CITY OF YORK
Safeguarding
Adults Board

7 Minute Briefing

Safeguarding Adults Review

MR A

THE ADULT

Mr A was born in South Africa, he moved to Sydney, Australia as a young man then returned to South Africa and attended Johannesburg University to study mathematics, chemistry and physics, but did not complete the degree course. He reportedly worked for a period of time as laboratory technician. His family, an older brother and sister lived in London. Both his parents died in the 1970's.

THE BACKGROUND TO THE REVIEW

Mr A suffered periods of ill mental health as a young man whilst travelling to different countries. Mr A was admitted to an Acute Psychiatric Hospital in London in 1971 following an episode of mental illness in which he attempted to take his own life. In 1973 Mr A was transferred to an Independent Hospital in York where he remained for the next 45 years. Mr A's care was funded privately by a Trust fund which had been set up by his parents. He was diagnosed with paranoid schizophrenia in 1971, which remained his diagnosis throughout his life. During the last 15 years of his life, care records referred to a likely diagnosis of Autism however a formal assessment was not completed. Mr A was detained under the Mental Health Act up until 2014 when he was discharged from this by his clinician and a standard authorisation under Deprivation of Liberty Safeguards (DoLS) was put in place until September 2015, he was then further detained under the Mental Health Act until his death in September 2020. In 2017 a large-scale safeguarding enquiry highlighted some concerns about Mr A's care within the scope of the impact of ward refurbishments but did not fully explore the concerns of neglect. Mr A's presentation and behaviour often challenged those who were tasked to provide care for him.

WHAT HAPPENED

In 2018 the Independent Hospital announced the decision to close their inpatient facility. Plans were put in place to review all patients, and this included Mr A. This brought Mr A to the attention of Health and Social Care services. Mr A's allocated social worker raised concerns and referred his case for a Safeguarding Adult Review. Of particular concern was the length of time he had been detained; whether there were missed opportunities where a less restrictive pathway could have been followed; and whether his rights were safeguarded. The Review found numerous occasions where safeguarding procedures could and should have been initiated due to institutional neglect. The paid Relevant Person's Representative (RPR) under the DoLS process had consistently recorded that Mr A had looked grubby, dishevelled and unkempt over the course of six visits in 11 months between December 2014 and November 2015. In September 2016, the psychiatrist who undertook the DoLS medical assessment commented that Mr A was showing evidence of gross neglect, matted hair and beard and that he looks like a vagrant. Hospital staff appeared to have concluded themselves that the placement was inappropriate but felt unable to act on this due to the opposition of Mr A's family to any changes. Mr A was transferred to a second Independent Hospital following the closure of the facility in York. During the short time in the new facility, records evidenced that Mr A experienced a reduction in distressed behaviours, fewer episodes of restraint and improved socialisation than previously. The team were beginning to consider discharge planning just prior to Mr A's untimely death in September 2020.

KEY LEARNING POINTS

ONE

1: Those who self-fund in private healthcare facilities have limited opportunity for independent oversight of the quality and suitability of their care provision. There is a positive obligation on the state to protect the rights of individuals who may be deprived of their liberty within private arrangements and apply an appropriate level of scrutiny to those arrangements. The role of the paid RPR or person representing P is to maintain contact with the person subject to DoLS and to support and represent them in relation to an authorisation. Case law has established that this means the RPR should be willing to request a review or take the case to the Court of Protection if necessary: **https://www.courtofprotectionhub.uk/cases/aj-v-a-local-authority-2015-ewcop-5**

TWO

2: Communication with Mr A was lacking; suggestions of reasonable adjustments were not pursued. Practitioners are directed to the Mental Capacity Act (2005) Principle 2: 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.' Best Interest Assessors (BIAs) should take appropriate steps to enable communication with the person, in order that their voice is clearly heard, and their choices and wishes are firmly established when completing capacity assessments and making best interests' recommendations.

THREE

3: DoLS practitioners (Liberty Protection Safeguards in the future), including BIAs, doctors and advocates, are reminded of the importance of raising issues of concern during DoLS assessments and visits, and the importance of raising safeguarding concerns where issues of abuse or neglect may be evident. Safeguarding enquiry officers should have access to all records including DoLS assessments to ensure that the appropriate conclusions are drawn and outcomes achieved for the individual in line with making safeguarding personal.

FOUR

4: The outcome of an approach that was more attuned and sensitive to the impact of Autism on Mr A enabled more trusted relationships to form, improved socialisation and fewer episodes of distressed behaviour. Autism is a life-long condition. Consideration needs to be given to the impact on the individual, especially where other complex co-morbidities exist. Commissioners and providers of health and social care services are asked to consider how services align to the needs of people with Autism. Where complexities exist professionals should satisfy themselves that they know how to escalate concerns and where to get help.