



**Plymouth
Safeguarding
Adults Board**

Safeguarding Adult Review

Ruth Mitchell

Safeguarding Adults Review (SAR)
Into circumstances surrounding the death of Ruth Mitchell
Scoped period June 2007 – September 2012

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1. Introduction

1.1 Ruth Mitchell was forty years old when she died at her home on 2nd September 2012.

Ruth, a white British woman, lived alone in a one bedroomed flat. The Coroner recorded the medical causes of her death as bronchopneumonia and pulmonary embolism. The Coroner recorded a narrative conclusion setting out the history of how Ruth came to die, noting that she was *“known to have schizophrenia, and that she was under psychiatric care”*. When found at her address on 2 September 2012 she was *“malnourished and on the balance of probability had previously consumed significant quantities of alcohol. She had ketoacidosis. On the balance of probability, she was not taking her medication, Risperidone. She had neglected herself”*.

At the time of her death Ruth weighed 7.8 stone, or 50 kilos. There were very few possessions in her flat, she appeared to have neglected herself over a period of time.

1.2 Ruth’s father made a referral to the Plymouth Safeguarding Adults Board (PSAB) Chair in March 2015, outlining the circumstances of Ruth’s death and concerns about the care his daughter received in the years prior to her death. The PSAB Chair determined that the criteria for a SAR had been met, but deferred the review until other processes relating to the circumstances of Ruth’s death were concluded, and the Safeguarding Adults Review could begin. Other processes included referral to professional bodies for some of the staff involved in Ruth’s care and a complaint which resulted in a report by the Health Ombudsman.

1.3 The Safeguarding Adults Review (SAR) in response to the death of Ruth Mitchell is commissioned by the Plymouth Safeguarding Adults Board (PSAB). The review is conducted in accordance with the PSAB Safeguarding Adults Multi-agency policy and procedures, which are underpinned by the statutory guidance requirements of the Care Act 2014, namely that:

“A Safeguarding Adult Review is a review of the practice of agencies involved with an Adult at Risk, commissioned to facilitate agencies to learn lessons and improve the way in which they work.... The purpose of having a Safeguarding Adult Review is not to reinvestigate nor to apportion blame, it is:

Lessons learnt - to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard Adults at Risk;

Review of procedures - to review the effectiveness of procedures (both multi-agency and those of individual organisations);

Improve practice:

- a. *To inform and improve local inter-agency practice;*
- b. *To improve practice by acting on learning (developing best practice).*

Reports - to prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action”.

2. The Terms of Reference for the Ruth Mitchell SAR can be found in Appendix 1. The terms of reference include details of the time period the review considers, together with how the review was conducted and the areas of focus considered.

3. Methodology

The methodology used in this review seeks to promote a thorough exploration of the events prior to Ruth’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 acted as they did, and why certain decisions were made, is essential if learning is to be derived from the Review. The methodology utilised a blended approach of systems-orientated models to maximise opportunities for learning in the specific circumstances of this review. The Review was supported by an extended SAR sub group which included senior representatives of the agencies described below. Because the events being considered occurred some five to ten years ago, the methodology also included a mechanism for considering the key events in the case in the context of 2016 – 2017 legislation, policies and practice.

Activities to inform the SAR have included:

Individual agency reports, the template for the agency Reports appears in **Appendix 2**. Collation of the chronologies provided within the individual agency reports, interviews with Ruth’s parents and with staff who worked in the agencies involved at the time, identification of key episodes, and a learning review event held to consider key events in a contemporary context.

Individual agency reports were commissioned from

Livewell Southwest

Devon and Cornwall police

South Western Ambulance Service NHS Foundation Trust

Ocean Health (was Stirling Rd Surgery)

Plymouth Community Homes

Plymouth City Council – Adult Safeguarding

Plymouth City Council – Community Connections

The lead reviewer interviewed:

Ruth's parents

A PCC team manager who worked in the integrated mental health service (from 2009)

The PCT/NHS Plymouth professional lead for adult safeguarding (2007 – 2012)

The local authority adult safeguarding lead (until 2012)

The local authority adult safeguarding administrator

Documents examined:

Report for the Coroner – authored by HP7 - 14 September 2012

Transcript of Corners Inquest Hearing 2013

Four versions of PSAB Vulnerable Adult Risk Management procedures dated between 2006 – 2011

Plymouth NHS Teaching Primary Care Trust Management structure 2007

PCC Adult Safeguarding Team structure 2008 onward

Letter from the Department of Works and Pensions regarding Ruth's benefits

Report by the Health Ombudsman for England into a complaint made by Ruth's parents, March 2016.

Letter to Ruth's parents in response to the Health Ombudsman for England Report 03 June 2016

PCH Letter to Ruth's parents 19 September 2014 regarding their letter concerning the "individual agreement"

NHS Litigation Authority Letter of Response to the personal representative of the estate of Ruth Mitchell 15 October 2015

Independent Psychiatric report into the matter of Ruth Mitchell 26 February 2014

CPA review 19 June 2007 including risk assessment; clinic letter from HP2 to GP

CPA review 16 July 2007 including risk assessment; and letter from HP1 to GP

Letter from HP2 to GP 12 February 2008 plus clinic notes

Reviews including risk assessments and clinic notes where available; follow up emails and letters to GP 26 February 2008 to 15 February 2012.

There have been challenges in ascertaining why specific decisions were made during key episodes in Ruth's life. These events occurred between ten and five years before the SAR began. Some records have been hard to trace as recording systems have changed, paper files have been destroyed or data deleted as part of each agency's formally agreed deletion schedules. Some information has been transferred between providers and, although theoretically data should not have been lost during transfer, some paper files may have done so. Reporting and recording systems of the time in some of the agencies do not appear robust, this has added to the challenge of identifying written evidence.

In the intervening period, some staff have also left organisations or indeed the Plymouth area. The lead reviewer is grateful to staff who, although working in another part of the country, were concerned that learning should take place from the circumstances of Ruth's death and have contributed to this review.

The outcomes from the learning event held on 3 May 2017 are documented in section 10.

4. Family Involvement with the SAR.

See 1.2 above, Ruth's father made a referral to the Chair of the PSAB for consideration of a SAR. Ruth's mother and father met with the independent reviewer to discuss the proposed terms of reference prior to the beginning of the SAR activity. They were also interviewed by the independent reviewer to gather information about Ruth and her life. Ruth's mother and father have submitted written evidence to the Review.

Ruth's parents reviewed and commented on a draft of the SAR report after the draft was presentation to PSAB in July 2017. Their formal response will be published with the Report.

5. Overview of Ruth's history prior to scoping period

Ruth left school with nine GCSE's. She left home shortly afterward and entered a relationship with an older man, described as a "heavy drinker", in which she was physically abused. Ruth returned home to her parents at the end of this relationship but then left to take up a new relationship. Ruth is thought to have begun using a range of street drugs and drinking alcohol during this time. She was employed as a waitress, a cashier and worked for the Inland Revenue. She gave birth to a child at the age of 22. When Ruth and her partner separated in 1999 her child remained with the father. Ruth initially maintained some contact with her child, but this ceased well before her child and ex-partner moved from the area.

Ruth's first contact with Mental Health Services was in July 1996 when a Mental Health Act assessment was undertaken. Her child had been admitted the previous day due to a possible accidental overdose of Ruth's tablets and concerns had been raised regarding Ruth's behaviour. A Mental Health Act Assessment was undertaken; Ruth was not detained

but followed up within the community mental health services. Ruth continued to be seen in outpatients and in September 1996 was admitted to a mental health unit describing a fear that something terrible was going to happen and that there was someone in her flat, a diagnosis of “probable Schizophrenia” was made at the time. Following discharge, she attended a day therapy programme and was supported in the community by a social worker and community psychiatric nurse (CPN). In 1997 her medication was changed to an oral anti-psychotic, Risperidone, and she continued to be reviewed within outpatients to receive support from a community mental health team. In 1998, it was noted that Ruth suffered with the side effect of weight gain, use of the antipsychotic medication, Risperidone, had led to her weight increasing to fourteen stone.

After the separation from her partner and child in 1999 there was an escalation in Ruth’s use of alcohol and she was referred to alcohol services by her CPN at that time, identified as HP4 in this review. Ruth did not pursue this referral. A diagnosis of hebephrenic schizophrenia, which is characterised by thought disorder and disorganised behaviour, was made at that time. Although other diagnoses were explored over the years, Ruth’s last consultant psychiatrist, HP7, thought that the diagnosis of hebephrenic schizophrenia was the most helpful in characterising Ruth’s presentation. Hebephrenic schizophrenia is described in ICD – 10 – 2010 as

“A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate, thought is disorganized, and speech is incoherent. There is a tendency to social isolation. Usually the prognosis is poor because of the rapid development of “negative” symptoms, particularly flattening of affect and loss of volition”.

Over the coming years Ruth remained on the Care Programme Approach pathway and continued to receive support from the community team, she had a consistent care co-ordinator, HP1, for some years. Ruth remained on Risperidone as the core of her treatment and was also prescribed Dothiepin, an anti-depressant, as she also presented with symptoms suggestive of depression. HP7, the last psychiatrist to see Ruth, described her symptoms of psychosis as “minimal and low grade” though she continued to live a solitary and isolated lifestyle.

In 2002 Ruth was assessed under the Mental Health Act 1983. Unwell, she had cut up her carpets and curtains, and sawn up furniture. She was not detained but her health improved with medication. Her parents were able to actively support her at this time. At this point Ruth is recorded as requesting that her information should not be shared with her family. Her family recall that she had welcomed regular contact with them, and for them to take part in her care, until an incident in the late 1990s when Ruth was told a sensitive piece of

risk information that Ruth's mother had confided to the care coordinator. After this Ruth began to distance herself from her parents and requested at various times that information should not be shared with them.

In December 2003 Ruth was assessed again under the Mental Health Act 1983. Her mental health had deteriorated toward the end of the year and she was referred to the home treatment team. She had been attending a day centre weekly. It was noted that when her mental health deteriorated her alcohol use increased. She was seen by mental health professionals as well-presented, whether she was well or unwell.

In 2004 Ruth experienced conflict with her neighbours, which led to her spending a night in the cells and being further assessed under the Mental Health Act, again she was not detained. Mental health professionals were concerned about her excessive use of alcohol at the time. Ruth's parents alerted mental health services to issues with neighbours and drinking behaviour. Ruth arranged a flat swap herself in 2004, moving into a one bedroomed flat away from her previous neighbours. Her previous accommodation had been a two-bedroomed flat which would have facilitated contact with her child.

In 2005 Ruth did not attend appointments with the mental health team, but she was still in contact with her parents, seeing them now on a three to four monthly basis. Her mother reported that she was well.

In April 2006 Ruth was picked up by police on section 136 of the Mental Health Act 1983 after conflict with her neighbours. A Mental Health Act assessment took place, Ruth was not detained but expressed concerning ideas and was noted to be drinking excessively at that time.

Just prior to the period in scope HP1 was acting as Ruth's care coordinator. Ruth's CPA care plan was a visit once a month to her home by her care coordinator, six monthly appointments with her psychiatrist and annual reviews with her GP. Police records show that Ruth was still drinking alcohol heavily in early 2007. On 12 March 2007 Ruth was arrested for being drunk in a public place and issued with a fixed penalty notice. On 20 March 2007 police attended Ruth as she was very drunk and could not remember where she lived. Mental health services do not appear to be aware of either of these events.

6. Scoped period: Key Episodes

The period within scope of the review is June 2007 until Ruth's death on 2nd September 2012. The period is divided into sections below to highlight particular key episodes. A summary of what interactions Ruth was having with agencies at the time is given for each section. The organisation which provided mental health services changed in 2011, from an NHS Primary Care Trust to a Community Interest Company, Plymouth Community

Healthcare CIC. Following expansion this organisation changed its' name to Livewell South West in January 2016. For ease of reading these organisations are referred to as "mental health services". Text in italics has been taken directly from a recording or is a direct quote from an interviewee.

June 2007 – February 2008.

On the 10th June 2007 police attended Ruth's flat, having been called by her neighbour who was concerned that he had not heard her since the previous day. The attending officers recorded in the police log that Ruth told them that she had schizophrenia, that she had mental health and alcohol issues and that there have been several similar calls to the address. Ruth responded to the police knocking her door, when they saw her she said she was "*happy and fit and well*". The police independent agency report author found no linked intelligence to suggest a referral was made to any other agency. There was no evidence that support was required so no new referral would have been required at the time. This was the third contact police had with Ruth in 2007.

Ruth was seen by her care coordinator, who will be referred to as Health Professional 1 (HP1) and her psychiatrist (HP2) on the 19th June 2007 for a planned CPA review. Ruth made a request to be discharged from Mental Health services. She agreed one further planning appointment with her care coordinator prior to being stepped down from the Enhanced Care Programme Approach (CPA) to standard care.

On 20 June 2007 Ruth's parents made a complaint to the mental health service about the support being offered to Ruth. They were particularly worried that she was so isolated, socially and from her family, and were concerned about "*her increasing and destructive dependence on alcohol with no apparent treatment strategy*". They were also concerned about the lack of communication from mental health services to them

The planning meeting to discharge Ruth from CPA took place at Ruth's home on the 16th July, as arranged at her last outpatient's appointment. A risk assessment was undertaken. Ruth was discharged from care coordination with the following plan:

"Discharge from care coordination;

Outpatient follow up with psychiatrist (HP2)

GP to inform services if prescription not collected;

Ruth contact HP1 if mental health deteriorates.

HP1 discharges Ruth from her caseload and Ruth remains under care of HP2 via

Outpatient appointments".

A letter was sent to the GP by HP1 requesting that they should *“contact mental health services should s/he have any concerns regarding Ruth or if Ruth fails to collect prescriptions.”* The GP notes only record that they must be aware of whether Ruth is picking up prescriptions or not, and to report any failure to do so to the mental health team.

In a letter (16/7/2007) to Ruth’s GP, HP1 also summarised Ruth’s current situation. The letter stated that her mental health was stable and she desired to be discharged from care coordination. There was evidence that Ruth had been drinking to excess over the previous few months. She had at times been non-compliant with her psychiatric medications and this had often coincided with an increase in her alcohol use. HP1 stated that although the police and Ruth’s landlord had contacted her with concerns about Ruth’s behaviour in the past *“this has not been a feature of Ruth’s presentation for some time”*. Ruth is reported to have spent much of her time alone, but *“prefers and is happy to live a solitary lifestyle. She wants no contact with her (child), and does not want any information about her mental health shared with her parents”*.

The GP surgery received the letter and a copy of Ruth’s risk assessment on 16th July. On 17th July HP1 also telephoned the GP to emphasise Ruth’s request that she wanted no information shared with her parents. Ruth’s parents were informed in August 2007 that she *“had been discharged from secondary mental health services to the care of her GP”* by the mental health trust complaints manager. Ruth had not, in fact, been discharged from secondary mental health services but was discharged from Enhanced CPA.

Ruth was now on a *“standard care”* pathway. Standard care at the time was defined as care and treatment provided within secondary health services for those whose needs do not require the support of CPA. The consultant psychiatrist took the role as lead professional.

During this period Ruth is recorded as picking up her prescribed medication every month from the GP surgery.

In January 2008 Ruth reported a problem with light fittings in her flat, a repair was carried out by Plymouth City Council staff.

Ruth is recorded as attending her annual mental health review with her GP on 12th February 2008. However, the form used to record the review is dated 30 January 2008. Her previous annual GP health review took place in January 2007. Her blood pressure was taken at this appointment but there is no record of her weight being measured at this or any other health check. Her GP notes record that she smelt of alcohol. If the review was held on 12th February, later that day Ruth attended her scheduled out patients’ appointment with HP2. HP1 also attended together with a junior doctor, HP3. Ruth was intoxicated and the clinic appointment could not take place. Ruth agreed that HP1 would visit and review her at home on 15th February 2008. It is unclear whether this visit took place.

Ruth attended a rearranged out-patient appointment on the 26 February 2008, also held at the GP Surgery and attended by HP1, 2 and 3. Ruth's goals were to be discharged from mental health services and no longer need to take medication. Those present expressed concern about her social isolation and the current evidence of her alcohol intake. Ruth said that she had recently given up alcohol and, although *"grateful to HP1 for the home visits"*, she did not want continued home visit support. A referral to a day centre was also discussed but Ruth felt that the organisation was better suited to young people. It was recorded that Ruth did not appear to lack capacity and could retain information and was *"given time to digest and reflect upon information"*.

At this appointment, options were offered to Ruth including

- Discharge to the GP with regular nurse follow up either on her own or with the GP
- Referral to a substance misuse service
- For the care plan agreed on 16 July 2007 to remain the same and for Ruth to continue to meet with HP2 for review on a six-monthly basis.

Ruth chose to continue meeting with HP2 explaining that she did not want the other options. She agreed to continue to take her medication. She was still on standard care and supported by secondary mental health services with her psychiatrist as the lead professional.

April 2008 – April 2009

Ruth continued to pick up her monthly prescription from the GP surgery during this period.

In March 2008 Gas Engineers commissioned by Plymouth City Council once again tried to undertake an annual safety check but were unable to gain access.

On 3rd April 2008 Ruth's neighbour called the police to express concerns about her welfare. He had not heard from her for two days. The police could get no response from Ruth from knocking at her door so forced entry, finding her asleep. Ruth said that she had been *"poorly"*. The officers have noted that Ruth had mental health issues but recorded *"female safe and well no concerns for her she will await council only damage to lock"*. A Plymouth City Council engineer was contacted to attend and repair the damage caused on entry, and did so the same day. Mental health services were not aware of this event.

On 11th April 2008 PCC gas engineers again attended Ruth's flat to attempt to check the safety of gas. They could not gain admission and therefore capped off the gas supply to her flat. Ruth had no immersion heater and so had no heating or hot water from this point until her death in September 2012. Plymouth City Council were unaware that Ruth was vulnerable and took no supportive action to check how she might keep warm. There is no record that PCC informed the mental health service that the gas supply had been capped.

On 15th April 2008 Plymouth City Council Housing repairs staff mended a cistern at Ruth's address.

In May 2008 Ruth wrote to the Department of Works and Pensions (DWP) to say that she had been "*discharged*" from mental health services. Ruth's parents recall that the word discharge was very important to her. She had in fact not been discharged from mental health services but her parents believe that she wanted to be "back to normal". Ruth's letter said that she had been "discharged" but did not ask to cease DLA, she asked for a form to complete to help her "sort her finances out". Her claim for Disabled Living Allowance (DLA) ceased at this time. She lived on income support of between £60-£65 per week.

Ruth's parents had made a formal complaint to the mental health trust about the decision for Ruth to be discharged from CPA in August 2007 and the lack of communication with them. Given the request of Ruth not to give her parents information about her mental health, a compromise process was developed in May 2008 whereby a new health professional, HP4, was bought into the care plan. HP4 had been known to Ruth and had acted as her care coordinator prior to 2000.

The letter which HP4 wrote to Ruth's parents to describe her input in May 2008 states that she would support the therapeutic relationship between HP2 and Ruth through out-patient appointments on a three-monthly basis and that "*within this contact I will utilise the opportunity to approach and explore Ruth's current social circumstances and continue to promote engagement with regards social networks and family*". HP4 also said that she would be available to Ruth's parents following each outpatient's appointment to update them of Ruth's attendance; Ruth's decision that no other information should be shared with her parents would forbid any other information sharing. However, Ruth's parents would have the reassurance that she was being seen.

On the 10th June 2008 Ruth attended a planned outpatient's appointment with HP2 and HP3. She reported that she felt well and was taking her medication. Her sleep pattern and appetite were "*normal*" and she had not drunk alcohol to excess "*in the past few weeks*". HP2 and 3 offered to assist her in arranging activities for herself and left this option open to her. From this point, there are no further references to Ruth's alcohol use in risk assessments undertaken during outpatient appointments.

In August 2008 Ruth booked an appointment for a gas engineer to call at her flat, but was out when the engineer attended on 6th August. A follow up letter was sent and Ruth did allow access to the engineer on 20th August. The outcome of this visit is unclear but Ruth appears to have remained without gas.

A follow up out-patients appointment with HP2 was arranged for September 2008, but Ruth did not attend. She did telephone to apologise however, saying that she had been physically unwell, and did attend her next appointment with HP2 on the 11th November.

HP4 also attended. Ruth reported that she was feeling “*alright*”, was not drinking alcohol on a regular basis but felt bored and as a result depressed from time to time. She did not want to take up any of the activities on offer, i.e. day centre. Ruth was described as “*ambivalent*” about what was on offer, seeing day centre activities as suitable for teenagers or young people. She agreed to continue to take her medication and a review for 6 months hence was planned.

In February 2009 HP4 moved to a new team and no longer worked in the area that Ruth lived in. However, she was left to fulfil the role agreed in May 2008; no further arrangements for any other liaison to take place were made. The move of team meant that HP4 had no regular input into the MDT that would discuss Ruth’s care.

Ruth attended her next outpatient’s appointment on 24 March 2009. HP2 was not present, but a Junior Doctor, HP5, took HP2’s place. HP4 was also present. Ruth described feeling physically unwell, feeling dizzy, finding it hard to concentrate, tired and low in energy. She had been experiencing these symptoms, along with heavy menstrual periods, for some months. Ruth was referred to her GP for tests to explore anaemia, heart or other problems.

It was recorded that Ruth became anxious when Disability Living Allowance (DLA) was discussed and the health professionals felt that she was unrealistic with regards to her current ability to manage with no support. Ruth did not feel that she needed DLA despite having to be very tight on her budget. A plan was made for HP4 to look into Ruth’s DLA application “*which she has signed off for several months now*”, and to get a mobile phone as “*part of her section 117 aftercare*”. Ruth does not appear to have ever been detained on a Section 3 of the MHA 1983, so would not have been eligible for section 117 funding. Consideration was given as to whether Ruth should be allocated a support worker; this would be discussed at a multi-disciplinary team (MDT) meeting. There is no evidence to determine whether this MDT discussion took place.

Within a week of referral Ruth attended the GP surgery and an EEG and blood tests had been undertaken. She was found to be anaemic and iron was prescribed to her from 16th April 2009 onward.

April 2009 – May 2010

Ruth continued to pick up her monthly prescriptions during this period.

Ruth was seen by HP2 and HP3 on 21st July 2009. Ruth was concerned about her irregular periods and is described as at times “*distracted*” during the appointment. Ruth is reported to only be in receipt of Income Support. She did not want a mobile phone. It was recognised by the health professionals that Ruth was not very good at engaging with services and placed together with a concern about her unrealistic view of her current abilities it was decided that Ruth would be discussed in the multidisciplinary team (MDT) meeting for potential support worker allocation and perhaps Assertive Outreach Service (AOS). Ruth was offered advocacy and “*various networks*” but was reluctant to consider this.

There is no evidence to determine whether this, or the previous, MDT discussion took place. There are electronic medical records (Eplex) to suggest a home visit was attempted but Ruth was not seen and did not respond to messages.

Ruth's next appointment with HP2 was scheduled for 27 January 2010. She did not attend. HP2 and HP4 recorded that they tried to visit Ruth at her home as they had not seen her since July 2009. The visit was "*unsuccessful*". HP4 was left to try to contact her. HP2 was leaving the trust.

Ruth attended her annual mental health review with her GP on 5 February 2010. She had her bloods taken again shortly afterward and was found to still be anaemic. On 9 March 2010, she told the surgery healthcare assistant that she was not taking her iron supplements. She was advised to do so and another blood test booked for 9 days later, a slight improvement in her anaemia was noted. The GP wrote to Ruth re iterating how important it was to take iron supplements.

On 27 April Ruth reported a faulty handrail and repairs were carried out.

Ruth's rearranged out-patients psychiatry appointment took place on 4th May 2010. She was seen by HP 6, a locum consultant. HP6 noted that she appeared "*stable in her adaptation*", giving a positive view of how she was getting on, she said that she was not drinking alcohol, and was "*getting by*" on her benefits. She described her accommodation as "*pretty rough...but I can get 4 hours sleep.*" HP6 was concerned at how isolated she was. HP6 asked if Ruth wanted to continue to be seen in the outpatients' clinic, Ruth said that she did, she is recorded as not being comfortable with being discharged. HP6 thought that "*it came across very clearly that she appreciates the contact this affords with our service, although plainly she is not receiving very much input from secondary mental health at the moment*".

June 2010 -January 2011

Ruth continued to pick up her monthly prescriptions during this period.

Ruth was seen by her GP surgery nurse practitioner on 1st June 2010. She again disclosed that she was not taking her iron supplements and was encouraged to do so. A further blood test on 25th June showed that her iron levels had improved and indeed continued to improve at every blood test in July and October. Her GP reviewed her medication on 8th October; Ruth said that she was happy on her medication and continuing to take iron.

Ruth was offered a heating upgrade by the Plymouth Community Homes gas team on 7th October 2010 but she refused gas heating.

On the 19th October 2010 Ruth attended an outpatient's appointment with HP7, the fifth consultant to see her, and the consultant she was to see until her death. HP7 assessed that Ruth had some thought disorder, odd speech content and ideas that were difficult to understand as they appeared jumbled. An example of this was that her parents did not

exist. HP7 discussed his assessment with HP1 and concluded that *“Ruth was not very different to usual”*.

On the 2nd of December 2010 Ruth’s neighbour called the police to express concerns that he had not seen or heard Ruth *“all day”*. The attending officer gained police held information regarding Ruth’s mental health issues and previous police contact. Attempts were made to gain entry via key holders including the council to no avail. Hospital checks were confirmed negative. Entry was forced to find Ruth in a cold house, curled up in a ball and with medication *“all over the room”*. An ambulance was requested and attended. The ambulance crew noted that, *“on arrival Ruth was lying in bed, and denied taking any tablets. The flat was described by the crew as very cold as there was no heating there. “Assessment undertaken and clinical observations noted. Ruth was assumed to have capacity, denied taking any overdose, denied any pain and felt well in herself. Left at home.”* Ruth told the crew that she had been seeing mental health services but that *“this had lapsed”*.

The ambulance crew notified the Devon Doctors out of hour’s service of events. This was the mechanism used in Plymouth at the time to inform the patients’ GP. The crew also recognised that Ruth was vulnerable and completed a SWASFT Vulnerable Adult referral form which was then faxed to the SWASFT Safeguarding Team who faxed this to the GP and Adult Social Care the following day. The referral asked for a review by the Mental Health Team and that noted that the flat needed heating. The referral was made without Ruth’s consent.

The police remained in attendance until the ambulance service had left and the lock was repaired. They were also aware that the ambulance service had made a referral to adult social care.

Ruth’s GP notes record the notification from out of hours GP as follows: *Out of Hours GPs – call 11pm: Welfare concern; no heating, Vulnerable adult, Ambulance called. Health checks completed no problem. Not admitted to hospital.*

There is no record of the receipt of the referral by adult social care. However, in HP4’s testimony to the coroner’s court after Ruth’s death she reports that she was told of the referral by the PCT adult safeguarding lead by both telephone and email.

HP 4 visited Ruth on the 6th of December. She appears to have made no notes on Ruth’s record regarding this visit but other reports that HP4 gave after Ruth’s death state that on that visit she found Ruth’s *“mental health slightly deteriorated than when I had last seen her previously but not warranting HTT (Home Treatment Team)”*. Ruth accepted HP4’s offer to drop off an electric heater which she subsequently did. In HP4’s testimony in the coroner’s court she said that she had found Ruth’s flat *“quite sparse”* in comparison to her previous accommodation.

The 11 January 2011 outpatients clinic note written by HP7 listed the concerns identified by HP4 on her visit to Ruth’s home: *Flat has become sparser than before; no flooring, won’t let*

people in to test gas heater; not bathing; no cooker; drinking again; left door open, bought man back. Neighbour has contacted police.

At this point the evidence is that Ruth is self-neglecting. She is also drinking alcohol and engaging in risky behaviours.

Ruth's parents were also concerned about her welfare when they visited her in December 2010. It was a very cold winter and they waited outside Ruth's flat for some time. She came down the street, wearing cotton clothes with no winter shoes or gloves. Her hair was short but not shaved on this occasion. She looked bizarre. Ruth had usually dressed well, was well groomed and wore make up. Ruth's father phoned HP4 but heard no more afterward.

Ruth's next outpatient's appointment was bought forward to 11 January 2011 from the 25 January. HP4 and HP7 were both present. The GP was subsequently updated that Ruth *"had become more reclusive and that there were concerns about her self-care within her home, which had no heating during the cold December"*. HP7's letter reported that *"she struggled to express herself coherently and there remains a degree of thought disorder"* but that *"there were no acute risks of harm to herself or anyone else that would necessitate a more dramatic approach and I am aware an over-intrusive approach with Ruth leads to increased disengagement from her"*. Ruth did agree at this appointment to consider a period of support for help around the house and with her finances. Accordingly, HP7 sent an email to the Community Mental Health Team (CMHT) assistant clinical manager, HP4 and a community care worker on 12th January 2010, requesting involvement and a period of *"general support"* including help with her finances. The community care worker was employed by Plymouth City Council but based within the Community Mental Health team (CMHT), day to day allocation of work and supervision was provided by the CMHT team manager.

What actions were taken as a result of this referral is not recorded. However, the community care worker involved did have an appointment to meet with Ruth on the 25th January in a diary but the planned meeting did not take place. The community care worker believed that the meeting was cancelled as Ruth had changed her mind about accepting support. HP7's report written for the Coroner on 14 September 2012 reported that

"An attempt to engage her with a further worker in the form of a Community Support Worker was unsuccessful as Ruth did not wish for any additional support from our services".

This would seem consistent with the belief that Ruth had changed her mind about getting further support from mental health services. No further risk assessment or plan was made to address the now recognised difficulties Ruth was having in managing her everyday life.

March 2011 – Feb 2012

Ruth continued to pick up her monthly prescriptions during this period.

The next psychiatrist out-patient appointment was scheduled for 29th March 2011 but on the 21st March 2011 a letter was sent to Ruth cancelling this appointment and it was rescheduled for 25th May 2011. Ruth did not attend. HP7 was the lone worker for that appointment and he did not update the GP as to Ruth's non-attendance.

Ruth had a blood test at her GP surgery on 30th June 2011; her iron levels were now normal but she agreed to continue taking iron for the time being.

Ruth had an outpatient appointment with her psychiatrist, HP7, on 5th July. Ruth had not been seen by her psychiatrist, the lead professional, for six months, despite the concerns of January 2011.

Ruth reported that she no longer had a cooker as she burnt things and used a microwave instead; she was not using drugs or alcohol and had occasional contact with her family via letters. Although HP7 observed that her thoughts remained a little jumbled, she appeared *"more appropriate generally"*. HP7 had the impression that Ruth was fairly stable and settled in herself, she lived an isolated and limited lifestyle but said that she was happy with this and declined any further support to look at her living situation or benefits.

On 8th August 2011, the Plymouth Community Homes gas team attended Ruth's flat to carry out a gas safety check. Ruth advised them that she had no gas appliances and did not require gas.

Ruth attended a planned outpatient's psychiatry appointment with HP7 on 1st November 2011. A medical student was also present. Ruth confirmed that she was still taking her medication but expressed a wish to one day come off prescribed drugs as they did leave her feeling sedated. HP7 described his conversation with Ruth about her lifestyle, he records that her *"somewhat isolated lifestyle helped her to feel more in control and stable within herself"*. Ruth reported that she occasionally had mild experiences of being uncertain of what is real, but was able to rationalise and manage these more appropriately, these occupied a small part of her life. Ruth reported that she had food and heating for the winter and she felt she was functioning well on a day to day basis. HP7 recorded that Ruth's *"mood was generally euthymic and reactive and her thoughts more clearly ordered than I have ever seen before. There is no evidence of any active psychosis and no thoughts of harming herself or anyone else. She appeared to demonstrate a good degree of insight into her situation and a happiness to continue to work with us in outpatient clinic"*. HP7 advised the GP that the risks around Ruth's situation at the moment appeared minimal.

On the 29 November 2011 Ruth's father telephoned HP4 to express concerns about her financial situation. He was concerned that the rules around claiming Disability Living Allowance (DLA) had changed; claimants had to attend an interview, and thought that Ruth was unlikely to do this. Ruth's father says that he was reassured by HP4 that she would contact the Department of Work and Pensions (DWP) and sort this out. No record was made of the telephone conversation or any actions taken by HP4, however she did subsequently

acknowledge that she did have this discussion with Ruth's father and agreed that she would find out if there was a possibility of Ruth being able to receive DLA without a face to face interview. At the time, people with serious mental health conditions might, if well evidenced, receive DLA without undergoing a face to face interview.

Ruth's father telephoned HP4 again on December 20th 2011, to report that he and his wife had met with Ruth. They were extremely concerned. Ruth's mental and physical health appeared to have declined dramatically since they last saw her. She had shaved her head. She wore men's clothing which was very unusual for her. They thought she was "*very thin*" and had poor dental hygiene. She was "*mentally unfocused*" and was talking incoherently. The winter was very cold. Ruth did not want them to enter her flat but saw them in a café nearby. This was the last time that they saw Ruth alive.

There is no record of the conversation with Ruth's father in Ruth's notes. HP4 made no follow up visit. This information does not appear to have been shared with HP7.

Ruth attended a planned out patients psychiatry appointment with HP7 on 14th February 2012. A medical student was once again in attendance. Ruth reported an "*uneventful Christmas*" and said she had contact with her parents during this time. HP7 recorded that Ruth was "*Well dressed and groomed and sat comfortably throughout the interview.*" "*Mild degree of thought disorder but no overt delusions and no ideas about harming herself or other people*" "*accepting that her medication, including her risperidone has contributed to her long-term stability*" He planned to review her care in four months' time, leaving her medication unchanged. This was the last time that Ruth was seen by secondary mental health services.

March 2012 – September 2012

Ruth continued to pick up her monthly prescriptions during this period. There appear to be gaps in May and in August 2012.

Ruth attended her GP surgery for bloods and a blood pressure check on the 21 May 2012. Both results were described as "normal"

On the 6th June 2012 police were called to Ruth's flat after her neighbour expressed concerns about her welfare. He had "not heard her" for several days. The police ascertained from previous contacts that Ruth had alcohol issues and a diagnosis of schizophrenia. They attempted to contact her next of kin "*to no avail*" as they could get no reply from Ruth the police forced entry to the flat. "*Ruth is fine- no concerns-said she is going back to bed shortly and said she has been quiet over the weekend*". There is no description of any concerns for R or any need for other agencies to be involved. There is no linked intelligence to show that a referral was made and mental health services appear unaware of this incident.

On 21st June 2012 Plymouth Community Homes repairs team were called to replace the Yale lock at Ruth's address. The reason for this is not known. It may have been related to the

police forced entry of the 6th June, but this seems some time to wait for a new lock, Plymouth Community Homes repairs teams are available out of hours if needed.

Ruth did not attend her planned outpatient psychiatry appointment on the 21st July. Her GP does not appear to have been informed of this by HP7.

At 7.30 pm on 2nd September 2012 Ruth's neighbour contacted the police expressing concern that he had heard noises the day before from Ruth's flat but no sound since. Getting no reply Officers forced entry and found Ruth "*possibly deceased*" with "*several empty vodka bottles*" and medication laying around her. The police called an ambulance. On arrival of the ambulance crew they noted that Ruth was lying on the floor, both rigor mortis and hypostasis were evident. Ruth had been dead for some time. There was evidence of alcohol and some tablets at the scene as well as hematemesis (vomited blood) in a bucket. Ruth's parents identified her body later that day.

On 4th September 2012 HP7 was concerned that Ruth had not arrived for her outpatient's appointment. He wrote to her GP and asked if Ruth was still picking up her medication and if the GP had any concerns. HP7 also asked a member of the CMHT to call on Ruth as she had missed two outpatient's appointments in a row". The mental health service was informed of Ruth's death on September 5th 2012.

Ruth's father has stated at the coroner's full inquest and on interview that when he entered Ruth's flat after she died he found that Ruth had no bed or mattress; she was sleeping on the floor. She had no heating, no TV, radio or means of hearing music, no curtains or floor coverings, no books. She only had a kitchen chair, a small kitchen table, a microwave and refrigerator. It seemed to him that Ruth had been giving her possessions away over a period of time. Indeed, there was a note arranging for the kitchen chair, table and microwave to be picked up on the 11th September.

The inquest into Ruth's death was opened on the 5th September 2012. The full inquest was heard in early July 2013.

The cause of Ruth's death was stated as pneumonia and pulmonary embolism. The toxicology report came back showing "potentially fatal ketoacidosis". The potential causes of this were suggested at her inquest by the consultant pathologist who examined Ruth's body. He stated that as diabetes was not an issue for Ruth, then the two other common causes, excess alcohol consumption and starvation, were possible explanations. Toxicology tests showed no evidence that Ruth was taking her prescribed drugs, however it was also stated that this may have been that she had not taken them in the last day or so. No "acute alcohol consumption" was shown in the toxicology tests. Ruth had neither alcohol or her prescribed medication in her system when she died.

The coroner recorded a narrative verdict, "*she was malnourished, and on the balance of probability had previously consumed significant quantities of alcohol. Post mortem evidence*

was that she had ketoacidosis. On the balance of probability, she was not taking her medication Risperidone. She had neglected herself”.

7. Post scoping period:

Ruth’s parents made complaints to mental health services in April 2013 and March 2015 regarding the care given to Ruth. Mental Health services commissioned an independent report which has informed the Livewell individual agency report and the SAR overview report. The Health Ombudsman Report (2016) on their decision regarding Ruth’s parents’ complaint has also informed both reports.

8. Key themes

There are six themes which emerge from examination of the circumstances surrounding Ruth’s life and death. These will be discussed below. Ruth’s death was attributed to “self-neglect”. The Care Act 2014 was not in place during the time considered and self-neglect was not therefore included in adult safeguarding arrangements. In 2006 Plymouth was one of the first local authorities in the UK to implement a procedure to address self-neglect, the Vulnerable Adults Risk Management Meeting process, or VARMM.

In analysing the themes which emerge from a consideration of agencies work with Ruth during the period in scope, the author has drawn on the research into effective responses to people who are self-neglecting (*Suzy Bray, David Orr and Michael Preston Shoot, various 2011 – 2015*). Each section is prefaced with a quote from the Michael Preston Shoot (2016) research into effective responses to people who are self-neglecting. This research was not available during the scoped period and would not have informed practice. However, it serves as a framework to analyse the responses of agencies to Ruth, and enables learning for the agencies currently working with people who self-neglect.

The six key themes discussed are:

1. How did agencies work together to support Ruth?
2. What assessments informed decisions about Ruth’s wellbeing?
3. How legally literate were assessors?
4. How were relationships with Ruth created and maintained?
5. What interventions were considered?
6. What was the organisational context in which these events occurred?

8.1 How did agencies work together to support Ruth?

“multi- agency involvement, with the team around the adult bespoke to that person’s needs and the type of self-neglect involved”; Preston Shoot 2016

Before considering how agencies may have worked together to support Ruth, it is helpful to consider how agencies understood and enacted their role and responsibility toward her as a

person who had both mental health and substance misuse issues which affected her everyday life. The primary agency involved in supporting Ruth can be identified as the mental health service. Ruth's case was open to secondary mental health services throughout the scoped period. At the beginning of the scoped period Ruth's care plan under the CPA documented that she had monthly visits to her home from her care coordinator (HP1), six monthly appointments with her psychiatrist and annual reviews with her GP. Once Ruth was discharged to standard Care she was seen by a psychiatrist for two or three interviews a year. The four CPA policies in use between 2006 – 2012, confirm that

“Each of the policies describes who will be the care-coordinator and what the responsibilities of that role are. When Ruth was stepped down to standard care from Enhanced CPA the policy followed Department of Health Guidance that where the client has standard needs and has contact with only one professional, that professional will in effect be the person who coordinates their care. When HP1 took the planned step down from her role as care coordinator, the consultant psychiatrist HP2 took the role”.

As can be seen from the key episodes in section 7 above, Ruth's isolation, difficulties with daily living and signs of deteriorating mental health, did result in three psychiatrists, HP5, HP2 and HP7 stating that they would discuss support for Ruth from the multidisciplinary team that they were part of. It is unknown if those discussions took place. HP7 did make a referral to the relevant community mental health team in January 2011 for a *“period of general support”* but it does not appear that Ruth met with the allocated support worker after she changed her mind about being supported.

The role and responsibility of HP4, introduced as a response to Ruth's parent's complaint in May 2008, was outlined in a written agreement shared with Ruth's parents. It appears to have been agreed that HP4 would attend outpatient appointments only, to share information with Ruth's parents and address some of their concerns about Ruth's social isolation. At the time of the agreement, HP4 was the team leader of the team managing Ruth's care. HP4's role was described as to *“Support the therapeutic relationship between Ruth and HP2 through OPA (outpatients' appointments) on a three monthly basis, this not requiring HP2 to be involved in any information sharing unless clinically indicated through risk”*

HP4 is *“to attend OPA and use this opportunity to approach and explore Ruth's current social circumstances and to continue to promote engagement with social supports and networks. Following the OPA I shall be available to you to contact me to produce up to date information with limitations. Primarily this will consist of clarification that Ruth has attended OPA.”*

Ruth agreed to this arrangement but it is unknown what she thought about it and how this affected any relationship she may have had with HP4.

HP 4 attended Ruth's OPAs in November 2008, March 2009, January 2010 (Ruth did not attend) and January 2011, after she had been asked to visit by the PCT adult safeguarding lead. In March 2009 HP4 had left the team covering Ruth's area and took up a post in another CMHT. No arrangements were made for another health professional to take over this role. Whilst Ruth was not on HP4's case load, it appears to have been expected by mental health services that she would continue to honour the arrangements agreed in May 2008. It was HP4 who was contacted by the PCT adult safeguarding professional lead and asked to visit Ruth in December 2010 after a vulnerable adult referral was made by SWASFT. HP4 had not seen Ruth for the previous 21 months. It is unclear why HP4 was asked to visit Ruth. HP4's involvement may have given a false sense of extra support to the Trust, but in reality, her role was insufficiently defined or supervised. The arrangements for contact with Ruth's parents could not consistently fulfil their purpose because Ruth's parents did not know when Ruth was having an appointment, and HP4 made no arrangements to phone them after any appointment. Whilst the arrangement was made in 2008, Plymouth Community Healthcare agreed with Ruth's father in September 2014,

"that the arrangement was authorised and agreed by the service management of Plymouth Teaching Primary Care Trust (PT PCT) in 2008 and at the time of transfer to PCH on 1 October 2011 all previous commitments would have been transferred as part of these new arrangements.... That the agreement was in addition to and outside of the usual care programme approach and therefore fell outside of the usual policies and supervision procedures and did not identify your daughter as being under the care of HP4 for monitoring purposes.... No electronic Epex record was made of this arrangement although a copy of the letter dated 11 May 2008 was available in the file....HP4 was not recorded as the care coordinator and the letter of 11 May 2008 was not copied to the team manager (sic)".

The role of the GP is fairly clear with regard to Ruth, although there is a slight difference of emphasis in the letter sent to the GP by HP1 when Ruth was discharged from CPA, and what the GP has recorded. The GP surgery has recorded that they should contact the mental health services should she fail to pick up her prescription. A letter was sent to the GP by HP1 requesting that they should *"contact mental health services should s/he have any concerns regarding Ruth or if Ruth fails to collect prescriptions."* The GP surgery recorded every month that Ruth was picking up her prescriptions. Whether Ruth was taking her prescribed psychiatric medication or not is unknown. The GP surgery responded well to the referral of March 2009 regarding Ruth's feelings of tiredness and dizziness. Ruth's bloods were monitored and encouragement given to take iron. Ruth did respond to this, attending appointments related to blood tests and becoming compliant regarding her iron intake.

The Police attended Ruth's flat or had contact with Ruth on six occasions before her death, two just prior to the scoped period and four during the scoped period. Mental health services were not informed by the police of Ruth's arrest on 12 March 2007 for being drunk in a public place or of police intervention on 20th March 2007 when Ruth was drunk and

could not remember where she lived. Police did not report their attendances at Ruth's flat, on 10 June 2007, 3 April 2008 or 6 June 2012, to the mental health trust. Indeed, there appears to have been no arrangement with the police from mental health services to do so. On these occasions, the police had no concerns about R's welfare, and although they were aware that she had both mental health and alcohol problems, no indicator had been added to the police system requiring any action.

Ruth did not on those occasions, meet the criteria for referral under "No Secrets" and so was not passed onto the Devon and Cornwall Central Referral Unit (CRU) for information sharing. At the time in scope, there was also an expectation that individual officers would refer individuals needing support directly to adult services themselves. The police agency report writer has identified that some individual officers working at the time recalled rarely using the CRU and referring directly themselves, others stated that making a referral to adult services themselves was very unusual. Referral pathways for the police to use were not clearly defined. It was clear to the police that Ruth's neighbour thought her vulnerable and at risk of harm because of her lifestyle and mental health, however they identified no other agency or person that may need information about their contact with her. Police fulfilled their responsibilities of the time to take positive action to ascertain and confirm Ruth's immediate welfare and, if she was unable to protect herself, to take protective action by arresting her (March 2007) or calling an ambulance (Dec 2010).

Plymouth City Council were responsible for providing Ruth's housing until November 2009. They are unable to identify any evidence that Ruth was flagged on their systems as a vulnerable person or a person with mental health issues. There does appear to have been some historical contact between the Council Housing services and Ruth's care coordinator recorded on a paper file. Plymouth City Council did not inform the mental health team that Ruth's gas supply had been cut off in 2008. No external or internal repair or service contractor raised concerns about Ruth's well-being or living conditions. There does not appear to be an expectation at the time that they would do so. Ruth's rent was paid directly to the landlord, she was never in debt and never identified as needing any form of tenancy support. PCC records do not show whether they did or did not make contact with mental health team to advise them that the gas supply had been cut off.

Plymouth Community Homes records did not reflect if they identified Ruth as vulnerable after they became her landlord in 2009, or if they received any contact from mental health services to indicate that she was vulnerable, or that actions needed to be taken regarding her gas supply or heating/hot water. Had Ruth been identified as a vulnerable tenant she may have received support from a tenancy support worker.

Building up a picture of a person who is self-neglecting, and devising a plan to support them, is dependent on agencies being aware of their own and other agencies responsibilities and sharing information. After Ruth was identified as self-neglecting in December 2010, or later in 2011, no enquiries were made of external agencies by mental health services, no

framework for information sharing was put in place. The risk assessment which informed Ruth's discharge from CPA in 2007 cites receiving no information from her landlord or the police as a positive indicator. However, there was no agreement in place for these agencies to share any information with the mental health trust as part of a monitoring arrangement.

In December 2010, there were options available at the time that could be used to support agencies to share information and work together. A "step up" to CPA from standard care could have been considered by the lead professional when concerned about Ruth's deteriorating ability to cope with daily living and indicators of drinking, previously seen as related to a decline in her mental health. CPA provides a vehicle for information sharing and multi-agency working on assessed risks and on risk management. It is unclear why Ruth was not escalated from standard care back to CPA, particularly when the growing concerns of health professionals about her ability to cope culminated in the events of December 2010, and the referral to adult social care. Concerns about the risk of Ruth's "disengagement," if further interventions were made, began to be documented at this time, although the risk of disengagement is one of the indicators for a return to CPA for a person in a deteriorating situation. The responsibility for making a decision to escalate to CPA rested with HP7 as the lead professional, but he would have been informed by HP4 who was an experienced CPN and had visited Ruth at home. The response of the Health Ombudsman to Ruth's parents' complaint after her death notes that

"It is not clear why HP4 did not recommend an increase to Ruth's CPA level after the welfare check in December 2010 as there was evidence of significant social disability due to mental health problems.... Once it was known Ruth was experiencing social isolation, difficulties with maintaining daily living and self-neglect issues, the CPA level should have been increased and home visits re-started. Ruth's care was poorly co-ordinated and outpatient reviews were not sufficient in co-ordinating her overall care package".

The second option that could have been considered was the vulnerable adult risk management meeting (VARMM) procedures available at the time. Ruth could have been referred for consideration under the VARMM procedures on two occasions, in December 2010 and in December 2011. The VARMM procedures were implemented in 2006 after recommendations made in the "Fred" SCR of 2005. The procedures were devised by the Plymouth adult safeguarding lead officers group which had representation from the mental health service. The procedures were initiated on the referral of an adult who is self-neglecting and refusing services. This referral would initiate a vulnerable adult risk management meeting (VARMM), chaired by either the Plymouth City Council adult safeguarding lead or the NHS Plymouth PCT adult safeguarding lead. The meeting would arrange for the most suitable person to undertake an assessment of the person's capacity if needed. If the person has capacity to make decisions about their own care a process will set up to

- a) *Critique the Care Plan and discuss with a network of professionals alternative options for encouraging engagement with the Vulnerable Adult, i.e. consider which professional is best placed to successfully engage, - would the vulnerable adult respond more positively to a health or a voluntary agency professional.*
- b) *Having established an alternative / holistic Care Plan, the vulnerable adult's resistance to engagement should be tested by the re-introduction of the new plan by the person or the agency most likely to succeed (this would be decided at the Risk Management meeting).*
- c) *If the plan is still rejected, the meeting should reconvene to discuss a review plan. The case should not be closed just because the vulnerable adult is refusing to accept the plan. Legal advice must be taken as to a reasonable review plan, including time scales.*

The procedures go on to note that: *Applying this robust formula should ensure all reasonable steps are taken to ensure safety; ideally by a multi-disciplinary group of professionals. (VARMM procedures June 2007)*

The forms for the use of this process were available on the local authority system but not on the mental health electronic recording (Epex) system. Staff in post during the time in scope, report that VARMM was generally not well understood or used within mental health teams. Both VARMM and adult safeguarding were a local authority process in a local authority system, i.e. separate from mental health. Operationally staff tended to go toward a Mental Health Risk management meeting and CPA rather than use VARMM. They thought that VARMM somehow had a statutory status and was to be used as a last resort.

The adult safeguarding lead for NHS Plymouth during the scoped period describes her role as being an *"integrated health and adult social care adult safeguarding lead focusing on domestic abuse, public protection, MAPPA / MARAC, and adult safeguarding"*. From June 2007 to April 2012 she worked from both the Plymouth City Council adult safeguarding office and the PCT/NHS Plymouth office. This role is described as within the dedicated adult safeguarding team in the PSAB annual report 2009 – 2010. The lead had direct contact with care coordinators and team managers in mental health and adult social care teams during this time. Adult Safeguarding and VARMM training was multi agency and the use of VARMM encouraged. However, she acknowledges that mental health workers had a culture of preferring to use the known CPA pathway.

Adult care team managers working within the mental health trust would have had a better awareness of VARMM, but were not responsible for day to day allocation or supervision of cases so unless directly approached may not have been aware of cases of self-neglect.

Both the adult care safeguarding lead and the PCT safeguarding lead state that VARMM was used extensively until 2009 when a review and restructure of adult social care was initiated. A culture of “avoiding” VARMM and in doing so, avoiding consulting with the adult safeguarding team, arose. VARMM was held to be too time and resource intensive and staff were encouraged by their managers to seek care management solutions. This was a confusing time for staff, on one hand adult safeguarding leads across agencies were encouraging the use of the VARMM procedures, but their managers were not. Staff began to avoid consulting the adult safeguarding team for advice.

Neither of the safeguarding leads interviewed had any memory of Ruth or could account for why there are no notes about her on either the local authority adult safeguarding system or Epex system. It was usual practice at the time for the safeguarding lead to ask a practitioner who knew the adult referred to go out and assess the situation, and then report back to her. If the person was not thought to be eligible for VARMM the professional would be asked to continue to monitor the situation and refer back as needed.

Use of the VARMM procedures may have engaged the other agencies involved in Ruth’s life and enabled information sharing. Through the VARMM meetings there could be consideration of an assessment of Ruth’s capacity to make specific decisions, identification of a worker who was not part of mental health services to engage with her if this was felt to be appropriate together with a testing out of Ruth’s tolerance for intervention, and monitoring of her welfare.

8.2 What assessments informed decisions about Ruth’s wellbeing?

“sensitive and comprehensive assessment, including physical, psychosocial, environmental and social risk factors” Preston Shoot 2016

Risk Assessments. At each of Ruth’s outpatient appointments a risk assessment was recorded. No risk assessments are available after 19 October 2010. It is unknown if HP7 undertook risk assessments for Ruth. Risks identified and documented initially are almost consistently around Ruth’s use of alcohol, her relationships with family or friends, her abilities regarding daily living and having activity in her life. Ruth was documented as being isolated, “*preferring to live a solitary life*” and “*managing her own condition*”. The risks presented by Ruth’s decision that information is no longer to be shared with her parents, who had acted as reporters of concerns or were able to corroborate Ruth’s self-reports in the past, are not explored.

Alcohol use: Risk ratings regarding Ruth’s alcohol use, and the impact this had on her mental health and ability to cope with daily living, were dependent upon her self-reports after CPA ended and no further home visits, where her drinking habits may be observed, were made. In late 2007 Ruth said she had given up drinking and the risk rating for alcohol

use was removed. She was turned away from an outpatient's appointment in Feb 2008 as she was intoxicated. At her subsequent appointment the risk rating for alcohol use was entered as moderately severe. No alcohol risk ratings are recorded after this date and a letter to Ruth's GP from her psychiatrist note that she has "given up drinking in the last two weeks" and from 2009 onwards she reports that she no longer drinks any alcohol. The ratings used within the outpatient appointments record behaviours that have occurred or been reported within the last two weeks. Ruth's optimistic self-reports resulted in risk related to alcohol use being lost, and the consideration of the interaction between alcohol addiction and Ruth's mental health condition unexplored. Whilst it is noted by HP4 on her home visit on 6 December 2010 that Ruth is drinking again, the impact of alcohol on Ruth's mental health, and whether stopping medication corresponds with an increase in Ruth's alcohol consumption, is not tested or noted. From 2009 onward concerns about Ruth's cognitive ability and living conditions begin to be included in risk assessments, prompting the plans for MDT discussions by HP2 and 3.

Use of information from third parties: Concerns were reported to mental health services about Ruth by third parties, by her parents in 2010 and 2011 and in 2010 the SWASFT. These reports describe a woman who is struggling to maintain care of herself and her environment. Ruth's presentation and positive self-reports were relied upon by HP7 to reassure that Ruth was managing and no further intrusion into her life was needed. When HP7 saw Ruth for the last time in February 2012 he appeared unaware that Ruth's father had contacted HP4 to express his grave concerns about Ruth's mental and physical health only two months before. Ruth's own reports and good presentation appears to have been given more weight within assessments than the reports of third parties. This is despite previous clinical records that note that whether ill or well, Ruth is always "*well presented.*"

No multi agency information was sought or used by the mental health professionals working with Ruth to inform their risk assessments. Whilst Ruth's 2008 post CPA discharge risk assessment said that there had been "*no contact from police regarding Ruth's behaviour*" clarification was needed in terms of what that actually meant in terms of risk identification. Ruth was having contact with the police but mental health professionals knew nothing of this. Mental health professionals may have decided that they would not make enquiries of other agencies in order to uphold Ruth's right to confidentiality. But if no checks have been made decisions should not be based on the absence of information or contact. A false sense of security was created by the absence of contact.

Risks relating to Ruth's environment were also not accurately recognised within the risk assessments undertaken by mental health professionals. Ruth's lack of heating and hot water due to the capping of her gas supply in 2008 appears unknown to mental health professionals until the SWASFT vulnerable adult report of December 2010.

The risk assessment templates used at the time by the mental health team had no reference to self-neglect. In hindsight Ruth can be defined as severely self-neglecting. But it is unknown whether the professionals at the time clearly saw her as fitting a criteria of self-neglect. Ruth is described as living a certain “*lifestyle*”. The term self-neglect is not used to identify the pattern of concerns around her.

Plymouth City Council did not factor in Ruth’s mental health condition when capping her gas in 2008. This may have been because she had not been identified as having this vulnerability on their tenant system.

Physical Health risks:

The GP surgery responded well when given a physical health problem which needs diagnoses and treatment. Ruth appears to be part of the risk discussion, having tangible proof of the risks via blood tests and a clear route of treatment. However, there appears to be little holistic consideration of Ruth’s general health. She did attend GP annual health reviews until 2010 when they appear to have ceased. Her blood pressure was checked. NICE guidelines in place since 2009 (CG82) recommended that people with diagnosis of schizophrenia should have annual physical health checks which should include assessments of smoking, elevated body mass index (BMI), blood glucose control, blood lipids and blood pressure. National Audits of services to people with schizophrenia in 2012 (NAS1) and 2014 (NAS2) commissioned by the Healthcare Quality Improvement partnership found that annual physical health checks were often incomplete,

“Even monitoring of something as basic as a service user’s BMI was only recorded for 52% in NAS2 and 51% in NAS1”

Unless Ruth was identified as experiencing self-neglect there may have been little urgency to check her weight or other indicators of wellbeing. However, see 8.3, legal literacy, below, her physical health may have had an impact on her mental capacity and cognitive functioning.

Ruth stopped attending the GP annual health reviews after 2010. The GP who attended Ruth’s inquest said that this was not unusual; if people were being seen by the community mental health team then they would “*see these reviews as a little bit of a waste of time*”. Mental health services were not made aware that Ruth was not attending the GP health checks. No checks of Ruth’s physical wellbeing were made at her psychiatry outpatient’s appointment, attendance at an annual health review would have provided a far more holistic assessment of wellbeing.

In conclusion, Risk Assessments which may have informed a recognition of self-neglect and the need to escalate to CPA, or consider intervention to support Ruth, appear partial and reliant upon Ruth’s self-reports. In undertaking risk assessments, the mental health service appears to be operating within a silo and unable to extend its understanding of the risks in Ruth’s life by reference to relevant information that may be held by other agencies. The

home visit undertaken by mental health services in 2010 shows a worrying picture of a person not coping well, however no other home visits, which could inform further assessment, are planned. It is uncertain whether at that time mental health services were identifying self-neglect, or considering these behaviours as part of a person's "lifestyle," needing respect rather than respectful challenge.

8.3 How legally literate were assessors?

"detailed mental capacity assessments that consider and routinely review the person's executive capacity – the ability to implement and manage the consequences of specific decisions – alongside their ability to weigh up information and communicate decisions" Preston Shoot 2016

The use of the Mental Capacity Act 2005 is considered in this section. Throughout the period in scope Ruth was assumed to have the mental capacity required to make decisions about her own self-care, finances, environment and wellbeing. No capacity assessments were undertaken during this time. Ruth was assumed to have capacity to decide on her care plan in 2007 when she was stepped down to standard care. During 2008 a mental capacity assessment was considered after a complaint made by Ruth's parents. The Health Ombudsman report of March 2016 notes that senior managers say there is *'still doubt on Ruth's capacity'* and it appears there was a misunderstanding about who was to arrange the capacity assessment and a second opinion. The Mental Capacity Act was implemented nationally in 2007 but use of its provisions was slow across all professional groups. The Health Service Ombudsman notes that *"at the time that Ruth was discharged from Enhanced CPA in 2007 it was not common practice to formally record a patient's capacity to take decisions about changes to treatment. The Mental Capacity Act 2005 says capacity should be assumed unless there is good reason not to presume so"*.

An assessment of Ruth's capacity to make decisions about how she was caring for herself and to give consent for support, should have been considered after the events of December 2010 or, had HP7 been aware of Ruth's father's concerns, as part of a review in January 2011. The impact of Ruth's mental health condition on her capacity to make decisions at that point, together with the impact of her cold environment and physical wellbeing on her ability to make decisions, should have been assessed.

The academic literature of the time (Bray 2011) describes the necessity of considering both decisional and executive capacity, i.e. the person may be able to make a decision about certain actions, but not have the capacity to cope with the consequences of those decisions, to initiate or complete the actions needed. This may have been relevant to Ruth who had to contend with both the negative effects of schizophrenia, alcohol addiction, and at times being cold and malnourished. The understanding of the subtleties of using the MCA 2005 are unlikely to be fully understood by mental health professionals, or indeed most agencies, up until 2011. Explanations of mental capacity assessments within the VARMM procedures are simplistic, the practice experience and case law regarding use of the provisions had not

yet come into being. Those interviewed as part of this SAR have reported that the provisions of the mental capacity act were not well understood in the mental health teams.

Psychiatrists did have access to regular training programmes on the mental capacity act 2005 as part of their section 12 Approval/Responsible Clinician roles. Approved Mental Health Professionals (AMHPs) and psychiatrists would have had the better understanding of the requirements of the MCA 2005. However in terms of other members of the multi-disciplinary team, those interviewed thought that there was better understanding in adult social care. "AMHPs probably understood the best as they used the provisions operationally. There was some training for Mental Health workers but it seemed a challenge to frame the act within a medical model".

To assess Ruth as having the mental capacity to make specific decisions on the basis of what she said only, could produce a false picture of her actual capacity. She needed an assessment based both on her verbal explanations and on observation of her capabilities, i.e. *"show me, as well as tell me"*. An assessment of Ruth's mental capacity would need to consider her ability to implement and manage the consequences of her specific decisions, as well as her ability to weigh up information and communicate decisions.

8.4 How were relationships with Ruth created and maintained?

"relationship-building skills involving persistence, patience, expression of concerned curiosity and honesty, aimed at understanding self-neglect as part of this person's life journey" Preston Shoot 2016

If an adult is assessed as having the mental capacity to make a specific decision, a number of considerations must be made. Whilst capacitated adults are considered self-determining, and in law (MCA 2005) have the right to make unwise decisions, a duty of care still exists on professionals to explore why the adult is making an unwise choice and what can be done to support them in caring for themselves. Research (Michael Preston Shoot 2015) notes that professional interventions work best when they respect the right to make choices, but *"continue to explore the choices being made and the reasons for that, and to monitor risks and offer support as much as possible, with consideration of imposed interventions when risks cannot be kept within acceptable limits"*. Research against the unthinking promotion of independence and choice without adequate consideration of safeguarding (Scourfield, 2010; Fyson and Kitson, 2010; Preston-Shoot and Cornish, 2014) supports this contention.

In order to be able to work with a person who is self-neglecting and very reluctant to engage with support, it is necessary to create a relationship with them. There is evidence that, within the interviews she had with psychiatrists or HP4, attempts were made to explore choices with Ruth, about her no longer claiming DLA or having no access to gas, but these explorations were unlikely to be successful given the infrequent nature of the discussions, lack of relationship or knowledge of the true circumstances of Ruth's life. Ruth saw five different psychiatrists between 2007 and 2012, with HP2 and HP7 being the more consistent

figures. With no regular visits to her home and half hour or so interviews with the lead professional, it appears unlikely that the type of relationship necessary to develop some trust and ability to respectfully challenge Ruth could be developed.

Mental health professionals refer to Ruth being “reluctant” to accept support. From January 2011 the risk of Ruth disengaging from the mental health service begins to concern HP7, *“I am aware an over-intrusive approach with Ruth leads to increased disengagement from her”*. In November 2011 HP7 records that her *“somewhat isolated lifestyle helped her to feel more in control and stable within herself”*. A hypothesis was developed that Ruth did need to feel in control of her life and the people that came into her life, and that any over-intrusion was likely to result in her disengaging. The lead professional was uneasy about her situation, but because of a perceived high risk of “disengagement” accepted her reluctance to engage. The relationship that might be made to enable Ruth to reduce the risks of self-neglect was not attempted. A common finding in SCRs relating to self-neglect (Preston Shoot 2015) is that *“staff may feel disempowered by the constant refusal of help in a context where options are perceived to be limited. They may be disinclined to visit and yet feel very responsible for case outcomes. They may be unclear how to respond when a self-neglecting adult refuses to give consent for a referral”*.

Ruth was clear that she did not want the intrusion of mental health services in her life. However, she appears to have worked well with the GP surgery in addressing her anaemia, attending blood tests, being honest about her medication use and ultimately choosing to take medication. She does report repairs she is concerned about to her housing provider. These are small acts, but significant in considering who might engage with a person who has been clear that she does not want to engage with a particular service. Ruth was given options in 2008 on two occasions as to whether she wished to use the GP surgery or continue to see a psychiatrist at outpatients. On both occasions she chose to continue to see the psychiatrist. She had determined at which level she will choose to engage.

No agency had a continued relationship with Ruth which could be used to understand her reluctance and her specific rationale for the decisions she made about who will and will not enter her flat. In the written evidence examined, and the agency reports written, there is no sense of Ruth as a person. We do not know what her rationale was for disengaging with services, with her family, and leading an isolated life. Were these decisions influenced by the negative symptoms of her mental health? Her addiction? Previous experiences? How did this way of living make sense to her? Why did she dispose of all her belongings, and why was she so eager to dispense with her Disability Living Allowance? Was Ruth’s mental health indeed very poor at the time, but obscured by a positive presentation for the brief amount of time she saw her psychiatrist. Any interventions considered would have to be built on the understanding of how Ruth thought, and what she believed.

In conclusion, in order to maintain a compliant relationship and avoid “disengagement”, mental health professionals thought that they could not attempt any further relationship building with Ruth. This was not tested however, and the possibility of other agencies engaging with Ruth under the guidance of mental health professionals was not considered.

8.5 What interventions were considered?

“interventions that are primarily negotiated but accompanied by imposed solutions where necessary, building on the person’s own perception of their needs and situation”; Preston Shoot 2016

It must be acknowledged that working with people who self-neglect is fraught with ethical dilemmas and conflicts. Professionals are aware at all times of the importance of an adult having the right to be self-determining, to make meaningful choices, to be in control of their own lives. The mental health Recovery model supports this principle. Professionals are also aware of their duty of care, to protect from harm and reduce risk. At times, the direction of intervention can be weighted too heavily on one side or another, a balance must be observed. A duty of care may mean taking steps to impose a solution on a person at grave risk, i.e. use of the Mental Health Act 1983 to detain a person in hospital. But it also means the duty to challenge unwise decisions that are cumulatively putting a person at risk, and to persistently and patiently support them to reduce the risks they have created.

After the reports from Ruth’s father and SWASFT in December 2010, as above, either a return to CPA, or use of the VARMM procedures, may have allowed for creative interventions to be considered to begin to engage Ruth and support her to improve her ability to self-care. The GP surgery appears to have been able to do this by using the results from regular blood tests. Discussions between primary and secondary care as to the dilemmas around Ruth’s engagement and the perceived risk of disengagement may have been helpful. The Housing provider may also have been able to have provided support that Ruth would have perceived as not connected to mental health services. Tenancy support officers may begin relationships by helping with small practical matters to build trust. Independent advocates can “walk alongside” a person and, in understanding the person’s perspective, seek to respectfully challenge their decisions and motivate them to take action.

Ruth declined, either immediately or on reflection, the supports offered by mental health services. Whilst working as a single agency mental health could not arrange any other form of engagement.

8.6 The Organisational context.

“organisational arrangements that recognise that time-limited eligibility driven workflow patterns will not provide the continuity and space required to work with adults who self-neglect; and supportive but questioning supervision” Preston Shoot 2016

Mental health services underwent considerable change during the period scoped. On 1st October 2011 Plymouth Community Healthcare began providing mental health services in Plymouth. Prior to this mental health services were provided by Plymouth Primary Teaching Care Trust (until 2008) and then Plymouth PCT, also known as NHS Plymouth. Plymouth Community Healthcare expanded and changed name to Livewell South West in January 2016. The NEW Clinical Commissioning Group came into being in April 2013, for the previous eighteen months mental health services commissioning had been carried out by Plymouth PCT.

Prior to 2011 Plymouth City Council and Plymouth PCT (aka NHS Plymouth) were in a partnership to provide mental health services with the NHS as the lead agency. Adult care workers were employed by Plymouth City Council but co located with the mental health teams. Staff who were part of the co-located service at the time remember that it was uncertain what the governance arrangements of the time were. The procedures for the allocation and oversight of work, for example, were not explicitly articulated as part of a formalised partnership arrangement. As there were no procedures, day to day case work supervision was undertaken by the manager of the mental health team that any adult care worker was located in. Plymouth City Council, as the employer, dealt with the administrative aspect of the worker's employment, i.e. sickness, professional development and "*things of an adult care nature*", i.e. direct payments or reviews of care home placements. These aspects were the responsibility of the co-located adult care team manager, who also managed the Approved Mental Health Practitioner (AMHP) service. Between April – June 2012 social care workers were pulled out of the mental health teams and went back to Plymouth City Council. Teams were disbanded in stages.

The Livewell individual agency report describes a significant amount of detailed work at senior leadership level to create the new organisation during 2010 – 2011. During 2010 – 2011 all levels of the organisation staff were involved in a consultation process about the changes and were concerned about what it might mean for pension and employment rights. This was described as a significant change process and not something that staff who had largely been employed within the NHS were familiar with. In early 2012 the mental health directorate came to an end and the Community Mental Health Teams were redesigned and separated into five localities under the senior management of five Locality Managers rather than one Mental Health Director. This was part of a longer-term strategy to provide integrated holistic mental and physical health care in localities aligned with GP Practices, and was a significant change for staff working in those teams.

The impact on individual workers within the Trust of such a major change would have been significant. Reports describing HP4's situation note that post 2009.

"you had a heavy workload, had moved to a different locality and team and your working environment was undergoing a number of changes".

There is a potential for adults at risk to become “lost” during a period of organisational change as individuals and organisations cope with uncertainty and new ways of working (CQC 2012). The fact that HP4 continued to be seen by her own organisation as the liaison with Ruth’s family, and to have a role in Ruth’s care in the events of December 2010, increased the risk of inattention to Ruth’s situation. Ruth was not on HP4s allocated caseload and as such there was no “supportive but questioning” supervision about the case. It is unknown how HP7 would have had his practice supervised. HP4 does not demonstrate any sense of ownership of Ruth, this may have been seen as the role of the lead professional, and in 2011 she did not pass information onto the lead professional. It is impossible to know what other pressures or concerns existed for HP4, and what priority an arrangement made in a different team several years previously had in HP4’s work. It is unknown why HP4 did not hand over this responsibility when she moved teams in 2009.

Ruth also saw five different psychiatrists between 1st June 2007 and the 19th October 2010. A period of stability ensued from October 2010 to the point at which Ruth died in September 2012, but she had little chance to develop a relationship with them, or they to get a clear view of her functioning across several years. When the organisation was experiencing pressure from high caseloads and reorganisations, what priority was given to patients on standard care? What were the pressures around patients on CPA? The organisation was experiencing pressure from high caseloads and reorganisations; it is unknown what priority was given to patients on Standard Care or what the pressures were around patients on CPA.

Ruth’s housing provider also changed in November 2009 when tenants transferred over to a new housing association – Plymouth Community Homes. Staff and policies, together with the IT system, Northgate, were transferred. All the data used in the course of providing the landlord service was also transferred. It is unlikely that any of the information relating to Ruth was lost during the transfer. However this cannot be conclusively known as much information has now been destroyed. At any point of data transfer care must be taken not to lose vital information.

The assessment of recording practices across agencies is difficult as notes have been destroyed as part of agreed data processes by the police, housing providers and adult social care. Recording relating to the decisions made, for example the rationale for the decision not to refer Ruth in to a VARMM process, does not appear to exist. Whether this is poor practice on the part of the practitioner or symptomatic of a culture within the mental health teams at the time cannot be directly evidenced, however staff interviewed who were part of the mental health service at the time have alleged that there was a period when paperwork and recording were not up to date and timeframes were set around completion of documentation. Managers at the time have confirmed that some individuals did not keep their recording up to date, these individuals were dealt with via performance measures, and they do not believe that there was a widespread culture of non-recording. Recording the rationale for decision making around Ruth’s care would be particularly important as she was

seen so infrequently. There needed to be a clear account of concerns, decisions made and actions taken together with Ruth's response to this in order to inform the oversight of her care through the years.

In conclusion, Ruth appears to have been at her most vulnerable at a time of organisational change in mental health services. It is unknown what personal, professional and structural changes were impacting on the performance of staff at that time. It is not known what mitigators were put in place for service users during this change. It would appear that all staff had heavy workloads, the predicament of a woman on standard care, who had been known for many years, may not have the attention it needed.

9. Significant changes since 2012:

Since the events of 2007 – 2012 there have been a number of changes, both in internal policies and procedures, and in the configuration of organisations.

Police: In 2013 /2014 Devon and Cornwall Police undertook a Safeguarding Vulnerable People review of how all vulnerable people were dealt with. This was a significant piece of work which instigated changes across the force. The main change was the development of the vulnerability indicator screening tool, or VIST. This gave frontline officers a tool to identify vulnerability and assess the needs of an individual and the appropriate response. A Central Safeguarding Team was also developed to receive the VISTs, review these and share the information as necessary with other agencies. Police decision makers were put in place in a Central Safeguarding Team (CST) to speak directly to single points of contact within adult social services to discuss and assess cases and to agree an appropriate response. It is to be noted that currently in the Plymouth CST, should a VIST identify that primary health needs are required, including mental health and alcohol issues, contact will be made with the person's GP. The current safeguarding adult policy (2016) is based on definitions contained within the Care Act 2014, replacing vulnerable adult with adult at risk. The VIST widens the definition of who is vulnerable to "anyone who has been or believed to be at risk of harm, abuse or exploitation following consideration of their individual circumstances and who is or may be in need of support or intervention." The VIST allows officers to grade the risk and specifically identifies that it does not replace direct referrals to social services and that if cases are at the highest range of risk immediate action must be taken. The implementation of the VIST and the CST across the force was reinforced to all officers by a day's training on how to use the new form and system. A further development is frontline officers having handheld devices to be able to make inputs including VIST from an incident.

Devon and Cornwall Police have recently initiated a street triage pilot in Plymouth; the pilot went live on 1st June 2017. The service is available for police officers at any incident where mental health of a person is considered an issue; it does not have to be in the street.

The pilot service provides real time information sharing during office hours, to allow Control Room Managers to appropriately assess and manage risks around incidents where mental health may be a concern. During peak policing times outside of office hours an experienced Senior Clinician is positioned in the control room to assist staff and officers. The Street Triage mental health staff can and will, where possible and appropriate;

1. Access Mental Health records and advise on appropriate actions and measures
2. Make contact with Officers and advise on Mental Health conditions and subjects
3. Make direct contact with service users and subjects where appropriate
4. Deploy to scenes of critical incidents with the authority of the Force Incident Manager.

If the pilot works effectively, tenders for a provider will be invited in spring 2018.

It is hoped that the pilot will improve the treatment of those experiencing mental health illness who come into contact with police.

Devon and Cornwall police have also improved the flagging system used. In 2007 – 2012 a system was in place whereby an address could have a marker on it. From the beginning of 2015 the STORM log system enabled details of concerns and actions to be taken against individuals details.

Plymouth City Council – all adult care staff based within mental health teams returned to Plymouth City Council between April and June 2012. From 1st April 2015 adult social care provision was commissioned by Plymouth City Council from Livewell South West. The adult safeguarding function is retained by the local authority as it is non-delegable. The Plymouth City Council Adult Safeguarding team is the decision maker for which cases are eligible for adult safeguarding and all cases must go through this single point of contact. The team also manages a reviewed and updated risk management process, supported by a “creative solutions forum” with clear criteria for referral and multi-agency working. Like the VARMM process before it, this policy and procedure has been devised by a multiagency working group of agencies represented on the SAB.

Livewell Southwest – as above, now manages adult social care services in Plymouth. Adult social care staff moved across to Livewell and now work in integrated teams co-located across the city in four localities. Each consists of a core team which includes Social Workers, Community Care Workers, District Nurses, Health Visitors, Therapists, Long Term Conditions Nurses and Community Mental Health Teams. Livewell is implementing the “Triangle of Care”. This is an initiative developed by The Princess Royal Trust for Carers and the National Mental Health Development Unit. The aim of the Triangle of Care is to *‘improve engagement between professionals and carers by a therapeutic alliance between service users, staff members and carers that promotes safety, supports recovery and sustains wellbeing’*. The Triangle of Care self-assessment tool and action plan has been completed for the mental health acute inpatient service and Assertive Outreach service and is being rolled this out across all our Mental Health Services.

A further action to support clinical staff in using the Data Protection Act (1998) where there may be a risk to patients has been completed. This applies to patients who have made an advanced statement of wishes or have explicitly stated they do not want their information shared with members of their family. Since 2014 all staff have been trained for when a risk is identified that it is permitted to breach this confidentiality with the support of the organisation. This training is updated annually and training attendance is recorded and monitored. Staff have also had training in working with people who self-neglect and in using the MCA 2005.

SWASFT: In 2010, the South Western Ambulance Service covered the counties of Cornwall, Devon, Somerset and Dorset, this changed on the 1st February 2013 when SWASFT merged with the Great Western Ambulance Service and became known as The South Western Ambulance Service NHS Foundation Trust. It is one of the largest ambulance services in England, covering 20% of the UK geographically. Since the summer of 2015 in Devon, SWASFT have moved to electronic patient clinical records (ePCR's) which has seen a vast improvement (South West Audit, 2015 & 2016) in the quality of information contained within them. Clinicians are able to complete these referrals whilst with the patient rather than waiting to return to an ambulance station to use a computer.

Plymouth Community Homes (PCH). Since the date of housing stock transfer, PCH reports it has become more customer focused and inclusive when dealing with all customers. Staff from all service teams, including tradesmen, are expected to report any concerns with property condition or vulnerabilities with customers to their line manager in order for Tenancy Management Housing Officers to make contact with tenants. They can then offer support and help in any way that is deemed appropriate to ensure the tenant can sustain their tenancy, and maintain a level of personal stability. A method of checking that these concerns have been investigated has also been introduced so that none slip through the safety net. The results are then fed back to the staff member who raised the concern, thus underlining their importance in identifying such issues.

Since the period considered by this SAR, PCH now operate a rolling gas-capped list for all tenants who have chosen to have the gas supply to their home capped. This is to ensure the tenant has adequate means of heating and hot water. All PCH homes now have electric showers and electric/emersion heaters are offered to tenants who have chosen not to have gas central heating.

10. Learning event Outcomes: 3rd May 2017

10.1 In order to capture learning that is current and relevant, the Safeguarding Adults Review group decided to hold a learning event which would examine the emerging themes from the SAR in a contemporary context.

The lead reviewer worked with a group of 30 staff from the following agencies:

Plymouth City Council

Livewell Southwest

Devon and Cornwall police

Plymouth Community Homes

New Devon CCG

An Advocate from Plymouth Highbury Trust

The group worked with case studies relating to key episodes in Ruth's life, pausing to summarise and reflect after each case study. To minimise the risk of hindsight bias participants were not told the story of Ruth's entire life, the character depicted in the case studies was referred to by a different name and the timeline brought into the period 2011 to 2017. The group identified what is available and working well in 2017, where gaps might be, and started to design together some best practice principles to work together in similar situations in the future.

Practices, what works well, and gaps where there are concerns about the effectiveness of provision are described below:

10.2 Working together:

Police: Response to vulnerable people. Attending officers are expected to have a conversation with a vulnerable person, and if concerned complete a VIST for the purposes of information sharing with either adult care or the adults GP. If concerns are severe, attending officers will telephone adult care or community mental health teams as well as submitting a VIST. The VISTs go to a Police Central Safeguarding Team (CST) who review the RAG rating of the VIST using a national decision making model. CST records the rationale for their decisions, producing a record for each. A PCSO or beat manager can be asked to monitor the situation, particularly when there is a risk of anti-social behaviour or harm occurring to the vulnerable adult.

Devon and Cornwall police carried out a consultation in relation to the implementation of the VIST, but report that how engaged and effective the discussion was varied across the Force. One of the drivers for the implementation of the VIST system came from previous adult Serious Case Reviews, where the need was identified for an information sharing form from the Police. The process is intended to provide police information to partners, so that a more holistic picture of risk can be ascertained. It is not a tasking process. Consultation with GPs did prove difficult as GPs are organised into small surgeries and groups. However, since the VISTs inception the CST has received queries from some GPs and their representatives. The CST response to those queries is that the VIST information is for the GP to assess against their own information and make a decision on whether there is further action they can or need to take.

A number of concerns were identified about information sharing. It is uncertain what GP surgeries do with VISTS, how they record these and how they act upon them. Anecdotally GPs have said that they would like instructions within the VIST about what seems to be needed. The police cannot give such instructions. Ruth's surgery does have a system of recording and processing VISTS, but it is uncertain whether other GPs do. There has been no briefing for GPs on how to respond to VISTS, although it is understood that such an event will take place with lead GPs in September 2017. Adult social care has no one agreed location for storing VISTS and this valuable information can therefore be lost. Whilst the police have become far more rigorous in sharing information, the recipients of this information have not.

Housing providers are left out of the information sharing loop. They do not receive VISTS. They are not contacted by those agencies who do. Housing providers can be in a position to undertake work to prevent crises and the loss of services or tenancies, they can be in a position to monitor or support tenants in a variety of ways. Housing officers may visit a person weekly, dependent on the support they may need.

Agencies are reliant on adult safeguarding to communicate information across agencies. If a concern does not reach the adult safeguarding team or does not meet the threshold for a statutory section 42 enquiry it is unlikely that information will be shared with other agencies. This principle is consistent with the requirements of the Data Protection Act 1998 in situations where a person has not consented to information sharing. But when consent has been given, information could be shared in order to prevent harm occurring. Alternative information sharing pathways need to be considered in order to prevent harm; in addition, agencies must develop their understanding of consent and data protection, and not assume that because a concern has been referred to adult safeguarding, information sharing will follow. For example, an adult who disclosed mental health issues and had come to the attention of the police because of an alcohol related issue and low-level welfare concerns, would not be referred to adult safeguarding but may trigger a "green" information only VIST to adult social care. This would not be shared further as the adult safeguarding threshold had not been met.

Livewell are currently developing their initial access or "front door" team and will need to consider how they can direct and share information for the purposes of preventing harm.

Housing providers:

Gas and other services – Plymouth Community Homes record tenants who no longer have access to gas. The provider ensures that tenants have access to a means to keep warm and use hot water, and will work with the tenant toward having their gas re connected. Plymouth Community Homes also have a financial inclusion team which supports tenants to claim benefits and pay bills.

Agencies are often not aware of the implications for an adult at risk of failing to have an annual gas check, and what “gas capped” means. Plymouth Community Homes manage 50% of Plymouth social housing stock, but it is unknown whether other housing providers provide the same support to tenants who are no longer accessing gas.

If Plymouth Community Homes staff attend a premises to carry out repairs or change a lock, they are also now expected to check the quality of the person’s environment. The report would be logged internally and a report made to adult social care if there were concerns about the adults’ wellbeing.

10.3 Assessments and legal literacy.

Practitioners demonstrate a more developed understanding of mental capacity and what factors may impact on an adult’s capacity. There was an understanding of the difference between decisional and executive capacity, but a concern was that this understanding was thought not to be universally developed across all agencies.

Attendees thought that more emphasis needed to be placed on assessing what affected a capacitated adult’s coping strategies. An adult’s mental health, physical health, environment and addiction issues can all make it very hard for them to be resourceful and act on their understanding of how to look after themselves. Assessors must also understand the negative symptoms of schizophrenia and how this links to non-engagement

Holistic assessments were considered important, to explore the adults’ physical wellbeing, as well as her mental well-being. Tracking BMI in someone whose weight may be affected by medication as well as alcohol or self - neglect would provide an alert of concerns.

10.4 Relationships and interventions.

Practitioners thought that if an adult declined to engage with services offered then the implications of “mental capacity” must be understood. No participants mentioned that understanding the adults’ rationale for declining services was also vital. Practitioners recognised that when an adult is self-neglecting, relationship based work becomes crucial. Psychiatrists still have heavy workloads and a thirty minute appointment two or three times a year with a psychiatrist, is inadequate to either create a working relationship with a person who is severely self- neglecting, or to assess a wide range of potential concerns related to self-neglect. A support worker, or an advocate independent of mental health services, can move at the adult’s own pace on whatever area she can at that time be engaged on. Just one worker may be enough for an adult to cope with. There are a range of services now in existence which can engage adults at different levels, from a formal six week rehabilitation programme, a ReThink reablement programme, Options etc. However, practitioners commented that there are not “*enough resources to go around*”. It was thought to be important to plan how and who would engage with an adult, via a risk management meeting if there were challenges to engagement with the adult.

How is engagement considered? Adult Safeguarding may consider that an adult is “engaged” with a service if, for example, they attend an out patients appointments with a psychiatrist on three occasions a year. It is important that decision makers understand the types of service being provided to an adult, and check what the level of engagement indicated in using those services is. Attending two or three outpatient’s appointments per year may indicate compliance, but not engagement. No assumptions should be made. On the other hand, participants recognised the danger of one service labelling an adult “hard to engage” without consideration of the adults’ rationale for not engaging with that particular service. The label of “hard to engage” may result in other agencies believing that there is little point in attempting to do so.

Participants thought that situations of risk should not be managed by one worker or one agency, but a shared risk approach was more effective, particularly when the agencies involved discussed risk assessment and management at a face to face meeting. All agencies can call a risk management meeting and in this way, work out a plan together to work with the adult. If one agency will not engage with this process the local authority adult safeguarding team will provide advice and support. Awareness of this possibility was still thought to be low, all agencies had further work to do to develop a wider awareness of self-neglect and risk management processes.

11. Findings and key learning points

The findings and key learning points are drawn from both analysis of the events in the scoping period, and the outcomes of the May 2017 learning event.

11.1 How agencies work together to support people who self-neglect.

11.1.1 In the case of Ruth, agencies worked very separately and shared no information. There was no formal arrangement in place for agencies in contact with Ruth to flag up their interactions with her for the purpose of monitoring any concerns, although emphasis on the lack of contact from other agencies was used in risk assessments to indicate that that all was well. Agencies had no opportunity to complement each other’s work. Ruth’s self-reports could not be respectfully challenged with other third-party information.

Key learning points: Agencies must develop processes to share information to prevent harm. For example, an MDT can share non-clinical information with partner agencies, including housing and police colleagues, e.g. “open to CMHT” to trigger a more considered response, particularly when an adult is declining assistance or support. The Livewell front door service may be developed to support this as an integrated health and social care trust.

If information is being shared it should be clear, using words understood by all agencies and avoiding statements that lead to assumptions and labels, e.g. rather than “hard to engage” use “this agency has been unable to engage”. Finally, there needs to be clarity about the

individual's consent and what exactly can and cannot be shared amongst agencies. Certain information may need to be shared in order to reduce risk.

11.1.2 Currently, Devon and Cornwall police are using a VIST system to share RAG rated incident information with adult social care and the persons GP. However, these notifications may not be stored, retrieved or reacted to consistently across GP surgeries. If the VIST does not result in an adult safeguarding S42 Enquiry then information may not be shared by adult safeguarding. The VIST information is not consistently saved in the same location by adult social care so thematic information about risk may be lost.

Key learning points: The VIST system in Plymouth is now two years old. A multi-agency review would be timely to appraise the efficacy of the system. Receiving agencies must review how VISTs are stored, retrieved and reacted to, in order to achieve consistency of response. VIST pathways need attention. It is uncertain that VIST information is passed from adult care or GPs to mental health practitioners, so creating a risk that important information to prevent harm, or assess risk correctly, is lost.

11.1.3 The two frameworks which may have prompted information sharing and working together, i.e. CPA or VARMM were not used in Ruth's case, so reducing the focus on responding to Ruth's self-neglecting behaviour.

Key learning points: If there are concerns that to return to CPA may result in disengagement, and there are significant concerns about self-neglect, a risk management meeting under the Plymouth multi agency adult safeguarding risk management, self-neglect and hoarding policy and guidance must be considered. Agencies must remember that an adult safeguarding referral must be made when self-neglect is identified.

11.1.4 Currently, any agency may call a risk management meeting and will be supported by Plymouth City Council adult safeguarding team to do so. Awareness of these procedures is still low across agencies.

Key Learning point: All agencies must follow the Plymouth multi agency adult safeguarding risk management, self-neglect and hoarding policy and guidance published in May 2017. The SAB should consider how to audit these arrangements.

11.1.5 There was no provision within the City Council or subsequent housing provider to identify and take action to support Ruth when her gas supply was disconnected. This provision, together with the expectation that external and internal tradespeople should report concerns they identify to the provider, now exists in Plymouth Community Homes.

Key learning point: Good practices developed by Plymouth Community Homes must be demonstrated by all housing providers in Plymouth.

11.2 How Assessments are carried out to identify people who self-neglect

11.2.1 Recording practices were poor at the time that mental health services were working with Ruth, case notes were not kept up to date. Ruth was seen very infrequently so that

recording each episode became very important in looking at thematic trends across the years she was in contact with secondary mental health services, understanding why decisions were made about her care, and ensuring that agreed actions were followed up. If concerns and actions taken are not recorded then risk indicators across a span of time cannot be captured accurately and the context of a person's life understood. It must be remembered that documentation and record keeping is a key part of professional standards and is part of a professional duty of care.

Key Learning Point: Good internal systems to record concerns, as well as external information sharing, are needed. If referrals are made they must be followed up to see if anything has been done. Agency records need to be made close to the time an adult is seen and have good personal, physical and environmental descriptors to assist the next agency or worker to understand if a deterioration has occurred. A multi-agency self-neglect risk assessment and management recording template is needed to ensure that self-neglect is captured and understood consistently across all agencies.

11.2.3 The risk assessments relating to Ruth emphasised her clinical presentation, omitted any assessment of the impact of alcohol use on her life and were reliant on her self reports about her wellbeing. With one exception, a home visit in 2010, assessments did not take account of third party concerns about Ruth or observations of her environment, and did not use these reports or observations to “respectfully challenge” Ruth’s accounts or identify the need for action.

In the 2017 learning event workshop there was no confidence that all agencies are able to recognise and understand the risks related to self-neglect, the legislative frameworks available to use in these circumstances should engagement fail, or their duty to report concerns to the local authority under the provisions of the Care Act 2014. Participants thought that assessors should also understand the negative symptoms of schizophrenia and how this links to non-engagement.

Learning points: An “aide memoire” to help workers consider risk management and self-neglect is needed. Multi-Disciplinary Teams in mental health services must actively involve adult social care colleagues who will help to promote understanding of self-neglect across the team.

11.2.4 Assessments of Ruth’s physical wellbeing were not carried out unless a specific physical issue, e.g. possible anaemia, was identified. A recent report by the Kings Fund (2016) highlights the reduced life expectancy amongst people with severe forms of mental ill health, largely attributed to poor physical health. Ruth refused referral to specialist alcohol services, and her addiction to alcohol remained unaddressed throughout the period in scope. Her weight was not monitored regularly, and, although her parents expressed concerns about her nutrition, weight, poor dental hygiene and unhealthy condition, no holistic health checks were made. To address the reduced life expectancy of people

diagnosed with psychosis or bi polar disorder the Kings Fund recommends that with an integrated approach to physical and mental health:

“All mental health professionals would receive substance misuse training, and there would be much closer working with addiction services. More fundamentally, cultural change within the mental health workforce would mean that all professionals see promoting physical health as being an important part of their role”.

Whilst Ruth’s GP was responsive when physical health concerns were identified, there appeared to be no consistent attention to Ruth’s physical health.

11.2.5 Key Learning Point: The Clinical Commissioning Group and all “Strategic Co-operative Commissioning” (including public health) must work with Primary care services, public health and Livewell Southwest to consider approaches to how the physical, as well as mental, wellbeing of people with severe mental ill health is supported.

11.3 Legal literacy in professionals working with people who self-neglect

11.3.1 Professional understanding of the provisions of the Mental Capacity Act 2005 during the scoped period was limited to assuming capacity based on Ruth’s verbal account of her rationale for making decisions. The concept of executive capacity appeared unknown at the time. Ruth had made a number of decisions herself which resulted in her being cold, experiencing a loss of income, being poorly nutritioned and having no comforts in her life. Whilst her “*ability to cope*” with the results of her decisions was questioned, her capacity to do so was not, and a self-determining approach to the dilemma of whether to intervene in Ruth’s life predominated.

Currently, understanding of approaches to assessing capacity does appear to have improved but is not consistent across all teams and agencies. Further development is needed.

Key Learning Point: Whilst developing the awareness of the Plymouth multi agency adult safeguarding risk management, self- neglect and hoarding policy and guidance, there must be a focus on promoting competence in mental capacity assessments as well as an understanding of all the legal frameworks available, and where to get advice regarding these.

11.4 How are relationships with people who are self-neglecting created and maintained? What interventions are being considered?

11.4.1 Ruth was not engaged in a relationship with any agency sufficiently to enable work to support her to make changes in her life. In 2017, practitioners understood that relationships were vital to help effect any change in the life of a person who is self-neglecting, but varied in their understanding of how to use such a relationship.

Practitioners were certain that work to manage the risks of self-neglect must be carefully planned, and the person “owned”, by a multi-disciplinary meeting.

There was some confusion about “engagement,” practitioners mistook an agency being engaged with a person, with the person themselves being engaged with the agency. Ruth appeared “compliant” with mental health services, not engaged. The belief that a person is “engaged” can preclude any further work being done through adult safeguarding.

Key Learning Points: As above, awareness of the Plymouth multi agency adult safeguarding risk management, self-neglect and hoarding policy and guidance, including the Creative solutions panel, to be promoted and its use audited.

Consideration must be given as to how to enable more professional face to face meetings regarding people who self-neglect, and are at high risk or hard to engage, this will result in well planned and managed interventions. Housing providers must be part of risk management meetings as they need to be part of any management plan.

Training should be undertaken for staff at all levels, and across agencies, in motivational interviewing, and relationship based approaches to people who self-neglect, using a person-centred approach throughout all activities.

Contacts must be circulated in each agency as key links in self-neglect, to enable agencies to easily and quickly establish contact with each other.

Each agency’s role must be understood, including that of the police regarding the limits of powers of entry.

11.5 How do organisations promote work with people who self-neglect?

11.5.1 The last two years of Ruth’s life, when her self-neglect became more acute, corresponded with a time of extensive organisational change within the mental health service. In addition, organisational concerns regarding resources across both the local authority and mental health services, allegedly created a “disconnect” between practitioners and the multi-agency adult safeguarding team. Ruth did not have the focus she needed from the organisations working with her at the time. We do not know the organisational culture surrounding risk, supervision, escalation and performance targets in mental health services at the time in scope. Reference has been made to individuals’ workloads as being “high”. Currently psychiatrist workloads are still high. The resource available to mental health services along with all statutory agencies involved in this SAR is stretched.

Key Learning Points: Agencies must risk assess and draw up plans to mitigate the risk of service quality diminishing for all service users during times of organisational change.

Whilst a wider range of resources now exists that could be involved in mitigating the risks associated with self-neglect, practitioners said “there was not enough resource to go around.”

Both commissioners and organisation leaders need to consider how to support meaningful work with people who self-neglect, how workflows can be adjusted to either undertake meaningful relationship building work, or to support other agencies undertaking such work.

12. Recommendations for the consideration of the Plymouth Safeguarding Adults Board

Recommendations are drawn from the key learning points above and are multi agency, to be actioned and monitored through the Plymouth Safeguarding Adults Board.

Single agency recommendations appear in section 13 below.

12.1. Information sharing to prevent harm:

12.1.1. A harm prevention information sharing agreement should be agreed between agencies detailing when information should be shared, and how information can be disclosed in accordance with the Data Protection Act 1998. Third sector as well as statutory agencies should be included in the agreement.

12.1.2 The SAB will facilitate, and receive reports on, an audit of the efficacy of the Devon and Cornwall police local VIST system. The audit will include

- How VIST reports are received, stored and acted upon
- Whether the current pathways are effective, are agencies receiving VISTS sharing these with other agencies appropriately

12.2 How the Plymouth multi agency adult safeguarding risk management, self-neglect and hoarding policy and guidance is being implemented and supported:

12.2.1 Agencies must assure the SAB that they are implementing and using the Plymouth multi agency adult safeguarding risk management, self-neglect and hoarding, policy and guidance at appropriate intervals. Assurance will include:

- Referrals made to report a concern about self-neglect
- Risk Management meetings convened, attendance at these. Have third sector providers, including as appropriate housing providers, been asked to attend and attended
- Quality and number of multi-agency risk management plans initiated.
- Appropriate referral and attendance at the Creative Solutions Forum.
- Are agencies including development activities to promote competence in assessment of mental capacity (MCA 2005) as part of implementation of the policy and guidance?
- Are agencies quality assuring Mental Capacity Act assessments to ensure that executive as well as decisional capacity is being considered?
- Are agencies ensuring that each agency's role is understood, including that of the police regarding the limits of powers of entry?

12.2.3 The PSAB should consider the learning and development needs of staff using the Plymouth multi agency adult safeguarding risk management, self- neglect and hoarding policy and guidance. Training should be undertaken for staff at all levels, and across agencies, in relationship based approaches to people who self-neglect, using a person-centred approach throughout all activities. Training in motivational interviewing may also be useful for a range of staff.

12.2.4 The SAB should consider how self-neglect is identified and recorded. An “aide memoir” to help workers consider self-neglect and risk management will be useful. A multi-agency self-neglect risk assessment and management recording template is needed to ensure that self-neglect is captured and understood consistently across all agencies.

12.2.5 To enable agencies to easily and quickly establish contact with each other when there are concerns about self-neglect, contacts must be circulated in each agency as key links in self-neglect.

12.3 Organisation responses to self-neglect

12.3.1 The SAB must consider how each member organisation will support meaningful work with people who self- neglect, how workflows can be adjusted to either undertake meaningful relationship building work, or to support other agencies undertaking such work.

12.4 Organisation responses to managing risk during organisational change.

12.4 1. Agencies must risk assess and draw up plans to mitigate the risk of service quality diminishing for all service users during times of organisational change, these plans must be shared with the SAB prior to organisational change, for the purpose of scrutiny.

12.5 Relationship with the Department of Works and Pensions

12.5.1 The SAB should consider its relationship with the Department of Works and Pensions. Should the SAB be assured that the DWP in Plymouth are meeting their obligations to vulnerable claimants?

13. Recommendations for individual agencies

13.1 Commissioners responsible for the health and well-being needs of people with severe mental health issues.

NHS England, Clinical commissioning group, public health and local authority commissioners (the “Strategic Co-operative Commissioning team”) must work with Primary care services, public health and Livewell South West to consider approaches to how the physical, as well as mental, wellbeing of people with severe mental ill health is supported.

13.2 Commissioners who are members of Plymouth Housing Services Partnership Forum

Commissioners must promote best practice through the Plymouth Housing Services Partnership Forum to promote good practice in supporting tenants who have had their gas supply turned off, or who are having any difficulty managing their tenancy. These good practises must be demonstrated by all Housing providers. There must be an expectation across housing providers that external as well as internal tradespeople report any concerns about the wellbeing of tenants to the Housing provider without delay.

13.3 Livewell Southwest

The provider must ensure that community mental health teams are informed by adult social care workers and that adult social care staff are included in multi-disciplinary meetings. This will enable perspectives from staff who may be more experienced in working with adults who self-neglect.

14. Glossary of abbreviations used:

AOS – Assertive Outreach Service (mental health)

CCG – Clinical Commissioning Group

CMHT- Community Mental Health Team

CPA – Care Programme Approach

CPN – Community Psychiatric Nurse

CRU – Central Referral Unit (Devon and Cornwall Police) – pre-implementation of VIST process

CST – Central Safeguarding Team (Devon and Cornwall Police) – post implementation of VIST process

DLA – Disability Living Allowance

DWP- Department of Works and Pensions

GP – General Practitioner

HP- Health Professional

PCC – Plymouth City Council

PCH – Plymouth Community Homes

PCT – Primary Care Trust

PSAB – Plymouth Safeguarding Adults Board

SAR – Safeguarding Adults Review

SWASFT – South Western Ambulance Service NHS Foundation Trust

VARMM – Vulnerable Adult Risk Management Meeting

VIST – Vulnerability Indicator Screening Tool

15. References

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Fyson, R and Kitson, D (2010) *Human Rights and Social Wrongs: issues in safeguarding adults with learning disabilities*. Practice: Social Work in Action

Naylor et al (2012) *Long term Conditions and Mental Health*. Kings Fund

Preston Shoot, M. (2016) "Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work" *Journal of Adult protection*. Vol. 18 No. 3 pp. 131-148

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Scourfield, P. (2010) "Reflections on the serious case review of a female adult (JK)", *The Journal of Adult Protection*, Vol. 12 Issue: 4, pp.16-30.

Appendix 1 Terms of Reference:

Terms of Reference:
Plymouth Safeguarding Adults Board
Safeguarding Adults Review (SAR)
Subject: Ruth Mitchell

1. Introduction:

1.1 Ruth Mitchell was forty years old when she died at her home on 2nd September 2012. GP records list the causes of her death as bronchopneumonia and pulmonary embolism. It is reported that the pathologists report presented to the Coroner indicated a secondary factor of ketoacidosis, attributable to malnutrition to the point of starvation. In reports made at the time of her death, she is described as very thin and malnourished; of living in a flat with no curtains, carpets and barely any furniture, completely isolated socially and from her family; and living in poverty. Ruth's father reports that Ruth had been known to the local mental health trust since 1996, and at the time of her death was allocated to a psychiatrist and a community psychiatric nurse for on-going support.

1.2 This Safeguarding Adults Review (SAR) is commissioned by the Plymouth Safeguarding Adults Board (PSAB) in response to the death of Ruth. The review is conducted in accordance with the Plymouth Safeguarding Adults Board Safeguarding Adults Multi-agency policy & procedures, which is underpinned by the statutory guidance requirements of the Care Act 2014, namely that:

"A Safeguarding Adult Review is a review of the practice of agencies involved with an Adult at Risk, commissioned to facilitate agencies to learn lessons and improve the way in which they work. Any agency or professional may refer a case.

The purpose of having a Safeguarding Adult Review is not to reinvestigate nor to apportion blame, it is:

- *Lessons learnt - to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard Adults at Risk;*
- *Review of procedures - to review the effectiveness of procedures (both multi-agency and those of individual organisations);*
- *Improve practice:*
 - *To inform and improve local inter-agency practice;*
 - *To improve practice by acting on learning (developing best practice).*

- *Reports - to prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.*

*From the Plymouth Safeguarding Adults Board Multi-agency policy & procedures; updated August 2016:
3.21 Safeguarding Adult Review*

1.3 Principles which inform SARs

SARs should reflect the six safeguarding principles: empowerment, protection, prevention, proportionality, partnership and accountability. SABs should agree Terms of Reference for any SAR they arrange and these should be published and openly available. When undertaking SARs, the records should either be anonymised through redaction, or consent should be sought.

The following principles should also be applied by SABs and their partner organisations to all reviews:

1. 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 to promote good practice.
2. The approach taken to reviews should be proportionate. This could range from a single agency review to a multi-agency Safeguarding Adult Review, with an independent author and chair according to the scale and level of complexity of the issues being examined.
3. Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
4. Families should be fully engaged and invited to contribute to reviews. They should be supported to understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.

In addition, agencies are under a legal duty as PSAB partners to cooperate in and contribute to the carrying out of a review under Section 44 of the Care Act 2014 with a view to:

- a. identifying the lessons to be learnt from the adult's case, and
- b. applying those lessons to future cases

2 Scope and specific area of focus of the SAR:

2.1 Timeframe: 1st June 2007 until Ruth's death in September 2012.

Rationale: Ruth was discharged from care coordination in July 2007. The first recorded concern from her neighbour was in June 2007. Significant changes occurred in Ruth's care from mid-2007 onward.

2.2 The specific area of focus will be on how individual agencies followed agreed policies and procedures in working with Ruth: how agencies worked together in identifying and addressing concerns regarding Ruth's welfare; and how agencies and staff were supported to follow agreed policies and protocols.

3. Methodology:

The methodology used in this review seeks to promote a thorough exploration of the events prior to Ruth'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.

The methodology utilises a blended approach of systems-orientated models in order to maximise opportunities for learning in the specific circumstances of this review. Activities will include: collation of chronologies, individual agency reports, conversations with key staff, identification of key episodes, and a learning review event.

A SAR overview report will be produced including thematic analysis of findings, key learning points, and recommendations to the Plymouth Safeguarding Adults Board on any improvements identified in multi-agency working.

The process will be supported by an extended SAR sub group which will include senior representatives of the agencies described below.

The review will be informed by the adult safeguarding policies and procedures in place at the time within the scope of the SAR.

3.1 Family participation:

Ruth's father made a referral to the PSAB Chair in (*no date on letter but saved as 12/3/2015*), outlining the circumstances of Ruth's death and concerns about the care his daughter received in the years prior to her death. Other processes have been in progress since the referral was made but have now concluded, and the time now appears right for the Safeguarding Review to begin.

Ruth's family will be invited to meet with the independent reviewer to discuss the proposed terms of reference prior to the beginning of the SAR activity. They will also be invited to be interviewed to contribute background information for the Review, including information about Ruth and her life.

A second meeting will be held with Ruth's family once a draft of the overview report has been approved by the PSAB Executive. Findings, learning and recommendations will be discussed in order for the family to question or comment prior to final draft approval at Board. A written draft will be provided to Ruth's family prior to publication.

3.2 Key Agencies:

- Devon and Cornwall Police
- Plymouth Community Homes
- South Western Ambulance Services Foundation Trust
- Livewell Southwest
- Stirling Rd Surgery
- Plymouth City Council
- Department of Work & Pensions

3.3 Chronology:

Agencies will be asked to provide a chronology of any significant events and safeguarding issues in respect of Ruth. This could include a significant event that falls outside of the timeframe if this is considered significant to learning.

When agencies have changed names, roles and responsibilities since the scope of the SAR, for example for adult safeguarding, every effort must be made to identify records by agencies involved.

A report template will be provided.

3.4 Conversations:

Agency reports will be analysed to identify key individuals for follow up conversations. These will be conducted by the independent reviewer and an agency representative and follow the Social Care Institute of Excellence (SCIE) Conversation structures.

3.5 Key episodes and review meeting:

Key episodes will be identified from agency reports and conversations for deeper analysis. This analysis will be developed via a learning review event with report authors, managers and agency or organisations representatives. The perspective of the review event will be one of appreciative enquiry, identifying the learning from the key episodes together and formulating practice improvements.

Below are a set of initial questions which will form the basis of the Agency report template. Further questions may emerge following analysis of the agency reports, and of the individual conversations, which can then be explored within the review meeting or via other avenues if appropriate.

A briefing will be delivered to agency report authors on compiling the individual agency report.

4. General questions underpinning the agency reports:

EVENTS: Critically analyse and evaluate the events that occurred, the decisions made and the actions taken or not taken. Were there any missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn? Were agreed actions carried out? Where there any indications that practice or management could be improved? Try to get an understanding of not only what happened, but why.

POLICIES AND PROCEDURES IN PLACE AT THE TIME: Review the effectiveness of policies and procedures (both single and multi-agency). Were staff aware of these policies and procedures? Did they have management support and training to follow these appropriately?

WHAT WAS HAPPENING IN THE AGENCY AT THE TIME: Were there periods of transition or limited resource/capacity?

INTER AGENCY WORKING: Were processes and communication effective between agencies? Did each agency understand the role and duty of others? Were professionals proactive in escalating concerns and providing effective challenge when appropriate?

SUPPORT TO EFFECTIVE WORKING: What supervision and management oversight was provided during the period of the Case Review? Were these in accordance with the agency's policy and procedures?

IDENTIFY EXAMPLES OF GOOD PRACTICE, BOTH SINGLE AND MULTI-AGENCY.

IDENTIFY WHAT HAS CHANGED SINCE THE SCOPED PERIOD (2007 – 2012).

4. Proposed Timetable for Safeguarding Adults Review

Terms of Reference Agreed: by when

- Family Contact completed
- Letters to Agencies October 2016
- Agency Report Authors' Briefing November 2016
- Agency Reports Submitted January 2017
- SAR Sub Group Meeting to Quality Assure Agency Reports January 2017
- Conversations February 2017
- Learning Review Event
- First Draft of Overview Report to SAR Sub-Group
- Second Family meeting
- Draft to PSAB Executive

Appendix 2 Template for individual agency reports

SAFEGUARDING ADULTS REVIEW

INDIVIDUAL AGENCY REPORT

Subject of Report: Ruth Mitchell

Timeframe: 1st June 2007 until Ruth's death on September 2nd 2012.

INDIVIDUAL AGENCY REPORT

1. Introduction

1.1 This document is intended to provide a review of the decisions, actions taken and services provided to Ruth Mitchell, who is the subject of a safeguarding adults review instigated by the Plymouth Safeguarding Adults Board relating to the circumstances prior to her death on 2nd September 2012.

1.2 The aim of the individual agency report is to review the circumstances at the time; and to develop an open critical analysis of both individual and organisational policy and practice, to see whether the case indicates that changes could and should be made. If the need for change is indicated, to identify how those changes will be brought about. If a change in policy and practice has already occurred, to document this thoroughly.

1.3 The individual agency report provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the adult at risk.

1.4 The findings from the individual agency report must be quality assured and approved by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

INDIVIDUAL AGENCY REPORT

Safeguarding Adults Review in respect of:	Ruth Mitchell
Date of birth	13 th April 1972
Date of death	2 nd September 2012
Author of Report	Signature _____ Date _____
Agency	
Quality Assured and Approved by	Signature _____ Date _____
Date of Submission	

Date of revision, if requested	
Date of final submission	
Contact details: Author Manager for Quality Assurance and Approval	

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SECTION 7	Individual Agency Report Quality Assurance Form
Appendix 1	PSAB Safeguarding Adults Review – Terms of Reference

1. METHODOLOGY

Describe how you have set about compiling this report. List the sources of information that have been used. This will include paper records, electronic records, supervision notes etc. Do also include details of interviews undertaken with relevant staff. If it has been impossible to interview staff, or to locate records, please indicate this and describe why difficulties have arisen.

2. CHRONOLOGY OF AGENCY INVOLVEMENT

This will need to be completed on the chronology template provided - below

What was your agency's involvement with Ruth Mitchell?

Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the adult at risk over the period of time set out in the SAR terms of reference, i.e. 1st June 2007 – 2nd September 2012.

Where abbreviations are used, please provide a glossary to explain them.

Safeguarding Adults Review - Chronology

Agency Chronology of Involvement

Name of Agency:

Name of Adult:

Name of Person Completing Chronology:

Job Title:

Date:

The key information which is required under each heading should be self-explanatory. The last column "Expected practice/ standards" should be used by the Agency Report author to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue. Only leave blank if the intervention meets expected practice or standards and no professional issues are raised. **The first row sets out an example.**

Date	Time	Source of evidence	Name of professional involved and role	Event, description, actions taken, decisions made.	Expected Practice/Standards
<i>Date</i> EXAMPLE	<i>09:30</i>	<i>Case file</i>	<i>Jane Smith – Social Worker</i>	<i>Social work visit following SWASFT report of poor living conditions. Adult assumed to have capacity to make decisions about adult safeguarding, referral made by Social Worker.</i>	<i>Social worker considered assessment of mental capacity but found sufficient evidence to assume capacity. Social worker considered use of adult safeguarding provisions but did not discuss this with the adult at risk.</i>
Date	Time	Source of evidence	Name of professional involved and role	Event, description, actions taken, decisions made.	Expected Practice/Standards

3. NARRATIVE ON THE CHRONOLOGY

Reflect on the information provided in the chronology and provide an analysis of the involvement of your agency and/or professionals with the adult at risk. This section should bring the chronology to life and tell the story of the adult and where appropriate, family involvement with your agency. This section will also include a description of the **key events and decisions** you have identified, highlighting concerns, omissions and good practice. It is important throughout this section to reflect on the experience of the adult during your agency's involvement.

4. CRITICAL ANALYSIS

In this section the author must review the information in the comprehensive chronology and narrative and produce a critical analysis. Do use the following headings in compiling the analysis. If a heading does not appear relevant to your agency do note why.

- i) **EVENTS:** Critically analyse and evaluate the events that occurred, the decisions made and the actions taken, or not taken. Were there any missed opportunities or episodes when there was sufficient information to have taken a different course? Were assessments conducted effectively and appropriate conclusions drawn? Were agreed actions carried out? Were there any indications that practice or management could be improved? Try to get an understanding of not only what happened, but why.

- ii) **POLICIES AND PROCEDURES IN PLACE AT THE TIME:** Review the effectiveness of the policies and procedures used (both single and multi-agency). Were staff aware of these policies and procedures? Did they have management support and training to follow these appropriately?

- iii) **WHAT WAS HAPPENING IN THE AGENCY AT THE TIME:** Were there periods of transition or limited resource/capacity?

- iv) **INTER AGENCY WORKING:** Were processes and communication effective between agencies? Did each agency understand the role and duty of others? Were professionals proactive in escalating concerns and providing effective challenge when appropriate?

- v) **SUPPORT TO EFFECTIVE WORKING:** What supervision and management oversight was provided during the period of the Case Review? (i.e. the scoped period 2007 – 2012) Were these in accordance with the agency’s policy and procedures?

- vi) **IDENTIFY EXAMPLES OF GOOD PRACTICE**

- vii) **IDENTIFY WHAT HAS CHANGED** since the scoped period (2007 – 2012).

5. WHAT DO WE LEARN FROM THIS CASE?

Following on from the critical analysis section previously, the author should identify specific lessons which the agency can learn from the case. These can include areas of good or poor practice identified, as well as ways in which practice can be improved.

6. RECOMMENDATIONS FOR ACTION AND SINGLE AGENCY ACTION PLAN

Recommendations for action should flow from the previous section 5; ‘What do we learn from this case?’

Any recommendation about improving or developing new procedures should be specified in terms of the expected practice outcomes and followed through to ensure it happens.

Individual agency recommendations for action contained in this IMR report will be considered by the SAR Panel for inclusion in the Overview Report. The SAR Panel may also recommend further actions for your agency to be included in the Overview Report. You should add as many actions for your agency as necessary.

Please note that any individual agency recommendations not included in the Overview Report are expected to be acted on within individual agency governance arrangements.

Recommendations for action must be included in the Single-agency Action Plan Template and the Template needs to be fully completed in order to be clear about;

- What action should be taken, by whom and by when?
- What outcomes should these actions bring about and how will the organisation evaluate whether they have been achieved

R – SAR [AGENCY NAME]

Lead Person: [NAME]

Action Plan Template

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date of completion
1		<p><i>Indicate the actions or series of actions to be taken to achieve the expected outcomes. These must be Specific</i></p> <p>Measurable</p> <p>Achievable</p> <p>Realistic</p> <p>Time scale</p> <p><i>Examples might be deliver training, develop new policy,</i></p> <p><i>Introduce new standard, Review working practices, etc</i></p>	<p><i>Describe the evidence you will provide to the SAB to show the actions are being undertaken or achieved</i></p> <p><i>These might include correspondence, minutes of meetings, new policy, training material, etc</i></p>	<p><i>What improvements in service and adult safeguarding will result from the actions?</i></p> <p><i>Examples might be increased awareness of multiagency referrals, quicker access to services, attendance patterns improved for adults at risk etc.</i></p>	<p><i>Designation of lead officer responsible for implementing the actions</i></p>	<p><i>Date by which actions will be completed</i></p>

SECTION 7

INDIVIDUAL AGENCY REPORT

QUALITY ASSURANCE FOR

Agency	
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Name and contact details of person completing this form	
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Adult Identifier	R
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Criteria	Yes	No	Partially	Comments
Author was independent				
Access to legal advice available where appropriate				
Report is completed within agreed timescale				
Report includes chronology of involvement for identified time period				
Report takes account of the individual needs of the adult(s) and family members				
Report is sensitive to the racial, cultural and linguistic identity of the adult (s) and family members				
Report reflects a critical examination of the facts and provides a credible explanation for actions/ decisions that were/ were not taken				

Criteria	Yes	No	Partially	Comments
Practice at individual and organisational level is analysed openly and critically against local and national requirements, professional standards and local procedural guidance				
Good practice is highlighted when beyond expected minimum practice				
Report contains an action plan with measurable and relevant recommendations for improvement and a timescale for implementation.				
Action plan has been agreed with relevant senior management groups				

Signed:

Date:

Appendix 3 – Family response to the Safeguarding Adult Review Report

This report adds to the existing body of evidence¹ arising from the circumstances of our daughter's treatment and death.

We are very grateful to the Lead Reviewer for the diligence and attention she has displayed in conducting this review and for providing additional evidence and explanation.

Her review has considered why and how Ruth's treatment failed on numerous occasions with tragic consequences, one can only hope and pray such failings will never be repeated.

Our response is one which is set against our loss, in circumstances which we now know were avoidable and our daughter need not have died.

Our response:

- The over-riding perceptions which emerge from our reading of the report are those of professional indifference and an absence of compassion at a corporate and clinical level, by those who had a responsibility and a duty of care for a very vulnerable patient suffering from a chronic and enduring mental illness.
- The events leading to our daughter's demise reach back to 2006/ 2007, when we first witnessed our daughter's deterioration and increasing reclusiveness and social isolation.
- Our concerns were not listened to then and we were forced to make a formal complaint regarding the effectiveness of Ruth's treatment plan and the clinical decision to discharge her to the care of her GP.
- It should be noted that Ruth's decline led to total reclusiveness, as far as any contact with us, her sibling, her son and her extended family was concerned.
- Until her death Ruth did not allow us to visit her at her home, shunned all attempts to maintain contact with her, and apart from an hour a year when she agreed to meet us in the weeks before Christmas, we had no other contact with her despite many attempts on our part to maintain contact.
- Ruth avoided any contact with her sister or other family members and refused to maintain any visitation or contact with her son.
- This was all explained to the clinicians treating Ruth who were made very aware by us of our desperate concern for Ruth's well-being and safety. She was totally isolated from anyone she knew or cared for her and was extremely vulnerable and at risk.

¹ Dr C McEvedy Independent report and HSO findings

- However, despite this, and meeting with senior clinical and executive management members of the Trust to press for Ruth's Enhanced Care Programme Approach (ECPA) to remain in place, the decision to discharge from the ECPA was adhered to.
- The care coordinator's role was removed from Ruth's treatment and she was 'stepped down' to standard care.
- This action took place even though Ruth's consultant HP2, expressed the need for a second opinion to test Ruth's mental capacity, which was never carried out, and his concern that he felt Ruth still needed a care coordinator, was apparently never discussed with the local mental health team.²
- We have never understood or accepted how clinicians could allow someone as vulnerable as Ruth, who was so isolated, to be 'stepped down' in such circumstances.
- To obviously placate us, a compromise was outlined in May 2008 by HP4, which indicated that HP4 would attend Ruth's out- patient quarterly appointments (OPA's) to address Ruth's familial and situational circumstances.
- This treatment plan did not follow normal clinical practice, and although approved and put in place by Trust senior management, it was implemented without any of the normal requirements needed to ensure clinical supervision, inspection or management of the CPN involved, or the plan.³
- No record was entered in Ruth's medical notes of the HP4's role, neither was it part of the electronic record of her treatment.
- In other words, other clinicians and clinical managers did not know about the plan and no one supervised HP4 or ensured the plan was being implemented effectively.
- Even so, as Dr McEvedy points out in his report, this arrangement may have worked, if everyone did want they said they would do; but HP4 did not honour her professional commitment, and consultant psychiatrists did not follow through on their own recommendations.⁴
- The lack of supervision and clinical management procedures allowed this situation to develop and continue.

² Source: - internal e mails PPCTT May 2008

³ Correspondence from Mr D O'Toole (Deputy CEO) PCH dated 19 Sept 2014

⁴ Dr C McEvedy report page 19 Para 91 lines6/7 – *"The difficulty came when neither of these appeared to be fulfilled" relating to the 08/05/08 letter from HP4 etc and speaking of the OPA frequency and HP4's attendance*

- Other issues and concerns about Ruth were recognized over the ensuing 5 years which signalled that Ruth was not coping well and was in decline.
- Three consultants highlighted concerns for Ruth's well-being and her ability to cope, referring matters to either HP4, MDT meetings or other clinicians.
- No action was ever taken and our daughter continued to decline.
- The review report outlines these instances and points to the lack of continuity in consultants treating our daughter - 5 different consultants were engaged with Ruth over the review period. (2007-2012)
- This report indicates that there was a lack of 'ownership' for Ruth's problems.
- The most notable instances when this neglect is evident can be seen in the circumstances of: -
 - (i) Ruth's OPAs on - 24th March 2009; 21st July 2009; 4th May 2010; 11th Jan 2011; (lack of further action)
 - (ii) Failure to action consultant's e mail request for intervention in Ruth's situational circumstances on 12th Jan 2011;
 - (iii) Failure to action parental concern re DWP support (DLA payments) November 2011;
 - (iv) Failure to instigate 'vulnerable adult' policy on 6th December 2010 and December 2011;
 - (v) The 4 years our daughter had no access to heating or hot water within her flat which was never questioned;
- The review report is also significant by its explanation of individual and corporate failings and professional disregard and indifference to good practice, for example, the failure to follow agreed policy regarding the Vulnerable Adult Risk Management (VARM) process; failing to maintain good interagency communication; failing to follow through on clear indications of a patient in decline; and failing to challenge Ruth's reluctance to claim Disability Living Allowance (DLA) which so critically impacted upon her ability to cope.⁵
- The review points to a period of organizational change effecting local mental health provision at that time, as another factor which may have worked against the proper care of a Ruth.
- In our opinion, this cannot excuse corporate or individual failure in the treatment of vulnerable socially isolated patients.

⁵ McEvedy report Pages 17 & 18 Paras 84,85 & 86

- However, what is significant and important, is the fact that clinical managers were made aware in 2009 by HP4, that her commitment to the treatment plan was compromised by her promotion, during this change period.
- HP 4 reported her inability to fulfil her commitment to Ruth due to work related relocation and added job responsibilities following that promotion.
- Area management did not heed her warning and took no action to remedy the situation and expected HP4 to maintain the commitment - which is unforgivable.
- It is equally unforgivable that as a result, HP4, an experienced nurse, allowed her commitment to Ruth to lapse by non-attendance to our daughter's OPAs.⁶
- Instead, HP4 relied upon an arrangement with the consultant, that if our daughter did not attend 2 consecutive OPAs she would then become involved, which could mean that our daughter could remain unseen by any clinician, for up to 1 year.
- Dr McEvedy is critically unsure of the clinical correctness of such an arrangement⁷
- Throughout this period (2009-2012), we as parents were totally unaware that the regular attendances of HP4 to Ruth's OPA's had in fact ceased.
- For us, it is yet another example of the gross neglect and professional indifference to the plight of a vulnerable patient and those who were concerned for her.
- As the report indicates, since 2010 it should have been obvious to clinicians, that Ruth was very ill and was in severe personal decline, and yet nothing was done; no consideration was given to any form of intervention or change in her treatment plan.
- This was despite a consultant's direct request for intervention in Ruth's situational circumstances on the 12th January 2011.⁸
- When Ruth died on the 2nd September 2012, it was following at least 2 years of self-neglect, albeit we feel that process started when she was "discharged" in 2007.
- She was living in quite appalling and unacceptable living conditions.

⁶ See below OPA record – source FOIA and Ruth Mitchell's medical records.

⁷ McEvedy report Page 19 Para 91 lines 7-11

⁸ Internal email Jan 2011 - request to HP4, an assistant clinical manager and a community MH social worker for social intervention and financial support

- No immediate internal investigation was carried out by mental health services following her unexpected death.
- Furthermore, we believe no such investigation would ever have taken place, but for the instigation of our NHS complaint and our persistence in trying to find out why our daughter had been allowed to decline to such a poor state.
- Following recent events at the Southern Health Care Trust, it seems to be an ‘industry norm’ that vulnerable patients can die suddenly and unexpectedly, and no clinical investigation is conducted as to the circumstances leading to those deaths by the health care provider.
- Our daughter was failed by mental health services not once but many times during her treatment period and the indifference and disrespect shown to her whilst she was alive and to her following her death is appalling.

Conclusion:

NHS Litigation Authority have stated in a letter of response following litigation proceedings by Ruth’s son for a breach of a duty of care, with the following admission of fault: -

“in so far as the care provided to Ruth after October 2011, but for the admitted failings, a full package of care would have resulted in an improvement in the Deceased’s mental state and negative symptoms that would have, in turn, lead to an improvement in her insight and collaboration with the clinical team and on the balance of probability the continual decline that led to the Deceased’s death would have been averted.”⁹

The statement sums up not just the last 12 months of Ruth’s life, but the reality of 5 years of missed opportunities, misguided clinical judgement and indifference to her situation and personal circumstances by 3 mental health service providers, being Plymouth Primary Care Teaching Trust, followed by Plymouth Community Healthcare and latterly Live Well SW

This Review Report adds to this finding by showing how it is possible and apparently acceptable, for a vulnerable and chronically ill patient to be allowed to decline and die, within the sight of and with the consent through indifference, of those very health professionals who had a professional duty to prevent such neglect and self-harm happening, and nothing is investigated and nothing is said thereafter.

R & A.E Mitchell

⁹ NHS Litigation Authority correspondence dated 15th October 2015 – independent litigation action **not** involving Ruth’s parents – breach of care by:- 1 Failure to carry out any systematic social care assessment; 2 failure of CPN to attend all OPA’s and liaise with parents on regular basis;3 Failure to trigger social care assessment; 4 Failure to provide assistance in claiming DLA; 5 Failure to liaise adequately with police and social services; 6 Failure to ensure consultant’s recommendations for increase support were implemented.

⁶See attached OPA record – source FOIA and Ruth Mitchell’s medical records.

OPA RECORD of ATTENDANCE

(Source: FOIA & Patient A’s medical records)

	<u>Ruth Mitchell</u>	<u>HP4</u>
<u>2008</u>		
10/06	YES	NO
23/09	NO	NO
11/11	YES	YES
Total	2	1
<u>2009</u>		
24/03	YES	YES
21/07	YES	NO
Total	2	1
<u>2010</u>		
26/01	NO	YES
04/05	YES	NO
19/10	YES	NO
Total	2	1 (does not include house visit on 06/12/10)
<u>2011</u>		
11/01	YES	YES
29/03	NO	NO
05/07	YES	NO
01/11	YES	NO
Total	3	1
<u>2012</u>		
14/02	YES	NO
17/07	NO	NO
21/09	Patient A deceased on 02/09/2012	
Total	1	0

<u>OVERALL TOTAL</u>	10	4