Safeguarding Adult Review - Andrew

Author: Helen Rankin

Acknowledgement

Members of the Swindon Safeguarding Partnership (SSP) and the independent reviewer express their sincere regret at the death of Andrew. Sincere condolences are offered to her relatives and friends.

The reviewer, working with SSP members, hope and intend that this review will enable lessons to be learned and will contribute to service development and improvement.

April 2022

1. Introduction

Andrew was a 77 year old male who on the September 2020 was found unresponsive inside a property besides his adult son who was found deceased at the scene. Andrew subsequently passed away in hospital. Since that time both deaths have been ruled as suicide by the coroner.

It was reported that they were holding hands and had Andrew's late wife's wedding ring in their hands. Andrew was transferred to hospital for treatment. Toxicology report indicates that Andrew had ingested Benzodiazepines which were not prescribed, Andrew never recovered and no further information was obtained before his death.

Andrew was open to Safeguarding Adults team within Swindon Borough Council with a Section 42enquiry on-going at the time of his death. A referral had been made by the Ambulance Service in March 2020 as a result of an incident whereby Andrew's son had given Andrew Pregabalin which he had bought from a friend which then resulted in Andrew being hospitalised and it was this enquiry that was still open.

Andrew lived alone and had a number of health conditions, including Atrial Fibrillation, history of depression and anxiety, hearing loss, prostate cancer and he had been shielding due to high risk of COVID-19.

Andrew's wife died in 2017 and in the years that followed, he was treated for depression and low mood. There is evidence from practitioners' reports that Andrew began to show signs of self-neglecting behaviours including a deterioration in his living environment, the cancellation of a care package from domiciliary care agency and poor self-care. Andrew's son was his unpaid family carer and was heavily involved in services being able to access his father to provide support.

2. Safeguarding Adult Reviews

Swindon Safeguarding Partnership (SSP) has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SSP knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SSP knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the SSP, its members or others worked together to safeguard the adult.

(Adapted from sections 44(1)-(3) & (5), Care Act 2014)

The SSP also has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whetheran individual's death was the result of abuse or neglect. Abuse and neglect include self-neglect.

SSP members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

The referral for consideration of this case for a SAR was sent by the Named GP for Safeguarding for the Banes Swindon Wiltshire Clinical Commissioning Group (BSW CCG) on 2nd October 2020. The referral indicated concern that Andrew was open to Safeguarding Adults team within Swindon Borough Council with a Section 42 enquiry on-going at the time of his death. A referral was made by the Ambulance Service on the 12.3.20 as a result of an incident whereby Andrew's son, had given Andrew Pregabalin which he had bought from a friend which then resulted in Andrew being hospitalised. In the SAR referral, under the heading *characteristics of the case,* physical abuse was indicated.

After discussion both the chair of the SSP and the SSP's Practice Review Group agreed that a discretionary review would take place because the case raised issues in relation to:

1. The relationship between father and son, co-dependency and own individual care and support needs?
2. Role of son as a Carer – did he see himself as such, was it a protective factor, were professionals aware of the context of their relationship and his own needs?
3. Coercion and control, review learning from Honour SAR and how things have changed in practice? Has the learning been embedded?
4. How clinicians manage DNAs in adults and recognise whether autonomy has been constrained or not – local practices, vulnerable people who require support to attend appointments.
5. Considerations of professional's unconscious bias – attitude to individuals who use substances to manage their daily lives and life experiences, understanding their background and trauma informed approach, holistic support and other services to support them.

6. Dual diagnosis of Substance Misuse and mental health – engagement within a service, support to remain in service
7. Impact of pandemic on service provision – did it impact on being able to meet with Father on his own?
8. Recognition of suicide ideation, suicide prevention through a safeguarding lens, looking at indicators in relation to life events, suicide prevention as a multi-agency issue not just single agency, in relation to wider work that is happening?
9. How accessible are services? Have we commissioned (specific) services in the right way?
10. What process was in place for severely suicidal patients including engagement and suicide prevention?
11. Was there a focus on understanding the behaviour in the context of risk management including trauma history?

The Practice Review Group agreed that the methodology for this review would be for the panel review all relevant information and as a group decide on findings and recommendations for the Partnership, this would also include involving frontline practitioners where appropriate for feedback.

Agencies were asked to provide details of their involvement with Andrew and Christopher and requested toprovide an Individual Management Report and accompanying reflection and analysis of practice.

Dominic Taylor led the review and chaired the review meetings with the report written by Helen Rankin, Development Manager, Swindon Safeguarding Partnership.

It was agreed that the period under review is to be from October 2018 through to 22nd September 2020 (the date when Andrew died)

Key events outside this period may be considered where they are deemed relevant to the aims of the review and where they will help to inform the overall analysis.

- Wife's death in 2017
- October 2018 – Safeguarding referral

The following agencies which had commissioned or provided services to Andrew contributed to thereview:

- SSP Development Manager
- Swindon Borough Council Adult Safeguarding Team
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- CCG BSW
- Primary Care
- Great Western Hospitals NHS Foundation Trust
- South Western Ambulance Service Foundation Trust
- Turning Point
- Wiltshire Police

The Practice Review Group received administrative support from the SSP Business Support Officer.

3. Review Process

The report writer was supplied with a series of relevant documents:

- Patient Safety Investigation Report 2020/148182
- A standard information form from each agency involved (including nil returns)
- Terms of Reference for the SAR

A SAR Panel Review Group Meeting was held on April 2021 to discuss the process and timeline of the review.
A SAR Panel Review Group Meeting was held on June 2021 to discuss the Individual Management Reports which were submitted and identify learning and recommendations.

All this information was analysed by the report writer and an initial draft of this report was produced and this went to the Panel Review group on October 21.

The report was agreed by the Practice Review Group on November 21.

4. Family involvement

Andrew's sister was contacted and invited to take part in the review. She requested a copy of the report which was shared with her and had a discussion about its contents.

5. Analysis of key lines of enquiry

<u>The relationship between father and son, co-dependency and own individual care and support needs</u>

A number of agencies were involved in the care and support of Andrew.

Both Andrew and Christopher had received services from Avon and Wiltshire Mental Health Partnership (AWP), this was predominantly within Primary Care Liaison (PCLS). Neither Andrew nor Christopher were inreceipt of Secondary Mental Health Services at the time of their deaths. Andrew was first known to AWP in June 2011 and there was evidence of suicide ideation and intent which was acted on. Andrew was referred a second time in November 2017 following his wife's death presenting with low mood but no evidence suicide ideation or intent. Andrew was referred to Older Adult Mental Health Liaison in March 2020 following admission to GWH following collapse at home. Andrew had been given street Pregabalin by his son for pain leading to this collapse. He was presenting with low mood, anxiety, agitation, hallucinations and paranoid thoughts but therewas no evidence of suicidal thoughts. Following referrals to the Memory service in May and

July 2020, a referral was received into PCLS on 10th August 2020 from Swindon Borough Council (SBC) Adult Safeguarding team who had visited Andrew at home and had concerns about his appearance and isolation. When PCLS contacted Andrew to conduct a telephone triage assessment, this was only partially completed due to Andrew's hearing difficulties. Andrew's son advised PCLSon the 12th August 2020 that his father did not need mental health services as he had been prescribed Pregabalin which was helping his anxiety. Andrew's son finally agreed for his father to be seen when challenged that he was not able to make this decision on his father's behalf.

The Primary Care Liaison Service (PCLS) attempted to make three home visits to Andrew and on 09th September 2020, the PCLS team received information from the GP Practice Safeguarding Lead and the SBC initial contact team at the Local Authority. Based on their information, the PCLS team adopted a two-person approach for the assessment (due to the potential concerns of coercive control from his son, and the reported tendency of the Son to dominate assessments). They were also given the contact details of the care agency, so they were ableto ensure that Andrew would be in, and the assessment was able to take place on 10th September 2020. The assessment took place and the son was not present at the time.

The outcome of the assessment was that the PCLS Team Doctor and PCLS Nurse who completed it considered that Andrew's social care needs were the priority. They found that Andrew had been low in mood due to the pandemic restrictions on his social activities and isolation as hewas categorised as vulnerable/shielding person. They stated that Andrew was able to discuss possible treatment options that could be available to him. They stated that during the assessment there had not been any thoughts around suicide, at that time and they had beenmore concerned about the impact of physical home environment, on his wellbeing and his social care needs. A formal capacity assessment was not carried out because there was no reason to doubt capacity and Andrew was worked with under Principal 1 of the Mental Capacity Act. Andrew declined any further support from mental health or a referral to adult social care for a care needs assessment. He was discharged from AWP Primary Care Liaison Service on completion of the assessment.

SBC Adult Safeguarding records indicated that two safeguarding referrals were made in respect of Andrew. The first referral in October 2018 was received from South West Ambulance Service Trust (SWAST) regarding concerns that his son was harassing him for financial assistance via credit card details. Ambulance also raised that his property was cluttered and unkempt. Andrew was taken to hospital and once he was discharged, a social worker spoke with him and Andrew did not express that his son ever puts him under pressure. The case was closed.

The second referral on 20th March 2020 was received into the Initial Contact Team from SWAST and recorded as self-neglect and passed to Adult Safeguarding team. There was an incident of Andrew taking prescribed medication Pregablin for back pain given to him by his

son Christopher, obtained from the street. The referral proceeded to a Section 42 enquiry on the basis of the concern that Andrew's son has given his Father Pregablin twice in one night causing a hospital admission. It was unclear as to whether or not Andrew had consented to taking the drugs or knew what he was being given. Andrew had care and support needs and was at risk or experiencing abuseand neglect and may not be able to protect himself from harm.

Case records from Adult Safeguarding detailed the Enquiry Actions that had been completed. In the course of the enquiry, a planning meeting was convened on 9th July between Police, GP Safeguarding Lead and the enquiry manager. Agreement was gained from police to undertake a welfare check as at the time there was concerns regarding cuckooing. This did not appear to be the case. An ICT referral was made and further visits were to be made by adult safeguarding. The GP had recently reviewed medications. It was established that Christopher was opiate dependent. A GP welfare call and Police welfare calls identified issues with the presentation of the home including empty alcohol bottles and unclean and soiled bed clothes. Home visits from adult safeguarding and adult social care social workers, welfare visits by Wiltshire Police and the GP took place on separate occasions.

A home visit was undertaken by the enquiry manager (EM) and enquiry officer (EO) on 21st July but Andrew refused to allow them to enter the property. A second home visit took place on 10th August 2020 while Christopher was present during which a discussion was held with Christopher regarding medication and his father - Christopher fully acknowledged that giving his father un-prescribedmedications was a poor decision and scared him at the time of doing so. Christopher noted that he would not repeat these actions again. Christopher cooperated when the EM and EO asked to speak with Andrew separately. Andrew noted they may argue sometimes but he was not scared of Christopher in anyway and appreciated his support. Andrew was felt to have capacity around the safeguarding concerns and was able to demonstrate insight and understanding into risks around misuse of controlled medications. Support needs were identified around mobility and some personal care tasks as bedroom was noted to be in a poor condition and some struggles with dressing onAndrew's behalf and there not being much food in the property. Christopher nor Andrew agreed that Christopher was misusing any of Andrew's controlled medication - Christopher stated he was on a script to manage opiate addiction and would go elsewhere if he needed illicit substances. Concerns were raised by Andrew's presentation - he appeared "absent in conversations" and the EM and EO stated that they worried about his mental health. Daily care calls were implemented, OT to be instructed with mobility and PCLS referral to be made. Christopher agreed to move items to reduce fall risk and to smoke cannabis outside of the property.

A follow up visit was made by the police. In case notes from the Safeguarding team updated on 14/09/2020, it stated "discussion was held around closure. Whilst recognising that there were still risks actions had been taken to establish that the risk had been reduced for Andrew.

Andrew was deemed to have capacity and was only willing to accept so much as per his wishes. The risk of the safeguarding was about Christopher giving medication to Andrew. Andrew demonstrated insight into the risks of this action"

Care calls were implemented and monitored by adult social care although they were advised Andrew had reduced care calls on the basis that he found the frequency of care too intrusive. Adultsafeguarding case notes recorded that "He was felt to have had capacity to do so although concerns regarding coercive control from son. Acknowledged coercive aspects of son and also recognise that Andrew identifies him as a support factor." A referral was also made to PCLS as detailed in the section above. The Section 42 enquiry was still open when Andrew died and there were no details provided about a formal risk assessment.

Health records indicated that Andrew's son was his father's carer from 2017. Records suggested that Andrew's son would often be the one to contact the GP for his father. It was reported that Andrew was hard of hearing and because of this Christopher had placed a note on the door of the property stating that all professionals should call him to gain access to his father. Christopher did not live at the property.

It was not recorded on the GP surgery Electronic Patient Records System that Andrew was being cared for by his son or that he identified himself as his father's main carer. However, records suggest that when dealing with the care agency providing support to his father that Andrew's son would reiterate that all contact should come through him. This is mirrored in the recording from Adult Safeguarding that Andrew's son organised contact with his father and provided information about him.

Health records also suggest that Andrew's son would use his caring role as a reason not to engagewith services regarding his own mental health despite articulating to staff that his needs were'complex' and he 'needed to be seen'. Andrew also declined services (and was deemed to have capacity to do so). On 12th March Andrew was admitted to ED at GWH with reduced consciousnessand the record suggests that Andrew's son was 'very reluctant for the patient to come in'. It is reasonable to suggest that an admission would lead services to question the health and well-being of both parties – an intrusion that records suggests was deflected on a number of occasions.

Andrew's son Christopher had his own care needs. He was assessed and provided with treatment recommendations by AWP Primary Care Liaison service for his mental health from April 2018 to January 2019. Christopher self-referred in April 2018 but was advised to request a referral via his GPwho referred him in June. He was assessed in July following a number of missed appointments. Christopher expressed low mood, anxiety and some paranoid thoughts. It is noted that"Christopher has thoughts of suicide but he has no plans or intent to act on them. His dad is a major protective factor for him." Christopher had a face to face review with

PCLS in august 2018 where he discussed his family history, his caring role for Andrew and his mental health concerns. Christopher was also known to Turning Point and had periods of engagement with the service. Christopher was a polydrug user and illicit pregablin was made reference to in his contact notes. Christopher stated that he was living with his father supporting with his basic living needs e.g. cooking, cleaning, attending GP appointments. Discussions were had with Christopher about ensuring both Christopher and Andrew had appropriate support in place, and Christopher was signposted to speak to Adult Social Care and Age UK. These signposts were not followed up on by Turning Point, as Christopher had never disclosed that hewas unable to cope in supporting his father (except during periods where his drug use wasproblematic). Christopher did not appear to need support to manage his own daily living.

There was no formal risk assessment or exploration of Christopher as a potential source of harm as well as support for Andrew and potential missed opportunities then which may have informed a robust multi-agency risk assessment and safeguarding plan. This also raises a question as to whether Christopher's drug use and its impact on his ability to care for Andrew needed to be explored in more detail. The Adult Safeguarding team at SBC were aware that Christopher was opiate dependent and was on a script. The reflection from the Individual Management Report (IMR) states that"focus had been on Andrew and in hindsight, the Enquiry Manager thought there could have beenmore focus on the son's needs; the EM identified this as learning: he would now try and access information that Turning Point held on the son; however, he was concentrated on keeping Andrew safe and the son seemed to play an active and crucial role in engaging Andrew. Further informationon Christopher's role as a carer is detailed in the next section.

Role of son as a Carer – did he see himself as such, was it a protective factor, were professionals aware of the context of their relationship and his own needs

All services that were involved in supporting Andrew were aware of and recorded that Christopher considered himself to be his father's main carer.

There is information within Christopher's Avon and Wiltshire Mental Health Partnership (AWP), records that he identified himself as Andrew's carer as early as 2018 and that he had considered this his role since the death of Andrew's wife and Christopher's mother in 2017. There is reference within Christopher's AWP records that identifies he struggled with feelings of guilt at letting his parents downand this impacted on his paranoid thought patterns. It is likely that the focus from social care and PCLS on Andrew's poor physical environment and evident significant self-neglect would have triggered his ongoing thoughts of guilt at letting both his father and mother down.

The assessor identifies that the death of Christopher's mother had been a significant event and he hadspent a lot of time trying to make sense of past events which had left him with a sense of immense guilt about the suffering of his mother in her life. Christopher reports he has been hearing voices for the past decade. At the time of the assessment he reported that frequency to be afew times a week. Christopher identified himself as the carer for his father

and stated that he found it heart-breaking seeing his father suffer. In the face to face review in August 2018 the assessor established that Christopher was visiting Andrew daily and supporting with meals and mobility. Andrew's presence in Christopher's life and his caring role was frequently referred to as a protective factor to his mental health and in particular Suicide ideation and intent. There is no record of discussion with Christopher re referral for assessment for Carer Support.

Turning Point recorded that Christopher did see himself as a carer for his father, though besides statingthat he helped with basic living needs, never elaborated or disclosed any particular need his father had, besides stating that he was "ill, or poorly". Christopher never stated that he felt burdenedby caring for Andrew. In December 2019 he stated that he was finding the arrangement mutually beneficial, and Andrew may have provided Christopher with companionship which benefitted his mental wellbeing. Turning Point were not aware of any Adult Social Care involvement for Andrew until the GP gave details of the circumstances leading up to Christopher being found deceased.

The perspective from Adult Safeguarding was that Andrew appeared to have seen his son as a supporting factor in his life. Christopher called to reduce the care calls for his father because they were 'intrusive'. The ICT worker was concerned about potential coercive control and confirmed this with Andrew directly; he said that he found the care calls intrusive and wanted them reduced. They were then changed to twice weekly. There was no evidence from Adult Safeguarding's records that Andrew was scared of his son. It is noted in the case notes that Christopher was spoken to aboutthe risks of giving his father the medication but it was not considered further in the context of being a marker for abuse / neglect. He appeared 'absent' during a visit and sometimes deferred to his son for responses or tasks; this was considered as a mental health/mood problem. The lack of professional curiosity around whether there was undue influence and coercion and control suggests there needs to be more understanding intergenerational abuseand coercion/control better. This would also support safeguarding planning and risk assessments in situations where there are concerns around these factors.

Adult Safeguarding reported that during the Section 42 enquiry, professionals did not rely solely on Christopher's informal support for Andrew; welfare visits were completed by GP, Primary Care Liaison Service, Police, Initial Contact Team, Safeguarding, and formal care was put in place with a package of care. Professionals recognised that Christopher provided some support to his father;for example, he enabled access to his father. (It was a condition by Andrew that Christopher arrange this for him. The Enquiry manager considered the relationship with the son as a supporting factor forAndrew but risks were also considered (especially mentioned were concerns about medication). No risk assessment form was completed but the Enquiry Manager had a planning meeting with the GP and police on 9 July and these minutes would have been shared with attendees. The safeguarding case notes dated 14.9.20 stated "*Discussion was held around closure. Whilst recognising that there were still risks actions had been taken to establish that the risk had been reduced for* Andrew. Andrew *was deemed to have capacity andwas only willing to accept so much as per his wishes. The risk of the safeguarding was about son giving medication to* Andrew. Andrew *demonstrated insight into the risks of this action."* A Carers assessment and support from Swindon Carers Centre was offered but declined by Christopher.

No information regarding Christopher's mental health history and how this may relate to his relationship with his father and the safeguarding concerns were shared with safeguarding colleagues or used to inform either Andrew's assessment or any information sharing with SBC Safeguarding or Great Western Hospital Primary Care Safeguarding Lead or indeed any multi-agency Safeguarding Enquiry. Equally it was not requested by the Section 42 Enquiry. The focus of the referral and request from the Adult Safeguarding team to AWP was on Christopher's mental health presentation. At the time the Section 42 enquiry engaged with AWP via a routine referral with PCLS. There was no consideration of any potential information held by AWP regarding the alleged source of harm Christopher.

Coercion and control, review learning from Honour SAR and how things have changed in practice. Has the learning been embedded?

All services involved with Andrew were able to demonstrate how learning from SAR Honour had changed internal practice and approaches to working with these cases. However, although partners may have been able to demonstrate some learning, as reflected further down in thereport within the Emerging Themes section there clearly are parallels with Andrew and SAR Honor.

The enquiry manger in the Adult Safeguarding team was given clear direction during several conversations with his line manager to check the information that Christopher provided and to explorewhat exact role he plays in his father's life instead of assuming that he acted as informal carer. The enquiry manager also assessed risk in a person-centred way and considered the balancebetween potential risks from Christopher due to his addiction but also to appreciate the important and supportive role he played in his father's life.

Wiltshire Police stated that force processes were reviewed following SAR Honour and in practice the attending officers following the correct process when dealing with a vulnerable adult and possible concerns for safety.

Andrew was discussed weekly at safeguarding meetings in the GP surgery practice and safeguarding concerns were shared with the named GP for safeguarding at the Clinical Commissioning Group. Follow-up was also attempted following discharge from home from hospital in March 2020 on receipt of the South West Ambulance Service Trust (SWAST) alert by Great Western Hospital (GWH) Adult safeguarding. (There was an 8 day delay between SWAST writing the report and the notification being received by the Trust Adult Safeguarding team) however none of this activity resulted in any intervention that may have helped prevent the outcome.

Since the publication of the Honor SAR, AWP central Safeguarding Team has under gone a restructure and implemented in 2019 an overarching 5 year Safeguarding Improvement Programme. The programme includes 7 Project streams with 4 cross cutting areas of work. As part of the restructure a Trust Domestic Abuse Lead role was implemented.

The 2021/22 Safeguarding improvement Programme Priorities are**:**

- Implementation of the Locality Hub and Spoke matrix model with Safeguarding Leads having responsibility for a Locality with a thematic lead for an area of safeguarding practice. This is fundamental to the CQC Action S12.
- Development of the Practice Influencer role within Localities to support the embedding of Safeguarding as a golden thread; everyone's business. This will include development of a role descriptor for the practice influencers and the initiation of a quarterly forum to support with developmental sessions.
- Training and Development review including implementation of Level 3 for Adults and development of role specific competencies for safeguarding practitioners and a safeguarding competency passport for all staff.
- Robust database to support progression of Improvement programme

How clinicians manage DNAs in adults and recognise whether autonomy has been constrained or not – local practices, vulnerable people who require support to attend appointments.

There is regular evidence of Did Not Attends and/or cancelling appointments in both Andrew and Christopher's history as Avon and Wiltshire Mental Health Partnership (AWP) service users. On the whole this is managed well by the active teams and in line with AWP Policy. In particular Primary Care Liaison Service went beyond their SOP and extended until a face to face assessment was achieved with Andrew.

There was one early refusal of entry by Andrew to Adult safeguarding practitioners but access waslater gained with support from the son. Andrew lived some distance away from the GP surgery and getting there was difficult due his mobility issues but no other concerns were flagged to Safeguarding.

Services at the Great Western Hospital NHS Foundation Trust are offered to support attendance for those with physical disability/Learning Disability and the Trust has a service (the OWL's service) that act as a meet and greet/escort for appointments and is a service that will stay with the patient for their entire visit if needed. The service needs to be booked in advance.

Considerations of professional's unconscious bias – attitude to individuals who use substances to manage their daily lives and life experiences, understanding their background and trauma informed approach, holistic support and other services to support them.

There is the possibility that Christopher was considered to be more of a risk factor in his father's life and the support he provided was overshadowed by this. Allegations in the Safeguarding planning meeting were discussed around cuckooing and the taking of Andrew's medication but noevidence was found to support them. Social work practitioners stated that they had witnessed evidence of Christopher's real concern for his father, in his wish to see him go out more, tomove to a nicer home and when he spoke about how much Andrew enjoyed certain activities. Thisis in contrast to information given to both Avon and Wiltshire Mental Health Partnership

(AWP) and Turning Point by Christopher at different points in his interaction with those services, in statements of guilt and deep concern of his father's suffering.

However it is important to pose the question of how effective the multi-agency work in contributing to the assessment of risk was beyond the initial safeguarding planning meeting which involved Police, GP Safeguarding Lead and the enquiry manager. Once it was known that Christopher was opiate dependent, there is no evidence that adult safeguarding contacted TurningPoint for further information or exploration of the potential impact of co-existence of substance misuse and enduring mental health. A referral was made to PCLS following the home visit by Adult Safeguarding on 10th August but there was no recorded evidence of a discussion with AWP about information held on Andrew or Christopher. Both AWP and Turning point were holding significant information re Christopher but were not part of any multi-agency meeting.

At the time of the incident, Andrew has been assessed by Primary Care Liaison Service four days prior to his death and the outcome of that assessment was that he declined any treatment options and was discharged. Christopher was not actively involved with AWP (last active involvement 18 months prior via PCLS involvement) and notes suggest that multiple Professional attemptswere made to engage with both Andrew and Christopher in treatment within mental health services.

When Andrew attended the Acute Trust a history of depression was noted in records and appropriate referrals were made to mental health liaison services which resulted in assessment, treatment and recommendations. Christopher was routinely reviewed by a GP who has expertise within substance misuse and mental health. In depth reviews had taken place between the GP and Christopher. Records suggest that Christopher was very open about the services he was willing to engage with and those he was not.

There is no obvious evidence of suggestion of unconscious bias effecting the support and services offered to both Andrew and Christopher.

Dual diagnosis of Substance Misuse and mental health – engagement within a service, supportto remain in service

As outlined in the previous sections, a treatment plan was suggested but a lack of engagement from Christopher meant that it was not put into place. This was potentially a missed opportunity to provide treatment for Christopher's expressed mental health symptoms and link them in with a substance misuse treatment pathway. Christopher had a long history of anxiety and depression. He was known to be prescribed mirtazapine by his GP, and consistently declined referrals to Primary Care Liaison Service (PCLS) from Turning Point to try and support him with his mentalhealth. Christopher was known to have self-harmed in 2008 when jumping off a bridge, though it wasnot disclosed if this was actually a suicide attempt. There was no recorded evidence found ofsuicidal ideation disclosed by Christopher during his treatment journey with Turning Point.

It is possible that there was a missed opportunity regarding the 'regular GP surgery reviews' in terms of further opportunities to engage Christopher with formal substance misuse services. Whilstit is 'best practice' to gain consent Practitioners should be aware of need to exercise their own duty of care even in circumstances where consent is not gained and especially where there is known and/or conceivable risk. This would apply to any referral where there maybe unmet care or support needs.

Impact of pandemic on service provision – did it impact on being able to meet with Father onhis own

All services were able to offer face to face appointments and services to Andrew with the exception oftwo services via health providers - the Memory service in May 2020 and the cardiology service. Great Western Hospital stated that there was no evidence Andrew suffered any health issues due to this temporary arrangement.

With regard to the memory service, Avon and Wiltshire Mental Health Partnership (AWP) stated that the memory service kept Andrew open to the service so that they could pick any patients up again once they were able to see people face to face. Potentially this meant that information was being shared with a team who weren't actively working with him despite being considered 'open' on his health records. This might have meant agencies sharing information felt that they were evidencing good Multiagency working when in effect all that was happening is a record was being kept with no actions being made.

It is important to consider the role of Andrew's son Christopher in services being able to see Andrew. Health records show that Andrew received home visits as required whilst at home shielding by GP's and Advanced clinical practitioners (ACP's), however access to the property was provided through Christopher as Andrew had reported not wanting to let people in, but also not hearing the door.

Christopher caused delay to the PCLS assessment initially scheduled for August, both directly and indirectly. AWP reported that Primary Care Liaison Service implemented positive practice and went beyond the accepted Standard Operating Procedures by extending the number of attempts to visit to assess and by acting on information shared to arrange access via the attending care agency.

Turning Point recorded that Christopher was flagged as high risk client on their database/rag rating system but was not invited in for a face-to-face medical review during the period March 2020 - 16th September. There is a possibility that a face-to-face intervention would have enabled apractitioner and/or clinician to better gauge Christopher's responses to questions through visual cluessuch as body language, and see emotional clues to responses to questions that may have ledto further professional curiosity being shown.

Recognition of suicide ideation, suicide prevention through a safeguarding lens, looking at indicators in relation to life events, suicide prevention as a multi-agency issue not just single agency, in relation to wider work that is happening?

During Christopher's last assessment with the GP on 30th July 2020, it was discussed and there was nosuicidal ideation however risks of previous suicide attempts were known. During last GP assessment services to support mental health were offered and declined. There was therefore recorded limited information to suggest Andrew and/or Christopher were intent on taking their own lives at the time when they did so. It would be reasonable and proportionate for the GPto enquire if the patient had thoughts to end their life (based on history). Assuming no risks was conveyed the GP response would be considered appropriate.

Andrew was known to have mental health concerns however on more than one occasion he deniedany problems despite presenting 'low in mood'.

How accessible are services? Have we commissioned (specific) services in the right way?

With regard to suicide prevention provision, both Andrew and Christopher were assessed and discharged from PCLS and did not access Secondary Mental Health services. Indicators included within the Avon and Wiltshire Mental Health Partnership (AWP) Suicide Prevention Strategy identifythat Access services are an area of risk. This needs to be viewed alongside the reduction of the suicide rate that may be directly attributable to the inevitable concentration of resource on those individuals who are in receipt of secondary mental health services and likely to havehigher suicide risk ratings. Further work needs to be considered across partner agencies to explore and consolidate learning from reviews to establish if there are gaps in commissionedservices, service delivery and/or practice and how these can be closed.
A Befriending or Counselling service could have been of benefit to Andrew, particularly as CRUSE bereavement support had a 6 month waiting list.

Great Western Hospital noted that within Acute Services the onus is on the patient to attend appointments and to request further follow-up following any missed appointments. This suggests that the way adult services are set up is that they default to adult autonomy, the presumption of capacity, and the right to choose whether to engage in a health care contacts or not.

What process was in place for severely suicidal patients including engagement and suicide prevention?

In the case of Andrew and Christopher some agencies held information on discussions around suicide ideation and intent. The Avon and Wiltshire Mental Health Partnership (AWP) Individual Management Report (IMR) stated "Both had a history of suicidal ideation and intent (9 yearspreviously for Andrew and 14 years previously for Christopher) alongside subsequent assessment by PCLS for Andrew where intent is not identified as being present." The GP records for Andrew indicated that "he had felt suicidal at times, but no plans or intent" in June 2017 and this was followed up inmore recent records "No active suicide thoughts, plan or intent."

Christopher's GP notes recorded "no apparent risk of suicide" during a routine telephone review of hismental health care plan on 16.07.2020. Turning Point stated "Christopher was known to have self- harmed in 2008 when jumping off a bridge, though it was not disclosed if this was actually a suicide attempt. There was no recorded evidence found of suicidal ideation disclosed by Christopher during his treatment journey with Turning Point."

The GP services were always accessible to both Andrew and Christopher and in most recent visits denied suicidal ideation or active plans. There is no indication in the Adult Safeguarding case notes that previous suicide attempts were known. The professionals who attended the planning meeting included the GP safeguarding lead and it is not clear if this information was shared and therefore formed part a multi-agency risk assessment and safeguarding plan.

From an Acute Trust perspective either patient would have had access to Mental Health Assessment services via AWP Mental Health Liaison Team 24/7 but this is only available when under the care of the Acute Trust and if that was recognised by the treating clinician. The Trust has polices and risk assessment processes to support the safe management of patients presenting with suicidal ideation.

Generally speaking Wiltshire police become involved with suicidal persons at the point of crisis. AWP staff sit in their control room in Devizes and provide 24 hour mental health support and links into mental health services. At the point that a person may be detained by officers under sec 136 of the Mental Health Act, contact would be made with the AWP triage worker to ensure the decision is appropriate. All Turning Point Workers and management are trained in Suicide Prevention/Awareness.

It was clear from the IMR's and discussions with partners that there is on-going work to develop pathways for patients with suicide ideation but this is an area which needs further development.

Was there a focus on understanding the behaviour in the context of risk management including trauma history?

Andrew had been open with health professionals that the death of his wife had a significant impacton him. Adult social care risk management considered bereavement, social isolation/withdrawal and Christopher keeping his wife's ashes in a box on the table.

Andrew appearing 'absent' in meetings with the enquiry manager and enquiry officer was considered a potential mental health issue. This triggered the referral to Avon and Wiltshire Mental Health Partnership (AWP) Primary Care Liaison Service (PCLS) for assessment. There was agreement between those social care professionals that there were mood/mental health problems, this also triggered the request to have some care support in place. Some history had been shared by AWP with SBC Adult Safeguarding re Christopher but is it questionable how detailed this was and whether it was used to inform a multi-agency risk assessment and/or safeguarding plan.

Christopher had articulated to the PCLS in 2018 that he was low in mood experiencing anxiety and paranoid thoughts. This was identified as being linked to childhood trauma which had been triggered by his mother's death the year before. He also disclosed that his drug use began atthe age of 13 and believed that his auditory hallucinations which were long standing had become worse since stopping drugs. On the occasions where Christopher did disclose about poor mental health to Turning Point, a concrete link was never established or explored specificallyaround trauma. Christopher was rightly signposted to appropriate services for support around his mental health (Community Mental Health Team, Counselling and LIFT psychology), however follow ups were not timely, nor were barriers to him accessing treatment with Turning Pointor other agencies ever really fully explored. Christopher potentially had care and support needs but there was no clarity about this.

---

6. Emerging themes

There are parallels in this case and that of Honor which need to be recognised.

- **Lack of recognition of complexities of and plan to safeguard against Intergenerational Domestic Abuse.**
- **Focus on social care needs as outcome for Safeguarding activity at the expense of investigating abuse**
- **Professional curiosity and working with unwise decision making**
- **Co-ordinated and effective multi-agency working**
- **Effective QA in Safeguarding across agencies**

This suggests that such a complex area of Safeguarding would benefit from a refresh of the learning from SAR Honor alongside the findings from this review across the Partnership.

Coercion and Control
There was recognition of a risk around coercion and control by agencies working with Andrew but no clear work to address it.

Mental Capacity and coercive control
A panel member suggested that there is a continued need to emphasise the need for a formal capacity assessment where there are any concerns raised about a person's capacity to makea decision, including documentation of all parts of that capacity assessment within the records.
-Should there be any concerns about coercive control, discussions with the patient including any capacity assessment should take place without the possible perpetrator of the coercive control present.
-If necessary to involve the police to enable (b) this should be organised (i.e. if the alleged perpetrator will not leave).

The inclusion of GPs in adult safeguarding planning meetings
In this case there was a lot of multi-agency communication and the agencies were working together and liaising at the beginning of September. It was suggested that the organisation of additional adult safeguarding planning meetings and the development of a specific associated adult safeguarding plan for Andrew may have benefited him and impacted the outcomeof events. The GP would have then been involved in the additional safeguarding planning meetings and could have helped to formulate the plan. The circulation of the plan (to agencies including the GP surgery) would have meant that the GP and other agencies would have been kept up to date with the safeguarding plan without needing rely on the adult safeguarding team for regular updates.

Bereavement Support
Turning Point believes an exploration of bereavement support for vulnerable people could be looked at in more detail. Often vulnerable people are significantlymore socially isolated than the rest of the population, and managing grief without friends/family support can make the process more difficult to manage, and in turn can precipitate a decline in mental health. Turning Point's understanding is that a referral to CRUSE cannot take place until 6 months post mortem. It also raises the question of whether or not services recognise that drug/alcohol users are vulnerable and need support in coping with caring responsibilities. What would it be like in to seek bereavement or carer support asan Opiate user?

Trauma Informed Practice
The understanding of trauma is now recognised as being a key development area for a number of services areas and agencies working with children and families and adults who may have care and support needs. Agencies should ensure that trauma informed approaches are being used and developed within their agencies when working with all their service users at the earliest opportunity. Trauma may not be known at the point at which agencies are working with people, a trauma informed approach enables professionals to open up conversations

about possible trauma histories and if identified can respond better to the impact of this trauma.

---

7. Good practice and improvements

A new mental capacity assessment template has been designed and implemented by Primary Care to ensure comprehensive capacity assessments are undertaken and documented correctly.

A multi-agency complex cases suicide prevention group has been formed to develop guidance for all practitioners in Swindon as to how to support adults who are in complex situations and are suicidal.

The Great Western Hospital (GWH) NHS Foundation Trust has identified that improvement is needed around how the Trust respond and manage non-attendance of appointments by patients with either the Trust or other agencies where the patient is identified as vulnerable. There have been improvements since SAR Honor and a better interface between Adult Safeguarding and Avon and Wiltshire Mental Health Partnership (AWP) being strengthened further to include AWP Safeguarding Team

Adult Safeguarding stated that the multi-agency work felt positive and that the Initial Contact Team, AWP, Adult Safeguarding, Safeguarding Adults Investigation Team worked well together. There was joined up planning and intervention. However it is important to draw a distinction between liaison across agencies and the co-ordination of effective multi-agency safeguarding enquiry and practice that is compliant with policy and legal framework.
SBC Adult Safeguarding team felt that that the capacity assessment was considered appropriately during the Safeguarding enquiry in March 2020 and the decision not to carry out was correct.

Eclipse training is now provided by a 'super user' in the team to address quality of information recorded and targets for completion of information recording.

Adult Safeguarding team recognise that suicide prevention requires specialist skill and training, and Safeguarding needs to be able to call on other practitioners for this. However, AWP have been approached to see if the safeguarding team would be allowed to access suicide prevention training for awareness.

AWP and Turning Point are implementing and progressing a collaborative working arrangement in relation to individuals with co-existence of substance misuse and mental health this includes the following:

- Joint Care Plan Development work between Turning Point and Swindon AWP.
- Referral pathways to AWP and Turning Point have been co developed and agreed.
- Operational Dual diagnosis supervision meeting for AWP and Turning Point has been established and meets regularly. This is led by Turning Point consultant and co facilitated by Recovery service.
- Training support being co-created and co-facilitated with AWP Swindon service manager and Turning point.
- Dual Diagnosis quarterly meeting led by Public Health in Swindon and attended by AWP, Turning Point and other related services including police etc. This forum really helps to drive inter agency working and improvements across the locality and is highly regarded by those who attend.
- Clinical Lead has met with the senior managers of Turning Point to create and build upon relationships between services.

Much of this focusses on Service Users who are established within Secondary Mental Health services. There is facility for any agency to request an MDT for complex cases being managed via PCLS. It is not clear that Christopher at the time would have met that criteria. Some parallels can be drawn with the 'Complex Trio' Model in Children's Safeguarding when coercive and controlling patterns are noted in the dynamic of an adult with care and support needs and their adult family members. This model would benefit from exploration to support aneffective toolkit for the management of intergenerational domestic abuse in Adult Safeguarding.

8. Learning from previous SARs and actions

Professional Curiosity – There were missed opportunities for professionals to explore the relationship between Andrew and his son further and follow up on concerns about Christopher's influence over his Father's decision making. There is a Professional Curiosity toolkit and 7 minute briefing available on the SSP website to support professionals further.

Legal Literacy - Practitioners should be aware about the application of the legal frameworks in terms of decision making in safeguarding, understanding and being able to use the Care Act, Mental Capacity Act and Human Rights Act. This content is covered in the Legal Literacy training which is part of the SSP training offer to ensure practitioners understand and feel confident in applying these principles.

Suicide Ideation – There is a continued need to explore suicidal ideation at every consultation about depression, with follow up and safety netting explored and documented by practitioners. The above described suicide prevention group is developing a process/7-minute brief about how individuals are supported in a multi-agency way. It was noted that this work needs to include those who do not transfer into secondary mental health care but whose mental health care remains under the care of their GP.

Suicide Prevention - Both Andrew and Christopher were assessed and discharged from PCLS and did not transfer into Secondary Mental Health services. Indicators included within AWP Suicide Prevention Strategy identify that Access services are an area of risk. This needs to be viewedalongside the reduction of the suicide rate that may be directly attributable to the inevitable concentration of resource on those individuals who are in receipt of secondary mental healthservices and likely to have higher suicide risk ratings. Further work needs to be considered across partner agencies to explore and consolidate learning from reviews to establish if thereare gaps in commissioned services, service delivery and/or practice and how these can be closed.

The GWH NHS Foundation Trust has taken action to support Practitioners in the following ways:

- The Primary Care Network is currently rolling out suicide prevention training to all staff.
- AWP Mental Health Liaison Team are facilitating a series of education sessions from May 2021 accessible to Trust staff in relation to Mental Health (including suicide prevention). Sessions are available monthly/90 min duration/TEAMS

Self-Neglect - If an adult is at risk of severe self-neglect that could result in harm or death, a referral to the REP or adult safeguarding team should be made depending upon severity of self-neglect and engagement by the patient. This links to the updated Self Neglect policy and training offer which provides guidance to professionals on how to work with adults who are self-neglecting.

Mental capacity and accessing support – It was suggested that there should be a greater use of the Risk Enablement Panel by agencies where a patient that has capacity who declines to engage can be discussed. Where a decision about referral or admission is being made and there are questions about someone's cognition and ability to make decisions. The SSP training offer includes MCA & Human Rights training.

Information sharing - A key area of learning is that there were two agencies holding information about the potential source of harm – AWP & Turning Point – and that multi-agency information sharing is not necessarily just about the adult at risk but also the potential source of harm.

Multi-Agency meetings – It was suggested that there needs to be consideration given to the existing multi-agency processes in place to discuss complex clients with unmet needs to ensure a coordinated response and how well embedded are these approaches including the Risk Enablement Panel.

Caring Responsibilities - Turning Point identified that they could have been more proactive in exploring the relationship between Andrew and Christopher and his caring role. Some internal learning which has been where known service users were providing informal care in any way, that should trigger a conversation with and potential referral to Adult Social Care, and there is now a monthly meeting between the agencies.

Recommendations

A. Development of Multi-agency Safeguarding guidance on inter-generational Domestic Abuse
B. Development of a Safeguarding Toolkit for Coercion and Control
C. Inclusion in above of a Multi-Agency checklist to instigate sharing of relevant history in relation to Adult at risk and source of harm when Coercion and Control identified
D. Suicide Prevention support to be developed by the Complex cases suicide prevention group.
E. Seek assurance from agencies about how mental health practitioners assess and measure the presence of risk in patients with suicide ideation.
F. SSP seeks assurance that there is a robust multi-agency Suicide Prevention pathway which is inclusive to all partner agencies across health, social care and the voluntary sector.
G. Promotion of the Risk Enablement Panel via training offer and Self-Neglect Policy and Guidance.
H. 7 minute briefing on Risk Enablement Panel to be developed / promoted.
I. SSP seeks assurance as to how agencies identify and work with complex clients in a multi-agency way via a mini audit questionnaire.
J. Where a trauma history is identified agencies must share this information with other professionals known to be involved with the person and at the point of making referrals to other services or agencies for treatment or support as part of multi-agency working.
K. SSP to consider commissioning training in Trauma Informed Practice in working with Adults to support the understanding and use of trauma informed approaches in practice.