of character' self-harm behaviours of this nature should heighten concern. This is analysed further in 8.83-8.85.

8.77. The ambulance crew noted that the meals on wheels' driver made a routine delivery to Adult C, who answered the door and accepted the meal. The ambulance crew did not make contact with the driver to support any access to the property. Despite the ambulance being parked outside the property, the meals on wheels driver did not know the situation and left not noting anything unusual. The ambulance crew could have alerted the meals on wheels driver to the situation as the property was approached. The ambulance service has indicated that they had tried several times and Adult C had made it clear that access was being denied. In such a situation, they needed to await the police as it was not safe for them to enter.

8.78. By 12.12 the ambulance service was informed that Adult C had confirmed an overdose and that speech was slurred and difficult to understand. When the ambulance retried to gain access, there was no response. Police were again called and upgraded their response.

8.79. Ambulance staff tried again to access Adult C and could not get a response and called the Police again.

8.80. The single officer on the scene then assessed the situation. It was identified that there were four dogs behaving aggressively, the curtains were all closed making it difficult to locate the room that Adult C was in. In line with policy, a request was then made to dispatch dog and firearms resources following this assessed the need. Due to dog units being a finite resource, it was not possible to identify a dog unit that was free to attend immediately.

8.81. The Police have explained, that in the event of having to deal with four aggressive dogs simultaneously, it would have required more than one dog handler and this would have taken considerable time. The reality however, was that the dogs were not sufficiently aggressive to prevent access by officers as demonstrated by their subsequent actions.

8.82. As needs escalated, Police on the scene requested further support. In the absence of additional resources, and with concerns for Adult C, Police gained entry using shields and captor spray.

8.83. In considering this incident, it has to be noted that Adult C had been verbally abusive and refused to put the dogs away. Adult C knew that there was an ambulance outside the house who had tried

several times to gain access to Adult C to offer treatment. These were possibly indicators that Adult C did not want to be treated.

8.84. It cannot be known that if there had been a robust plan in place to manage the stress in the previous week, Adult C may have felt more supported. However, the initial responses to Adult C stating the intention to take an overdose were timely and efficient.

8.85. This incident also needs to be put into the context of what emergency services are dealing with every day. Those services informed the review that these types of calls and situations are not uncommon. Based on the risk gradings of the incident made by the police and ambulance service, they arrived in a very timely manner. From an ambulance perspective, the highest grading for calls relates to those that are already in cardiac arrest and not breathing or having a heart attack. To have arrived within seven minutes was well above the target timescale expected for this type of call. The Police grading was made in terms of the information that they had at the time the call was made and was later upgraded as further information became available. It was deemed, on reflection, to be accurately graded according to force policy.

8.86. It is fair to say, that there is a difference of opinion between mental health colleagues and police regarding the term 'immediate risk to life', however, it can be seen that this would be the case given the different roles and expertise within these services.

8.87. More involvement from Mental Health Teams on the day may have provided a better understanding of risk. The emergency services may have had a better understanding of the escalating stress that Adult C had presented with over the last few weeks and what had led to the situation arising on that day. It could be argued that that attendance to the home by a mental health professional to support those emergency services and advise on managing Adult C and the behaviour may have been beneficial.

8.88. The Telecare service have indicated that they can be contacted to gain access to a property as key codes can be shard in an emergency. It is noted that this is possible but on this occasion it was the dogs and Adult C's behaviour that was the main barrier to access.

Learning Point 14: Effective emergency responses require accurate information sharing in order that risk is understood. Recommendation 8

Learning Point 15: Utilising all available avenues to access a patient in an emergency is key to managing difficult and risky situations Recommendation 8

Learning Point 16: Collaboration between agencies when an emergency situation is not resolving may support a shared understanding of risk, resulting in an early upgrade of response grading. Recommendation 8

9. Good Practice

9.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, Safeguarding Adult Reviews can also provide evidence of this as well as practice that goes over and above what is expected. Attendees at the workshop were asked to identify these from their own and other agencies involvement. It is important to highlight these as areas where learning can occur.

9.2. The following was identified as good practice by the reviewer and LRW attendees:

- Hospital social workers saw Adult C and the Partner separately when undertaking their assessments.
- The Mental Health worker recognised the need to refer to Adult Social Care.
- The Housing agency expedited a move to more suitable accommodation and made timely adaptations to the home to support Adult C's needs.
- Ambulance crew responded in a timely manner to the emergency call on the day Adult C died. Ambulance crew also called for Police support and made contact with the mental health team for more information about Adult C.
- Police officers demonstrated professionalism and bravery by entering the property using captor spray and shields for protection. They got the dogs under control and enabled paramedics to safely attend to Adult C.
- The emergency duty team recognised an unmet need over the extended bank holiday period and referred to the outreach team. Albeit not usual practice, the outreach team accepted and supported Adult C over the holiday period.
- A misunderstanding within the Telecare service regarding Adult C's request for more equipment was picked up by a manager and rectified.
- The GP contacted the Complex Care Team to discuss Adult C's request for a medication change.
- The assessments in the Emergency Department by the Hospital Social Workers and the Psychiatric liaison team identified issues of concern and they attempted to address these and pass information back to the community teams.
- Adult C was transferred to the Clinical Decision Unit to give a longer time for assessment.
- The Mental Health NHS Trust worked flexibly to accommodate Adult C, undertaking home visits and bringing forward appointments as required.
- There was handover of information to the Psychiatric liaison team from the hospital social workers on completion of their assessment.
- The Telecare Service were very responsive to calls from Adult C.
- Meals on Wheels had information on their system to indicate that Adult C may need time to get to the door.
- The independent living service left the referral open at the end of their intervention in case a need arose.
- The Hospital Social Worker liaised with the duty manager in the community team regarding next steps following Adult C's discharge.

- GP completed home visits when it was believed there were mobility issues in Adult C accessing the surgery.
- There was a wealth of information in all records enabling Agency Review Reports to provide good information for the review.

10. Conclusions and Learning

10.1. Adult C had a primary diagnosis of personality disorder and suffered with epilepsy. Throughout the scope that this review covers, Adult C was known to several agencies.

10.2. To the professionals involved, Adult C appeared to function well on a day to day basis and could access services and chase referrals and appointments and clearly inform people of needs.

10.3. Adult C's mental health care was managed as a non-CPA patient; the epilepsy was manged under the care of a neurologist with numerous medications managed by Neurologist, GP and Mental Health Services.

10.4. Everyone was told by Adult C that the Partner was the carer and on one occasion stated that the Partner was cared for by Adult C. Neither of these situations led to the offer of a carer's assessment for either Adult C or the Partner. This review acknowledges that the eventual social care input would have included a carers assessment, but this was towards the latter part of the scoping period of this review and could have been offered much earlier. This may have led to a greater understanding by all the level of dependency that Adult C had on the Partner.

10.5. This dependency was not understood and the different professionals understood different things about Adult C's need for care. In fact, it is now believed that Adult C's expressed need for care related to the epilepsy and fear of seizures rather from any other physical healthcare need. It was not clear if the diagnosis of epilepsy could have been reviewed; professionals were not aware that the neurologist had questioned the definitive diagnosis. Adult C's personality disorder was likely to have led to an inability to manage day to day with the diagnosis of epilepsy, despite it being a long-standing problem.

10.6. An earlier carer's assessment for Adult C or the Partner may have alerted professionals much earlier as to how Adult C's Partner was feeling and that the level of dependency and demands by Adult C was becoming too much. By the time that Adult C's Partner was seen by the hospital social workers, the disclosure was behaviour in Adult C that could have constituted domestic abuse. This led to a period in an 'up to seven day assessment bed' to consider next options.

10.7. At the point that Adult C appeared to be suffering from additional stress and stated that the need for more support, an appropriate referral was made to Adult Social Care. This referral did not lead to a timely assessment in some part due to a misunderstanding of the needs and the team that would be best able to support Adult C. When Adult C was allocated a worker, there was no capacity for that worker to undertake any immediate work.

10.8. There was a lot of activity over the bank holiday period with various professionals responding to Adult C's numerous calls but all in 'parallel lines' rather than as any coordinated support plan.

10.9. As discussed in section 8.42-57 there were several frameworks that could have been used to bring professionals together in a coordinated way, but these were not utilised. In the absence of any other appropriate framework, professionals were continuing to try and support Adult C and the Partner independently of each other.

10.10. It appears that the culmination of the periods that Adult C was left alone when the Partner was in hospital were having a negative impact. This meant that when the Partner required transfer to a seven-day assessment bed, and services had not yet been able to put any further support in place, Adult C was again alone and feeling desperate. The nature of Adult C's personality disorder almost certainly impacted on the ability to cope without support.

10.11. The response to the crisis on the final day has been discussed and analysed. It cannot be stated that the outcome would have been any different had there been immediate assistance and earlier entry to the property had been successful. By using the dogs and abusive behaviour to prevent assistance, Adult C did not make it easy to be rescued. Adult C knew the ambulance was outside but did not seek help.

10.12. What may have made a difference was coordinated multi agency assessment and intervention much earlier to really understand the relationship and dependency that Adult C and the Partner had on each other. This may have led to a clearer understanding of how Adult C would respond without the Partner to be a support and the impact of the personality disorder on coping strategies. It may have also led to a better understanding of how Adult C's Partner was feeling about the demands of Adult C on the Partner and some of the behaviours from Adult C that could have been indicative of abuse and control. When Adult C faced a further period alone, and requests for extra care at home had not materialised, Adult C informed professionals of the intention to take an overdose of medication and died before rescue could occur.

11. Recommendations

11.1. Where agencies have made their own recommendations in their Agency Reviews, WSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

11.2. The following multi agency recommendations are made to the WSAB as a result of the learning in this case:

1. WSAB should ensure that on receipt of referrals for SARs, that the facts are verified to ensure accuracy during the decision-making process. Learning Point 1.

2. WSAB should provide a learning briefing to all agencies regarding all the learning points from this review. Audit of evidence of circulation should be undertaken. Impact of learning should be

assessed by the Board Multi Agency Case file process. (All Learning Points)

3. WSAB should seek assurance regarding the effectiveness of all types of referrals. This should include that telephone referrals are followed up in writing by whatever means appropriate by the services making and receiving referrals. Learning Point 3

4. WSAB should seek assurance that carers' needs are identified by all agencies and that carers assessments are offered to all those in caring roles as required by Care Act (2014). Carers assessments must include assessment of the interdependency between the carer and cared for. Contingency arrangements for when the carer can no longer undertake the role must be considered in the cared for person's care plans etc. Learning Points 7, 8 & 9.

5. WSAB should ask all agencies who hold clinical responsibility for managing epilepsy to review their Management of Epilepsy Guidance and ensure that it considers current NICE Guidance. Learning Point 10 & 12

6. Based on the learning from this and other reviews locally and nationally, WSAB should ask for updates on the Insight Wolverhampton Shared Care Record at board meetings. Once this is in place to include impact on cases via audit and/or case examples. Learning Point 12 & 13

7. WSAB, should ensure that recommendations from the Adult B Learning Lessons Briefing regarding the development of a Multi-Agency Engagement Pathway are expedited, given the similar learning in this SAR. Learning Point 12

8. WSAB should ask Police, Ambulance and Mental Health Services to explore current pathways to respond to a mental health patient in crisis and ensuring that there is a coordinated response to such crisis situations. (Learning Point 14, 15 & 16)