BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult L

Executive Summary August 2019

To Note:

This is a brief anonymised summary of an Overview Report that was finalised in May 2019 and ratified by the Buckinghamshire Safeguarding Adults Board (BSAB) in June 2019.

The original Report was instigated on the 20th May 2015. The original Author presented a Draft Report on 30th November 2016. On review it was determined that there were key elements of the care and treatment of Adult L which had not been included or explored adequately. As a result of this and an agreement by the BSAB not to commission a new Report, a subsequent process was instigated and completed by the Board's Safeguarding Adults Review (SAR) Sub Group. The final Overview Report was therefore a product of this lengthy and unusual process. The overarching methodology remained, however, a traditional one with relevant agencies completing Individual Management Reviews and Chronologies and of these being considered by a Panel.

1. Introduction

This Report summarises the findings of an Overview Report ratified by the Buckinghamshire Safeguarding Adults Board (BSAB) in June 2019.

Adult L was aged 23, and single, at the time of his death. He was receiving services to meet his assessed care and support needs through the Learning Disability Team of Buckinghamshire County Council Adult Social Care.

Adult L died on the 8th May 2015 whilst in Milton Keynes Hospital. He had been on life support in that hospital following a suicide attempt on the 3rd May 2015 whilst remanded into custody at HMP Woodhill.

The Prison and Probation Service Ombudsman has undertaken a review into the death of Adult L whilst he was in custody, A Review Report was published in February 2019 which identifies a number of recommendations for HMP Woodhill.

The Coroner's Inquest took place 15/01/2019 - 22/01/2019, recording a conclusion that the cause of death was suicide.

2. Reason for the Review

The referral for a Safeguarding Adults Review was considered by the SAR Sub Group on the 20th May 2015.

It was agreed that the case met the criteria for a SAR: '*when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult*'

3. Terms of Reference and Methodology

The time period for the Review was agreed as the 1st May 2012 until the 8th May 2015.

The following Terms of Reference were agreed:

- To establish the extent to which health, social care, and criminal justice agencies demonstrated their understanding of the needs of an adult with learning disabilities.
- To establish if information was appropriately shared between health, social care, and criminal justice agencies and acted upon.
- To consider if assessment and care planning took full account of Adult L's learning disability and other needs.

- To establish if health, social care, and criminal justice services were appropriately provided to Adult L to prevent the escalation of his level of need.
- To establish how well the legislation, policy and practice were applied to meet Adult L's needs.
- To establish if Adult L's wishes were sought and taken account of.

The following agencies were asked to complete Chronologies and Individual Management Reviews:

- Thames Valley Probation
- Milton Keynes University Hospital NHS Foundation Trust
- Buckinghamshire County Council (BCC) Adult Social Care
- NHS Chiltern Clinical Commissioning Group
- SMART (drug and alcohol services)
- Thames Valley Police
- Berkshire Healthcare NHS Foundation Trust (Liaison and Diversion Service)

Additional Specific questions were discussed with:

- Oxford Health NHS FT Caldicott Guardian
- Prison and Probation Ombudsman
- Buckinghamshire Clinical Commissioning Group and NHS England

The final report, of which this is a summary, brings together those individual reports. They are the basis for the overview of what took place, and the conclusions and recommendations.

4. Involvement of Family

The original review process made no clear attempt to involve the family of Adult L. The refreshed process identified this as a gap the family was contacted in April 2018. No response was received. There has therefore been no involvement of Adult L's family in this process. They will be notified and offered the opportunity to again meet with the Board prior to publication of this Executive Summary.

5. Summary of Facts as they were known to Services

Adult L had a history of drug and alcohol abuse and displayed behaviours consistent with long term use of cannabis. He was also later assessed as having a learning disability. He had a conviction history dating back to 2002, had served custodial sentences since 2011 and had been at HMP Woodhill before.

During 2012 Adult L was arrested for a number of offences including suspicion of burglary, harassment, shoplifting and theft of a motor vehicle. He was charged with possession of an offensive weapon in November 2012 where he received a 12-week custodial sentence. During this period he did not have access to an Appropriate Adult whilst in custody and no specific risk factors were identified whilst in police custody during this time.

Adult L was released from prison on the 21st January 2013. He met with his Probation Service Officer and it was at this meeting where it was agreed that a basic learning disability screening assessment would be completed and a referral made to Adult Social Care.

A Learning Disability Screening assessment was undertaken on the 27th March 2013 with the results indicating that Adult L met the threshold for Learning Disability. He was accepted onto the caseload of the Learning Disability Social Care Team in June 2013.

From July 2013 to October 2013 Adult L was arrested three times. Whilst in custody during this time Adult L did not have an Appropriate Adult and no risk factors or vulnerabilities were documented in his custody records.

In November 2013 the Social Worker emailed the Police Custody suite giving reasons why Adult L needed an Appropriate Adult when in Police Custody.

From November 2013 until July 2014 Adult L was arrested seven times. On each occasion he had access to an Appropriate Adult.

Between September 2014 and October 2014 Adult L was failing to attend Probation appointments.

21st April 2015 Adult L was arrested following a fire at his mother's address. He was seen by the health practitioner in custody who recommended an Appropriate Adult. Adult L was charged with Arson and Burglary and remanded in custody.

Whilst in custody both the Probation Service Officer and the Team Manager of the Learning Disability Team made several attempts to ensure that a Social Worker could act as the Appropriate Adult. No Appropriate Adult was secured. The information provided in the Report was that Adult L's solicitor stated that Adult L did not give consent to share information.

On the 1st May 2015 Thames Valley Police contacted the Learning Disability Team to request an Appropriate Adult for a meeting at the prison the following week.

On the 3rd May 2015 Adult L was found in his cell with a ligature around his neck. He was taken to Milton Keynes Hospital where he died on the 8th May 2015.

Following a Coroner's Inquest in January 2019, the Coroner ruled Adult L's death a suicide.

6. Key Findings of the Review

The Review Panel considered each of their findings in line with the Terms of Reference:

To establish the extent to which health, social care, and criminal justice agencies demonstrated their understanding of the needs of an adult with learning disabilities

Adult L's Learning Disability was not identified by agencies until a Learning Disability Screening Assessment was completed by the Probation Services Worker in March 2013. As an adult with a learning disability, Adult L should have had access to an Appropriate Adult to support him during periods in Police Custody and when being interviewed under caution.

To establish if information was appropriately shared between health, social care, and criminal justice agencies and acted upon

The Review established that there was effective joint working between the Probation Service, Adult Social Care and housing providers, but this was not recorded clearly within Adult L's sentence plans.

At the time of the Criminal Justice Liaison and Diversion service being commissioned for Buckinghamshire, there was no introduction to or information shared with, the Learning Disability services regarding the service. It should be noted that at the time the Liaison and Diversion service was a mental health specific service hence its remit did not include Learning Disability.

Adult L was a service user of the social care Learning Disability service, his social care records were held on the BCC records system. Entering records onto Oxford Health's clinical record system did not therefore aid information sharing. This aspect remains a national issue and the future plans to introduce connected care may aid in mitigating this risk in the future.

Adult L's Solicitor refused to share information with his Learning Disability team during the last court process. This decision was on the basis that Adult L would need to give consent to such information sharing and that he was refusing. The Review was unable to identify Adult L's solicitor, as a result they were not able to contribute to the review and no further comment was made on the decision making in this scenario.

To consider if assessment and care planning took full account of adult L's learning disability and other needs

The first record of Adult L's learning disability needs being identified was on the 27th March 2013, which led to a referral to Adult Social Care being received on the 18th April. There was a delay in an assessment of Adult L's Social Care needs being completed, due to an assumption that the referral had been picked up by the 'Health' Learning Disability Team.

A Psychiatric report shared with Prison In-Reach team was one completed a year prior to his remand into custody. Whilst this information was shared with the intention of being helpful, had liaison taken place with the Learning Disability Team they may have understood that there were significant concerns about his current presentation on this occasion, and changes since the previous report was completed.

Adult L had spent many periods in custody. The assessment of the Social Worker and the resultant concerns indicated that on this last occasion there was a change in presentation and level of risk which warranted further consideration by the court. The Report highlighted that liaison with prisons and criminal justice agencies is not a common area of practice within adult social care, undertaking such liaison therefore would be outside of their frame of reference and guidance from a specialist service would have been helpful.

Once Adult L's learning disability was identified, from that point his needs were considered in the care and support planning processes. Any gaps in his care took place prior to his learning disability being identified. His learning disability was not formally diagnosed until specialist intervention and testing by Adult Social Care, primarily due to the fact that generally he presented well and had coping mechanisms in place. There was no Appropriate Adult used when Adult L was in custody up until the point at which the police were told that he needed one. From that point onwards one was used.

To establish if health, social care, and criminal justice services were appropriately provided to Adult L to prevent the escalation of his level of need

Adult L was very well known to criminal justice agencies with a long history of offending and of convictions with community and custodial sentences. It is not possible to state whether there are any actions which could have prevented the level of need from escalating, but there were missed opportunities for joint work at periods of an increase in needs. Of particular concern is the reported lack of response from adult social care to the probation service at times of a change in presentation and escalation of offending and chaotic behaviour.

To establish how well the legislation, policy and practice were applied to meet Adult L's needs

Throughout the review period, the various agencies involved have referred to Adult L making decisions. Examples include choosing to leave accommodation, deciding not to attend probation appointments, to continue to commit offences and to breach court orders. There are no references found of assessments of Adult L's capacity to make these decisions and to any legal frameworks which could have been considered. The Local Authority could have considered use of the Mental Capacity Act 2005 or Guardianship under S7 MHA 1983

To establish if Adult L's wishes were sought and taken account of

Agencies report that Adult L was involved in the assessment and care planning processes and in the case of the probation service his sentence planning and supervision.

RECOMMENDATIONS

The Report makes eleven recommendations for the Board to consider.

It is to be noted that given the time passed since the death of Adult L, the majority of these have now been implemented or, where the action is more complex, are in the process of being implemented.

1. All agencies to confirm that clear processes are in place for cover arrangements in the case of staff absence.
2. Contact details for Adult Social Care teams to be shared with Probation Service and Community Rehabilitation Company and vice versa.
3. GP practices receiving correspondence regarding de-registered patients should contact the sender to inform that patient is no longer registered. Such contact may result in the decision to de-register being reconsidered.
4. Custody Officers should seek advice from Liaison and Diversion (where in place) and/or the care team of a detained person (where known) with regards conditions of Police Bail.
5. Where professionals' meetings take place, these should be minuted, with actions recorded.
6. Where multiple agencies are involved with an adult with care and support needs, a lead agency should be identified.
7. Magistrates to receive training in issues relating to Learning Disability.
8. Magistrates to take account of recommendations with regards to sentencing options for adults with care and support needs.

9. For Berkshire Healthcare NHS FT to consider sharing CJL&D assessments and reports with Primary Care in order to ensure a single care record exists, where it is indicated and appropriate, with consent from the patient.
10. For Buckinghamshire County Council to facilitate access to the Adult Social Care records system for Berkshire Healthcare Liaison and Diversion staff
11. For the Adult Social Care Learning Disability Service to ensure assessments take place prior to decisions regarding eligibility for the service.