SOUTH GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW:

'MR. D'

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1. Background to the review

1.1 Mr D. had a diagnosis of Paranoid schizophrenia and Depression. He had needs for care and support sufficient to have generated a referral for potential self-neglect. He also had chronic back pain due to an old injury which was not managed by the pain medication prescribed. Neighbours are reported as hearing screams which Mr D. said was due to uncontrolled pain. Mr D. died on 05.01.2021 as a result of suspected suicide by apparently self-inflicted multiple stab wounds.

1.2 A Safeguarding Adults Board (SAB) is required to undertake a Safeguarding Adults Review (SAR) where

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect
- There is reasonable cause for concern about how the SAB, its members or others worked together to safeguard the adult

1.3 The SAR sub-group of the South Gloucestershire SAB determined that there was reasonable cause to consider that agencies failed to work together to safeguard Mr. D. and it was therefore decided that a Safeguarding Adults Review should be completed.

1.4 On 20th January 2022 an inquest was held which recorded that Mr. D. died due to the consequences of self-inflicted wounds to his abdomen, wrist and neck. The conclusion of the inquest was suicide.

1.5 A mortality review has been undertaken on behalf of Avon and Wiltshire Mental Health Partnership Trust. There are no other reviews taking place into the circumstances of his death.

2. Scope of the review and key questions to be addressed

2.1 Establish which organisations and professionals were involved with Mr. D. and consider whether their engagement followed expected routes in accordance with the agreed regional Multi-Agency procedures.

For example by:

a) Identification of the key opportunities for assessment, decision making and effective intervention
b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
d) The quality of any risk assessments undertaken by each agency

e) Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

2.2 Identify examples of good practice, both single and multi-agency.

2.3 Consider how the views and wishes of the family were balanced with appropriate challenge where required.

2.4 Consider how the adult safeguarding system manages risk when self-neglect is evident.

2.5 Take account of how professionals across agencies can best work with individuals who appear to be exercising their right to make life choices that may put themselves or others at risk?

2.6 Consider whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

2.7 Identify whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

2.8 Establish the effectiveness of inter-agency communication and information sharing.

2.9 Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision and safeguarding.

2.10 Organisations were asked to provide a chronology of involvement with Mr. D. from January 2020 until 05.01 2021 supplemented by any relevant information outside the time period.

3. Organisations involved with Mr. D.

The following organisations have contributed information to the review.

3.1 *Avon and Wiltshire Mental Health Partnership Trust (AWP)*

Held responsibility for Mr. D. under section 117 aftercare. Managed by practitioners from the South Gloucestershire and Swindon Recovery teams. The Trust has made available the findings of its mortality review.

3.2 *Bromford Housing* – a Housing Association providing properties across central and southwest England and providing a tenancy for Mr. D.

3.3 *Cadbury Heath Healthcare General Practitioner* – Had known and treated Mr. D. since February 2018

3.4 *North Bristol NHS Trust - Southmead Hospital* – had contact with Mr. D. on three occasions in the time period

3.5 *South Gloucestershire Adult Social Care (ASC)* - Contact was limited to two telephone enquiries in early 2020.

3.6 *South Western Ambulance Service NHS Foundation Trust* – attended to Mr. D. on three occasions in 2020.

3.7 *Swindon Borough Council – Housing* – responsible for determining whether Mr. D. could be allocated housing in Swindon.

3.8 Information was also received from the Victim Liaison section of the National Probation Service (NPS) in Swindon.

3.9 The agencies are spread across two safeguarding adult areas, South Gloucestershire Safeguarding Adults Board and Swindon Safeguarding Partnership. Mr. D. lived in the former area and was registered with a local GP practice. He had also been in contact with the South Gloucestershire Recovery team of AWP. However, responsibility for his aftercare under section 117 of the Mental Health Act was held by the Swindon Recovery team. This had caused some confusion in 2017 (see 5.8).

3.10 Representatives from the key agencies have constituted a Review Group to oversee the progress of the SAR. Some members of staff who had direct contact with Mr. D. were invited to meet with the lead reviewer at a practitioners meeting. There was also a 1 -1 conversation with Mr. D's GP.

3.11 The report and recommendations have been quality assured by the SAR subgroup of the Board.

4. Mr.D. and his family

4.1 Practitioners who had met Mr. D. describe him as shy and reserved but straightforward, easy to talk to. His GP felt that you could have honest conversations with him. He always seemed to be calm. Apart from his brother he had no close family or friends, did not engage with neighbours and had no social networks. He was not employed. He liked to use his bicycle for exercise and shopping.

4.2 Mr. D's brother was in regular contact with agencies. He is very clear that he believes services failed his brother and that if he were to have been supported, especially with housing, that his brother would still be alive.

After initially agreeing to become involved with this review, he then declined to speak to the lead reviewer, stating that no one had acted on his concerns before.

Some information concerning his views has therefore been taken from those he expressed to the author of the mortality review.

5. Mr. D. relevant background history

5.1 In November 2007, in Swindon, Mr. D. stabbed two neighbours in an unprovoked attack. He was remanded in custody, but it was clear that he was mentally very unwell and in December 2007 he was transferred to Fromeside hospital under section 48/49 of the Mental Health Act (1983). He had been a full-time carer for his mother, had had little sleep, believed the neighbours were spying on him and he was hearing voices speaking to him in a derogatory way. An initial diagnosis was made of Depressive Disorder with Psychosis. He was prescribed antipsychotic medication and his mental state improved quickly. In August 2008 he was convicted of two offences of wounding with intent and made subject to a restriction order under Section 37/41 of the Mental Health Act (1983).

5.2 After two years, in June 2010, Mr. D. was given a deferred conditional discharge and he left hospital to live at supported accommodation run by the Maples[1]. From August 2010 until November 2016 he was subject to Section 42 of the Mental Health Act (1983). In January 2011 he moved to his own independent flat but continued to receive support. In 2015, Health records indicate that he was now diagnosed with Paranoid Schizophrenia and that Olanzapine medication was helpful. Mr. D. was under the care of the Bristol Recovery South Community Mental Health Team from August 2010 to January 2015. After a number of changes he moved to the South Gloucestershire Recovery Team (AWP) on 17th August 2015. In July 2016 Mr. D. took up a starter tenancy with Bromford Housing and moved to Cadbury Heath, where he lived until his death.

5.3 There are two references to potential overdoses during this period. In September 2015 Mr. D. did not attend a medical review, which was unusual and as a restricted patient could have placed him in breach of his conditions. There were apparently concerns about his hostility, instability and alcohol use at the time. A visit to his flat found him unconscious with a suspected overdose and he was admitted to hospital. However after assessment he was diagnosed with pneumonia and an overdose was ruled out.

5.4 In February 2016 he overdosed on prescribed medication but this was deemed to be 'not intentional'.

5.5 In June 2016 the Victim Liaison Officer from the National Probation Service wrote to AWP. He detailed that the victims of Mr. D's Wounding offences were extremely

[1] The Maples Community is a group of organisations working together to provide specialist rehabilitation, recovery and accommodation services, including for individuals with a forensic or high-risk history.

anxious about his possible return to Swindon. Both victims had suffered severe emotional trauma following the assaults. At this point the exclusion condition, i.e. that he should not return to the area in Swindon where the victims lived, was still operative.

5.6 A subsequent report was prepared by the NPS as part of the papers for a Mental Health Review Tribunal in November. One of the victims stated that she had lost her home and employment because of the impact of the attack upon her. The report indicated that she remained at high risk of emotional and psychological harm if she saw Mr. D. again. As a result of this hearing Mr. D. was given an Absolute Discharge and became an informal community patient. As he had once been subject to Section 37, he was eligible for aftercare under Section 117 of the Mental Health Act. The Tribunal decision removed the exclusion condition and this information was communicated to the victim by the Victim Liaison Officer. She was very disappointed and remained anxious that Mr. D. may return to Swindon and try to contact her.

5.7 22/06/2017 - Mr. D. was keen to move back to Swindon and had been exploring social housing since 2016. After an interview with the Housing Department he was found ineligible to join the Swindon Housing Register. 'you have a housing association tenancy……. which is considered suitable accommodation, therefore you have no housing need'. He was eligible for sheltered accommodation on the basis of age, but it was felt this was not appropriate and he may not have accepted it. He was advised to seek a mutual exchange by registering on homeswapper.co.uk.

5.8 In August 2017, following a CPA (Care Programme Approach) Review, Mr. D. was discharged to his GP (who would continue to prescribe Olanzapine) from the South Gloucestershire Recovery Team. Health records describe him as being isolated and experiencing 'low level back pain' from a longstanding injury. On 17/8/17 a joint decision (by South Gloucestershire Council and South Gloucestershire Clinical Commissioning Group) was made to end eligibility to section 117 aftercare. He had been stable, judged to be 'low risk' since 2016 and not used secondary mental health services for a considerable period. This decision, in part, reflected Mr. D's long held and adamant view that he did not want or need any input from mental health. His only acknowledged need was to be rehoused. However, the ending of section 117 eligibility was inadvertently invalid, as Swindon was the responsible jurisdiction.

5.9 In February 2018 Mr. D. was diagnosed with gastritis and a gut motility disorder. Multiple medications including acid suppression treatment, gut relaxants, opiates, sleeping tablets, diazepam and neuropathic analgesics were tried for this but none had a significant effect on Mr D.'s symptoms. He repeatedly declined access to mental health support and denied suicidal or self-harm thoughts. There appears to have been no CPA review this year as he was not formally under a Recovery team between July 2017 and January 2019.

5.10 During 2019 Mr. D. was treated for back pain and intermittent breathlessness, including one attendance at Southmead hospital Emergency Department in October.

Medications that were tried were not helpful and he consistently declined mental health or pain team involvement.

5.11 In 2019 Mr. D. was advised by telephone that the termination of his 117 status had not been completed. He was annoyed by this and it may have compromised future attempts at engagement by mental health services. Mr. D.'s brother contacted AWP to report that frustration at being unable to move to Swindon was having an adverse effect on Mr. D's mental health. In November 2019 a meeting was arranged with Mr. D. and his brother at which Mr. D. stated that he was fine and did not wish to discuss his mental health. It was agreed that the housing issue would be the focus of any future contact.

6. Chronology of involvement from January 2020

6.1 January

The Bromford Housing neighbourhood coach completed 2 visits to Mr. D.'s address but he was not in. She subsequently contacted a member of Swindon Recovery Team (AWP) about her concerns. She discussed his severe pain difficulties. She reported that he wakes early in the morning writhing with pain and his yells had led to an anti-social behaviour complaint from a neighbour. At this stage some indicators of self-neglect were reported, i.e. an undecorated front room with a bare floor, a partially covered old sofa bed mattress on a cold floor with no bedding. He did not use the heating and had the windows open in very cold weather. He was not receiving any support. She then spoke to Mr. D. and his brother to advise them of support available.

6.2 February

The Bromford neighbourhood coach was in discussion with a different member of the Recovery Team who advised that she would be a making a referral to Adult Social Care so that a Care Act assessment could be completed to ascertain any help he may need with his physical health. It was felt he might be more accepting of this. In the event Mr. D. would not consent to the referral but it was made against his wishes. The worker who sent the referral was then redeployed and it was not followed up later by her colleague who took over the case.

Contact was also made by the coach with South Gloucestershire Adult Social Care to check if there was any knowledge of Mr. D. She outlined his position, including his spartan home conditions and desire to move back to Swindon. She advised that he was not unkempt or the property 'smelly'. His care and support needs were not known. The coach was advised to call again if, after talking with his brother, she felt the situation gave rise to safeguarding concerns.

The Recovery Team social worker requested a joint visit to Mr. D. which the coach was unable to attend.

The Neighbourhood coach made contact with Swindon Housing to promote Mr. D.'s desire to move to Swindon. He was said to be refusing support at this time.

The Recovery Team social worker contacted Swindon Housing which advised that Mr. D. had already been interviewed for sheltered housing and it had been agreed it would not be suitable. The social worker advised that it was difficult to assess him for general housing needs as he was not engaging with services. She only saw him once a year for review. It was recognised that he had minimal furniture and no heating on.

Mr. D. saw his GP who felt that he was agitated and tremulous. She offered him a second opinion if he felt dissatisfied in respect of progress with his symptoms.

Also in February Mr. D. was seen in the pain clinic at Southmead hospital for longstanding back pain. Previous Medical History was reported as being Major Depressive Episode with Psychotic symptoms, not Schizophrenia.

6.3 March

AWP social worker attempted a face-to-face review but Mr. D. refused to open the door. She also had an appointment with Swindon Housing but this was cancelled due to sickness of the Housing worker.

The major concerns and restrictions around covid-19 began.

6.4 April

The Bromford neighbourhood coach made contact with Swindon Recovery team to advise of a noise complaint. This had related to screams coming from Mr. D's flat during the night. Upon investigation it was identified that he had been experiencing a lot of pain due to physical health issues. The flat was unfurnished with no carpets. Mr. D.'s case had been transferred between AWP staff again and was not allocated at the time of the contact. An anti-social behaviour case was opened by Bromford Housing following the complaint about noise, which also included loud music.

6.5 May 2020

Mr. D. had a telephone consultation with a consultant in pain management who suggested a pain management programme. He agreed to attend physiotherapy as part of this but declined the proposal of a nerve block.

Following a phone consultation he was discharged by the consultant gastroenterologist who recorded that his gut symptoms had now settled.

6.6 June 2020

The Bromford Housing coach made 2 telephone calls, one to Mr. D. and one to his brother. She contacted Swindon Housing and was advised he was adequately housed and would not be considered for rehousing in Swindon.

The Swindon Recovery team also approached the Housing Options Officer. Swindon Housing determined that he was not homeless as he had a tenancy in his name nor was he threatened with homelessness. In their view the health issues disclosed did not warrant an emergency. Again advice was given about sourcing accommodation by mutual exchange or to look in the rented sector. The name of the Home Bid manager was provided to facilitate discussion of the exchange. This contact appears not to have been followed up, although the social worker advised the Bromford coach that she had passed Mr. D.'s details to a housing worker who would be in contact with him. She advised that she would seek an update the following week and keep her informed. The Bromford Housing coach was said to be assisting Mr. D. to access a website to find private rented accommodation. No further contact is then recorded from the Recovery Team until 4/9.

Bromford Housing had a discussion with his brother concerning noise management and the fact that Mr. D. was not accepting of support being offered. They agreed that Mr. D. should purchase some floor coverings to reduce the impact of any noise on the flat below.

6.7 July

Bromford Housing made 2 phone contacts and 2 text messages with Mr. D. A welfare check was undertaken and information passed on about a new colleague in Swindon who was looking at 1 bedroom properties that may be available. Advised Recovery Team about the same issue.

The Ambulance Service was called to a road accident involving Mr. D. He had collided with a car while on his bicycle. He did not know what had happened but said he possibly didn't hear the car as his right ear was blocked. He had not hit his head. He had a wound to his foot, lower right arm and abrasions. He was offered a lift home or to hospital but he declined and wanted to cycle into Bath. He would not sign a refusal form, spoke with Police and then left on his bicycle.

6.8 August

Bromford Housing surveyor visited to assess repairs.

The anti-social behaviour case was closed because there had been no further incidents and the complainant had not responded to requests from the coach.

6.9 September

Bromford Housing spoke to Mr. D. and his brother concerning the current situation. Further contact was made with Swindon Housing who advised again that the only option was a voluntary exchange.

The Swindon Recovery Team held a telephone call with Mr. D. Although the staff member would have had access to previous records, this was the first direct contact between the social worker and Mr. D. The latter advised he was stable with his mental health and agreed to a decision to discharge his case. No record/assessment was made of the relevance of the housing situation to his mental health nor of the conditions in which he was living. A follow up call was made to his brother who also raised housing issues as well as number of physical health difficulties. His brother acknowledged that Mr. D. was not helping himself nor being proactive in moving.

11/9 Discharge letter sent to GP by AWP. This included a brief history from 2007-2016 including the index offences. It stated that Mr. D. remained compliant with his medication and his mental state had remained stable. It mentioned his concern to move back to Swindon and the contact AWP had had with Swindon Housing. In the view of the social worker he no longer needed or wanted the involvement from the Recovery Team.

6.10 October

Noise reports from neighbours prompted a Bromford Housing welfare call-out. Mr. D. was struggling with his breathing 'a little bit'.

A phone consultation was held with the Health Psychologist from the Chronic Pain Clinic at Southmead hospital regarding his 'longstanding degenerative back pain secondary to changes to lumbar spine'. Mr. D. reported not using prescribed pain relief due to fear of reliance. He did acknowledge using alcohol for pain relief at times. Reported that he regularly exercised.

During the consultation pacing activity levels and use of prescribed pain relief were discussed. Mr. D. expressed not finding this helpful previously.

6.11 November.

No contact

6.12 December

Mr. D. contacted by Bromford repairs team.

11 and 12/12 – Ambulance staff attended twice with Mr. D. complaining of chest pain and breathlessness. Mr. D. was assessed at Southmead hospital. Investigations showed no evidence of a heart related problem. Mr. D. was still complaining of pain and struggling to breathe. He declined paracetamol. Medication for acid reflux was given.

A diagnosis was made of anxiety related shortness of breath and reflux with recommendation to GP for follow up repeat tests. Psycho-education given around breathing exercises and anxiety management. "Social history – independent and no frailty concerns"

This appears to have been the last occasion that Mr. D. was seen in person by any professional worker.

14/12 – T/c with GP practice to discuss paramedic call and hospital visit. Mr. D. requested intermittent treatment for the episodes of breathlessness but the GP advised that this was not recommended. She offered to prescribe a beta blocker (to slow his pulse and relieve anxiety symptoms) but he declined. They agreed that he would book a blood test in January as abnormal blood tests noted at the hospital needed to be repeated.

7. Analysis and findings

Establish which organisations and professionals were involved with Mr. D. and consider whether their engagement followed expected routes in accordance with the agreed regional Multi-Agency procedures.

7.1 Identification of the key opportunities for assessment, decision making and effective intervention

7.1.1 The decision by the Mental Health Review Tribunal in 2016 was a pivotal point for a number of reasons.

- It was followed by the unsuccessful attempt to discharge Mr. D. from his section 117 requirement.
- From 2017 -2019 he was then either not under the care of a Recovery Team or there was a 'light touch' approach towards him.
- Mr. D. now began efforts to move back to Swindon.
- The victims of the assaults would have been left with no legal framework to ensure that Mr. D. did not contact them again. There is no indication that he would have, but equally there was no restriction on where he could live if he did return to Swindon.

Towards the end of 2019 the meeting was held by AWP with Mr. D. and his brother where it was decided to focus upon a move back to Swindon. Then in 2020 concerns began to be expressed by Bromford Housing about his living conditions and personal welfare.

7.1.2. Three opportunities to reassess Mr. D. were missed in 2020.

7.1.3 In February there had been a referral made to Adult Social Care by the AWP social worker at the time. The referral was sent to Bristol ASC, which was the wrong adult social care area as Mr. D. was living in South Gloucestershire. However Bristol ASC advised that they have no record relating to Mr. D. It has not been possible to establish the content of the referral. The social worker did recognise that Mr. D. may have been in need of wider support. The mortality review mentions a safeguarding

referral, but the accuracy of this cannot be established from the AWP records as there is no form outlining the referral.

7.1.4 In April there was escalation to the AWP Service Manager to assist with Mr. D.'s housing situation and to check if there had been a safeguarding referral by any agency. A contact with South Gloucestershire Adult Social Care had revealed no safeguarding referral and that the only knowledge of Mr. D. was from the previous contact from the Bromford Housing coach in February 2020 which had not proceeded further. The AWP Service Manager set out a plan which involved the allocation of the case to an integrated social worker 'for review of case, completion or arrangement of care act assessment and capacity assessment'. The allocated professional did not consider this to be necessary and no assessments were completed until the telephone review with Mr. D. at the point of discharge in September. There appears to have been no management oversight to challenge the practitioner for not following such a clearly expressed view by a senior manager nor to agree/approve the discharge of his case when these actions had not been carried out.

7.1.5 Had a multi-agency meeting been held there would have been more opportunity to take a coordinated approach to the concerns being raised about Mr. D.'s situation. This is discussed in more detail in section 9.

7.2 <u>Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.</u>

7.2.1 As the organisation responsible for providing 117 after-care services to Mr. D. AWP were expected to undertake an annual Care Programme Approach (CPA) review.

7.2.2 A CPA review dated 12/03/2019 stated that Mr. D. had no furniture or carpets other than 2 deck chairs and a mattress and had been without any for approximately 12 months. He had been advised not to furnish his flat if he wanted to move, although it is not clear who gave him this advice. He had applied for Personal Independence Payment (PIP) but been refused all health elements. He was experiencing chronic back pain. It is noted that he had not come to the attention of the Police. He had expressed a wish not to be involved with mental health services and there is no plan in the review of any actions to be taken by his worker.

7.2.3 The next review in March 2020 was completed by a different worker by telephone after Mr. D. refused to see her. It notes little change to his position other than reference to complaints from neighbours about noise and the fact that he is at risk of losing his tenancy. By this time he had been without furniture for two years and was no closer to realising his wish to move to Swindon. There is no reference to liaison with his GP concerning his back and stomach pain in either review. Although it is not recorded in the review, this worker had made the referral to Adult Social Care (7.1.3)

as she was concerned about his physical needs following dialogue with the coach from Bromford Housing. She left her role during this month.

7.2.4 A new social worker was allocated to Mr. D. in April 2020. She made initial contact with the Bromford coach and liaised with Swindon Housing in June. Her only recorded contact with Mr. D. was by telephone firstly with him and then his brother in September when she decided to discharge his case. It is not clear from the CPA review in March what the previous social worker at that point hoped to materialise from the referral to ASC, but there was no continuity or any plan as to how the issues which prompted the referral or the risk to his tenancy might be addressed.

7.3 <u>Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.</u>

<u>Whether organisational thresholds for levels of intervention were set appropriately /or applied correctly, in this case.</u>

7.3.1 The mortality review comments that 'it is likely that a move to Swindon would have been an important protective factor in the prevention of relapse.'

7.3.2 Contacts with Swindon Housing were made in 2017 by AWP and in 2020 by both AWP and Bromford Housing. Mr. D. had been exploring social housing in Swindon since 2016 but there is no record to account for what happened between 2017 and late 2019. He had met the criteria for sheltered accommodation and was interviewed by a member of Housing staff in 2017 but it was agreed that this would not be appropriate for his needs.

7.3.3 In respect of his homeless application in 2020 there was a 1st triage and then a full assessment by Swindon Housing. As he had a tenancy in his name he did not meet eligibility for homeless assistance. At that point he was advised to look in the private sector. The AWP worker was given a contact with the Home Bid Manager to pursue a mutual exchange route.

7.3.4 Mr. D. was on Home Swapper for an exchange anywhere in the country. However he had no photos of his flat and because it was not decorated and had no furniture, this would have made it unattractive for an exchange. Bromford Housing had several conversations advising Mr. D. about how to improve his situation and he was offered furniture but he declined.

7.3.5 There were further routes that could have been pursued, although it is not possible to judge whether they would have been successful. A referral could have been made to the Social Care and Housing Panel in Swindon. I am informed that the panel is a good route for escalating issues and sharing the perspectives of different agencies. A referral could potentially have been made by the AWP social worker. This route could have been hampered by Mr. D.'s lack of engagement with services and the fact that he did not live at the time in Swindon.

(Recommendation 16.1)

7.3.6 A second option could have been a transfer within Bromford Housing to properties owned by the association in Swindon. From December 2019 until December 2020 5 single bed properties became available in one block in Swindon.

7.3.7 Overall the liaison with the Housing Department was intermittent and efforts to assist Mr. D. with his desire to move, at one point considered to be 'desperate', lacked urgency and were not systematic.

7.3.8 It does not appear that the position of Mr. D.'s victims was ever considered in these discussions. The contact with Swindon Housing did not reach a point where they would have determined where to accommodate him. If he had been successful on Home Swapper, he could inadvertently have moved close to the victims.

Learning point

Although there was no longer any formal obligation upon AWP or Mr. D., it would have good practice to have brought this issue into discussions with him and his brother in 2019 and thereafter. In addition to the potential impact upon the victims, it would not have been beneficial for Mr. D. to find himself in proximity to people he had previously assaulted with the risk that this may have provoked a reaction against him.

7.4 The quality of any risk assessments undertaken by each agency

7.4.1 AWP

The risk assessments in 2018 and 2019 ('new information added to the Risk Summary') and CPA reviews in 2019 and 2020 indicate that Mr. D. was assessed as low risk to himself and others and did not want mental health services involvement. The CPA reviews reflect a wish to respect his right to self-determination and to promote Mr. D's moves towards independence. The risk assessments do not indicate which risk factors or relapse indicators had been evaluated when making a risk rating. The last risk assessment was in February 2019.

7.4.2 The most recent relapse indicators recorded in Mr. D.'s crisis relapse and contingency plan (April 2019) were:

- Continuing poor sleep
- Complaining of ongoing poor sleep
- Marked irritability with others and
- Ideas regarding neighbours causing him problems

7.4.3 The discharge summary and letter to his GP in 2020 does not indicate whether risk factors such as Mr. D's isolation, (an earlier relapse indicator, exacerbated by restrictions around covid-19) chronic pain and potential self-neglect had been taken into consideration. In 2020 the anti-social behaviour noise complaint by neighbours,

which Mr. D. found stressful, was also relevant to a risk assessment in the light of his offending history and his relapse indicators. The mortality review suggests that a forensic opinion would have concluded that the risk to others should always have been medium given his offending history.

(Recommendations 16.2 and 16.3)

7.4.4 Bromford Housing

Between January and September 2020 there was an ongoing management of an anti-social behaviour case by Bromford Housing, which involved complaints by neighbours of Mr. D. about the noise emanating from his flat. Some of this noise was attributed to him screaming with pain. This was managed sensitively by the coach including through a number of contacts with Mr. D. and his brother. Both were at times agitated about the complaint and Mr. D.'s brother complained that it was making his brother scared and anxious. At an early stage it is recorded that the complainant had 'confronted' Mr. D., who had immediately turned down his loud music. At other points the noise was reported to be caused by Mr. D. using his gym equipment late at night. 3 risk assessments of the 'victim' were made. The first 2 were recorded as 'low' the third, 5 weeks before the case was closed, was graded 'medium'.

7.4.5 Bromford Housing's approach to managing anti-social behaviour complaints of this kind focusses largely upon a risk assessment of the complainants who are requested to complete a self-assessment questionnaire. They are asked questions about the severity and impact of the anti-social behaviour. They are also asked to rate 'how much you feel you or your family to be at risk of harm as a result of the Anti-Social Behaviour'. There is no reference to the person against whom the complaint has been made. In these circumstances this was a significant omission. The offences for which Mr. D. had been imprisoned involved violence against neighbours. This may have been 12 years earlier and in different circumstances, but a more thorough risk assessment of the situation could have been carried out, taking account of Mr. D.'s history and the impact upon him of the complaint.

7.4.6 However, Bromford Housing and therefore their neighbourhood coach were not aware of the specific offences for which Mr. D. had been imprisoned. He had been accepted for a tenancy from the South Gloucestershire housing register in 2016. On his application form he disclosed that he had served a short period of imprisonment for Grievous Bodily Harm due to mental health issues. He was coming from supported accommodation and had a support worker at the Maples who advised that he was ready to move on, had positive relationships with other service users and would make an excellent, responsible tenant. The reference included no detail about his index offences. This information was also not shared with the Housing Association by Mr. D.'s social workers at AWP.

7.4.7 Bromford Housing have a system whereby a property can be flagged if there are any potential risks in respect of a tenant. They can also request information about a tenant from Avon and Somerset Police in defined circumstances. They felt that they had no reason to do so in relation to the complaint against Mr. D., although it would have been reasonable to clarify with the Maples the nature of the offending history he himself had disclosed when the reference was originally received.

7.4.8 In my view Bromford Housing had a 'need to know' about Mr. D.'s offending history. Although the index offences were some years before he took up the tenancy and he was felt to be progressing well in his rehabilitation, from late 2019 his emotional state appears to change with indicators of self-neglect, isolation, chronic pain and frustration at not being able to move on from his property into Swindon. Although there is no evidence of psychosis at this time, these risk factors were evident at the same time as the complaint by his neighbours. This is not to argue that it was likely that he would have caused harm to others again. However potential scenarios should have been assessed and Bromford Housing needed to ensure that they would not be exposing their coach or other tenants to avoidable risk.

(Recommendation 16.4)

8. <u>Establish the effectiveness of inter-agency communication and information sharing.</u>

8.1 There was a lack of coordination between AWP, primary care, Swindon Housing and Bromford Housing. There may have been 'good conversations in isolation', but no one was exercising any grip over Mr. D.'s wish to move to Swindon. This is illustrated by the fact that Swindon Housing were contacted separately by Bromford Housing and AWP on the same issue during June 2020 and the long gap in liaison between 2017 and 2020.

8.2 When a decision was taken by the AWP social worker to discharge Mr. D. from her caseload, there was no prior consultation with either Bromford Housing or his GP. As far as can be seen from the records Bromford Housing were not informed of the decision subsequently. It is not clear that the sharing of information about his discharge was clarified and agreed with him.

(Recommendation 16.3)

8.3 The referral to ASC in February is an example of a positive decision to involve other agencies, but ultimately this came to nothing.

8.4 His GP advises that she had not been aware that Mr. D. was eligible for Section 117 aftercare until she received the letter notifying her that his case had been closed. She stated that contact with mental health services may have helped her in seeking other views about his wider social circumstances, especially when not making progress with other treatments. She was also working to the previous diagnosis of

psychotic depression and had not been advised of the change of diagnosis to schizophrenia.

9. Consider how the adult safeguarding system manages risk when self-neglect is evident.

9.1 Self-neglect indicators were identified in 2019 and became more apparent throughout 2020. The Bromford Housing coach who saw Mr. D.'s living conditions in person conveyed this information to both Adult Social Care and AWP social workers. Although his GP did not notice indicators of self-harm and felt that Mr. D. was well presented during consultations (largely before 2020), his outward appearance masked the fact that he was living in spartan conditions and was generally isolated with no social contact or support except from his brother. The latter noted that he was not changing his clothes regularly, not attending to his personal hygiene and losing weight. These factors were not recognised as potential indicators of self-neglect by those working with him at the time.

9.2 Consequently key components of good practice known to be important in working with people who self-neglect[2], were absent in the care and treatment of Mr. D. There was no multi-agency approach to care planning. No organisation took on a role of lead agency. A multi-agency risk management meeting (MARM) to review risks and agree a coordinated support plan would have been helpful for Mr. D. The South Gloucestershire SAB self-neglect practice guidance (appendix 3) sets out a flow chart to support this approach. Such a meeting would have enabled better information sharing with those agencies at a distance by the Bromford coach who had witnessed his environment and living conditions. It could also have taken account of Mr. D.'s negative views of contact with mental health services and agreed which agency could have tried to build a positive relationship with him and undertake face-to-face work. AWP staff were best placed to call a multi-agency meeting but this could have been triggered by any of the agencies working with Mr. D.

(Recommendation 16.5)

9.3 The Swindon Safeguarding Partnership policy and guidance about self-neglect is comprehensive and includes a risk assessment tool[3] and a section on different ways of engaging with a person who self-neglects. From discussions within the Review group it would appear that this guidance is not well known to AWP staff in Swindon. Certainly the risk assessment tool was not used in respect of Mr. D.'s circumstances.

(Recommendation 16.6)

[2] See 'Working with people who self-neglect' Research In Practice December 2020

[3] Self-neglect guidance often now focuses on hoarding but in Mr. D's case it was the absence of furniture and possessions, an environment described as a 'spartan squalor', which was a cause for concern.

10. Take account of how professionals across agencies can best work with individuals who appear to be exercising their right to make life choices that may put themselves or others at risk?

10.1 It is clear from all reports that Mr. D. had capacity when well. However he frequently declined to take up treatments to assist with his physical difficulties. He was particularly averse to being engaged with mental health services and was described at one point as 'fiercely independent'. His GP believes this is a common reaction by individuals who have previously been subject to court sentences or mental health 'sections', seeing their continuing freedom from such restraints as important indicators of their improving health and independence.

10.2 Although these characteristics made it difficult for professionals to work with Mr. D., the only person who persisted in trying to engage with him during 2020 was the Bromford Housing coach.

10.3 The referral to Adult Social Care by the AWP social worker in February 2020 was made without Mr. D.'s consent. It was not followed up when there was a change in worker. (Learning point 16.7)

His case was then discharged although he had been living with minimal furniture for two and a half years, was still experiencing chronic pain and in the absence of any plan to assist him to move nearer to Swindon where he could receive greater support from his brother. As already noted, this could have been a protective factor in respect of his ongoing emotional wellbeing. Mr. D. was very reluctant to engage with mental health services and was therefore always likely to agree to be discharged. However it is questionable whether he recognised the consequences of having no keyworker to coordinate services or advocate on his behalf.

(Recommendation 16.3)

11. Consider whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

11.1 There were no specific equality issues in respect of Mr. D.'s background. What was important was for professionals to be sensitive to his own perceived journey as a former mental health patient/prisoner. His desire for this experience to be past history was often a barrier to engagement with services in the present.

12. Identify whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

12.1 Bromford Housing acknowledge that there has been learning for them in respect of supporting staff to escalate their concerns to relevant agencies. The coach who worked with Mr. D. was by her own admission inexperienced and new to the role. She now feels she would have been more confident in escalating the issues. However she also felt hampered by the lack of consistency of workers in AWP where there were three different social workers responsible for Mr. D. between January and April 2020.

The South Gloucestershire SAB Resolution of Professional Differences (Escalation) policy is a helpful resource for organisations in this respect.

13. Consider how the views and wishes of the family were balanced with appropriate challenge where required.

13.1 There is evidence of good links with Mr. D.'s brother by staff at Bromford Housing who contacted him on at least 4 occasions between January and September. This was usually to discuss concerns about his welfare. There was also the management of the anti-social behaviour complaint. This did involve some challenge as Mr. D.'s brother was initially upset on his behalf.

13.2 Mr. D.'s brother did discuss the views of his family with the author of the mortality review. According to this discussion his family reported that a long serving practitioner working in the South Gloucestershire recovery team formed a strong therapeutic relationship with Mr. D. and took great care to involve them in a collegiate way. There are two recorded contacts by the Swindon recovery team in 2020. The first was in March when the CPA review was undertaken by telephone, the second was at the point in September when Mr. D. was discharged. The mortality review comments on 'The value and importance of proactively seeking views of loved ones to inform assessment and key decisions – family suggest that his recent probable relapse could have been spotted before his apparent suicide had their insider knowledge about behavioural changes been sought'.

14. Identify examples of good practice, both single and multi-agency.

14.1 The primary point of contact for Mr. D. was the Bromford Housing coach. Apart from ambulance and hospital staff in December she was the only person who saw him in person after the beginning of covid-19. She was persistent in trying to liaise with statutory agencies to try to resolve some of the issues he was facing. The Housing Association also offered Mr. D. some practical support in the form of mattress and floor covering which he declined.

14.2 Mr. D. saw his GP regularly up to February 2020. She made a number of referrals to specialist services to try to manage his physical symptoms. She offered him the opportunity of a second opinion when 'stuck'. She believed that there was a

relationship between his physical difficulties and pain and his mental health. She had specifically sought reassurance from him about the risk of self-harm and suicide, although not since December 2019. As far as she is aware he was regularly taking his anti-psychotic medication, prescriptions for which were re-issued every two months.

14.3 The guidance on the web-sites of both South Gloucestershire SAB and particularly the Swindon Safeguarding Partnership is a helpful and informative resource for practitioners and managers working with people who self-neglect.

15. The impact of covid-19

15.1 During 2020 all agencies were stretched and challenged in seeking to deal with the impact of the coronavirus. Bromford Housing suspended visits to residents from April until June 2020. I am advised that there was no policy in AWP preventing workers from visiting clients but staff would have been required to wear Personal Protective Equipment (PPE). It is likely that this could have been a further barrier to their engaging with Mr. D.

15.2 The impact upon the emotional wellbeing of someone already isolated such as Mr. D. may have been significant. His admission to the hospital emergency department on the 13th December 2020 indicated that he was physically unwell during this month. When The Ambulance Service first attended he was constantly calling his brother to come to be with him. His brother however could not drive into a tier 3 area. Then, during the Christmas and New Year period families living apart were unable to visit one another. Mr. D. relied heavily for emotional support upon his brother. It is entirely feasible that that these events had a cumulative effect upon him prior to him taking his own life.

16. Recommendations

This section includes both multi-agency and single agency recommendations addressed to organisations in both safeguarding adult areas.

It is recommended that

16.1 Swindon Borough Council Housing and AWP clarify the role of the Social Care and Housing panel and the circumstances in which referrals can be made to support patients with housing/accommodation need.

16.2 AWP staff document clearly the risk factors and relapse indicators taken into consideration in risk assessments and ensure that they are also referenced in Care Programme Approach reviews.

16.3 AWP ensure that, before withdrawing from a case, an up-to-date risk assessment is undertaken, staff consult with other partners involved and fully evaluate the impact of closure upon the individual.

16.4 Bromford Housing establish information sharing agreements with mental health services so that they can be made aware of tenants' previous criminal and mental health history where appropriate.

16.5 All agencies familiarise staff with the self-neglect guidance and provide more detailed training to relevant practitioners so that, when self-neglect indicators are identified, they are fully aware of the importance of coordinating and involving partners in multi-agency meetings.

16.6 South Gloucestershire SAB and Swindon Safeguarding Partnership review and promote their guidance concerning self-neglect in the light of the findings of this SAR.

Additional learning point

16.7 It should be an expected practice within all agencies to acknowledge receipt when a referral is made by a partner organisation. If no acknowledgement is received, this should always be followed up by the referrer.

The author

Barrie Crook is a coach and consultant who is independent of the organisations involved in this review. From 2015-2021 he was the Chair of the Dorset and Bournemouth, Christchurch and Poole Safeguarding Adults Boards. Prior to this he was the Chief Executive of Hampshire Probation Trust.