7 minute briefing

Anthony

Safeguarding Adult Review

Background

Anthony was a 58 year old Black British man and described by family as having a long history of mental health problems over 15 years. In July 2017 he had a collapse which involved him hitting his head and having some form of seizure. In 2018 Anthony was under the care of the Home Treatment Team following a suicidal overdose. Also at this time he also split from his partner and moved into a Holiday Inn where his behaviours continued to get more erratic and there was an alleged further suicide attempt. In 2019 Anthony suffered a stroke and his daughter was very concerned about his welfare and following the stroke in 2020 he was diagnosed with frontal lobe syndrome however, he did not meet the criteria for transfer to neuropsychiatry services and it was unclear if any alternative plan was considered. He was discharged from hospital into the community with limited support. In mid 2020 he was admitted to the Bethlem Royal Hospital and at the end of 2020 he was discharged to his own flat with support from the Trust and then a Lookahead support worker and his GP. In June 2021 contact was lost with Anthony and after visits by the family, the police were called and Anthony was found dead in July 2021.

Key Learning

- The most specific concern is the adequacy of the ongoing support he received at points of transition in his care.
- The interface between safeguarding and mental health under a Section 75 agreement. It was not possible to track what action was taken in response to the safeguarding concerns that agencies raised.
- Anthony's family were concerned about their level of involvement and the degree of support available to them. This picture is complicated because he placed limits on the sharing of information with family.
- A gap in the care pathway for people with lower level, but nonetheless significant, cognitive damage.
- The SAR raises questions about the use of the Mental Capacity Act. In particular, the importance of considering executive capacity.
- The need for clear leadership in the care of complex clients: i.e. a care coordinator and ongoing multi-agency management

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Good Practice

Most professionals appear to have worked appropriately with him within the framework of their individual disciplines. Some of the work with Anthony was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and to maintain services during that difficult period. Some of the IMRs received, e.g. from the Mental Health Trust, the General Hospital Trust and the Police were very open and honest about practice and how it can be improved.

Two specific points of good practice did emerge: His GP Practice was positive in supporting Anthony in the last months of his life after discharge from Mental Health Services and the local user led voluntary organisation Hear Us appears to have built a good relationship with Anthony at one point in his care.

Recommendations

A. Croydon SAB needs to reassure itself that the local General Hospital Trust, Mental Health Trust and Adult Social Care have clear pathways and procedures at each point of transition in care and that there is training to support practitioners to support people through transitions.

B. Croydon SAB should seek assurance from those reviewing the local Section 75 agreement, that they are considering the concerns highlighted in this SAR (and other local SARs), e.g. about the recording of action in response to safeguarding concerns.

C. Croydon SAB should request both the Mental Health and General Hospital Trusts to review whether a care pathway is required for people with significant cognitive impairment but which is at a level that does not meet the current Neuropsychiatry criteria.

D. Croydon SAB should seek assurance from all partners that guidance and training is available to support professionals to use the Mental Capacity Act. In particular this should include reminders about the importance of considering executive capacity.

E. Croydon SAB should ask all key partner agencies to ensure that they have guidance and training to support professionals who are working with individuals who are refusing family involvement. This will include how to escalate concerns about this and if appropriate work consistently to encourage family involvement as much as is possible.

F. Croydon SAB should seek assurance that all professionals in relevant partner agencies are aware of the need for clear leadership in the care of complex clients: i.e. a care coordinator and ongoing multi-agency management and Croydon SAB should continue to raise awareness of the potential role of the local Risk and Vulnerability Multi-agency Panel.