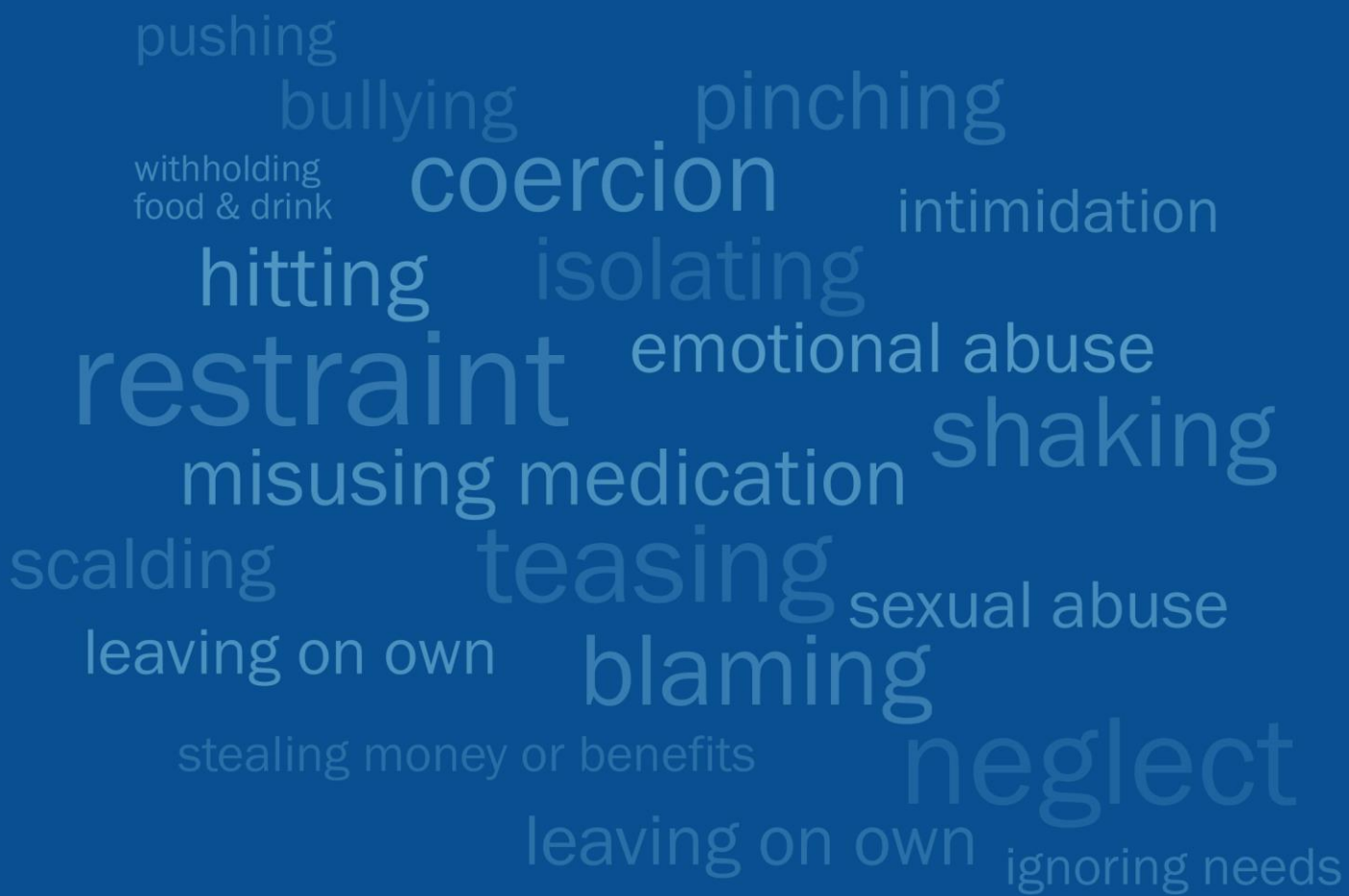
Solihull Safeguarding Adults Board
Protecting Adults Together

Safeguarding Adults Review Learning from the circumstances surrounding the death of 'Stephen'

Executive Summary



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1. Introduction

Stephen was 59 years old when he died in August 2018. The cause of Stephen's death was 'upper airway obstruction', he had choked on a sandwich whilst alone in a room in his flat. At the time of his death Stephen was supported to live in his own tenancy by staff from a domiciliary care agency, two staff members were meant to be with him at all times of the day and night.

Stephen, a white UK citizen, was disabled after sustaining head injuries, he also experienced epilepsy and diabetes, and had been diagnosed with Korsakoff's syndrome. In November 2016, whilst Stephen was a long-term patient at a Neurological Centre, he was diagnosed with cancer, he could not tolerate the chemotherapy necessary to treat the disease and as a consequence his lifespan was expected to be limited. Stephen did not have the mental capacity to make decisions about his own care and treatment, and so decisions were made in his 'best interests'. Stephen was discharged from the neurological centre with the expectation that he would live in his own tenancy near his family until his death.

2. Terms of Reference

2.1 The specific areas of focus within the Review Report are:

2.1.1 How were Stephen's medical and social care needs assessed prior to and during the time he lived at his home? Once needs were identified how were risk assessments and risk management plans developed?

2.1.2 How did multi agency partners work together to meet Stephen's needs? If there were concerns about how agencies worked together how were these escalated?

2.1.3 How did multiagency partners use the provisions of the Mental Health Act 1983 and the Mental Capacity Act 2005 to promote Stephen's wellbeing and safety?

2.1.4 How were services to support Stephen at home commissioned? How were these services supported? How were these services monitored?

2.2 Timeframe for the SAR: August 2016 to August 2018

The rationale for this timeframe is that planning for Stephen's discharge from the Neurological Rehabilitation Centre (NRC) began in earnest in August 2016. The time frame ends shortly after Stephen's death.

3. Methodology

3.1 The methodology used in this review sought to promote a thorough exploration of the events prior to Stephen's death, whilst avoiding the bias of hindsight which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

3.2 Activities undertaken during the Review process have included: collation of chronologies, individual agency reports, examination of documentation as appropriate, identification of key episodes, exploration of these episodes and the lead Reviewers' initial findings through a learning workshop event with the agencies and personnel involved with the case. The SAR lead reviewer also had access to the bundle of evidence submitted to the Coroner conducting the Inquest into Stephen's death.

3.3 The following agencies have contributed to the Review:

Birmingham and Solihull Clinical Commissioning Group
AB Surgery
Birmingham & Solihull Mental Health Foundation Trust
The Care Quality Commission
Neurological Rehabilitation Centre (NRC)
Two Macmillan nursing teams
Solihull Action through Advocacy
Solihull Community Housing
Solihull Metropolitan Borough Council
University Hospitals Birmingham
Solihull NHS Community Services
West Midlands Ambulance Service NHS Foundation Trust
West Midlands Police
Z Care Services were invited to participate in the review but did not respond to the initial approaches to be involved in the SAR.

4. Involvement of Stephen's Family

Stephen's family reviewed the SAR draft terms of reference prior to their formal adoption. The family met with the lead reviewer and provided information to inform the SAR. A second family meeting was held prior to submitting the final SAR report to the Solihull SAB, the family were invited to comment on the draft SAR findings and to make a statement if wished to accompany the Report.

5. Brief Summary of Key Events

5.1 Stephen had been a patient at the NRC since 2011, in 2012 discussions began about his discharge from the hospital, by 2015 the NRC multi-disciplinary team assessed that Stephen needed a placement in the community, but that his one bedroomed flat was not suitable to meet his needs. It was noted that 'Stephen has high risks and complex needs. Specialist care in the community required'. It was difficult to find provision for someone with Stephen's needs in the community. The multi-disciplinary team caring for Stephen at this time was highly skilled and included a Consultant Neuropsychiatrist, Consultant Psychologist and assistant, Specialist Behavioural Nurse, RMN/RNLD nursing staff, speech and language therapy, an Occupational Therapist and a Physiotherapist. During 2016 Stephen was allocated to a new Social Worker, and discharge planning meetings were held more regularly. He was assessed as being eligible for funding under s 117 of the Mental Health Act 1983. However, funding for his placement post discharge was unclear throughout the time considered by the SAR with a 'joint funding' arrangement in place topped up by Stephen's family. The joint funding arrangement did not lead to joint coordination and monitoring of Stephen's care. The provisions of the Mental Capacity Act (MCA) 2005 were used well during this process and included best interest meetings.

5.2 Stephen was diagnosed with cancer in September 2016. The provisions of the MCA 2005 were used inconsistently by both acute health trusts during his hospital treatment, leading to unlawful actions and a missed opportunity to plan for how Stephen's particular needs would be supported whilst he was an inpatient. The acute trusts were very concerned that Stephen should have the best possible treatment and when he could not tolerate treatment took his case to the hospital ethics committee. Because Stephen's cancer could not be treated, he was considered by his doctors to have a poor prognosis with perhaps months left to live. Stephen retuned to the NRC where he was supported by MacMillan nurses working closely with the NRC staff who knew him well.

5.3 Once Stephen had recovered from his operation, plans to discharge him to his own property began. Professionals were very focused on providing him the best quality of life 'in his last days' in the least restrictive environment.

Previous assessments had advised that Stephen needed larger accommodation if he were to have 24/7 care, and that 'step-down' provision to help him transition from institutional care to his own flat would be helpful. Now that Stephen's life was thought to be ending these proposals were put aside.

Two risk assessments undertaken by Stephen's social worker indicated a range of risks - that Stephen would leave his flat, would not allow carers into his flat, and that he would physically hurt his carers. The presence and support of Stephen's mother was cited as a mitigation for these risks, but no assessment of her needs as a carer under s10 of the Care Act 2014, or conversation about how Stephen's family could be supported, took place.

How Stephen's needs would be supported in the community was also not considered, apart from the intention for his new GP to refer him to the MacMillan team in his area once he was discharged. A plan was put in place for Stephen to have leave at home, and for his new carers to work with NRC staff to get to know him.

This plan was not entirely successful as the first provider withdrew and a new provider, Z care services, was identified only ten days before the planned date of discharge. In the event Stephen was discharged to his own flat 19 days later with 24/7 2:1 care from Z care services.

5.4 During the 14 months Stephen was living in his flat he was supported by MacMillan nurses until his condition was deemed stable and he had no further need for specialist support around his cancer. He was also supported by community district nurses for short periods of time until it was decided he did not 'want' further support. His capacity to make these decisions was not assessed and any impact as a result of community services withdrawing was not discussed with the other agencies involved. He was not referred for specialist help with his 'gait' or his increasing propensity to choke on food. His key supports were his GP, Z care services and his social worker, a contrast to the specialised support he was receiving whilst in the NRC.

Stephen's needs had not changed, he was challenging to staff and extremely vulnerable to harm, often trying to get out of his flat by himself, or actually leaving the flat and being out in the street alone, harming himself by drinking or eating inappropriate substances and choking on food in June 2018. Stephen was often challenging to the staff caring for him, and some members of staff became afraid of him. These incidents were not always reported reliably by the provider, Z care, and the staff working with Stephen appear unsupported by the agency. Staff were advised to withdraw when Stephen was challenging, and in the latter weeks of his life were spending hours every day standing outside of his flat. In addition, the provider did not make sure that Speech and Language Services informed the risk assessment put in place after Stephen choked in June 2018. Concerns about the provider were reported by Stephen's family and a number of measures were taken by staff in adult social care to remedy the provider's deficiencies and monitor their performance, however these efforts were not supported by quality monitoring staff or coherent processes. No consideration was given to what support the provider agency needed to work with a man with such complex needs.

Stephen was seen by police and hospital staff after incidents but referrals to adult safeguarding or his social worker were not made as Stephen's vulnerability was perhaps disguised by perceptions of his challenge to services.

Stephen's mental capacity was not assessed, and best interest decisions did not inform the support given to him. His voice was absent from considerations, in particular his long term deprivation in his own tenancy was not bought to the attention of the Court of Protection, a step which may have led to a closer look at the restrictions on Stephen and the impact of living in such a restricted setting.

Latterly, consideration was given to requesting an assessment of Stephen's mental health needs under the Mental Health Act.
Commissioning agencies did not work together to identify a bed for Stephen, although this crisis did result in the CCG and adult social care beginning to consider how they would work together and a bed at the NRC was discussed, plans were made for his admission at a future date. Stephen's GP identified areas that could be explored to begin to improve Stephen's situation. Tragically Stephen died before any of these new plans and approaches could be attempted.

Stephen choked on food whilst alone and unsupervised in his flat. The failure of Z care agency to access an assessment of his choking risk from speech and language therapy and to appropriately support the staff caring for him resulted in a fatal outcome.

6. Findings and Learning Points

6.1 Findings will be summarised under each area of focus within the terms of reference for the SAR and relevant learning points made for each area.

6.2 How were Stephen's medical and social care needs assessed prior to and during the time he lived at his home? Once needs were identified how were risk assessments and risk management plans developed?

6.2.1 Stephen had access to a multi-disciplinary team with a wide range of expertise at NRC. The process for planning discharge was initiated and supported well by SW1, and a series of assessments undertaken to define Stephen's care and accommodation needs, decisions were made in his best interests. Provision for people with Stephen's complex needs was limited and this delayed discharge plans, especially as it was agreed to be in his best interests to be near his family.

6.2.2 Community agencies were not involved in discharge planning and did not contribute to plans made to support Stephen once in the community.

The failures to consider what supports Stephen needed regarding his mental health and neurological needs before and after discharge meant that he had limited support for his many complex needs.
His GP was left to make a referral to a new McMillan team to provide palliative care to this man with complex needs and to manage a range of medications which addressed both mental and physical needs. The housing provider had no opportunity to assist as they were not kept involved with discharge plans. Stephen's transition into community living was not well planned with the agencies who were about to support him, and vital expertise was lost in the process.

Learning Point 1

1.1 When people with complex needs are being discharged into the community the agencies who will support them must be part of discharge (transition) planning. Discharge planning must address the early months of community living and how the agencies involved can access support. Specialist support must be defined and confirmed prior to discharge.

Stephen's life limiting prognosis overturned many of the previous assessments regarding the care and accommodation Stephen needed together with previous decisions made in his best interests. The involved agencies and Stephen's family expected his life to be short and for physical frailty to be the determining factor in the type of care he would need. Previous concerns about the size of his accommodation, restrictions, and the safety of Stephen and those caring for him were set aside.
No formal best interest meetings were held although staff and family appear committed to act in Stephen's best interests to support a good quality of life for him. Stephen's best interests could have been further supported by an application for a community DoLS.

Learning Point 2

2.1 The circumstances which form the basis for a decision may change. Monitoring and reviewing a person's situation will ensure that the implications and impact of how needs are changing or not following a predicted course are understood, and previous decisions can be reviewed. In Stephen's case, after January 2018 it was increasingly apparent that the current accommodation and support arrangements may no longer be in his best interests, especially as he no longer appeared to be at the end of his life. A reconsideration of where Stephen's best interests lay, together with a legal authorisation process to support the deprivation of his liberty, would have provided focused decision making, and most importantly, a 'voice' for Stephen.

Risk assessments and plans were based on a short and intermittent period of 'home leave' which did not explore how he would live with two carers in a one bedroomed flat.

The support of Stephen's mother was factored in as a risk mitigator in risk assessments and plans, but no carers assessment (Care Act 2014 s10) was undertaken with his mother as to how this could be sustained in the community, and no advice was given under the LA wellbeing duty (Care Act 2014 s2) as to who would support her and her family in this endeavour. Risk assessments were not used to inform the care arrangements, although Stephen's need for consistent carers was identified this did not result in commissioning an agency who could provide a 'team' of regular carers around Stephen.

Learning Point 3

3.1 The local authority has a legal duty to offer a range of advice, supports and assessments to carers.

This duty may apply even when the local authority is already funding formal care and is particularly pertinent when the support of the carer is instrumental to the success of a support plan or arrangement.

Once discharged into the community Stephen continued to have complex needs but no longer had the support of a skilled multi-disciplinary team around him. The provider's care plan was reviewed by commissioners in August 2018 and updated by the provider in response to incidents, but not informed by specific expertise, for example of a Speech and Language therapist, Brain Injury, or another neuro specialist. The emphasis was on the provider's ability to create risk assessment and management plans, but the provider had no expertise in these areas. In addition, the provider proved unreliable in reporting incidents and risks, whether Z could be relied upon to create robust risk management systems should have also been in doubt. It was known that Z staff were not able to support Stephen at all times and would leave the premises as agreed during discussions with professionals and as documented in care plans. The risk of this to him was not explored and latterly the emphasis was on finding suitable alternative provision, not on how to mitigate the daily risks to Stephen, a person who did not have the mental capacity to understand the impact of his own actions and was completely unable to ensure his own safety.

Learning Point 4

4.1 When people have complex needs consideration must be given to how the provider is accessing specialist expertise and what expertise the provider has. Whilst we need to be able to rely on the provider to tell us if they are struggling to meet a person's needs and ask for assistance, we also need to be able to readily provide access to advice and support on how to manage everyday risks when people's needs are particularly complex.

This learning point also relates to Learning Point 7, and how specialist input for people with complex needs must be available as part of a s117 or CHC funded discharge.

4.2 Agencies did not report their concerns into ASC, to the AAD team or to adult safeguarding. Since December 2018 West Midlands police have had the facility to refer in a safeguarding concern electronically from the scene of any incident. It is uncertain whether Stephen would be recognised as an adult at risk however, he appears to be the perpetrator of harm to his own staff, only when the complete dependency of Stephen on others is understood can the high risk of his neglect be understood. The acute hospital trusts also need to understand how risk can present, an adult who has self-harmed but is either in a care setting or has 24-hour care should arouse curiosity in staff and further referrals should be considered. The housing provider did demonstrate curiosity and made contact appropriately to express concerns.

Learning Point 5

5.1 An adult at risk may be harmful to others, including their own staff or carers, but if they are completely dependent on the people they are harming for their wellbeing and safety this will increase their risk of harm, particularly neglect. It can be difficult to immediately recognise a situation as one where there is a risk of harm, but if the situation appears unusual as Stephen's situation did, or there is an accumulation of incidents, this should result in a report to the local authority. Use of Professional Curiosity approaches can support staff to understand the potential impact of harmful behaviour.

5.2 Actions agreed at meetings, including adult safeguarding meetings, were not always progressed in a timely manner or followed up. In particular the actions agreed at the review meeting of August 2017, the safeguarding meeting of December 2017 or the family meeting in January 2018 could have added further supports to the Stephen and his staff and carers, but the agreed referrals or actions do not all appear to have been taken place or were not sufficiently timely to be effective in the changing risk situation.

Learning Point 6

6.1 The principle of accountability applies to all agreed actions arising from meetings held to prevent or respond to harm regarding an adult with care and support needs. Agreed actions must have timescales, be checked and if they have not been undertaken the reasons for this and alternative actions or decisions recorded.

6.2 How did multi agency partners work together to meet Stephen's needs? If there were concerns about how agencies worked together how were these escalated?

6.2.1 As above, agencies involved after Stephen was discharged from NRC were not involved in his discharge planning and struggled to meet his needs. The team around Stephen became very small, and whilst his social workers and GPs were very committed to his wellbeing, they did not have the expertise to address all of his needs. SW1s' request to the CCG for a health professional to advise on Stephen's medication, and the need for joint management and decision making in a jointly funded package, was not progressed.

Confusion over the funding pathway meant that the range of agencies that should have been considered to support Stephen and his carers were not identified by the CCG, CSU, or ASC. Stephen, like many people who have complex mental and physical needs, did not fit neatly into a defined pathway, and did not benefit from the expert overview of mental and/or physical health services. When Stephen was in crisis no one in the CCG could be identified to work with ASC AMHPs or social workers to identify a resource to help him.

The CCG has explained that the Mental Health Joint Commissioning Team deal with every S117 case and there are S117 nurses who review the care of people with S117 aftercare packages. Prior to this people with mental health diagnoses that were deemed 'organic', e.g. brain injury, were the responsibility of the CHC teams. This played a part in the confusion that resulted in Stephen's case.

The CCG now hopes that having one team to work with both organic and functional mental health cases will prevent this. In addition, the CCG now has an Acquired Brain Injury pathway dedicated clinician who oversees all cases and liaises with other pathways as needed.

Learning Point 7

7.1 Any person discharged with complex needs with CHC or s117 funding must be overseen and have the support of specialist nurses and other clinicians, and their needs, rather than their diagnosis should determine the pathway, with liaison with other clinicians as necessary.

7.2 The SAR has not identified any use of an escalation pathway which would have been an appropriate step to take regarding non-engagement of the CMHT team with Stephen's discharge, or the CCG lack of support with identifying a bed for Stephen in July 2018.

Learning Point 8

8.1 Agencies should publicise their escalation pathways and contacts, and ensure their staff know when and how to use these effectively and appropriately.

8.2 How did multiagency partners use the provisions of the Mental Health Act 1983 and the Mental Capacity Act 2005 to promote Stephen's wellbeing and safety?

8.2.1 The Mental Health Act appears to have been used when appropriate within the time considered by the SAR, i.e. to detain Stephen at NRC and to support home leave. GP2 determined that there were alternative actions that could be explored and taken with respect to the risk Stephen was presenting to himself and others in July 2018. A person should not be detained if there are other options to address their mental health issues and related risks. GP2 identified that Stephen's agitation could relate to his family relationship and work was needed to address this as much as possible.

This observation did need to be acted on quickly but does not appear to have been an action arising from the subsequent multi agency meeting of the 31st July, or indeed or any further immediate risk management activity undertaken.

8.2.2 The provisions of the Mental Capacity act were used poorly at times across all agencies:

Community Health (District Nurses) – no assessment of Stephen's mental capacity or use of best interest decisions, this may have led to a perception of Stephen actively 'refusing' or being non complaint, and contributed to the absence of planning to manage his engagement with the service.

MacMillan nurses 2 – did not record any assessment of Stephen's capacity.

GP – no assessments of Stephen's mental capacity to make decisions about his own treatment were recorded, or any observations of his preferred means of communication.

Acute trusts – as documented in section 6 above, the provisions of the MCA 2005 were used inconsistently and do not inform plans which could support Stephen's best interests with regard to treatment.

Without an understanding of Stephen's mental capacity professionals were at risk of misinterpreting his understanding, motivations or intentions. Stephen did not always get a preventative and responsive approach to issues identified by health professionals, referrals for primary care services were not always made (his gait/SALT) and health staff found it very difficult to meet simple needs (ear care/gluing a wound/weighing him) as well as complex needs (chemotherapy).

Learning Point 9

9.1 An assessment of capacity and, where needed a best interest decision or Deprivation of Liberty Safeguard application, is an opportunity to assess and plan the best way to act in a person's best interests.

It is not the time consuming and overly bureaucratic process sometimes described in acute health settings, there is a good patient care reason to engage with the provisions of the MCA (Marshall 2018).

9.2 SMBC did not progress an application for a Community Deprivation of Liberty Safeguard although this was a recurrent agreed action from two meetings. Stephen certainly met the criteria for application as he was not free to leave his flat and was 'under continuous supervision, monitoring and control'. An application could have been made before he was discharged, or afterward, and would have prompted more thought about the restrictions of the placement on Stephen, whether these could be reduced and if they were in his best interests. His rights would have been taken into consideration and the limits to his restriction understood. Stephen would have had a 'voice' as part of the assessment and best interest discussions, and potentially an advocate to enable a focus on his past and present wishes.

Learning Point 10

10.1 Understanding of the potential circumstance that constitute a deprivation of liberty in the community, and the duties to respond to this, need to be understood together with the pathways for progressing legal actions prior to the implementation of the Liberty Protection Safeguards planned for late 2020.

10.2 How were services to support Stephen at home commissioned? How were these services supported? How were these services monitored?

10.3 The CCG appear to have sourced provider Z as an urgent action when provider X withdrew.
It is unknown what due diligence actions the CCG took in determining that Z was suitable provider for a person with the complexity of Stephen's needs. The local authority did not take any opportunity to make enquires of other local authorities regarding their experience of Z but relied on the CCG's recommendation. No records exist of how Z staff performed in any home leave trials, and we do not know how well they were observed to be able to meet Stephen's needs.

Certainly the 'nurse specialist' identified as being able to support Stephen's carers later explained to CQC that her role was as an educator, she did not advise or monitor but gave training to staff. She was not a mental health specialist nurse.

Learning Point 11

11.1 How commissioners identify agencies to meet complex needs should be clearly understood, other agencies who have a duty of care toward an adult may also wish to make their own enquiries although this should not be relied upon. Quality marks set against agreed standards may be a useful way of identifying agencies who can work well with specific needs.

11.2 As above, provider Z was not well supported, and once they were commissioned emphasis was placed on the ability of Z to create plans to address risk.

11.3 Attempts were made by SW1's team manager to monitor Z's performance with regard to Stephen's care, but these monthly meetings did not inform any agency action plans and were not supported by any contract compliance or quality team. SW2 combined monitoring with improved communication with Z with the expectation of regular emails. However once poor performance by the agency was identified no actions were taken to remedy or mitigate concerns about quality whilst a new placement was identified. Neither the CCG or SMBC took responsibility for monitoring the quality of the provider and confusion over the funding stream exacerbated this vacuum, had Stephen been recognised as being on s117 the CCG believed that SMBC were responsible for monitoring, although this was not discussed or stated at meetings with either SW1 or SW2. Z's main client group was in another local authority area, so reducing the possibility that other concerns about performance would be identified.

Learning Point 12

12.1 Any jointly funded support package or placement must specify the responsibility for monitoring the performance of a provider, and the actions to be taken should there be concerns about quality.
Actions should include a risk assessment of the impact on the service user of poor-quality care, risk assessment should include consultation of the person and their representatives. In this way the serious consequences of poor-quality care for the individual will be understood and acted upon.

7. Conclusion

Stephen's care and support in the community was compromised by a lack of clarity about roles and responsibilities around a jointly funded discharge and management of support to a man with complex needs. The commissioning agencies did not work together to coordinate Stephen's discharge, or, until he was in crisis in July 2018, to manage his needs and the sustainability of his placement in the community.

In common with the majority of Safeguarding Adult Reviews in England, this review demonstrates the inconsistent understanding and use of the provisions of the Mental Capacity Act 2005 in all organisations in Solihull. A key theme in this SAR is perhaps the lack of understanding of why the provisions are important, what the benefits are to patients and service users of using the legislation to support their care and treatment.

The inconsistencies in the application of the Mental Capacity Act 2005 across all agencies have resulted in potentially unlawful practice in the consent given for Stephen's operation through to detention on a hospital ward without a Deprivation of Liberty authorisation in place and long-term deprivation in his home without the protection of a community Deprivation of Liberty authorisation.

The impact of failure to use the provisions of the MCA 2005 had two further consequences. Firstly, without an understanding of Stephen's mental capacity professionals were at risk of misinterpreting Stephen's understanding, motivations, or intentions. Stephen did not always get a preventative and responsive approach to issues identified by health professionals.

Secondly Stephen's voice could not be heard via the process of best interest decision making, application for a Deprivation of Liberty authorisation in hospital or in the community and the appointment of an advocate via these processes.

8. Recommendations

Recommendation 1

Birmingham and Solihull CCG and Solihull Metropolitan Borough Council are recommended to undertake joint work to address the following:

• Ensure that the funding pathways for people with complex needs, and the roles and responsibilities of the organisations involved, are clearly defined and understood.

• That the processes used to judge the quality and suitability of commissioned services are clear, understood and used consistently.

• That a clear agreement is in place regarding commissioned service monitoring responsibilities, roles, and processes to include standards, risk indicators, risk assessment and mitigation processes.
(This recommendation addresses learning points 1, 4, 7, 11,12)

Recommendation 2

The SSAB should seek assurance from Birmingham and Solihull CCG and Solihull Metropolitan Borough Council that work is being undertaken jointly to address the items specified in recommendation 1 above, and to receive Reports on the progress and completion of this joint work.

Recommendation 3

The SSAB should assure itself that all partner agencies have arrangements to escalate and address non adult safeguarding issues, e.g. a breakdown in joint working to identify a hospital or other resource.
Agencies should publicise their escalation pathways and contacts, and ensure their staff know when and how to use these effectively and appropriately.
(This recommendation addresses learning point 8)

Recommendation 4

Birmingham and Solihull CCG and Solihull Metropolitan Borough Council are recommended to agree a process to follow in respect of planning and managing very complex discharges.

The processes should include :

- Discharge plans informed by assessed need, not diagnosis
- Ensuring that mechanisms are in place to make sure that health and social care specialist and community supports for people with complex needs are identified, are involved in discharge planning and are in place prior to discharge
- Identification of mechanisms to support transition into the community, including a review of needs, risks, and plans at agreed intervals post discharge.

(This recommendation addresses learning points 1,2,4 and 7)

Recommendation 5

The SSAB should consider how to amend procedures and practice guidance in order to specify the nature of vulnerability and potential harm in situations where the adult at risk is also a source of harm to others. All partners must consider how to prevent and respond to such situations, share information with partners, identify themes and cumulative risk, and consider the need to refer an adult safeguarding concern.

(The Norfolk SAB (2018) Guidance on Professional Curiosity in Adult Safeguarding will support partners' consideration of these situations and the development of professional curiosity in all agencies.)
(This recommendation addresses learning point 5)

Recommendation 6

The SSAB should consider how it might promote the positive benefits to patients and service users of using the provisions of the Mental Capacity Act, including mental capacity assessments, best interest decision making, commissioning advocates, understanding what a lasting power of attorney is and how it is used, and authorisation of deprivation in the community.
(This recommendation addresses learning points 9 and 10)

Recommendation 7

The SSAB should seek assurance from the local authority, CCG, health trusts and community health teams that action plans have been developed to address the inconsistencies and potentially unlawful practice identified in this SAR regarding the use of the Mental Capacity Act.
(This recommendation addresses learning points 2, 9 and 10)

Recommendation 8

Solihull Metropolitan Borough Council is recommended to use the learning from this SAR to review guidance on carers assessments and support to family carers where there are also commissioned services providing 24-hour care.
(This recommendation addresses learning point 3)

Recommendation 9

SSAB should request a report from Solihull Metropolitan Borough Council on how the principle of 'Accountability' is evidenced through follow up to agreed adult safeguarding plans in all teams who undertake s42 enquiries.
(This recommendation addresses learning point 6)

Recommendation 10

The SSAB should request a joint Report from Birmingham and Solihull CCG, Solihull Metropolitan Borough Council and the CQC detailing their learning from the events relating to the closure of Z between January 2019, when notice was served on Z by CQC, and April 2019 when Z voluntarily de registered.
A report on the outcomes of this learning should be presented to the SSAB together with actions plans to address any identified gaps in arrangements.

(This recommendation addresses area of focus 2.1.5)

Recommendation 11

The SSAB is recommended to share an update with Stephen's family in a year's time on what has changed as a result of the SAR learning and subsequent action plans. This recommendation is a family request.

9. Glossary of terms used

ABI – Acquired Brain Injury
ADD –All Adults Disability team
AGEM - Arden and Greater East Midlands Commissioning Support Unit, also referred to as the 'CSU' or Commissioning Support Unit.
ASC – Adult Social Care
AMHP – Approved Mental Health Practitioner
BHH – Birmingham Heartlands Hospital
CCG – Clinical Commissioning Group
CHC – Continuing Health Care
CMHT – Community Mental Health Team
CoP – Court of Protection
CPA – Care Programme Approach
CQC – Care Quality Commission
DN – District Nurse
DNAR/ or DNAR/CPR – Do Not Attempt Resuscitation/Do Not Attempt CPR - (Cardiopulmonary Resuscitation)
DoLS – Deprivation of Liberty Safeguard
ED – Emergency Department
GP – NHS General Practitioner
IMCA – Independent Mental Capacity Act advocate
IMHA – Independent Mental Health Act advocate
LPA – Lasting Power of Attorney
MCA – Mental Capacity Act
MHA – Mental Health Act
NRC – Neurological Rehabilitation Centre
QEH - Queen Elizabeth Hospital
SALT – Speech and Language therapy
SMBC – Solihull Metropolitan Borough Council
SPOA – Single Point of Access
SAR – Safeguarding Adults Review
SSAB – Solihull Safeguarding Adults Board
SW – Social Worker

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