Learning briefing

System learning findings from Safeguarding Adult Review 'Simon'

Who was Simon?

Simon was a white UK citizen aged 71 years, at the time of his death. A gay man, Simon chose not to have intimate relationships and had lifelong relationships with close friends. Simon experienced mental ill health throughout his adult life, his first mental health crisis occurring in his early twenties. Simon was diagnosed with a 'schizophrenic-type' illness, bipolar disorder and psychosis. On several occasions throughout his life, Simon received inpatient hospital treatment for his mental disorder, on an informal basis (meaning being admitted to a psychiatric hospital voluntarily and having capacity to understand and agree to his treatment).

During his life Simon gained great insight into his own mental health and became 'an expert by experience'; Simon used his experiences to mentor and advise others. After almost 20 years of being well, Simon moved from Dorset to Scotland to pursue his love of art by taking a foundation course in the Western Isles. Whilst in Scotland Simon was treated for cancer and around the same time became mentally unwell again due to a combination of factors including the effects/ incompatibility of medication for both his physical and mental illness. This crisis resolved quickly but soon afterwards Simon decided, against medical advice, to stop taking some prescribed medicine and he began to experience delusional beliefs and compulsive behaviours. Simon's mental health declined to the extent that he was detained and admitted to a psychiatric hospital in Scotland for a period of 14 months, during which the Covid-19 pandemic restrictions were in place for 9 months. This meant that Simon's family could not visit him. After discharge Simon could no longer live independently and moved to a care home. He was unhappy there and decided to return to Dorset, a familiar place where he would be close to family members. The Western Isles authorities made no formal arrangements regarding Simon's move back to Dorset and his family were left to manage alone, navigating the additional complexities of Simon travelling during the pandemic. Restrictions in place at the time also prevented Simon's family from visiting him upon arrival to a residential setting in Dorset. The care home specialised in dementia care and mental health, but Simon did not have dementia and found this difficult. Dorset Council, together with both primary and secondary health services, had no information about Simon, the care home into which he moved had minimal information.

For the first three weeks following Simon's move back to Dorset, he was left without support for his complex needs due to the need to isolate (Covid guidance) and agencies receiving relevant information regarding his care and support needs. The organisations working with Simon subsequently struggled to support him and also the care home staff. The impact of Simon's perception; that the care home was full of demons that planned his death and worse, was not fully appreciated. Although the care home was deemed a 'place of safety', Simon did not feel safe. Despite the failure of a plan of least restriction being put in place after a Mental Health Act (MHA) assessment. There was no contingency plan about re-assessment of Simon's mental health and no planning or resource to provide him with the 'wrap around' care that may have helped him to feel safe in the care home. Practitioners did their best to find and share information, but there was no multi-agency meeting involving all who knew Simon or could offer guidance on working with him. His supportive family was not involved in his care by the community mental health team. Simon died by suicide six weeks after arriving in Dorset, he left notes explaining his fears about his fate in the care home.

Key learning points

Careful planning for transitions between areas

Careful planning is essential when a person with care and support needs moves from one area to another, whether between UK countries or within England and Wales across local authority boundaries. When a person has complex needs, the transition plan will need to be multi-agency, often involving GPs and primary health services, secondary healthcare, social care providers and adult social care. These plans will take time to develop which may mean that the option to delay the transfer should be considered for the necessary arrangements to be made.

Transition plans should be unique to each individual. All of these elements are best explored via direct contact and multi-agency planning between host and placing authorities. Advice from the **Association of Directors of Adult Social Services** and from **The National Institute for Clinical Excellence (NICE 2016)** indicates that these activities will be led by the placing organisation with the cooperation of the host area.

Think: If you are placing someone with a range of health and social care needs in a different local authority think about convening a multi-agency meeting between all involved in both placing and host authorities.

Plan: What will all involved do if there is a crisis in the new placement?

Think: Have the relevant mental health teams met and undertaken a detailed handover?

Does the relevant local authority have the right information?

Will there be a timely transfer of GP records?

Strengths-based approaches

Consider: Who is available to support the person?

Family/friends can be an important source of information and support on plans to meet a person's needs. The contribution of family and friends should always be considered and sought out by organisations. This is even more important when a person is new to an area or mistrustful of formal offers of support.

Person-centred approaches: Understanding the person and what lies behind the decisions they make

Decisions and plans need to be informed by empathy for the person's perception of their situation. This understanding can be shared with other organisations to create a common understanding of the significance of the person's behaviour and what actions may alleviate their distress.

The Mental Capacity Act (2005) Code of Practice (section 2 part 11) encourages consideration of what is informing an unwise choice which may harm the person or appears irrational or out of character. The person may still have the mental capacity to make that choice, or may not, **but we cannot dismiss harmful behaviour as 'an unwise choice' without further investigation.**

Making contingency plans

Shared contingency plans to support a person who is mentally unwell, but not detainable under the Mental Health Act (MHA) 1983, should stipulate under what circumstances a further assessment under the MHA should be considered and who is responsible for initiating it.

Remember: Family and friends can be an important source of information to support contingency plans, their input should be sought as a priority.

Multi-agency working

Multi-agency meetings are essential to formulate plans to address complex or acute need and mitigate risk. Ensuring everyone is involved to meet together will lead to far more effective and coordinated actions as opposed to having separate conversations with each organisation involved.

Think: Do you know how to convene a multi-agency meeting?

How can you develop your knowledge and confidence in this?

Documents that might provide additional information

- MARM (Multi-Agency Risk Management) Guidance
- MARM (Multi-Agency Risk Management) Summary Guidance
- Multi-Agency Safeguarding Adults Procedures
- Safeguarding Adults Review - Learning from the circumstances around the death of Simon