A thorough internal investigation.

Some of the Commission's recent investigation reports have criticised the way that mental health and social work services carry out internal investigations. We found that some internal reports did not investigate possible failures thoroughly and impartially. We are pleased to report a case where an internal investigation was conducted to a high standard.

We heard about the case of a man who developed alcohol-related brain damage. When we looked at the information supplied to us, we thought there were many similarities with the case of "Mr H", one of our previous investigations. We found evidence to suggest that health and social care staff should have identified his problems at an earlier date. We asked the local authority to investigate on the basis of our concerns.

We received an excellent report, carried out under Adult Protection procedures. We were pleased that this local authority acted swiftly and thoroughly to address the concerns we raised with them. Their report was open, honest and appeared to us to address the failings in this case.

We agreed with the local authority that we would publish the report on our website. The report was produced by the local authority but also covered issues of NHS care. We thought that other services could learn from the report's findings, recommendations and action plan. In particular, other services should study the robust and objective nature of the internal investigation. In our view, it is a good example of how a service can and should investigate its own actions.

SOCIAL WORK SERVICES

Report into the Care and Support of Mr A

October 2010

Contents

1 Introduction

1.1 Background to the investigation

1.2 This report is based on the findings of an investigation carried out during August and September 2010 into the care and support of Mr A, a 61 year old man who is currently an in-patient at a psychiatric Hospital.

1.12 The investigation was undertaken at the request of the Mental Welfare Commission (MWC) who contacted the Directors of Social Work and Housing in June 2010 after Mr A's admission to hospital.

1.13 Concerns had been raised following Mr A's compulsory admission to Hospital where he presented as having been significantly ill for a considerable period of time. The MWC were concerned that despite involvement from three Council services from March 2009, his difficulties were not appropriately addressed until January 2010.

1.14 After their preliminary review of evidence gathered from the services involved the MWC concluded that Mr A was:

***** An 'adult at risk', being both a risk to himself and to others, in terms of the Adult Protection guidelines;

***** He potentially lacked capacity in terms of the Adults with Incapacity Act but this was not adequately considered and

***** Health were not involved until January 2010, despite concerns about both his physical and mental health.

1.15 The responsibility for the investigation was remitted to the Multi-Agency Adult Protection Committee by the Director of Social Work. The Committee was charged with identifying investigators and directing the scope of the investigation***.***

1.2 Terms of Reference

1.21 The MWC requested that the investigation address the following:

- Whether action should have been taken sooner to protect a vulnerable adult
- Whether processes, procedures and the knowledge of these are in place to support such action

1.22 In addition, the MWC asked that the investigation ensured the appropriate involvement of
other agencies, in particular health and in addition to involving representatives

from the three
teams who were involved with Mr A., to consider the involvement of the Adult Protection
Coordinator.

1.23 Social Work Services were asked to report back to the MWC on the findings before
the beginning of October and to detail what action, if any, was felt necessary and a
timescale for any action identified.

1.3 Investigation Team

1.31 The investigation team comprised of two senior managers from social work and health. The team were asked to undertake the investigation under the direction of the Adult Protection Committee (APC) and to follow the principles of the Adult Protection Critical Incident Review Group Guidelines.

1.4 Methodology

1.41 The investigation team had been provided with a chronology of significant events by the MWC. Relevant information and case records were gathered from all agencies. Further written material was also gathered. This included the Council's Protection of Vulnerable Adults/Adult Protection – Inter Agency Policy and Procedures, Housing Support service documentation and good practice guidelines.

1.42 Staff called to interview are detailed at paragraph 1.5. All interviews took place on 10th/11th and 31st August 2010. There was full cooperation from all agencies in the collation and
provision of documentation and at attendance at interview. Notes were taken at the point of
interview and are attached as appendices to the report. All have been signed as an accurate
reflection of the interview by the interviewees.

1.43 All interviewees were informed that a report would be completed following the interviews and that this would be presented to both the Adult Protection Committee and to the MWC.

1.5 Staff Interviews

1.51 All staff interviewed are detailed below. Those who had a direct responsibility for the care and support of Mr A are highlighted in bold. Others were interviewed to give some context to the

frameworks in place for staff around adults at risk and to provide information on best practice
within the Council on Adult Protection.

Social Work Staff
Staff Member 1, Senior Social Worker (SSW)
Staff Member 2, Social Work Assistant (SWA)
Staff Member 3, Social Worker (SW)

Housing Support Staff
Staff Member 4, Housing Support Manager
Staff Member 5, Housing Support Officer
Staff Member 6, Housing Support Officer

Housing and Property Staff
Staff Member 7, Housing Officer

Others Interviewed
Staff Member 8, Adult Protection Coordinator
Staff Member 9, Mental Health Officer (MHO)

Telephone Interview
Staff Member 10, Senior Social Worker

1.6 Other Agency Information

1.61 Chronologies were received from both Police and Fire & Rescue.

2 Detail of Agency Intervention

2.1 The investigation concentrated on the involvement of all agencies from March 2009 up to Mr A.s admission to hospital on the 25th January 2010.

The following commentary seeks to answer the concerns raised by the MWC in their chronology and is based on the information gathered from the staff interviews, case recording and clarification sought from individual staff following interview.

2.2 **01/04/09** A housing officer was called out to Mr A.'s house following the activation of the smoke alarm. *The MWC questioned whether the housing officer considered contacting social work at this point*. At interview, the housing officer stated that he would not have contacted any
other agencies he would always refer to housing support for situations like this and would
only refer to Social Work if there were children involved. It was established at interview that the

housing officer did not feel that Mr A was exhibiting any signs of having a mental health
problem at the visit and therefore referred him to housing support.

Throughout the interview, it was clear that the housing officer would refer to housing support in the first instance for any support that service users required (except in the case of child
protection issues) as he felt that they would then refer on to the most appropriate service.

2.3 **11/05/09** At the point of the housing officers referral to housing support, the MWC noted that
Potential mental health issues identified but neglect due to living conditions not explicit in
referral. Was there any consideration of whether this was 'adult at risk' in terms of ASP Act by
Housing Support or referrer? Any consideration of lack of capacity?'

The housing officer stated that he was aware of vulnerable adults' legislation but had not received any training in relation to this subject. He thought however that it was aimed
at adults being harmed. He stated that he had had no training in relation to AWI nor had any
other housing officers. Given the lack of any structured training or information to this housing
officer in relation to the legislation mentioned, it is unlikely that he would have considered Mr
A. to be at risk in this sense or to consider capacity issues.

One of the housing support staff stated they had no knowledge of either the interagency policy
and procedures or AWI whilst one had some basic knowledge around both however it would
appear that neither had enough knowledge at the time to consider risk elements or capacity
issues.

2.4 **18/05/09** Following contact from Fire and Rescue Service, social workers visited
Mr A. The MWC questioned '*Should this have been identified as ASP inquiry 4.2.5 of the*
Interagency AP Guidance? Would seem from initial assessment that meets definition of 'adult
at risk'. At interview, the SWA who wrote the case note stated that <u>in hindsight</u>, her description
of Mr A. at the time met with her perceived definition of an adult at risk however in relation to
this and AWI considerations, she felt that this case was clouded by Mr A's

housing situation
and alcohol problem. Both staff were aware of the Protection of Vulnerable Adults/Adult
Protection Interagency Policy and Procedures and both had received training in Adult
Protection. Both workers however focused on the presenting problem which appeared to them
to be alcohol.

The case note entry for the visit read *"Client appeared to have cognitive disturbance with talk of having been (sic) accused of been (sic) a German, used by other people against him. He stated this in three different contexts."* Staff did not appear to consider that there was a possible mental health issue or that this gentleman was at risk from anything else other than fires. At the time of interview when reading her case notes, the SWA felt that in hindsight, an MHO should have been contacted at the time.

The SW present at the visit felt that despite what was recorded by the SWA on return from the visit, Mr A appeared capable of making informed decisions about his care. Her knowledge of AWI however seemed limited and focused on guardianship and intervention.

2.41 It would appear that no referral was made to a GP at the point of this visit as neither of the staff felt that this was necessary. Staff noted that Mr A. was 'very shaky, possibly due to peripheral neuropathy' however neither felt that there was anything physically wrong and put this down to the alcohol problem.

2.42 Social Work contacted housing support following this visit and the MWC noted *'This was second contact with Housing Support-seems no indication by HS to either Housing or SW of when they would be visiting- yet this is 'adult at risk'. How are referrals prioritised?*'
On speaking with the housing support manager, she is responsible for the receipt of all referrals and will then distribute them to the appropriate teams. The teams will then prioritise their visits.
They take into consideration whether the person would require access to services quickly, what support is already in place for someone or whether the person is at risk of losing their home (It should be noted that at this point the person had not been identified as being at risk).

The teams do encounter levels of no access and this can sometimes result in a period of time between referral and visit. If the housing support workers workload is high, the staff will ensure a referral is made to other services such as the Association for Mental Health or the Council on Alcohol so that some support will be going in until they can visit. This could potentially be the reason why there was five weeks from referral to visit. From the information at initial referral and also the information passed on to following the social work visit it is possible that Mr A. should have been targeted as a higher priority, but this was not requested a such by social work, and neither had Mr A been assessed as being vulnerable..

Despite the fact that this type of service user may present no access challenges, perhaps

assertive outreach approaches would assist with other service users in this position.

2.5 **07/07/09** The MWC noted that following a no access on this date, there was no record of any

further attempts by housing support to visit Mr A. until 25/01/10. Having spoken with housing

support staff it is entirely possible that further 'no access' visits took place but were not recorded. This however cannot be verified so it would appear that there was no service available to this service user.

The MWC note '*Should Housing Support particularly, or Housing not have referred back to SW under ASP if unable to engage with Mr A?'* During the interviews, it emerged that there did not seem to be an agreed understanding across services in relation to particular services responsibilities. Whilst none of the housing support staff said they were familiar with the AP1 referral form all stated that they were aware that if they thought someone was at risk, then they should make a referral to social work.

There were however different interpretations of how to deal with people dependent upon alcohol, with differing interpretations around the ability to intervene, and the ability to require people to comply with certain services. This limited the options that some social work staff felt were open to them, when they were also of the view that it was appropriate for the housing support service to work with people with alcohol problems. There was a difference in opinion between the two services about the level of support that could be provided to clients, and who was best placed to do this.

The housing support manager however felt that as a service, this meant they were in the position of maintaining certain service users and providing support to clients beyond their

eligibility criteria.

It is clear from the housing support eligibility criteria that any case with low to medium *non-specialist* support needs can be dealt with by Housing Support.

Where there are factors such as mental health problems, drugs or alcohol misuse in low to medium level that require *specialist support* the service may commission support from a specialist provider. This would require an assessment to be carried out to indicate the level of support required, and it is not clear that this happened in this case.

Again the fact that Mr A had not been identified as being actually or potentially vulnerable/at risk set the context in which a range of responses were made.

2.6 07/07/09 Social work contacted housing support requesting an update on Mr A. At that time the social work duty was managed by 2 SSWs on alternate weeks. The case had been on the duty list for follow up since the first visit of 18/05/09. On 7/7/09 social work contacted the housing support service to get an update on the situation. On receiving the information that housing support were still involved with Mr A, the decision was made to take no further action with the case. However as in 2.5 above, following this date (7/7) when no access was available to housing support there was no further recorded contact from the service until January 2010. It is not clear that there was a full understanding of the nature of the involvement of housing support at this time.

The judgement made within social work was that housing support would be able to deal with a case like this, and that on the basis of information available, and in comparison with other referrals, adult protection issues were not a consideration at this time.

2.7 13/01/10 Following an incident on 26/12/09, Mr A. was visited by a housing officer and
concierge to issue him with a warning re fire risks. Again they referred to housing support and
discovered that a referral had already been made however Mr A. had not engaged with the
service. At this point, there had been six fires within the year, reports of incoherence, hazardous living conditions and self neglect. From discussion with housing staff, it is clear that they saw no other option open to them for taking this forward other than housing support. All staff involved from these two services clearly thought that Mr A's behaviour stemmed from his drinking and nothing else.

2.8 15/01/10 A joint visit was carried out by housing and housing support as another fire was
reported. Fire and Rescue were in attendance and had to force entry into the flat as
Mr A. was not in. This led to a further joint visit on **22/01/10** where intervention commenced in
terms of new goods to Mr A. and arrangements made for a flat clean. The cooker, the source of
most of the fires, was removed at this point.

2.81 At the point of the visit on 22/01/10, a GP appointment was arranged by housing support staff.
The reason for the appointment was due to the fact that the staff member saw a clear change in
Mr A. She was concerned about his weight loss and the fact that she thought his memory was
failing.

At the time of the visit, Mr A. spoke about cuts on his thumbs which weren't visible to the worker
and stated that the government had caused the fires in his flat. Still at this point, the worker did
not question his mental health, but did state that the felt this was indeed the case at the time of the GP appointment the following week.

2.9 25/01/10 The housing support officer accompanied Mr A. to the GP appointment and it was at this time that she questioned whether Mr A. had mental health problems. She felt that there was a marked change in his behaviour on that date. His eventual admission to hospital on that date for voluntary assessment saw his behaviour deteriorate further and it was clear to both the GP and the MHO that Mr A. was suffering from a mental illness. Housing support staff stated that they may have picked this up sooner had they been able to establish regular visits which would have allowed them to pick up a pattern of behaviour.

3 Key Findings

3.1 No assessment of need was carried out on Mr A. by any agency. There was no evidence of any
risk assessments being undertaken. Adult protection should have been considered with the first
Fire and Rescue referral. The referral from standby flagged up adult protection concerns which
were not acted upon.

3.2 Communication was poor between the three services and there appeared to be confusion or lack of understanding about the role of housing support and what it could undertake in the way of service delivery. Social work services did not consider the case warranted intervention under the Adult Support and Protection Act. The provision of service therefore remained with Housing
Support which is a low level service who would have been unable to provide the specialist
support or potentially recognise that this was required.

3.3 There was no consideration given by any staff to the involvement of health at an earlier stage. In hindsight, all agencies felt that they would now contact primary health care services. Dialogue
with either primary care or specialist services may have prompted an

appropriate response to
the care and treatment of Mr A.

3.4 An appropriate agency chronology may have alerted staff to the number of incidents and
involvements with Mr A. There were two uses of 'significant events' in the case recording. The
first was by the social work duty staff on the 12th of May when a screening visit was arranged.
The second use was at the SW visit of 18 May. None of the other interventions by staff were
recorded as significant.

3.5 There was evidence that awareness raising/ training had been made available for housing
support staff but does not seem to have been in place for housing officers.

3.6 There was a lack of knowledge about Adult with Incapacity legislation. Whilst in social work, there has been training delivered, the staffs' understanding of the use of the
legislation and their responsibilities under the act seemed to vary.
The Housing staff member interviewed stated that neither he nor any of his colleagues had
received AWI awareness raising or training. The Adult Protection Committee is already in the process of refining its inter agency training strategy.

3.7 A number of factors such as the duty system in place at the time, and the management arrangements for this, the timescale for an update from housing support contributed to the fact that earlier action wasn't taken and this could have identified risks earlier.

3.8 There was a prolonged period where Mr A. no access issues facing housing support meant that there was no direct service involvement, though this should be seen in the context that Mr A had not at that time been identified as being vulnerable

3.9 There was no recognition by any staff at any point until the day of admission to hospital that Mr
A, may have had mental health problems. This might suggest that staff are not adequately
equipped to spot the signs of what may be a mental illness, are unfamiliar with the impact of
prolonged alcohol abuse on people or that they deal only with the presenting

problem as they
see it – which in this case was alcohol.

4 Actions/Recommendations

4.1 There should be a structured mechanism to facilitate the sharing of information between agencies and ensure the appropriate care management and assessment of clients by the appropriate agency. Where there is any suggestion of an adult at risk, staff that are on electronic case records should use the Adult Protection module and staff who do not use such electronic records should refer using the Adult Protection referral form. **A strategy to put this mechanism in place should be produced by December 2010 with the expectation that this will be implemented in January 2011.**

4.2 The communication and coordination of care between all agencies was poor. **It is recommended that a joint protocol on assessment and care management should be developed. This should be put in place by January 2011.** Agencies should also consider action to ensure that all agencies have a clearer understanding of each others services and their criteria for working with individuals.

4.3 The instigation of joint training as opposed to single agency training should reinforce the role of multi agency work in the field of adult protection**. It is recommended that the work already underway to develop full multi agency training is in place for January 2011.**

4.4 An interagency chronology should be developed which would better highlight a history of risk factors and significant events. This would lead to more robust risk assessments being undertaken and is crucial in the overall management of risk reduction and risk management. The introduction of any chronology should be accompanied by robust briefing or training and should meet with the SWIA best practice guidance on chronologies. **It is recommended that further work is done to progress this, and that this should be reported to the Adult Protection Committee by January 2011.**

4.5 Despite the interagency policy and procedures and training for all relevant staff groups about adult protection, it would appear that more needs to be done by the Council to

ensure that staff are aware of where clients could be considered adults at risk. It is noted that Housing have already put into place a strategy for training. **It is recommended that the Council take the opportunity of the launch of the procedures to revisit adult protection with all relevant staff groups.**

4.6 All relevant staff should be aware of AWI legislation and it should be established that this is a core piece of legislation for all staff and not just for use by MHOs. Better staff understanding of AWI and the implications for considering this with assessment and care management should be made clear. When dealing with clients with any addiction issues, consideration should be paid as to the capacity of that individual to make informed choices in terms of lifestyle, intervention by professionals and/or consent to plans of care.

It is recommended that the Council put into place a robust training strategy to ensure that all relevant operational staff are familiar with AWI and their roles and responsibilities within this Act. The strategy should be in place by January 2011.

4.7 Social work have implemented a new 'duty' system which should eliminate service users potentially at risk from remaining on duty lists for prolonged periods without any contact from staff or any intervention. **It is recommended that a method of quality assuring that this happens is put in place. This could be done by the extension of the Case Sampling Framework which is already in use by social work staff. This should be done by December 2010.**

4.8 **The** Housing support service should consider more assertive outreach work when clients who are at risk are referred to them. This would allow them to identify at an earlier stage where service users may be at risk and give them robust information about the client's degree of vulnerability. The practice of 'postcarding' may be appropriate in some circumstances however the decision as to when to follow up no access cases should be accompanied by a robust risk assessment. **It is recommended that the housing support system develop and put into place a no access risk assessment by December 2010.** The housing support service should also look at their current process of prioritising cases and extend the triggers for prioritising visits to include risk factors.

4.9 There was a demonstrated lack of knowledge of staff about mental health issues. It was also
stated by all staff that the number of people that they are dealing with who have Alcohol Related Brain Disease is increasing. **It is recommended that the Council put into place appropriate training/information to staff about dealing with people with alcohol problems and working with people who have mental health problems. A strategy for delivering this training/information should be completed by January 2011.**