Safeguarding Adults Review

Learning from the circumstances around the death of

Simon

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Appendix 1 Terms of Reference

Glossary.

AMHP – Approved Mental Health Professional.

APU – Acute Psychiatric Unit.

ASC – Adult Social Care.

CMHT or OPCMHT – Community Mental Health Team (generic on Barra and Uist) or Older People's Community Mental Health Team (Dorset).

Comhairle nan Eilean Siar – the Western Isles, also referred to as the Outer Hebrides.

CPA – Care Programme Approach.

CPN – Community Psychiatric Nurse.

DC – Dorset Council

DOLS – Deprivation of Liberty Safeguards.

D(SAB) – Dorset Safeguarding Adults Board.

HTT – Home Treatment Team.

ICB – Integrated Care Board.

LPA – Lasting Power of Attorney.

MAPPA – Multi Agency Public Protection Arrangements (in relation to a review referenced in 6.2.1.7.)

MCA – Mental Capacity Act 2005.

MHA – Mental Health Act 1983.

NHSE – National Health Service England.

OPCMHT – Older People's Community Mental Health Team.

SIRI – Serious Incident Requiring Investigation.

1. Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Dorset Safeguarding Adults Board in order to learn from events surrounding the death of Simon on the 30th of June 2021. The decision to commission a SAR was made on the 13th of April 2022 following a referral from Dorset Adult Social Care. The organisations involved contributed to the terms of reference which were reviewed by Simon's family and finalised in January 2023.

1.2 Simon was a white UK citizen. He was close to his mother, brother and sister-in-law. Simon was gay, he chose not to have intimate relationships with men but made lifelong close friendships. Simon experienced his first mental health crisis in 1974 and was admitted to Wonford Hospital in Exeter. He went on to university and achieved a 2.1 BA Honours in Italian and English. This was achieved despite continuing to experience poor mental health for which he was prescribed regular Modecate injections. Simon worked with his mother to develop a property now owned by the National Trust in the South West. He particularly enjoyed his work in the tearoom and hoped to run another tearoom one day. After the property was sold in 1992 Simon moved to Dorchester with his mother, she then left the UK in 1994. Simon found this transition hard at first and was hospitalised on four occasions, the last time in July 1998. Simon settled into life in Dorchester, he saw his family at weekends and had a wide circle of friends. He helped to establish a drop-in centre, 'Out of the Wood' and was a mentor to younger people with mental health issues. His love of art led him to take up a place on an Art Foundation course in Lochmaddy, North Uist on the Western Isles (Comhairle nan Eilean Siar) in 2015. Simon moved back to Dorset in May 2021. He died by suicide on the 30th of June 2021.

1.3 Under section 44 of the Care Act 2014 a Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there:

- is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,
- and the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

2. Terms of Reference

The full terms of reference can be found in appendix 1 at the end of this Report.

2.1 Timeframe: The time period explored by the SAR is the 18th of March 2021, when active plans began for Simon to move to Dorset, until the 30th of June 2021, the day of his death.

2.2 The general areas of focus for the SAR are:

- To establish whether there are lessons to be learnt from the circumstances of the case and about the way in which professionals and organisations work together to safeguard adults at risk.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- To inform and improve systems and practice around 'out of area' placements.
- To inform and improve local multi and inter agency practice.
- To improve practice by acting on learning (developing best practice).
- To connect the learning from previous Safeguarding Adults Reviews (SARs).

2.3 The specific areas of focus for the SAR are:

- How was Simon's transition from the Western Isles to Dorset managed? Were there barriers to an effective transition plan and communication between the two areas? What went well? What can we learn to inform practice and systems around transition from one area to another?
- How did organisations in Dorset work together to respond to a) Simon's distress and b) the care home's challenges in supporting him? Were there barriers to working together? What went well? What can we learn to inform practice and systems around multi and inter agency working in Dorset?
- Did the restrictions necessary in relation to the COVID-19 pandemic have an impact on the above areas of focus? What can we learn from this?

2.4. Methodology

2.4.1 Organisations in the Western Isles and in Dorset were asked to complete a Chronology and an Analysis report regarding the actions and decisions of their own organisation.

2.4.2 A Panel of report authors worked with the lead reviewer to identify the initial themes from the chronologies and reports.

2.4.3 The themes were explored further in a Practitioner Reflection and Learning Workshop with the practitioners and first line managers who worked with and made decisions about Simon.

2.4.4 The Panel supported the lead reviewer to produce a summary report including findings and recommendations.

2.4.5 After the DSAB has accepted the recommendations of the SAR the final report will be shared with the Chair of the Outer Hebrides Adult Protection Committee to inform the development of systems and practice in the Western Isles.

3. The voice of the person.

Simon's family kindly contributed some of Simon's writings to the Review which illustrated his life up to 2012 and also reflected on his experiences in the Dorset care home just before his death. Simon's mother, brother and sister-in-law have also contributed to the Review via interviews, sharing their recollections of Simon's life and the events prior to his death.

4. Parallel processes.

The Dorset Health NHS Foundation Trust undertook a Serious Incident review of Simon's care from the 14th of June until the 30th of June 2021. This is now complete and was made available to the SAR. An inquest into Simon's death concluded on the 27th of October 2022.

5. Relevant history prior to the time in scope.

Simon was thought to have a 'schizophrenic type' disorder during the 1970s and 1980s. He was diagnosed with a Bi-Polar disorder in 1991. He was knowledgeable about his own condition and was compliant with the drug regime which had kept him well for many years. He had no admissions to hospital after 1998. Simon was proud that despite having frightening thoughts or hallucinations he was never violent to a living being. He did feel stigmatised by his illness and felt unwelcome in some shops and cafes. More than that he felt Dorchester was boring 'Dullchester' and wanted a new challenge.

Whilst living in the Western Isles Simon was diagnosed with a lymphoma[1] in February 2017. During his treatment he was given steroids and became mentally unwell as a result, the first mental health crisis he had had since 1998 and his first contact with the Western Isles Community Mental Health Team. He recovered from the lymphoma and his mental health crisis resolved quickly. Simon's mother moved to be near to him in 2018, he helped her to equip her bungalow and the pair hoped to support each other. Simon's lithium was stopped in early 2019, his family think because of potential kidney damage, and he was not taking care of himself. He seemed well during the summer of 2019 when his brother visited him but shortly afterward Simon decided to stop taking his usual anti-psychotic drugs and to try Haloperidol, against medical advice. The switch in medication triggered a new mental health episode, during which Simon began to experience night-time incontinence of urine. This incontinence took on a compulsive nature and Simon's CPN in Scotland observed that it

[1] A cancer that starts in the lymph glands or other organs of the lymphatic system.

might relate to a delusional belief. These compulsive behaviours occurred both at home and in hospital.

In October 2019 Simon set the bathroom curtains in his apartment on fire. He is reported to have said that a devil told him to do this. The fire brigade was called, and Simon was sectioned and taken to the Acute Psychiatric Unit (APU) at Stornoway Hospital, where he remained until December 2020.

Simon now struggled to care for himself. He tried a weekend home supported by his close friend, but this did not go well. Simon could not have carers at his existing property due to its isolation and access difficulties. Simon considered social housing, but nothing was available to rent locally at the time. By October 2020 Simon had been assessed as needing 24-hour care and support. Due to the COVID restrictions of the time Simon's family were unable to visit him in the APU.

In December 2020 Simon transferred from the APU to a care home in South Uist, (care home 1). His compulsive behaviours had diminished, he was now taking lithium and anti-psychotic medication and his psychiatrist had investigated any physical cause for the compulsive behaviour. The placement was temporary as Simon really wanted to go to a care home in North Uist where he could be nearer his mother. However, there were no vacancies in this smaller care home at the time. This was the first care home Simon had lived in. The care home cared for people with dementia rather than with mental health issues.

By March 2021 Simon's behaviour was becoming too challenging for staff at care home 1 who could no longer meet his needs. Simon was also not happy living there and said that he felt frustrated at being told what to do by the staff. When challenged about his behaviours he assaulted a member of staff. Simon's consultant reviewed his mental health treatment on the 15th of March on Teams whilst his CPN and social worker considered the appropriateness of Simon's placement.

6. Key Events and Analysis of the time period considered by the SAR

6.1 Time period 1: 18th March 2021 – 28th May 2021.

6.1.1 On the 18th of March 2021 a review meeting was held via Teams. Simon attended along with his brother and sister-in-law and his close friend. Simon's sister-in-law and close friend had Lasting Power of Attorney for welfare and financial matters. Simon wanted to be moved to a placement that would better support his mental health, he hated care home 1 and feared *'something was going to happen'* if he remained there, he did not feel safe. At the meeting it was agreed with Simon that the social worker would look for an alternative and more specialised placement on the mainland of Scotland whilst his family would look at possible placements in Dorset. Simon is reported to have been happy about the Dorset option as he thought that eventually his mother would move there. After this meeting there

was consideration as to whether Simon might be detainable. The CPN advised that Simon's actions were 'behavioural', and that Simon was not detainable.

6.1.2 On the 24th of March a safeguarding concern was raised by care home 1. Simon said that he wanted to kill himself and had made superficial marks on his right arm with a razor blade. Simon was admitted to Uist and Barra community hospital later that evening. This 29 bedded community hospital does not have a psychiatric unit. Simon had not previously talked about suicide or tried to harm himself or end his life. He did have friends however who had done so.

6.1.3 At the beginning of April 2021 Simon was described as unsettled, his behaviour was very challenging to staff and he refused all care. By the 8th of April Simon's family had identified a potential placement, a care home in Weymouth which specialises in supporting people with mental health issues (care home 2). They were unsure that this would be a suitable placement for Simon, this was the only option which would enable Simon to live near to them. Simon is reported to have been positive about the prospect of care home 2 and became convinced that this was where he wanted to go.

6.1.4 Simon's social worker contacted care home 2 and emailed Simon's care and support needs assessment to the manager. As part of the assessment the care home manager spoke with a nurse on the community hospital ward. Simon's family looked around the care home which was very near to where they lived and sent Simon photographs of the 'cottage', a separate building for five people independent of the main care home. He was familiar with the local area. Simon's family hoped that he could regain access to his previous community, attend art projects and groups as he had previously done when living in Dorchester, spend time with his brother and be able to rebuild his life.

6.1.5 On the 19th of April ASC sought permission from the Assistant Director of the NHS Western Isles Mental Health service for a CPN to escort Simon to Dorset. Permission was given. However, the CPN identified to support the transfer is reported to have emailed the social worker on the 22nd of April to say that this was no longer possible. At this time the CPN was working alone in the South Uist CMHT. Both substantive postholders, including the senior charge nurse, were unavoidably away. The pressures on this team are high, there are no third sector organisations on the island and the CMHT works with a very wide range of adult mental health needs. The social worker covers all of the adult social care cases on South Uist. Escorting Simon meant two or three days off the island.

6.1.6 Simon's social worker and psychiatrist visited him in the community hospital on the 20th of May. Simon is reported to have hoped that his compulsive behaviour would not reoccur in Dorset as he felt motivated to "change his behaviours" as he wanted to be nearer to his family. There was a shared belief between some practitioners that Simon's behaviour related to his wish to leave the care home or community hospital.

6.1.7 Simon moved to Dorset on the 21st of May 2021 accompanied by his brother and sister-in-law. This entailed two plane journeys which Simon coped with. The journey was unaccompanied and unfunded by organisations in the Western Isles. COVID restrictions at the time meant that Simon was 'in isolation' at care home 2 for two weeks after arrival. However, in practice he did go into the main house and socialise after the second day. His reception at care home 2 is reported to have been awkward, he had to take a COVID test before entry and sat in the car waiting for the result. His family could not accompany him and indeed could not visit him for the first two weeks of his stay. This was in line with the government recommendations of the time.

6.1.8 On the 24th of May Simon was registered with a GP in the care home 2 link surgery. Simon's family had brought his repeat prescriptions and the contact details of his previous GP with them. Simon was visited the next day by the surgery advanced nurse practitioner who was allocated to the care home and began drawing up Simon's care plan. Simon's GP telephoned the GP surgery in the Western Isles regarding Simon's notes, and subsequently received a brief patient summary on the 15th of June.

6.2 Analysis.

6.2.1.1 Simon's social worker on the Western Isles made a formal request for the local CMHT to facilitate Simon's transfer to England. Mental health teams in both the Western Isles and Dorset are clear that an effective transfer should involve direct contact between CMHTs, the exchange of background information including the person's treatment plan, current medication information, mental health history, risks including any suicide ideation, physical health history and family/LPA contact details. In addition, the Western Isles local CMHT is very clear that the usual process would be for Simon's journey to Dorset to be carefully planned and risk assessed, fully escorted and funded. In addition, information would be exchanged with the host CMHT. It appears that the CPN in the Western Isles did not or could not follow this process and did not share information with services in Dorset. The matter was not escalated to management by either the CPN or social worker. It is unclear how much the low staffing levels in the CMHT contributed to this situation, the relevant CPN has now left the organisation. There does not appear to have been any consideration of delaying Simon's transfer until the correct supports were in place and staff available to facilitate this effectively. Simon was unhappy at the community hospital and had great hopes of a better life in Dorset. He was presumed to have the mental capacity to make this decision. However, the absence of transfer information was a key factor in the struggles Dorset organisations had in understanding and responding to Simon's needs. We will explore the impact of this in sections 6.4 onward.

6.2.1.2 How common are problems around transfer procedures? Participants in the SAR have indicated areas where transfer is problematic:

- Transfer between UK countries, between GPs and local authorities and mental health trusts.

- Transfer between local authorities in England.
- Information sharing with care homes and other providers.

What protocols already exist?

6.2.1.3 Transfer protocols for mental health patients between UK countries include those underpinned by legislation[2]. These are only relevant for people who are detained under the various mental health legislation or are subject to a legal order in the community, i.e., a community treatment order. This would not apply to Simon who was not subject to any legal order. The National Institute for Health and Care Excellence has guidance[3] to support transitions between hospital and care home settings. These principles underpin the statements made in Dorset and the Western Isles as to what would constitute good practice. Simon was transferred from a community hospital, but he was under the care of a psychiatrist who should have been overseeing his transfer. The psychiatrist is reported to have also been away at the time of the transfer. A mental health setting may have understood the importance of a transfer of mental health related information, but this does not appear to have been identified by the community hospital.

6.2.1.4 Simon was not entitled to Mental Health Act (MHA) 1983 S117 aftercare which would also prompt joint planning as to his needs and care. Scotland appears to have no equivalent aftercare section, although there is a duty on the local authority to assess and support. Simon's eligibility was checked for the purpose of the SAR, but not as part of any planning for his care once in Dorset. A check on S117 eligibility will be a useful part of transitional planning.

6.2.1.5 There appears to be no system for transfer of electronic records between GPs in different UK countries [4]. NHS Scotland report that they are working with other UK NHS agencies to develop this. [5] NHS Scotland Inform states that *"if you are moving to another part of the United Kingdom, we then print your records to paper to allow them to be used by your new GP"*[6] This paper transfer is stated as taking place '*within six weeks'*. In Simon's

[2] https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/15/

[3] NICE (2016) Guideline 53: Transition between inpatient mental health settings and community or care home settings

[4] https://www.nhsinform.scot/care-support-and-rights/nhs-services/doctors/transfer-of-your-gp-health-records#moving-your-health-records

[5] Ibid.

[6] https://www.nhsinform.scot/care-support-and-rights/nhs-services/doctors/transfer-of-your-gp-health-records#understanding-access-and-timing-for-moving-your-records

case, and perhaps in others, this did not happen, no paper notes were sent. 25 days after Simon arrived in Dorset his GP managed to obtain only a brief patient summary. Simon's GP only had Simon's repeat prescriptions to hand and any information supplied by either the care home or family. This information could not provide the detail needed to understand Simon's health needs correctly.

6.2.1.6 The English government has published principles to support continuity of care when moving across UK borders[7] although there does not appear to be clear guidance to assist practitioners. The social worker in the Western Isles shared a care plan with Care Home 2. She made her expectation clear that she wished to be kept informed of Simon's wellbeing and assisted when contacted by family, care home 2 and mental health services. This alone was not sufficient, there also needed to be clear communication between the mental health teams involved in Simon's care.

6.2.1.7 Transfers between local authorities in England have been explored in various SARs[8] as well as a joint SAR/MAPPA/Domestic Homicide Review in the local authorities adjacent to Dorset[9]. The guidance pertaining to transfers between local authorities [10] was updated in an Advice Note for Directors of Adult Social Services in 2018. Amongst other recommendations, the Advice Note asks;

- placing authorities to contact host authorities and ICBs to discuss contingency plans,
- to notify host authorities that the person is moving to their area,
- to ensure that specialist provision can in fact meet the needs of the person and
- to work with providers to ensure that the person's needs are compatible with the needs of others living in the service.

Despite the Advice Note these processes are not always carried out. Local authorities do not always contact relevant services and can be confused as to how to do so. This is exacerbated when working between different countries which have different legislation, service configurations or even practice guidance. We must ask ourselves, how easy is it for a practitioner outside of my local area to find the right front door?

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[7] DHSC (2015) https://www.gov.uk/government/publications/continuity-of-care-when-moving-across-borders-within-uk/principles-for-maintaining-continuity-of-care-when-moving-across-borders-within-the-united-kingdom

[8] Somerset SAB (2018) Mendip House SAR. Find at https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20180206_Mendip-House_SAR_FOR_PUBLICATION.pdf

[9] Bournemouth, Poole and Christchurch DHR "Regarding Colin who died in January 2019".

[10] https://www.local.gov.uk/sites/default/files/documents/Advice%20Note%20-%20commissioning%20out%20of%20area%20care%20and%20support%20services%20paper%20-%20FINAL%20LGA%20ADASS%20LOGO.pdf#:~:text=The%20term%20%E2%80%9Cout%20of%20area%E2%80%9D%20relates%20to%20an,to%20get%20the%20right%20services%20close%20to%20home.

6.2.1.8. Care home 2 has reflected on what actions they can take in the future to ensure better assessment and transfer of care practices. It is important that they have all information about a person's needs, including their health history. They were not made aware that Simon had cancer in the past and been seriously ill. This may well have affected his mental health and fears for his own future. Care home 2 find that sometimes a person's history is withheld with the idea that care home staff are not 'qualified to understand'. They needed more than Simon's care and support needs assessment. In future care home 2 would request a month of daily notes from a person's previous placement, a psychiatrist's letter, and the most recent mental health history, including that leading up to any recent legal detention. This would also assist in a compatibility assessment, looking at how Simon's needs might impact on the needs of others living in the building.

6.2.1.9 Care home 2 hope for a uniform platform for the whole of the UK to use in transition. Although there are existing uniform protocols across England these are not always utilised. South-West ADASS, in conjunction with the Local Government Association and NHSE, have recently produced a toolkit to support transitions for use by health teams, commissioners and providers([11]and[12]) when working with people who have a Learning Disability and/or Autism. Each partner in transition uses a checklist to ensure that they have both shared and received the correct information. Provider services are key to this, they will initially often be the only service in a local area that is aware of a potential out of area placement. They have a key role to play in checking that actions have been undertaken by placing organisations, for example that contact details are available to support a handover of information on mental or physical health, that agencies have worked together to share information with the provider in order to undertake a compatibility assessment, that the placing organisations have indeed contacted the host authority and host secondary health teams. Providers and other involved organisations will need an escalation route to use should placing organisations not comply with agreed processes. These ideas may be worth building on in Dorset to create a systematic approach to ensuring transitions are fully supported by all organisations involved.

6.2.10 Simon could not see his family for two weeks after entering care home 2. He may well have felt anxious and abandoned, this was not how he envisaged returning to Dorset.

[11] https://somersetprovidernetwork.org.uk/out-of-area-ooa-placements-and-transfers-of-care-for-people-with-a-learning-disability-and-or-autism/

[12] https://www.somersetloop.org.uk/wp-content/uploads/2022/07/Guidance-for-operational-staff-and-commissioners-making-Out-of-Area-OOA-Placements.pdf

6.3 Period 2: 28th May 2021 -15th June 2021

6.3.1 After visiting Simon on the 24th May the advanced nurse practitioner asked Simon's GP to organise his depot injection and a COVID vaccination. Simon had been vaccinated in the community hospital prior to travelling to England but the care home had no date for his first vaccination. The GP tasked the surgery advanced nurse practitioner to check on Simon's antipsychotic depot with a note that the local Older People Community Mental Health Team (OPCMHT) should administer this. However, this task was not taken forward, no referral was made to the OPCMHT. The GP also noted that Simon needed his blood monitoring but had no information as to when a lithium blood check was last done as Simon's notes had not yet arrived from Scotland.

6.3.2 The advanced nurse practitioner visited Simon again on the 1st of June and recorded that he was refusing medications, and had been aggressive. She noted that Simon had a long history of "*schizophrenia and bipolar". He is prescribed lithium and has weekly* (sic) *depot injections. There is a lack of medical history and Simon is not forthcoming with information'.* The nurse recorded that Simon was *'known to CMHT'* locally, which he was not. The nurse planned to visit him weekly to try to engage him. She noted that his care plan needed to address his routine and urgent health needs.

6.3.3 The following week, on the 8h June, the nurse was still unable to engage with Simon and talked with the care home deputy manager about the importance of his depot injection. The deputy manager spoke with the OPCMHT and asked for involvement but was told that this would need a primary care referral. The nurse tasked the GP to make a referral to the OPCMHT, but the next day, 9th June, the GP returned the task and asked the nurse to send an urgent letter as a referral.

6.3.4 On the 14th of June the care home emailed the GP to ask if a referral had been made to the OPCMHT. The care home manager reports that it is not unusual for a person to take a month to settle in and be unwilling to engage but the level and intensity of Simon's belief that the devil was in the care home and that this devil within him must be cleansed was overwhelming. His compulsive behaviours were occurring daily. The other people living in the cottage were taken aback by his behaviour and demanded to know what he was doing. Simon was also refusing food and fluids. In an attempt to help him with his distress about the devil the care home manager had contacted a Catholic Priest and Simon also had a cross in his room. Simon was later offered another room. The manager felt at a loss as to how to soothe him, he seemed in mental turmoil.

6.3.5 The GP realised that there had been a miscommunication and sent an urgent referral to the OPCMHT on the 14th of June explaining the concerns and the lack of handover information from Scotland. By the 15th of June the GP had received a brief patient summary from Simon's GP in Scotland and sent this to the OPCMHT. Simon was seen on the 15th of June, the day after the GP referral was received, a swift and timely response to the referral.

However, three weeks had passed since Simon was admitted to the care home who were now struggling to support him.

6.3.6 On the 15th of June an OPCMHT locum psychiatrist and CPN visited Simon at care home 2. Simon was exhibiting the compulsive behaviours. He was described as verbally aggressive and had also punched a staff member in the face. Simon was not taking medication and was reported to have refused to give a blood sample to check lithium safety. The date of his last depot injection was unknown, although it was known that he had fortnightly injections. Simon did not want to talk to the visiting professionals and asked them to leave. The psychiatrist thought that because of his aggressive behaviour treatment appeared "*impossible*", he was thought to "*lack insight and capacity*".

6.3.7 The locum psychiatrist asked for a Mental Health Act (MHA) assessment which took place at 4pm that afternoon. The locum psychiatrist, together with another section 12 doctor and an Approved Mental Health Practitioner (AMHP) attended Simon. The locum psychiatrist observed a difference in Simon's presentation from the morning. He was keen to talk and there was an improvement in his emotional state. On the grounds of this presentation it was assessed that he did not warrant a compulsory detention in hospital. Neither psychiatrist found evidence of mania, depression, hallucinations or perceptual disorder, and both presumed that he had the mental capacity to make decisions about his treatment and care. Simon was agreeable to a voluntary admission to hospital. It was thought that a psychiatric hospital admission would not offer anything different to what was available in the community, but that an alternative care home placement should be sought. Remaining in the care home was the least restrictive option[13] for Simon. The AMHP had no role in the assessment as both s12 doctors were in agreement about there being no grounds for compulsory detention.

6.3.8 Simon initially consented to a depot injection and blood tests as he was concerned about his thyroid. The MHA assessment team attending reported that when it became evident to him that he was not going to be admitted to hospital he became irritable and saw no point in having blood tests or a depot whilst he remained at the care home. He wished to leave, his bag was packed up, and he believed that he could stay with his brother until alternative accommodation was found. He left the care home.

6.3.9 After the assessment the AMHP telephoned Simon's mother who was his nearest relative within the provisions of the MHA[14]. Although she lived a great distance away she did not wish to delegate her role to Simon's brother. The AMHP telephoned Simon's brother to

[13] Mental Health Act 1983 Code of Practice: Chapter 1.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
[14] s26(1) of the MHA 1983

alert him to Simon's departure for his home and to try to gather more information about the history and context of Simon's behaviour and mental health[15].

6.3.11 Around 6.45 pm on the 15th of June Simon was reported as a missing person by care home 2. This report was made via email rather than 101 and was therefore not picked up by the police until almost midnight. Simon had returned by this time having been spotted enroute to his brother's house in wet clothes and lugging a suitcase. Simon's brother returned him to the care home. This was a difficult situation; Simon did not have to remain at care home 2 and had made it clear he did not wish to be there. Simon's family report that the care home left it as very much '*Simon's choice'*. He decided to stay one more night. He had nowhere else to go. His social worker in Scotland later said that he would need to return to Scotland should the placement at care home 2 be unable to meet his needs. But there was no legal framework to require Simon to comply with this.

6.3.12 On hearing that Simon was not to be detained care home 2 reported that they could no longer meet his needs. They were advised to give Simon notice to leave. They did not do so; it was unclear where else he would go.

6.4 Analysis

6.4.1 The primary care team were supportive of Simon's early days at care home 2. The advanced nurse practitioner attended three days after Simon's arrival and attempted to undertake a holistic assessment of his health needs. She continued to try to engage and support Simon. The OPCMHT reacted very quickly to the GP's referral, attending Simon within 24 hours of receiving the referral and working with the AMHP team to arrange an assessment under the MHA 1983 the same day.

6.4.2 The lack of handover led to misunderstanding from the beginning of Simon's stay. The nurse thought that he was known to the OPCMHT, Simon's medication regime was unclear. When undertaking the MHA assessment the two section 12 doctors had no access to Simon's previous history. They were able to ascertain perhaps the nature of his illness, but not the degree as they had no historical or contextual information to use in understanding Simon's behaviour. One of the section 12 doctors had seen Simon that morning, a helpful aspect as he could identify changes in Simon's presentation between the two meetings.

6.4.3 Simon, and care home 2 were without support from a secondary mental health team for just over three weeks after his arrival in Dorset. Misunderstandings and miscommunication at the GP surgery led to this delay, care home 2 attempted to get the OPCMHT involved two weeks after Simon's arrival but met the barrier of the requirement for a primary care referral. Had there been a transition plan secondary mental health services could have been involved from the point of Simon's arrival in Dorset.

[15] MHA 1983 S13 (1A) (b)

6.4.4 The two section 12 doctors found no grounds to detain Simon, he was also agreeable to voluntary admission and initially also agreed to taking his medication and blood tests. The MHA principle of the least restrictive option[16] was met.

6.4.5 Simon was regarded as having the mental capacity to make decisions about his care and treatment during the MHA assessment. Simon had been using mental health services for over 50 years, he was an expert by experience regarding symptoms and medications**.** The basis for his decision making needed further exploration, at this and subsequent encounters. We will explore this further in sections 6.6.5 and 6.6.8 below.

6.4.6**.** By the end of the assessment the situation was still unpredictable. Simon was refusing to take medication or have a blood test and had indeed left the premises. The attending AMHP observed that Simon would probably be re-referred for a second MHA assessment. No multi agency support plan or contingency plans were made after the decision was made not to detain Simon. Care home 2 learned of the outcome of the assessment the next day and initially said that they could no longer meet his needs. They were offered support from the OPMHT but, as we learn in 6.5 below, there was no shared and agreed plan as to how they were to support Simon and what other organisations would do support them.

6.4.7 How can care homes be supported to work with people with deteriorating mental health? Care home 2 is a specialist care home for people with dementia and mental health issues, OPCMHT staff visit the people who live there regularly. Should there be an exception for such premises to enable them to access mental health advice without a primary care referral? Simon needed a 'wrap around' plan to enable him to stay safely at care home 2 whilst another placement was found or to give him the best chance of settling. Simon was not eligible for s117 funding, but it will be useful to understand this status as part of any transition planning. Paper records need to be accessed to ascertain 117 status, this takes time and would not be undertaken by an AMHP team.

6.4.8 People with dementia are supported by a dedicated in-reach team, but there is no such provision for people over 65 who have a mental illness. There had at this point been no contact with the social worker in Scotland to explain the situation and request any necessary extra resource. Beds for people over 65 with functional mental health issues are in short supply in the county with beds in two wards for people who agree to admission. Later we see that Simon was also denied support from the Home Treatment Team on various grounds including the idea that care home 2 was a 'Place of Safety'. There are gaps in the support available to people living in care homes exacerbated by difficulties in coordinating uncertain and pressurised resources for this group of people.

[16] Ibid 1983

6.5 Key Episode 3

6.5.1 On the 16th of June Simon's brother and sister-in-law told his social worker in Scotland about the events described above. The social worker emailed the care home asking to be kept up to date with incidents. His family began to visit Simon daily as he was so unsettled, they helped him to telephone his mother each day.

6.5.2 The organisations involved with Simon undertook a great deal of information gathering and sharing during the next few days. The GP spoke with care home 2 and began to work with the OPCMHT. Simon was allocated to a CPN who began to collect information and tried to plan with the various organisations involved.

6.5.3 The care home told the OPCMHT that they did not feel they could meet Simon's needs. In addition to the other concerns Simon was saying that the other four residents in the 'cottage' were the devil. There was an increased risk of a resident assaulting Simon as they were in a situation they had no control over. The OPCMHT advised the care home to make a safeguarding referral. Care home 2 reported that they spoke with a safeguarding advisor and had been told that they were doing everything that they could in the circumstances.

6.5.4 The OPCMHT spoke with the social worker in Scotland on the 17th of June who also gave the name of Simon's psychiatrist. She did not suggest contacting the CMHT but said she had worked with Simon for a long time and knew him well. The social worker said that talking about the devil was new and something that she had not heard before and that it was previously believed that most of his presentation was "behavioural" as he was not happy at care home 1. She also felt that due to his current presentation and inconsistency in taking medication, he needed a hospital admission to monitor, review medication and to treat him to ensure compliance. The OPCMHT left a message for the consultant psychiatrist in Scotland to make urgent contact to discuss treatment plans. This information was relayed to the care home 2 manager, and it was agreed that the manager would continue to try to gain Simon's consent to have a blood test. The CPN had no answer from the psychiatrist who is thought to have been on leave at the time.

6.5.5 Also on the 17th of June the GP and OPCMHT agreed that Simon's lithium should be stopped in view of his refusal of blood tests. The care home manager was also concerned that Simon's behaviour indicated toxicity. The risk of removing this previously stabilising factor was recognised and acknowledged, the current risks to Simon, to others and from others, would continue to increase. The GP and OPCMHT agreed that there was no current legal framework in place and that Simon had been "*deemed to have capacity*", he was potentially currently making "*unwise choices*". The OPCMHT was unsure that Simon did have capacity. If the risks continued to escalate and Simon continued to refuse medication the OPCMHT would ask for another MHA assessment.

6.5.6 The OPCMHT contacted the Home Treatment Team (HTT) and discussed the current situation, concerns, and risks. The team did not think there was currently a role for their input. The rationale was that Simon was "*in a place of safety"*, it was unclear if he was mentally unwell or "*if it is behavioural"*, there was no background information regarding his mental health, treatment, and baseline and that staff were managing medication although he was currently non-compliant.

6.5.7 Lastly, the OPCMHT contacted the AMHP team. Whilst Simon's mental health had not deteriorated further since the MHA assessment the risks had increased as other residents were beginning to retaliate against his actions. There is some disparity in how this conversation was seen, the AMHP desk recording that an assessment was not requested and the OPCMHT recording that an assessment was not offered.

6.5.8 The OPCMHT reflected that it was hard to know how to support the care home and Simon. The OPCMHT was advised by the AMHP desk to call a Multi-Agency Risk Management meeting (MARM) and to invite Simon. The OPCMHT talked through how to convene a MARM with the team administrator. It seemed hard to quickly get hold of people or work out who to invite from Scotland. OPCMHT thought that the MARM would likely involve the CPN, the GP, the Western Isles social worker and care home 2, people who were already communicating.

6.5.9 Later on the 17th of June the care home 2 manager spoke with the local authority MCA/DoLS team for advice. She believed that Simon had fluctuating capacity and was concerned that she should not let him leave the care home at times when he did not appear to appreciate risk. The manager was advised that she should complete a risk assessment with Simon when he had capacity to make decisions about his care and treatment and agree what actions could be taken to promote his safety and welfare without infringing on his right to liberty and autonomy. The plan should specify what would happen when Simon was assessed as lacking capacity when he wished to leave the care home, what actions should be taken in his best interest to promote his safety and welfare in the least restrictive manner. Simon's friend and sister-in-law had Lasting Power of Attorney for his health and welfare and should be involved in such decisions.

6.5.10 On the 21st of June Simon's brother emailed the AMHP who had attended Simon on the 15th of June. He was concerned that no action had been taken as a result of Simon withdrawing his consent to take medication and have a blood test. The plan of least restriction had never been adhered to. He also reported that Simon had a voice in his head commanding him and thought that he was going to be '*taken away'* today. The AMHP emailed Simon's brother explaining that there was no legal authority to force Simon to accept treatment and that the OPCMHT were aware of the situation and could request a further MHA assessment if this seemed necessary. The care home spoke with the OPCMHT later that day, Simon was now untreated and distressed.

6.5.11 The CPN and the locum psychiatrist visited the care home on the 22nd of June. From talking with the care home manager they realised that Simon only behaved '*inappropriately'* in own his room or in the 'cottage'. Within the main building he was calmer. They therefore spoke with Simon in the conservatory. Simon was calm and keen to talk, his mood was *"even"* and his *"affective reactions adequate".* Simon presented with no depressive or anxiety symptoms. Whilst Simon's speech was normal in rate, flow, and volume, the content was *"difficult to quantify".* Simon believed that he must be sacrificed and would go to hell. He thought that perhaps returning to Scotland was his best chance of survival as he had not seen any "*semi-devils*" there. Simon agreed that he was missing his depot injections and agreed verbally to have them. But he was concerned as to what would happen to him if he was in a "*comatose*" state.

6.5.12 Given this presentation the psychiatrist hoped that Simon would get used to the care home and discover that nothing bad was going to happen to him there. With Simon's consent the CPN was able to administer his depot injection to him. Simon was still refusing to have a blood test and so his lithium could not be recommenced. The CPN recorded that there were risks from others to Simon as the people he lived with were becoming frustrated by his behaviour, there continued to be a risk to himself as he neglected his own health and personal needs. The depot injection was being reintroduced and so had to be titrated, it would be some time before it took effect. The CPN was also concerned that in the 'cottage' Simon spent a good deal of time alone, and that this also increased risk.

6.5.12 On the 29th of June Simon's family emailed the social worker in Scotland saying that things at the care home were looking more positive and that staff were managing Simon's behaviour better. At the OPCMHT meeting on the 30th of June a plan was agreed to administer a depot every fortnight to Simon. The CPN would continue to discuss the blood test and try to gain Simon's consent. The care home also reported an improvement in Simon's behaviour and planned to move him out of the 'cottage' into main building as soon as possible.

6.5.13 Simon's body was found on the morning of the 30th of June. He had left suicide notes for family and friends. Each alleged that care home 2 was an enclave or training school for Satanists and being supported by the authorities, that he was being 'trained' as a victim and would have his body mutilated.

6.6 Analysis

6.6.1 The OPCMHT CPN worked quickly to ascertain as much information as possible about Simon and to create a plan that would support both him and care home 2. The CPN continued to support care home 2.

6.6.2 The efforts of the CPN encountered several barriers. Again, the lack of a transfer meant that it was hard to know who to contact and who had the most relevant information. The social worker could not be the most reliable reporter regarding Simon's mental health

history. There was no contact with the Western Isles CMHT or their managers and the psychiatrist did not return messages.

6.6.3 OPCMHT did not contact Simon's family in Dorset. They could have been able to work with Simon to support him to have a blood test and accept medication earlier. Simon's family could have supported both OPCMHT and care home 2 staff in working with Simon to begin to trust that he was safe at care home 2 and could take his medication there. Simon's family have noted that they were not included in any decision making about Simon, they believe that Simon would have valued their input and support.

6.6.4 Care home 2 were struggling to support Simon. Simon's family had already noted that whilst some staff were able to work with Simon, some used a very directive approach. Simon's family had complained about a member of staff they heard shout at Simon, this staff member was taken off Simon's rota and the family did not wish to make further complaint. There was no agreed approach as to how to work with Simon.

6.6.5 A person centred approach may have informed agreement as to how to work with Simon together with a risk assessed contingency plan. Ideas of '*its behavioural'* and '*unwise choice*' were unhelpful in considering Simon's predicament. He was terrified in the setting and taking actions to keep himself safe by remaining prepared and alert. He was worried that taking medication might render him unable to fend for himself. A move to a different part of the building may have helped Simon, but in the interim OPCMHT recognised that more support was needed.

6.6.6 The Home Treatment team rejected the referral from OPCMHT on several grounds, in particular a lack of knowledge about Simon's history. However, they also considered care home 2 a 'place of safety'. Care home 2 was not a place of safety for Simon, he was afraid there and wished to leave. A hospital setting may have felt safer to Simon. The extreme pressures on resources mean that a person cannot be admitted to hospital because they feel safe there. It may well have been useful to have conversations with Simon about where and when he felt safe and to develop a relationship based on empathy for his fear. Furthermore, care home 2 had already said that they were struggling to meet Simon's needs and to do so safely. The care home could not be a place of safety for Simon.

6.6.7 OPCMHT consulted the AMHP desk on the 17th of June, two days after Simon's MHA assessment. They did not speak with the AMHP who attended on the 15th of June, this AMHP was unavailable. Simon's mental health had not deteriorated but the GP and CPN had already agreed that he could no longer take Lithium. It was agreed with the AMHP desk that if Simon "*continued to refuse medication*" another MHA assessment would be requested. There is some incongruity in how the NHS Serious Incident Report and the analysis submitted by Dorset Council (DC) report this conversation, DC report that an assessment was not requested whilst the SIRI reports that an assessment was not offered. In the meantime, the risks to Simon in the care home were thought to be escalating, he was a risk

to others who in turn were a risk to him. His behaviour risked retaliation from the other people living at the cottage. They also had mental health issues and their own vulnerabilities. Simon's social worker in Scotland had recommended that he needed a hospital admission to monitor, review medication and to treat him to ensure compliance. Simon's brother had emailed the AMHP to express his concern that the plan of least restriction had not started, and that Simon was deteriorating. Perhaps for a long-term resident of a care home who is well known to services a plan to treat him and support him in a familiar setting might work, but Simon was new to the area, unknown to services, risked losing his home because of his behaviour and was untreated for his diagnosed mental disorder.

6.6.8 Those working with Simon did not share a common understanding of whether he had the mental capacity to make decisions about his care and treatment at all times. The concept of making capacitated 'unwise choices' is only useful in understanding a person's capacity within the meaning of the Act[17], i.e., a person making unwise choices should not be thought to lack capacity. The MCA Code of Practice encourages consideration of what is leading the person to make unwise choices and a response to the trauma, duress or thinking that has led to a choice that may damage their wellbeing. Simon's CPN and care home 2 understood that Simon's capacity could 'fluctuate' in different situations. Care home 2 sought advice from the local authority specialist MCA team as to how to plan a response with Simon to his leaving the care home, the advice was good practice and would have involved Simon and his family in considering the situation.

6.6.9 Simon was considered in three multi-disciplinary meetings with the OPCMHT. These meetings are attended by a range of disciplines within the community mental health service and are very useful settings for discussion about clinical needs, risk and responses to these. Wider multi-agency meetings after the 17th of June could have involved colleagues from Scotland, Simon's GP, the Dorset AMHP desk, the local authority MCA team, care home 2 and Simon's family and if wished and appropriate, Simon himself to some or all of the meetings. The meetings could consider all aspects of Simon's situation and create an agreed, risk assessed plan to support him. There are several vehicles to support this, MARM was recommended however OPCMHT did not appear to be familiar with MARM arrangements. Other organisations have commented that arranging a MARM takes confidence and an understanding of role, responsibility and processes. A safeguarding enquiry into Simon's self-neglect and his impact on others in the care home could also be used as a framework to support multi-agency problem solving but no organisation made a safeguarding concern referral. The Care Programme Approach was not in use for Simon at

[17] https://www.communitycare.co.uk/2019/06/28/misinterpretation-unwise-decisions-principle-illustrates-value-legal-literacy-social-workers/

that time, but CPA meetings can also be used as multi-agency meetings. A multi-agency meeting could have brought all organisations together, a more effective approach than a series of individual conversations. Such meetings can take time to convene and must be given priority by busy organisations.

7.Findings and Learning Points

The findings below are set against the specific areas of focus as detailed in the agreed terms of reference.

7.1 How was Simon's transition from the Western Isles to Dorset managed? Were there barriers to an effective transition plan and communication between the two areas? What went well? What can we learn to inform practice and systems around transition from one area to another?

7.1.1 Simon's transition from the Western Isles to Dorset was not effectively planned, risk assessed or supported. Simon had complex needs and any transition should have been carefully planned and well supported. The information exchanged between areas did not detail Simon's mental health needs or treatment plan, his history or the intensity of his needs. A key organisation, the mental health trust, was not made aware that Simon was arriving in the area. There were no joint discussions prior to Simon's arrival and no contact details for relevant practitioners to use for liaison. Despite the best efforts of individuals in both the Western Isles and Dorset the transition plan was inadequate. This omission had several consequences:

- Care home 2 was not able to undertake an effective compatibility assessment, so putting Simon and his fellow residents at risk of harm.
- Simon's care was not immediately picked up by the OPMHT, this was exacerbated by local delays which meant that he was in Dorset for three weeks before secondary mental health knew of his presence.
- There were significant delays in Simon being offered his regular medication and blood testing regime.
- There was uncertainty about the degree of Simon's illness, which had some impact on decision-making about detention under the MHA, voluntary admission and support from the Home Treatment team.
- There was a lack of contingency planning by the placing authority on actions to be taken should the placement break down.
- No exploration of Simon's MHA s117 status in England which, if he were eligible, could have assisted with aftercare and prevention of readmission.
- Confusion about who was involved in the Western Isles and how to contact them led to partial information sharing.

Learning Point 1

Careful transition planning is essential when a person with care and support needs moves from one area to another within the UK. When a person has complex needs the transition plan will need to be multi-agency and will take some time to develop.

Learning Point 2

The potentially negative consequences of undertaking the transition of a person with complex needs without an agreed plan may mean that the option to delay the transfer should be considered in order to make the necessary arrangements.

The absence of transition plan may be attributed to short staffing in the Western Isles services together with a lack of escalation. Simon's distress and conviction that he would feel better in Dorset may have also hastened his departure. Simon was in an inappropriate placement but, given the scarcity of resource in the Western Isles, he was in the only placement possible at the time.

Those contributing to the SAR have identified that a transition plan for a person with mental health complex needs should include:

Direct contact between CMHTs to exchange information including the person's treatment plan, current medication information, mental health history, risks including any suicide ideation, physical health history and family/LPA contact details.

A multi-agency approach to planning the transition, involving care providers and other relevant involved organisations at planning meetings arranged by the placing area.

Support for the provider's assessment of needs and compatibility assessment

An agreed contingency plan informed by current risk assessments.

Reliable contact details for key practitioners and managers in both host and placing areas.

Agreement on reviewing arrangements.

Learning Point 3

As well as containing vital basic information transition plans may need to be unique to each individual, these elements are usefully explored via direct contact and discussion with expectations of multi-agency planning. These activities will be led by the placing area with the cooperation of the host area.

Identified barriers to successful transition planning included confusion over who to contact. This barrier will impede both simple and complex transitions. Most organisations in a host area will not be aware of the individual unless organisations in the placing area can identify who to inform. Provider organisations will be aware of a proposed placement and are in a good position to identify that the necessary arrangements are consistent with local guidance, and to escalate if this is not the case. Work already undertaken by South West

ADASS[18], which Dorset Council will be aware of, could inform the development of local guidance.

Learning Point 4

Whilst organisations in England and Scotland appear aware of best practice guidance about transitional planning it can be difficult to know who to contact and how to work together. Any local practice guidance, tools and templates, should be available to all organisations, in particular to care providers.

There appears to be no agreed system or processes to transfer GP electronic records between England and Scotland. This has had significant adverse consequences for Simon, a person with complex needs that cannot be easily understood from a patient summary. The health care needs of other patients will also be put at risk from the absence of agreed processes.

Learning Point 5

Agreed national processes must be in place to support people moving from one UK country to another. The endeavours of individual practitioners and organisations will not be able to support a safe transition without these national systems in place.

7.2 How did organisations in Dorset work together to respond to a) Simon's distress and b) the care home's challenges in supporting him? Were there barriers to working together? What went well? What can we learn to inform practice and systems around multi and inter agency working in Dorset?

7.2.1 Responding to Simon's distress.

Individuals recognised Simon's distress, particularly his fears regarding his room, and attempted to address this in a number of ways. Care home 2 tried to give him practical reassurance that the room was safe. The psychiatrist recognised that Simon was less distressed in the main building and recommended moving room. The psychiatrist hoped that Simon would begin to understand that he was safe at care home 2.

Simon's family had much to offer in terms of reassurance and support to Simon, especially regarding taking medication and having blood tests. Whereas others did not have his trust or the ability to persuade and negotiate with him, his brother and sister-in-law did. Because of COVID restrictions Simon had not been able to see them for the first two weeks at care home 2 which may well have exacerbated his fears. He had come to Dorset to be closer to them, he may have needed the reassurance of their physical presence. The OPCMHT did not work with Simon's family to utilise their valuable assistance.

[18] Ibid 2022 at https://www.somersetloop.org.uk/wp-content/uploads/2022/07/Guidance-for-operational-staff-and-commissioners-making-Out-of-Area-OOA-Placements.pdf

Learning Point 6

Families and friends can be an important source of information and support to plans to meet a person's needs. The contribution of families 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.

There does not appear to be a commonly shared view of what was informing Simon's distress. The idea that his actions were 'behavioural' and related to his wish to leave both care homes 1 and 2 was unhelpful. This idea led to assumptions that Simon was in control of his behaviour and was deliberately being antagonistic in order to be sent somewhere else. In his writing Simon appears aware of this idea but also very convinced of the threat from devils and the need to prepare for his own imminent death. Simon has written that he felt safe in APU and indeed there his behaviours had diminished, this may have informed his wish to be in a hospital. He told people that he did not feel safe at care home 2, that he did not trust either staff or other people living in the cottage, that he felt that he was going to be tortured and killed. These fears were strong and imminent and needed to be understood and appreciated in order to create a timely plan to support him. Simon did not consider care home 2 'a place of safety' and this also needed to be factored in the decisions made about his care. Simon was concerned as to what would happen to him when he recommenced anti-psychotic medication, we do not know why he refused blood tests. What did Simon think needed to happen to make it safe for him to do so?

Learning Point 7

Decisions and plans need to be informed by empathy for the person's perception of their situation. This understanding can be shared with other decision makers so creating a common understanding of what the meaning of the person's behaviour is and what may alleviate their distress.

There was no commonly shared view of Simon's capacity to make decisions about his own care and accommodation, this was generally seen as 'fluctuating' but with no clear formulation of what was informing this fluctuation. Care home 2 sought further useful advice from the local authority MCA team. Simon was also seen as making 'unwise choices' with no exploration of what was informing those choices. This relates to Learning Point 6 above, whilst Simon was assumed to have the mental capacity to make decisions about his care and accommodation, there was no explicit shared awareness of why he was making those decisions.

Learning Point 8

The MCA code of practice[19] 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.

A plan of least restriction was developed during the MHA assessment of 15th June. Before the assessing team had left Simon had refused to cooperate with the plan. In the following two days risks to Simon, and to others, grew. By the 17th of June the decision had been made to stop Simon's lithium as he did not consent to blood tests. Care home 2 was clear that they could no longer meet his needs. A further MHA assessment was indicated, on the grounds that Simon was not compliant with the plan, his diagnosed mental disorder was untreated, risks were increasing, he was unknown to services and at risk of losing his home because of his behaviour. An MHA assessment was not requested, or in the view of the OPMHT, offered. AMHP 1 was not spoken with. Simon's brother was also concerned that the plan made at the MHA assessment could not be followed. He was not the nearest relative and so could not request an assessment under the MHA 1983[20]. He was reassured by AMHP 1 that the OPCMHT would request an assessment if needed.

Learning Point 9

Shared contingency plans to support a person who is mentally unwell, but not detainable under the MHA 1983, should stipulate under what circumstances a further assessment under the MHA should be considered and who is responsible for initiating this. All efforts should be made to follow this up with the original AMHP who will be aware of the situation.

7.2.2 Responding to the care home's challenges in supporting Simon.

The OPCMHT recognised that the care home needed support to meet Simon's needs safely. Over a period of weeks circumstances might have improved but in the interim Simon was not 'in a place of safety' and presented risk to himself and to others. If Simon were not to be detained, care home 2 required substantial support whilst alternatives were explored.

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[19] The MCA Code of Practice points out that

"There may be cause for concern if somebody:

• repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or

• makes a particular unwise decision that is obviously irrational or out of character.

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices." Page 25 MCA Code of Practice 2005

[20] MHA 1983 section 26

The Review has heard that there is a significant gap in resources for people over 65 who have a functional mental illness. There is no in-reach service to support care homes whilst the Home Treatment team is unlikely to support a care home, viewing it as a 24-hour place of safety. There are very few inpatient beds available locally. Simon needed 'wrap around' support, the focus of which would have been clinical support, but also support from his placing authority in the shape of extra resource and from Dorset specialist advisors, including MCA and adult safeguarding. The OPCMHT kept in close communication with the care home, offering advice and support. Simon and care home 2 needed more than this.

Learning Point 10

There is a gap in Dorset services for people over the age of 65 with functional mental illnesses which leads to an inequality of provision to this group. This gap means that care homes where older people are in mental health crisis are not supported well, this can lead to breakdown in placements and un-necessary admission to hospital as well as harm to self and others.

A multi-agency meeting would have been useful to assemble all potential contributors to a plan to risk assess and problem solve together. There are several processes that could assist this. In Simon's case a MARM or a safeguarding strategy meeting. CPA meetings are currently also useful vehicles for multiagency discussion.

Learning Point 11

Multi-agency meetings are essential in formulating plans to address complex or acute need. Organisations may not be confident in how to convene or chair such meetings, what their purpose is or the importance of attendance and participation. These barriers have an impact on organisations' ability to create and share plans to mitigate risk.

7.3 Did the restrictions necessary in relation to the COVID-19 pandemic have an impact on the above areas of focus? What can we learn from this?

7.3.1 The key impact of COVID restrictions on Simon was separation from his friends and family. Although his mother lived close by, he was not able to see her face to face. He came down to Dorset with his brother and sister-in-law but may have felt abandoned to strangers as they were unable to visit for his first two weeks at care home 2. Like many others in his situation, COVID restrictions denied Simon's Human Rights Act article 8 rights in order to preserve article 2 rights. The emotional impact on many people in this situation was profound[21].

See Learning Point 6.

[21] https://committees.parliament.uk/publications/5747/documents/65438/default/

7.3.2 Practitioners continued to see Simon face to face. He appears to have been reviewed by his psychiatrist in the Western Isles via video on one occasion but all other visits in Dorset as well as Scotland were in person. It is unknown whether COVID was a factor behind the staff absences in the Western Isles. The use of technology assisted his family and friends to attend a review of Simon's needs in the Western Isles. Technology did and would have assisted multi-agency communication across both countries.

8. Conclusion.

Simon's suicide was unexpected. There was nothing in his history or presentation at the time to indicate this risk. We have however identified aspects of practice, multi-agency working across and within areas, policy and the systems/resources that people work within, which can be developed to improve support to people in Simon's situation. Simon may have been surprised, and, given his kindness and mentoring of others, pleased that we have used his experiences in this way. A late entry in Simon's journal whilst he was at care home 2 reflects:

This is an attempt to express myself, as a Testament. I don't expect there will be any memorial; and after a while, not even be remembered. A "sad" case indeed, as someone said. I can write this, not even suspecting it will be read, or could be used as evidence somehow. It makes me (temporarily) feel better, and that is <u>something</u> at least.

9. Recommendations to Dorset Safeguarding Adults Board.

9.1 Dorset Safeguarding Adults Board is recommended to share the learning from this SAR with the Outer Hebrides Adult Protection Committee. The Outer Hebrides Adult Protection Committee is invited to share Simon's case with NHS Scotland with regard to the impact of the absence of a jointly agreed system to share GP electronic records between Scotland and England.

9.2 The SAB Chair is recommended to use regional and national SAB escalation pathways to consider how to highlight the impact on individuals of the absence of agreed national systems for the transfer of GP electronic records and establish the progress of plans to initiate such a system.

9.3 The SAB Chair is also recommended to ask the national SAB Chairs network to write to the national COVID inquiry with the purpose of contributing the SARs relating to the impact of COVID on adults with care and support needs.

10.Recommendations to specific organisations.

10.1 NHS Dorset and Dorset Council are recommended to lead work with health and social care providers to build on the existing SWADASS work[22] to create a toolkit to support the transition of adults with care and support needs, including mental health needs, into and out of the local area.

Learning Points 1,2,3, 4 and 5.

10.2 Dorset Council and Dorset Healthcare University NHS Foundation Trust are recommended to address the lack of provision for adults over 65 with functional mental illness in a) care homes and b) across in-patient mental health services, and to escalate to NHS Dorset according to the agreed process.

Learning Point 10

10.3 The Dorset Healthcare University NHS Foundation Trust is recommended to take steps to assure the Dorset SAB that plans are person centred and strengths based, with an empathic approach to the perspective of the person at the centre of these. A strengths-based approach will also involve the support of families and carers as appropriate. These principles are reflected in the NHS England Position Statement (2021) [23] on the future of CPA and as such may be developed alongside new approaches in Dorset.

Learning Points 6 and 7.

10.4 All organisations are recommended to take steps to ensure that practitioners understand and use the provisions of the Mental Capacity Act (MCA) in accordance with the MCA Code of Practice, understanding that 'unwise choices' that may lead to harm need further investigation and understanding.

[22] https://somersetprovidernetwork.org.uk/out-of-area-ooa-placements-and-transfers-of-care-for-people-with-a-learning-disability-and-or-autism/

[22] https://www.somersetloop.org.uk/wp-content/uploads/2022/07/Guidance-for-operational-staff-and-commissioners-making-Out-of-Area-OOA-Placements.pdf

[23] https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

Learning Point 8

10.5 Dorset Council AMHP service and the Dorset Healthcare University NHS Foundation Trust are recommended to work together to plan how the re-referral of an individual for an assessment under the MHA 1983 is explicit in detailed contingency plans made if the person is not detained and risk remains. These are particularly important when a plan of least restriction is no longer being followed by the person.

Learning Point 9.

10.6 All organisations are recommended to support their practitioners and managers in understanding and confident use of the MARM process and other multi-agency forums.

Learning Point 11.

Appendix 1 Terms of Reference.

Terms of Reference:

Dorset Safeguarding Adults Board (DSAB)

Safeguarding Adults Review (SAR) Mr TH

1. Introduction

1.1 Mr TH was found deceased in his room in an annex to a Care Home in Dorset on the 30th June 2021. At post-mortem he was found to have died of asphyxia after placing a ligature and a plastic bag around his head.

1.2 Mr TH had moved to Dorset from the Western Isles on the 21st May 2021. He is reported to have arrived at the Care Home without full transfer information which impacted on his support and administration of medication in Dorset. Mr TH had been talking about the possibility of moving with local practitioners in the Western Isles since early April 2021. At this point he was in hospital, his previous care home placement having broken down and no other care home in the area able to cater for his needs. Mr TH is reported to have made the decision to move to Dorset, wanting to be closer to his family who were willing to support him and facilitate his move.

1.3 The Dorset Safeguarding Adults Board has commissioned a Review under section 44 of the Care Act 2014 in order to learn from the circumstances around Mr TH's death, how agencies worked together to safeguard him and how the wider safeguarding system supported this.

1.4 All Safeguarding Adults Reviews, whether mandatory or discretionary, are held under section 44 of the Care Act 2014. The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. A SAB can also arrange a SAR under section 44 of any other case involving an adult in its area with needs for care and support.

Under section 45 of the Care Act 2014, all organisations who are requested by DSAB to supply information to the SAR are required to do so for the purpose of enabling or assisting the SAB to exercise its functions.

1.5 The general areas of SAR focus are:

- To establish whether there are lessons to be learnt from the circumstances of the case and about the way in which professionals and organisations work together to safeguard adults at risk.

- To review the effectiveness of procedures (both multi-agency and those of individual organisations).
- To inform and improve systems and practice around 'out of area' placements.
- To inform and improve local multi and inter agency practice.
- To improve practice by acting on learning (developing best practice).
- To connect the learning from previous Safeguarding Adults Reviews (SARs).

2. Time period and specific areas of focus

2.1 The time period covered by the review is 1st April 2021, when Mr TH began to talk about a plan to move to Dorset, until 30th June 2021, the day of his death.

2.2 The specific areas of focus for this review:

2.2.1 How was Mr TH's transition from the Western Isles to Dorset managed? Were there barriers to an effective transition plan and communication between the two areas? What went well? What can we learn to inform practice and systems around transition from one area to another?

2.2.2 How did organisations in Dorset work together to respond to a) Mr TH's distress and b) the care home's challenges in supporting him? Were there barriers to working together? What went well? What can we learn to inform practice and systems around multi and inter agency working in Dorset?

2.2.3 Did the restrictions necessary in relation to the COVID-19 pandemic have an impact on the above areas of focus? What can we learn from this?

3.Methodology:

3.1 This Safeguarding Adults Review will be undertaken using a hybrid methodology that will analyse the complex circumstances that practitioners work in and provide opportunities for shared learning, focusing on improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and wellbeing of adults.

3.2 Each organisation involved will be asked to complete a Report which will focus on the actions and decisions of their own organisation, this will include a chronology with analysis of practice and decision making. Organisations will include those in the Western Isles and in Dorset.

3.3 A Panel of Report authors will work with the lead reviewer to identify initial themes from the organisation's reports. This will include authors from the Western Isles and Dorset. Initial themes will be explored further in a Practitioner Reflection and Learning Workshop with the practitioners and first line managers who worked with and made decisions about Mr TH. These will ensure their involvement in the review and will help to develop an

understanding of the context in which practice took place and how it could be further developed.

3.4 The Panel will support the lead reviewer to develop a summary Report which will then be subject to further governance before the presentation to DSAB.

3.5 After the DSAB has accepted the recommendations of the SAR the final report will be shared with the Chair of the Outer Hebrides Adult Protection Committee to inform the development of systems and practice in the Western Isles.

4. **Family participation:**

4.1 Mr TH's family will be approached to give their views on the Terms of Reference. They will be invited to further contribute to the SAR, and to review and comment on the final draft of the Overview Report after approval by the DSAB SAR subgroup.

5. Parallel processes

5.1 Dorset Health NHS Foundation Trust undertook a Serious Incident review of Mr TH's care from the 14th June until the 30th June 2021. This is now complete.

6.Organisations contributing to the SAR:

Western Isles:

Health Board

Local authority - Adult Support & Protection and Mental Health

Dorset:

- Dorset Health Care University NHS Foundation Trust – Community Mental Health Team
- Dorset County Council - Adult Safeguarding and AMHP Hub
- Dorset Police
- Agincare – Crecy Care Home