Richmond Safeguarding Adults Board

Safeguarding Adults Review

Mr T

Lead Reviewers:
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Contents

1 Introduction

1.1 Why this case was chosen to be reviewed

This case was chosen to be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR). The case involved the death in a fire of Mr T, who had significant health and social care needs. As the area of fire risk was one that had been known about by the key agencies for some time there were questions about how effectively the safeguarding partners had been working together, and whether they could have prevented the fire.

1.2 Succinct summary of case

Mr T had been diagnosed with Multiple Sclerosis (MS) twenty years earlier. By 2015 he was using a wheelchair and increasingly staying in bed. He was supported by community nurses, an Occupational Therapist (OT), a Social Worker (SW) and was in receipt of double up personal care visits four times a day, provided by Mears, a local care agency and funded by Richmond Adult Services Department. Mr T lived alone and was fiercely independent, wishing to retain as much control over his life as possible. He accepted a care-line pendant which he refused to wear, but kept on the table by his bed. He had full mental capacity in relation to decision-making. Mr T was clear what he did and did not want, and so it was not always easy for practitioners and care workers to know where their professional responsibilities started and ended. During 2015 there were several small fire incidents; however, he continued to smoke despite the fire risks this involved. All the agencies involved demonstrated good practice and commitment to supporting Mr T, and risk reduction equipment was in place, although there were some measures that had not been fully pursued, and some omissions in terms of communication. Mr T was only partially compliant with the fire risk advice he was given. His physical and emotional condition deteriorated in November 2015 and concerns were raised about possible neglect and self–neglect, resulting in a safeguarding enquiry opening at the beginning of January 2016. A safeguarding plan was put in place but sadly Mr T died two weeks later in a fire.

1.3 Family composition

Mr T was divorced. He retained contact with his daughter; as she lived a considerable distance away their contact was largely over the telephone. Mr T's daughter was able to visit her father a number of times in the final year of his life.

1.4 Review timeframe

It was decided that the critical time period to review was from June 2015, when the first known fire incident occurred, until January 2016 when Mr T died.

1.5 Organisational learning and improvement

Statutory guidance to support the Care Act 2014 states that:

> "The Safeguarding Adults Board (SAB) should be primarily concerned with weighing up what type of 'review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. Safeguarding Adults Reviews (SARs) may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases". (DoH[1] 14:135)

Richmond Safeguarding Adults Board (SAB) identified that the review of this case held the potential to shed light on particular areas of practice including addressing the following research questions:

[1] Statutory Guidance to support the Care Act 2014, Chapter 14

- Are there approaches that can be taken to reduce risk in cases where an adult has mental capacity but still chooses to take high risks?

- How well are the responses working that we have already put in place to try to reduce these kinds of risks?

- Are there better ways that front-line practitioners and managers can capture and record the complexity of thinking behind decisions on high risk cases?

- Do we need to find additional ways of ensuring the effectiveness of multi-agency communication?

- How can we improve multi-agency approaches to shared risk assessment and risk management?

The use of research questions in a *Learning Together* systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of Systems Findings.

1.6 Methodology

Statutory guidance requires SARs to be conducted in line with six principles:

- "there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively." (DoH,14:138)

It also gives SABs discretion to choose a review methodology that suits particular circumstance:

"The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected". (DoH, 14:141)

Richmond SAB commissioned the SCIE *Learning Together* systems model (Fish, Munro & Bairstow 2010). The SAB asked that the review process should be based around a one-day Learning Together Workshop, which was used to engage the front-line practitioners and line managers, and generate the qualitative data needed to inform the review process. Details of what the review entailed is contained in the appendix of this report.

1.7 Reviewing expertise and independence

The SAR has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Alison Ridley is accredited to carry out SCIE reviews and Mary

Burkett who is trained and undertaking her accreditation. Neither has any previous involvement with this case, or any pertinent previous or current relationship with Richmond Council or partner agencies.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

1.8 Methodological comment and limitations

Participation of professionals

All key practitioners and managers involved with the case were able to participate in the Learning Together Workshop. The Lead Reviewers were also able to talk separately with several key practitioners following the event to clarify factual information, and to meet with the senior agency managers who subsequently formed the Review Team. Although the local GP was unable to attend the Workshop, he was able to join the Review Team and contributed at a strategic level.

Perspectives of the family members

Mr T's daughter was invited to be involved in the review process, however she felt that she did not want to be actively engaged in the process. She did not have any particular concerns about how her father's care and support had been provided or managed.

1.9 Structure of the report

First the Appraisal of Professional Practice section provides an overview of what happened in this case. This clarifies the view of the Review Team about the timeliness and effectiveness of the help given to Mr T, including where practice was above and below expected standards. Secondly a short transition section reiterates the ways in which features of this particular case are common to the way professionals work with other adults and therefore provides useful organisational learning to underpin improvement. Thirdly the Findings form the main body of the report.

Statutory guidance requires that SAR reports "provide a sound analysis of what happened in the case, and why, and what needs to happen in order to prevent a reoccurrence, if possible (DoH, 14:149)

2 The Findings

2.1 Appraisal of professional practice in this case: a synopsis

Introduction to the Appraisal of Practice

This case highlights the practical challenges and ethical dilemmas that are generated when practitioners are supporting a service user who has the mental capacity to make key decisions about their care and support arrangements, but chooses to continue with risky behaviours. In this case the service user's severe physical disabilities meant that his wish to continue smoking placed him (and to a lesser extent his neighbours) at risk of an accidental fire. Despite a comprehensive care package and concerted efforts made by the key services to work in partnership with Mr T to reduce risks, there was also a continuing sense of powerlessness, anxiety and frustration felt by the practitioners and care workers who understood that a fire risk remained.

Mr T's choices and situation did not result in self-neglect until shortly before his death, as he was eating and drinking and was in receipt of a comprehensive care package. However, as his physical and emotional condition deteriorated, there are some clear links between the management of this case and the dilemmas that practitioners face when they work with people who have mental capacity and are self-neglecting, or for example abusing substances. In these situations there can be high risks but there are limited legal options available to support effective risk management plans. Practitioners and care workers were trying to find the right balance between listening to and supporting Mr T's wishes, and knowing how robustly they should challenge his 'risky' behaviours. The Care Act 2014 confirms that where an adult has mental capacity in relation to their support decisions but declines assistance "this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction" (chapter 14.92). These ethical dilemmas are explored in **Finding 3.**

The case also highlighted how difficult it is to work effectively on a case of this nature without having a formal multi-agency framework to support the sharing of information and reflection on the risk management plan. This lack of a framework will be the case when situations do not meet the safeguarding criteria, or involve long term risks that are not appropriate to work with in a safeguarding framework for long periods of time. Throughout most of the period under review, even though high risks were present, Mr T was not being abused or self-neglecting, and so he only came within the remit of safeguarding much later in the review period. The impact when there is no multi-agency forum to support reflection and shared decision-making in high risk cases is explored in **Finding 1.**

A great deal of constructive multi-agency practice was achieved, however sadly the efforts of the services were not successful in preventing Mr T's death in a fire. However, practitioners used their professional experience and knowledge to influence how the case was managed. The management support and team culture that was present and supported practitioners to work creatively in a person centred (as opposed to process driven) way is explored in **Finding 2.**

Appraisal of Practice

Initial fire incident leads to short hospital admission and follow up (June – July 2015)

On 13th June 2015 Mr T accidentally dropped his cigarette which started a small fire. The London Fire Service were called and removed him from his property. Mr T suffered some superficial burns and smoke inhalation. He was admitted to Kingston Hospital. The doctors who examined him confirmed that he was mentally alert and had capacity. Mr T told them that he felt he could maintain his safety at home and that he wanted to continue to smoke. The London Fire Service (LFS) arranged for an Accidental Dwelling Fire review to be undertaken to investigate the causes of the fire and advise the Local Authority and housing provider. The discharge process remained user focussed and made use of the available 'step down' resources. The OT and the Social Worker (SW1) worked in an integrated team which assisted with good communication and working relationships. The OT arranged for the specialist equipment to be delivered. The Fire Service advised the housing provider that a fire had occurred at the property. Two officers from the housing provider (RHP) ensured the property was secure and visited Mr T in hospital. Their approach was thorough and also ensured that the Housing Provider were aware of the potential risks in this case.

Mr T was discharged home on 26th June. The Fire Service gave advice about risks to Mr T. Two smoke alarms had been fitted by the LFS the previous year, one on each level of the property. The view of the London Fire Service was that Mr T's circumstances and choices posed a serious risk to him, and to a lesser extent potentially to the surrounding properties. It is understood that the Fire Officer discussed with Mr T the possibility of linking the smoke detectors to Care line, however Mr T was not willing to fund that service. The Social Worker was not aware of this option, so the issue of whether Local Authority funding might have been considered was not explored. The dilemmas raised for practitioners in responding to the choices made by service users who have mental capacity in relation to their decisions is explored in **Finding 3**.

The care package and DNs visits re-started, and Mr T was cared for in bed until his new wheelchair arrived. Fire retardant bedding was installed the following day. A second set of bedding could have been ordered from the Fire Service if required (for use when the first set of bedding was being washed); it was reported that this was not usual practice and did not occur in this case. Mr T had several pressure sores which were treated by the community nurses in partnership with the carers and with support from the GP, and healed well. A pressure mattress and hospital bed was already in place.

The care workers undertaking direct work with Mr T would generally not give him cigarettes when he asked for them, as they were conscious of the dilemmas of finding the right balance between responding to Mr T's requests, rights and needs and their professional responsibilities to reduce the risks of harm that he faced. It was known that Mr T was smoking when care workers were not present, and refusing to give him cigarettes tended to antagonise him, potentially endangering working relationships and their engagement with him. Some care workers would allow Mr T to smoke while they were in the house, because at least during the period that they were present, the risks were reduced, even though this meant that they became passive smokers. A further example of the ethical challenges for care workers came when for a period of time he resisted them using a hoist to lift him. He was too frail to use a standard hoist and not comfortable using other equipment, so ultimately he chose to be cared for in bed. It would have been useful for this particular dilemma to have been discussed across agencies to produce a consistent response for Mr T and one that care workers felt had been considered and more formally sanctioned in terms of their moving and

handling guidance. The ethical and practice dilemmas faced by practitioners and care workers in cases of this nature are explored in **Finding 3.**

Two weeks after Mr T's discharge home SW1 held a review meeting on 7th July to re-assess his needs, risk and his capacity. Mr T only had the use of one arm and, despite advice, he continued to use matches, rather than a lighter to light his cigarettes. A lighter, which would have been safer, was suggested but Mr T refused it. SW1 noted that Mr T was aware of the fire risks, and that he agreed to a second fire safety check by the Fire Service, which occurred on 16th July. SW1 arranged to be in the property at the same time as the Fire Officer, but, on the day, the Fire Officer arrived early so the visit was undertaken with a care worker present instead. Safety advice was again given and the Fire Officer confirmed that sufficient fire alarms were already in place. Mr T retained mental capacity and all agencies were conscious of the high risks his choice to smoke involved. SW1 and the carers discussed with Mr T alternative accommodation that would provide him with a greater level of monitoring, but he was not keen to consider a move. The evidence of concerted interventions to reduce risk by the care workers, the OT, the Social Worker and the Fire Service showed a high level of commitment to reducing risks. This practice was in contrast to the evidence quoted in the House of Lords Scrutiny Committee report (2014), which illustrated a tendency for agencies to disengage with cases where an adult retains mental capacity and choses to continue behaviours that generate risks[2].

<u>Mr T burnt his shoulder which led to further co-ordinated measures being taken to try to reduce risks (October/November 2015)</u>

On 25th October, a care worker noticed that Mr T had accidentally burnt the top of his shoulder causing superficial burns. The care worker checked the injury and followed usual processes in terms of communicating with all key parties. Several days later a care worker visited and found that Mr T's ashtray had caught fire. The incident was reported to the Social Care out of hours team (AEDT). In response SW1 tried to persuade Mr T to accept a different type of ashtray that would have been less risky, but he refused and remained clear that he would still continue to smoke. SW1 called the care agency to discuss how she could support them and Mr T to reduce the fire risk, demonstrating a further positive practical attempt to reduce risk. The professionals also visited Mr T when his care workers were making their scheduled visits to maintain good communication with everyone involved.

Mr T was a tenant, his property and some of the neighbouring properties were owned and managed by RHP (the Housing Provider), who are responsible for maintaining the property and managing the tenancy. The housing provider was aware of the previous fire incident at the home and understood that risk mitigation measures were in place. Liaison between the Housing Provider and the Local Authority was very limited, which was an omission in this case. The value of finding opportunities for multi-agency sharing of information and shared risk management planning in cases where there are high risks but the concerns have not necessarily fallen into the safeguarding arena, is explored in **Finding 1.**

The DNs noted that Mr T's pressures areas were intact and that he was eating and drinking well. On 9th November 2015, a re-assessment was undertaken by SW1 with a care worker also present. The Local Authority care planning and review format prompts consideration of fire risks and so these

[2] Report (2014) of the House of Lords Select Committee – post legislative scrutiny of the Mental Capacity Act 2005

were also considered each time his needs were reviewed by SW1. There were no concerns noted in relation to Mr T's mental capacity, and SW1 ensured that he was aware of the fire risks so that his decisions were properly informed. The care agency had ensured that as far as possible the care workers who visited Mr T, who tended to either 'love' or 'hate' people, were the same ones. This provided a continuity of carers, which was critical to maintaining good engagement with Mr T and ensured a high quality of care was delivered.

SW1 and OT had agreed that due to the risks in this case, in addition to the case being reviewed on a three-monthly basis (which was usual where a high risk was present) the case should also be held open and continue to be allocated to the same Social Worker to provide continuity and a higher level of responsiveness. This decision was a sound one, demonstrating good risk assessment and risk management by those practitioners, and support by their managers, and an ability to work creatively. The positive practitioner and management culture required to keep the needs of service users at the centre of the work is explored in **Finding 2**.

Mr T's physical condition deteriorates further and the quality of care becomes an issue (December 2015)

At times Mr T resisted having personal care, such as having his beard groomed, and this appeared to become more of an issue during late November and December. Contact was made by the Care Agency Visiting Officer with his daughter on 27th November to see if she would arrange for Mr T's hair and nails to be cut. Agency care workers had become concerned about Mr T's weight loss and discussed this with the GP. On 8th December, a nurse visited who had not seen Mr T for some time and she was worried by his weight loss. She felt that he appeared unkempt and the house seemed untidy. Mr T had been reluctant to allow the care workers to shave him because the particular care worker that he liked to do that task was on leave, so his beard had been allowed to grow. The nurse was also concerned to find that the pressure mattress was not working properly. The mattress provider had been informed by the care agency but had not yet mended the mattress, and this had not been followed up by the care agency. This was reported by the nurse to SW1 who arranged for the mattress provider to visit the same day to mend it. The nurse noted two pressure sores on Mr T's sacrum and a grade 2 sore on his hip. The nurse discussed her concerns with the care worker whom she perceived to be rather defensive. The nurse reported her unhappiness with the care, and raised her concerns about the fire risk ensuring the SW1 was aware. The following week a DN noted that the pressures sores were almost healed and the one on the left buttock remained a grade 2. The DN service had worked effectively over a long period with Mr T, providing good care and maintaining his skin integrity. They discussed supplement drinks with Mr T who was agreeable to taking the ones that he liked.

Safeguarding Enquiry co-ordinated (January 2016)

On 1 January Mr T fell out of bed and was found by a care worker on the floor, who called an ambulance and waited with him. The ambulance crew checked him over and as there were no injuries, they put him back in bed, however they were concerned by both his appearance and because he told them that he had scratched one of his eyes two weeks earlier but this had not been treated by the carers. The Ambulance Service raised a safeguarding concern (received on 4 January 2016) to the Local Authority which highlighted potential neglect by the care agency and also potential self-neglect by Mr T. The Local Authority had made effective efforts to increase awareness

about self-neglect amongst safeguarding partners in response to the implementation of the Care Act 2014. SW1 went out to visit Mr T and then had a discussion with her team. The swift response was good practice. She specifically asked that another colleague (SW2) lead on the safeguarding response to allow a fresh pair of eyes to look at the case, and she advised SW2 that there were fire risks in addition to the potential neglect and self-neglect concerns. This was further evidence of the team and management culture supporting practitioner's judgements and providing a person centred, high quality response.

The following day the case was allocated to SW2 to arrange a multi-agency safeguarding meeting with Mr T. The swift allocation of the case and beginning of the enquiry demonstrated responsive practice. The next day (7th January) SW2 visited Mr T at home to discuss the safeguarding concerns. She noted that fire alarms and a protective blanket set were in place. Mr T initially said that he did not want or need to have a safeguarding enquiry, however SW2 persevered and persuaded him that it would be worthwhile. He agreed. This piece of very positive practice illustrated how the Local Authority were putting the principles of 'Making Safeguarding Personal'[3] into practice, ensuring that the adult was at the centre of the process, and that his views and wishes were considered. SW2 was effective in building trust with Mr T, an approach which has been shown in research to be the most effective way to work with adults who tend to self-neglect[4]. SW2 co-ordinated the safeguarding enquiry process, liaising with the community neuro-rehab team, dietician, OT, MS specialist and telecare. However, there had not been any liaison with the London Fire Service or housing provider at this point, which was an omission.

The following day the initial safeguarding enquiry meeting was held with Mr T at his home with SW, the OT, the DN and the care agency all present. It was very positive to have arranged for the key partner agencies most directly involved to be present at Mr T's home. It is not possible or appropriate for multi-agency safeguarding meetings held in the homes of service users to be large or formal. In this case the principles of 'Making Safeguarding Personal' were clearly followed. The agreed actions included a further re-assessment by Mr T's Social Worker, a review of the care logs, and actions to contact Mr T's daughter, GP and OT. It was also agreed that given the risks and complexity of Mr T's condition it would be appropriate to start a Continuing Health Care checklist to explore whether the funding of the care package should be shared or taken on by the NHS. It was also agreed that feedback should be provided to the DN who had raised the safeguarding concern. The actions were undertaken very swiftly over the following days and the emphasis placed on feeding back outcomes to the referrer was notable, a task that is highlighted often overlooked.

The OT continued to discuss equipment options with Mr T. He confirmed that he was happy with his care and still wanted to remain at home. He was agreeable for another safeguarding meeting to be held at his house. The SW followed up by sending an email to the Dietician regarding Mr T's weight loss and also made plans to source hair washing equipment and a mobile hair dresser. These are further examples of how the Local Authority practitioners were putting the principles of the Care Act 2014 into practice; the action plan illustrates a well-balanced focus, not only on safety and protection, but also on wellbeing. On 11th January, the OT emailed the Fire Service to request additional fire retardant bedding. The SW also discussed Mr T's needs with the Physiotherapist regarding bed positioning, the Community Neuro Physio Therapist and the MS Nurse specialist. On 14th January SW2 met Mr T's daughter who agreed to arrange for his hair and nails to be cut and to assist with ordering shopping.

[3] Chapter 14, Care Act statutory guidance

[4] SCIE Self-Neglect research paper

Fatal fire incident (19th January 2016)

At 10:00 a DN visited Mr T, who was found to be alert in bed. The house smelt of cigarette smoke, which was not unusual. The nurse did not recall seeing the fire retardant bedding in use; it is not known whether it was or not. Mr T's pressure areas were intact. At 15:39 SW2 rang Mr T to arrange a home visit, however there was no answer, so she left a message. It was not unusual for Mr T not to answer his phone. The 'No Response' policy was followed and a message was left advising the care agency that he had not responded. At 18:14 a fire was reported to the Fire Service by Mr T's neighbour. The Fire Service arrived at the house at approximately 18:22, at the same time as the care worker. The Fire Service sadly found Mr T dead at 18:24. The care agency informed the out of hours AEDT. The Police and the family were then informed.

2.2 In what ways does this case provide a useful window on our systems?

This case has several elements which are common to other cases involving adults who have mental capacity but may still be at risk of abuse or neglect, and/or at risk of self-neglect. Cases of this nature can be particularly challenging for professionals if the adult is not keen to engage with protective measures, and instead chooses to make what may seem to be 'unwise decisions'. Professionals may subsequently struggle to reduce risks effectively. In these cases, practitioners face complex ethical and practical challenges with limited legal powers to intervene. These dilemmas are emotionally demanding and may leave professionals feeling powerless and frustrated. There are rarely any easy legal or ethical answers to the questions raised by this kind of case, however the findings that have emerged from this SAR identify three areas of learning which will apply more broadly in other cases where adults are at risk of abuse, neglect or self-neglect and have mental capacity but are choosing to accept high levels of risk.

2.3 Summary of findings

The review team have prioritised three findings for the SAB to consider. These are:

	Finding	**Category**
1.	Outside safeguarding there are limited mechanisms that bring staff together from key agencies to plan and review their work in cases involving high risks, increasing the chances of interventions being less effective.	Communication and collaboration in long term work
2.	In Richmond, a willingness to make management decisions that effectively support professional judgment generates a positive climate in which person centred practice thrives.	Management systems
3.	The tensions that exist when an adult has capacity and continues to choose high risk behaviours can leave practitioners feeling personally and professionally responsible when they have limited legal or practical authority or power to keep the person safe.	Service user-professional interaction

2.4 Findings in detail

2.4.1 FINDING 1: Outside safeguarding there are limited mechanisms that bring staff together from key agencies to plan and review their work in cases involving high risks, increasing the chances of interventions being less effective.

Safeguarding processes provide a statutory response where there are concerns of risk to adults who due to the nature of their disabilities are less able to protect themselves from abuse and neglect. Previously safeguarding enquiries were focused on situations where the service user was being abused or neglected by a perpetrator, however the Care Act 2014 broadened the safeguarding categories to include cases of self-neglect, which often have a particularly difficult combination of high levels of risk and service users who are reluctant to engage with services.

Even though cases of self-neglect now fall within the remit of safeguarding, the nature of these cases is long term and they do not always have specific incidents of harm that lend themselves to a one-off safeguarding enquiry. The risks are chronic and not generally easy to minimize. Cases of this nature can be particularly demanding for practitioners. Opportunities for multi-agency information sharing, reflection and joined up risk planning are essential to effectively support service users and assist practitioners in their role. Where self-neglect cases do come within safeguarding framework, this will only be for a short period, which is unlikely to fit well with the chronic nature of the risks that need to be managed.

In Richmond since the death of Mr T, a risk panel has been set up, which has increased the opportunity for shared multi-agency risk management, but is still in its first phase of development and is not yet known about across all agencies.

How did this issue manifest itself in this case?
Through most of the period under review the practitioners discussed the case informally with colleagues in other agencies, however the case was managed largely outside of the safeguarding framework, so there was no formal multi-agency structure for practitioners to share information or undertake shared risk planning. Mr T's situation was only brought within the safeguarding framework for a short period in the same month as the fatal fire. At that time, there was no other multi-agency forum or framework for practitioners or their managers to use to reflect on the case, or to undertake shared risk decisions.

There was a consistently high level of input to Mr T across agencies and a good level of continuity of support was maintained; with some staff having worked with him for several years. However it would appear that the multi-agency conversations did not benefit from having all practitioners in the same place at the same time and so there was incomplete information available. For example, it was only after his death that a practitioner very close to him realised how much information was held by others involved in his case who she had previously not had direct contact with.

What makes this an underlying issue rather than particular to this case?
There are a large number of cases where there are high risks but safeguarding criteria are not met, where for example the nature of the service user's condition or behaviour generates risks but abuse or neglect are not a part of the picture. This can also happen in cases where service users are misusing alcohol or substances. Additionally, cases which involve chronic risks that are not easily reduced or resolved (such as cases of self–neglect), and those where a traditional one-off safeguarding enquiry approach does not fit with the on-going nature of risk management, may not fit well within the safeguarding process. Members of the Review Team and practitioners who attended the Learning Workshop were able to identify many cases that fell into this category, and they expressed the view that a multi-agency meeting across health, social care and other agencies, would bring benefit to the broader management of these cases.

As a result of Mr T's death a Multi-Agency Risk Panel has been established in Richmond, the Vulnerable Adults Management Panel (VAMA), which has provided a forum for the discussion of the most difficult cases which do not fall within the safeguarding criteria. However, responses from practitioners at the Learning Workshop and from some members of the Review Team suggest that

there are still cases which do not currently benefit from this kind of opportunity and there is a lack of awareness of the panel.

What is known about how widespread or prevalent the issue is?
Members of the Review Team acknowledged that opportunities for multi-agency case discussion across health and social care agencies are not always available, and this seems to be a particular issue in terms of finding opportunities to for social care to link directly with primary care. Social workers in Richmond have regular contact with the community matrons to discuss cases, and three local GP practices have regular social care involvement in case discussion meetings; however, social care members of the Review Team acknowledge that the way they currently provide input into these three practices could not be rolled out across Richmond.

It became apparent at the Learning Workshop that not all participants were aware of the VAMA, so although it is in place, further work is required to ensure all agencies know how to refer cases into the forum. Some concerns were also expressed that the VAMA was not always able to respond quickly to requests for case discussion due to the level of demand.

Although information sharing protocols exist these do not include all agencies in Richmond which might be involved in this type of case. Some members of the Review Team questioned how effective the protocols are in practice. The Fire Service have broader information sharing agreements in place with other boroughs which they feel aids communication more effectively between front line practitioners.

Safeguarding Adults Boards in other areas have developed a variety of ways of responding to cases of complex and chronic risk which are not open to a safeguarding process. In Reading a multi-agency risk panel provides a similar approach to the VAMA panel, and actively involves the service user in the risk planning process. In Hampshire, instead of having a stand-alone risk panel, the local agencies have signed up to use a multi-agency risk framework, which builds on existing frameworks such as the Care Programme Approach (CPA), and provides key good practice principles, such as holding multi-agency risk planning meetings, for cases involving chronic risk[5].

What are the implications for the reliability of the system?
Managing cases where there are chronic risks is difficult intellectually and emotionally. In these situations practitioners will be able to provide their best response to support service users when there are opportunities to review risk in a multi-agency forum. Without effect mechanisms in place to share information and manage risk across agencies, there is a higher risk of poorer outcomes for service users and emotional exhaustion for staff.

In Richmond, the VAMA panel (which was set up in February 2016) has members from social care, health, housing and the fire service, and receives referrals for cases where there is cause for concern due to tensions between the rights and choices of the adult and where the level of risk for the service user is high. This has increased the potential for cases to be captured and examined in a senior multi-agency forum, and also provides a valuable way of lessening the intense emotional burden described by front line staff when they are holding a case which involves high risk but where there are limited ways of reducing the risks. Assumptions about the roles and responsibilities of other agencies can be clarified and constructive challenges can be raised about how well existing risk plans are working. By working through possible solutions senior managers on the panel can utilize their experience and knowledge to generate fresh ideas, or ensure practitioners are supported with their existing plan. Additionally, agencies can support each other in seeking legal sanctions if this needs to be the case. The VAMA has provided a good starting point for agencies in Richmond to

[5] Details of the risk framework can be found on the Hampshire SAB website.

respond to this finding, however further thought is required to ensure it is working as effectively as possible.

FINDING 1 – Outside safeguarding there are limited mechanisms that bring staff together from key agencies to plan and review their work in cases involving high risks, increasing the chances of interventions being less effective.

The complex nature of health and social care support to service users requires a variety of mechanisms to manage risk across agencies, to ensure that the voice of the service user remains central to the risk management planning and to support front line practitioners. Formal safeguarding processes provide this for those cases which meet the safeguarding criteria, but for high risk cases that fall outside safeguarding other options are needed.

The newly established VAMA panel has made a positive start to respond to this issue but feedback suggests it struggles at times with workloads and is also not yet known about across all key agencies.

- How can SAB members gain a clear picture of the kind of outcomes the VAMA have been able to achieve so far?
- Maintaining a positive risk taking approach and avoiding defensive practice is a key quality indicator in risk management. How can the VAMA maintain this kind of quality in its responses?
- Are all the necessary agencies represented at the VAMA? And are all agencies aware of how to refer?
- What mechanisms will the Board need to ensure that the VAMA is resourced appropriately and is sustainable?
- During the course of this review one suggestion that emerged from staff was that the VAMA had a small budget to support costs of one off items to assist in risk reduction. How practical would this be?

2.4.2 FINDING 2: In Richmond, a willingness to make management decisions that effectively support professional judgment generates a positive climate in which person centred practice thrives.

The Care Act 2014[6] underlines the importance of working in a person centred and holistic way to support service users. Explicitly it states "A move to outcome and needs based assessment would put the individual and their views, needs and wishes at the centre of the work as the setting of outcomes is both a personal and subjective process". In relation to safeguarding practice, the 'making safeguarding personal' ethos introduced in the Care Act embeds person centred working at every stage of the safeguarding process. This can though be quite challenging for agencies to get the right balance between making good use of formalized or automated risk management processes and still provide a personalised response to individual cases.

In many agencies assessment forms generate recommendations about how cases should be managed. In Richmond Borough Council practitioners use LBRuT 'framework-i', a computer based risk matrix assessment format. This allows key risk information to be identified and recorded by

[6] The Care Act 2014 Department of Health

practitioners as part of the assessment process, the level and type of follow up required is automatically recommend based on this information. A potential challenge when risk assessment formats or processes are in use, can be to find ways to enhance opportunities for practitioners to effectively influence key decisions about how cases are managed. It is important that the practitioner's professional views are a part of the decision making, as this will usually support more individualised and person centred outcomes for service users.

How did the issue manifest itself in this case?
Mr T had a progressive illness, was a smoker and limited to his bed. He had the capacity to make decisions about his care and was fiercely independent. He was making decisions that posed potential risks to himself and to a lesser extent, others. The social worker undertook the usual assessment on 'framework-i' and the tool's outcome for this case was a recommendation for quarterly review by the Duty Team (as opposed to the case being held by one worker consistently). However the social worker and OT involved in the case did not feel this was appropriate given the particular dynamics of this case and Mr T's tendency to only accept a some of measures to reduce the risks his choices generated. They approached their manager to discuss this and gained agreement to keep the case 'active' and allocated to the same worker to support continuity and speed of response if there were any difficulties; the request was agreed. In this case the manager was willing to agree to the request because the practitioners knew Mr T well and were able to make a clear case to show that, in this case, the management of risks would be more effective if the case remained open rather than just being reviewed quarterly.

This flexibility by the manager provided them with the ability to respond in a person centred way with Mr T, providing the level of engagement and oversight to his care that they thought was required in order to minimize his risk. By keeping him on their active caseload they ensured that they could continue to review his progress, that staff who made decisions about his care where those who knew him best, and that there was continuity to maintain a good working relationship with him. This also provided continuity of support for the care staff providing personal care to an adult whose choices were known to generate risks.

What makes this an underlying issue rather than particular to this case?
The social worker and manager confirmed that this was usual practice in their team. When we discussed this with the social worker, she confirmed that she has several examples on her caseload of similar cases posing high risk being retained as open active cases for longer periods (e.g. one that has been kept open for 2 and a half years). This is typical practice within that Care Management Team where practitioners have open conversations with their managers and the combination of 'experience and gut instinct of the practitioner' is valued and trusted by their manager. The underlying philosophy is that the team knows its local population and service users.

What is known about how widespread or prevalent the issue is?
Feedback from the Review Team confirmed that this approach is standard practice within this social care team in Richmond; the team has a positive culture of involving practitioners in practice discussion meetings and decisions. Within the team the proportion of cases where it has been agreed that cases should be held open over a longer-term period in response to the needs of the individual cases is approximately 25%. It has not been possible within the scope of this review to explore whether this positive approach and culture is established in other local social care teams or in teams within other agencies locally.

What are the implications for the reliability of the system?
While risk tools provide an essential basis to work from, a willingness by practitioners and managers to remain alert to professional judgement which may vary from a tool or process outcome, helps to prevent an automated and uniform response to people's support and helps ensure that personalised and individualised decision making is in place, aimed at keeping people safe by responding to their

specific needs. Decision-making needs to draw on the results of risk assessment tools, not be dictated by them. Where this is understood and supported managers are more able to effectively support the critical thinking of their workforce, and it is less likely that errors will occur based on an automated approach.

Finding 2: In Richmond, a willingness to make management decisions that effectively support professional judgement generates a positive climate in which person centred practice thrives.

Professor Eileen Munro in her Review of Child Protection discussed the implications when priority is given to process over practice. She identified that managerial attention in the services she reviewed had often focused on the adherence to process and performance indicator targets, which limited the ability of practitioners and managers to remain effectively focused on the needs of service users. It is essential that front line practitioners are supported by managers who value their professional judgement. While systemized risk tools offer a useful basis for decision making, the approach taken by social care managers in Richmond ensures that staff are not just reliant on the outcome generated by the system, and where appropriate decision making also draws on the experience and knowledge of practitioners, delivering a more personalised response.

Questions for the Board:

- Would the Board find it useful to 'health check' the typical cultures that exist in other agencies within Richmond?
- What can be learnt about the positive impacts for staff and for service users of this kind of practice culture?
- Is this an approach the Board wish to actively own and support, and if so how can it be more actively shared across the system?

2.4.3 FINDING 3: The tensions that exist when an adult has capacity and continues to choose high risk behaviours can leave practitioners feeling personally and professionally responsible when they have limited legal or practical authority or power to keep the person safe.

The Mental Capacity Act 2005 is very clear that adults with mental capacity have the right to make their own decisions. Capacity should be assumed until there is a clear assessment that confirms a lack of capacity. Practitioners must support a person's right to choose where the individual has mental capacity. However, there are many cases where an assessment of capacity is extremely difficult to make. Professionals have to be alert to recognizing whether a turning point has been reached when several lifestyle choices which are deemed to be 'unwise' (but still being made with mental capacity) become on the 'balance of probabilities'[7] a pattern of high risk decisions which may indicate that the person is no longer making an informed decision, and mental capacity has been lost in relation to certain decisions.

The dilemmas experienced by practitioners can be demanding. When a service user with capacity continues to make choices that generate risks, public expectations can be a cause of great conflict for front line staff. The public often wish that agencies and staff could eliminate risk entirely to protect people 'from themselves', but at the same time professionals can be criticized for defensive

[7] MCA Code of Practice (4.10)

practice, being over protective and ignoring people's wishes. In recent years, there has been an increased focus on positive risk taking as an approach that lends itself to working in partnership with the service user. Guidance on risk assessment and management from the DoH highlights the value of service users being supported to take risks, and refers to risks being a 'natural and healthy part of independent living'.

Even in cases where the adult lacks capacity in relation to certain decisions, and the Courts become involved to make a decision in their best interests, the courts support the need for a balanced approach to the management of risk. The Court of Appeal (v Buckinghamshire CC) turned down a claim of negligence against the Local Authority who had 'allowed' a young woman with learning disabilities to have a continuing sexual relationship. The judge pointed to the need to balance the young woman's happiness with managing risk "there is no point in wrapping people in cotton wool if it makes them miserable".

How did this issue manifest itself in this case?

Mr T had capacity, as defined under the Mental Capacity Act 2005, and was aware of the risks he was taking by smoking in bed, to himself and to a lesser extent others. He had had two burns from smoking, one resulting in a hospital admission. The risks were repeatedly explained to him by staff working with him and were documented. However, Mr T's quality of life was a key issue and something that he and the workers around him were focused on. He valued having as much dignity and self-determination as possible, particularly because of the way that his illness had restricted him. Practitioners and care workers needed to balance this with a focus on their duty of care towards Mr T. At times, they would be appropriately directive with Mr T to try to persuade him to accept further measures to reduce risks, however he would remind practitioners that it was his right to choose and that he should not be treated
like a child. On one occasion the OT took a different colleague with her in an attempt to persuade Mr T, however Mr T became very angry and a 'shouting match' ensured. Mr T's fierce independence was central to his identity and this was something that practitioners understood that they needed to respect and work with.

What makes this an underlying issue rather than particular to this case?

We discussed this issue further with practitioners who attended the Learning Workshop and with members of the Review Team, as we wanted to understand if these dilemmas were specific just to this one case. Feedback received confirmed that practitioners often find themselves working on cases where service users have mental capacity to make key decisions but make choices which do not help to reduce risks and, in some cases, increase risks. The Housing Provider also discussed the challenge to their agency when their tenants' choices create a risk to themselves and their property, and the provider has to reach conclusions about whether and when to seek legal enforcement to ensure the safety of tenants and property.

The Review Team referred to a number of other cases where service users had mental capacity but their choices generated risks that were difficult to manage. One example was a woman with limited mobility with Cerebella Atrophy who regularly drank alcohol through the day. She hoarded items particularly food and smoked. She did not have access to a phone in her bedroom if she needed to call for help. She was deemed to be at multiple risk from possible fires, financial abuse, self-neglect, increase in depression and alcohol use due to stress. She was assessed as having capacity and despite the risks she chose to continue with her lifestyle decisions. Practitioners working with her did their best to reduce risks to her, but were very aware that she remained at high risk of serious harm.

What is known about how widespread or prevalent the issue is?

Working with these kinds of tensions and ethical dilemma is a regular part of working with adults. There have been other cases where similar tensions have been explored. For example, the case

(West Berkshire[8] Safeguarding Adults Review 2016) where a service user was mis-using alcohol and at risk of self-neglect. He was not willing to engage with practitioners, but had been assessed as having mental capacity, so the team working with him had very limited options in terms of intervention.

The Care Act 2014 statutory safeguarding guidance (chapter 14.108) recognizes the dilemma posed to staff in these situations. It states that 'that if the adult has the capacity to make decisions in this area of their life and declines assistance, this can limit the intervention that organizations can make'. Research into cases of self-neglect by Preston Shoot and Braye[9] SCIE (Fact sheet 46) acknowledged the particular difficulties for front line staff who are working with adults who are neglecting themselves and are reluctant to engage with staff. Preston Shoot and Braye noted the frustrations and difficulties stating that "professionals' express uncertainty about causation and intervention".

What are the implications for the reliability of the system?
These tensions will continue to be part of the pattern of work life for practitioners, therefore practitioners need to be well equipped to engage with these ethical dilemmas and tensions within their professional practice. Despite the risks that are posed, the rights and wishes of the service user with capacity should continue to be at the heart of decision-making along with considerations for the quality of their life.

In order to ensure good practice outcomes and reduce the frequency of staff burnout, consideration is needed about how best to support practitioners who are working with these tensions. Multi-agency working can be a great help as it allows for a mixture of views, healthy challenges and shared risk management planning. Access to good practice advice, and to legal advice if court action is being considered, are also key. Senior and strategic managers can consider what kind of organizational ownership there is of these kinds of issues in their agencies, or by the multi-agency Safeguarding Adults Board, to avoid practitioners being left with the sense that they are having to handle these tensions as isolated individuals.

FINDING 3: The tensions that exist when an adult has capacity and continues to choose high risk behaviours can leave practitioners feeling personally and professionally responsible when they have limited legal or practical authority or power to keep the person safe.

It is particularly emotionally demanding for practitioners who work with service users who have mental capacity but continue to make choices that generate risks over long periods of time. Practitioners are needing to balance a mixture of priorities including the legal requirement to support the wishes of the capacitated adults, to support positive risk taking where it is appropriate, but also to do all that they can feasibly do to reduce risks.

There is relatively little guidance currently available nationally in relation to the management of these kind of dilemmas. Over time can potentially they can result in poor practice or emotional burnout if practitioners are not given the kind of supports and systems that help them to manage these cases positively.

Questions for the Board:

- What kind of organizational ownership does each agency take in relation to these tensions and their potential impact on staff?
- What steps would the Board want to pursue to provide staff with guidance and support in

[8] West Berkshire Safeguarding Adults Review Mr I (July 2016)
[9] SCIE research paper no.46 - Self Neglect

their management of these cases?

3. Appendices

3.1 How the 'Learning Together' review process was undertaken in this SAR

The Learning Together methodology can be used flexibly to provide bespoke reviews to gather and analyse the data and then develop the appraisal of practice and the findings. How the key components of the methodological heart were undertaken in this SAR:

- Generating the 'View from the Tunnel' – from the data provided by front line staff to reduce 'hindsight bias' and generate a more complete understanding of what happened and why. In this SAR that phase of the process was undertaken by front line staff at the one day Learning Together Workshop.

- Analysing the data using 'Key Practice Episodes' to 'chunk' up the timeline, to appraise the practice of the professionals, and to understand what the contributory factors were. In this SAR that phase of the process was undertaken by front line staff at the one day Learning Together Workshop. The analysis work was then developed by the Lead Reviewers and written up in the Appraisal of Practice, with input from the Review Team.

- The 'Window on the System' – the generic findings which provide a window on the local safeguarding system, is generated through the analysis of learning from the specific case, in order to tease out which pieces of learning have a broader application. This phase of the review was undertaken by the Lead Reviewers and the Review Team.

Richmond SAR Process – Key Meetings		
Date	**Key Activity**	**To achieve**
30.09.16	SAR training session for SAB members and local front line staff	Familiarity with the SCIE Learning Together model
05.10.16	Learning Together SAR Workshop for frontline practitioners and managers	Gather and analyse case data
11.10.16	SCIE independent supervision session for Lead Reviewers	To quality assure and support development of appraisal of practice and emerging findings
27.10.16	Meeting of Lead Reviewers and Review Team	Verify developing analysis of practice and input to emerging generic findings
05.12.16	SAB SAR subgroup meeting review of the SAR report	SAR subgroup to quality assure the SAR report
15.12.16	Lead Reviewers facilitate SAB Findings Workshop	To share findings with SAB and facilitate development of SAB action plan

3.2 Members of the Review Team

Member of the Review Team	**Role**	**Agency**
Alison Ridley	Independent Lead Reviewer	
Mary Burkett	Independent Lead Reviewer	
Caroline Hand	Safeguarding Lead	Richmond Housing Trust
Dr Alex Norman	GP	Richmond CCG
Barbara Grell	Safeguarding Board Manager	LB Richmond upon Thames
Barbara North	Safeguarding Lead	Richmond CCG
Sian Davenport	Manager	Mears Care Agency
Anne Stratton	Director of Clinical Services	HRCH
Virindar Basi	Team Manager, Adult Social Care	LB of Richmond upon Thames

Andy Cane	Borough Commander	London Fire Brigade
Lynn Wild	Head of Safeguarding and Professional Services	LB of Richmond upon Thames

3.3 Chronology of key events

The period under review is June 2015 – January 2016.

DATE	KEY EVENT
13.06.15	Mr A accidently starts a small fire, suffers superficial burns and was admitted to hospital
16.06.15	SW1 makes a referral to the Fire Service to review potential fire risks
26.06.16	Fire check undertaken by Faire Service and 2 smoke alarms fitted, fire safety advice given.
26.06.15	Mr A was discharged home
27.06.15	Fire retardant bedding installed
07.07.15	Social Worker (SW1) undertakes care review, including assessment of risks and mental capacity, liaises with fire service to arrange second fire review
16.07.15	Second fire review undertaken by Fire Service
25.10.15	Superficial burn noted by care worker, relevant parties advised
29.10.15	Mr A's ashtray catches fire, agencies share information and review risks with Mr A
09.11.15	Social Worker (SW1) undertakes care review, mental capacity remains good and Mr A is aware of the risks associated with his behaviours
During 12.15	Concerns emerge about Mr A's care, weight loss and potential self–neglect. Nurse advises social worker (SW1).
01.01.16	Mr A falls out of bed, paramedics (called by the care workers) check him
04.01.16	Ambulance service raise a safeguarding alert in relation to potential neglect and self-neglect.
05.01.16	Social worker (SW1) visits Mr A to review situation
06.01.16	Safeguarding enquiry opened
07.01.16	Safeguarding social worker (SW2) visits Mr A to undertake safeguarding interview, he is reluctant but agrees to section 42 enquiry meeting
08.01.16	Multi-agency section 42 meeting held at Mr A's home, action plan agreed
11.01.16	SW2 emails fire service to order second set of fire retardant bedding
14.01.16	SW2 liaises with Mr A's daughter re support for his shopping and aspects of personal care
19.01.16	18:14 Fire reported by neighbour, Mr A subsequently found dead (at 18:42) by fire service