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Bracknell Forest Safeguarding Board

Safeguarding Adults' Review

For GH

Overview Report

This SAR was originally commissioned by the Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board but was completed and published after the board had separated from Windsor & Maidenhead to form the Bracknell Forest Safeguarding Board. For this reason, you may find references to both boards within this report.

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A Bracknell Forest Windsor and Maidenhead Safeguarding Adults' Board Commission

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Chapter 1

Overview Report

1 Introduction

1.1 This anonymised Safeguarding Adults' Review (SAR) was commissioned by Bracknell Forest and Windsor & Maidenhead Safeguarding Adults' Board (SAB). It concerns GH, a 62-year-old male who died from an overdose of prescription drugs in the early hours of the 21st September 2018 at his home address. The circumstances, participation and safeguarding action of agencies prior to GH's death, and the effectiveness of the safeguarding plan and action taken, the SAB believed, met the criteria to conduct a SAR to identify lessons to be learnt for the future.

1.2 An appropriate safeguarding action plan was developed after concerns of GH's mental health and possible suicidal ideation was reported by practitioners which commenced the evening before. The action taken was in compliance with Local Safeguarding Adults Policy and Procedures. Emphasis however changed hours before his death and the action planned to execute a Section 135(1) Mental Health Act (MHA) 1983 (as amended 2007) in order to assess his mental health, was delayed. In the interim period, Thames Valley Police (TVP) were asked to attend his address around midnight to conduct a safe and wellbeing check. Due to circumstances of the delay in co-ordinating the execution of the warrant, unclear communication and decision making with no additional risk assessment conducted, the warrant to assess his Mental Health (MH) was never carried out. Only hours later in the morning of the 21st September 2018, GH was tragically found dead in his home by his support care worker.

1.3 This SAR has looked at how the relevant agencies managed the safeguarding concerns in the immediate 24-hour period leading up to his death, the scoping period defined by the Terms of Reference (TOR) in Chapter 2. This SAR has identified findings and recommendations outlined below and detailed in Chapters 3 and 4 of this report.

1.4 **During the process of completing this SAR, GH's case became the responsibility of Bracknell Forest Borough Council (BFBC) Safeguarding Board, as he was a resident in their local area. They assumed responsibility to authorise the completion of the review because as of June 2019, the Joint Board no longer exists, with each area now making their own Board arrangements.**

1.5 **Events of GH's life for consideration**

1.6 The review details three periods of GH's life which is outlined in the Key Events and Professional Practice in Chapter 3 and 4 as follows: -

Period 1 - Background history of GH.
Period 2 -The analysis of the 24-hour period leading up to GH's death.
Period 3 - The outcome of the police investigation and post mortem.

1.7 **Abstract of Findings**

1.8 The SAR has identified the following findings which are further developed within the analysis in Chapter 3 (See Findings, BFBC SAR OV Report and Individual Agency Recommendations in Chapters 5) as follows: -

Finding 1 - Sec 135(1) MHA 1983 warrant applications and compliance to agreed guidance.
Finding 2 - Governance and Supervision to ensure practitioners compliance.
Finding 3 - Risk Assessments, to be regularly reviewed and more comprehensive.
Finding 4 - Recordkeeping and communication**.**

1.9 Purpose of the SAR

1.10 The legislation, guidance and definitions are defined within the TOR in Chapter 2. It outlines the legislative requirements and expectations on individual agencies to safeguard and promote the well-being of adults in the exercise of their respective functions. It relates to adults with the need for care and support and for their carers providing a framework for SABs to monitor the effective implementation of policies and procedures as in GH's case. The following principles and legislation also apply below and are subject to further comment within the narrative of analysis in Chapters 3 and 4, namely: -

1.11 Adult Safeguarding Principles – Sharing Information

1.12 There are six adult safeguarding principles underpinning practice that professionals need to take into account when dealing with a safeguarding adult case and was considered when completing this SAR as follows: -

- **Empowerment**. People being supported and encouraged to make their own decisions and informed consent.
- **Prevention.** It is better to take action before harm occurs.
- **Proportionality.** The least intrusive response appropriate to the risk presented.
- **Protection.** Support and representation for those in greatest need.
- **Partnership.** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability.** Accountability and transparency in safeguarding practice.

1.13 S 135 (1) MHA 1983 warrants.

1.14 Significant to this SAR was the application to a Magistrate and the granting of a Section 135(1) MHA 1983 warrant. The warrant is used for police and healthcare professionals to enter a person's property, should there be a concern for that person's mental health. In order to obtain a Section 135(1) warrant, an Approved Mental Health Professional (AMHP) needs to provide a magistrate with evidence as to why they need permission to enter into someone's home.

1.15 In order to execute a Section 135(1) warrant, the following parties are required to be present: 1) The Police; 2) Ambulance Service; 3) a minimum of one Doctor and 4) an AMHP. Two Doctors are usually on stand-by to attend but only one doctor needs to be present for the execution of the warrant. As in GH's case, an AMHP will make contact with the police and ambulance service at the first instance to set out an appropriate time for the professionals to attend with this information passed to the Doctor who needs to be present for a full assessment to take place.

1.16 Once inside a person's home, an assessment can take place to see whether that person needs to be taken to a place of safety, usually a hospital, for a further assessment. Sometimes an assessment will take place at the person's home and it will be deemed the person does not need to be removed to a place of safety for a further assessment and they can remain in their property. It was the role of police to execute the warrant under the instruction of the Bracknell Forest Emergency Duty Service (EDS) AMHP.

1.17 Voice of GH

1.18 The voice of GH is evident throughout the narrative within the short timeframe of this review. It is clear practitioners listened and complied with his views. He was well supported by ASC and his allocated social worker (SW). He was not always compliant with practitioners who had dealings with him and in particular attempting to support him during the hours preceding his death. This review cannot determine whether and to what extent his mental health impacted on his communication and understanding of actions he was taking at the time, as the Sec 135(1) warrant was never executed in order to assess his mental health and suicidal ideation.

1.19 Diversity

1.20 There is no information within the submissions from agencies in this review to suggest diversity or culture was an issue.

Chapter 2 - SAR Terms of Reference (summarised)

2 Overarching aim and principles of the SAR

2.1 The main aim of this review is to look at how GH was risk managed by the different agencies involved with him in the immediate 24 hours period leading up to his death.

2.2 The purpose and underpinning principles of this SAR are set out in section 2.9 of the Multi-Agency Safeguarding Adults Policy and Procedures[1]. All SAB members and organisations involved in this SAR and all SAR panel members agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation and reflected the current realities of practice ("tell it like it is").

2.3 Legislation

2.4 Section 44 of the Care Act 2014 places a statutory requirement on Bracknell Forest Borough Council SAB to commission and learn from SARs as laid out in the statutory guidance.

2.5 Governance and accountability

2.6 This SAR was conducted in accordance with the requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014.)
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015).
- Multi-Agency Safeguarding Adults Policy and Procedures; and
- Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Review Framework.[2]

As the accountable body responsible for its commissioning, Bracknell Forest SAB has delegated the oversight of this review to the Safeguarding Adults Review Subgroup. The final report will be presented to the Safeguarding Adults Board.

2.7 Subject of the SAR

2.8 **GH** aged 62 years at time of death.
(See family involvement below).

2.9 Methodology

2.10 The Significant Event Analysis model (Option D in the Framework) has been selected as the methodology for conducting this SAR. This involves gathering factual information about the case and uses a facilitated workshop with staff.

2.11 Specific areas of enquiry

2.12 The SAR Panel (and by extension all contributors) considered and reflected on the following objectives:

1. To look at the effectiveness of how the individual agencies assessed and managed risk for GH on the night of 20.9.18 and how this was shared with other organisations.
2. To review the effectiveness of how agencies worked together in responding and managing risk for GH on the night of 20.9.18.
3. To identify practice improvements particularly around the implementation of the local multi agency risk management process.

[1] https://www.berkshiresafeguardingadults.co.uk/
[2] https://bfrbwm.safeguardingadultsboard.org.uk/assets/1/joint_bf_wm_sar_framework_september_2017.pdf

4. To identify lessons learnt from this case including any wider learning about how agencies work together to provide care and support for adults at risk.

The review concentrated on the immediate period prior to GH's death on the 20th to 21st September 2018.

2.13 Timescales for completion

2.14 This SAR commenced in February 2019, to be completed within six months. Timelines for publication was not affected and there were no criminal or court proceedings in GH's case.

2.15 Liaison with the Police, Criminal Justice System and Coroner

2.16 The case was referred to the Independent Office for Police Conduct (IOPC) and the Coroner for the Local Authority and no date for an inquest has been set. The SAR Chair was responsible for ensuring appropriate ongoing liaison with the, Coroner and the Police as required.

2.17 Chair and membership of the SAR Panel

2.18 The chair and panel membership for this SAR were as follows: -

CCG
Optalis
SAR Report Author
Thames Valley Police
Berkshire Forest Council
Berkshire Forest Council Emergency Duty Service
Berkshire Forest and Windsor & Maidenhead Safeguarding Adults Board
Berkshire Healthcare Foundation Trust
South Central Ambulance Service

2.19 Evidence and submissions to the SAR

2.20 The following organisations submitted a summary report and chronology of events to the SAR as follows: -

Thames Valley Police.
GP and East Berkshire Clinical Commissioning Group.
Berkshire Healthcare Foundation Trust.
South Central Ambulance Service.
Sheltered housing provider.
Domiciliary care provider.

2.21 SAR report and publication

2.22 Mr David Byford was commissioned as the Lead Reviewer for the SAR. He had no previous involvement in the case or with any person or agency concerned within the SAR process for GH. The appointment is in line with Section 9 of the Bracknell Forest and Windsor & Maidenhead SAB SAR Framework and the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures. It contains the transparency of analysis necessary for others to scrutinise the findings.

2.23 The SAR Panel will discuss with the Bracknell Forest SAB how to publish the final report, setting out clear reasons for any recommendations made to promulgate learning and the extent of anonymisation required unless there are exceptional circumstances not to publish the final SAR Overview Report.

2.24 Involving family and friends

2.25 The review sought to identify any family or close friends and involve them in this SAR, agreeing to what extent they wish to be involved. Contact was made with two siblings but there was no response received from them wishing to participate in the review.

2.26 **Involving and supporting key staff and volunteers**

2.27 The review sought the perspectives of all key staff and volunteers at a facilitated workshop giving them the opportunity to share their views on the case. The event was held, and helpful views and information was obtained for the purposes of completing the review.

2.28 The SAR Panel member from each agency was responsible for ensuring relevant staff and volunteers were provided with a safe environment to discuss their feelings and offered emotional support where needed, including counselling or other therapeutic support.

Chapter 3 - Analysis of Key Events and circumstances of GH's death

3 Key Events

3.1 An analysis of the key events of GH in the 24-hour period under review of professional practice, is detailed below with analytical comment. The significant events have been considered and where relevant are addressed within the Findings and BFBC OV Report and Individual Agency Recommendations in Chapter 5.

3.2 Period 1 - Background History of GH

3.3 GH was receiving dedicated adult care within the community at the time of his death from Bracknell ASC. GH had been a long-term intravenous drug user for over five years prior to the involvement of the Adult Community Team (ACT) and known to the Drug, Addiction and Alcohol Team (DAAT). His first contact with the ACT was in February 2015 but at this time he was not engaging with DAAT. During this period, he was served an eviction notice for his accommodation and attended the local council offices following a visit to Accident and Emergency (A&E). Within two weeks of him contacting services he was admitted into hospital and had a right, below knee amputation and became a wheelchair user.

3.4 ACT initially supported his hospital discharge to find him suitable accommodation to return to. He was discharged in April 2015 and his case was transferred to his current SW at the time of this review for long-term support. It took time to find him appropriate settled accommodation and in the intervening period he moved from hotel to hotel (due to room availability). He had a pet dog which was not allowed to be with him for most of this time. In the BFC report to this review his SW describes GH as "distraught" with the possibility of not finding accommodation which would enable his dog to accompany him.

3.5 The SW displayed dedicated and consistent professionalism in order to obtain him secured accommodation. Efforts were successful as his housing provider offered him a sheltered accommodation flat and allowed his dog, who had been his companion for 18 years, to live with him.

3.6 GH was often reluctant to accept the offer of support from carers and practitioners as he felt it was an intrusion on his privacy but eventually he was convinced to accept a support package which was put in place for him.

3.7 The SW continued to maintain regular contact to support him for a variety of issues including housing, tenancy, support for personal care, money and debt management. The SW noted he had episodes of low mood swings, possible suicidal ideation and the SW was in contact with health services for him. He disclosed to her he was lonely with erratic friends and family. These concerns were assessed and managed by ASC.

3.8 Significant factors

3.9 Significant factors known by ASC which may have impacted upon GH's emotional health and wellbeing in the preceding six months of his life was:

- He smoked cannabis and was on controlled drugs (including opiate based medication) to manage pain. He was not known to be using drugs intravenously at this time.
- Having had his right leg amputated a few years before, there was a possibility he would require an amputation to his left leg as his health deteriorated.

- He was reported by the SW to have very low mood swings.
- The notified intention to evict him ten days before his death due to the behaviour of his friends and problems with his dog fouling in the house which staff had to clear up.
- Seven days before his death, his dog was taken away by the RSCPC due to its poor health and condition, and unfortunately for GH, had humanely been put down on the 17th September 2018 due to cancer.
- A few days before his death, he called ASC as he had been served an eviction notice by his housing landlord, received on the same day his dog was put down. The eviction notice was being addressed at the time of his death with support from ASC and his SW and is outlined below.

3.10 Eviction notice and housing provider background information

3.11 The reason for him receiving a Notice of Seeking Possession (NOSP) occurred because, on several days in June 2018, visitors to his property were rude and abusive towards other residents which caused a nuisance, upset and fear. His visitors caused alarm by kicking the communal front door and it was believed were using illegal drugs within his property where drug paraphernalia was found. Concerns of breaching his tenancy agreement continued as follows:

- 12th September 2018, GH's sister and nephew were staying in the flat. When management entered the flat drug wrappers and tablets were over the floor. GH had been sleeping on the sofa. His sister and nephew were directed to leave.
- A RSPCA Inspector told him they could have pressed charges as the dog's infection to the head was very bad and he was in a lot of pain. (There is no evidence to suggest he was going to be prosecuted).
- 14th September 2018, as he was continually in breach of his tenancy agreement, he was served with the NOSP order and his SW was also notified.
- 17th September 2018, an ambulance was called to GH's flat and police were also called as GH had said his morphine had been taken. He was taken to hospital but returned the same night. It was believed his sister may have taken his morphine. Community police officers were made aware.
- 18th September 2018, GH pulled the emergency cord in his flat and said he was on the floor in the bathroom but managed to get himself up and back into the wheelchair with assistance from accommodation staff.
- 19th September 2018, GH again pulled the cord and said he was on the bathroom floor. A SCAS ambulance crew attended and managed to help him up. He did not require being taken to hospital. His SW also arrived to see him regarding the NOSP that had been issued.

3.12 GH family background

3.13 GH had two siblings, a younger brother and sister. Neither of his siblings lived with him, although they did live locally and often visited him. GH described himself as feeling responsible for his siblings and wanted them to feel free to visit him at his home. In addition, there was a female acquaintance who GH described as a close friend who saw herself as his sister. His SW confirmed she was not his sister but was taken in by the family when she was younger and identifies herself as his foster sister; she also lived locally and carried out some domestic tasks for GH such as shopping.

3.14 GH and some of his family members were known to social services historically and there had been involvement over the years with them; they were known to be a family who at times

required a high level of input from social services. It was believed GH shared his medication with his family members, but he stated that they had taken it from him.

3.15 The ASC Safeguarding Manager assessed the safeguarding procedures in respect of these matters as not appropriate and advised the SW to speak with GH about the situation to ensure he understood the consequences of some of his activities involving his family members. This action taken appears appropriate by ASC at the time.

3.16 **GH's two siblings have been written to and asked if they would like to contribute to the review. The SAB have not received any response from them, and it is assumed, unless information is subsequently obtained to the contrary, they do not wish to participate in the review.**

3.17 **Period 2 -The analysis of the 24-hour period leading up to GH's death.**

3.18 **20th September 2018**

3.19 **10.30 hrs.** An allocated solicitor made contact with the Community Services Team (CST) agreeing to support GH regarding the eviction notice. The solicitor sent an email to GH arranging a meeting to discuss his case. The Assistant Housing Manager (AHM) of his accommodation had informed the SW that GH was being evicted because of the attitude of the people who visited him, not because of GH. He had been good, always paid his rent money on time and at the time of his death had overpaid on his rent. It was the people he surrounded himself with who caused the issues and was the reason he was given a repossession order for his flat.

Comment: ***The solicitor spoken to after GH's death, felt he had a good case against the eviction as the concerns within the home was the poor behaviour of his apparent visitors and not the action of GH personally.***

3.20 **Mid-morning.** GH's GP surgery called his sheltered accommodation office to ask why GH kept calling an ambulance. The GP practice had tried calling him, but he was not answering their calls on his mobile. The AHM went up to his flat to ask him to call his GP. Another resident was checking on him at the same time who used to go into his flat to make him breakfast. He was on his mobile phone arguing with his sister. The manager left after a short while to let him eat his food.

3.21 **13.00 hrs**. GH's sister appeared at the housing office upset GH was being verbally abusive to her and she was going to contact his SW when she got home.

3.22 **15.30 hrs.** GH's sister (not believed a blood relative as mentioned above) called his SW and told her GH said she was not wanted by him and he did not want to see her. She stated GH was abusive towards her and threw her out of his flat. She confirmed she informed the housing manager that GH was in bad way and she was worried, reporting he had taken an overdose. She also reported a friend (details unknown) had turned up at the house and was also told to go away by GH.

3.23 **17.00 hrs.** Due to the reported concerns, his SW completed a home visit as she had previously tried to make contact with him. She managed to get into his flat and saw GH. She started a conversation about the solicitor she had obtained for him after twelve previous attempts to secure legal support for his eviction notice. This was positive practice as the SW decided to go around after work to visit him, informing her line manager of her intentions to help GH with the solicitor paperwork he needed to complete.

3.24 GH was very abusive towards her and stated the SW was no help, his friends could not help and was also abusive about the solicitor. He spoke about his dog which had been put to sleep, on the same day he got his re-possession order. He held his head in his hands and said, *"I can't deal with this."* She felt uncomfortable as he said his *"head was all over the place."* At one point he moved his wheelchair to pin the SW into her chair and she also noted tin foil on the cabinet and his eyes were bloodshot.

3.25 **18.00 hrs.** For safety reasons the SW removed herself from the property. She called her office and explained GH was in a bad place emotionally and he had reported to her would kill himself. The ASC Team Manager (TM) confirmed access to the Crisis Resolution Home Treatment Team (CRHTT) was still available and informed the SW. The SW made an immediate telephone call to the CRHTT reporting her concerns regarding his deteriorating mental health and the risk of suicide and also asked them to visit him that day. The SW explained she had worked with GH for 3 years and had never seen him in such an emotional state. She was aware he could be moody and had bad days or weeks. However, she felt he was serious about killing himself. The CRHTT, given the reported concerns, agreed practitioners would visit him. The SW informed CRHTT she would keep her personal mobile phone on and updated the EDS of the action taken.

3.26 **18.43 hrs.** EDS AMHP1 was allocated the case and carried out background records check on RiO (the case management system). He records there was very little MH history for GH but there were however significant social stressors recorded '*these factors add up to potential risk of self-harm/suicide*'. AMHP1 outlined to move GH's case forward and a decision would be made after the outcome of the home visit by CRHTT.

3.27 **20.09 hrs.** AMHP1 recorded the outcome of the CRHTT home visit. Two members of staff had attempted to visit GH, but he refused them access having answered his intercom to them. He told the practitioners he was too out of it to talk and declined an offer to rearrange another time when they could visit. AMHP1 recorded on the case file that a Section 135(1) MHA warrant will be required due to likely access issues to GH.

3.28 **20.45 hrs.** AHMP1 telephoned and spoke to the SW. As a result of the SW information, AMHP1 confirmed he would be applying for a warrant so that a MH section (assessment) could be carried out as he did not believe GH would co-operate. The EDS report states, '*Discussion with SW from BFC who validated her concerns about this man's suicide risk, stating that he made clear statements that he would end his life - it is suspected by overdose of drugs.'* He had told the SW to get out of his flat which was out of character for him who believed he was at risk of taking an overdose. An overview of the discussion was: -

- In-depth discussion re: presenting risk factors, indicators and stressors.
- Plan of intervention discussed and agreed a course of action to seek a Section 135(1) warrant due to presenting risk factors.

Comment: ***A transcript of the telephone conversation between the SW and AMHP1 confirms a thorough conversation of the risk to GH who had said, "I am going to kill myself."***

3.29 **21.09 hrs.** AMHP 1 called the Clerk of the Local Court requesting a warrant under Section 135(1) of the Mental Health Act 1983 (as amended 2007). AMHP1 completed the required administrative enquiry '*Information Before the Magistrate's Form*' which was submitted. At

21.51 hrs there was a conference call between AMHP1 and the Clerk to the Court and Justice of the Peace (Magistrate). The current risk factors and the intervention required to keep GH safe was reported. The Magistrate agreed the request was appropriate and a warrant was granted.

3.30 **22.02 hrs.** AMHP1 telephoned and spoke with the Duty Senior Nurse at a nearby hospital enquiring the availability of the Health Based Place of Safety (HBPOS) as the S135(1) was to be executed. A HBPOS bed was made available for GH.

3.31 **22.04 hrs. First AHMP call to TVP.** AHMP1 telephoned TVP Control Room (via 101) requesting police attendance to execute the warrant for GH. AMHP1 gave background information to assist the police with their risk assessment; he had a history of dealing and taking drugs; there might be a potential for drug dealers and drug paraphernalia likely to be present inside the property and he was uncharacteristically hostile towards friends and services.

3.32 AMHP1 was provided as policy requires with a police Unique Refence Number (URN). It was agreed by the control room operator they would contact AHMP1 with a time of attendance at GH's house. AHMP1 proposed a time of execution between 23.00 and 23.15hrs. This was to allow him to co-ordinate and obtain two Section 12 Doctors *(a doctor trained and qualified in the use of the MHA 1983, usually a psychiatrist or responsible clinician if the clinician is a doctor)* and once the time was provided by police, he would book SCAS to undertake the conveyance to hospital as delegated by the AHMP under section 137 Mental Health Act.

3.32 The Independent Office for Police Conduct (IOPC) conducted a subsequent investigation to assess TVP action as they had contact with GH shortly before his death and is a matter of process in such cases. Their report suggests the police operator dealt with this call appropriately and attempted to establish all the relevant information, as is set out in the Inter-Agency Partnership Agreement 2017 and the call entered onto an incident log.

3.33 **22.16 hrs.** After a review by the control room, AHMP1's call was downgraded from 'Urgent Attendance' to 'By Arrangement'. TVP policy in relation to call grading states the following types of incident should warrant an 'Urgent Attendance' response grading: 'Victim Vulnerability', 'Critical Incident' and a 'Genuine concern for somebody's safety'. Calls graded as urgent should be resourced within 60 minutes.

3.34 The IOPC and this review believes the decision to downgrade the call request appears to have been appropriate given AMHP1 was attempting to arrange an appointment for a time in the future. It is also noted that during his phone call, AMHP1 did not communicate there being any heightened immediate concerns for GH's welfare, which may have warranted an immediate or urgent response from police.

3.35 TVP's view is a Section 135(1) warrant would indicate GH may have been vulnerable and there were concerns for his safety. However, the police's ability to respond would have been determined by the time set by AMHP1 and his ability to co-ordinate other agencies and professionals for a multi-agency approach to executing the warrant.

3.36 **22.52 hrs. Second AHMP1 call to police.** AHMP1 called police to chase up a response. During this call, AHMP1 made a comment to the call operator in relation to his team being concerned about GH committing suicide. The call operator acknowledged concern but stated there were other calls ongoing at the moment of equal importance, if not of greater priority. In the event,

AMHP1 was asked whether anything else had happened in the interim whilst he had been waiting for a response. He responded "No" but informed the operator they could not move forward with executing the warrant until they had received an arrival time from TVP. The operator apologised for the delay and informed him he would update the sergeant (supervisor) and hopefully they could review their resources. As a result of this call, the operator recorded on the incident log 'No new information that might influence risk grading'.

3.37 The IOPC records the operator did not question or explore the suicide concern comment. However, the operator did give AHMP1 the opportunity to update him on anything that may have changed since his original call. The initial time requested to assist the execution of the warrant had not yet passed at this time and the action appeared appropriate to the IOPC and to this SAR by keeping the risk grading the same whilst on-going efforts took place to resource AMHP1's request.

3.38 **23.35 hrs. Third AHMP1 call to police.** AHMP1 telephoned TVP 101 as he was concerned that over an hour had passed and he had received no update from police. He informed the operator he had fresh concerns for GH's welfare, and that he may have already taken an overdose. He stressed the length of time had now passed with no clear indication of when police will be available to execute the warrant and it may be placing GH at significant risk if he has already taken an overdose. During this call AHMP1 on the recorded tape was heard to tell the operator, "*I mean realistically if they [CRISIS team] had that fear they should have done a welfare check there and then, but I think they were thinking about a warrant. But time is ticking on and I'm worried that actually we could have seen the start of an overdose then".* He said his original plan had been to execute the warrant but "*the warrant is a secondary issue*". The AMHP1 requested police and ambulance to go out and check GH's health and welfare. Due to the reported suicide concerns police were immediately dispatched during this conversation at 23.37 hrs and SCAS called to apprise them of the situation.

3.39 AMHP1 agreed once police and paramedics were on scene, he or colleague AMHP2 (EDS oncoming AMHP) would be able to attend the address with Section 12 doctors very quickly. AHMP1 requested police and paramedics contact him as soon as possible with an update. SCAS Control in turn telephoned AHMP1 enquiring if they were required to be on scene or should they await a decision from him.

Comment: ***The response to the downgrading of the call in the circumstances appears appropriate at the time. This SAR has had access to the telephone tape transcripts of the communication between the police call operator and the AHMP1 where he did not initially raise the concern of GH's suicide risk that he may have already taken an overdose. The information GH may have already taken an overdose should have been shared initially which would have stimulated an urgent and immediate response by police.***

3.40 **23.50 hrs.** A police unit with two officers arrived outside GH's address. Whilst on the telephone with SCAS, AHMP1 put them on hold as the TVP officers on scene called him wanting to know the reasons behind the safe and wellbeing check (referred to as a welfare check by other professionals). AHMP1 highlighted the risk factors and concerns – that GH may have already taken an overdose of illicit substances. Police asked if the warrant would be executed or not. AHMP1 explained if GH has not taken an overdose then the warrant will be executed but if it is suspected he has, then urgent medical treatment will be required. It was agreed police will make a decision as to whether SCAS attendance is required and will provide an update once they had seen GH.

Comment*: The importance of language used by different agencies is extremely important, as terminology and different interpretations can affect subsequent actions. It was clear in the practitioners facilitated workshop that a welfare check also known as a safe and wellbeing check by police can have a different meaning to other agency practitioners. Agencies need to clearly explain what they require when requesting a welfare check to be conducted by police. Each agency needs to be aware of the others responsibility, capability, limitation, expectation of the outcome from action to be taken.* (See Finding and BFBC OV Report Recommendation 4 in Chapter 5).

3.41 **23.52 hrs**. AMHP1 continued his call with the SCAS and notified the operator he had been informed GH has answered his intercom and he believed the police will now conduct an assessment. (Not the duty of police). When asked by SCAS whether the EDS still plan to go ahead with the S135(1) warrant he said he will review once the police have had a discussion with GH. He reported police will update the SCAS Control once they have sighted GH and if he has not taken an overdose the plan will be to execute the S135(1) warrant and an ambulance will be required for conveyance purposes. The AMHP1 placed the emphasis on police by informing SCAS the decision to have an ambulance attend, should be up to the police, as they are with GH. Both SCAS and Berkshire EDS AMHP's awaited the update from Police.

Comment*: The AMHP1 comment that the warrant will be executed if GH had not taken an overdose (as police subsequently confirmed having spoken to GH him), never occurred and is confusing. There needs to be clearer instructions and communication between practitioners. AHMP1 having spoken to the police at the scene, could have attended and met them there. It was only half an hour from the original time requested and a very short time after his third call to TVP raising the suicide concern which provoked an immediate response from police. Neither he nor his colleague attended the scene contrary to the suggestion made to do so as stated to the call operator. There was also no consideration for an earlier opportunity to nominate a suitable rendezvous point for all services to meet in order to effect the necessary co-ordination of agency action to safeguard GH. (See Findings, BFBC OV report Recommendations in Chapter 5).*

3.42 **<u>21st September 2018</u>**

3.43 **00.05 hrs**. The two police officers who attended GH conducted a safe and wellbeing check. The officers state they saw GH at the door in his wheelchair and did not observe any immediate threats to his welfare. He had denied taking any drugs, other than his prescribed medication. Police did not ask to enter GH premises, as it was felt they had no grounds to enter, as they felt there had been no cause for concern.

3.44 **00.12 hrs**. The police officers updated the control room of the outcome of the safe and wellbeing check on GH. The control room operator informed the officers they would update AHMP1 and then the operator closed the incident log.

Comment: ***TVP's Incident Attendance Policy states incidents involving an 'Imminent risk to life or of serious harm to any person' should be graded as 'Immediate'. It is expected police will arrive on scene within 15 minutes of receiving a call of this nature. The response grading was upgraded on the incident log, following receiving new information from AHMP1. Once the risk was upgraded a police unit did arrive on scene within 15 minutes of AHMP1's call which is in line with the TVP policy for calls given the highest response grading of, 'Immediate.'***

3.45 **00.25 hrs.** AHMP1 provided a handover to Shift Lead, Senior Social Worker (SSW) and AMHP2 (incoming and overnight EDS AMHP) who were both undertaking the night shift. A full verbal handover was given to AHMP2 regarding GH and recorded in the required handover form.

3.46 **01.13 hrs.** A paramedic at SCAS Control telephoned AHMP2, but spoke to the SSW as AHMP2 was on another call, asking if EDS had received any update from 'on the scene' officers. No update had been received and the paramedic agreed to call TVP control. SSW passed the information of the call to AHMP2. The paramedic was informed the officers who had attended the scene had spoken with the AMHP1 and the warrant was being rearranged for the morning. The paramedic was informed this was because the AMHP and doctor were unable to attend at that time.

3.47 **01.25 hrs**. SCAS called the TVP control room for an update regarding GH. On receiving this call, an operator immediately contacted one of the officers who had attended GH to obtain a more detailed account of their safe and wellbeing check. The police officer spoken to informed the call operator he was of the belief the Section 135(1) warrant was going to be rearranged for GH. The operator also informed the SCAS they would update the EDS regarding this information.

3.48 SCAS control recorded the police update found no concerns regarding GH, he had not apparently taken an overdose of either illicit or prescribed medication, he was tired due to the time of night and reported the police stated the section 135(1) warrant will go ahead later in the morning. The SCAS closed their call log for GH at that time.

3.49 The TVP call operator called EDS and spoke with AMHP2 and confirmed she had just spoken to SCAS who requested she contact EDS with an update regarding the police safe and wellbeing check on GH. They confirmed GH had not taken an overdose and had no concerns. Police stated they could not see if he was steady on his feet as he was in his wheelchair but stated that he was tired due to the time of night and that the section 135(1) remains in place. AMHP2 explained the welfare check was for a fear of safety regarding a possible overdose but guidance is required regarding the need for section 135(1) warrant.

3.50 **01.35 hrs.** AMHP2 records there is no further role for EDS and closed the case

Comment: ***There was a need, due to the ongoing risk, for clear instructions of the continuing safeguarding action plan for GH, as the decision made requested local practitioners to follow up in the morning. It required an agreed rationale for the reasons not to carry out the warrant that evening. The quality of the handover from AMHP2 was vague and did not indicate to execute the outstanding warrant.*** **(See Findings and BFBC SAR OV Report Recommendations in Chapter 5).**

3.51 The IOPC report states there is no record, or log of the TVP control operator having called back AHMP1. It is noted, even if the operator had given an immediate update to AHMP1, he was no longer on duty. This is in fact correct as he had handed over GH's case to AHMP2. The IOPC were also concerned the incident log has been closed without any information being added in relation to the control room updating AHMP1, SCAS or EDS as to the outcome of the safe and wellbeing check on GH. Even though there was a delay in updating GH's safe and wellbeing check, the information supplied was accurate. According to the IOPC, police would have allowed both the SCAS and EDS to make their own risk assessments, and to consider what, if any further actions needed to be taken by their own organisations.

Comment: ***This review agrees with this view as safe and wellbeing checks by police are not an alternative to a proper MH assessment which a Sec135(1) warrant would have allowed. The lack of an update and the closure of the incident log is individual learning for the call operator regarding the omission and delay of not updating the interested parties. In the circumstances, this action is acceptable, proportionate and no recommendation is required as there is no evidence this was a systemic problem within TVP from the information supplied to this review.***

3.52 AHMP2 in a statement to the IOPC (a copy of the statement was requested but was not available to the SAR) states she came on call at midnight to take over from AMHP1 with a shift from midnight until 7am. She recalled receiving a handover and was informed that the CRISIS team (CRHTT) had made a referral regarding GH who had made remarks about committing suicide. AMHP2 stated, *"I was also informed AMHP1 had attempted to coordinate the execution of a Section 135(1) warrant. However, I was informed that the police did not have the resources to execute the warrant but would be conducting a welfare check as requested by AHMP1*".

3.53 AMHP2 recalled SSW was informed GH appeared tired, but that this did not appear out of the ordinary given the time of night. *"I was also aware that the police had cancelled the ambulance given that they (police) did not have any concerns for his welfare,"* and "*This information led me to believe that the execution of the warrant was not required immediately. My view was that an assessment should still take place, but could take place the next day etc. Warrants can only be used once to enter a person's property. As the police had not used the warrant to conduct their welfare check, the warrant could be used at a later stage."*

3.54 She could not recall whether she updated the CRISIS team over the phone or not and added, "*The log would have been picked up by the day shift team (at 9am) and they would have been responsible for speaking with the CRISIS team and continuing efforts to have GH assessed."* AHMP2, disclosed even though there was a Sec 135(1) warrant, they wanted to be guided by the police. If they had no concerns there would be no need to go ahead with the warrant. She confirmed this was the information from the handover she received from AMHP1 if the police had no concerns.

Comment: ***There needed to be more clarity from AMHP2 in the circumstances, as AMHP1 had said, if there were no police concerns and GH had not taken an overdose; the warrant could be executed. There is some confusion as to communication and record keeping with no professional curiosity displayed to consider the ongoing risk. (See Findings and BFBC SAR OV Report and Agency Recommendations in Chapter 5).***

3.55 **09.10 hrs.** ASC received AHMP2's report later that morning regarding the outcome of the safe and wellbeing check and the decision for Community Mental Health (CMH) team and ultimately ASC to follow up.

3.56 **09.40 hrs.** The Deputy Housing Manager (DHM) called GH's flat but received no response. As she was preparing to go and check on him, his support care worker arrived and was let into the building. A few minutes later the care worker went to the office and called '999' as she could not gain access to the flat. She had seen GH lying on the floor behind his front door blocking access and he was unresponsive.

3.57 Both practitioners went back to GH's flat after calling the emergency services and saw GH in the same situ. They were still unable to get into his flat and saw no visible signs of life and he

was still unresponsive to voice. The DHM went down to wait for the arrival of an ambulance and the carer stayed with GH.

3.58 A SCAS paramedic attended and requested the assistance of the fire service to gain entry. The fire service arrived and gained entry to GH's flat via a window. A member of the fire service had to slightly move GH to allow the paramedics access to his flat. Two blister packets of diazepam were found next to GH, as well as some vomit on the floor.

3.59 Meanwhile, CRHTT sent an email to GH's SW to advise her the police welfare check outcome was no further action (NFA) was required. *(This gives the impression there was no clear instructions whether the warrant was still effective)*. They had also left a voice mail and telephone number of CRHTT was given to the SW should she feel GH would need further urgent mental health input.

3.60 **09.52 hrs.** The SW, showing professionalism tried telephoning and texting GH as she had not seen any EDS report when she came in to do safeguarding that morning. As she had not obtained a response from GH, she then contacted his sheltered accommodation office but could not get an answer for some time.

3.61 **10.08 hrs**. Meanwhile, SCAS pronounced GH deceased at the scene.

3.62 The SW finally spoke to the DHM who informed her a SCAS paramedic at the scene had said GH had passed away and they had called the police who arrived shortly afterward at 10.38hrs. After the conversation GH's brother arrived at the DHM's office. He started banging on the main entrance door and shouted abuse at her and police spoke with him. Police preserved the scene and asked the DHM not to allow anybody to enter the flat until the crime scene officers had finished. (Concluded on the 24th September 2018).

3.63 **11.30hrs**. The SW visited the sheltered accommodation with an Assistant Team Manager (ATM) and spoke to police who confirmed GH had died having been found by his care support worker. The SW later spoke with the solicitor and reported GH was deceased. As alluded to previously, the solicitor believed GH had a good case to challenge his eviction.

3.64 The SW having come on duty, continued to show safeguarding care and concern for GH's welfare and this is evidenced throughout the analysis of this review. Her concerns of him being a suicide risk unfortunately became true.

Analytical Comment: ***It is clear from the information in this chapter there was no clear instruction on the safeguarding action to be taken to execute the warrant from EDS, or clarity from AHMP2 whether the warrant was going to be executed early the following morning. It fell upon locality teams or his SW if it was felt GH needed safeguarding support, to follow up. The Section 135(1) warrant appears to have been forgotten.***

There are mixed messages and confusion with no apparent intention to execute the warrant even though TVP, SCAS and AMHP2 record it would be executed in the morning. The handover from EDS AMHP2 to ASC MHT was for them to pick up the case and deal. Communication and recordkeeping were lacking with no clear safeguarding action plan to protect and assess GH, recorded or made. There was no supervision of the action or non-action whether the warrant deemed necessary hours before would be executed or updated risk assessment carried out.

Preference would have been for AMHP1 to have gone to the scene knowing police had been dispatched and having spoken with the officers outside GH's home and taken the opportunity to meet police to start the process. The Doctor and SCAS could have been called to the scene as they were on standby awaiting an update. AMHP2, when later receiving the belated police update on GH, did not consider the present risk to GH any further, even though a safe and wellbeing check carried out by police would not have been a thorough assessment of GH's mental health. AHMP2 closed the case in relation to GH to EDS. GH's mental health and the outstanding warrant was not actioned adequately.

3.65 **Period 3 - The outcome of the Police Investigation and Post-Mortem.**

3.66 A Post Mortem was carried out by a Consultant Histopathologist on the 25th September 2018 at WPH and a subsequent toxicology report confirmed the **Cause of Death is: 1a. Drug intoxication** (an overdose of prescribed medication).

3.67 TVP concluded an investigation into GH's death and found there was no third-party involvement involved in GH's death and submitted a report for the information of the Coroner for the Local Authority area.

Chapter 4 - Analysis of Professional Practice and Practitioners facilitated workshop

4 Professional Practice

4.1 Professional practice has been analysed, together with the key events and learning from the practitioner's facilitated workshop, which outlines the professional interaction, issues with guidance and safeguarding decision making in GH's case. The findings and lessons to be learnt are detailed within the Findings and Bracknell Forest SAR Overview Report and Agency Recommendations within Chapter 5. The following is a summary of agency involvement in the review and is not a replication of the analysed narrative above, as follows:

4.2 Agency Involvement

4.3 **Adult Social Care.** The allocated SW was part of the Adult Social Team (AST) of ASC responsible for supporting GH. The commitment and support provided to GH by his SW is captured in the narrative above. The SW's professional concern of GH's suicidal ideation was well founded. A question raised however, is whether previous concerns may have warranted a risk assessment earlier? From the information provided to this review, the reported concerns were being managed by ASC and in particular his SW as well as his housing provider, even though he had recently been served with a Notice of Seeking Possession (NOSP).

4.4 **Emergency Duty Service.** The BFC EDS is a service which aims to provide an emergency social work service outside normal office hours on behalf of the six unitary authorities in Berkshire. The objective of the EDS is to respond to emergencies where immediate social care intervention is required to safeguard a vulnerable adult or child.

EDS safeguarding proceeded well and in line with policy guidelines until there was difficulty in co-ordinating the Sec 135(1) warrant by the AMHP1 and TVP. There was a lack of professional curiosity in relation to risk when the warrant was not executed. EDS records AMHP2 closed the case to all services as police reported GH had not taken overdose. The quality of the handover between the two AMHPs and the reason to allow the warrant not to be executed until the following morning is unclear other than a requirement by AMHP2 for locality ASC to follow up.

There were no reported resource issues, described as an average evening of work for EDS. AMHP2 had another commitment on the night which should not have impacted on a decision to enact the outstanding warrant. EDS did not update CRHTT who attended GH's home two days later to follow up on GH's welfare, only to find he had died.

4.5 **Thames Valley Police.** TVP officers acted appropriately and efficiently to the request to conduct a safe and wellbeing check which, is referred by other agencies as a welfare check. The different terminology and an understanding of what action can be expected from making such a request is addressed in Communication at Finding 3. There was, however, an aspect highlighted in the narrative above regarding the TVP Control Room operator not informing the EDS, AMHP and SCAS immediately of the outcome of the safe and wellbeing check without SCAS having to make enquires with TVP Control. TVP confirm this is individual learning for the call operator which this review agrees is appropriate in the circumstances.

4.6 **Independent Office of Police Conduct.** The IOPC conducted a review as police had been in contact with GH shortly before his death and is normal required practice. EDS provided the IOPC with a transcript of a call which took place between SCAS and EDS SSW and had access to the TVP control room telephone tapes. Their TOR was to investigate:

- Whether TVP responded to the AMHP's call for assistance on 20 September 2018 in line with local policies and national guidance.
- Whether the actions and decisions made by the officers who attended GH's property were appropriate and in line with local policies and national guidance.

The IOPC report author and lead investigator further considered the following:

- What evidence is available regarding the nature and extent of police contact with GH prior to his death?
- What evidence is available in relation to whether the police may have caused or contributed to GH's death?

The IOPC investigation concluded they did not identify any evidence linking GH's death to anything the officers did or failed to do. The conclusion was evidenced within the IOPC report and is supported by the SAR Lead Reviewer having reviewed the IOPC report.

4.7 **Berkshire Healthcare NHS Foundation Trust (BHFT).** Their CRHTT treat people with severe mental health conditions who are currently experiencing an acute and severe psychiatric crisis that, without the involvement of the CRHTT, would require hospitalisation. They assist persons who may have psychotic episodes; severe self-harm and suicide attempts are also examples of acute mental health crises.

They responded positively when notified of the concerns from GH's SW. They attempted to contact him by telephone without success and then sent two members of staff expediently to GH's home. They spoke to him, but he refused entry. CRHTT staff reported the facts immediately for a proper assessment to EDS AMHP1 and appropriate safeguarding action continued. Unfortunately, when following up with GH's welfare two days later, having visited his home, found out he had died. They had not been informed by EDS of his death.

4.8 **East Berkshire Clinical Commissioning Group**. GH had been registered with his GP Practice since 15th November 2015 and had a medical history of peripheral vascular disease, a below knee amputation and a history of drug abuse. He was not a regular attender at the Practice and the main role the GP had was to prescribe and review his medication. The GP appropriately followed up concerns regarding GH who kept calling SCAS and communicated with his housing provider to check on him. The GP made an appropriate referral to Bracknell Forest Integrated Intermediate Care Services to request a rapid response community visit to assess his safety at home was faxed to the community hub (no response was received). The GP did not have any further contact with any other agency involved in supporting GH until the Coroner informed the Practice on 24th September 2018 of his death.

4.9 **South Central Ambulance Service.** There were no issues in this review for SCAS. On the night they were on standby and in communication with AMHP1 and TVP. They were not required to attend GH's home on the night. In the preceding days they attended his home on two occasions. Once as he reported a loss his of medication and he was taken to hospital as a precaution but returned home the same day and again due to a fall where he required help to get up but did not require being taken to hospital.

4.10 **Sheltered housing provider**. GH moved into his sheltered accommodation in a secure block of residential flats in October 2017. The management of the housing scheme had dealt with a

series of other residents' complaints as outlined in the background in Chapter 3 above. Due to repeated concerns and the breach of his tenancy agreement having been warned regarding abusive visitors, his dog fouling his accommodation and his sister and nephew staying in the property without authority, together with the possible concerns of potential drug taking on the premises, GH was served with a NOSP. The Housing staff however, still continued to support him and the DHM attended to help him on the morning of the 21st September 2018 when his care support worker found him collapsed and unresponsive behind his front door.

4.11 **Domiciliary care provider.** As GH's domiciliary care provider, they provided a package of care to GH which consisted of three visits a week on Mondays, Wednesdays and Fridays to provide personal care, housework, laundry and shopping. It was GH's care support worker who found him collapsed behind the front door of his flat and called the emergency services.

4.12 Practitioner facilitated workshop

4.13 A practitioner facilitated workshop was held and attended by agency practitioners involved in GH's case. The issues discussed were elicited from the analysis of agency submissions. Practitioners' views were taken into consideration and identified further analysis subject to the findings in this report.

4.14 All the issues and views raised have been, where relevant, incorporated within the narrative and learning of this SAR for GH. It was clear, the event confirmed, that practitioners only wanted the best outcome for GH and always offered him advice and support, but he did not always accept the help or advice offered.

4.15 It was clear there were confusing pathways for practitioners in relation to executing the Sec 135(1) warrant but there was agreed Inter-Agency Partnership Agreement from 2017 in place which was not followed to allow the smooth transition of a full assessment of GH's mental health.

4.16 The group came to the conclusion the Sec 135(1) MHA warrant should have been executed. It was recognised AHMP2 had another case on-going at the same time and gave it priority as TVP attended GH's home to establish he was alive, with SCAS on stand-by for the execution of the warrant which was not carried out.

4.17 AHMP2 closed the GH's case to EDS and left it open for the day CMH team to pick up in order to execute the warrant. It was felt AHMP2's recording of her decision making needed more clarity in readiness for the handover to the day team.

4.18 There was also recognition at the event how complicated this case was; it was in the middle of the night, with other cases in action and involved trying to co-ordinate all the relevant services to be in place at the same time.

4.19 It was also noted a previous SAR (AB nursing home in Bracknell Forest) discussed in Chapter 6, had contained a recommendation regarding general welfare checks. Police present agreed they are not qualified to make a mental health assessment. These checks are limited to visual and verbal contact only by the police (see comment in Para 3.40). TVP officers would expect to be led by the professionals who had obtained the warrant (the AMHP1 in this case). The safe and wellbeing check seems to have muddied the waters.

4.20 Good Practice

4.21 GH's Social Worker. His allocated SW showed professionalism and dedication which is evident from the narrative of this report. She provided a significant amount of support and escalated

concerns as soon as they arose. She recognised GH was a suicide risk and instigated the safeguarding procedures for GH, made herself available on the telephone, liaised with both CHRTT and AMHP1 and followed up in the morning, only to be informed GH had died.

4.22 CRHTT practitioners visited GH the same evening at his home to follow up but he refused to let them enter his premises. Safeguarding procedures were needed to be put in place and they passed his case onto the EDS for the immediate attention of an AMPH.

4.23 AMHP1 when informed of the SW's concerns for GH carried out a background checks, contacted CRHTT and the SW and made a successful application via Legal Services to a local Magistrate outlining the professionals concern of GH's mental health and possible suicide risk. He successfully obtained a Section 135(1) Mental Health Act 1983 warrant to effect entry to his home to conduct an assessment of his MH. He also arranged for a Doctor to be on standby and a hospital bed was made available for GH. He then contacted TVP and SCAS. This was extremely efficient safeguarding by AMHP1 but the complexity of arranging and co-ordinating the execution of the warrant that evening with other safeguarding partners and the confusion of communication and lack of a risk assessment complicated the safeguarding plan.

4.24 The GP Practice showed professional curiosity in following up GH's calls to SCAS and when unsuccessful trying to contact him, communicated with his housing provider to check on his welfare and to request GH to call the Practice.

4.25 **Resourcing issues**

4.26 There were resource issues for TVP but only due to the original grading of the request by AMHP1 for Police to confirm a timeline to execute the Sec 135(1) warrant. At the time of the request they were dealing with other calls requiring a more urgent response. AMHP1 on the third occasion having previously been asked if he had new information of concerns for GH upgraded his response and informed the operator GH may have already taken an overdose and was a suicide risk. He asked for a police welfare check. Within two minutes of the call on being given this fresh information, the police call operator sent officers to GH's home for a safe and wellbeing check, who arrived a short while later.

4.27 EDS informed the SAR they had an average evening's workload and no apparent resource issues. AMHP2 had another case as well as GH to consider that night.

4.28 **Specific areas of enquiry**

4.29 The TOR in Chapter 2 identified specific areas of enquiry for agencies and the SAR to consider and answer. Information provided from agency responses have been considered and the specific areas of enquiry have been addressed within the Analysis of Key Events in Chapter 3 and within this chapter and are subject to the Findings and BFBC SAR OV Report and Agency Recommendations within Chapter 5.

Chapter 5 - Findings and SAR Recommendations for the consideration of Bracknell Forest SAB

5 This chapter outlines the findings identified from the analysis of professional practice. They are produced for consideration by the BFC SAB to reflect and implement any learning from the review. The findings contain SAR Overview Report Recommendations that overarch, encompass and support Individual Agency Recommendations which have come from an analysis of the chronologies, summary reports and the views from the practitioner facilitated workshop. The Findings and SAR Overview Report Recommendations are as follows: -

FINDING 1 - Sec 135(1) MHA 1983 warrant applications and compliance to agreed guidance

What are the issues and what should be considered? Practitioners need to understand the complexity of co-ordinating the execution of Section 135(1) MHA 1983 (as amended 2007) warrants in order to understand roles, responsibilities and the guidance available. An Inter-Agency Partnership Agreement dated December 2017 outlines suitable guidance for East Berkshire Health Services including EDS and TVP which was not followed. AMHP1 had sufficient safeguarding concern to indicate GH was high-risk and vulnerable which satisfied a Magistrate to grant a Section 135(1) warrant. The guidelines, if followed, aid co-ordination by nominating a rendezvous point such as a designated police station or other suitable location for practitioners to meet in order to plan and execute the warrant. It also relies on full and accurate information being supplied and supervisors' oversight to aid communication.

The difficulty arranging a time for police attendance was not helped by the suicide risk not being upgraded by AMHP1 until the third contact with TVP. The AMHP1 then requested that the Police conduct a safe and wellbeing check on GH which police complied with immediately as his suicide risk was heightened. There was unclear decision making by the AMHP1 who stated the execution of the warrant was secondary, but GH's welfare was paramount, and he would make a decision once he obtained information from officers attending GH. The AMHP received a telephone call from the officers outside GH's address for an update. An opportunity for AMHP1 to attend the venue knowing police were on scene was not taken. The emphasis and confusion of executing the warrant changed as AMHP1 and the oncoming AMHP 2 appeared to rely on police having seen and spoken to GH for feedback to make the final decision as to the action to be taken. As there were no obvious signs of concern to police, the AMHPs informed police the warrant could be executed later the following morning. The police, other than checking on GH, have not the experience to assess a person effectively who may be suffering from anxiety, depression, possible mental health issues and suicidal ideation. AMHPs accepted the feedback as an alternative to executing the warrant. AMHP2, having received the feedback of no apparent concerns from police, closed the case shortly afterwards to EDS. This decision making was a missed opportunity to re-assess the risk, as a proper assessment was not carried out from the original action identified which may have protected GH that night and early morning. In order to ensure lessons are learnt the following recommendation is made: -

Recommendation 1 - Bracknell Forest SAR Overview Report Recommendation for Bracknell Forest Safeguarding Partners

It is recommended Bracknell Forest Safeguarding Adults Board is assured by all safeguarding partner agencies concerned in the execution of Section 135(1) MHA 1983 (as amended 2007) warrant, granted to assess the mental health of an identified vulnerable person, comply with the following instructions:

- **If a Section 135(1) warrant is granted by a Magistrate, it must be executed as soon as reasonably possible. If it is not be executed, a full risk assessment is carried out, the rationale recorded with agency supervision, oversight and agreement before any closure of the case.**
- **Police should not be requested to conduct a safe and wellbeing check as an interim measure instead of executing a Section 135(1) warrant. An AMHP should carry out the assessment with the identified Health Professionals and Police in compliance with the Inter-Agency Partnership Agreement dated December 2017. Clear instructions for the participating professionals of the action and decisions made must be recorded and applied.**

FINDING 2 – Governance and Supervision

What are the issues and what should be considered? There is a requirement for enhanced governance and supervision oversight in ensuring the effectiveness of action in conducting Sec 135(1) MHA 1983 (as amended 2007) warrants. Supervision is required to be enhanced to capture the wider picture of an individual's wellbeing and to ensure professional curiosity of action and non-action is displayed and the rationale is recorded. Learning from previous SARs must be known and learning applied in order to ensure previous findings do not keep repeating themselves.

In this case, a request was made for a police safe and wellbeing check on GH instead of executing a Sec 135(1) warrant due to the difficulty in co-ordinating professionals to execute the warrant. An Inter-Agency Partnership Agreement dated December 2017 to assist in such arrangements was not followed. An opportunity for AMHP1 to attend knowing the officers were at GH's address was not taken, deciding to wait for the police to feedback which was delayed by the TVP Call operator (Individual learning). By the time of the update, AHMP2 had come on duty. No suitable risk assessments were carried out by either AMHP1 or subsequently by AMHP2 to question further the outcome of the welfare check with police. AMHP2 acknowledges that in hindsight she should have questioned police more who had attended GH. The AMHPs had an over reliance on police to assess GH which is not acceptable considering the worrying concerns that he may commit suicide, prompting initial and efficient safeguarding action and preparation by professionals to obtain a warrant in the first place.

Supervisors and managers should be involved in the process. They should ensure professional curiosity is applied by practitioners in any decisions and actions made. At midnight the officers updated the control room they had spoken to AMHP1 and that he was not attending and nor was a doctor. They informed the control room AMHP1 had wanted to execute the warrant that evening, but he was rearranging for the morning. The decision, it is suggested, required supervision oversight to ensure safeguarding was in place. To ensure lessons are learnt the following recommendation is made:

Recommendation 2 - Bracknell Forest SAR Overview Report Recommendation for Bracknell Forest Safeguarding Adults Partners

It is recommended Bracknell Forest Safeguarding Adults Board are assured by all safeguarding partner agencies that supervisors will ensure staff comply with the procedures for the execution of Section 135(1) MHA 1983 (as amended 2007) warrant, granted to risk assess the mental health and wellbeing of an identified vulnerable person in order to provide the necessary support and care to include: -

- **Compliance to the Inter-Agency Partnership Agreement dated December 2017 is followed.**

- **Ensure professional curiosity and clarity of action and non-action is displayed, and if there is a change in an agreed safeguarding action plan, there must be a thorough updated risk assessment carried out with the rationale recorded for transparency.**

FINDING 3 - Risk Assessments

What are the issues and what should be considered? The supervision of risk assessments is mentioned in Finding 2 above. This review, however, has highlighted the need to remind all practitioners of the requirement to carry out a risk assessment of safeguarding action, if circumstances in assessing the mental health of a vulnerable person changes an agreed safeguarding plan. An updated risk assessment displaying professional curiosity must be made to ensure all known factors and possible risks are considered and acted upon to safeguard an individual, as in GH's case applying the six adult safeguarding principles (Chapter1).

There was a discussion within SAR meetings and at the practitioners' facilitated workshop that both the SW and CRHTT staff could have considered calling Police and SCAS to GH's home the evening before. Practitioners should be mindful of this fact and if they felt at that time, if a person had taken a drug overdose, then emergency services must be called. In this case, the professionals took a decision, having spoken to him, and their professional judgement was to follow up the safeguarding concerns as GH required a thorough assessment. Concerns were appropriately escalated from the SW to CRHTT and then to an AMHP. We know their professional decision to escalate was correct in the circumstances, as GH was still alive at the subsequent police safe and wellbeing check. The AMHPs in the case should have considered re-assessing GH's risk given the change in the action plan not to carry out the Sec 135(1) MHA warrant for him; there were missed opportunities.

The SW provided a significant amount of support and escalated concerns as soon as they arose. There was a question by ASC whether GH's case could have been predicted and responded to earlier by services, given his history and recent converging negative events? The evidence supplied for the short timescale of this review is clear; the concerns identified leading up to his death were being assessed and addressed by ASC, his SW, GP and other professionals. Whether issues further back in his background history may have identified an opportunity for an earlier intervention is not subject to the TOR outlined in this review. To remind practitioners to comply with available policies, procedures and guidance, the following recommendation is made: -

Recommendation 3 - Bracknell Forest SAR Overview Report Recommendation for Bracknell Forest Safeguarding Partners

It is recommended Bracknell Forest Safeguarding Adults Board are assured by all safeguarding partner agencies to the review that all staff are reminded of the need to comply with National and Local Safeguarding Adults policies and procedures, in the management of risk and the reassessment of risk as changes develop in a safeguarding plan, applying the six adult safeguarding principles, when dealing with a vulnerable person.

FINDING 4 - Record keeping and Communication

What are the issues and what should be considered? The record keeping and communication initially was followed and effective in identifying GH as high-risk, particularly to taking his own life by a drug overdose. An effective safeguarding plan was instigated which due to circumstances of the complications in executing the Sec 135(1) warrant and AMHP1 requesting police to conduct a safe and wellbeing check on GH confused the overall plan.

AMHP1 did not inform TVP Police Control and raise the suicide risk level GH may have actually taken a drugs overdose until the third contact. Police immediately upgraded their response and within two

minutes and during AMHP1's call sent a unit to GH's home. There were mixed messages given by AMHP1 which stated if GH had not taken an overdose the warrant would be executed, and he would quickly arrange of the attendance of a Section 12 Doctor and SCAS to assist with the assessment of GH. Yet having spoken to the police officers, who telephoned him from outside GH's home for the reason for the safe and wellbeing check before they saw him, he did not take the opportunity to go to the scene. In his handover to AMHP2 around midnight he explained they awaited the outcome of police having spoken to GH (which was not obtained until an hour later due to operator error) by which time AMHP1 had gone off duty. AMHP1 speaking to police at the scene had intimated and later confirmed by AMHP2, a decision would be to carry out the execution of the warrant later in the morning, so the Police, SCAS and EDS all closed the call. This decision was not apparently reassessed for risk and unfortunately, it came too late as shortly after 9am GH was found dead at home by his support worker. During this intervening period, GH remained unprotected.

The importance of language used by different agencies is extremely important, as terminology and different interpretations can affect subsequent actions as alluded to in the narrative above. Agencies need to clearly explain what they require when requesting a safe and wellbeing or welfare check to be conducted by police. Each agency needs to be aware of the others responsibility, capability, limitations and expectations of any action asked to be taken.

A subsequent EDS record check reported their last involvement with GH was when they had initially requested police attendance to execute a section 135(1) warrant and AMHP1 requesting an urgent welfare check due to concern GH may have taken a life-threatening overdose. Records further verify the AMHP 2 reported the police had said GH had not taken an overdose and the case was closed to all services including EDS. There is no clarity to this decision or rationale and is in contradiction of the original intent to execute the warrant. AMHP2 has acknowledged (with hindsight) perhaps she should have questioned TVP more closely on the night.

The fact GH had died was not shared with CRHTT who two days later carried out a follow up visit to GH's home. They had to contact EDS who confirmed the death. This review is of the opinion there is a need for clarity of the decision making, recording keeping and communication must be completed with clear instructions and a rationale recorded with the assessment of risk , with any change of agreed action to be taken recorded and communicated to all professionals involved in the safeguarding action plan, to ensure appropriate sharing of information.

CCG note it is not recorded if the GP made a safeguarding referral to the ASC on the day before GH's death and this is subject to CCG Agency Recommendation 2.

Recommendation 4 - Bracknell Forest SAR Overview Report Recommendation for Bracknell Forest Safeguarding Partners

It is recommended the Bracknell Forest Safeguarding Adults Board are assured by all safeguarding partner agencies they have robust and efficient recordkeeping systems in place where the rationale of decision making, handover of cases, changes of safeguarding action to be taken and outcomes of risk assessments are diligently recorded with relevant information expediently communicated to other interested parties to the safeguarding process with clear instructions. Language and terminology can have a different interpretation between agencies and can affect subsequent actions. Agencies when requesting action from another agency must confirm what they require and what can be expected from any action taken.

Agency Recommendations

5.1 Listed below are the individual agencies recommendations submitted to the SAR. Not all agencies identified learning however; the BFC SAR OV Report Recommendations above apply to all the agencies involved in the review process to consider.

5.2 **Berkshire EDS**

Recommendation 1. All EDS AMHPs have attended Group Legal Supervision to focus on the execution of S135(1) Warrants Out of Hours and the proportionality of such intervention. (*Recommendation completed*).

Recommendation 2. All EDS AMHPs are to attend a forthcoming Mental Health Report Writing Training Day.

5.3 **GP and East Berkshire Clinical Commissioning Group CCG**

Recommendation 1. GH's story should be presented as a case study in the Safeguarding Supervision programme for GP's to share good practice and learning across Primary Care.

Recommendation 2. The Primary Care Safeguarding Adults training programme should continue to provide GP's with information on how to liaise and refer to Adult Safeguarding teams; as well as referring to provider agencies at the time that the GP has assessed that the vulnerable adult is at risk.

5.4 **Adult Social Care** - No recommendations were made but posed a question: -

Could GH's concerns have been predicted and responded to earlier by services given his history and recent converging negative events? This has been addressed. **(See Finding and BFC SAR OV Recommendation 3 above).**

5.5 **Berkshire Healthcare Foundation Trust** - No recommendations.
Domiciliary Care provider - No recommendations.
Sheltered housing provider - No recommendations.
South Central Ambulance Service - No recommendations.
Thames Valley Police - No recommendations.

Chapter 6 – Conclusion

6.1 This SAR Overview Report for GH is the Bracknell Forest SAB response to his sad death. The SAB intend to prioritise and implement positive changes from the learning identified within the review to ensure lessons are learnt so GH's death was not in vain. A Bracknell Forest SB Action Plan will accompany this report for the promulgation of the learning for the safeguarding, health and wellbeing of other persons for the future.

6.2 Predictability and Preventability

6.3 It must be appreciated that dealing with vulnerable adults, often with additional complex needs, is a very difficult process for practitioners to contend with. This is particularly so when there may be added possible mental health and substance misuse concerns that can impact on their health and welfare. The need for agencies to co-ordinate an effective strategy to carry out the execution of a Sec 135(1) warrant as soon as reasonably is an absolute necessity. For a Magistrate to be satisfied to issue a warrant, having been satisfied by an AMHP of possible mental health concerns and the high-risk of suicide, the warrant should not be delayed but proceeded with unless there are significant reasons why it is not required to be executed following an appropriate risk assessment. In GH's case, the high-risk and the circumstances had not changed, even allowing for a police safe and wellbeing check who, were not qualified to assess the mental capacity of GH.

6.4 This review confirms practitioners wished only the best for GH and tried to work with him to provide care, advice and support. An opportunity to carry out the Sec 135(1) MHA warrant was reliant on the safe and wellbeing check by police and the opportunity to execute the warrant and safeguard GH was not taken. No additional risk assessments were carried out as circumstances changed. The Inter-Agency Partnership Agreement, 2017, approved to guide professionals in how to conduct and co-ordinate the execution of a warrant, was not followed.

6.5 On the information supplied to this review, GH's case remained high-risk from the emerging interaction with practitioners. The likelihood of a tragic outcome for GH was evident from the information supplied by the SW and AMHP1 on the evening before his death. It cannot be known for certain but it is suggested in GH's case that it was both predictable and preventable, certainly during the 24-hour period under review, as not executing the warrant to assess his mental health wellbeing failed to protect him. Learning from previous SARs (see below) must be applied in order to ensure previous findings do not keep repeating themselves.

6.6 Previous SARs

6.7 Previous SARs were reviewed and those relevant to GH's review and should be considered, are:

6.8 **Safeguarding Adult Review AB 2018.** AB was a retired district nurse who lived alone in the community. Unfortunately, she died in a house fire whilst in her bed in May 2017. The review found the risk was not adequately identified and dealt with. The Risk Framework alluded to in this report including a risk framework tool was developed and is now being rolled out to all other agencies, with the implementation of training and case studies. The recommendations relevant to SAR GH are:

Recommendation 1 - The SAB ensures there are policies and procedures in place (and that practitioners are aware of how to access such a pathway) for a multi-agency forum to review high risk or complex needs cases.

Recommendation 2 - A review of training is undertaken across agencies in terms of the Mental Capacity Act to ensure practitioners are clear that the assumption of capacity principle does not prohibit formal capacity assessments being undertaken.

6.9 **Safeguarding Adult Review West Berkshire Mrs. H 2016.** Mrs H was living in an annexe of her son's home. She had a private carer and safeguarding alerts at the time said that Mrs H had been hospitalised. She was described as being severely malnourished, needing blood fluids and feeding. Mrs H passed away in hospital in 2014. A finding of a lack of, or late, responses to professionals on outcomes of requested actions results in a mismatch of information and incomplete understanding of the levels of risk in decision-making. *(This mirrors GH's case. The Local Authority Risk Tool as stated above, has now been implemented).*

6.10 **Safeguarding Adult Review Leicester SAR Bert 2018**. The following learning was identified:

Key Learning 1 - The range of crisis care available post-midnight is very reduced. This caused significant delays in convening the Mental Health Act assessment. This resulted in a long delay for Bert to be assessed under the Mental Health Act and had an adverse knock-on effect for police who were waiting with Bert. (*This has similar elements and is a finding in this review, regarding the co-ordination of agencies*).

Key Learning 3. The review highlighted the importance of understanding different professional roles and responsibilities and the legal parameters in which professionals work. This enables clear communication of risk assessments and agreement over each partner's contribution to the risk management plan. (*The difficulty in arranging a time for the execution of the Sec 135(1) warrant and EDS requesting police to conduct a safe and wellbeing check in lieu of executing the warrant, mirrors the key learning and is subject to a finding in this review)*.

6.11 **Slough Domestic Homicide Review - Mr F November 2016 for TVP.** The following learning was identified:

Recommendation 2 - When Adult or Children's Social Care or any other statutory body request Police welfare checks, CR&ED should be reminded to record all information shared by the partner agency with justification for Police attendance and a level of defined risk; also, to specify exactly what is required of the Police during the welfare check.

Comment: *The above recommendation is relevant to this SAR. The Inter-Agency Partnership Agreement (December 2017) for TVP, East Berkshire Health Services, including EDS and ASC should have addressed this recommendation. In GH's case, compliance to the guidance was not applied.* (See Chapter 5).

6.12 **Submission of Overview Report**

6.13 This SAR Overview Report for GH is submitted to the Bracknell Forest Council SAB to consider the findings and recommendations and to promulgate necessary learning through the SAR Action Plan that will accompany this report.

Appendix 1 – Bibliography

The following legislation, documentation and guidance was consulted for the process of completing this SAR (see also inserted footnotes for additional review and research material): -

Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board Annual Report 2017-18

Bracknell Forest and Windsor & Maidenhead Multi-Agency Safeguarding Adult Policy and Procedures

Bracknell Forest and Windsor & Maidenhead Multi-Agency Risk Framework February 2019

Local Government Association 'making safeguarding personal resources'

Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC

Care Act 2004, 2014

Equalities Act 2010

European Convention on Human Rights (ECHR)

Human Rights Act 1998

Inter-Agency Partnership Agreement for East Berkshire (December 2017).

Mental Capacity Act 2005

Mental Health Act 1983 Section 135(1) warrants

Review of previous SAR's (Chapter 5).

Appendix 2 – Glossary of terms

Accident and Emergency	A&E
Adult Community Team	ACT
Adult Social Care	ASC
Allocated Social Worker	ASW
Approved Mental Health Professional	AMHP
Assistant Team Manager	ATM
Berkshire Healthcare NHS Foundation Trust	BHFT
Bracknell Forest Borough Council	BFBC
Bracknell Forest and Windsor & Maidenhead	BFWM
Community Safety Team	CST
Drug, Addiction and Alcohol Team	DAAT
Crisis Resolution Home Treatment Team	CRHTT
Emergency Duty Service	EDS
Emergency Duty Team	EDT
General Practitioner	GP
Health Based Place of Safety	HBPOS
Housing Manager	HM
Independent Office of Police Conduct	IOPC
Lead Reviewer	LR
Local Authority	LA
Mental Health	MH
Mental Health Act	MHA
Mental Health Team	MHT
Notice of Seeking Possession	NOSP
Police Officer	PO
Royal Society for the Protection of Animals	RSPCA
Safeguarding Adults Board	SAB
Safeguarding Adult Review	SAR

Senior Social Worker	SSW
Social Worker	SW
South Central Ambulance Service	SCAS
Team Manager	TM
Terms of Reference	TOR
Thames Valley Police	TVP
Unique Reference Number	URN