

**West of Berkshire**  
**Safeguarding Adults Board**

**Safeguarding Adult Review**

**Mr I**

Accredited Lead Reviewers:  
Kathy Kelly and Alison Ridley

July 2016

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# 1. Introduction

## 1.1 Why this case was chosen to be reviewed

Mr I's death (due to alcohol related illness) had aspects of many other cases where alcoholism and self-neglect are features. He was assessed as having mental capacity in relation to key decisions about his care and had a strong and consistently expressed wish for the services to leave him alone. These particular needs and issues generated a difficult picture for professionals to respond to effectively. The practice issues relating to capacity and working alongside service users who do not wish to engage with services are explored in this review.

Mr I's case was felt to meet the criteria for a Safeguarding Adults Review (SAR) to be commissioned by the West of Berkshire Safeguarding Adults Board (SAB) because there were features of self-neglect and the case highlighted difficulties in how effectively the teams and agencies involved were working together at the time of his death.

## 1.2 Research Questions

The use of research questions in a SCIE *Learning Together* (LT) systems review provides a framework which are equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the Safeguarding Adults Board (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. The research questions are posed prior to the start of the process to provide a frame of reference for the review work:

1.2.1 How clear is the interface between Mental Health and Adult Social Care to staff/managers and service users, with particular reference to thresholds and eligibility criteria?

1.2.2 What can we learn about the understanding of responsibilities and accountabilities for cases held jointly between Mental Health and Adult Social Care?

1.2.3 What does this case tell us about what helps or hinders risk management, safeguarding and interagency communication?

1.2.4 How effective is the procedure and practice surrounding case closure in integrated and joint services in Reading?

## 1.3 Succinct summary of case

Mr I had suffered a brain injury and had a lower leg amputation. He was prone to depression and developed an increasingly severe dependence on alcohol. He resented contact from the services and was aggressive to visitors including the regular care staff who had been

commissioned by the Local Authority to provide daily support and monitoring. His case was transferred from the Local Authority Long Term Team (LTT) to the Mental Health Review and Reablement (R&R) Team in June 2013, but despite their best efforts the new keyworkers struggled to develop a working relationship with him. Mr I was assessed as having the mental capacity to make decisions about his health and welfare. The keyworkers took his case to the Risk Enablement Panel (REP) in April 2014 hoping that the case would be transferred, however the REP instead encouraged them to continue with their attempts to engage Mr I. However no meaningful work was possible due to Mr I's use of alcohol and reluctance to engage, and so it proved very difficult to reduce the risks involved.

The daily carers continued to call but often did not manage to see Mr I, so the police would occasionally be asked to undertake welfare checks. In July 2014 it was agreed by the workers and managers of both teams that the case should be transferred back to the LTT and held on duty (as opposed to being allocated), however due to other work pressures the mental health keyworker did not progress the transfer. In April 2015 the keyworker took the case back to the REP who agreed that the decision to transfer the case back to the LTT should be progressed. However the usual procedures for handover recording and case transfer on the health and the Local Authority IT systems were not completed correctly by the R&R team.

At this time a significant re-structure of the Local Authority teams resulted in the LTT duty function being provided by the Single Point of Access (SPOA) team. A period of confusion and increasing frustration between teams followed. The case began to be managed by the SPOA but they had no access to the recent mental health records and the transfer had not been formally confirmed. This led to a lack of clear accountability for the case. During this period the teams were unaware that Mr I's physical health was significantly deteriorating. He died unexpectedly in June 2015 and was found in his home several days later by the police.

## **1.4 Methodology**

The SCIE Learning Together model was used, which provides a systems approach to generate generic learning that will support organisational improvement, and actively involves front line staff and managers in the review process.

### Lead Reviewers

Kathy Kelly and Alison Ridley are both accredited to lead SCIE reviews. Kathy Kelly is the named Safeguarding Professional working for the local Clinical Commissioning Group (CCG). Alison Ridley is a registered social worker works as an Independent Safeguarding Consultant. Neither have had any direct involvement with this case. 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.

### The Case Group

The Case Group was made up of local practitioners who had been directly involved in the case and their immediate line managers. Most of the professionals who had been involved in the case were able to participate in the case review process although there were several people who were unable to due to either having moved to other posts.

### The Review Team

Local key managers and safeguarding officers joined the Review Team and provided local operational and strategic knowledge to the review process.

<b>Name</b>	<b>Agency</b>
Simon McGurk	Reading Borough Council
Jacque Phillips	Thames Valley Police
Elizabeth Porter	Royal Berkshire NHS Foundation Trust
Suzannah Johnston	NHS Berkshire
Olajumoki Omoniyi	Total Health Care Provider

### Involvement of the family

The Review Team made efforts to engage Mr I's family members in the review process, however the family decided they did not want to become involved, so we have not been able to reflect their views as a part of the process.

Good practice in relation to case reviews suggests that they should be conducted in line with certain 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 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, Care Act Statutory Guidance 14:138)

The SAB have used the SCIE *Learning Together* (LT) systems model (Fish, Munro & Bairstow 2010) in order to facilitate reflective learning. Further details of the model and review process are available in Appendix 1.

## 2. The Findings

This section contains three findings that have emerged from the review. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding could create potential risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

First, an overview is provided of what happened in this case. This clarifies the view of the Review Team about how timely and effective the help that was given to Mr. I, including where practice was above or below expected standards.

A transition section reiterates the ways in which features of this particular case are common and/or different to other work that professionals conduct and therefore provides useful organisational learning to underpin improvement.

### 2.1 Appraisal of professional practice in this case: a synopsis

This appraisal sets out the view of the Review Team about how timely and effective the interventions with the service user were in this case, including where practice fell below or above expected standards. The case illustrates the particular challenges for professionals working with service users with mental capacity who are not keen to engage with services and choose to live in situations which can generate a considerable level of personal risk.

#### Brief background

Mr I had experienced sexual, physical and emotional abuse as a child, and was prone to periods of depression and paranoia and episodes of self-harm. He spoke German and had an interest in history, cycling and books. It is thought he may have worked as a nurse. He was married with a young son; however in 2008 he suffered a head injury. His marriage broke down and he sadly lost contact with his wife and son. He also became physically disabled following the amputation of the lower part of one leg and developed an increasing dependency on alcohol. He lived independently but showed signs of self-neglecting behaviour, tending to hoard his possessions.

When he was sober Mr I was agreeable and affable, however when he was drunk (which was the majority of the time) he could become verbally and occasionally physically aggressive. For this reason he was understood to pose a potential threat to lone workers. He would at times refuse to look at or speak to staff and then would shout and swear at them to get out of his house.

#### Initial engagement by the Review and Reablement (R&R) Team (June 2013 – April 2014)

- 2.1.1 The case had been held for some years by the Reading Borough Council (RBC) Long Term Team (LTT), during which time the allocated social worker had developed an effective relationship with Mr I, however despite this Mr I's increased

reliance on alcohol and deteriorating memory proved to be exhausting for the LTT to manage, leading to their request for the case to be transferred. In June 2013 a senior manager agreed that the case will be transferred to the Mental Health Review and Re-ablement (R&R) Team. The rationale for the decision was that a change of team will allow a 'fresh pair of eyes' to consider the case. However from the outset there was some disquiet about the case transfer. It did not meet the usual R&R mental health criteria and there was no agreement discussed between the teams in relation to how long the R&R team would hold the case. This sense of reluctance is echoed again later in the case, and gives an early signal about how challenging it is for professionals to manage cases where service users are actively refusing to engage with services.

- 2.1.2 Bearing in mind the known risks presented by Mr I, the R&R Team Manager (R&R TM) allocated the case to two male staff to work on the case together, the Occupational Therapist (OT) who had recently moved from hospital work to community work, and had a great deal of experience working with people who were reluctant to engage with services and a very experienced Community Support Worker (CSW). The two practitioners had different professional backgrounds and their assessment of risk also differed. From the outset the practitioners could see that it was going to be very difficult to engage Mr I, who was most often found to be drunk and not wanting to talk to staff or to become involved in activities. His poor short term memory meant that he struggled to remember the names of the two workers. The OT regarded the risks Mr I posed to himself and to others as 'moderate', while the CSW felt that a much higher level of concern about the potential risks to others in particular. However despite the known and perceived risks and challenges of the case, both workers were committed and keen to engage Mr I.
- 2.1.3 A Care Agency had previously been commissioned by RBC to provide personal care to Mr I, in particular to assist with cleaning (as Mr I had a tendency to hoard belongings) and shopping. The Care Agency continued to provide daily visits and showed a consistent commitment and willingness to provide support to Mr I, although he had consistently shouted at visitors to leave and could be verbally and racially aggressive towards his carers. The Care Agency maintained good regular contact with all key agencies. The OT worked creatively, arranged for a key safe to be put in place with the formal agreement of Mr I and held planning meetings with the Care Agency to confirm the arrangements. However the Review Team felt there were missed opportunities for a more formal review of the support package to see how appropriate the package was and whether Mr I's expressed wishes for less 'intervention' could in some way have been enabled to shape the nature of the package.
- 2.1.4 After several months the OT and CSW felt increasingly frustrated at what they perceived to be a lack of progress as Mr I continued to refuse to engage with them or to leave his flat. Appropriately seeking the input of their colleagues, they took the case to their team meeting for discussion. Increasingly concerned by his behaviours, the OT and CSW considered possible legal frameworks they might use to intervene and perhaps move Mr I to a residential placement to reduce the risks his behaviour was generating for others and for him. Drawing on the expertise within the team, the

OT asked his social work colleague (SW1), an Adult Mental Health Professional (AMHP) to visit in order to provide a second opinion on Mr I's mental capacity in relation to key decisions. The AMHP felt that Mr I had mental capacity in relation to key decision-making when he was sober, and he did not exhibit any symptoms or behaviours that warranted intervention under the Mental Health Act or the Mental Capacity Act.

#### Increasing concern and the case is taken to the Risk Enablement Panel (April – June 2014)

- 2.1.5 At this point the OT and CSW had held the case for approximately one year and felt that there was very little that they could achieve for Mr I. The OT and CSW were unsure whether there was any value in their continuing involvement. The nature of the case meant that it did not fit easily into the remit of any of the local teams and the lack of supporting protocols or guidance about cases of this nature appears to have added to the sense of uncertainty about how the case should be managed and by which team.
- 2.1.6 On 4<sup>th</sup> April 2014 the OT and CSW took the case to the Risk Enablement Panel (REP) for discussion, providing an earlier updated risk assessment. Their hope was that the case would be transferred to the Senior Practitioner who worked specifically with people who found 'difficult to engage'. However instead the REP advised that they should continue with their existing approach and monitor regularly. The panel recommended a number of actions including referrals to alcohol services, befriending service, memory clinic and a fire safety check, though the Review Team have noted that it would have been unlikely that Mr I would have given his agreement for any referrals to be made on his behalf. The Review Team were surprised that the panel discussion did not appear to have considered the implications of Mr I's assessed capacity to make decisions about his support package (when sober) and whether an advocate might have offered an additional way to ensure that Mr I's voice and wishes were listened to in relation to the services he received. Further exploration of Mr I's mental capacity would have enabled more informed planning and active consideration of to what extent he had meaningful capacity to make informed choices. If Mr I did have capacity it would have been useful if the REP had explored how his wishes and choices could have been appropriately respected, and how the practitioners could find a balance between respect for human rights with their duty of care. However the Review Team acknowledges that a more in depth assessment of capacity was difficult to achieve as Mr I was rarely sober, which was not something that could be predicted. **The complexities in relation to the assessment are explored in Finding 1.**
- 2.1.7 On multiple occasions the police were asked by the LA or care agency to undertake 'welfare visits' to Mr I. These requests were usually made if the Care Agency had been unable to gain access over several days or gain a response from Mr I. On those occasions the Care Agency would become concerned that he may be very unwell and so they contacted the Local Authority (as the commissioners) or the police. The police generally responded positively to these requests and attended to persuade Mr I to open his door so they could make sure he was ok. Twelve such

visits took place between March 2014 and July 2015. On two occasions the police needed to break down the door when Mr I was unwell. The Review Team noted that the practice of requesting 'welfare checks' by the local agencies was largely inappropriate but had become normal practice, and was based on a misunderstanding of when it is reasonable to ask the police to gain entry to the home of a person. Mr I was understood to have mental capacity and had a right to actively refuse to answer his door to care staff who called on him. On 20 April the police note that Mr I told them that he was tired of people coming around and disturbing him. **The dilemmas for practitioners in terms of how they balance the rights of service users with their professional duty of care are explored in Finding 3.** It would have been good practice for the OT to have arranged a meeting with the local agencies (including the police) to discuss the case, Mr I's wishes and rights, the potential risks and to have developed a jointly agreed management plan.

**2.1.8** On 30 July 2014 following discussions with their manager (TM1) and the Long Term Team Manager (LT TM) it was agreed 'in principle' that the case would be transferred back to the LT Team once the case summary and risk assessment were completed by the OT. The rationale for this decision was that the R&R team was a mental health team and Mr I did not have a diagnosed mental health problem, the practitioners had attempted to see if they could offer a 'fresh take' on the case but had been unable to make any headway. The Review Team felt that the decision to transfer the case back to the LTT was reasonable, however there was no protocol to provide guidance about the handover of cases from Mental Health Teams to the Local Authority, and in practice there was variation in how handovers were managed. **This is explored in Finding 2.**

**2.1.9** The LT TM decided that the reluctance and/or inability of Mr I to engage actively with staff suggested that the case was not well suited to being allocated to an individual worker, and that instead once the case was transferred it would be more important for the Care Agency, who were maintaining direct contact with Mr I, to have access to the LT duty team as this would ensure a quick response to any concerns the Care Agency had. The Review Team felt that while the discussion meeting had achieved a clear plan for transfer, the practitioners and managers missed the opportunity to consider creatively whether a different package was needed, whether capacity issues had been fully explored and whether Mr I's wishes could better be responded to. The outcome of the meeting was to continue with the general approach with one key change, the proposed removal of an allocated worker. The Review Team felt that the plan was reasonable, given that the structure of the LT team at that point in time, would have meant that the TM would have had direct involvement and close oversight of any case being held by the LT duty function.

Case continues to be held by the Review and Reablement Team (July 2014 – February 2015)

**2.1.10** Although the plan had been agreed, the follow up actions to progress the transfer did not occur. During the late summer the case continued to generate concerns for the Care Agency who visited on a daily basis but were often refused entry. When the

police visited Mr I in August they described his flat as “untidy, unclean and almost uninhabitable”. However the police did not escalate their concerns.

- 2.1.11 Over the winter months the picture changed somewhat, the Care Agency gained access to Mr I with less difficulty and so the general level of concern about Mr I went down. During this period there was reduced active involvement by the OT and CSW. The OT did not complete the risk assessment and other paperwork to progress the formal handover of the case. He was aware that Mr I's situation was a chronic one, there had been no fresh concerns, and that the support package that was in place was managing the more obvious risks. He therefore did not prioritise the recording as he was responding to other cases that presented more acute issues on his caseload, however the Review Team felt that this was a significant oversight on his part.
- 2.1.12 The R&R Team Manager (TM) had an ‘open door’ policy and was accessible and supportive to her staff when they needed to discuss cases, however the Review Team were surprised that during this period there was not more formal supervision undertaken by the R&R TM that could have prompted the OT to undertake the necessary recording and transfer of the case.

#### A further Risk Enablement Panel and some significant structural changes at RBC (March – April 2015)

- 2.1.13 This period marked a significant change in the management of the case, with the practitioners and managers involved all focussing more proactively on the case. On 21 April the OT and CSW took the case back to the REP, which confirmed the earlier ‘in principle’ agreement that the case should be transferred back to the LT Team. The Review Team were surprised that again the REP did not take advantage of the opportunity to explore the more challenging practice issues; the potential safety issues for staff, the on-going questions of user capacity, legal frameworks and how to respond to Mr I's expressed wishes.
- 2.1.14 At this point the issue of which team had active responsibility for the case became unclear. TM1 exchanged emails with the LTT TM to progress the transfer and took steps to update the name of the allocated worker on the RBC IT system (framework I front page), she changed it to ‘LTT duty’ which she incorrectly thought would make it clear that the case had been transferred to the LTT duty. However she was unaware that an additional step was required in order to formalise the transfer on the IT system. This led to subsequent confusion about the ownership of the case amongst RBC teams. The R&R Team have to use two separate IT systems in order to provide key records for both the MH Trust and for the Local Authority. This adds to work pressures and frustrations for the team.
- 2.1.15 During this period RBC were in the process of implementing a number of significant structural changes to their front line services in preparation for anticipated increases in the volume of requests for services, following the implementation of the Care Act 2014. The newly created Single Point of Access (SPoA) team had been established from existing staff with a broad ‘front door’ remit. The team is made up of Advisory Officers who are office based and gather information over the telephone, and

qualified Social Workers who work primarily on the telephone but also undertake home visits where necessary. Shortly before the new service went live it was decided to further increase the remit of the team to include safeguarding and significantly for this case), a duty function for unallocated work held by other teams including the LT Team. The Review Team were struck by the views expressed by staff within the SPoA about how demanding it had been for them to cope with the extension of their remit at such short notice.

#### Management of the case by the Single Point of Access (SPoA) Team until Mr I's death (May – June 2015)

2.1.16 This period was marked by a level of confusion and tension between the teams, and difficulties for the operational managers involved in finding a resolution to the question of which team had ownership of the case. The Care Agency had been advised by the R&R team that the case had been transferred across to LT duty, and those cases were now being managed by the SPoA team. The Agency began to make regular calls to the SPoA with updates about Mr I. Considerable confusion was generated because both the health and RBC IT systems stated that the case was still open to the R&R Team. The SPoA team members felt very stretched and were under constant pressure, however the SPoA Advisory Officers worked diligently, screened the case, gathered information and escalated potential areas of risk to the SPoA Social Workers to consider. The SPoA team had no recent case information available to them because they did not have direct access to the Health IT system. The minutes of the recent REP meeting might have shed some light on the status of the case, but had yet to be uploaded onto the RBC IT system. The nature of the case proved very difficult to manage on duty with such limited recent information available to make informed risk judgements. The LT Team Manager asked again for a case summary to be provided by the OT. The Review Team felt that the lack of clarity about which team owned the case at this point was not helped by there being no agreed protocol in place between the mental health service and the Local Authority to provide guidance about how case transfers should be managed. **An issue which is explored in Finding 2.**

2.1.17 The SPoA Social Worker was increasingly concerned and liaised with the SPoA manager, the LTT manager, the R&R manager and the Safeguarding Manager to press for a decision to be made about the allocation of the case. The SPoA TM was conscious of her legal duties in relation to eligibility for services, and did not think the case could be closed to the Local Authority. She knew of Mr I's case historically and that there had been a pattern of non-engagement with services. It was understood that he was still shopping for food when he wished to, and the Care Agency advised that he had mental capacity and could manage his medication. There had been no clear evidence of self-neglect or safeguarding issues, so the SPoA TM made a judgement not to send out SPoA Social Workers at this point, while there was still a lack of clarity about which team owned the case. The Review Team felt her judgement was a reasonable one under the circumstances.

- 2.1.18 The SPoA Advisory Officers liaised with the GP surgery providing regular updates, largely for information. The Care Agency showed on-going resilience and commitment during this period and continued to ensure that all parties were kept updated about Mr I, who was seen on 1<sup>st</sup> June when he refused to let carers in but told them that he was OK. Mr I was seen again on 3 June, and the GP advised the SPoA that his current behaviour was normal for Mr I.
- 2.1.19 On Friday 5<sup>th</sup> June Mr I found blood in his urine and went to A&E, where he was observed as appearing unkempt by A & E staff. He was diagnosed with a Urinary Tract Infection and haemorrhoids, was treated, discharged home and advised to seek follow up with his GP. The GP was made aware by A&E and by the SPoA team. On Monday 8<sup>th</sup> June the SPoA workers liaised with A&E for information, which showed good communication and information gathering. The SPoA again contacted the R&R team to seek clarification about who was holding the case. The R&R team confirmed that the case was still open to the R&R team on the health IT system (RIO) but that in reality the case was actually closed to the R&R team. The carers saw Mr I that day and he again told them that he did not want support. He was not seen by the carers on any subsequent days that week.
- 2.1.20 The Review Team noted that the SPoA Manager and the LT Manager had sought to resolve the situation at their own level without escalating it, which was appropriate and an expected approach to be taken by experienced operational managers. At this stage Mr I's behaviour was consistent with his known behaviours. However as the situation continued, it generated considerable work and anxiety for the SPoA team. It would be expected that the managers would begin to consider escalating the case through usual line management channels to find a resolution. On Thursday 11 June the SPoA Manager contacted the RBC Safeguarding Manager, and she subsequently emailed to ask the LT TM to allocate the case. The Review Team were struck by her positive and proactive involvement, in trying to move the situation forward, however unfortunately she mistakenly omitted to copy the email to the LT TM.
- 2.1.21 On Saturday 13 June the Care Agency reported that they had not gained entry but had heard music being played at the address, however by Monday 15<sup>th</sup> June Mr I still had not been seen. The SPoA Social Worker took a positive and proactive measure by emailing the LT TM to ask for an update. In response to this LT TM again asked the R&R TM for a risk assessment and contingency plans. The SPoA Social Worker anticipated that if the LTT did not allocate the case urgently it would be necessary for a SPoA Social Worker to go out. She requested a welfare visit by the Police, but this was refused on the grounds that they had been undertaking regular welfare checks and there was nothing to suggest a change to the existing risks.
- 2.1.22 The police had decided to begin working to an existing (but not previously implemented) jointly agreed policy which required that a relevant person (e.g. social worker) should visit the person before a request is made for a police welfare visit. The SPoA were unaware of the police decision to implement the policy and were surprised and frustrated that the police would not go out. The Review Team noted that while the joint policy itself was good practice, encouraging joint working and

information sharing, it was unhelpful that the police had decided to implement it in this case without any prior warning to partner agencies.

2.1.23 The same day the LTT TM agreed to take over active management of the case. He acted appropriately. His decision was necessary at that point because it had become clear that some level of active involvement was required in order to provide a up to date risk assessment, to establish contact with Mr I to advise him that the case had been transferred, and to relieve pressure on the SPoA Team who were struggling to manage the case on duty. The Review Team noted that given the known, historical and very recent ‘non engagement’ behaviours of Mr I, there was no reason to suggest that Mr I had come to serious harm, though it was clear that a visit was now needed. On 16 June LT TM allocated the case and two LTT staff visited the house but could not gain access and noted a number of flies at the premises. They contacted the police who subsequently gained entry to the flat and found Mr I dead. The cause of death was subsequently confirmed as ‘sudden unexpected death in alcohol and peripheral vascular disease’ by the Coroner, who confirmed that Mr I had been dead for some days.

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

This case highlights some of the particular challenges that develop for professionals when the needs presented by an individual service user do not neatly meet the criteria of existing teams, which can lead to confusion and/or tensions between teams about ownership. The case also outlines the challenges for professionals in seeking to find an appropriate response when service users are actively resistant to intervention. Professionals are faced with a difficult balance of priorities, while they must seek to respect the wishes of the service user who appears to have capacity, they are also concerned by the high risks of harm that are involved in the choices the service users makes. In this case the assessment of mental capacity was not straight forward and highlights some of the challenges in this complex area of work.

## 2.3 Summary of findings

The review team have prioritised three findings for the SAB to consider. Findings are also linked to a typology category to assist in the wider analysis of findings as they build up across the country. The findings are:

Findings	Typology
Finding 1 - Supervision processes are not supporting practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours, with the result that assessments of capacity are made but practitioners act as though capacity is lacking.	Management systems
Finding 2 - The tendency to assume that everyone knows about and	Management

understands policy, procedure and guidance, but not quality assuring how well they actually do, is resulting instead in a culture of informal agreements, misunderstandings and tensions	systems
Finding 3 - There is a confusion about the meaning of the 'duty of care' that is generating risk averse practice and preventing the voice of the service user being heard	Innate Human Bias

**The findings relate to what was found to be occurring during the period under review and does not include any significant improvements since that time. Following the case and during the review supervision work in particular has been given priority and there is a system in place that is being monitored.**

## **2.4 Findings in detail**

**Finding 1 - Supervision processes are not supporting practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours, with the result that assessments of capacity are made but practitioners act as though capacity is lacking**

### **What is the issue?**

The Mental Capacity Act 2005 provides a clear framework to support the assessment of capacity in relation to specific decisions. The assessment is a challenging piece of work, even more so in cases where the person's capacity presents a complex picture, where the risks are high and where significant decisions are being considered. Most individuals who have impaired decision making (e.g. an individual with a severe learning disability) do not have fluctuating capacity. They might retain capacity to make smaller day to day decisions but lack the capacity to make the larger more significant and complex decisions.

However, responding to the needs and rights of an individual who has fluctuating capacity is in many ways more complicated. The Mental Capacity Act Code of Practice gives clear advice<sup>1</sup> that individuals should be assessed in relation to the specific decisions they need to make at the time the decision is required. Where someone has fluctuating capacity it is important to delay the assessment (if safe) until they are more able to make an informed decision.

The theme of 'executive capacity' is particularly relevant when assessing an individual who has addictive or compulsive behaviours. Executive capacity has to date been more purposefully explored in America than in the United Kingdom (UK). However valuable UK research undertaken by Preston Shoot and Braye et al<sup>2</sup> highlighted the importance of considering the ability of an individual to put a decision into effect ( executive capacity) in addition to their ability to make a decision (decisional capacity)<sup>3</sup>. Both these abilities need to be considered as a part of the process of assessing mental capacity, for example if you are assessing the ability of

<sup>1</sup> Mental Capacity Act 2005, Code of Practice chapters 3 and 4

<sup>2</sup> SCIE report 46: " Self-Neglect and Adult Safeguarding: Findings from Research"

<sup>3</sup> See concept of executive and decisional capacity explored by Naik (2008)

someone with an obsessive need to clean, you would want to understand not only their ability to think through the risks and benefits of a choice to moderate their behaviours, but also their ability to actually make a change in practice as opposed to just being able to articulate an intellectual decision making process.

In addition to considerations about executive capacity, where capacity is fluctuating with the individual regaining capacity only when they are sober, practitioners and managers also need to consider how and when to assess capacity. An individual with fluctuating capacity may be deemed to have capacity in relation to significant decisions that they have been able to sober up sufficiently to make (such as where to live) but lack capacity to make practical daily decisions because they are rarely sober enough to make those daily decisions. It is essential that separate assessments are fully explored to ensure the Act is being followed and to support individual's rights to self-determination on specific decisions. In some cases it may be possible to have the capacity to make significant decisions, but lack the capacity to make decisions about their daily safety needs, which then need to be made for them in their best interests. Staff working with service users on a daily basis need to be given clear advice and care plans to identify when they may need to override the individual's wishes (in their best interests when capacity is lacking) and when they need to respect and support the specific decisions that they have the capacity to make.

### **How did the issue manifest in this case?**

Mr I's mental capacity presented a complicated picture. He had suffered a brain injury, experienced low mood at times and misused alcohol. However, despite that complex combination of conditions and the subsequent effects they had on his mental capacity, he was described by all the professionals who knew him as having mental capacity<sup>4</sup> when he was sober. His capacity was never formally assessed because he was so rarely sober that practitioners could not undertake the assessment. This meant that Mr I did not experience sustained periods of time when he was able to make or act on informed decisions. Practitioners were following the first principle of the Act that says "a person must be assumed to have capacity unless it is established that they lack it"<sup>5</sup>, however given the fact that he was so rarely sober during the day, practitioners and managers should perhaps have considered undertaking an assessment in relation to his ability to make day to day care decisions even though he was drunk. The Code of Practice does not specifically address this conundrum, but the lack of clarity about Mr I's capacity in this case did not support or formalise considerations about when it was appropriate to respect his wishes and rights and when it was legitimate to go against his wishes (e.g. his repeated request for carers to stop visiting him).

Some of the key areas of decision making for Mr I were in relation to his decision about whether to engage with addiction treatment or therapy, and whether he wished to have daily practical support in his home. Mr I consistently chose not to engage with addiction treatment or therapy even though he was at high risk of life threatening, alcohol related illnesses. He consistently voiced his wish not to have carers coming into his flat each day even though his lack of understanding or concern about how to refrigerate and cook his food safely meant that he was at a risk of food poisoning. Mr I was regarded by professionals as having capacity to make those key decisions but he was felt to be making unwise decisions in refusing support. If the principles of the Act were followed, his unwise decisions should be respected. However, in

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<sup>4</sup> In line with MCA principle 1 that a person must be assumed to have capacity unless it is established that they lack it.

<sup>5</sup> Mental Capacity Act 2005, section 1(2)

practice what happened was that his consistently expressed wish not to engage with therapy and not to have a daily package of support were ignored.

The health and social care teams that worked with him over many years continued to actively seek to undertake therapeutic work with him and to persevere in commissioning the daily care package. Mr I was consistently resistant to working with the support workers and repeatedly told them not to call. Similarly he generally told the mental health key workers and even the police officers who visited him that he did not want to see them or work with them. The professionals and their immediate managers struggled to know how to respond to the complex picture of capacity, need and risk that Mr I presented. While they felt that they did not have sufficient grounds to intervene in a significant way (for example by using the MCA to move him into a residential setting), they did feel it was appropriate to continue to maintain a longstanding support package and active keyworker involvement.

In addition to the seemingly contradictory decisions being taken by the front line staff and their immediate line managers, Mr I's case was taken by his keyworker to the Risk Enablement Panel (REP) on two occasions for discussion because of the continued high level of risk involved in Mr I's choices. The panel also accepted that Mr I had mental capacity, however they recommended that the support package should continue, despite his stated wish for it to stop.

#### **What makes it a broader underlying issue as opposed to only specific to this case?**

This case illustrates a broader pattern of unclear thinking by professionals in relation to risk and mental capacity, which is also found in other local cases. Within the Review Team a number of other cases were mentioned where professionals wanted to make decisions on behalf of people they had already assessed as having capacity. One case involved a woman who mis-used alcohol who was admitted to an acute ward for treatment for the effects of alcohol abuse. She wanted to leave to go and get a drink, but the doctor refused to allow her to leave the ward even though he was aware that she had been assessed as having the capacity to decide whether to drink or not. The doctor believed that the woman was making an unwise decision in wanting to continue drinking, but he had no legal power to intervene.

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

Local specialist teams of practitioners working solely with people who have addictive behaviours are used to assessing the complexity of their client's mental capacity, but professionals and managers working with adults from other care groups, who are less familiar with the particular capacity issues that addictive behaviours can generate, may struggle to know how to respond and assess this complex capacity picture. National statistics for 2014-15<sup>6</sup> show that during that period 295,224 adults had been in contact with drug and alcohol misuse services in the United Kingdom, but there will be many other individuals who misuse substances with fluctuating capacity that choose not to engage with services.

In 2014 the national review of how effectively the Mental Capacity Act (2005) had been implemented<sup>7</sup> found a "recognition from many witnesses that the instincts of social workers tended to emphasise the need to protect vulnerable adults rather than to enable their decision-making" (para 78).

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<sup>6</sup> Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) (DoH) 1 April 2014 to 31 March 2015

<sup>7</sup> House of Lords Select Committee on the Mental Capacity Act 2005 (2013–14): post-legislative scrutiny

O'Brien et al<sup>8</sup> have explored the dilemmas faced by practitioners in cases of self-neglect but these could equally apply to other situations where compulsive or addictive behaviours are the key presenting issues, where in line with the Mental Capacity Act, the need for an individual's autonomy and personal rights are prioritised over a more interventionist approach. However a potential disadvantages of this approach can tend to prevent proactive professional intervention being taken at an early stage in the case, even though research suggests that early intervention can potentially result in a better outcomes (2000, p 16).

Dong and Gorbien (2006) advise professionals dealing with such questions to consider decision-making capacity as a spectrum rather than a simple dichotomy. They also make the point that respect for the individual's independence does not, and should not; mean disengaging from continued involvement with them. This approach seems to be the one that has been taken informally by professionals in the case of Mr I and is explored in more depth by Preston Shoot et al in their more recent paper (2011) on self-neglect.<sup>9</sup>

### **What are the implications for the reliability of the system?**

The Mental Capacity Act 2005 enshrines the rights of individuals to be actively supported to make their own decisions, and where they lack the capacity to do that the Act ensures that their best interests (including their wishes) govern the outcome. Getting the outcomes legally and ethically right requires a more careful assessment of capacity, not only for the significant decisions but also for the day to day decisions. It is a significant concern if practitioners and front line managers are not putting the principles of the Act into practice because they have not sufficiently teased out the complex picture of capacity, as there is a high likelihood that the rights of service users are not being respected.

These are complex legal and ethical issues, and it is essential that practitioners and commissioned care staff are well supported by their managers and have clear guidance and care plans that differentiate actions required, identifying which decisions the service user has and does not have capacity to make. The assessment and management of cases of fluctuating capacity need particular attention where there are high risks to the service user. At times the autonomy and rights of the person can seem to be in conflict with the need for services to intervene to reduce risk. Good quality staff supervision is key and members of risk advisory panels need to be conversant with these issues and willing to enter into the complex discussions required to support the proper implementation of the Mental Capacity Act.

**Finding 1 - Supervision processes are not supporting practitioners to work with the complexity of capacity decisions in relation to adults with addictive behaviours, with the result that assessments of capacity are made but practitioners act as though capacity is lacking**

There was a unanimous view amongst professionals that Mr I's capacity was retained in relation to key decisions about his health and welfare, however the reality of his daily situation suggest that he was rarely sober enough to make informed day to day choices. There was a tendency by the Local Authority and Mental Health Trust team to work with Mr I as if he lacked capacity and required 'best interest' decisions to be made on his behalf. This was probably because in relation to many day to day decisions, because he

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<sup>8</sup> O' Brien et al

<sup>9</sup> SCIE report 46

was not sober, Mr I did lack capacity. However, capacity assessments were not undertaken to confirm that and consequently there were no clear best interest care plans in place to support Mr I or the care staff working with him.

Issues for the Board to consider:

- What is the prevalence of cases where the assessment of capacity has proved challenging for front line teams?
- How confident are practitioners about managing cases where there is fluctuating capacity?
- Are practitioners and managers struggling to fully explore the ethical and risk related issues in these cases? What are their key concerns?
- How could the Board work to demonstrate good outcomes for service users in this key area of risk and rights.

## **2.4.2 Finding 2**

**The tendency to assume that everyone knows about and understands policy, procedure and guidance, but not quality assuring how well they actually do, is resulting instead in a culture of informal agreements, misunderstandings and tensions**

### **What is the issue?**

Policies and procedure provide a structure and roadmap for practitioners to follow, in order that they understand what to do, when and how to evidence their thought processes and decision-making. None of this will work properly if busy practitioners are not supported to use policy and procedure appropriately and to understand why it is so important to do so.

### **How did the issue manifest itself in the case?**

Throughout the period under review, informal agreements developed and were used between teams and practice was sometimes at odds with the policies, procedures and guidance that were in place. This can be seen at each stage of the case:

- **The way the case was initially transferred**

Mr I's case was initially managed by the Local Authority (LA) Long Term Team (LTT) but they were having difficulty in engaging Mr I. During a professionals' meeting it was decided and agreed by a jointly appointed senior manager that the integrated Adult Mental Health R&R team would take on the case try to offer an alternative approach to engage Mr I in services. Mr I's case did not meet the usual threshold for secondary mental health and so this left the team with questions about why the case had been transferred. The allocation of the case and the team's agreement to accept it were at odds with the usual mental health eligibility criteria, and the rationale for this decision was not well documented.

- **Supervision of staff**

A clinical and managerial supervision policy was in place in the Trust and all staff were expected to have formally recorded regular supervision to allow opportunity for managerial oversight and

reflective practice. Practice in the R&R team showed that there was a culture of informal supervision. An “open door” from the manager meant that she was accessible but supervision was not regular or formalised and there was little recording of the supervision. The manager was expected to follow the policy and provide recorded formal supervision; the policy was not followed, resulting in a reduction in the usual quality assurance function provided by supervision.

- **The SPOA process**

Practitioners in the Single Point of Access (SPOA) team whilst communicating with the police requested a welfare check on Mr I. The SPOA team had regularly requested welfare checks and usually the police agreed, however on this occasion the police response was unusual in that the SPOA team were advised that a social worker was required to visit first. The police made reference to the joint policy partnership agreement governing ‘welfare checks’ to people with mental health problems<sup>10</sup>. The SPOA team social worker was not aware of the joint policy because it pertained principally to MH service users and so was not commonly used by the separate LA teams and thus this was confusing and appeared to the SPOA social worker and colleagues to be a change in practice. In fact the policy had been in place prior to 2014 but was not used consistently by the police.

- **The handover back to the Long Term Team**

Mr I’s final case handover demonstrated a further lack of recording or use of the formal processes between the Mental Health Review and Reablement (R&R) team and the Adult Social Care Long Term Team (LTT). Key meetings were not always minuted, there were unrecorded agreements made over the telephone, and unrecorded agreements during informal conversations. Handover arrangements made between teams informally led to confusion and different understandings about what was required to conclude the transfer process. The LTT team manager thought an agreement had been reached for the MH R&R team to send a risk assessment and summary, however this information was never sent. The MH R&R team also failed to follow the trust formal discharge policy in terms of IT recording and did not provide a discharge summary or supporting information to the LTT or SPOA teams. The absence of this discharge summary impacted on the SPOA team who did not have sufficient information about Mr I or clarity about who was managing the case.

### **What makes it an underlying issue and not a quirk of the case?**

There are other examples of this issue occurring. One such example was shared by the Review Team, which involved a case within Berkshire (*not Reading*) where the service user moved to a nursing home out of the area and was no longer receiving any active input from the team; however the case was kept open for a significant period of time, contrary to policy. The team were trying to be helpful, however their approach resulted in confusion for other professionals involved and the family who struggled to understand who was managing the case.

Members of the Review Team have asked other Local Authority partners across Berkshire if their staff are aware of the *Berkshire Management of Mental Health Crisis Interagency Partnership Agreement Between Thames Valley Police and Health and Social Care Agencies* and found that the response from health and social care staff was mixed. It appeared that the

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<sup>10</sup> *The Management of Mental Health Crisis Interagency Partnership Agreement Between Thames Valley Police and Health and Social Care Agencies and Single Agency Policy and Guidance to Manage Complex Cases (2014)*

policy was more widely known by the mental health and joint integrated teams and much less known by some of the other LA teams. This illustrates the difficulty that staff and managers can experience in ensuring that important policies are widely understood and followed.

### **What is known about how widespread or prevalent is it?**

Our review team confirmed that from their experience in various teams and sectors, practitioners and managers sometimes have to use their initiative and deviate from a policy when this is appropriate. Most policies are understandably written with ideal practice in mind and envisage also optimum conditions such as staffing levels, however in practice ideal conditions rarely prevail. While policy and procedure provides the framework that should support good practice, there are times when professionals need to make autonomous decisions to practice safely and well.

Within integrated teams there are additional pressures, relating to the potential conflict between policies or procedures (particularly IT systems) that may be implemented in one agency but not the other. A recent national survey by the Merseyside NHS Trust<sup>11</sup> explored how differing performance indicators for health and social care staff within an integrated team can affect frontline practitioners, commenting “the effect is of increasing tensions and pressures on all staff, health and social care and if not managed, those tensions can become destructive to relations between individuals, teams and services thus undermining integration”.

Other Serious Case Reviews (SARs)<sup>12</sup> have identified systemic issues related to situations when failures in policy compliance have resulted in poor outcomes for people. National research on supervision suggest that a combination of informal “open door” approach is positive when combined with a formal recording process. This is supported by SCIE research in 2013 which supports the need for “clear articulation of the purpose and practice of supervision, which is embedded within communication and performance management systems”<sup>13</sup>

### **What are the implications for the reliability of the system?**

Informal agreements are variable, open to interpretation and human bias they are only as reliable as the person making them and the relationship at that time. A policy or guidance is a standard that provides a bench mark. Without effective compliance of guidance and policy we risk human bias, miscommunication which can lead to tension and poor relationships.

High quality procedures support good practice, providing realistic and practical guidelines that promote best practice, and clarity about how professionals work together and across agencies. However procedures and policies are not always well understood or communicated to staff. Where there is a culture of staff not following procedure, there is a risk of confusion and tensions emerging between teams and agencies. It is also vital that senior managers undertake quality assurance checks to see how well policies are being understood and implemented and what the practice implications are when they are not being followed. If a local policy is actively

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<sup>11</sup> Mental Health Integration Past, Present and Future, A Report of National Survey into Mental Health Integration in England” (2016)

<sup>12</sup> <http://www.hampshiresab.org.uk/learning-from-experience-database/serious-case-reviews/>[accessed 10.06.16].

<sup>13</sup> SCIE 2013, *Practice enquiry into supervision in a variety of adult care settings where there are health and social care practitioners working together*

monitored the organisation has an opportunity to make changes and staff can contribute to design of these changes to improve their working practice and service user outcomes.

**Finding 2 - The tendency to assume that everyone knows about and understands policy, procedure and guidance but not to quality assure how well they actually do, is resulting instead in a culture of informal agreements, misunderstandings and tensions**

Despite local agencies having clear policies and procedures in place , there is a pattern of these not always being followed , which suggest a need for quality assurance around the policies to ensure the polices are appropriate and workable for staff and to promote a safer system of care and accountability.

Issues for the Board to consider:

- Is the tension and/ or policy compliance a known problem for the Board? If so does it matter?
- How is the Board assured of key policy compliance (e.g. supervision) in safeguarding across their key stake holders?
- Has the Board any role in considering a mutual set of standards for best practice for joint or partnership working?
- Is the Board interested in gathering front line feedback on how well the policies and procedures relating to joint working across agencies and within integrated teams are working?

**Finding 3 - There is a confusion about the meaning of the ‘duty of care’ that is generating risk averse practice and preventing the voice of the service user being heard.**

**What is the issue?**

The concept of the ‘duty of care’ is found in case law, generated by negligence cases that have been taken to court. A claimant in a negligence case seeks to demonstrate that a professional or organisation has failed in its duty of care to them owing to a careless action, decision or omission of care<sup>14</sup>. The concept of the ‘duty of care’ has been generated through common law rather than statute (primary legislation), and so our understanding of the duty is largely dependent upon ever evolving case law.

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<sup>14</sup> The ‘duty of care’ generally relates to operational practice decisions rather than harm that is linked to a lack of resources or policy.

The 'duty of care' is most often judged in court by how well practitioners and organisations undertake the key processes of risk assessment and risk management. Generally speaking a finding of negligence requires evidence that risks were not properly assessed and/or proportionately managed. However a limited understanding of the duty by practitioners appears to have resulted in a skewed, rather paternalistic interpretation of the duty, linking it particularly to the need to reduce risk and ensure the safety of service users, with little reference to protecting their rights and choices.

It is important that the duty is interpreted in a more empowering way, with clearer reference to the legal framework of the Mental Capacity Act 2005 and our responsibility to hear the wishes of the service user. When staff do not have a broad understanding of the meaning of the 'duty of care' there is a danger that it is a piece of common law which can generate and /or be used to defend risk averse practice which impacts negatively on the rights and empowerment of service users.

### **How did the issue manifest in this case?**

In this case a number of practitioners tended to respond to risks that Mr I presented to himself in a way that could be regarded as risk averse. One example of this was exploration undertaken by his mental health keyworkers into the possibility of using the Mental Health Act or Mental Capacity Act to move Mr I into a residential care home. While this option might have provided a level of enhanced monitoring and support (if Mr I wanted it) it would certainly not have been in line with his expressed wish to remain independent in his own home.

The mental health professionals working with Mr I were conscious that there were high risks for him in relation to his physical health, due principally to his drinking behaviour and the short term memory loss that accompanied that. They were understandably working to try to reduce those risks by maintaining the on-going provision of daily visits by support workers to assist Mr I with personal care related tasks, however again their focus on maintaining his safety prioritised risk reduction over his expressed wishes.

The line managers of the keyworkers and the Local Authority managers sitting on the Risk Enablement Panel (REP) showed a similar approach, seeking to reduce risk but not seeming to balance that with consideration of Mr I's wishes. The REP recommended that the mental health keyworker make several referrals to other services (e.g. befriending service, alcohol service and the fire service), while these recommendations seek to reduce risks for Mr I, it is unlikely Mr I, if he had been consulted, would have been in favour of the proposed referrals.

### **What makes it a broader underlying issue as opposed to only specific to this case?**

Professionals work within the legal framework of the Mental Capacity Act 2005, which as a starting point assumes that individuals have the mental capacity to make decisions unless this is proved otherwise. The outcomes of risk assessments and risk management plans vary widely depending upon the individual practitioner undertaking the work, influenced by factors such as their own knowledge and values, their own willingness to take risks and the culture of their team and organisation in relation to risk. If practitioners work in organisations where they are fearful that they may be unreasonably blamed if a service user on their caseload came to harm, this is likely to affect how they practice. In our society the tendency for health and social care staff to be blamed and to even be made an example of by the press, has an impact on practice.

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 and prioritising their wishes and needs. Guidance on risk assessment from the DoH refers to risks being a 'natural and healthy part of independent living'<sup>15</sup>. Similarly the courts support the need for a balanced approach to risk, the Court of Appeal (Slater 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 court pointed to the need to balance happiness with manageable risk; there was no point in wrapping people in cotton wool if it made them miserable.

A further judgement from case law (Local Authority X v MM) underlines the same point, with the judge commenting that "all life involves risk....we must avoid the temptation always to put physical health and safety of the ...vulnerable adult before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be brought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk taking, not striving to avoid all risk whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks .....what good is it making someone safer if it merely makes them miserable".

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

The Mental Capacity Act 2005 is essentially a radical and very empowering piece of legislation, which promotes the rights of individuals to make their own choices wherever possible, and provides a clear framework to support decision making for professionals to follow in situations where there is a lack of mental capacity. When the Act is employed according to the letter and spirit of the law it will ensure that practice is not risk averse.

However in 2014 a national review of how the Act had been implemented (by the House of Lords Select Committee<sup>16</sup>) raised concerns that the principles of the Mental Capacity Act had not been well understood or put into practice by health and social care professionals, highlighting a tendency to take a paternalistic and defensive approach in decision making. The review found that the Act "has suffered from a lack of awareness and a lack of understanding. For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed."

### **What are the implications for the reliability of the system?**

One of the most concerning consequences of risk averse or defensive practice is that the service user is not empowered to have greater control over their lives, instead the protection of the practitioner or organisation is in effect prioritised. In recent years there has been a concerted move by the sector towards more person centred practice, which empowers the service user and places their voice and wishes at the centre of support planning. The philosophy and duties of the Mental Capacity Act 2005 and the Care Act 2014 have placed an

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<sup>15</sup> LAC (2002) 13, para 41, DOH

<sup>16</sup> The House of Lords Select Committee on the Mental Capacity Act 2005 (2013–14): post-legislative scrutiny

increased emphasis on the need for the service user's voice to be heard. While huge efforts have been made across the sector to move practice and systems closer towards the goal of meaningful empowerment, the barriers to this are sometimes subtle ones yet can have a huge impact on decision making.

Sound professional decision-making requires individual workers to make choices and to understand not only the rationale for their decisions but also the more subtle influences that are at work. This kind of reflective practice is not always easy to achieve in the midst of the busy workplace. It is essential that opportunities are found and supported to enable practitioners and managers to actively reflect on their practice and decisions, and identify the powerful influences that can push them unconsciously towards risk averse practice. It is vital that practitioners understanding of their 'duty of care' is a broad and empowering one, which supports sound and empowering risk management work.

**Finding 3 - There is a confusion about the meaning of the 'duty of care' that is generating risk averse practice and preventing the voice of the service user being heard.**

There is a need for managers and practitioners to reflect on the influences at work which can impact upon their risk assessment and risk management work, in order to ensure that a misunderstanding of their 'duty of care' does not lead them to prioritise the safety of the service user to the detriment of their wishes, happiness and holistic wellbeing.

Issues for the Board to consider:

- To what extent do local agencies have an awareness of the approaches being taken to risk assessment and risk management within their organisations?
- How far would members of the Board want to prioritise gaining a better understanding of how those prevailing cultures are influencing practice at the front line?
- What steps could the SAB consider to ensure that the voice of service users is being appropriately prioritised within risk assessment processes?

## **2.5 Additional Learning**

In other Local Authorities (e.g. Hampshire County Council) best practice guidance was developed to support staff in the allocation and initial management of complex cases where a service user might have a combination of needs that did not easily fall into one obvious care group. Allocation of these cases can cause tensions between teams, but a clear policy to assist in these situations generally works well to resolve decision making quickly and in the best interests of the service user.

### **3. Appendices**

#### **3.1 Methodology and Process of the Review**

The case review used the systems methodology called Learning Together (Fish, Munro & Bairstow, 2009). The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the ‘deeper’, underlying issues that are influencing practice more generally. It is these generic patterns that count as ‘findings’ or ‘lessons’ from a case and changing them will contribute to improving practice more widely.

The methodological heart of the Learning Together model has three main components:

- Reconstructing what happened – unearthing the ‘view from the tunnel’ and understanding the ‘local rationality’.
- Appraising practice and explaining why it happened through the analysis of Key Practice Episodes (KPE’s).
- Assessing relevance and understanding what the implications are for wider practice – using the particular case as a ‘window on the system’.

Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation.

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings between the Lead Reviewers, Review Team and Case Group members. Initially there was a meeting between the Lead Reviewers and the local practitioners and managers to explain the SCIE Learning Together model and the role of the Review Team and Case Group in the process. The SCIE model was explained to the groups and their role in the review process was clarified. Case Group members were informed they would be involved in individual conversations with Review Team members and Lead Reviewer and given the opportunity to reflect on and explain their involvement with the case. They were also informed that they could be accompanied by a supporter at the conversation if they wished. There were ten individual conversations which took place over a period of three days. During the course of the review the Review Team met four times to progress analysis of the data and to discuss emerging learning. The Case Group were also invited to several meetings to hear the emerging learning and give feedback. The Review Team were also present in these meetings. The review followed the process and meeting structures as outlined by SCIE with one additional final meeting of the Case Group to reflect on the experience of using the SCIE model.

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