Adult E

Brent Safeguarding Adults Board

Report for the Coroner's Inquest

17th October 2019

Independent Reviewer: Fran Pearson

Section 1

Introduction by Professor Michael Preston-Shoot

I have been the Independent Chair of the Safeguarding Adults Board (SAB) in Brent since June 2016. I am also the Independent Chair of a SAB in another London borough. I have overseen a number of Safeguarding Adult Reviews (SARs) in both areas. My background is in social work and academia. I have authored a number of Safeguarding Adult Reviews and Serious Case Reviews across locations in England where I have no connection and can evidence my independence.

I introduce the SAR into the case of Adult E, who passed away aged 83. He died in tragic circumstances after leaving his extra care accommodation and was found deceased approximately ten weeks later in an outer London borough. His case was referred to the Safeguarding Adults Board in the final part of 2017 and the Board accepted that his case met the criteria for a Safeguarding Adult Review in that there was reasonable cause for concern about how the SAB, members of it or other persons worked together to safeguard the adult and Condition 1 of Section 44 of the Care Act 2014 had been met:

Condition 1 is met if -

1. a) the adult has died, and
2. b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

In January 2018 the Safeguarding Adults Board then wrote to the agencies involved, requesting chronologies of their involvement in Adult E's case. I met with both of Adult E's daughters in May 2018 to discuss the purpose of a Safeguarding Adults Review as laid out in the Care Act 2014 and the accompanying statutory guidance. Both daughters communicated to me at the time that they hoped that any inquest would not be long in concluding and that their priority was wanting agencies to learn lessons from Adult E's case in order to avoid a similar event taking place in future. Both also informed me that they wished to be active participants in the review process.

An Independent Reviewer was selected by the Board who I met with in June 2018. The reviewer that was selected has a social work background and is an experienced SAR author. The reviewer is also an Independent Chair of both Safeguarding Adults and Safeguarding Children Boards in other areas. The reviewer indicated during our preliminary meetings and discussions the particular methodology she wished to adopt in this case. This model involved setting up a panel of professionals that would meet on a regular basis with the reviewer. This model would also involve undertaking at least one multi-agency 'Learning Event' where the case would be discussed, information shared, practice challenged and learning points agreed. The planned learning event and the panels would enable the reviewer to test theories and open them up for challenge to all agencies at the same time to invoke practice discussions. The purpose of the panel and the learning event is to find agreement where documentation may be unclear or where there are polarised views.

Prior to panel and learning event taking place, as the Independent Chair, I supported the Independent Reviewer in communicating with the agencies in order to lay the foundations for the case to be discussed in a safe environment where professionals feel able to engage. I did this by promoting the Care and Support Statutory Guidance published by the Department of Health and Social Care during the early stages of the review. This guidance states that, "SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death". The statutory guidance goes on to say that, "this is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account". The guidance continues, "it is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing

of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial".

Both of Adult E's daughters were invited to contribute to the terms of reference for the review. As a result of this contribution the end point for the period under review was changed to 20th November 2017 to cover the period when their father's body was released to them by the Coroner. Specific focus was emphasised on the application of the Mental Capacity Act 2005 and on whether the package of care and accommodation in place was capable of managing the risks posed. The terms of reference were finally agreed in November 2018.

In terms of the timeframes for completion of a SAR, the statutory guidance states; "The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings". The first panel was held in the Summer of 2018 with a second panel held in the Autumn of 2018. This represented the time where the Safeguarding Adult Review was formally initiated. The first learning event was planned for early 2019.

During the early Autumn of 2018, the Safeguarding Adults Board became notified that the Inquest into the death of Adult E was likely to be held at short notice. However, the proposed Inquest at that time was delayed. During the following weeks, the scope of the Inquest widened. I understand that this was a decision made by the presiding Coroner at the time. Following this, concerns began to be shared by some of the SAB partners regarding whether they could fully engage in the learning event, openly and in a transparent way; given that any information provided may not be used solely for the SAR but for other purposes for which it was not intended. These concerns followed the widening of the Inquest and receipt of notice that other proceedings might be initiated by the family once the Inquest had concluded.

The concerns expressed to me by partners led to a further delay to the learning event being arranged and required the Board to reflect on how best to proceed in ensuring the lessons of the case are learned. I met with Adult E's daughters in May 2019 to update them as to

these events and explain that the SAR would have to proceed in a different way to that which was agreed during our first meeting. I explained the rationale for this and I believed that this was understood at the time.

In order to ensure that the SAR progressed, the Independent Reviewer was asked within the terms of reference to prepare the SAR using the information that has been provided to date. Partners were not asked to engage in a learning event or provide any further information. The Court will be aware that as the SAB is an Interested Party, some new information was shared with the Safeguarding Adults Board. As the Independent Chair I considered whether it would be appropriate to include this new information in the Safeguarding Adult Review and I discussed this with the Independent Reviewer. We agreed that as this information was shared with the Court for the purposes of the Inquest and not for the purpose of the Safeguarding Adult Review, this additional information would not be used within the Review at this time. Therefore this report has been prepared by the reviewer by accessing chronologies and using the initial information obtained from the two panels which took place, one interview with the Social Worker and one interview with Adult E's daughters.

The report that has been produced is an analysis by the Independent Reviewer of the information provided. The report makes recommendations to the SAB regarding the key lines of enquiry for the SAR to ensure that lessons are learned in relation to supporting adults with dementia in the community. Once the Inquest has concluded, the Board will consider how best to further investigate these key lines of enquiry and disseminate the resultant learning.

Section 2

Why this Review was commissioned and the Care Act Requirements

2.1 A summary of Adult E's case

2.1.1 Adult E was a sociable and energetic man from the African-Caribbean community. He had worked for London Underground and was used to being 'out and about'. He was rooted in one part of Brent where he had lived for 40 years before being diagnosed with Lewy Body dementia in late 2012. The combination of declining memory but being unusually fit and active for someone in the second half of their 80s, were the two crucial factors in the

risks for Adult E. These risks were well understood by his two daughters, who had Lasting Power of Attorney for Finance, and for Health and Welfare.

2.1.2 Adult E became increasingly at risk in his home of 40 years and in the summer of 2015, in response to consensus about risk between Adult E's daughters and his professional network at the time, it was agreed he would move to a different sort of housing, with the aim of reducing this risk. This was a scheme managed by a social landlord, as flats of which each older person was a tenant. However, care and support was part of the arrangement and this was delivered by another organisation. For the rest of this report it is referred to as 'Extra Care Housing' or 'the scheme'.

2.1.3 The recurrent and most concerning risk for Adult E was that of leaving his home and going missing. Following his move to new accommodation this continued. In the period under review he went missing [1]20 times. Professional activity and actions by Adult E's daughters, concentrated on responding to and reducing the likelihood of these missing episodes. It seems from CCTV footage that Adult E left the scheme at 11pm on 3rd August 2017 for the final time. He was not carrying his keys with a GPS tracker which was one of the pieces of 'geofencing' technology provided by professionals in response to risk. Very sadly, Adult E's body was found on 19th October 2017.

2.2 The Care Act 2014 and why the threshold for a Safeguarding Adults Review was met

2.2.1 The Independent Chair's introduction sets out why Brent Safeguarding Adults Board initiated this review under Section 44 of the Care Act 2014.

2.2.2 Safeguarding Adults Reviews should reflect the six safeguarding principles of the Care Act 2014

Empowerment: people being supported and encouraged to make their own decisions and give 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

[1] Source: Metropolitan Police *BACKGROUND AND REVIEW OF MISSING EPISODES*

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

2.3 Statutory Guidance on approaches to carrying out Safeguarding Adults Reviews and how far this process has met them. The Independent Chair's introduction has commented on these issues but below is further independent comment on how far the process has been able to meet Statutory Guidance

2.3.1 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learnt from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council. [2]

2.3.2 **Comment:** This approach underpinned the commissioning of the original SAR. The amended process means that the Independent Reviewer is able to list what did not work for Adult E and to acknowledge that he liked living at the scheme and that his family and professionals recognised this and tried to minimise risk there. But currently there is no basis that enables an account of why professional practice was at it was, and subsequently to make recommendations about learning that takes this into account.

2.3.3 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty and sharing to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.[3]

2.3.4 **Comment:** The approach to this SAR has not included the opportunity to do the usual accompanying work to build trust and encourage honesty and sharing because of the impact of parallel processes. This report is based on the Reviewer's interpretation of

[2] Care and Support Statutory Guidance s14.126
[3] s14.127

database entries without local perspectives to balance this and give an account of the local context.

2.3.5 The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. We do not believe a one- size-fits-all approach is an appropriate response. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of people who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB. [4]

2.3.6 **Comment:** The commissioning of this review was originally planned entirely in line with the specific circumstances of this case but subsequently had to be managed differently. The follow on is untested as it is yet to be agreed. The issue of family involvement is considered below.

2.3.7 When the SAB has decided to arrange a SAR it should appoint one or more suitable individuals to lead the SAR. The SAB should have evidence that those who are appointed are sufficiently skilled and experienced in adult safeguarding matters. The lead reviewer(s) will chair the SAR. The lead reviewer(s) should be independent of the SAB and the organisations involved in the case. [5]

2.3.8 **Comment:** the Lead Reviewer meets these criteria.

2.3.9 The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were Involved with the adult. [6]

2.3.10 **Comment:** this has not been possible.

2.4 Involving Adult E's family

2.4.1 The Care and Support Statutory Guidance quoted above (s14.128) sets out that *The focus [of a SAR] must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of people who have died or been seriously abused or neglected*.

[4] 14.128.
[5] 14.129.
[6] 14.130.

2.4.2 Adult E's daughters met with the Independent Reviewer at the start of the Review process. The meeting was intended to be one of several during the course of the Review process as envisaged at that time. The focus of the meeting was on hearing their initial thoughts and questions about the process and gathering what might be important for them to see included in the Terms of Reference.

2.4.3 In the chronologies there are many references to emails, meetings and telephone calls with Adult E's daughters, reflecting their involvement with their father but also indicative of the amount of time and anxiety that arose for them from the risk to their father. Police records in particular give an account of quite regular instances of calls to Adult E's daughters to say he was missing. Adult E's social worker said that Adult E liked his home at the Extra Care Housing scheme and that his daughters and professionals all recognised this and consequently tried to address the risks to him there so that he did not have to leave. At the same time his daughters were aware that there were other options and were waiting to visit a new scheme that was only at the stage of being built, to see what this might offer, should their father have to move again.

2.4.5 Adult E's daughters gave a strong sense of the deterioration in their father during 2017. This fits with the entries in chronologies but their description is striking: *there were periods of calm, there was a settled spell, then it was like a switch was thrown.* They gave an account of how they viewed their father's right to his liberty as his mental capacity declined, with one daughter recalling a 'candid conversation' with the social worker about Deprivation of Liberty and that she 'was open to that'.

2.4.6 Adult E's daughters also highlighted issues that are not visible in the chronologies. The key dates table below includes reference to 1:1 activity commissioned to try and occupy Adult E so he did not go out as much. According to his daughters this had unintended consequences. A recurrent risk was Adult E leaving his tracking device at the scheme because it was attached to his key fob. At home, before the move, Adult E used to reliably ask for his keys, so a fob was a viable device. 'The 24 hours [ie the 1:1] commissioned care per week had the consequence of undoing this certainly'. His daughters continually asked staff to charge the device correctly and to make sure Adult E had his keys. The importance 'was not filtered to the day-in-day-out team – so didn't appreciate it'.

2.4.7 Also invisible in the chronologies but important to Adult E's daughters, was the allocation of a social worker to their father. It is not absolutely clear but looks from the chronologies that the allocated worker was a consistent presence for at least 18 months, leaving at the end of March 2017. A second social worker was allocated on 11th June 2017 [7]but the hiatus of 'being in a pool' [of cases] was frustrating for Adult E's daughters.

Section 3 Terms of Reference

3.1 The period under review and rationale for this

3.1.1 The Independent Chair's introduction sets this out.

3.2 Agencies involved with Adult E in the period under review

Brent Council
Registered Care Provider in LB Brent
Landlord managing the accommodation in LB Brent
GP services
London Ambulance Services
The Police (Metropolitan and British Transport Police)
Care Quality Commission
Community Mental Health arrangements that support people with dementia in the community (such as memory clinics or mental health outreach teams)
Public Guardian

3.2.1 The Office of the Public Guardian and London Ambulance Services were not initially approached to contribute chronologies to this Review, therefore their perspective is not currently present in any way.

3.3 Data used

3.3.1 The main source of data for this report was the chronologies provided to Brent Safeguarding Adults Board at the start of the Review. These were requested on a standard template, provided by Brent Safeguarding Adults Board onto which agencies extract and enter the date and type of information that they recorded about an individual. The period under review has been stated above but some agencies included entries from their systems

[7] Brent Council Chronology

prior to this date, selected and included because it informed an understanding of the context for Adult E and professionals' response to him. The chronology is a standard tool in safeguarding reviews but usually it supplements a variety of other data and opportunities to interpret that data.

3.3.2 There is a column in the Brent template for agencies to make initial comments or register their thoughts about possible practice issues. Below I have indicated the extent to which any of these reflective comments were included. For the number of entries there is only a small proportion of reflective comments to assist the reviewer. In addition these comments reflect the view of the agency that generated the chronology and do not necessarily reflect the view of Adult E's case that other agencies took. The example I give later of a meeting that one agency thought was called to pursue a "Best Interests" discussion with Adult E, and the other chronologies simply describe as 'a meeting' illustrates the difficulty of working from chronologies without context and discussion. The Care Quality Commission and Metropolitan Police provide data to all reviews in their own format. The table below indicates what each agency submitted.

AGENCY	**Number of entries on database extracted for chronology**	**Number of entries in the 'author's comments' column**
GP Services	46	3
Adult Social Care	169 entries	16
Care Provider – Extra Care Housing scheme	104	19
Building Landlord – Extra Care Housing scheme	19	Zero
Adult Mental Health	11	3
Metropolitan Police	61 page document *BACKGROUND AND REVIEW OF MISSING EPISODES*	This appears to be a collation of all recording by officers of their case work. It contains opinions and reported conversations. There are some discrepancies with reported totals of missing episodes and some dates

		are either mis-numbered or out of sequence but is the case recording on 15 or 16 missing episodes during the period under review and the attempts to locate Adult E following his final disappearance
The Care Quality Commission	Spreadsheets for the following standard CQC reporting headings for any review: Chronology Timeline Whistleblowing Safeguarding Records Ratings Inspections Breaches Complaints Compliance inspections Notifications	'No data available' for Whistleblowing, Breaches, or Compliance inspections (with the comment 'all old methodology inspection records' for the last of these). Not all the data included relates to Adult E. However within the chronology sheet there is included a record of an inspection within the review period, on 4 & 7 July 2017

3.3.3 Two additional pieces of data were used:

Notes of an introductory meeting with Adult E's daughters.

Notes from a discussion with the allocated social worker who had been working with Adult E for two and a half months at the time of Adult E's final disappearance.

3.4 Overarching or 'Research' Questions for Consideration in this Review

3.4.1

1. How well does the local safeguarding system respond to the needs of adults whose risk and vulnerability is increasing? Where possible comment on the effectiveness of Reactive systems; eg Merlins, Safeguarding Referrals, Missing Person alerts and Proactive systems eg contract monitoring and care reviews.

2. What is the ability of professionals to respond in a timely and proportionate manner that also understands the role of families in these situations? Where possible, comment on the added complexity when family members hold the legal authority to make decisions.
3. How does the adult safeguarding and care management system in Brent understand, and support the application of, the Mental Capacity Act? What weight is given to this in comparison to all the other competing factors in the system?
4. How well do professionals in all relevant settings apply and understand the Mental Capacity Act in LB Brent?
5. What is the current rationale behind use of either residential care or extra care housing for older people with dementia? In both types of settings, is there learning that could be applied to commissioning of appropriate levels of support for tenants (extra care housing) or: residents (care home settings) that is not static but is dynamic and has implications for everyone who lives in that setting, as well as the professionals providing the services.
6. Is there any learning in terms of how local organisations work with the regulator (CQC) in supported living / extra care / people receiving care in their own homes?
7. What is the role of the landlord in the supported living model when risks are escalating?

3.4.2 Where possible, based on the evidence already obtained the Board would like the Independent Reviewer to identify barriers to best practice and, where possible, compile a list of multi-agency recommendations that could be implemented to assist the SAB in:

- Developing a strategy to ensure that the escalating numbers of people with dementia within the borough are able to live their lives free from abuse and neglect.
- Reduce the risks to individuals whilst appropriately maintaining the balance of care vs control.
- Make suggestions as to where joint working should be improved to ensure a multi-agency approach to safeguarding high risk individuals.

3.5 Parallel processes

- The inquest into Adult E's death has yet to commence.
- There are no NHS Serious Incident processes in relation to Adult E.

- There are no known further unconcluded processes such as disciplinary cases or complaint investigations.

3.6 Timeline of key dates

Date	Episode	Source
7th February 2015	In response to increasing risk to Adult E at his flat of many years, Adult Social Care organised an assessment for Extra Care Housing for him on this date. This had been preceded by repeated instances of him going wandering, 20 of which involved the Police. Additionally there were reports, followed up by the Police, that his flat was on occasion used by people who he had not invited in, and who may have used drugs there.	Brent Council chronology; Police *BACKGROUND & REVIEW OF MISSING EPISODES*
17th February 2015	The first mention of Lasting Power of Attorney. It occurs in the context of the request for Extra Care Housing being 'declined' by an allocation or funding panel. Case recording says 'To explore alternative options with family as they have LPA'.	Brent Council chronology
17th April 2015	A case note refers to emails between Adult E's allocated worker and one of his family members and Extra Care Housing is again to be explored.	Brent Council chronology
26th May 2015	First mention of the Mental Capacity Act – Adult Social Care give information about the "MCA process" to one of Adult E's family members.	Brent Council chronology
27th May 2015	There is a safeguarding meeting and Mental Capacity Assessment completed.	Brent Council chronology
9th June 2015	There is a recorded conclusion about Adult E's Mental Capacity in relation to his accommodation '[Adult E] does not have capacity in relation to where he lives / care needs'.	Brent Council chronology
26th June 2015	Adult E has now been approved for Extra Care Housing but the scheme, where he eventually moves, do not	Brent Council chronology

	want to accept him as they believe his needs to be too high.	
3rd August 2015	Adult E moves into the Extra Care Housing scheme. There is no record that gives a clue as to whether the care provider's concerns were acknowledged or responded to.	Care Provider chronology
26th September 2015	First Police Missing report following move. Police contacted by care staff in the first instance. Adult E had made his way across north London and the staff in a kebab shop called the police, concerned there was 'a male in the venue very confused'. The Police in that borough take him to the local Police Station, and a care worker collects him.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
23rd Oct 2015	Adult E registers for GP services.	GP services chronology
late October 2015	From the outset of Adult E's tenancy at the Extra Care Housing scheme, Brent Council's chronology has reference to his daughter expressing concerns about the tracking device that was used. In response, a new GPS system is put in place. This is the next mention of Lasting Power of Attorney and of Mental Capacity and the first reference to Best Interests in the context of the Mental Capacity Act .'Person with LPA to agree geofencing in best interests'.	Brent Council Chronology
1st November 2015	Police Missing report, Police contacted by care staff in the first instance. Adult E is found the same day.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
3rd November 2015	The second reference to a 'Best Interests' decision in respect of Adult E. The context is that the GP felt it necessary to refer Adult E for a medical issue and assessed him using the Mental Capacity Act 2005, concluding that Adult E lacked the capacity to agree to	Brent Council Chronology

	this referral, so sought, and was given, consent from Adult E's daughter the following day.	
24th November 2015	Police Missing report. The care staff have not reported this.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
22nd December 2015	Differing opinions, none of them Adult E's, about how well the placement is going. Adult E is reported by the care provider as having walked 3.5 miles away as 'he would not respond to staff… stated cannot manage community support any longer'. Meanwhile the same council recording system entry says '[his daughter] reports placement going well'.	Brent Council Chronology
27th December 2015	Police Missing report. The care staff have not reported this and Adult E was 'found wandering'.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
29th December to 31st December 2015	Memory Service reopen Adult E's case having been involved with him for a period that ended in 2012, in response to concerns from the GP who wrote a referral letter on 29th. New assessment takes place on 31st December.	Adult Mental Health Chronology; GP Services Chronology; Brent Council Chronology; Care Provider Chronology
31st December 2015	Summary by psychiatrist: Risk of wandering appears high. His GPS tracker has proved ineffective (he does not wear it at times) and main entrance door is easily accessed by a push button. We have recommended that he have an identity bracelet. Staff supervision remains essential to reducing this risk.....both I [the psychiatrist] and [the Primary Care Dementia Nurse] do not feel that his placement … can contain the real and active risk of his	Adult Mental Health Chronology

	wandering behaviour. Therefore I have proposed that a best interest meeting be arranged with social services, [Adult E's] family and his current care team to look at his placement needs.	
18th January 2016	Discrepancies and differences in perception and purpose of a Multi Agency meeting - attendees Primary Care Dementia Nurse and Psychiatrist, manager of care service (the post-holder was changing around this time), Adult E and his daughter and the social worker.	Adult Mental Health Chronology; Care Provider Chronology; Brent Council Chronology
21st February 2016	Police Missing report. Police contacted by care staff in the first instance. Adult E is found by Police and returned home the same day	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
28th April 2016	Police Missing report. Police contacted by care staff in the first instance. Adult E goes missing twice on the same day. ***[not possible to cross reference on the integrated chronology created from those of the Council / Adult Mental Health/ Care Provider and building landlord]***	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
29th April 2016	Police Missing report. Adult E is found wandering, not reported by care staff.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
13th May 2016	First entry in Care Provider's chronology which makes any mention of Adult E going missing.	Therefore no basis for author to understand Care Provider's rationale, response or assessment to any missing episodes prior to this date

14th May 2016	Police Missing report. Adult E is found wandering and a member of the public reports to Police. The Police take him home.' Not reported by care staff' according to Police.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
21st May 2016	Police Missing report. Adult E is found wandering by Traffic Police walking along the central reservation of a major London ring road. 'Not reported by care staff ' - who Police note were still unaware Adult E was missing at the point the Police took him home. The 'tracker tag' has been left at home.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
1st July 2016	Police Missing report. Police contacted by care staff in the first instance. Police bring Adult E home at 3am the following morning[8].	Care Provider Chronology and Police
4th July 2016	Adult E's daughter asked that family be involved in any future multi-disciplinary meetings and that the manager from the care provider and the social worker, 'discuss the matter' [this appears to refer to Adult E's most recent episode of going missing] with the GP.	Care Provider Chronology
8th July 2016	First recorded notification to the national care regulator, the Care Quality Commission of a Statutory Notification, by the Care Provider, again this appears to relate to the missing episode of July 1st.	Care Provider Chronology
22nd August 2016	Care Plan review meeting involving one of Adult E's daughters, care provider manager and social worker. Adult E's situation appears to have 'stabilised'.	Care Provider Chronology
18th September 2016	Adult E's case is put onto 'annual review' by the local authority. On the same day that records refer to a transfer summary being completed by the social worker, the chronology entries for the care provider	Brent Council Chronology

[8] There is more than one police record which appears out of sequence and therefore is not included in the key dates because it is placed in sequence for one year but dated another.

	and the local authority both reference a protocol that was emailed between the social worker, care provider manager and one of Adult E's daughters for Adult E's absences from the scheme.	
October 2016 till March 2017	The only recording in any chronology is continued references to whether or not the GPS is working properly. It is possible that this is a more 'stable' or 'quieter' time for Adult E.	
24th March 2017	Occupational therapist assesses for a temporary GPS device with a temporary device being delivered on 31st and a permanent one ordered for set up on 4th April (no confirmation of this in records of any agency).	Brent Council Chronology
3rd April 2017	"Last care plan drawn up for [Adult E]. A special risk assessment addressing wandering risk (undated, but believed to be around May) was appended later)".	Brent Council Chronology
21st May 2017	Adult E goes missing - and for the remainder of May and throughout June, July and August 2017 there are email or telephone exchanges on average every other day, between Adult E's family, the care provider manager, and Brent Council about addressing the increasing risk of his going missing and responding to episodes when he does leave the building, which include the Police as well. The care provider manager repeatedly states that Adult E cannot safely live at the scheme.	Police *BACKGROUND & REVIEW OF MISSING EPISODES;* Brent Council Chronology; Landlord Chronology; Care Provider Chronology
30th May 2017	Police Missing report. At 11pm at night, members of the public call the police because they are concerned to have met Adult E who 'could not tell them his name and could not remember where he lives'. In the first instance not reported by care staff.	Police *BACKGROUND & REVIEW OF MISSING EPISODES*
23rd June 2017	A new social worker is allocated to Adult E and there are either one or two meetings – that same day and / or on 26th. This /these take place at the scheme and involve the social worker, the care provider manager,	

	one of Adult E's daughters, and the team leader from the organisation managing the building. 'the care provider manager had called this meeting to discuss the concerns around [Adult E's] wandering. It was agreed to install a door sensor to alert staff when [he] leaves his room. It was also agreed to request a blood test as it was thought infection might have caused increased wandering risk. The Care Provider chronology contains a note that 'we don't ever seem to have received minutes'.	
26th June 2017	Meeting and first mention of Deprivation of Liberty Safeguards – the context is a meeting between the social worker, Adult E, Adult E's daughter, and the care provider manager. Case records state: [Adult E] wandering 4/5 times per week. Police do not have resources to keep bringing him back, has been away for 2 days, always needs someone to bring him home, daughter agreed to DoLs and not going out unsupervised, either needs to move from [scheme] or greater obstacles at [scheme] to prevent him going out.	Brent Council Chronology
Remainder of June and all of July	Email exchanges within Brent Council and between different combinations of Adult E's daughters, the social worker, commissioners within the Council, and the care provider manager about the possibility of altering the door entry mechanism in order to make it harder for Adult E to leave.	
23rd July 2017	Reference to Deprivation of Liberty – Care Quality Commission's local inspector follows up on one of the care provider's notifications of Adult E going missing and reportedly reminds the provider manager that they cannot unlawfully restrict Adult E.	Care Provider Chronology

July 2017	This month sees the first case note recording for over a year by the organisation managing the building that the scheme is in. The area manager requested a quote from 'door entry system contractor'. The record says that this quote was not progressed by the time Adult E went missing. And the comment is made in the text of the case note (although not in the 'comments' section of the chronology, so it is unclear if it is being made with hindsight) "This request may not have been agreed in any event due to DoLs concerns."	Building management company chronology
2nd August 2017	The care provider manager raises a safeguarding alert to the dedicated team at Brent Council. There is reported agreement that a placement review would be a good idea but the safeguarding alert is not pursued 'as not abuse' - 'NFA' (No Further Action).	Brent Council and Care Provider Chronologies
3rd August 2017	Adult E goes missing for the final time. As reported to the Police 'one of the night duty [staff] saw him in his room at 22:45 hours… he was then discovered not in his room at 0800 hours on August 4th'.	
14th August 2017	The Care Quality Commission publishes its report of an inspection visit of the care provision on 4th and 7th July. Overall rating for the provider – Requires Improvement with the following domains: is the service safe? Requires Improvement; Is the service effective? Good; Is the service caring? Good; Is the service responsive: Good; Is the service well-led? Requires Improvement.	CQC Chronology
23rd October 2017	Family members telephone Brent Council to report that their father was found dead the previous day.	Brent Council Chronology

Section 4 Lines of enquiry to take forward

1. **How well does the local safeguarding system respond to the needs of adults whose risk and vulnerability is increasing? Where possible comment on the effectiveness of Reactive systems; eg Merlins, Safeguarding Referrals, Missing Person alerts and Proactive systems eg contract monitoring and care reviews.**

4.1.1 It is not possible on the basis of chronological information about one individual, one introductory conversation with family members, and one social worker, to answer a systemic question. No data provided gives any indication of quality, approach to, and effectiveness of any of the mechanisms listed above or the multi-agency contribution to them. However from the data available, Brent SAB could follow up the lines of enquiry below:

Risk and missing episodes

4.1.2 Based on the experience of Adult E's daughters at the terribly distressing point when Adult E's body was found by Hillingdon Police, one line of enquiry is for Brent SAB to ask how well the Police liaise across boroughs, and how relatives' experiences inform learning in the Met about responding with compassion in these very difficult circumstances. The Herbert Protocol is a national scheme introduced by the police in partnership with other agencies which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. The Metropolitan Police use this and Brent SAB could ask how often it is used in Brent and whether there is anything that can be learnt from other police forces – for example Bedfordshire Police have worked with local Alzheimer's Society groups to further refine the process with carers, but there will be other examples and indeed there may be other existing initiatives in the Met.

4.1.3 Brent SAB could follow up a number of lines of enquiry linked to risk assessment and adults with dementia who go missing. This could begin to answer some questions about proactive and reactive systems. In Adult E's case for example, a next step in the review would have been to ask for a copy of a protocol for his absences which was seemingly developed around August 2016, and to establish the extent to which this had involved his daughters and whether it was developed based on a Brent policy of the time. A further question could be why, seemingly, this protocol did not involve the Police, which is inferred by its being emailed to Adult E's daughters and the care provider manager, from the social worker. The Police appear from a cross-referencing of their report with other agencies'

chronologies, to have been central to responding to episodes when Adult E went missing, and more reliable at documenting them than the care provider.

Safeguarding Referrals

4.1.4 It is of note that 2nd August 2017, despite the level of risk attached to Adult E's situation, appears to be the one and only recorded time after his move to the scheme that a safeguarding referral is made – by the care provider manager. The Council chronology contains, in the case record column 'NFA [No Further Action] to safeguarding as not abuse. Advise review of care.' As there is no comment in the column of the chronology allocated for reflection / analysis, there is no indication of what lay behind this response. However any agency could have made a safeguarding referral for Adult E at any time and asking the question about why this did not happen earlier, or on more occasions, is an additional and related line of enquiry that Brent SAB could pursue.

Multi-agency meetings

4.1.5 Meetings and discussions with family members are a central part of assessing risk and planning how to be proactive in the case of adults who go missing. In Adult E's case, a total of three meetings which included one or more family members, are recorded in the local authority, the care provider, and the mental health trust chronologies. There are no additional multi-agency meetings recorded.

> **January 2016** – the meeting described by the mental health trust but no other agency, as a Best Interests Meeting.
> **August 2016** – a Care Plan review meeting which concluded that Adult E 'seemed to have stabilised' and that 'wandering risk was being … controlled'.
> **June 2017** – a multidisciplinary meeting called by the care provider manager to discuss concerns around Adult E's wandering.

4.1.6 However, the same chronologies indicate regular exchanges of emails and telephone calls between Adult E's daughters and professionals. A next step in the review process would have been to obtain minutes of these meetings in order to assess the weight given to family opinions, and to have further discussion with Adult E's family, as well as the professionals involved, in order to ask how they perceived the meetings and email exchanges.

4.1.7 As mentioned elsewhere a next step in the review process as originally envisaged would have been to ask for the minutes of these meetings. Records of meetings have value in establishing whether everyone in attendance had the same view of what the goal was. One difference in understanding is explored in the section on Mental Capacity in relation to the January 2016 meeting. However, it is noted that according to the care provider's chronology, they did not receive minutes of the third meeting listed above (June 2017) and the SAB might want to explore the way in which written notes of multi-agency meetings are distributed and with what consistency.

4.1.8 For the care provider, a possible line of enquiry is to explore their recording of episodes when Adult E went missing. The significance of this is that understanding of risk relies on accurate documenting of level and type of risk. In the Key Dates table it has been pointed out that the Police had already recorded instances of Adult E going missing after he moved to the scheme in August 2015, before the first recording in the care provider's chronology which is not until May 2016. The Police information provided to this review has some dates that appear out of sequence but nonetheless they note each instance on which they found Adult E, and yet the care provider had not reported him missing. This raises questions about the awareness at the scheme that Adult E had gone missing and when to report and record such instances. It is possible that care staff were aware he was not where he was expected to be, but did not understand their responsibilities – maybe because these were not clearly set out by the care provider management. More troubling are the occasions when his absences were not noticed.

2. What is the ability of professionals to respond in a timely and proportionate manner that also understands the role of families in these situations? Where possible, comment on the added complexity when family members hold the legal authority to make decisions.

4.2.1 From the available information it is not possible to reach any conclusions on an issue that is, as the question identifies, so complex. Chronologies only indicate at what time certain professional actions took place. Adult E's family members and the social worker who was allocated to him at the time of his death, all indicated that this is the right question to be asking and to be keeping central to the review. At the outset of the review there was every intention of returning to further develop that conversation with Adult E's daughters.

4.2.2 The same was true of an initial conversation with Adult E's social worker that indicated the value and respect he placed on the representation of their father's wishes by Adult E's daughters. Brent SAB could ask, as a next line of enquiry, how confident professionals feel in working with families who have Lasting Power of Attorney; what their understanding is when they work with families who are in this position; and what proportion of relatives have Lasting Power of Attorney either for Finance and/or for Health and Wellbeing.

3. How does the adult safeguarding and care management system in Brent understand, and support the application of, the Mental Capacity Act? What weight is given to this in comparison to all the other competing factors in the system?

4.3.1 From the available information it is not possible to respond to a question about a system or weigh up comparative factors. However, the Best Interests principle in the Mental Capacity Act 2005 (the Act) states that any act done or decision made on behalf of an adult lacking capacity must be in their best interests. The chronology entries about the meeting of January 2016 show striking differences of perception in the three agencies involved about both the purpose and outcome of that meeting in relation to the concept of Best Interests.

4.3.2 The mental health trust entry describes the meeting as a Best Interest meeting; this expression is not used by either Brent Council or the care provider. The entries about what was achieved are as follows:

- Care provider: Agreed with all (including family) that [the scheme] was suitable and that the situation would be reviewed in three months.
- Mental Health Trust: 'Concerns Highlighted- high risk of wandering also discussed - concerns that current placement is not secure enough to prevent wandering and associated risks e.g patient getting lost, exploited, vulnerable to weather and exploitation.' There is then a note of the plan (primarily based on increased scheduled activities) that will be put in place. However the analysis / reflection column contains the comment: 'No evidence of assessment of [Adult E's capacity to decide where he was placed or his thoughts or wishes... No evidence in clinical records that principles and standard relating to making a best interest decision on

behalf of an individual who lacks capacity were followed. This may however be on social services records in their role as "decision maker" for [Adult E]'.

- Local authority: the note on the content of the meeting was 'Agreed to try different activities, find external carer… [The scheme] will continue to care for him. Review in 3 months' and the reflection on the meeting is 'Least restrictive options considered though other options maybe not fully explored'.

4.3.4 These chronology entries reflect very different levels of understanding and application of the Mental Capacity Act principles of Best Interests and least restrictive options. That variation could be the starting point for a line of enquiry by Brent SAB.

4. How well do professionals in all relevant settings apply and understand the Mental Capacity Act in LB Brent?

4.4.1 It is only possible to reference and make tentative comment on the points in the period under review when the Mental Capacity Act was applied but not to comment on 'all relevant settings in LB Brent'.

4.4.2 In chronologies, the absence of references to the Mental Capacity Act and its application could perhaps say as much as the instances where it is included. A first line of enquiry for Brent SAB could be to explore whether there were other instances in Adult E's case where professionals might have considered use of the Mental Capacity Act

4.4.3 On 27th May 2015, before Adult E moves to the Extra Care Housing scheme, the first Mental Capacity Act assessment is completed by either an employee of Brent Council or their contractor. 'No note here about the outcome of the MCA, [Adult E's] views or wishes and no form uploaded on the system'[9].

4.4.4 The Mental Capacity Code of Practice is clear that capacity to make decisions and understand information is specific to time and place,

- *Whenever the term 'a person who lacks capacity' is used, it* ***means a person who lacks capacity to make a particular decision or take a particular action for***

[9] Brent Council Chronology entry for 27/05/2015

themselves at the time the decision or action needs to be taken. *This reflects the fact that people may lack capacity to make some decisions for themselves, but will have capacity to make other decisions.*

4.4.5 Consequently Brent SAB could explore what was meant on 9th June 2015, by the local authority's conclusion that "Adult E does not have capacity in relation to where he lives / care needs" yet without any apparent updated assessment, it is not clear from the chronologies how later assessments of capacity were made and in turn connected to escalating risk.

4.4.6 The GP carried out a Best Interests assessment before referring Adult E for a medical procedure – the SAB could consider promoting and sharing practice such as this that appears in line with the Mental Capacity Act Code of Practice and use it as an opportunity to explore what might help professionals in longer term situations that need reassessing.

5 What is the current rationale behind use of either residential care or extra care housing for older people with dementia? In both types of settings, is there learning that could be applied to commissioning of appropriate levels of support for tenants (extra care housing) or residents (care home settings) that is not static but is dynamic and has implications for everyone who lives in that setting, as well as the professionals providing the services.

4.5.1 The national 'SARs Library' of 118 published Safeguarding Adults Reviews (23/09/2019), only includes two from extra care settings. Neither contain any analysis that could help answer the question above. The extra care provider organisation, eROSH, would be a possible source of information on these issues as might a specific request to the national SAB network or via the contacts of Brent SAB partners. Brent SAB could follow up on these lines of enquiry.

4.5.2 A second line of enquiry relates to a potentially under-used tool that could respond to dynamic risk in the case of adults with dementia, including those who go missing - a 'Community Deprivation of Liberty Safeguard'. In interview, Adult E's social worker mentioned an instance of its use in Brent, and suggested that there could be actual or perceived barriers around the volume of 'paperwork' and length of time involved in setting

one up. A line of enquiry for Brent SAB would be to explore the use and feasibility of Community Deprivation of Liberty Safeguards and whether they open up opportunities to manage dynamic risk in extra care schemes. Since the time when Adult E was most at risk in extra care, planned changes around Liberty Protection Safeguards have been consulted on and currently approach the implementation stage. These significant requirements mean that there is an obligation as well as an opportunity to change the system in Brent.

4.5.3 The Brent Council chronology contained relatively few references to the commissioning function of the local authority, which is not unexpected given that the case notes are nearly all about operational social work. The review process, as originally intended, included local authority commissioners in order to explore what the Council's rationale has been in developing the two types of provision referred to above, and what the experience of tenants with dementia in extra care has been in recent years. The Brent SAB could follow this up as a line of enquiry.

6 Is there any learning in terms of how local organisations work with the regulator (CQC) in supported living / extra care / people receiving care in their own homes?

4.6.1 Based on the information in the chronologies, the first recorded 'Statutory Notification' from the care provider to the CQC came after Adult E went missing at the start of July 2016. This raises a line of enquiry again about appropriate **recording** of missing incidents by the provider, as there may not have been clarity about when to make one of these notifications. It might be useful for Brent SAB to do some work around shared understanding of the concept of **'Statutory Notification'** in conjunction with the CQC. Thirdly, the SAB could test out, mutual **understanding of roles and responsibilities** of the regulator and agencies in Brent.

7 What is the role of the landlord in the supported living model when risks are escalating?

4.7.1 It has not been possible given the approach to creating this report, to seek the view of the landlord for Adult E on this question, nor any agencies in the review or partners of Brent SAB. However the following lines of enquiry could be pursued by Brent SAB, using information in the landlord organisation's chronology

4.7.2 The importance of case notes has been flagged up earlier as a line of enquiry in relation to the care provider. However the lack of entries by the landlord is striking compared to other agencies. This may be entirely appropriate but asking about this might help to answer the question about the role of the landlord. Aside from a record of Adult E signing his tenancy agreement, and a note that the social worker has copied a Review Plan to them in November 2015, there is no recorded action by the organisation until 19th July 2017 when the landlord requested a quote from a contractor for the door entry scheme.

4.7.3 The same chronology entry for 19th July 2017 in relation to the quote for the door entry scheme concludes 'This request may not have been agreed in any event due to DoLs concerns.' Without further exploration, although it seems likely the 'DoLs concerns' related to Adult E, the concerns from the landlord perspective might have related to other tenants being restricted as a unintended consequence. Because landlords of extra care schemes are essential in agreeing to changes to the building, the SAB might want to test out, in any future work around Mental Capacity, the specific issues for those landlords in relation to Deprivation of Liberty in the light of their responsibilities to all their tenants at a scheme.

Section 5 Recommendations to the SAB regarding the key lines of enquiry for the SAR to ensure that lessons are learned in relation to supporting adults with dementia in the community

In Safeguarding Adults Reviews, recommendations are typically developed collectively with the aim of reflecting the views of families and securing the buy-in of organisations who are party to the review. From the information provided, all seven overarching questions in the Terms of Reference appear to be important and relevant and therefore worth pursuing. The suggested lines of enquiry listed above could form a basis for engaging all the relevant agencies and Adult E's family, in order to gain an understanding of their perspectives and what they have learnt from this case, and to result in actions to improve the system.